

Glasgow City Health & Social Care Partnership

Monday 30th March at 10.00

In the City Chambers, George square, Glasgow

AGENDA

1. Minutes

To approve as an accurate record the Minutes of the Minutes
Meeting of the Shadow Board held on 23rd February 2015

2. Matters Arising (not otherwise on the agenda)

3. Integration Scheme

Paper

David Williams (Chief Officer Designate)

4. HSCP financial Governance Arrangements

Paper

Sharon Wearing (Head of Service Development)
Jeanne Middleton (Head of Finance)

5. Financial Plans (2015 – 2016)

Paper

Sharon Wearing (Head of Service Development)
Jeanne Middleton (Head of Finance)

6. HSCP Participation and Engagement Strategy

Paper

7. IJB Membership

Paper

David Williams (Chief Officer Designate)

8. HSCP Management Development Programme

Paper

David Williams (Chief Officer Designate)

9. Children's Services Developments GIRFEC

Presentation

Mark Feinmann (Sector Director)

Mike Burns (Head of Social Work)

10. Community Addiction Team Review

Presentation

Susannah McCorry Rice (Interim CHP Director)
Mike Burns (Head of Social Work)

11. Date of Next Meeting – 27th May at 0930 hours.

SHADOW HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD.

Minutes of Joint Board Meeting (DRAFT).

Glasgow, 23rd February 2015.

Present: Councillor Archie Graham (Chair); Peter Daniels, NHS GGC (Joint Chair), Bailie Mohammed Razaq and Councillors James Adams, Malcolm Cuning, Marie Garrity, Emma Gillan and Russell Robertson, Glasgow City Council; Trisha McAuley, Robin Reid, Rev Norman Shanks and Donald Sime, Board Members NHS GGC.

Also present: Mari Brannigan, Director of Nursing, NHS GGC; Ian Leech (staff representative SWS GCC); Alex McKenzie, Director, Glasgow CHP; John McVicar (carers representative); Peter Millar (independent sector representative); Ann Souter (patient representative); Shona Stephen (third sector provider organisations representative); and Sharon Wearing, SWS Glasgow City Council.

Apologies: David Williams, Chief Officer Designate; and Ros Micklem, Richard Groden, Andrew Robertson and Ken Winter, NHS GGC.

Attending: Anna Castelvechi (Clerk); Sybil Canavan and Isla Hislop, (NHS GGC); Mike Burns, Janette Cowan and Stephen Fitzpatrick (SWS Glasgow City Council); Hamish Battye, Sybil Canavan, John Dearden, Mark Feinnman and Fiona Moss, (Glasgow CHP); and Professor John Bolton.

1 Minutes of 26th January 2015 approved.

The minutes of 26th January 2015 were submitted and approved, subject to

- (1) the deletion at page 6 paragraph 6 of the phrase "However no response had been received and so", and
- (2) an amendment to the sederunt to include Mari Brannigan, Richard Groden and David Williams to those recorded as being present.

2 Development of Strategic Plan – Update noted etc.

With reference to the minutes of 17th November 2014, (Page paragraph) noting proposals for the development of a Strategic Plan for the Glasgow Health and Social Care Partnership, there was submitted a further report thereon by the Chief Officer Designate, advising that

- (1) 6 strategic planning groups had been established encompassing older people, mental health, disabilities, homelessness, addictions and

carers and representative bodies had been invited to nominate individuals to join one or more of the groups;

- (2) the development of the Plan was being coordinated through the Strategic Planning Forum which would report to the Executive Group prior to its consideration by the Joint Board, when it was established;
- (3) a revised timetable, as appended to the report, had been produced and consideration was being given as to how the public consultation process would be undertaken; and
- (4) alongside development of the Strategic Plan, work was ongoing to develop an integrated Performance Management structure which would evidence achievement of the statutory National Health and Wellbeing Outcomes, further guidance on which was expected from the Scottish Government later in 2015.

After discussion, the SIJB

- (a) noted the report; and
- (b) agreed that a seminar should be arranged for members to discuss the emerging strategic plan to include care group specific plans; and
- (c) agreed that members be provided with information regarding vacancies and nominations to serve on the strategic planning groups.

3 Delayed discharge plans and investment – Presentation noted.

There was heard a presentation by Stephen Fitzpatrick regarding delayed discharge plans and investment,

- (1) setting out the demographic and health context within which the health and social care system in Glasgow was operating;
- (2) providing detailed information on emergency admissions to hospital by the over 65 age group together with statistics on the number of bed days lost to delayed discharge;
- (3) advising that the new target for discharging patients who had been confirmed as fit to leave hospital was 72 hours and setting out progress on meeting that target;
- (4) describing current arrangements for intermediate care which were focussed on affording individuals the opportunity to remain in their own homes for as long as possible; and

- (5) confirming that in future there would be more emphasis on early identification of those at risk in order to pre-empt emergency admission to hospital.

After a full discussion, and having heard Professor Bolton regarding Glasgow's progress towards increasing the numbers of people being supported to remain in their own homes rather than being admitted into a care setting, the SIJB

- (a) noted the presentation; and
- (b) requested that the presentation document be circulated to members for information.

4 Development of Integration Scheme - Progress report noted.

With reference to the minutes of 26th January 2015, (page 4, paragraph 4) noting the arrangements and timescale for the production of a revised Integration Scheme, there was submitted a further report thereon by the Chief Officer Designate, advising that

- (1) the Shadow Board had previously considered versions 15 and 17 of the draft Integration Scheme, the latter of which had been presented to the Health Board on 20th January and to the Executive Committee of the Council on 5th February 2015;
- (2) the 18th version of the Integration Scheme had been produced as a result of comments from Health Board and following a meeting with civil servants and legal representatives from the Council;
- (3) changes made to the document, as detailed in the report were minor and technical and had been submitted to the Health Board's Director Corporate Planning and Policy for final comment, prior to its submission to the Scottish Government.

After consideration and having heard Alex McKenzie advise that further meetings had been arranged between the parties to finally conclude outstanding issues, and Donald Sime advise that his view was that at bullet point 2, workforce governance issues should remain in the main scheme and not be moved to page 5/6 of the document, the SIJB noted the report.

5 Integrated Care Fund - Update report noted etc.

With reference to the minutes of 26th January 2015 (page 5, paragraph 5) noting progress with the approval process for the Integrated Care Fund (ICF) in 2015/16, there was submitted a further report thereon by the Chief Officer Designate, regarding further discussions with the Third Sector on the ICF submission, advising that

- (1) the Chief Officer Designate had convened a further meeting involving officers from all four sectors who had been involved in the original discussions on the ICF proposals;
- (2) the meeting had concluded with progress on the following areas:-
 - (a) the development of governance arrangements on the implementation and performance of the ICF;
 - (b) confirmation of the establishment of a programme of work to take forward the Accommodation Based proposals;
 - (c) agreement on £471,000 of proposed expenditure options within the Early Intervention and Prevention programme and where responsibility and accountability for decision making on this sat, which was accepted to be within the Third Sector; and
 - (d) some further potential flexibility around the provision of 'Community Connectors' by the Third Sector;
- (3) subsequent to the meeting on 30th January agreement had been reached to
 - (a) increase expenditure on options with the Early intervention and prevention programme from £417,000k to £83,000; and
 - (b) the Community Connectors proposal being developed within the parameters set out in the accomodation based programme.

After a full discussion and having heard Alex McKenzie advise that formal agreement had now been reached with the Third sector to enable it to sign up to the bid document and Shona Stephen and Councillor Graham and after a full discussion, the SIJB

- (i) noted the report;
- (ii) thanked Shona Stephen for her efforts in securing the agreement of the Third sector to the bid; and
- (iii) requested that a report be submitted to a future meeting with details of the expenditure within the bid.

6 Publication of Board papers noted.

There was submitted and noted a report by the Chief Officer Designate advising that in the interests of openness and transparency it was proposed to make all previous and future shadow Board papers publically available on the Glasgow City Council and Glasgow CHP websites respectively.

7 Presentation on Locality Planning noted.

There was heard and noted a presentation by Mike Burns describing the development of Locality Planning and highlighting the challenges and opportunities which it faced in the future.

8 Next meeting date noted etc.

The SIJB noted that the next meeting would take place on 30th March 2015 at 1000 hours and that the 11th May 2015 meeting had been rescheduled to 27th May 2015 at 09.30 hours, both in the City Chambers, Glasgow.



Item No 3

30th March 2015

Glasgow City Council / NHS Greater Glasgow and Clyde Shadow Integration Joint Board

Report By: Chief Officer Designate

Contact: David Williams

Tel: 0141 287 8853 (ext. 78853)

Update on Integration Scheme

Purpose of Report: To provide an update to the Shadow Integration Joint Board on the development of the Integration Scheme

Recommendations: The Shadow Integration Joint Board is asked to:

- Note this report

Implications for IJB	
Financial:	None
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	None
Implications for Glasgow City Council	None
Implications for NHS Greater Glasgow & Clyde	None

1. Purpose

- 1.1 To provide an update to the Shadow Integration Joint Board on the development of the Integration Scheme

2. Background

- 2.1 The Shadow Integration Joint Board has previously considered versions 15 and 17 of the draft Integration Scheme, the latter of which has been presented to the Health Board on 20th January and to Executive Committee of the Council on 5th February.
- 2.2 Version 20 of the Integration Scheme was submitted to the civil servants on 16th March. This has been produced following comments made by the Health Board on the 20th January, the Health Board's Director Corporate Planning and Policy, and following a meeting that was held on 21st January with the civil servants and involving one of the Council's legal officer. There has also been a continuing dialogue and negotiation between the Health Board and the Council. Whilst version 20 has been submitted to the civil servants, there remains one area requiring agreement between the two Parties, namely the position on hosted services. This requires resolution by the 31st March in order to enable submission to the Scottish Ministers.

3. Current Position

- 3.1 The changes that are made from version 18 are as follows:
- Page 8 a bullet point inserted to reflect that the Integration Joint Board will be responsible for the planning of acute services working with the Health Board but that the latter will be responsible for operational delivery.
 - Pages 9-10 the 6.2 para on performance has been redefined in relation to the development of targets, measures and reporting arrangements following further input from one of the Council's legal officers.
 - Pages 13-14 movement of text relating to clinical and care governance from an annex into the report body.
 - Pages 16-17 some additional text inserted confirming that the Chief Officer has delegated responsibility for delivery of integrated services, except acute hospital services, with oversight from the Integration Joint Board. Also confirms that the Health Board Chief Executive is responsible for the operational management and performance of acute services and will provide the Chief Officer with regular updates on this.
- 3.1 At the time of writing, the Chief Officer Designate is awaiting a decision from the Chief Executives of Glasgow City Council and the Health Board on hosted services. A verbal update will be provided at the Shadow Board.

4. Recommendations

- 4.1 The Shadow Integration Joint Board is asked to note this report.



Item No 4

30 March 2015

Glasgow City Council / NHS Greater Glasgow and Clyde Shadow Integration Joint Board

Report By: Sharon Wearing and Jeanne Middleton

Contact: Sharon Wearing, Head of Service Development

Tel: 0141 287 8838

FINANCIAL PROCESSES AND PROCEDURES

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

Recommendations: The Shadow IJB is requested to note this report.

Implications for IJB	
Financial:	Sets out processes and procedures in relation to financial management and accountability.
Personnel:	
Legal:	
Economic Impact:	
Sustainability:	
Sustainable Procurement and Article 19:	
Equalities:	
Implications for Glasgow City Council	As above.
Implications for NHS Greater Glasgow & Clyde	As above.

1. Introduction

- 1.1 This report describes the work carried out to date on establishing a set of processes and procedures to determine the governance arrangements for a range of matters in relation to financial management and accountability within the Integration Joint Board (IJB).
- 1.2 Those matters which have been agreed so far are attached to this report, and further information will be brought to the IJB as it becomes available.

2. Background

- 2.1 In respect of the 6 local authorities within the NHS Greater Glasgow and Clyde area, a Technical Finance Working Group (TFWG) has been established to coordinate the task of producing the various papers which will form the basis of a set of guidance notes to assist the Partnerships in these financial management arrangements.
- 2.2 The TFWG is chaired by Lynn Brown, Executive Director Financial Services, Glasgow City Council, and is attended by senior officers of each of the 6 local authorities and NHSGG&C. 3 sub-groups were created, and each allocated a number of issues on which they presented papers to the TFWG for approval. Those papers prepared by Workstreams 1 and 2 will be combined into a single document, acting as a point of reference for guidance on the range of issues covered. Workstream 3 ran into resourcing issues, and much of their workload was taken up by the other 2 workstreams.
- 2.3 There remain a number of issues that have yet to be clarified. At the February meeting of the TFWG it was noted that there were a number of issues which are outstanding and subject to national guidance. These issues, and their current status, are noted below.
 - Treatment of VAT – the Scottish Government advises that they have finalised agreement with HMRC, and that material will be included in the revised IRAG (Integrated Resources Advisory Group) guidance to be issued to all partnerships in March.
 - Status of the IJB – the Scottish Government have provisional assessment from the Treasury that the IJB is a local government body.
 - Reserves Strategy – we can now formulate a reserves strategy on the basis of the above provisional assessment that the IJB will be a local government body.
 - Formal documentation of accounting treatment, the format of accounts (including structure of notes and content of accounts), and the treatment of support services – Scottish Government advice is that the IJB will need to produce accounts for 2015/16 irrespective of the date of commencement in the Strategic Plan. It is anticipated that these issues will be covered in the revised IRAG guidance.
- 2.4 Those papers prepared by Workstream 1, and which will be submitted to the Shadow IJB in due course, include:

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

2.6 Those papers prepared by Workstream 2 and approved by the TFWG are attached.

3. Recommendations

3.1 The Shadow IJB is requested to note this report.



Item No 5

30 March 2015

Glasgow City Council / NHS Greater Glasgow and Clyde Shadow Integration Joint Board

Report By: Sharon Wearing and Jeanne Middleton

Contact: Sharon Wearing, Head of Service Development, SWS

Tel: 0141 287 8838

2015/16 BUDGET

Purpose of Report: To outline draft budget available to the IJB for 2015/16 from NHSGG&C and Glasgow City Council.

Recommendations: The Shadow IJB is requested to note this report.

Implications for IJB	
Financial:	Draft 15/16 budget outlined below.
Personnel:	
Legal:	
Economic Impact:	
Sustainability:	
Sustainable Procurement and Article 19:	
Equalities:	
Implications for Glasgow City Council	15/16 budget approved 19 February 2015.
Implications for NHS Greater Glasgow & Clyde	15/16 budget will be approved in June 2015. Attached budget is indicative at this stage.

1. Introduction

- 1.1 This report outlines the draft budget available to the IJB for 2015/16 from NHSGG&C and Glasgow City Council. While the Council's 2015/16 budget was approved on 19 February 2015, the Health Board budget has yet to be approved. For the purposes of this report, therefore, the 2014/15 Health Board budget has been used, and total 2015/16 budget figures must be considered indicative at this stage.

2. Glasgow City Council

- 2.1 The Council's budget was approved at the full Council meeting of 19 February 2015. The Social Work element of that budget, excluding central support charges, amounts to direct departmental net expenditure of £395.88m.
- 2.2 The 2015/16 Social Work budget incorporates a number of changes from the 2014/15 budget, the most significant of these being as follows;
- Various items within the Service Reform programme have reduced net expenditure by £8.1m.
 - Permanent budget transfers, mainly in respect of admin and clerical staff transferring from Social Work to CBS, have reduced net expenditure by £12.9m.
 - RSG redeterminations have increased the net expenditure budget by £2m.
 - Inflation in respect of pay and increases to Cordia rates has increased net expenditure by £2.67m.
- 2.3 Within the Service Reform programme, the undernoted items comprise the £8.1m referred to above:
- Shifting the balance of care for older people - £3m
 - Strategic review and reform of Mental Health Services to adults - £0.8m
 - Extension of mobile working across the Service - £1m
 - Framework tender for Personalisation - £1m
 - Strategic review and reform of Addiction Commissioned Services – £0.8m
 - Strategic Review and reform of Homelessness Services - £0.5m
 - Review of Transport provision - £1m
- 2.4 The approved Social Work budget for 2015/16, excluding central support charges, is shown at Appendix1.

3 NHS Greater Glasgow & Clyde - Health Revenue budget

- 3.1 At this stage work is near completion to finalise the CHP 2015/16 budget in line with the overall NHS Greater Glasgow & Clyde Health

Board financial plan. Final adjustments will be actioned in June in respect of 15/16 uplifts. The indicative CHP budget amounts to net expenditure of £614.4m

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

- The Change Fund, funding for which had been in the Board's baseline, has now been discontinued. That funding, together with additional investment from SG, will now support the new Integrated Care Fund. The net impact for Glasgow is an increase of £5.4m.
 - As part of the Barnett consequential funding in 2015/16, SG has provided £30.0m as a contribution to delayed discharges. NHSGGC's share of this funding is £7.1m of which Glasgow will be allocated £3.9m.
 - Pay provision: Current indications are that a provision of 1.0% for pay uplift in 2015/16 is reasonable. On top of the 1.0%, provision has been made for additional the additional costs of a £300 increase for staff earning up to £21,000.
 - Superannuation: A provision of £17.0m has been made for the recurring implications of the increase of 1.4% to 14.9% in employers' superannuation contributions.
 - Prescribing cost growth projection for 2015/16 is based on initial indications from the Board's Prescribing Advisers. This work is well underway and final amounts will be finalised over the next period.
 - Other costs inflation: 1.0% general provision has been set aside for inflation on non-pay costs excluding prescribing costs, energy costs, and capital charges costs. In line with the allocation uplift, 1.8% has been set aside for inflation on Resource Transfer, legal / contractual cost commitments and inflation on amounts payable to other NHS Boards and Voluntary Organisations, related to SLAs agreements
- 3.3 In addition the CHP is required to finalise savings adjustments as part of its financial planning process. At this stage draft plans are currently being finalised within Partnerships collective service redesign programme to reduce net expenditure by £15m. This also includes a CHP local savings target of £3.2m.
- 3.4 The outcome of this work will be included within the final 15/16 revenue budget.
- 3.5 Additional detailed breakdown of individual costs at care group level are reported in Appendix 2 of this report.

4. Recommendations

- 4.1 The Shadow IJB is requested to note this report.

Appendix 1

Social Work budget 2015/16

Client Group	Employee Costs	Premises Costs	Transport	Supplies & Services	3rd Party	Transfer Payments	Capital Financing Costs	Gross	Other Grants	Customer & Client Receipts	Income	Net
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Community Care												
Addiction	6,575	148	73	183	12,185			19,164	5,129	644	5,773	13,391
Carers	484		5	10	1,220			1,719		93	93	1,626
Dementia	390	17	17	61	19,343			19,828	10,363	2	10,365	9,463
Older People	35,305	3,428	773	4,589	122,766	1,316		168,177	14,822	30,340	45,162	123,015
Fieldwork					33	15		48			0	48
Learning Disability	6,808	444	1,737	665	56,312	903		66,869	27,695	8,667	36,362	30,507
CC Management & Support	3,056		11	659	278			4,004		180	180	3,824
Homelessness	11,375	11,265	162	3,942	26,174	19,121	972	73,011	16,962	17,493	34,455	38,556
Physical Disability	1,718	630	67	691	21,201	5,628		29,936	2,668	4,363	7,031	22,905
Mental Health	4,153	15	33	117	16,882	92		21,292	13,426	1,929	15,355	5,937
Children and Families	46,478	1,615	1,559	3,552	75,078	1,712		129,994	659	389	1,048	128,946
Criminal Justice	11,475	450	93	2,571	1,974	52		16,615	17,949	635	18,584	-1,969
Fieldwork	6,108	2,929	116	416	45			9,614	1,218	365	1,583	8,031
Support Services	8,152	2,404	128	1,093	88			11,865	67	197	264	11,601
TOTALS	142,077	23,345	4,774	18,549	353,580	28,839	972	572,136	110,958	65,297	176,255	395,881

Appendix 2

Patient/Client Care Group	Pay	Non Pay	Family Health Services	Gross Expenditure		Income	Fhs Income	Total Income		Net
	£'000	£'000	£'000	£'000		£'000	£'000	£'000		£'000
Addictions - Community	4,430	404		4,834		(210)		(210)		4,625
Addictions - Hosted	9,709	7,710	5,368	22,786		(1,054)		(1,054)		21,732
Adult Community Services	19,954	2,543	38	22,536		(106)		(106)		22,430
Child Services - Community	12,653	896		13,550		(25)		(25)		13,525
Child Services - Specialist	24,505	2,766		27,271		(7,965)		(7,965)		19,306
Fhs - Gms			85,767	85,767						85,767
Fhs - Other	47		85,854	85,901			(8,016)	(8,016)		77,885
Fhs - Prescribing			117,766	117,766						117,766
Hosted Services	10,750	6,905	143	17,797		(655)		(655)		17,142
Learn Dis - Community	2,037	106		2,143						2,143
Learn Dis - Inpatient/Other	9,932	1,735		11,667		(774)		(774)		10,893
Men Health - Adult Community	14,196	3,496		17,693		(50)		(50)		17,643
Men Health - Adult Inpatient	44,968	19,017		63,985		(4,291)		(4,291)		59,693
Men Health - Elderly Services	16,994	8,741		25,735		(867)		(867)		24,868
Men Health - Other Services	27,495	5,778		33,273		(10,729)		(10,729)		22,544
Other Services	8,994	10,823	59	19,876		(594)	(1,167)	(1,760)		18,116
Planning & Health Improvement	4,071	2,478		6,549		(16)		(16)		6,533
Resource Transfer - Local Auth		63,736		63,736		(625)		(625)		63,111
Sexual Health Services	7,587	1,920		9,507		(817)		(817)		8,690
	£218,322	£139,054	£294,994	£652,371		£(28,777)	£(9,182)	£(37,960)		£614,411

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

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Section 1 - Management of Integrated Budgets - Guiding Principles

1. Introduction

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

2. Background

- 2.1 The Health and Social Care Partnership (HSCP) will be responsible for managing expenditure within allocated budgets. This responsibility is made more complex by the mix of different Health and Social Work budget categories which will be integrated to form the Integrated Joint Board's (IJB) overall budget.
- 2.2 Each IJB will be responsible for managing NHS and L.A. service budgets and will be accountable to each agency for the management of budgets allocated by them. Many of these service budgets will derive from general funding allocations and so will be governed by the Standing Financial Instructions/Financial Regulations of each agency on the application of budgets, however, some will also require to be managed in a different way and is detailed further in section 3.
- 2.3 This paper establishes a set of principles which will guide budget holders in the exercise of their budgetary management responsibility. This will require to be exercised within the context of the already established budget and service planning process currently operated by local authorities and NHSGG&C, and which will take account of the IJB joint strategic plan. IJB must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility (the Chief Finance Officer). The Chief Financial Officer (CFO) is the Accountable Officer for financial management and administration of the IJB. The Chief Officer has all other accountable officer responsibilities. The Chief Financial Officer's responsibility includes assuring probity and sound corporate governance and responsibility for achieving Best Value. Appendix 1 details the responsibilities.
- 2.4 In establishing these guiding principles, a number of considerations have been key.

These are:

- (i) Budget responsibility should as far as possible, follow ability to commit resources/control expenditure CFO will have a key responsibility in ensuring that budget holders are fully aware of their responsibilities as budget holders.
- (ii) The need for policies and procedures in respect of control, routine monitoring and reporting of performance in line with local arrangements.
- (iii) The need to achieve delegation of responsibility to an appropriate level of financial stability, recognising the statutory responsibilities of local authorities and NHSGG&C to manage their budgets.

- (iv) The need to provide for the financial stability for services in the event of sudden changes in demand, to allow them to respond flexibly to such changes.
- (v) Where ring-fencing restrictions are in place, there may be limited scope for virement of these resources. This is discussed further in section 3 below.
- (vi) The need to have in place clear and proportionate arrangements which support effective service delivery within the budget available.
- (vii) The need to manage all aspects of the business of the IJB and the implementation of its strategic plans in a way which achieves best value in the use of its resources and safeguard its assets
- (viii) The SFIS/FRegs of each partner organisation and those of IJB will cover virement within and across agency boundaries. This is covered in more detail in a separate paper on virement.

3. Budget Categories

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

These are as follows:

<u>Category</u>	<u>Description</u>
------------------------	---------------------------

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

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

3.2 Category 1 - Directly Managed (DM)

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

3.3 Category 2 - Directly Managed Ring fenced

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

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

3.4 Category 3 – Managed on Behalf (MOB)

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

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

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

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

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

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

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

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

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

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

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

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

4. Risk Sharing Arrangements

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

- (i) Individual HSCP underspends and overspends will be pooled to arrive at a net overall position relative to overall budget.
- (ii) If (i) produces an overall overspend, this will be offset in the first instance against a joint general contingency which has been established by the HSCPs pre integration and held centrally by the Board. If this leaves a residual overspend, each HSCP will establish the scope for containing this within the totality of its service budget, before approaching NHSGG&C Board as a last resort to explore the scope for release of further funding on a recurrent or non recurrent basis as appropriate.
- (iii) if (i) or (ii) produces an overall underspend, this will be available for distribution to each HSCP on a pro rata basis, based on the proportion of its primary care prescribing budget to the overall consolidated total of HSCP primary care prescribing budgets.

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

5. Non Recurring Funding

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

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

6. Other Important Points

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

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

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

Management of Integrated Budgets – Guiding Principles

The Chief Financial Officer in a public service organisation:

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

To deliver these responsibilities the Chief Financial Officer:

- must have access to appropriate financial information and analysis.

Core CFO responsibilities:

Developing and implementing organisational strategy

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

Responsibility for financial strategy

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

Influencing decision making

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

Financial information for decision makers

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

Value for money

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

Safeguarding public money

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

Assurance and scrutiny

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

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

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

Management of Integrated Budgets – Guiding Principles'

Budget Categories – Resources Controlled and Managed by the IJB

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

Section 2 - Budget Setting

1. Introduction

- 1.1 The legislation requires that the Integration Joint Board (IJB) produce a Strategic Plan which sets out the services for their population over the medium term (3 years). This Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan, which will comprise both the Integrated Budget and the notional budget, i.e. the amount set aside by the Health Board for large hospital services used by the IJB population.
- 1.2 This paper considers how the Integrated Budget may be determined, taking account of the need to consider existing financial plans of the Local Authority and Health Board, and is drawn largely from the IRAG Professional Guidance.

2. Determination of Budgets

- 2.1 The IRAG recommends that integration authorities undertake a shadow period in 2014/15, and that allocations in the shadow period should be based on the existing financial plans of the Local Authority and Health Board, including the planned efficiencies and consideration of recent financial outturn and trends in expenditure. This process must be transparent and the assumptions underlying the budgets must be available to all partners.
- 2.2 The IRAG also recommends that the financial performance of the Integrated Budget is monitored during the shadow period with full transparency so that all partners have a clear understanding of the cause and type (recurrent/non-recurrent) of variances and the remedial actions taken by the Local Authority and Health Board. They should have a clear understanding of the adequacy of the budgets in the financial plan for the following year and the assumptions on which they are based.
- 2.3 The initial payments to the IJB should be based on analysis of the shadow period in 2014/15 to provide the Local Authority, Health Board and IJB with reassurance that the delegated resources are sufficient to deliver the delegated functions. It should also consider the respective financial plans of the Local Authority and Health Board including full transparency on the budget assumptions and planned efficiency savings. These allocations should be tested against the actual performance in the shadow period and adjusted if necessary. Although not included in the payment, the analysis in the shadow period should include the notional budget for hospital services.
- 2.4 This is an essential part of the financial planning and management of the IJB and all partners must ensure clarity and transparency of information to allow the IJB financial officer, the Health Board accountable officer and the Local Authority Section 95 officer to carry out due diligence and develop confidence in the Integrated Budget.
- 2.5 The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. While the IRAG guidance advises that partners should aim to give indicative three year

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

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

- **Activity Changes.** The impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes;
- **Cost inflation.** Pay and supplies & services cost increases. Pay increases will largely be determined by national agreements. Some supplies & services cost increases will be influenced by contractual arrangements regarding uplifts;
- **Efficiencies.** All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Integration Joint Board, Local Authority and Health Board as part of the annual rolling financial planning process to ensure transparency;
- **Performance on outcomes.** The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Local Authority and Health Board;
- **Legal requirements.** Legislation may entail expenditure commitments that should be taken into account in adjusting the payment;
- **Transfers to/from the set aside budget for hospital services** set out in the Strategic Plan;
- **Adjustments to address equity.** The Local Authority and Health Boards may choose to adjust contributions to smooth the variation in weighted capita resource allocations across partnerships; information to support this will be provided by ISD and ASD;
- **Resource Transfer.** Some Social Work expenditure budgets will be funded by resource transfer payments. It is recommended that the Health Board continue paying resource transfer to the Local Authority and exclude it from its payment to the Integration Joint Board. The Local Authority would include in its payment to the Integration Joint Board the social work services funded by the resource transfer. It is assumed that an annual inflationary uplift will continue to be applied to resource transfer by the Health Board.

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

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

- 2.8 The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board.
- 2.9 The legislation will require that a direction should be in writing and must include information on:
- The integrated function/(s) that are being directed and how they are to be delivered; and
 - The amount of and method of determining the payment to carry out the delegated functions.
- 2.10 It anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction.

3. Overheads

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

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

- 4.1 The resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget of each Integration Joint Board. The legislation takes powers for Ministers to set this out in regulations. Each Integration Joint Board will be required to include in its strategic plan the capacity required from the hosted service by its population. It is recommended that the Chief Officer responsible for managing the hosted service take the lead in coordinating the Integration Joint Boards in development of their strategic plans for that service.
- 4.2 The purpose of the guidance, produced jointly by the Integrated Resources Advisory Group and the Joint Commissioning Steering Group, is to provide advice on;
- Implementing the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) and regulations in respect of the amounts to be set aside for those delegated provided in 'large hospitals',

- The treatment of hosted services included in delegated functions.

4.3 The guidance covers;

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

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

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

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

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

Section 3 - Development of Joint Financial Framework

Scheme of Virement – Revised for Integrated Joint Board (IJB)

1. Introduction

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

2. Background

- 2.1 The establishment of an IJB requires local NHS and local authorities' social work managers to take responsibility for the joint planning, resourcing, and delivery of services, lead by the Chief Officer supported by the Chief Finance Officer.
- 2.2 The retention of existing organisational frameworks in Scotland means that health boards and local authorities will continue to exist as separate legal entities with statutory responsibility for the management of the resources allocated to them under agreed governance arrangements of the IJB.
- 2.3 To support the establishment of joint working arrangements, there is a need to provide a scheme of virement for the IJB which will overlay the existing arrangements operated by both partner bodies, and work in partnership with them to provide an enabling framework to allow flexible use of resource across agency boundaries where this is required and appropriate in line with the joint strategic plan. The current mechanism used for resource transfer will be followed for this purpose.
- 2.4 In terms of formal reporting arrangements, existing schemes of virement within local authorities and Health Boards will continue to operate. The level at which virement requires approval of local authority Committee or Health Board will be determined by the various schemes of delegation, which will also identify any differences in the treatment of recurring and non-recurring virement.
- 2.5 The arrangements described below seek to provide this flexibility, but in doing so seek to guide the use of virement to secure the maintenance of financial stability within the new national context of IJB in partnership with Local Authorities and Health Boards.
- 2.6 In developing this framework, the over-riding consideration has been to provide an enabling framework which will promote the flexible use of resources in support of the achievement of service aims and objectives while maintaining overall financial stability for the IJB, Local Authority and Health Board.
- 2.7 Arrangements in respect of virement should be specified in the financial regulations and standing instructions within the partner authorities.

3. **Proposed Scheme of Virement**

Range of services and budgets

- 3.1 The services which come within the scope of this scheme of virement are the resources covered by the Strategic Plan of the IJB. This will cover the amount in respect of delegated adult social care services, the amount covered by delegated primary and community health care services and for those delegated hospital services and the amount set aside by the Health Board for services provided in large hospitals for the population of the IJB. Whilst the IRAG guidance sets out the minimum budgets that are required to be included IJB will be able to include other services through local agreement i.e. Children's Services
- 3.2 IJB budget will comprise both new and existing funds. It is recognised that there will generally be limited room for manoeuvre in the short term where costs are fixed in nature (e.g. permanent staffing budgets), however the need to at least provide for the option to use resources flexibly where the opportunity arises is considered important.
- 3.3 Where budgets have specific conditions attached to their use by the Scottish Government, the operation of virement arrangements will require to ensure that funding continues to be deployed in a way which satisfies these conditions.

3.4 **Exercise of virement**

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

3.4.1 **Annual budget setting**

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

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

3.4.2 **In year budget adjustments**

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

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

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

3.5 **Set Aside (Acute)**

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

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

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

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

3.6 **Guiding principles**

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

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

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

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

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

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

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

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

3.7.1 Virement opportunities will emerge from the process of: -

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

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

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

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

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

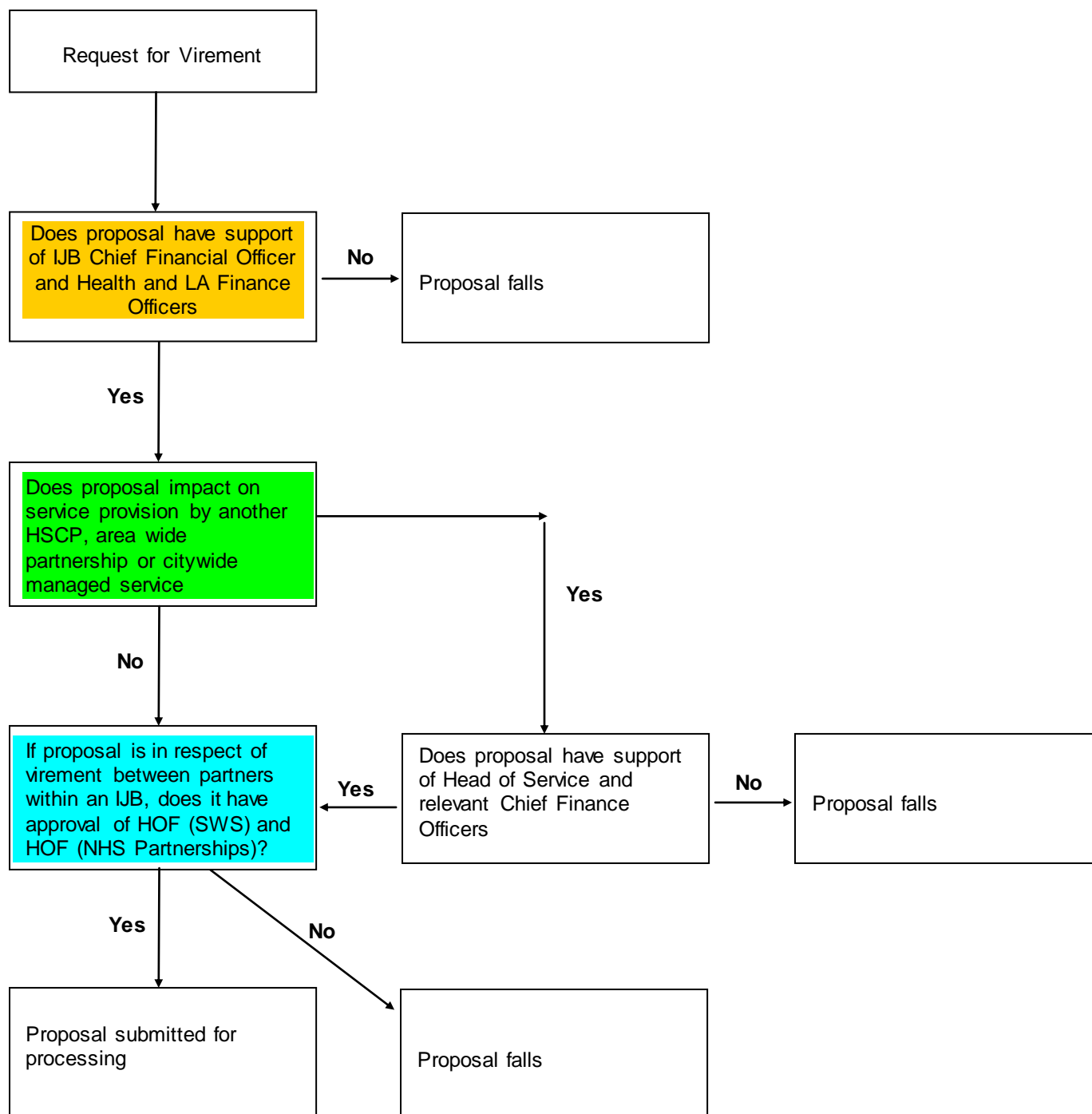
3.7.5 Virement proposals should be submitted in writing or electronically using a prescribed form.

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

- 3.7.7 Virement proposals exceeding the locally agreed limits will require to be submitted by the Chief Officer and Chief Financial Officer to the Integrated Joint Board for approval.
- 3.7.8 All budget movements during the year will require to be reported as required to Committee for authorisation within 4 weekly financial monitoring reports or relevant financial period.
- 3.8 Overspends/underspends
- 3.8.1 Where resources have been vired from one partner to another, and an overspend arises in relation to resources so transferred, it will be the responsibility of the Integrated Joint Board's Chief Officer and Chief Financial Officer to manage this within the context of the Integrated Joint Board's overall services budget and advise each partner, as appropriate, regarding how this overspend will be managed or contained.
- 3.8.2 Where resources have been vired from one partner to another and an underspend arises in relation to resources so transferred, it will be the responsibility of the Integrated Joint Board's Chief Officer and Chief Financial Officer to manage this within the context of the Integrated Joint Board's overall services budget and advise each partner, as appropriate, regarding how this underspend will be managed. This will have to take account of the reserves policy in place for the Integrated Joint Board.
- 3.8.3 In framing virement proposals, managers will require to take cognisance of existing contractual arrangements and any other conditions attached to funding.

Scheme of Virement

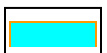
**Procedural arrangements in respect of Virement within or across Partnerships
(NB – does not include potential need for LA or HB approval as stated in the respective Schemes of Delegation).**



Within a Partnership



Across Partnerships



Across the wider system, including Acute

Section 4 - Capital Planning Process

1. Introduction

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

2. Background

- 2.1 The Integrated Resources Advisory Group (IRAG) professional guidance for shadow integration arrangements indicates that as the Integration Joint Board (IJB) will not directly own any property or assets, nor receive any capital allocations, grants or have the power to borrow or invest in capital expenditure, the Chief Officer of the IJB is recommended to consult with the local authority and Health Board partners to make best use of existing resources and develop capital programmes.
- 2.2 This paper acknowledges that in the short term at least, current arrangements within each partner organisation will continue to apply, but that in the longer term the Chief Officer will wish to consider alternative arrangements in the discharge of the IJB business.
- 2.3 The IRAG states that in developing the Strategic Plan, the Chief Officer of the IJB is advised to consider the CIPFA guidance on place based asset management. www.cipfaproperty.net/fileupload/upload/one%20public%20estate_v2112201111519.pdf
- 2.3 The respective processes for the approval of the capital programmes of the Health Board and local authorities are attached at Appendices 1 and 2.
- 2.4 Where the Chief Officer identifies the need for new investment within the Strategic Plan, a business case should be developed for the proposal for both partners to consider. Options may include one or both of the partners approving the project from its capital budget or where appropriate using the hub initiative as the procurement route to deliver the capital investment. This is a matter for local agreement.

3. Proposal for management of the Capital Plan

- 3.1 It is proposed that each HSCP will initially prepare a capital plan in tandem with the rolling annual capital planning process operated within each partner organisation. This will be the outcome of a strategic review of HSCP service priorities, and should take the form of an itemised list of proposed capital spending, set out in priority order. A brief summary should be provided for each scheme and this should include the following items: title of scheme, brief overview, timing, intended benefits, funding plan including, net funding requirement, revenue funding consequences.

- 3.2 Each HSCP will be expected to update and formally approve its capital plan on an annual basis.
- 3.3 In tandem with an annual update of its capital plan, each HSCP shall review its premises needs, including existing owned and leased clinical and office premises. The output of this review should be a premises plan which identifies **(a)** requests for new/upgraded accommodation **(b)** planned disposal/vacation of premises no longer required, over the forthcoming period. Major requirements for new/upgraded accommodation would almost certainly feature within the HSCPs capital plan with minor schemes being set out in a supplementary listing. (In Glasgow, this function is managed by Access, the Council's Property and ICT provider. Other authorities may have similar arrangements).
- 3.4 There will be an annual process by the lead Chief Finance Officer and involving all HSCP Chief Officers or designated representatives to reach agreement on an allocation of formula capital funding to each individual HSCP in respect of minor works and minor equipment. This is in accordance with current arrangements which are in place within the NHS Scheme of Delegation.
- 3.5 It is proposed that the HSCPs Capital Plan be developed within a Joint Capital Planning Group (JCPG). Together with the supplementary listing of planned minor premises schemes, the HSCPs Capital Plan would be submitted for approval by the HSCP Management Team, and thereafter to the IJB.

4. Joint Capital Planning Group

- 4.1 It is proposed that a local JCPG will be established within each HSCP. This group will be responsible for taking an overall strategic overview of HSCP capital plans with a view to assessing potential sources of finance and also assessing opportunities for joint proposals across more than one HSCP, and providing advice on how best to take forward capital proposals within the Health Board and/or LA capital planning processes. Responsibility for prioritising capital projects will continue to be exercised by the Health Board and LA partners within already established capital planning/capital bidding processes. In this light it will be important for group membership to include officers possessing a good working knowledge of existing and potential sources of finance.
- 4.2 Following review by JCPG, HSCP capital plans will be taken forward within the Health Board and LA capital planning process as appropriate.
- 4.3 A joint operational capital sub group will also be established within each HSCP at a local level, comprising of officers with appropriate skills and experience.
- 4.4 The joint operational capital sub group will take responsibility for;
- maintenance of a register identifying all LA and NHS Community based properties, utilising information provided by partners. This will be used as a reference point when considering draft HSCP capital plans.
 - maintenance of a register of jointly occupied premises, recording details of joint funding agreements related to such jointly occupied premises and ensuring that this is kept up to date. This work will be co-ordinated by LA and

NHS Capital planners, who will be accountable to the Chief Officer HSCP (tbc) in this regard on a day to day basis.

5. Rolling Capital Planning Process

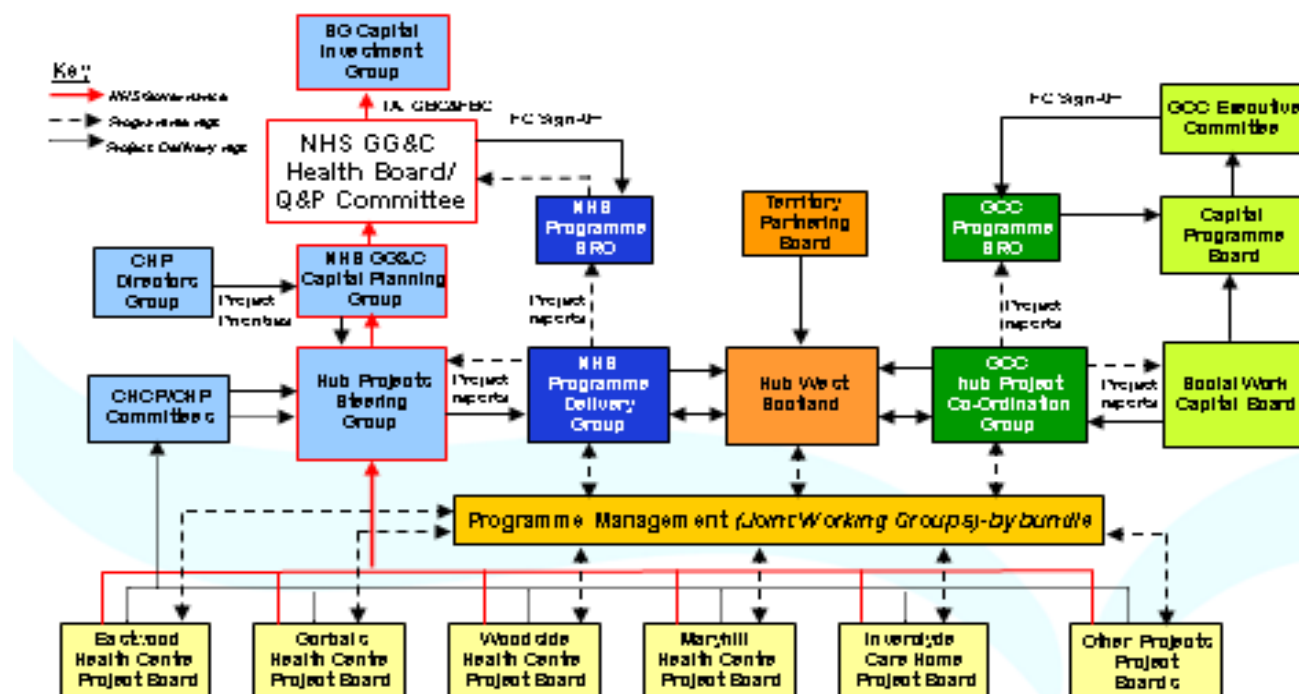
- 5.1 Both Health Board and LA operate a rolling capital programme. The governance arrangement for Health is shown at Appendix 1. The governance arrangements within the appropriate LA will be attached at Appendix 2 to provide an HSCP specific paper. The governance arrangements within Glasgow are attached as an example.

6. Business Case Preparation and Guidance

Existing documented procedures for developing business cases to source capital funding should be utilised. Where a project is funded via Health Board, the Health Board documentation and process will be followed. Where a project is funded via LA, the LA documentation and process will be followed. Where joint bids are being made, the approval of both partners through their respective processes will be required. Approval levels with the Health Board and LA will be determined by the appropriate Schemes of Delegation.

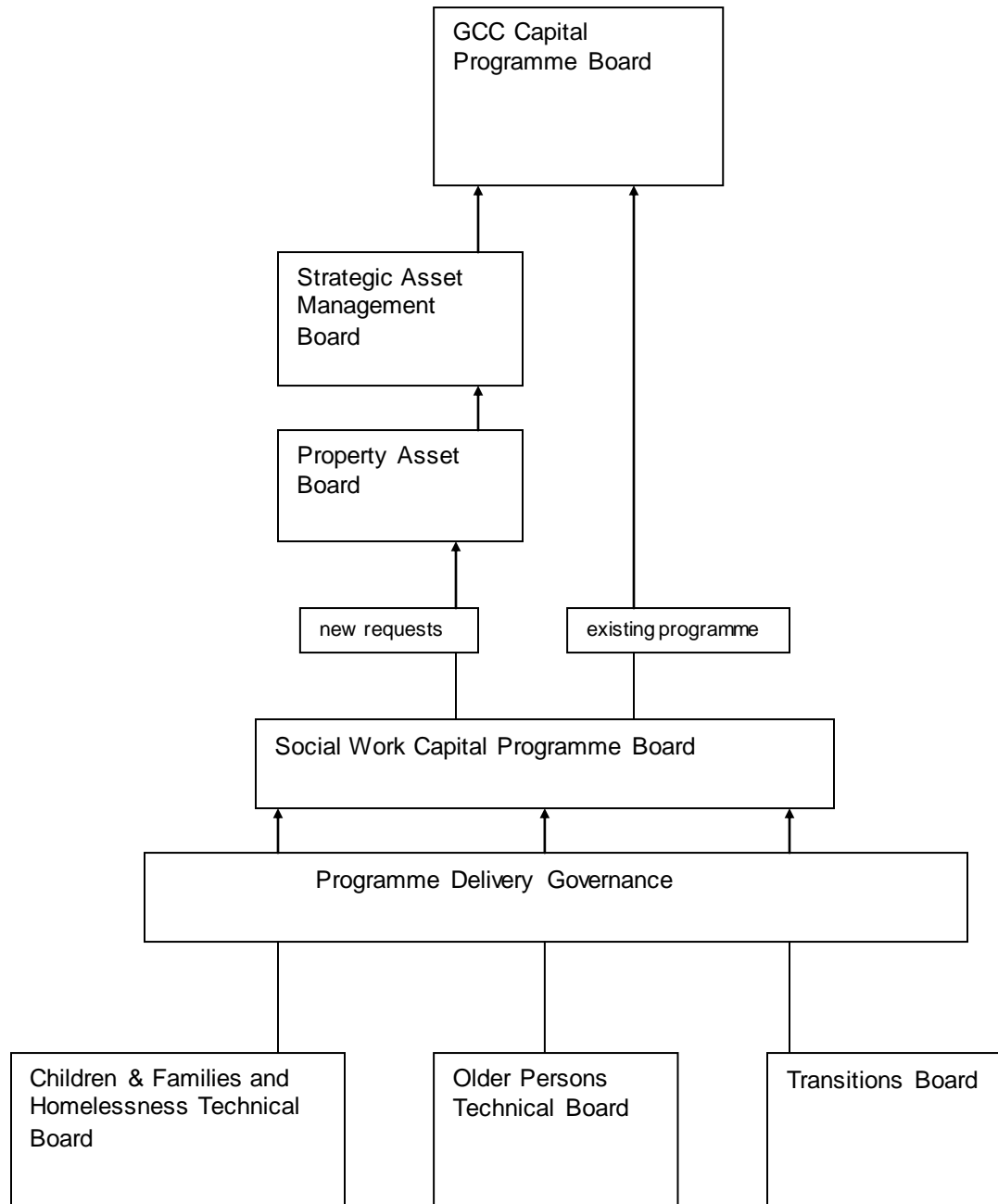


Governance Arrangements –



Local Authority Capital Planning – Governance Arrangements

Glasgow City Council – Social Work Services



Section 5 - Managing Financial Performance

1. Introduction

- 1.1 The purpose of this paper is to outline provisions for managing in-year financial performance of the Integrated Budget, as directed in the Integrated Resources Advisory Group (IRAG) professional guidance for shadow integration arrangements. This will require that the Chief Officer receives financial performance information for both their operational role in the Health Board and Local Authority and strategic role in the Integration Joint board (IJB).

2. Budget monitoring

- 2.1 The Health Board and Local Authority Directors of Finance and the IJB financial officer will establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the IJB as a whole. It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person to carry out both this role and the role of financial officer for the joint board, but this is a matter for local determination.
- 2.2 Whilst the Health Board and Local Authority will each continue with their own schedule of in-year financial reporting and forecasting requirements, reporting to the IJB will be in line with the schedule of IJB meetings. Full reporting requirements to be confirmed in line with new IJB governance arrangements.
- 2.3 The Health Board and Local Authority will agree a consistent basis for the preparation of management accounts reported to the IJB. This should initially reflect the current reporting arrangements for each organisation.

3. Budget Management

- 3.1 The IJB will direct the resources it receives from the Health Board and the Local Authority in line with its Strategic Plan, and in so doing seek to ensure that the planned activity can reasonably be met from the available resources viewed as a whole and achieve a year end breakeven position. This is essential for the financial stability of the IJB itself and for the Health Board and Local Authority.
- 3.2 The Chief Officer will be responsible for the management of in-year pressures and should take remedial action to mitigate any net variances and deliver the planned outturn. Expenditure outwith the total resources available should not be incurred.
- 3.3 The Chief Officer will be able to transfer resources between the two arms of the operational Integrated Budget subject to appropriate approvals. This will require in-year balancing adjustments to the allocations from the IJB to the Local Authority and Health Board. Further guidance is available in the Scheme of Virement document.

3.4 Managing overspends

3.4.1 If an overspend is forecast on either arm of the operational Integrated Budget, the Chief Officer and the Chief Finance Officer should agree a recovery plan to balance the overspending budget. Where appropriate, approval should be sought in line with the scheme of delegation. This plan should include clear options and target savings with named persons responsible for delivering them, which are closely monitored and controlled.

3.4.2 In addition, the IJB may increase the payment to the overspending partner, by either

- Utilising an underspend on the other arm of the operational Integrated Budget to reduce the payment to that body; and/or
- Utilising the balance on the general fund, if available, of the IJB in line with the reserves policy.

3.4.3 If the recovery plan is unsuccessful and there are insufficient general fund reserves to fund a year end overspend, then the partners have the option to:

- Make additional one-off payments to the IJB;
- Provide additional resources to the IJB which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan in place to address this; or
- Reprioritise in-year expenditure, subject to other governance arrangements).

3.4.4 The IJB will not ordinarily be required to contribute to the management of in-year overspends on non-integrated budgets in the Local Authority or Health Board. In the event of a projected in-year overspend elsewhere across the Local Authority or Health Board non-integrated budgets, they should contain the overspend within their respective non-integrated resources.

3.4.5 The exception to this general principle relates to exceptional circumstances as defined by local arrangements.

3.4.6 The IJB will not be required to contribute to overspends in other IJBs within the Board area other than in those specific budget areas where risk sharing applies as set out in the Management of Integrated Budgets Guiding Principles document. Otherwise, the responsibility for this lies with the overspending IJB who should apply the process noted above within their own authority for in-year overspends. However, financial risk should be managed through the financial management process noted above and the use of reserves, where available.

3.5 Managing underspends

- 3.5.1 Any net underspends on either arm of the operational integrated budget, with the exception of ring fenced budgets should be returned to the IJB by the Local Authority or Health Board and carried forward through the local authority general fund, where the accounts of the IJB will be held.
- 3.5.2 The exception to this general principle relates to exceptional circumstances as defined by local arrangements.
- 3.5.3 In some years the IJB may plan for an underspend in order to build up reserve balances, although in practice the scope for this will be constrained given the context of financial challenge at least over the short to medium term.

4. Reserves

For further information on reserves refer to Reserves Strategy document.

5. Financial Returns

- 5.1 The Health Board and the Local Authority are currently required to complete the following financial/statistical returns for the Scottish Government:
- Health - routine financial performance monitoring returns are submitted to the SGHSCD and any other statutory organisation as required. Including Scottish Financial Returns (SFRs) for Annual Accounts and Cost Book SFRs.
 - Local Authority – Local Financial Returns (LFRs), Provisional Outturn and Budget Estimate (POBE) and Free Personal and Nursing Care data (FPNC).
- 5.2 Proposals will be developed by the Scottish Government to revise these returns to reflect the integration arrangements. Information on the revised arrangements for the LFR3 will be issued by Scottish Government. Guidance on the SFR will continue to be provided in the Unified Board Accounts Manual.

6. Statutory Performance Indicators

- 6.1 All Local Authorities are required to report annually on a set of operational and financial performance indicators known as Statutory Performance Indicators (SPIs) as specified by Audit Scotland. Of those specified for Social Work, none relate specifically to finance.
- 6.2 From 2013/14, all Local Authorities are also required to participate in the Local Government Benchmarking Framework (LGBF) which will be used by Audit Scotland to compare their performance against a suite of indicators. Of the 8 listed for Social Work Services, 4 relate specifically to financial measures. Details can be found at:
<http://www.improvementservice.org.uk/benchmarking/index.html>

- 6.3 The Health Board is required to report on a range of performance measures including HEAT targets and standards; targets identified at Health Board level; and other local performance indicators specified by the CHP in its wider Development Plan.

The specific HEAT target for financial performance sets out that NHS Boards are required to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement. NHS Boards have an obligation to operate within their allocated funds and ensure value for money.

- 6.4 As a tool for performance management, there will be a requirement to continue reporting on all these indicators.

7. Role of budget holders

- 7.1 The Chief Financial Officer will ensure that budget holders receive impartial advice, guidance and support and are provided with accurate, timeous and appropriate information to enable them to effect control over expenditure and income.
- 7.2 Budget holders are ultimately responsible for the budgets assigned to them and will be held accountable for all such budgets within their control.
- 7.3 The IJB will ensure arrangements are put in place to hold budget holders to account, particularly where financial problems or potential overspends have been identified. This should consist of formal meetings held on a regular basis chaired by the Chief Officer and/or Chief Financial Officer, where the Budget Holder will be expected to report on areas of concern and propose corrective actions.
- 7.4 Budget holders have a responsibility to formally report any major financial problems identified within the service to the Chief Financial Officer who can instruct appropriate action and report to the IJB if required.
- 7.5 Budget holders should alert and consult the Chief Financial Officer where no budget is available but where expenditure is essential to the discharge of the functions of the IJB.
- 7.6 Budget holders should at all times comply with the LA's code of Practice on Financial Management and Control and NHS Health Boards SFIs Budgetary Control and Reporting and Scheme of Delegation.



Item No 6

30th March 2015

Glasgow City Council / NHS Greater Glasgow and Clyde Shadow Integration Joint Board

Report By: Chief Officer Designate

Contact: David Williams

Tel: 0141 287 8853

Participation and Engagement Strategy Development

Purpose of Report:

To update the Shadow Integration Joint Board on the development of a Participation and Engagement Strategy for Glasgow Health and Social Care Partnership

Recommendations:

The Shadow Integration Joint Board is asked to:
a) note this report; and
b) note that further reports will be submitted in due course

Implications for IJB	
Financial:	None
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	None
Implications for Glasgow City Council	None
Implications for NHS Greater Glasgow & Clyde	None

1 Purpose

- 1.1 The purpose of this report is to update the Shadow Integration Joint Board on the development of a Participation and Engagement Strategy for Glasgow Health and Social Care Partnership.

2 Background and Policy Context

- 2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act') received Royal Assent on 1st April 2014.
- 2.2 The Act requires the Health and Social Care Partnership to produce a participation and engagement strategy to ensure that there is effective engagement with all communities and partners to ensure that local needs and expectations for health and social care are being met, and this is reflected within the draft Integration Scheme.
- 2.3 The Community Empowerment Bill is currently going through the legislative process with the deadline of 2nd April 2015 for Stage 2 proceedings of the Bill. The Bill sets a requirement that public bodies should engage with 'community bodies' to improve outcomes, and gives those community bodies a right to participate in processes to improve outcomes. The Bill requires the Integration Partnership (and other Public Bodies) to put in place a participation process, and in due course report on the outcomes, including how engagement has shaped the result.
- 2.4 The Patients Rights (Scotland) Act 2011 aims to improve patient's experiences of using health services and to support people to become more involved in their health and health care.
- 2.5 Scottish Government Policy Circular 'CEL 4' Inform, Engage, Consult places a duty on Health Boards to involve the public in formal consultation in relation to major service redesign and change.
- 2.6 The Scottish Government's National Standards for Community Engagement (2005) set out best practice principles for the way that government agencies, councils, health boards, police and other public bodies engage with communities. Additionally the Scottish Health Council (part of Healthcare Improvement Scotland) has a role to audit the scope and quality of public involvement in healthcare planning and delivery; Health Boards must comply with their Participation Standard monitoring framework.

3. Current Service user and Engagement

- 3.1 Glasgow City Community Health Partnership (CHP) and Glasgow City Council Social Work Services (SWS) currently engage with service users, carers,

communities and third sector through a range of service, planning, and engagement groups and structures in localities and on a city-wide basis.

- 3.2 The principal engagement structure for the CHP is the Public Partnership Forums (PPFs), based in each of the three localities. The key SWS engagement structure is the Voices for Change network that bring together service users and carers across adult care groups, at city and the three localities.
- 3.3 CHP and SWS Community Development and Engagement staff support these engagement structures facilitating appropriate engagement with SWS and CHP managers and developmental processes.
- 3.4 In addition to these key engagement structures staff support a variety of adult care related community/service user groups at area level including Carers Reference Groups and Kinship Carers.

4. Development of Partnership Participation and Engagement Strategy

- 4.1 A review of current engagement structures is currently underway. The review scope and methodology includes:
 - Preparation of a definition for the Partnership on what their participation and engagement requirements are;
 - Scoping and articulating the various statutory requirements, policy drivers, and quality standards, and their requirements/implications;
 - Scoping out stakeholders (service user, carers, equality groups, voluntary sector etc) and their existing processes, both city-wide and in localities for engaging within and beyond their stakeholder group, and consider how existing or revised arrangements will connect with the Partnership
 - Engagement with stakeholders including Voices for Change, PPFs, communities and equality groups will take place through a series of focus groups and workshops; stakeholder meetings and events; and online SurveyMonkey Questionnaire for all stakeholders.
- 4.2 The above activity will inform and ensure a co-production approach to producing proposals for an engagement framework for the Partnership and will ensure that 'to be' structures meet with legislative requirements as outlined in para 2 above and the Partnership's development expectations for locality planning. These proposals will also outline the proportionate level of support for participation and engagement to be provided by the HSCP in both officer and financial terms.
- 4.3 An initial meeting was held on 18th March 2015 with representatives of the PPFs and Voices for Change to advise of the review. Further consultation events and sessions will be held with a range service users, carers and other stakeholders as the participation and engagement strategy is developed for the Partnership.

- 4.4 It is expected that this review and consultation will be concluded in late Autumn 2015 with a report back to the Integration Joint Board by the end of the year with proposals to take effect from 1st April 2016.

5. Recommendations

- 5.1 The Shadow Integration Joint Board is asked to:

- a) note this report; and
- b) note that further reports will be submitted in due course.



Item No 7

30th March 2015

Glasgow City Council / NHS Greater Glasgow and Clyde Shadow Integration Joint Board

Report By: Chief Officer Designate

Contact: David Williams

Tel: 0141 287 8853

Participation and Engagement Strategy Development

Purpose of Report:

To update the Shadow Integration Joint Board on the development of a Participation and Engagement Strategy for Glasgow Health and Social Care Partnership

Recommendations:

The Shadow Integration Joint Board is asked to:
a) note this report; and
b) note that further reports will be submitted in due course

Implications for IJB	
Financial:	None
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	None
Implications for Glasgow City Council	None
Implications for NHS Greater Glasgow & Clyde	None

1 Purpose

- 1.1 The purpose of this report is to update the Shadow Integration Joint Board on the development of a Participation and Engagement Strategy for Glasgow Health and Social Care Partnership.

2 Background and Policy Context

- 2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act') received Royal Assent on 1st April 2014.
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- 2.4 The Patients Rights (Scotland) Act 2011 aims to improve patient's experiences of using health services and to support people to become more involved in their health and health care.
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 - Preparation of a definition for the Partnership on what their participation and engagement requirements are;
 - Scoping and articulating the various statutory requirements, policy drivers, and quality standards, and their requirements/implications;
 - Scoping out stakeholders (service user, carers, equality groups, voluntary sector etc) and their existing processes, both city-wide and in localities for engaging within and beyond their stakeholder group, and consider how existing or revised arrangements will connect with the Partnership
 - Engagement with stakeholders including Voices for Change, PPFs, communities and equality groups will take place through a series of focus groups and workshops; stakeholder meetings and events; and online SurveyMonkey Questionnaire for all stakeholders.
- 4.2 The above activity will inform and ensure a co-production approach to producing proposals for an engagement framework for the Partnership and will ensure that 'to be' structures meet with legislative requirements as outlined in para 2 above and the Partnership's development expectations for locality planning. These proposals will also outline the proportionate level of support for participation and engagement to be provided by the HSCP in both officer and financial terms.
- 4.3 An initial meeting was held on 18th March 2015 with representatives of the PPFs and Voices for Change to advise of the review. Further consultation events and sessions will be held with a range service users, carers and other stakeholders as the participation and engagement strategy is developed for the Partnership.

- 4.4 It is expected that this review and consultation will be concluded in late Autumn 2015 with a report back to the Integration Joint Board by the end of the year with proposals to take effect from 1st April 2016.

5. Recommendations

- 5.1 The Shadow Integration Joint Board is asked to:

- a) note this report; and
- b) note that further reports will be submitted in due course.



Item No 8

30 March 2015

Glasgow City Council / NHS Greater Glasgow and Clyde Shadow Integration Joint Board

Report By: Chief Officer Designate

Contact: Mark Feinmann/ Isla Hyslop

Tel: 0141 314 6245

Management Team Development Programme

Purpose of Report: To outline the development programme for the new leadership group for Glasgow City Health and Social Care Partnership

Recommendations: Shadow Integration Joint Board is asked to note this report

Implications for IJB	
Financial:	None
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	All development activity will address equalities issues where relevant. Accessible arrangements and venues will be used for the facilitation of the development programme sessions.
Implications for Glasgow City Council	None
Implications for NHS Greater Glasgow & Clyde	None

1. Background

- 1.1 A previous paper (3 March 2015) outlined a plan to support the development of the new management team for the HSCP. Following feedback from the Joint Executive Group this paper now aims to provide a detailed framework for delivery of the development programme over the coming months.

2. Introduction

- 2.1 One of our key aims is to see the HSCP develop as a learning organisation. It is central to the success of the organisation that we challenge ourselves to think and work differently, to understand what is happening in the wider environment and produce creative solutions using the knowledge and skills of all within the organisation.

- 2.2 We are focused on the following outcomes;

- Improving our knowledge and understanding of the broad range of services provided, the challenges and wicked problems they face
- Ensuring senior managers are equipped to challenge each other, think differently, working in a way that is constructive and effective
- Improved partnership working which will prepare the HSCP for the challenges that lie ahead.

3. Proposed Framework

- 3.1 There are four stages to the development programme;

3.2 Stage 1

Utilising the knowledge and intelligence of our senior management team in focused, interactive short briefing and learning sessions which are focused on the three identified care group clusters of Children, Adults and Older People. Leads have been identified to design and plan the session and guidance developed to ensure some degree of consistency in how we approach the sessions and the outcomes we work towards.

- 3.3 It is proposed that each cluster group begins to meet regularly after this initial session to develop the framework for Session 3. A cluster group includes Operational and Strategic Leads, Locality Heads, Planning and Finance Officers.

- 3.4 The first three sessions will focus on the three care group clusters as follows;

Session	Topic	Proposed Lead	Proposed Date / Venue / Time	Outcomes
1.	Children's Service	Mark Feinmann	Campanile Hotel 8.30 – 10am	1. Service update, vision, policy, local context.
2.	Older People's Services	Stephen Fitzpatrick	Campanile Hotel 8.30 – 10am	2. Identifying key challenges for which there are no clear solutions and areas of ambiguity in the context of;
3.	Adult Services	Doug Adams	Campanile Hotel 8.30 – 10am	4. Resources 5. Quality and performance 6. Eligibility / access 7. Engagement with partners and 8. Organisational change

3.5 Stage 2

A one day focused workshop on adaptive leadership. The aim is to give senior managers the tools for analysis of their leadership capability and language for discussion. Managers are encouraged to use these tools and techniques with their own management and service teams to cascade the learning and ensure the culture of adaptive leadership is evident throughout the organisation.

Session	Topic	Proposed Lead	Proposed Date / Venue / Time	Outcomes
4.	Introduction to Dialogue and Structural Dynamics	Isla Hyslop	Campanile Hotel 9am – 4.30pm	<p>1. The ability to engage in collective inquiry into the key issues.</p> <p>2. Understanding and developing a skill set in Structural Dynamics to help create an environment which supports learning and innovation.</p>

3.6 Stage 3

The next three sessions will pick up on the ‘wicked issues’ identified in each of the care group clusters above using the tools and techniques outlined in session 4 above. They will provide an opportunity to explore in some detail our understanding of the issues and create opportunities for solution focused dialogue. Each session will have a local sponsor and a keynote speaker who will challenge us to think and act differently and develop innovative solutions to the challenges we face. We will build in some reflective capacity by ensuring OD colleagues support these sessions to provide feedback on the application of the Dialogue and Structural Dynamics learning from session 4.

Session	Topic	Proposed Lead / Keynote Speaker	Proposed Date / Venue / Time	Outcomes
1.	Children's Service	Sir Harry Burns Mark Feinnmann Mike Burns	Campanile Hotel 8.30 – 10am	1. Agreement on the nature of the challenges 2. Action focused plan and process identified to address wicked issues
2.	Older People's Services	Sir John Bolton Stephen Fitzpatrick	Campanile Hotel 8.30 – 10am	3. Managers understand the contribution they are expected to make re Strategic / Operational lead roles.
3.	Adult Services	Doug Adams	Campanile Hotel 8.30 – 10am	4. Output from service clusters feeds into developing Strategic Plan.

3.7 Stage 4

3 x Locality based workshops which provide an opportunity for those working together locally to translate the detail of the care group cluster work programmes developed above into a local plan – identifying the issues and resources that will need to be addressed locally to implement the agreed plan. In particular, these sessions will focus on how we interface and engage with local partners and the contribution they can make to addressing the challenges. The events will be staggered in order that colleagues (outwith the Locality operational structure) can attend all three. Locality Leads should give some thought to if / how we open up these sessions to a range of partners.

Session	Topic	Proposed Lead / Keynote Speaker	Proposed Date / Venue / Time	Outcomes
1.	South Glasgow Locality	David Walker	Campanile Hotel 9am – 12noon	1. Clarity for all re local issues and interface with Strategic Plan
2.	North West Glasgow Locality	Jackie Kerr	Campanile Hotel 9am – 12noon	2. Practice collaborative thinking to create innovative solutions
3.	North East Glasgow Locality	Ann-Marie Rafferty	Campanile Hotel 9am – 12noon	3. Identification of local resources available and required

4. Key points and considerations

- 4.1 All sessions will be introduced and closed by Alex MacKenzie, Susanne Millar or Sharon Wearing. All sessions will be breakfast sessions at the Campanile 8.30am – 10am (excluding the all day session re Dialogue and Structural Dynamics). Members of the SMT are expected to attend all sessions, contribute constructively and share their learning. These sessions will only work well if we have buy-in from SMT.
- 4.2 Support will be provided by OD to help leads plan and consider the range of content that can be covered in each session. For example, in the Adult Services sessions it may make sense to prioritise or focus on one care group first and plan future sessions to focus on other care groups.

5. Next steps

- 5.1 Following approval of the programme;
- a detailed timetable, with confirmed dates, will be drawn up in conjunction with senior managers and sent to all SMT members.
 - presentation / facilitation guidance will be developed and shared with senior managers to ensure a consistently structure, input and outputs.
 - development session on 23 March will set the context for this work.

6. Recommendations

- 6.1 The Shadow Integration Joint Board is asked to note this report
- 6.2 Shadow Board is asked to note that these sessions are mandatory for the leadership team, and to note that for the blocks of sessions 1, 3 and 4, an invitation is extended to all members of the Shadow Board to attend if they so wish.