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ADDITIONAL CIRCULATION

ABERDEEN
CITY COUNCIL

To: All Members of the Council

Town House,
ABERDEEN, 27 February 2015

COUNCIL MEETING

The undernoted items are circulated in connection with the meeting of the **COUNCIL** to be held here in the Town House on **WEDNESDAY, 4 MARCH 2015 at 10.30am**.

JANE G. MACEACHRAN
HEAD OF LEGAL AND DEMOCRATIC SERVICES

B U S I N E S S

GENERAL BUSINESS

7(c) Draft Health and Social Care Integration Scheme - referred by Shadow Integration Joint Board of 24 February 2015 (Pages 1 - 122)

7(d) Aberdeen City Region Deal

The above item will now be submitted to a Special Council meeting on 12 March 2015 at 10.30am

7(g) Aberdeen Sports Village and Sport Aberdeen - Recruitment of Board Members - Revised Report (Pages 123 - 128)

7(h) Twinning and International Partnerships

The Chief Executive has withdrawn the above report as Standing Orders in relation to consultation on draft reports had not been followed

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Aberdeen City

Shadow Integration Joint Board

Report Title	Integration Scheme
Lead Officer	Judith Proctor
Report Author	Geraldine Fraser/Karen Donnelly/Kevin Toshney
Date of Report	25th February 2015
Date of Meeting	Full Council - 4th March 2015

1:	Purpose of the Report

The Public Bodies (Joint Working) (Scotland) Act 2014 requires all local authorities and health boards to integrate adult community health and social care services and to submit an "integration scheme" to the Scottish Government setting out the local governance arrangements for integration. The legislation requires us to consult on a draft integration scheme and to submit a final integration scheme to the Scottish Government by 1 April 2015.

A revised Health and Social Care Integration Scheme for Aberdeen City is in Appendix 5.

This includes a further technical finance revision since the agreement of the final draft at the Shadow Integration Joint Board meeting which took place on the 25th of February 2015. These minor technical changes have come about from the recommendation of the Joint Resources Group – which is made up of finance leads for NHS Grampian and for the 3 Local Authorities in the North East.

The changes are at sections 12.7.1, 12.7.2 and 12.8.1 and relate to the following areas:

- clarity on the frequency of financial reporting by the Integrated Joint Board (IJB) which should be at least quarterly;
- clarity in the information to be provided to the IJB from the NHS on the cost

of services in acute hospitals; and

- Allowing for flexibility on both parent bodies to increase funding to the IJB.

Given the challenges of timescales and potential need for minor or technical changes to the Integration Scheme, the Shadow IJB agreed that such minor changes could be made with the agreement of the Chair of the sIJB and these changes have been made within that authority and included in this final draft for agreement.

It is likely that further changes may be requested to all schemes in Scotland following their review at Scottish Government level and to ensure a timely response this paper recommends that Full Council endorses future minor or technical changes resulting from Scottish Government review to be made following agreement of the Chair and Vice Chair of the shadow IJB.

2:	Summary of Key Information

2.1 Introduction.

The development of this Integration Scheme has been led by a legal resource (Geraldine Fraser) shared with Aberdeenshire and Moray Councils working to a template designed by the Scottish Government.

2.2 Consultation.

Consultation of the Aberdeen City draft Integration Scheme took place over a six week period December 2014 - January 2015.

A summary of the consultation process is set out in Appendix 1 and the full results of the consultation with corresponding responses from the Aberdeen City Health and Social Care Partnership is set out in Appendix 2.

2.3 Legal requirements for the Integration Scheme

Once approved by Scottish Ministers, the integration scheme must be published and will be a legally binding agreement between Aberdeen City Council and NHS Grampian. The integration scheme must be reviewed after five years, but any amendments prior to that can only be made after further consultation and further approval by Scottish Ministers.

The arrangements that are to be included in the integration scheme are set out in Regulations, and therefore are legal requirements. Only information that is prescribed in the legislation can be included – Scottish Minsters cannot approve additional information.

The legislation requires the integration scheme to set out the following arrangements for integration:

- Model of integration (body corporate or lead agency)
- Scope of functions and services that are to be delegated
- Integration Joint Board membership and governance
- Local governance arrangements
- Corporate support services
- Targets and performance
- Clinical and professional governance
- Financial management
- Chief Officer
- Workforce and organisational development
- Information sharing
- Complaints handling
- Liability and indemnity
- Risk management
- Dispute resolution

Further detail of how the integration scheme was developed is set out in Appendix

3.

2.4 Equalities, Staffing and Financial Implications

An equality impact assessment has been carried out as part of the development of the integration scheme. It is included at Appendix 4. It identifies predominantly positive impacts.

An impact upon staff has been identified. All staff will remain employed by their current employer. If the roles of staff are to be transferred, Aberdeen City Council and NHS Grampian will ensure that the principles of TUPE will be adhered to. A process will be agreed for this and set out in a separate document.

An impact upon financial arrangements has been identified. As the Partnership moves to a single integrated budget, there will be wide ranging changes to the financial arrangements. Both Aberdeen City Council and NHS Grampian finance teams are working closely together with respect to these arrangements.

2.5 Conclusion

Aberdeen City Council and NHS Grampian have worked jointly to develop an integration scheme which sets out the arrangements for the integration of health and social care services. Authority is sought to submit the integration scheme to Scottish Ministers for approval.

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3:	Recommendations for Action

Council is asked to:

3.1 Approve the Health and Social Care Integration Scheme for Aberdeen City.

3.2 Agree that this Integration Scheme can be submitted to the Scottish Government for approval, pending the agreement of Aberdeen City council and NHS Grampian.

3.3 Agree that any minor and technical changes, resulting from the Scottish Government initial review, be agreed for the Scheme by the Chair and Vice Chair of the Shadow Integrated Joint Board and that no further consultation take place.

4:	Opportunities and Risks

There is an opportunity to develop an Integration Scheme which provides the parent bodies with the necessary reassurance and confidence about the governance and operation of the Integration Authority. The Integration Scheme will underpin our integrated activities and provide a platform for our strategic aspirations.

There is a risk that our current Integration timeline will be further affected by external variables over which we have little control (ie time taken by Scottish Government for scrutiny of 30 Integration Schemes).

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Appendix 1: Consultation Summary

1.1 A joint consultation on the integration scheme took place between December 2014 and the start of February 2015. It was conducted using face to face discussions, by email, telephone conversations and wider integration activities.

1.2 Prior to the consultation period the Transitional Leadership Group were presented with a consultation draft of the Integration Scheme and a summary of their own Q&As which had influenced its formation. This draft Integration Scheme was approved by the TLG for consultation.

1.3 The Chief Officer (Health and Social Care Integration) presented the consultation draft integration scheme to NHS Grampian Board and an Elected Members' briefing.

1.4 The documents were made available to:

- Integration Scheme Programme Board
- CHP Managers (and distributed to staff thereafter)
- SC&WB Managers (and distributed to staff thereafter)
- Trade Unions
- Staff side Partnership reps
- Third Sector
- Independent Sector
- Elected Members
- NHS Grampian Board Members
- GPs
- Members of the public (via ACC and NHS Grampian websites and accompanying press release)
- Sensory Impairment Strategy Group
- Participants of Integration workshops held in December and January.
- Other stakeholders with whom integration conversations and activities were held

1.5 We received submissions from:

- NHS Grampian Area Clinical Forum
- NHS Grampian Board Executive
- Chief Social Work Officer
- Marie Curie
- Enable
- Scottish Care
- NHS Grampian employees (3)
- Aberdeen City Council employees (3)

1.6 All submissions made in the consultation have been considered by the Aberdeen City Health and Social Care Partnership. Responses have been used to develop the integration scheme.

Appendix Two: Draft Integration Scheme Consultation Responses

THEME	RESPONDENT	CONSULTATION RESPONSE	RECOMMENDATION to SHADOW IJB
Aims and outcomes of the Integration Scheme	Liz Taylor, ACC	The vision statement is weak, lacks ambition and should certainly reflect the wider concept of wellbeing of the population.	Vision and values will be considered at workshop on the 24th of February
	Susan Lowes, Marie Curie	We agree with the aims, vision and detail laid out in the health and social care integration scheme for Aberdeen City. We welcome the culture of cooperation and coordination and the emphasis on high quality person centred health and social care services. We believe integration provides the opportunity to produce better person-centred care and improve outcomes, enabling people to access the right care for them at the right time and ensuring that people are at the heart of services and decisions surrounding their own care.	Noted
	Lynn Morrison NHSG	'the main purpose of integrated services is to improve the wellbeing of service users' - should the statement be broader than service users to reflect the need for the partnership to be more upstream in improving health and wellbeing, ie to influence people before they ever become service users? Comment applies to the bulleted list on page 3 too	Draft presented reflects the "Integration Planning Principles" as set out in the legislation

		which is heavily towards service users rather than the preventative element that we need to grow and develop.	
	Sandy Reid NHSG	Vision is great.	Noted
	Heather MacRae NHSG	Page 3 re the partnership will be obliged, make it a more positive statement, and welcome?	Noted
	Denise Thomson ACC	With respect to the integration principles: Instead of 'recipients' I would suggest that the wording is kept consistent so perhaps refer to service users as this includes patients and recipients. Instead of 'particular needs' this should be individual needs. 'Different parts of the area in which the service is being provided'; this is not clear. Takes account of the particular characteristics and circumstances of different service users; Could remove this if 'individual needs' suggested above is used. This is all about meeting individual needs and providing seamless services. Replace 'safety' with 'safe from harm'. Focuses on prevention would be better – we can't prevent needs arising.	Noted but not recommended this is changed as wording reflects regulations – the legislation says "service users" so this could be changed. The rest is set out in the Act as you say.

	Sarah Ward ACC	With respect to the following values: • co-operation (or 'to be co-operative') • – (I'm struggling to see how this could be a value but it would be 'to be outcome focused') • (as above, I'm struggling to see how innovation is a value but it should be 'to be innovative') Also, • The Partnership will be obliged *to provide* evidence of how well the nine National Health and Wellbeing outcomes are being met; these *outcomes* are:	Noted but recommend no change
Definitions and Interpretations	Graeme Smith NHSG	The roles of the key officers in the NHS Grampian should be defined in this section e.g. the role of the Chief Executive in relation to ultimate accountability for health resources and the responsibilities of the Medical Director and Director of Nursing in relation to professional validation and regulatory matters.	Scheme re-drafted to reflect. A new definition of "Accountable Officer" has been included in the Definitions. The responsibilities of the Chief Executive of NHS Grampian are detailed in the "Chief Officer" section. The responsibilities of the Medical Director and Director of Nursing are set out in the reframed "Clinical and Professional Governance" section.

Local Governance Arrangements	Graeme Smith NHSG	Reference should be made to the need for the IJB to reach agreement with NHS Grampian in relation to changes in health services which have an impact on other parts of the health and social care system. This relates to changes included in the strategic plan or other operational delivery changes that may be sought. The IJB, specifically the Chief Officer, will participate in a coordinating process involving all IJBs which will ensure that changes relating to health services provided across Grampian are managed and organised effectively and efficiently. This section should also make it clear that all resources at the disposal of the Parties relating to the functions which have been transferred to the Integrated Joint Board will be managed to ensure that the arrangements for carrying out the integrated functions, as set out in the strategic plan, are implemented in full. The section should also state that if the Integrated Joint Board proposes to take a significant decision about the arrangements for carrying out of their functions, and intends the decision to take effect other than by revising the strategic plan, the Integrated Joint Board will seek and take account of the views of the North East Partnership	Advice from Scottish Government review team that it is not acceptable to set out here how the IJB will go about its role and that this cannot be added to the text of the scheme As above. A paragraph to reflect this has been added to “Local Operational Delivery Arrangements”.

		Steering Group (or other such group established to undertake strategic level coordination of health and social care in the north east of Scotland) and take such action as it thinks fit having consulted with the service users for whom the service is being or may be provided. Whilst the IJBs will lead the strategic planning of the delegated hospital based services identified in the Regulations reference should be made in the Scheme that this planning will be coordinated by NHS Grampian as part of a broader plan for acute and other non delegated services for the Grampian and north of Scotland as appropriate.	Advice from Scottish Government review team that it is not acceptable to set out here how the IJB will go about its role and that this cannot be added to the text of the scheme As above.

	Lynn Morrison NHSG	'Strategic plan..provision of health and social care services' again wondered if this is a prescribed statement from the legislation or whether this could be expanded to better reflect the non-service delivery/ public health type function that we will need to do more of - or maybe the word 'service' in this context is intended to include all of that?	Reflects wording in the model scheme – no change recommended
	Heather MacRae	(Section is) good and clear.	Noted
Board Governance	Graeme Smith NHSG	A broad statement should be included in this section in relation to the numbers of Board members who will be members of the IJB. This will permit local agreements to be made regarding the detail of IJB membership. If this is not permissible the Scheme should state that NHS Grampian will nominate four Health Board members (this will comprise a minimum of three non executive members), and the Council will nominate four councillors. The decision of the appointment of a chair needs to be clarified. It is proposed that the terms of office for Chair and Vice Chair should be one year.	Changes recommended in text of final scheme

		It would be useful if the Scheme specified the non-voting membership of the IJB. Consideration should also be given to the inclusion of staff side representation on the IJB to be consistent with the NHS principle of partnership working.	Change not agreed – process for agreeing chairing arrangements and office to remain as previously agreed by TLG in December 2014 Non-voting membership will be as set out in the regulations and this list will be added to the scheme. This includes staff side representation.
	Martine Gallacher, Enable	Once the IJB is established, is there scope to appoint further non-voting members of the IJB that include - third sector representatives, service users residing in Aberdeen, persons providing unpaid care in Aberdeen staff of the parties engaged in the provision of services under the delegated functions? If there is a representation of the groups mentioned above how will you ensure that the views of all providers are taken into account?	Non-voting membership is set out in the regulations and this will be shown in the scheme. This includes representation for those groups. Regulations set out the range of people and groups that must be consulted with in relation to both locality planning and development of the Strategic Plan
	Heather McRae NHSG	(section) is good and clear (do wonder re suitable finances with the financial targets we will have to make but we do have the	Noted – issue of chairing arrangements will be set out as per

		transitional money). Is there a reason the term of office of a Board member is 3 but the Chair is 2?	previous TLG agreement
	Sarah Ward ACC	'The IJB may require various support services in order to perform its functions' truism?	Noted – wording reflects the regulations and model scheme and this element reflects the need to ensure services from parent bodies support the IJB as required to enable it to carry out its functions
	ACF & GAAPAC	The number of NHSG Board members in the IJB is left subject to agreement. Some concern about how many if they are all to be non-execs. Can the non-execs sustain the commitment to the IJBs, NHSG and other roles? Depending on numbers there will be be very little 'give' if there is an absence/illness etc. Clearly NHSG Board members need to populate IJBs but important to recognise how many directions they may be pulled in and look at whether this makes it difficult to be effective. Does this leave room for the opportunity for the informal contact and shared understanding to be established between board members and clinicians.	Noted and agreement has been reached in relation to voting membership which will be reflected in the final draft. This will set out a membership of 4, with NHS members comprising 3 non-execs and 1 exec.
Delegation of Functions	Graeme Smith NHSG	The Scheme identifies the services to be delegated and extracts from the Regulations associated with the legislation are included in appendices. It will be necessary to identify those services that will be delegated in	This has been set out in a new Annex 4.

		terms of strategic planning only (hospital services) and those that will delegated in terms of both service delivery and strategic planning (community services) as previously reported to the NHS Grampian Board. In addition there needs to be scope in the wording of the Scheme to permit the delegation of services that are not included as mandatory in the legislation i.e. this needs to state that there will be a process and criteria agreed between NHS Grampian and the IJBs to make the decision on further delegation of services – this process will lead to a formal decision made by the NHS Grampian Board and the IJBs. The Scheme should also include reference to services that are currently hosted by CHPs that will continue to be hosted on behalf of all three IJBs in the Grampian area. Reference should also be made to the potential for reaching a local agreement in relation to the hosting of strategic planning and service delivery by one IJB on behalf of the other IJBs on a rotational basis. In addition to the IJB taking into account the Parties' requirements to meet their statutory obligations reference should also be made to the need to meet standards required by government and other organisational and service delivery standards set and agreed	This is dealt with in "Local Operational Delivery Arrangements", Annex 3 (hosted services) and Annex 4 (services delegated for strategic planning only). This is set out in Annex 3.

		by the Parties. It would be useful if the Scheme specified the non-voting membership of the IJB. Consideration should also be given to the inclusion of staff side representation on the IJB to be consistent with the NHS principle of partnership working.	As above. It is for the IJB to decide on hosting arrangements. This has been added. This has been added.
	Jenny Wishart Care Home Provider and Scottish Care Member	Regarding non voting membership of the IJB; why there is no representation from the Independent sector on that body?	Not required in the regulations – independent sector are required to be involved in consultation and development of strategic plan and in locality work
	Heather MacRae NHSG	Re 4:3, is it more than just our statutory duty? Responsibilities?	Wording reflects model integration scheme so no change recommended
	ACF & GAAPAC	Some concern has been raised by others	This level of operational detail is

		about how to envisage professional groups such as 'allied health professionals' and 'clinical psychology' being included as delegated services when these are groups of professionals working in services spanning many clinical areas. For example, the majority of psychologists do work within outpatient mental health services but others work within surgery, cancer, persistent pain, diabetes, cardiac services and forensic mental health. Does the individual continue to be part of the non-delegated service? NHSG also employs a significant number of other applied psychologists such as health, counselling and associate psychologists so as a group we would refer to ourselves as 'applied psychologists' Annex part 2 refers to allied health professionals as persons registered with the HPC. All applied psychologists are registered with the HPC. For the purposes of these documents does this term include psychologists as there is no specific mention of them elsewhere other than in the supporting paper.	not required and would not be accepted in the Integration Scheme. This will be set out in operational and workforce plans that we are required to develop.
Local Operational Delivery Arrangements	Graeme Smith NHSG	An important issue for NHS Grampian is the operational delivery of services to patients from more than one IJB and the need for a degree of coordination and consistency across the IJBs e.g. in relation to patient flow, delayed discharges etc. Appropriate text should be included in this section which provides an assurance of a coordinated	To be reflected in revised scheme. We will add "NHS Grampian and the IJB will work together to ensure that the planning and delivery of

		approach. A related issue is the need to support the delivery of Scottish Government targets and standards, and the requirement for a collaborative approach across all partners. These issues also need to be reflected in amendments to this section. In relation to the above the Scheme should confirm that the IJB will take shared responsibility for the planning and delivery of services provided across the Grampian area. Reference should also be made to the need for the IJB to participate actively in the performance monitoring and management arrangements that will be put in place by NHS Grampian to ensure that agreed targets and standards are met, and that the Chief Officer will be accountable to the Chief Executive for the delivery of agreed targets and standards. This section refers to NHS Grampian and the Council providing such information as required by the Chief Officer – this should be amended to "information as may be reasonably required". The relevant paragraph should also state that the IJB will also provide such information as would be reasonably required by the Chief Executive of the Health Board in relation to the planning of the delegated services provided within hospitals.	integrated (and non-integrated) hospital services are consistent." The Parties are not permitted to inform the IJB how it should go about its strategic planning business. This has been included in the new section on "Targets and Performance Measurement". This has been amended.

	Heather MacRae NHSG	(section) is good and clear.	Noted
	Sarah Ward ACC	I think this section would benefit from some diagrams that map out the roles and relationships between the parties.	This is not required in the scheme and will be set out in operational and workforce plans and papers
Support for Strategic Planning	Graeme Smith NHSG	Reference should be made to the need for the IJB strategic plan to support the delivery of Scottish Government and NHS Grampian aims, targets and standards. This section should also include a statement that the Parties individually require to be involved in and approve the IJB strategic plan. Reference should be made to the need to consult with other Health Boards and other IJBs outwith the Grampian area in the preparation of strategic plans.	This is covered in the new section on "Targets and Performance Measurement". This is not permitted by the legislation. The Scottish Government will not allow the scheme to state this. The Parties will be consulted in the development of the strategic plan as is set out in the legislation. Requirements for consultation on the strategic plan are set out in the legislation. The Parties are not permitted to inform the IJB how it is to go about its strategic planning so this cannot be included in the scheme.
	Lynn Morrison NHSG	Similar thoughts (to those expressed in 'local Governance arrangements') related to point 6.7 which focuses again on service users rather than 'people' or 'population'.	Noted but no change recommended

	Heather MacRae NHSG	(section) is good and clear.	Noted
	Sarah Ward ACC	Re 6.7: 'consideration' is all very well, appropriate or otherwise but surely we need proper cross boundary arrangements in place??	Noted – but these not required to be set out in the scheme
Clinical and Professional Governance	Graeme Smith NHSG	This section of the Scheme should be amended to provide clarity on the role of the Board's Clinical Governance Committee as NHS Grampian will retain responsibility for the clinical governance of the delegated services. i.e. the scheme should state that NHS Grampian Board is responsible for clinical and professional governance. Professional governance responsibilities are carried out by the professional leads through to the health professional regulatory bodies. Reference should also be made to the need for the IJB to develop a supporting clinical governance structure and process and that NHS Grampian will support the development of clinical and care team governance to support integrated working and service delivery. This section should be specific about the validation, regulation, supervision, learning, support and continuous improvement of staff. It should be made clear that the	This section has been significantly reworked. The issues have been addressed.

		Professional Reference Group is not a governance group as the governance responsibilities remain with the NHS Grampian Board, Chief Social Work Officer and the IJB i.e. this section should state that Professional Reference Group, bringing together senior professional leaders across Grampian, including Medical Director, Nurse Director, Chief Social Work Officers, and the Director of Public Health, will be established. This group, chaired by one of its members, will oversee professional standards of care and practice to ensure the delivery of safe and effective person-centred care within Grampian. This group will ensure that the responsibilities for Clinical and Professional Governance which remain with NHS Grampian and the Council relate to the activity of the IJB. Reference should be made to the effect that the IJB will ensure that there is evidence of effective information systems and that there are relevant professional and service user networks or groups to feed into the agreed clinical and care governance and professional governance framework. There should also be a statement which confirms that the IJB will be responsible for ensuring that effective mechanisms are in place for service user and carer feedback and complaints handling. The section should also provide clarify that	

		the NHS Grampian Area Clinical Forum (and clinical advisory structure), Managed Clinical and Care Networks, Local Medical Committees, other appropriate professional groups, and the Adult and Child Protection Groups and the clinical advisory structure will be available to provide clinical and professional advice to the IJB. With regard to staff governance the scheme needs to state that NHS Grampian is responsible for ensuring that the NHS national staff governance standards are implemented for those services where NHS Grampian remain the employing organisation. The Integrated Joint Board will be responsible for ensuring that these staff governance standards are embedded within the delegated services.	
	Lynn Morrison NHSG	No mention of where AHP advice will be provided from? - will there be an AHP advisor as part of the non-voting membership and if not how will this advice be sought. This is important to clarify as for example OT services are currently being provided from the health and social care (with the latter provided at arms length through BAC), both with different governance arrangements. Integrated professional governance group - assuming that the 'other clinical leads' would include an AHP lead to ensure governance for this staff group?	AHP Advisor is not a requirement of the regulations or legislation and AHP advice will be sought from the wider professional reference and advisory structures Issues of operational management and structures will be set out in operational and workforce plans

	Heather MacRae NHSG	7;3 In terms of the professional guidance and support, it is more than that, for example to ensure the professional role/function is integral to the structure, and the importance of clinical professional leadership at all levels|? Do worry re duplication as we don't have the capacity to do things in 2 places, would we say as a result of the governance being in existing organisations, we would manage our staff through individual organisations policies, we need to think through how we will do this and it perhaps is something we test when we do the double running? 7:5 clinical and professional, nut it is about all staff governance as well not just professional. 5 Is it more than just under this act, for example as we will have HV's and school nurses and others, in children's services under the children and young peoples act. 7:7 needs to say something re the importance of engagement with all levels of clinical and professional leadership not just hierarchical? Maybe add in something about all levels? Re shared governance? And it isn't just in terms of turning to for advice but professional representation available appropriately during discussions? 7:13 not sure what this means? Need to be clear about where the responsibility for	Noted and will be reflected in operational and workforce plans

		referrals re clinical practice to the IJB is this about lessons learned and reporting ? Need to make sure this is efficient, and using the same templates etc, can see there could be confusion re where the reporting lines are, esp in transition.	
	Sarah Ward ACC	I suspect that social workers and health care professionals might welcome some sort of diagram/s that map out who will be responsible for whom. Re 7.6: In partnership with SCSWIS and Health Improvement Scotland? Re 7.9: 'The non-voting members of the IJB will have a key role in the planning and delivery of services', truism?	Noted but operational and not required for the scheme
	ACF & GAAPAC	Professional supervision and advice – for small professional groups, this may need to be arranged across IJBs on a Grampian wide basis. Further discussion would be welcome about the Integrated Professional Governance group and how will relate to the ACF. What will the membership be? (may not need to be specified for the purpose of this document). Will the individuals in this group be responsible for operational management in the IJB? There has been some feedback that there appears to be a blurring of the operational management focus and strategic focus. There is no mention of professionals other	Noted and a revised section will address this in the final scheme

		than social work, medical and nursing at this level but presumably other clinicians would be part of this group. Would a member of the Integrated Professional Governance group from each IJB attend the ACF? Who will be in the strategic planning group and if/when clinical advice is required where will this come from. Will all IJBs follow the same model? Clear preference expressed for a Grampian wide model.	
Chief Officer	Graeme Smith NHSG	This section should be amended to state that the Chief Executive of NHS Grampian is responsible for the planning and delivery of public health and health services across Grampian not delegated to IJBs. The Chief Executive or a delegated officer will provide information to the Chief Officer on the operational delivery of services etc. There should also be a statement that the Chief Officer is the Accountable Officer for Health and Social Care Integration to the Joint Board. A key element of this role will be to develop close working relationships with elected members of the Council and Non Executive and Executive NHS Grampian Board members. In addition reference should be made to the need for the Chief Officer to establish and maintain effective working relationships with a range of key stakeholders across NHS Grampian, the Council, the third and	This has been added. The Chief Officer's responsibilities to the IJB are set out in the legislation. Re close working relationships - this has been added.

		independent sectors, service users and carers, Scottish Government, trade unions and relevant professional organisations.	This has been added.
	Heather MacRae NHSG	thought this section was good and clear.	Noted.
Workforce	Graeme Smith NHSG	This section should state that staff engaged in the delivery of delegated services shall remain employed by their existing organisations on their current terms and conditions of employment. No changes to terms and conditions of employment are anticipated as a result of integration and should these be identified at a future date, this would be subject to consultation as per the appropriate legislation and terms and conditions. Within the NHS staff have a legal entitlement to be treated in accordance with the Staff Governance standards. This right will continue to apply.	We have included as much detail on this as is permitted by the Scottish Governement.

		This section should state that the Parties are committed to the continued development and maintenance of positive and constructive relationships with recognised trade unions, staff side representatives and professional organisations involved in the integration of health and social care. The section should also include a statement that the Chief Officer will receive support from the human resources and organisational development functions of both parties and together will work with trade unions, staff side representatives and professional organisations to ensure a consistent approach to their continued involvement in the integration of health and social care. There should also be a statement that the establishment of any group, including employee or trade union representatives, will not replace or supersede the role and functions of existing established consultative and partnership arrangements with the Council, NHS Grampian and trade unions without prior agreement. In addition the Scheme should indicate that the Parties are committed to developing any arrangements that may be required to enable a member of staff from one organisation to be managed by a member of staff from another organisation where	

		matters must be dealt with under the arrangements of an individual's employer. Employers will take every opportunity to ensure that policies enable outcomes for individuals and the security and safety of staff within the spirit of integration	
	Heather MacRae NHSG	9:4 is it worth adding in something in this section re professional leadership/guidance? 9:6 we don't have the same statutory supervision that social work has, we have clinical supervision which has been implemented in Health visiting but not in Community nursing. There is a resource issue around this for us? Not sure ensuring an opportunity is the right words, perhaps more an agreed process? 9:7 do we need to say how this joint workforce plan relates to each organisations workforce plan?	These issues have been addressed in the new "Clinical and Professional Governance" section. That is not required.
	Liz Taylor ACC	Suggested new wording for section 9.6: Arrangements will be in place to ensure that professional supervision for clinicians and social workers, required by statute or policy, is provided.	This has been covered in "Clinical and Professional Governance".
	Denise Thomson ACC	'A joint process for the handling of staff complaints will be developed in line with the Parties' existing procedures, which the IJB shall approve'; will staff representatives be consulted on this?	The IJB will no longer approve this – it is for the Parties to make arrangements for this as they consider suitable. It is likely that consultation would take place.

Finance	Graeme Smith NHSG	There should be a statement which confirms that the Council will host the financial transactions of the IJB and that these transactions will cover payments made to the IJB by the Partners and the Direction back to the Partners for commissioned services, cost of the IJB, external audit and the Chief Officer. The recording of the individual transactions of the delegated services will continue to be hosted by health board and local authority. In the paragraphs relating to overspends the the Scheme should state that in the event that an overspend is evident following the application of reserves, the following arrangements will apply for addressing that overspend :- First complete financial year of the IJB – the overspend will be met by the Partner to which the spending Direction for service delivery is given i.e. the Partner with operational responsibility for the service. Future financial years of the IJB – Either a) A single Party may make an additional one off payment to the IJB, or b) The Parties many jointly make additional one off payments to the IJB in order to meet the overspend. The split of one off payments between Parties in this circumstance will be	This is already set out in the Finance section. This has been added.

		based on each Party's proportionate share of the baseline payment to the IJB, regardless of in which arm of the operational budget the overspend has occurred in."	
	Heather MacRae NHSG	10:1:3 Need to be clearer I think in terms of audit and internal scrutiny and how this relates to external scrutiny. Realise now this point and the next one relate to finance only? 10:1:4 again do we need to say something about also relating to each organisations risk assessments etc, in terms of not duplicating, Seems to be a lot of detailed info re finance, maybe need to make sure it is balanced with the other considerations of service provision?	We have been advised to remove these sections from the scheme so they may be set out elsewhere – the Scottish Governement have indicated that it is for the IJB to make these arrangments, not for the Parties to determine.
	Denise Thomson ACC	'In the event of a return of funds to the Parties, the split of returned payments between Parties will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of which arm of the operational budget the underspend occurred in'; Just a query, is this a statutory instruction?	No. This has been amended for the first financial year – see above.
	Sarah Ward ACC	Re 10.1.6: Further details of financial governance and Financial Regulations are contained in a separate document out with this Scheme (what is this document called? Is it publicly available?) Sections 10.6 and 10.7 would benefit from	Work is still underway on this by the Joint Resources Group.

		diagrams that map the roles and relationships between parties.	Noted.
Participation and Engagement	Heather MacRae NHSG	(section is) good and clear.	Noted.
	Sarah Ward ACC	For 11.1 to be true then the methodology used to consult with the various stakeholders groups should be mentioned here (the consultation feedback should be pulled together in a separate report). 12.1; Would the noun 'protocol' not be better suited in this context?	Yes, that has been added. That is not the terminology expected by the Scottish Government.
Information Sharing and Confidentiality	Kate McKay, ACC	Clarification on who will be the data protection lead? Will each organisation continue to adhere to its own processes in relation to data management, data protection and data sharing?	A Joint Grampian Information Sharing Group for integration has been established. We already have a Grampian Memorandum of Understanding and Information Sharing Protocol for adult services. The Group will review these documents and the procedures etc.
	Heather MacRae NHSG	(Section is) good and clear.	Noted.
Complaints	Kate McKay, ACC	A joint complaints protocol between ACC	Noted.

		and NHS(G) already exists. Until such time as the SW legislation is repealed, there will need to be a process for managing complaints within the different legislation – this includes an independent ACC committee to review complaints (Complaints Review Committee).	
	Heather MacRae NHSG	13:3 needs to be a bit stronger than communicate, communicate and work together if appropriate ? 13:5 should it be feedback, as we do get good feedback that we need to share as well, lessons learned, think it would be good to acknowledge building on good practice already in each organisation? Something about continuing good principles of enabling staff to do local resolution?(there would be words in both our existing organisations feedback systems you could probably cut and paste.)	Further arrangements may be made but these will not be included in the integration scheme. The legislation only requires this section to deal with Complaints. Further arrangements can be made outside of the scheme.
	Sarah Ward ACC	13.2: 'The IJB will aspire to have a streamlined process for complaints relating to delegated services. Until such time as this process is achieved, complaints should continue to be made to the Parties using the existing mechanisms'. I'm not sure 'streamlined' is the best adjective to use in relation to complaints – what about 'comprehensive'? (the way I read this paragraph is that the IJB will be responsible for dealing with complaints that relate to delegated services).	We have clarified that any changes to existing complaints procedures will be set out in an amended integration scheme after further consultation. We will require to await changes to the existing legislation on complaints before this can happen.

			Including this in the scheme makes it a legal requirement.
		Re 13.3 'The parties shall communicate with each other in relation to any complaint that requires investigation or input from the other organisation'; truism? Re 13.5: The IJB will use complaints as a valuable tool for improving services and to identify areas where further staff training may be of benefit. Good for the IJB! Is this statement necessary? Re 13.7: The complaints procedures will be clearly explained, well-publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services (but not streamlined!! What will be the relationship with existing NHS/Council procedures? It wouldn't be good if users of delegated services had a less effective route of redress that those of non-delegated services. What will be the relationship between the IJB and the statutory regulators (HSE, SCSWIS, and Healthcare Improvement Scotland).	Yes, this is required in order to meet Scottish Ministers' approval. Any changes to the complaints process will only occur after further consultation (and changes to the legislation) – see above. Details of this have been added to the "Clinical and Professional Governance" section. They will still provide external scrutiny.
Claims Handling,	Denise Thomson ACC	Will both ACC and NHSG be retaining their	Yes.

Liability and Indemnity		own public and employers liability insurance?	
Risk Management	Graeme Smith NHSG	This section should indicate that a process will be put in place which will ensure that risks and responsibilities for risks will be clearly identified and apportioned using the NHS Grampian risk management process as appropriate.	This is addressed in this section.
	Heather MacRae NHSG	15 this is headed up risk management, but is this just risk management relating to the IJB? Is each of our organisations still having a risk register? Or is all our risks within the IJB ? Is this the case during the transitional period as well?? 15:6 don't understand this statement, risk management is in all our job descriptions some more than others. Is it more about resourcing the process's required? Or is a statement saying we need to resource to safely deliver what is expected of us? In which case that is difficult as I don't think we have that now?	Both Parties will still require to manage risks. This section deals mainly with risks for the IJB, but recognises that there may be overlap. It means resources are required for the IJB to have an effect risk management strategy in place.
	Sarah Ward ACC	Will the Risk Management strategy be made public? Re 15.6: The Parties will provide appropriate resource to ensure that the risk management of the IJB is delivered to a high standard (this doesn't read too well.	That is for the IJB to determine. See comment above.

		What about something along the lines of: The Parties will provide the appropriate resources to ensure that the IJB can manage the identified risks.	
Other Comments	Sandy Reid NHSG	Unpaid carers - still reads at times to me that they are not recognised as a key part of our "workforce" eg " main purpose is to improve wellbeing of service users" (page 2) ; 6.7 " the plan is written for users (no reference to carers).	That is the way this is set out in the legislation – we cannot alter the wording.

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Appendix 3: Development of Integration Scheme

1.1 A model integration scheme was produced by the Scottish Government's Legal Working Group in consultation with SOLAR (The Society of Local Authority Lawyers & Administrators in Scotland) and the CLO (NHS Central Legal Office). The Aberdeen City integration scheme follows this model and has been significantly developed in line with local requirements.

1.2 Careful consideration has been given to the level of detail in the integration scheme – arrangements must be clear and fit for purpose, however they require to retain some flexibility for ongoing development of integration arrangements over the next five years.

1.3 Of particular importance to the development of in the integration scheme has been the Scottish Government's guidance entitled "A guide to reviewing an Integration Scheme". This is an internal Scottish Government document which was developed to support Scottish Ministers to review integration schemes when considering them for approval. It provides an overview of what the Scottish Government expect integration schemes to contain. This document was shared with Chief Officers in late December 2014, to support local work to develop integration schemes.

1.4 In considering the above guidance, it was noted that further detail required to be added to the Aberdeen City draft integration scheme in order to meet Scottish Minster's expectations and thus approval. Accordingly, the integration scheme has been developed in line with this.

1.5 The section on "Clinical and Professional Governance" was completely revised. It was considered that this section in the consultation draft was not sufficiently robust and further work was carried out to strengthen the arrangements, having regard to the Scottish Government's Clinical and Care Governance Framework, other national input and further consideration of the existing local arrangements.

1.6 Other additions have been added to various sections. These do not result in any material changes from the consultation draft, but are included to provide extra information regarding the arrangements, where that is considered to be helpful or necessary to meet the level of detail required.

Appendix Four: Rapid Impact Checklist; an Equality and Diversity Impact Assessment Tool:

Health and Social Care Integration Scheme for Aberdeen City, February 2015

Which groups of the population do you think will be affected by this proposal?
Other groups:

- Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers)
- Women and men
- People with mental health problems
- People in religious/faith groups
- Older people, children and young people
- People of low income
- Homeless people
- Disabled people
- People involved in criminal justice system
- Staff
- Lesbian, gay, bisexual and transgender

NHS Grampian and Aberdeen City Council staff involved in the provision of health and social care services in Aberdeen City. People who live in Aberdeen City and who use health and social care services. These individuals may be members of several of the above groups.

N.B The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed	What positive and negative impacts do you think there may be? Which groups will be affected by these impacts?
What impact will the proposal have on lifestyles? For example, will the changes affect: • Diet and nutrition	√ Positive. The Integration Scheme emphasises the need for people to look after and improve their own health.

• Exercise and physical activity	√ Positive. The Integration Scheme emphasises the need for people to look after and improve their own health.
• Substance use: tobacco, alcohol and drugs?	√ Positive. Drug and alcohol services are included in the Integration Scheme.
• Risk taking behaviour?	√ Positive. One of the key aims of the integration process is to ensure that services are provided in such a way that users are kept safe from harm.
• Education and learning or skills?	√ Positive. The Integration Scheme is a learning opportunity for NHS Grampian and Aberdeen City Council staff involved in the provision of health and social care services in Aberdeen City. It is also a learning opportunity for people who live in Aberdeen City and who use health and social care services and the wider community in general.
Will the proposal have any impact on the social environment? Things that might be affected include:	
• Social status	None.
• Employment (paid or unpaid)	Negative. All re-organisations lead to uncertainty and stress for the staff directly involved. Integration may also have implications for employment prospects.
	√ Positive. A key aim of the Integration Scheme is to provide support for unpaid carers to reduce any negative impacts that caring may have on their own health and well being.
• Social/Family support	√ Positive. A key aim of the Integration Scheme is to provide support for unpaid carers to reduce any negative impacts that caring may have on their own health and well being.

• Stress	Negative. All re-organisations lead to uncertainty and stress for the staff directly involved. Integration may also have implications for employment prospects.
• Income	Negative. Integration may have implications for employment and thereby income.
Will the proposal have any impact on the following?	
• Discrimination?	Negative. The Integration Scheme document does not fully comply with the requirements of the Royal National Institute for the Blind “Good Practice“Guidelines.
• Equality of opportunity?	None.
• Relations between groups?	None.
Will the proposal have an impact on the physical environment? For example, will there be impacts on:	
• Living conditions?	√ Positive. The integration process should allow people with disabilities, long term conditions or who are frail, to live as far as reasonably practical, independently and at home, or in a homely setting in their community, for longer.
• Working conditions?	Negative. The Integration process might require staff to move locations. This can be stressful to staff.
• Pollution or climate change?	None.

• Accidental injuries or public safety?	√ Positive. One of the key aims of the integration process is to ensure that services are provided in such a way that users are kept safe from harm.
• Transmission of infectious disease?	None.
Will the proposal affect access to and experience of services? For example,	
• Health care	√ Positive. The integration of health and social care should lead to "seamless" care for the population of Aberdeen City. This should enhance the health and social care experience.
• Transport	None.
• Social services	√ Positive.
• Housing services	√ Positive. Care Home and other residential provision will be part of the integrated service.
•	
• Education	√ Positive. The Integration Scheme is a learning opportunity for NHS Grampian and Aberdeen City Council staff involved in the provision of health and social care services in Aberdeen City. It is also a learning opportunity for people who live in Aberdeen City and who use health and social care services and the wider community in general.

For further information please contact: Nigel Firth, Equality and Diversity Manager on (01224) 552245 or by email at: Nigel.firth@nhs.net or internal NHS Extension 52245

Comments on the Health and Social Care Integration Scheme for Aberdeen City, February 2015

The Aberdeen City Health and Care integration Scheme is an extremely well written document that reflects the hard work and careful consideration that went into its production. The author(s) are to be congratulated. The document conveys a great deal of important information, in a straightforward and easy to understand way.

There is only one item which requires to be addressed to make the Integration Scheme compliant with all current equality and diversity legislation. This is detailed at 1 below. Some other, hopefully helpful suggestions are made at 2.

1. Royal National Institute for the Blind (RNIB) Guidelines

As public bodies, both Aberdeen City Council and NHS Grampian must be exemplars of good practice. Accordingly, both organisations must ensure that their published literature complies with the Royal National Institute for the Blind (RNIB) Good Practice Guidelines, as contained in the RNIB publication: “See it right, making information accessible for people with sight problems”. The RNIB guidelines require that material is produced in a format that most partially sighted persons can read, without the need for adaptations. This is “mainstreaming” the needs of the partially sighted. If we do not make information accessible, we are in breach of the Disability Discrimination Act 2005 General Duty Section f) and the Equality Act 2010.

The Integration Scheme is largely compliant, except for:

- Text in tight boxes merges with the box and is exceptionally difficult for a person with a sight problem to read. There is text in a tight box on page 66.

- Text should be in a sans serif font such as Arial, minimum font size 12. The Integration Scheme has text in Arial size 10 throughout the document, for example on pages 7, 8, 9, 10, 11, 12, 13, 17 etc.

2. Other considerations

(i) Pagination on pages 12, 17, 25, 28 and 68

Headings appear at the bottom of these pages, but the text to which they refer is on the next page. It is suggested that the pagination requires to be adjusted

(ii) Paragraph spacing

The paragraph spacing is irregular throughout the document. For example, on pages on pages 7, 8, 9, 11, 21, 31 etc and requires to be adjusted.

(iii) Irregular indentation of paragraphs

There is an inconsistency of paragraph indentation throughout the document. For example on pages 8, 9, 11, 14, 15, 19, 21 etc. This requires to be addressed.

Rapid Impact Checklist: Summary Sheet

Health and Social Care Integration Scheme for Aberdeen City, Consultation Draft December 2014

Positive Impacts (Note the groups affected)	**Negative Impacts (Note the groups affected)**
The Integration Scheme: • Will enable health and social care services to be provided "seamlessly" for the population of Aberdeen City. This should enhance the health and social care experience. • Allow people with disabilities, long term conditions or who are frail, to live as far as reasonably practical, independently and at home, or in a homely setting in their community, for longer. • Emphasise the need for people to look after and improve their own health. • Will provide enhanced support for unpaid carers to reduce any negative impacts that caring may have on their own health and well being. • Ensure that services are provided in such a way that users are kept safe from harm. • Is a learning opportunity for NHS Grampian and Aberdeen City Council staff involved in the provision of health and social care services in Aberdeen City. It is also a learning opportunity for people who live in Aberdeen City and who use health and social care services and the wider community in general.	• The Integration Scheme document does not fully comply with the requirements of the Royal National Institute for the Blind "Good Practice" Guidelines • All re-organisations lead to uncertainty and stress for the staff directly involved. Integration may also have implications for employment prospects and require some staff relocations.
Additional Information and Evidence Required None.	
Recommendations	

If the one item described on the attached Comments Sheet is addressed, the Integration Scheme will be fully compliant with all current equality and diversity legislation.
From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not? Yes, but this one item can be easily overcome if the changes detailed on the attached Comments Sheet are made. A full EQIA is not required

Signature(s) of Level One
Impact Assessor(s)

Date:

Signature(s) of Level Two
Impact Assessor(s) Nigel Firth,
Equality and Diversity Manager,
NHS Grampian

Date: 16th February 2015

Appendix 5

Health and Social Care Integration Scheme for Aberdeen City

March 2015

This document is also available in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on (01224) 551116 or (01224) 552245.

1. Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 provides a framework for the effective integration of adult health and social care services. Its policy ambition is to:

"…improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their own homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older."

To realise this ambition, the Aberdeen City Health and Social Care Partnership (the Integration Authority) will be established with a remit to engage with the people who use our services, their carers, our workforce, the third and independent sectors and community representatives in the planning and delivery of integrated adult health and social care services that will make a positive difference to the health and wellbeing of our City's population.

2. Aims and Outcomes of the Integration Scheme

The parent bodies, Aberdeen City Council and NHS Grampian have a strong and shared sense of commitment and motivation to work closely with the citizens and communities of Aberdeen to deliver good quality, person centred integrated health and social care services.

This commitment is reflected in the Partnership's vision "***A caring partnership working together with our city communities to enable people to achieve fulfilling, healthier lives".***

The underpinning values that will inform the Partnership's approach to planning and service delivery are:

- Person Centred
- Caring
- Empowering
- Enabling
- Team work/Co-operation

The parent bodies are required to take into account the integration principles when preparing this Integration Scheme. These principles clearly state that the main purpose of integrated services is to improve the wellbeing of service users and these services should be provided in a way in which, so far as possible:

- Is integrated from the point of view from recipients
- Takes account of the particular needs of different recipients
- Takes account of the particular needs of recipients from different parts of the area in which the service is being provided
- Takes account of the particular characteristics and circumstances of different service users
- Respects the rights of service users
- Takes account of the dignity of service users
- Takes account of the participation by service users in the community in which service users live
- Protects and improves the safety of service users
- Improves the quality of the service
- Is planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising, and
- Makes the best use of the available facilities, people and other resources

The Partnership will be obliged to evidence how well the nine National Health and Wellbeing outcomes are being met; these are:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5. Health and social care services contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

7. People using health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of health and social care services.

Integration Scheme

The parties:

THE ABERDEEN CITY COUNCIL, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at Town House, Broad Street, Aberdeen AB10 1AQ (hereinafter referred to as "the Council" which expression shall include its statutory successors);

And

GRAMPIAN HEALTH BOARD, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Grampian") and having its principal offices at Summerfield House, 2 Eday Road, Aberdeen AB15 6RE (hereinafter referred to as "NHS Grampian" which expression shall include its statutory successors)

(together referred to as "the Parties", and each being referred to as a "Party")

1. Definitions and Interpretation

1.1 In this Integration Scheme, the following terms shall have the following meanings:-

"The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;
"The Parties" means the Aberdeen City Council and NHS Grampian;
"The Scheme" means this Integration Scheme;
"IJB" means the Integration Joint Board to be established by Order under section 9 of the Act;
"Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;
"The Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

“IJB Order” means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;
“Delegated services” means the functions and services listed in Annexes 1 and 2 of this Scheme;
“Strategic Plan” means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Act;
“Direction” means an instruction from the Integration Joint Board in accordance with section 26 of the Act;
“Integrated Budget” means the Budget for the delegated resources for the functions set out in the Scheme;
“Payment” means all of the following: a) the Integrated Budget contribution to the Integration Joint Board; b) the resources paid by the Integration Joint Board to the Parties for carrying out directions, in accordance with section 27 of the Act and c) does not require that a bank transaction is made;
“Chief Officer” means the Officer appointed by the Integration Joint Board in accordance with section 10 of the Act;
“Accountable Officer” means the NHS officer appointed in terms of section 15 of the Public Finance and Accountability (Scotland) Act 2000; and
“Section 95 Officer” means the statutory post under the Local Government (Scotland) Act 1973 being the Accountable (Proper) Officer for the administration and governance of the financial affairs of the Council.

1.2 In implementation of their obligations under the Act, the Parties hereby agree as follows:

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

2. Local Governance Arrangements

2.1 Having regard to the requirements contained in the Regulations, the Parties require to supply the detail of the remit and constitution of the IJB which includes, but is not limited to, the following:

2.1.1 The IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in their area in accordance with sections 29-39 of the Act.

2.1.2 The regulation of the IJB's procedure, business and meetings will follow the Standing Orders which will be agreed by the IJB, and which may be amended by the IJB. The Standing Orders will be set out in a separate document.

2.1.3 NHS Grampian and the Council will continue to have in place an appropriate governance structure to ensure effective delivery of any functions or services not delegated as part of this Scheme.

2.1.4 NHS Grampian and the Council and any of their Committees will positively support through productive communication and interaction the IJB and its Committees to allow it to achieve its Outcomes and Vision. The IJB will similarly support through productive communication and interaction NHS Grampian and the Council and any of their Committees in their delivery of delegated and non-delegated services.

2.1.5 The IJB will have distinct legal personality and the autonomy to manage itself. There is no role for NHS Grampian or the Council to independently sanction or veto decisions of the IJB.

2.1.6 The IJB will create such Committees that it requires to assist it with the planning and delivery of delegated services.

2.1.7 The IJB will be a statutory partner in the Community Planning Partnership.

3. Board Governance

3.1 The arrangements for appointing the voting membership of the IJB in accordance with the IJB Order are as follows:-

3.1.1 The Council shall nominate four councillors; and

3.1.2 NHS Grampian shall nominate four health board members, which shall comprise of three non-executive directors and one executive director.

3.2 The voting membership of the IJB shall be appointed for a term of up to 3 years.

3.3 Provision for the disqualification, resignation and removal of voting members is set out in the IJB Order.

3.4 Whilst serving on the IJB its voting members carry out their functions under the Act on behalf of the IJB itself, and not as delegates of their respective Parties. Accurate record-keeping and minute-taking will be essential for transparency and accountability purposes.

3.5 The IJB is required to co-opt non-voting members to the IJB.

3.6 The non-voting membership of the IJB is set out in the IJB Order and includes (subject to any amendment of the IJB Order):

a) the chief social work officer of the local authority;
b) the Chief Officer, once appointed by the IJB;
c) the proper officer of the integration joint board appointed under section 95 of the Local Government (Scotland) Act 1973;
d) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in

accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;

e) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and

f) a registered medical practitioner employed by the Health Board and not providing primary medical services;

and at least one member of each of the following groups:

g) staff of the constituent authorities engaged in the provision of services provided under integration functions;

h) third sector bodies carrying out activities related to health or social care in the area of the local authority;

i) service users residing in the area of the local authority; and

j) persons providing unpaid care in the area of the local authority.

3.7 NHS Grampian will determine the non-voting representatives listed in d)-f) above, in terms of the IJB Order.

3.8 The arrangements for appointing the Chair and Vice Chair of the IJB are as follows:

3.8.1 The first Chair shall be nominated by the Council.

3.8.2 The organisation which has not nominated the Chair shall nominate the Vice Chair.

3.8.3 After the term of the first Chair comes to an end, the Vice Chair will become the next Chair and the outgoing Chair's organisation will then nominate the next Vice Chair, which the IJB shall appoint.

3.8.4 The term of the first Chair shall end on 31 December 2016.

3.8.5 The second term of Chair shall begin on 1 January 2017, with further terms of Chair beginning on the first day of January every two years thereafter.

4. Delegation of Functions

4.1 The functions that are to be delegated by NHS Grampian to the IJB are set out in Part 1 of Annex 1. The services to which these functions relate, which are currently provided by NHS Grampian and which are to be integrated, are set out in Part 2 of Annex 1.

4.2 The functions that are to be delegated by the Council to the IJB are set out in Part 1 of Annex 2. The services to which these functions relate, which are currently provided by the Council and which are to be integrated, are set out in Part 2 of Annex 2.

4.3 In exercising its functions, the IJB must take into account the Parties' requirements to meet their respective statutory obligations, standards set by government and other organisational and service delivery standards set by the Parties. Apart from those functions delegated by virtue of this Scheme, the Parties retain their distinct statutory responsibilities and therefore also retain their formal decision-making roles.

4.4 The delegation of functions from the Parties to the IJB shall not affect the legality of any contract made between either of the Parties and any third party, which relates to the delivery of delegated or non-delegated services. The IJB shall be mindful of the Parties existing contracts and shall enter into a joint commissioning strategy with the Parties.

4.5 Some delegated services may be hosted by the IJB on behalf of other integration authorities, or some delegated services may be hosted by another integration authority on behalf of the IJB. The IJB will consider and agree the hosting arrangements.

5. Local Operational Delivery Arrangements

5.1 The local operational arrangements agreed by the Parties are:

5.2 The responsibilities of the membership of the IJB in relation to monitoring and reporting on the delivery of delegated services on behalf of the Parties are as follows:-

5.2.1 The IJB is responsible for the planning of delegated services and achieves this through the Strategic Plan. It issues Directions to the Parties to deliver services in accordance with the Strategic Plan.

5.2.2 The IJB will continue to monitor the performance of the delivery of delegated services using the Strategic Plan on an ongoing basis.

5.2.3 The IJB will as a minimum make an annual report in the form of a bulletin to NHS Grampian's Health Board and the Council's Full Council. This may be in the form of the annual performance report required by the Act. It informs the Parties by reporting on the performance of the delivery of services against the Strategic Plan.

5.3 The IJB will have operational oversight of delegated services, including services that it hosts but not including the health services listed in Annex 4 or services which are hosted by another integration authority.

5.4 The IJB will take decisions in respect of delegated services for which it has operational oversight.

5.5 The IJB shall ensure that resources are managed appropriately for the delivery of delegated services for which it has operational oversight, in implementation of the Strategic Plan.

5.6 On the date on which functions are delegated to the IJB, criminal justice services shall initially be operationally managed by the Council. However, it is anticipated that a date will be identified when the IJB will become responsible

for the operational oversight of this service, through agreement of the Council and the IJB.

5.7 The IJB will, through the Chief Officer, have an appropriate role in the operational delivery of services by the Parties in the carrying out of integration functions. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved. For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

5.8 For delegated services that the IJB does not have operational oversight of, the IJB shall be responsible for the strategic planning of those services. The IJB shall monitor performance of those services in terms of outcomes delivered via the Strategic Plan.

5.9 NHS Grampian and the Council will be responsible for the operational delivery of delegated services in implementation of Directions of the IJB.

5.10 The Parties shall provide such information as may be reasonably required by the Chief Officer, the IJB and the Strategic Planning Group to enable the planning, monitoring and delivery of delegated services.

5.11 NHS Grampian and the IJB will work together to ensure that the planning and delivery of integrated (and non-integrated) hospital services are consistent.

6. Corporate Support Services

6.1 The IJB will require various corporate support services in order to fully discharge its duties under the Act.

6.2 In preparation for integration, the Shadow IJB (Transitional Leadership Group) has been provided with corporate support by the Parties through joint "workstreams". This has allowed appropriate advice and support to be given on areas such as finance, legal, human resources, information sharing etc.

6.3 The Shadow IJB shall identify, and may review, the corporate resources it requires for the period between April 2015 and April 2016, including the provision of any professional, technical or administrative services for the purpose of preparing a Strategic Plan and carrying out delegated functions. This assessment shall be made available to the Parties.

6.4 Between April 2015 and April 2016, the Parties shall be responsible for ensuring that the IJB has provision of suitable resources for corporate support to allow it to fully discharge its duties under the Act.

6.5 The Parties and the IJB shall reach an agreement in respect of how these services will be provided to the IJB which will set out the details of the provision.

6.6 Before the end of April 2016, the Parties and the IJB will review the support services being provided to ensure that these are sufficient. The Parties and the IJB shall agree on the arrangements for future provision, including specifying how these requirements will be built into the IJB's annual budget setting and review process.

7 Support for Strategic Planning

7.1 The Parties shall share with such other relevant integration authorities, the necessary activity and financial data for services, facilities or resources that

relate to the planned use of services provided by those integration authorities for the users of adult health and social care services of Aberdeen City.

7.2 The Parties shall consult with the IJB on any plans to change service provision of non-delegated services which may have a resultant impact on the Strategic Plan.

7.3 The Strategic Plan is written for users of adult health and social care services within Aberdeen City. A number of individuals will receive services across a boundary of an integration authority. NHS Grampian will provide support to enable the appropriate planning of such services for these individuals.

8. Targets and Performance Measurement

8.1 The Parties will make a recommendation to the IJB setting out which performance targets and improvement measures it considers the IJB should take account of as it discharges its functions.

8.2 The Parties will identify which performance targets and improvement measures are connected exclusively with the planning and delivery of delegated functions and for which responsibility should transfer exclusively to the IJB.

8.3 The Parties will identify which performance targets and improvement measures relate to services which have both delegated and non-delegated functions and for which it is considered that the responsibility for those targets and measures should be shared between the IJB and the relevant Party. Where the responsibility for achieving the targets span delegated and non-delegated services, the Parties and the IJB will work together to deliver these.

8.4 A set of shared principles for targets, measures and indicators will be developed and agreed by the Parties and the IJB. This will take into account

the Scottish Government's Guidance on the Outcomes and the associated core suite of indicators for integration.

8.5 A group comprised of senior staff from both Parties will be responsible for developing a performance framework. The framework will be underpinned by the Outcomes and will be developed to drive change and improve effectiveness. The framework will be informed by an assessment of current performance arrangements and the development of a set of objectives which the framework will be intended to achieve.

8.6 This work will be completed by the time the IJB assumes responsibility for delegated functions and resources.

9. Clinical and Professional Governance

9.1 Outcomes

9.1.1 The IJB will improve and provide assurance on the following Outcomes through its clinical and professional governance arrangements:

- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

9.1.2 The Parties and the IJB will have regard to the integration planning and delivery principles and will determine the clinical and professional

governance assurances and information required by the IJB to inform the development, monitoring and delivery of its Strategic Plan. The Parties will provide that assurance and information to the IJB.

9.2 General Clinical and Professional Governance Arrangements

9.2.1 The Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act.

9.2.2 The Parties remain responsible for the clinical and professional governance of the services which the IJB has instructed the Parties to deliver.

9.2.3 The Parties remain responsible for the assurance of the quality and safety of services commissioned from the third and independent sectors in line with the requirements set out in the Strategic Plan.

9.2.4 The IJB will have regard to healthcare and social care governance quality aims and risks when developing and agreeing its Strategic Plan and its corresponding Directions to the Parties. These risks may be identified by either of the Parties or the IJB, and may include professional risks.

9.2.5 The Parties and the IJB will establish an agreed approach to measuring and reporting to the IJB on the quality of service delivery, organisational and individual care risks, the promotion of continuous improvement and ensuring that all professional and clinical standards, legislation and guidance are met. This will be set out in a report to the IJB for it to approve.

9.3 Clinical and Professional Governance Framework

9.3.1 NHS Grampian seeks assurance in the area of clinical governance, quality improvement and clinical risk from the NHS Grampian Clinical Governance Committee, through a process of constructive challenge. The Clinical Governance Committee is responsible for demonstrating compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland (or any successor). To achieve this, the Committee oversees a governance framework including a strategy, annual work programme, infrastructure of governance groups and an annual report.

9.3.2 The Council is required by law to appoint a Chief Social Work Officer to oversee and make decisions in relation to specified social work services, some of which are delegated in relation to integration functions, and to report to and alert the Council and elected members of any matters of professional concern in the management and delivery of those functions. He or she has a duty to make an annual report to the Council in relation to the discharge of the role and responsibilities. The Chief Social Work Officer will be a non-voting member of the IJB. If required, he or she shall make an annual report to the IJB in relation to the aspects of his or her position which relate to the delivery of integrated functions. The Chief Social Work Officer will retain all of the statutory decision-making and advisory powers given by statute and guidance, and the Medical and Nursing Directors shall not be entitled to countermand or over-rule any decisions or instructions given by the Chief Social Work Officer in carrying out that statutory role.

9.3.3 External scrutiny is provided by the Care Inspectorate (Social Care and Social Work Improvement Scotland) (or any successor), which regulates, inspects and supports improvement of adult social work and social care.

9.3.4 The Scottish Government's *Clinical and Care Governance Framework for Integrated Health and Social Care Services in Scotland, 2014* (or any updated version or replacement) outlines the proposed roles, responsibilities and actions that will be required to ensure governance arrangements in support of the Act's integration planning and delivery principles and the required focus on improved Outcomes.

9.4 Staff Governance

9.4.1 The Parties will ensure that staff working in integrated services have the right training and education required to deliver professional standards of care and meet any professional regulatory requirements.

9.4.2 The IJB and the Parties shall ensure that staff will be supported if they raise concerns relating to practice that endangers the safety of service users and other wrong doing in line with local policies and regulatory requirements.

9.4.3 Staff employed by NHS Grampian are bound to follow the NHS Staff Governance Standard. This Standard is recognised as being very laudable and the IJB will encourage it to be adopted for all staff involved in the delivery of delegated services. The Staff Governance Standard requires all NHS Boards to demonstrate that staff are:

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

9.4.4 The Standard places a reciprocal duty on staff to:

- Keep themselves up to date with developments relevant to their job within the organisation;
- Commit to continuous personal and professional development;
- Adhere to the standards set by their regulatory bodies;
- Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation;
- Treat all staff and patients with dignity and respect while valuing diversity; and
- Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

9.5 Interaction with the IJB, Strategic Planning Group and Localities

9.5.1 An Integrated Clinical and Professional Governance Group will be established by the Parties to oversee the clinical and professional governance arrangements for integrated services. It will be co-chaired by a senior member of the social work team and the Clinical Lead of the IJB. The Integrated Clinical and Professional Governance Group will have membership of senior professionals which shall be representative of the range of professional groups involved in delivering health and social care services. This shall include at least one lead from each of the Parties' senior professional staff, which may be the Chief Social Work Officer and Nursing and Medical Directors.

9.5.2 The three professional advisors of the IJB listed at 9.5.5 b)-d) shall be members of the Integrated Clinical and Professional Governance Group. One of these professional advisors may be the Clinical Lead. These advisors will continue to report to the Nursing and Medical Directors.

9.5.3 The role, remit and membership of the Integrated Professional Governance Group shall be developed between April 2015 and April 2016 and shall be set out in a separate document which the IJB shall consider for approval, and which may be reviewed and amended by the IJB.

9.5.4 The Integrated Clinical and Professional Governance Group will provide clinical health care and professional social work advice to the IJB, the Strategic Planning Group, the Chief Officer and any professional groups established in localities as and when required. This can be done through the Chairs of the Integrated Clinical and Professional Governance Group (or such other appropriate members) informing and advising the IJB, the Strategic Planning Group, the Chief Officer and any other Group, Committee or locality of the IJB as and when required.

9.5.5 The IJB and the Chief Officer shall also be able to obtain clinical and professional advice from the IJB non-voting membership, which shall include (subject to any amendment of the IJB Order):

a) The Chief Social Work Officer;
b) A registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
c) A registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and
d) A registered medical practitioner employed by the Health Board and not providing primary medical services.

9.5.6 The Integrated Clinical and Professional Governance Group will be represented on the established clinical and professional forums/groups of both the Council and NHS Grampian to address matters of risk,

safety and quality. The Integrated Clinical and Professional Governance Group will be aligned with both Parties' arrangements.

9.5.7 A Schematic showing the Integrated Clinical and Professional Governance Group's relationship to the NHS Grampian Clinical Governance Committee and the health board is set out in a separate document.

9.5.8 A similar Schematic is not available for the Council's assurance mechanisms, since this does not have a similar structure. If the Chief Social Work Officer is not a member of the Integrated Clinical and Professional Governance Group, then that Group will provide such information as may be required by the Chief Social Work Officer to provide him/her with the necessary assurance regarding the arrangements for social care governance for delegated services. In turn, the Chief Social Work Officer may then report to the Council to provide any necessary assurance as required.

9.5.9 The NHS Grampian Area Clinical Forum (and clinical advisory structure), Managed Clinical and Care Networks, Local Medical Committees, other appropriate professional groups, and the Adult and Child Protection Groups and the clinical advisory structure will be available to provide clinical and professional advice to the IJB

9.6 Professional Leadership

9.6.1 The Act does not change the professional regulatory framework within which health and social care professionals work, or the established professional accountabilities that are currently in place within the NHS and local government. The Act through drawing together the planning and delivery of services aims to better support the delivery of improved outcomes for the individuals who receive care and support across health and social care.

9.6.2 Medical Directors and Nursing Directors are ministerial appointments made through health boards to oversee systems of professional and clinical governance within the Health Board. Their professional responsibilities supersede their responsibilities to their employer. These Directors continue to hold responsibility for the actions of NHS Grampian clinical staff who deliver care through delegated/integrated services. They, in turn, continue to attend the NHS Grampian Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by NHS Grampian.

9.6.3 In addition to the Integrated Clinical and Professional Governance Group, advice can be provided to the IJB and the Strategic Planning Group through the Clinical Executive Directors of NHS Grampian and the Chief Social Work Officer of the Council on professional / workforce, clinical / care and social care / social work governance matters relating to the development, delivery and monitoring of the Strategic Plan, including the development of integrated service arrangements. The professional leads of the Parties can provide advice and raise issues directly with the IJB either in writing or through the representatives that sit on the IJB. The IJB will respond in writing to these issues where asked to do so by the Parties.

9.6.4 The key principles for professional leadership are as follows:

- Job descriptions will reflect the level of professional responsibility at all levels of the workforce explicitly.
- The IJB will name the Clinical Lead and ensure representation of professional representation and assurance from both health and social care. The Nurse and Medical Directors will continue to have professional managerial responsibility.
- All service development and redesign will outline participation of professional leadership from the outset, and this will be evidenced in all IJB papers.

- The effectiveness of the professional leadership principles will be reviewed annually.

10. Chief Officer

10.1 The IJB shall appoint a Chief Officer in accordance with section 10 of the Act. The arrangements in relation to the Chief Officer agreed by the Parties are:

10.2 An interim Chief Officer may be appointed by arrangements made jointly by the Chief Executives of both Parties in consultation with the Chair of the IJB.

10.3 The Chief Officer will be responsible for the operational management of delegated services, other than those listed in Annex 4 or hosted by another integration authority. Further arrangements in relation to the Chief Officer's responsibilities for operational management and strategic planning will be set out in a separate document, which the IJB shall consider for approval and which it may amend.

10.4 The Chief Officer will be responsible for the development and monitoring of operational plans which set out the mechanism for the delivery of the Strategic Plan.

10.5 The Chief Executive of NHS Grampian will be the Accountable Officer for the planning and delivery of non-delegated health services.

10.6 The Chief Executive of NHS Grampian will be the Accountable Officer for the delivery of the acute services that the IJB has strategic planning responsibility for and will provide updates to the Chief Officer on the operational delivery of those services provided and the set aside budget on a regular basis.

10.7 The Chief Officer will be a member of the appropriate senior/corporate management teams of NHS Grampian Health Board and the Council. This will

enable the Chief Officer to work with senior management of both Parties to carry out the functions of the IJB in accordance with the Strategic Plan.

10.8 The Chief Officer will be line managed by and will report to the Chief Executive of the Council and the Chief Executive of NHS Grampian.

10.9 The Chief Officer will develop close working relationships with elected members of the Council and non-executive and executive NHS Grampian board members.

10.10 The Chief Officer will establish and maintain effective working relationships with a range of key stakeholders across NHS Grampian, the Council, the third and independent sectors, service users and carers, the Scottish Government, trade unions and relevant professional organisations.

10.11 The Chief Officer will work with trade unions, staff side representatives and professional organisations to ensure a consistent approach to their continued involvement in the integration of health and social care.

11. Workforce

11.1 The arrangements in relation to their respective workforces agreed by the Parties are:

11.2 Staff engaged in the delivery of delegated services shall remain employed by their existing organisations on the date the IJB is established. If the roles of staff are to be transferred, the Parties will ensure that the principles of TUPE will be adhered to. The Parties will develop an agreed process for this which will be set out in a separate document.

11.3 The IJB is planning to have a fully integrated management arrangement where it is recognised teams will have individuals reporting through a person employed by the other organisation. Both Parties are in agreement that staff

employed by them will be subject to direction from a manager from the other organisation.

11.4 A joint process for the handling of staff complaints will be developed in line with the Parties' existing procedures.

11.5 The Council and NHS Grampian will develop a joint workforce plan that will be aligned to objectives set by the IJB.

11.6 The joint workforce plan will cover the strategic Organisational Development outcomes, workforce planning and development, and will support the workforce in the delivery of integrated services. The plan will cover staff communication, staff engagement, staff and team development, leadership development and the training needs for staff that will be responsible for managing integrated teams. This will encourage the development of a healthy organisational culture. The Parties will work together in developing this plan along with stakeholders. The plan will be presented to the IJB for approval by 31 March 2016 and will be reviewed regularly through an agreed process to ensure that it takes account of the development needs of staff.

12. Finance

12.1 Financial Governance

12.1.1 Details of financial governance and Financial Regulations are contained in a separate document outwith this Scheme.

12.2 Payments to the IJB – General

12.2.1 The payment made by each Party is not an actual cash transaction for the IJB. There will be a requirement for an actual cash transfer to be made between the Parties to reflect the difference between the

payment being made by a Party and the resources delegated by the IJB to that Party to deliver services. Any cash transfer will take place between the Parties monthly in arrears based on the annual budgets set by the Parties and the directions from the IJB. A final transfer will be made at the end of the financial year on closure of the annual accounts of the IJB to reflect in-year budget adjustments agreed.

12.2.2 Resource Transfer – The existing resource transfer arrangements will cease upon establishment of the IJB and instead NHS Grampian will include the equivalent sum in its budget allocation to the IJB. The Council payment to the IJB will accordingly be reduced to reflect this adjustment.

12.2.3 Value Added Tax (VAT) – the budget allocations made will reflect the respective VAT status and treatments of the Parties. In general terms budget allocations by the Council will be made net of tax to reflect its status as a Section 33 body in terms of the Value Added Tax Act 1994 and those made by NHS Grampian will be made gross of tax to reflect its status as a Section 41 body in terms of the Value Added Tax Act 1994.

12.3 Payments to the IJB – 1st Financial Year

12.3.1 Each Party will follow their existing budget setting process in setting budgets for delegated functions for the financial year commencing 1 April 2015, giving due consideration of recent past performance and existing plans. The outcome of this process will be to set a recurring budget for the IJB for delegated functions as at 1 April 2015.

12.3.2 In doing so, the Parties will treat budget setting for delegated functions in a manner which is consistent with their budget setting process for other services provided by the Parties (i.e. the fact that delegated functions will become integrated should not influence the way in which

budgets are set for delegated functions). Appropriate due diligence will be carried out by the IJB and Parties. This process will be transparent and the assumptions underlying the budgets must be available to all Parties.

12.3.3 If the IJB becomes formally established part way through the 2015/16 financial year, the Director of Finance of NHS Grampian and the Section 95 Officer of the Council, in consultation with the Chief Finance Officer of the IJB, will agree on a proportionate split of the budget for the year. This would be formally ratified by the Council and NHS Grampian.

12.3.4 Each Party acknowledges that Integration arrangements will still be evolving in 2015/16 and therefore accepts that payment in the first year to the IJB is likely to be indicative in nature. A further due diligence exercise will be carried out at the end of the 2015/16 financial year to assess the adequacy of the payment made in the first year for delegated functions.

12.4 Payments to the IJB - 2nd Financial year onwards

12.4.1 The payment that will be determined by each Party requires to be agreed in advance of the start of the financial year. Each Party agrees that the baseline payment to the IJB for delegated functions will be formally advised to the IJB and the other Party by 28th February each year.

12.4.2 In subsequent years, the Chief Officer and the Chief Finance Officer of the IJB will develop a case for the Integrated Budget based on the Strategic Plan and present it to the Council and NHS Grampian for consideration as part of the annual budget setting process, in accordance with the timescales contained therein. The case should be evidence based with full transparency on its assumptions and analysis

of changes, covering factors such as activity changes, cost inflation, efficiencies, legal requirements, transfers to / from the “set aside” budget for hospital services and equity of resource allocation.

12.4.3 The final payment into the IJB will be agreed by the Parties in accordance with their own processes for budget setting.

12.4.4 The IJB will approve and provide direction to the Parties by 31st March each year regarding the functions that are being directed, how they are to be delivered and the resources to be used in delivery.

12.5 Method for determining the amount set aside for hospital services

12.5.1 The IJB will be responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway.

12.5.2 The IJB and the hospital sector will agree a method for establishing the amount to be set aside for services that are delivered in a large hospital as part of the emergency care pathway which will show consumption by the residents of the IJB.

12.5.3 The method of establishing the set aside budget will take account of hospital activity data and cost information. Hospital activity data will reflect actual occupied bed day and admissions information, together with any planned changes in activity and case mix.

12.6 Financial Management of the IJB

12.6.1 The Council will host the financial transactions specific to the IJB.

12.6.2 The IJB will appoint a Chief Finance Officer who will be accountable for the annual accounts preparation (including gaining the assurances required for the governance statement) and financial planning (including the financial section of the Strategic Plan) and will provide financial advice and support to the Chief Officer and the IJB.

12.6.3 As part of the process of preparing the annual accounts of the IJB the Chief Finance Officer of the IJB will be responsible for agreeing balances between the IJB and Parties at the end of the financial year and for agreeing details of transactions between the IJB and Parties during the financial year. The Chief Finance Officer of the IJB will also be responsible for provision of other information required by the Parties to complete their annual accounts including Group Accounts.

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

12.6.5 The Parties will provide the required financial administration to enable the transactions for delegated functions (e.g. payment of suppliers, payment of staff, raising of invoices etc.) to be administered and financial reports to be provided to the Chief Finance Officer of the IJB. The Parties will not charge the IJB for this service.

12.7 Financial reporting to the IJB and the Chief Officer

12.7.1 Financial reports for the IJB will be prepared by the Chief Finance Officer of the IJB. . The format and frequency of the reports to be agreed by the IJB, the Chief Officer and the Chief Finance Officer of the IJB, but will be at least on a quarterly basis. The Director of Finance of NHS Grampian and the Section 95 Officer of the Council will work with the Chief Finance Officer of the IJB to ensure that the information that is required to produce such reports can be provided.

12.7.2 To assist with the above the Parties will provide information to the Chief Finance Officer of the IJB regarding costs incurred by them on a monthly basis for services directly managed by the IJB. Similarly, NHS Grampian will provide the IJB with information on use of the amounts set aside for hospital services. This information will focus on patient activity levels and not include unit costs; the frequency will be agreed with the IJB, but will be at least quarterly.

12.7.3 The Chief Finance Officer of the IJB will agree a timetable for the preparation of the annual accounts with the Director of Finance of NHS Grampian and the Section 95 Officer of the Council. The timetable for production of the annual accounts of the IJB will be set following the issue of further guidance from the Scottish Government.

12.7.4 In order to give assurance to the Parties that the delegated budgets are being used for their intended purposes, financial monitoring reports will be produced for the Parties in accordance with timetables to be agreed at the start of each financial year. The format of such reports to be agreed by the Director of Finance of NHS Grampian and the Section 95 Officer of the Council, in conjunction with the Chief Finance Officer of the IJB.

12.8 The process for addressing in year variations in the spending of the IJB

12.8.1 Increases in payment by Parties to the IJB

The Parties may increase in-year the payments to the IJB for the delegated services with the agreement of the IJB.

12.8.2 Reductions in payment by Parties to the IJB

12.8.2.1 The Parties do not expect to reduce the payment to the IJB in-year unless there are exceptional circumstances resulting in

significant unplanned costs for the Party. In such exceptional circumstances the following escalation process would be followed before any reduction to the in-year payment to the IJB was agreed:-

a) The Party would seek to manage the unplanned costs within its own resources, including the application of reserves where applicable.

b) Each Party would need to approve any decision to seek to reduce the in-year payment to the IJB.

c) Any final decision would need to be agreed by the Chief Executives of both Parties and by the Chief Officer of the IJB, and be ratified by the Parties and the IJB.

12.8.3 Variations to the planned payments by the IJB

12.8.3.1 The Chief Officer is expected to deliver the agreed outcomes within the total delegated resources of the IJB. Where a forecast overspend against an element of the operational budget emerges during the financial year, in the first instance it is expected that the Chief Officer, in conjunction with the Chief Finance Officer of the IJB, will agree corrective action with the IJB.

12.8.3.2 If this does not resolve the overspending issue then the Chief Officer, the Chief Finance Officer of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council must agree a recovery plan to balance the overspending budget.

12.8.4 IJB Overspend against payments

12.8.4.1 In the event that the recovery plan is unsuccessful and an overspend is evident at the year-end, uncommitted reserves held by the IJB, in line with the reserves policy, would firstly be used to address any overspend.

12.8.4.2 In the event that an overspend is evident following the application of reserves, the following arrangements will apply for addressing that overspend:-

12.8.4.3 In the first complete financial year of the IJB – the overspend will be met by the Party to which the spending Direction for service delivery is given i.e. the Party with operational responsibility for the service.

12.8.4.4 In future years of the IJB, either:

a) A single Party may make an additional one off payment to the IJB,
or
b) The Parties may jointly make additional one off payments to the IJB in order to meet the overspend. The split of one off payments between Parties in this circumstance will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of in which arm of the operational budget the overspend has occurred in.

12.8.4.5 The recovery plan may include provision for the Parties to recover any such additional one off payments from their baseline payment to the IJB in the next financial year.

12.8.4.6 The arrangement to be adopted will be agreed by the Parties.

12.8.5 IJB underspend against payments

12.8.5.1 In the event of a forecast underspend the IJB will require to decide whether this results in a redetermination of payment or whether surplus funds will contribute to the IJB's reserves.

12.8.5.2 The Chief Officer and Chief Finance Officer of the IJB will prepare a reserves policy for the IJB, which requires the approval of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council. The reserves policy will be reviewed on a periodic basis.

12.8.5.3 In the event of a return of funds to the Parties, the split of returned payments between Parties will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of which arm of the operational budget the underspend occurred in.

12.8.6 Planned Changes in Large Hospital Services

12.8.6.1 The IJB and the hospital sector will agree a methodology for the financial consequences of planned changes in capacity for set aside budgets in large hospital services.

12.8.6.2 Planned changes in capacity for large hospital services will be outlined in the IJB Strategic Plan. A financial plan (reflecting any planned capacity changes) will be developed and agreed that sets out the capacity and resource levels required for the set aside budget for the IJB and the hospital sector, for each year. The financial plan will take account of :-

- activity changes based on demographic change;
- agreed activity changes from new interventions;

- cost behaviour;
- hospital efficiency and productivity targets;
- an agreed schedule for timing of additional resource / resource released.

12.8.6.3 The process for making adjustments to the set aside resource to reflect variances in performance against plan will be agreed by the IJB and the Health Board. Changes will not be made in year and any changes will be made by annual adjustments to the Strategic Plan of the IJB.

12.9 Capital

12.9.1 The use of capital assets in relation to integration functions

12.9.1.1 Ownership of capital assets will continue to sit with each Party and capital assets are not part of the payment or “set aside”.

12.9.1.2 If the IJB decides to fund a new capital asset from revenue funds then ownership of the resulting asset shall be determined by the Parties.

12.9.1.3 The Strategic Plan will drive the financial strategy and will provide the basis for the IJB to present proposals to the Parties to influence capital budgets and prioritisation.

12.9.1.4 A business case with a clear position on funding is required for any change to the use of existing assets or proposed use of new assets. The Chief Officer of the IJB is to develop business cases for capital investment for consideration by NHS Grampian and the Council as part of their respective capital planning processes.

12.9.1.5 The Chief Officer of the IJB will liaise with the relevant officer within each Party in respect of day to day asset related matters including any consolidation or relocation of operational teams.

12.9.1.6 It is anticipated that the Strategic Plan will outline medium term changes in the level of budget allocations for assets used by the IJB that will be acceptable to the Parties.

12.9.1.7 Any profits or loss on sale of an asset will be held by the Parties and not allocated to the IJB.

12.9.1.8 Depreciation budgets for assets used on delegated functions will continue to be held by each Party and not allocated to the IJB operations in scope.

12.9.1.9 The management of all other associated running costs (e.g. maintenance, insurance, repairs, rates, utilities) will be subject to local agreement between the Parties and the IJB.

13. Participation and Engagement

13.1 A joint consultation on this Scheme took place in January and early February 2015. It was conducted using face to face discussions, by email and by telephone conversations.

13.2 An email address was supplied for people to send their views. Webpages were created on both Parties' internet sites to increase understanding and accessibility of the proposed integration arrangements.

13.3 The Chief Officer presented the consultation draft Scheme to NHS Grampian Board and elected members of the Council in briefing sessions.

13.4 Principles endorsed by the Scottish Health Council and the National Standards for Community Engagement were agreed by the Parties and followed in respect of the consultation process, including the following:

13.4.1 It was a genuine consultation exercise: the views of all participants were valued.

13.4.2 It was transparent: the results of the consultation exercise were published.

13.4.3 It was an accessible consultation: the consultation documentation was provided in a variety of formats.

13.4.4 It was led by the Chief Officer: the Chief Officer and the IJB will be answerable to the people of Aberdeen City in terms of the content of the Scheme.

13.4.5 It was the start of an on-going dialogue: the Integration Scheme will establish the parameters of the future strategic plans of the IJB.

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

Health professionals;
Users of health care;
Future users of health care;
Carers of users of health care;
Commercial providers of health care;
Non-commercial providers of health care;
Social care professionals;
Users of social care;
Future users of social care;
Carers of users of social care;
Commercial providers of social care;
Non-commercial providers of social care;
Staff of NHS Grampian and the Council who are not health professionals or social care professionals;
Non-commercial providers of social housing;
Third sector bodies carrying out activities related to health or social care; and

Other local authorities operating with the area of NHS Grampian preparing an integration scheme.

13.6 The Parties will enable the IJB to develop a Participation and Engagement Strategy by providing appropriate resources and support. The Participation and Engagement Strategy shall ensure significant engagement with, and participation by, members of the public, representative groups and other organisations in relation to decisions about the carrying out of integration functions. The Parties will encourage the IJB to access existing forums that the Parties have established, such as Public Partnership Forums, Community Councils, groups and other networks and stakeholder groups with an interest in health and social care. The strategy shall be developed alongside the Strategic Plan and will be presented for approval to the IJB in the second half of 2015 and prior to consultation on the Strategic Plan.

14. Information Sharing and Confidentiality

14.1 The Parties shall agree to an appropriate information sharing accord for the sharing of information in relation to integrated services. The information sharing accord shall set out the principles, policies, procedures and management strategies around which information sharing is carried out. It will encapsulate national and legal requirements.

14.2 The Parties will work together to progress the specific arrangements, practical policies and procedures, designated responsibilities and any additional requirements for information sharing for any purpose connected with the preparation of an integration scheme, the preparation of a strategic plan or the carrying out of integration functions.

14.3 The Parties shall be assisted in this process by a Joint Information Sharing Group which shall review an existing Memorandum of Understanding and Information Sharing Protocol to see whether these are suitable for the purposes of integration, or whether replacements, modifications or

supplements are considered necessary. The Group shall report their findings to the Parties and the IJB.

14.4 If the Joint Information Sharing Group consider that a further high level accord or information sharing protocol is required, or if amendments are necessary to existing ones, they shall assist the Parties and the IJB by preparing these and making them available with their recommendation to the IJB in the first instance for comment.

14.5 If a new information sharing accord and/or procedures for information sharing are necessary, these will be agreed to by the Parties by the time functions are delegated to the IJB.

14.6 The information sharing accord may be amended or replaced by agreement of the Parties and the IJB.

14.7 The Parties will continue to develop information technology systems and procedures to enable information to be shared appropriately and effectively between the Parties and the IJB.

15. Complaints

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

15.2 Complaints should continue to be made to the Parties using the existing mechanisms.

15.3 Complaints can be made to the Parties through any member of staff providing integrated services. Complaints can be made in person, by telephone, by email, or in writing. On completion of the complaints procedure, complainants may ask for a review of the outcome. At the end of the complaints process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman (or any such successor). Where appropriate,

complainants will also be advised of their right to complain to the Care Inspectorate (or any such successor).

15.4 The Parties shall communicate with each other in relation to any complaint which requires investigation or input from the other organisation.

15.5 The Chief Officer will have an overview of complaints made about delegated services and subsequent responses. Complaints about delegated services will be recorded and reported to the Chief Officer on a regular and agreed basis.

15.6 The IJB shall develop a process for complaints against the IJB and the Chief Officer which will follow any Scottish Government Guidance.

15.7 The IJB will use complaints as a valuable tool for improving services and to identify areas where further staff training may be of benefit.

15.8 The IJB will ensure that all staff working in the provision of delegated services are familiar with the complaints procedures and that they can direct individuals to the appropriate complaints procedures.

15.9 The complaints procedures will be clearly explained, well-publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

15.10 The IJB will aspire to have a streamlined process for complaints. When this is achieved, the Scheme will be amended using the procedure required by the Act.

15.11 In developing a streamlined process for complaints, the Parties shall ensure that all statutory requirements will continue to be met, including timescales for responding to complaints.

15.12 In developing a single complaints process, the IJB will endeavour to develop a uniform way to review unresolved complaints before signalling individuals to the appropriate statutory review authority.

16. Claims Handling, Liability & Indemnity

16.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

16.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

16.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

16.4 Each party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

16.5 Each party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

16.6 In the event of any claim against the IJB or in respect of which it is not clear which party should assume responsibility then the Chief Officer (or his/her representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which party should assume responsibility for progressing the claim.

16.7 If a claim is settled by either party, but it subsequently transpires that liability rested with the other party, then that party shall indemnify the party which settled the claim.

16.8 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

16.9 If a claim has a “cross boundary” element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

16.10 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

16.11 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

17. Risk Management

17.1 The Parties have developed a shared risk management strategy that sets out:–

17.2 The key risks with the establishment and implementation of the IJB. The key risks are identified in a separate document which has been shared with the Shadow IJB (Transitional Leadership Group). This has identified an approach to risk that the IJB will be asked to consider and approve at its inception.

17.3 The IJB will develop a Risk Register to which it will have full access. The Risk Register will be available to the IJB from the day it is established.

17.4 The IJB will establish the risk monitoring framework which it will use and will agree this at its inception. The risk monitoring framework will identify, assess and prioritise risks related to the delivery of services under integration functions, particularly any which are likely to affect the IJB’s delivery of the Strategic Plan. The processes for mitigating those risks will be identified and described. Reporting arrangements to the Parties will be set out in the framework. This will include an agreed reporting standard that will enable other significant risks identified by the Parties to be compared across the organisations.

17.5 The Chief Officer will identify a single person responsible for drawing together the risks from the Parties and the IJB.

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

17.7 The Parties and the IJB will consider these risks as a matter of course and notify each other where the risks may have changed.

17.8 Any changes to risk management strategies shall be requested through formal paper to the IJB.

17.9 The Parties will provide appropriate resource to ensure that the risk management of the IJB is delivered to a high standard.

18. Dispute resolution mechanism

18.1 This provision relates to disputes between NHS Grampian and the Council in respect of the IJB or in respect of their duties under the Act. This provision does not apply to internal disputes within the IJB itself.

18.2 The IJB will develop a process with other IJBs for disputes relating to hosted services and non-delivery of outcomes.

18.3 Where either of the Parties fails to agree with the other on any issue related to this Scheme and/or the delivery of delegated health and social care services, then they will follow the process as set out below:

(a) The Chief Executives of NHS Grampian and the Council and the Chief Officer of the IJB will meet to resolve the issue;

(b) If unresolved, NHS Grampian and the Council and the IJB will each prepare a written note of their position on the issue and exchange it with the others within 21 calendar days of the meeting in (a).

(c) Within 14 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions.

(d) In the event that the issue remains unresolved, the Chief Executives and the Chief Officer will proceed to mediation with a view to resolving the issue. The Chief Officer will appoint a professional independent mediator. The cost of mediation, if any, will be split equally between the Parties. The mediation process will commence within 28 calendar days of the meeting in (c).

(e) Where the issue remains unresolved after following the processes outlined in (a)-(d) above and if mediation does not allow an agreement to be reached within 6 months from its commencement, or any other such time as the parties may agree, either party may notify Scottish Ministers that agreement cannot be reached.

(f) Where the Scottish Ministers make a determination on the dispute, that determination shall be final and the Parties and the IJB shall be bound by the determination.

Annex 1

Part 1

Functions delegated by the Health Board to the Integration Joint Board

Schedule 2 Regulation 3

Functions prescribed for the purposes of section 1(8) of the Act

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

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	
	section 2(7) (Health Boards);
	
	section 2CB([1]) (Functions of Health Boards outside Scotland);
	
	section 9 (local consultative committees);
	
	section 17A (NHS Contracts);
	
	section 17C (personal medical or dental services);
	
	section 17I([2]) (use of accommodation);
	
	section 17J (Health Boards' power to enter into general medical services contracts);

([1]) Section 2CA was inserted by S.S.I. 2010/283, regulation 3(2).
([2]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

section 28A (remuneration for Part II services);

section 38([3]) (care of mothers and young children);

section 38A([4]) (breastfeeding);

section 39([5]) (medical and dental inspection, supervision and treatment of pupils and young persons);

section 48 (provision of residential and practice accommodation);

section 55([6]) (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);

section 64 (permission for use of facilities in private practice);

section 75A([7]) (remission and repayment of charges and payment of travelling expenses);

([3]) The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.

([4]) Section 38A was inserted by the Breastfeeding etc (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.

([5]) Section 39 was relevantly amended by the Self Governing Schools etc (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3 and the Standards in Scotland's Schools Act 2000 (asp 6), schedule 3.

([6]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

([7]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers

section 75B([8])(reimbursement of the cost of services provided in another EEA state);

section 75BA ([9])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82([10]) use and administration of certain endowments and other property held by Health Boards);

section 83([11]) (power of Health Boards and local health councils to hold property on trust);

section 84A([12]) (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of

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in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([8]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([9]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

([10]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([11]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

([12]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

certain bodies connected with the health services);

section 98 ([13]) (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([14]);

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;

The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;

The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;

([13]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.

([14]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

	The National Health Service (Discipline Committees) Regulations 2006/330; The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183; The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([15]).

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7 (Persons discharged from hospital)	

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	

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

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical

([15]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.

practitioners);

section 34 (Inquiries under section 33: co-operation)([16]);

section 38 (Duties on hospital managers: examination notification etc.)([17]);

section 46 (Hospital managers' duties: notification)([18]);

section 124 (Transfer to other hospital);

section 228 (Request for assessment of needs: duty on local authorities and Health Boards);

section 230 (Appointment of a patient's responsible medical officer);

section 260 (Provision of information to patients);

section 264 (Detention in conditions of excessive security: state hospitals);

section 267 (Orders under sections 264 to 266: recall);

section 281([19]) (Correspondence of certain persons detained in hospital);

([16]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([17]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([18]) Section 46 is amended by S.S.I. 2005/465.
([19]) Section 281 is amended by S.S.I. 2011/211.

	and functions conferred by—
	The Mental Health (Safety and Security) (Scotland) Regulations 2005([20]);
	The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([21]);
	The Mental Health (Use of Telephones) (Scotland) Regulations 2005([22]); and
	The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([23]).

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23
(other agencies etc. to help in exercise of functions under this Act**)**

([20]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([21]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([22]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([23]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([24]).

([24]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

Part 2

Services currently provided by the Health Board which are to be integrated

Schedule 3 Regulation 3

Part 1

Interpretation of Schedule 3

1. In this schedule—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([25]); and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

([25]) S.S.I. 2004/115.

Part 2

2. Accident and Emergency services provided in a hospital.

3. Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;

(b) geriatric medicine;

(c) rehabilitation medicine;

(d) respiratory medicine; and

(e) psychiatry of learning disability.

4. Palliative care services provided in a hospital.

5. Inpatient hospital services provided by General Medical Practitioners.

6. Services provided in a hospital in relation to an addiction or dependence on any substance.

7. Mental health services provided in a hospital, except secure forensic mental health services.

Part 3

8. District nursing services.

9. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

10. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

11. The public dental service.

12. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([26]).

13. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([27]).

14. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([28]).

15. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([29]).

16. Services providing primary medical services to patients during the out-of-hours period.

17. Services provided outwith a hospital in relation to geriatric medicine.

18. Palliative care services provided outwith a hospital.

([26]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.
([27]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.
([28]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.
([29]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

19. Community learning disability services.

20. Mental health services provided outwith a hospital.

21. Continence services provided outwith a hospital.

22. Kidney dialysis services provided outwith a hospital.

23. Services provided by health professionals that aim to promote public health.

Part 4

In addition to the functions that must be delegated, NHS Grampian has chosen to delegate the following service to the extent that it relates to adults:

24. Sexual health services provided in the community.

Annex 2

Part 1

Functions delegated by the Local Authority to the Integration Joint Board

Schedule Regulation 2

Part 1

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

Column A	*Column B*
Enactment conferring function	*Limitation*
National Assistance Act 1948([30])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([31])	
Section 3 (Provision of sheltered employment by local authorities)	

([30]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([31]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Social Work (Scotland) Act 1968([32])	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.

([32]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 12AA (Assessment of ability to provide care.)	
Section 12AB (Duty of local authority to provide information to carer.)	
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with	

Column A *Enactment conferring function*	*Column B* *Limitation*
nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([33])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	

([33]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.

Column A *Enactment conferring function*	*Column B* *Limitation*
Disabled Persons (Services, Consultation and Representation) Act 1986([34])	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([35])	
Section 10 (Functions of local authorities.)	

([34]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

([35]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions.
The Housing (Scotland) Act 2001([36])	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.

([36]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Community Care and Health (Scotland) Act 2002([37])	
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([38])	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.

([37]) 2002 asp 5.
([38]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([39])	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007([40])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	

([39]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.

([40]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons' property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013([41])	
Section 3 (Support for adult carers.)	Only in relation to assessments carried out under integration functions.
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	

([41]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

Part 2

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([42]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([43])	

([42]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([43]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Part 3

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(5) of the Public Bodies (Joint Working) (Scotland) Act 2014

In addition to the functions that must be delegated, the Council has chosen to delegate the following functions to the extent that they relate to adults.

Column A	*Column B*
Enactment conferring function	*Limitation*
Criminal Procedure (Scotland) Act 1995	
Section 51(1)(aa), 51(1)(b) and 51(5) (Remand and committal of children and young persons in to care of local authority).	
Section 203 (Local authority reports pre-sentencing.)	
Section 234B (Report and evidence from local authority officer regarding Drug Treatment and Testing Order.)	
Section 245A (Report by local authority officer regarding Restriction of Liberty Orders.)	
Management of Offenders etc. (Scotland) Act 2005	
Section 10 (Arrangements for assessing and managing risks posed by certain offenders.)	

Section 11
(Review of arrangements.)

Column A *Enactment conferring function*	*Column B* *Limitation*
Social Work (Scotland) Act 1968	
Section 27 (Supervision and care of persons put on probation or released from prison.)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence is deferred.)	

Part 2

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

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

Annex 3

Hosted Services

NHS Grampian has noted the services that are currently hosted across the areas of the Grampian IJBs and offer this for consideration to the IJB as they take forward strategic planning:

Service	Current Host
Sexual Health Services	Aberdeen City
Woodend Assessment of the Elderly (including Links Unit at City Hospital)	Aberdeen City
Woodend Rehabilitation Services (including Stroke Rehab, Neuro Rehab, Horizons, Craig Court and MARS)	Aberdeen City
Marie Curie Nursing	Aberdeenshire
Heart Failure Service	Aberdeenshire
Continence Service	Aberdeenshire
Diabetes MCN (including Retinal Screening)	Aberdeenshire
Chronic Oedema Service	Aberdeenshire
HMP Grampian	Aberdeenshire
Police Forensic Examiners	Aberdeenshire

Annex 4

This Annex lists the services provided within hospitals which the IJB will have strategic planning responsibilities for which will continue to be operationally managed by NHS Grampian:

Services:

- Accident & Emergency Services provided in a hospital;
- Inpatient hospital services relating to: general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine and psychiatry of learning disability; and
- Palliative Care services provided in a hospital.

In so far as they are provided within the following hospitals:

- Hospitals at the Foresterhill Site, Aberdeen (which includes Aberdeen Royal Infirmary, Royal Aberdeen Childrens Hospital and Aberdeen Maternity Hospital)
- Hospitals in Elgin (which includes Dr Gray's Hospital)

Annex 5

Additional Local Information

This document contains additional local information which is not part of the Integration Scheme. It is not for consideration by the Scottish Government. The contents of this Annex are not legally binding upon the Parties or the IJB.

Board Governance

- A voting member of the IJB from the Council shall cease to be voting member of the IJB if he/she resigns or is no longer in office. A Health Board member shall cease to be a member if he/she no longer holds his/her membership with the Health Board. The IJB voting members are there *ex officio* (by nature of their other appointment).

- A voting member of the IJB shall also cease to be a voting member of the IJB if he/she fails to attend three consecutive meetings of the IJB, provided the absences were not due to illness or other reasonable cause (which shall be a matter for the IJB to determine). In this event the IJB shall give the member one month's notice in writing of his/her removal. The IJB will at the same time request that the organisation of that member nominate a replacement, who will be appointed to the voting membership of the IJB as soon as the other member is removed, or within such other time as is reasonably practicable.

Local Operational Delivery Arrangements

- The IJB shall provide such information as may be reasonably required by the Chief Executive of NHS Grampian in relation to the planning of integrated services provided within hospitals.

Workforce

- The Parties anticipate that the IJB will have a management structure where professionals may report to someone of a different profession. For all professional groups, an appropriate professional structure will be put in place to support both managers and practitioners with the provision of professional supervision and advice as required. The IJB will enable professions to develop mechanisms to obtain peer support or supervision within teams.

- The Council and NHS Grampian will make arrangements for jointly appointed positions to be made together. The recruitment process may be run jointly, 'hosted' by either of the Parties using their normal recruitment arrangements, or via new process specific to the IJB. There will be agreement on representation on appointment panels making appointment decisions.

Finance

- The IJB will have no cash transactions and will not directly engage or provide grants to third parties.

- The IJB will have appropriate assurance arrangements in place (detailed in the Strategic Plan) to ensure best practice principles are followed by the Parties for the commissioned services.

- The IJB will, initially, not have a separate Audit Committee. Areas requiring scrutiny and review such as the internal audit plan, internal audit reports, annual accounts, external audit reports, etc. will be considered at the next appropriate meeting of the IJB. The IJB can establish a separate Audit Committee if it is subsequently considered that this is merited.

- The IJB will be responsible for establishing adequate and proportionate internal audit service for review of the arrangements for risk management, governance and control of the delegated resources. The IJB will accordingly appoint Internal Auditors to report to the Chief Officer and IJB on the proposed annual audit plan, ongoing delivery of the plan, the outcome of each review and an annual report on delivery of the plan.

- The Accounts Commission will confirm the external auditors for the IJB.

ABERDEEN CITY COUNCIL

COMMITTEE	Council
DATE	4 March 2015
DIRECTOR	Gayle Gorman
TITLE OF REPORT	Aberdeen Sports Village and Sport Aberdeen – Recruitment of Board Members
REPORT NUMBER:	ECS/15/015
CHECKLIST:	YES

1. PURPOSE OF REPORT

There are currently vacant Council director positions on the Aberdeen Sports Village (ASV) Board and Sport Aberdeen (SA) Board. In line with the Articles of Association, Aberdeen City Council is required to appoint any new council director to the board. This report brings to the attention the proposed recruitment timeline and asks that the Council confirms the selection panel for the vacant director positions.

2. RECOMMENDATION(S)

It is recommended that the Council:

- Notes the content of the report;
- Expresses its thanks to Nick Dalgarno and Paul McDonald for their time as board members on the ASV and Sport Aberdeen boards respectively;
- Agree the timeline for the recruitment process that will be followed for the Aberdeen Sports Village;
- Agree the establishment of a selection panel made up of 9 elected members consisting of 3 Labour, 3 SNP, 1 Independent, 1 Conservative, and 1 Liberal Democrat member with support from an appropriate officer;
- Delegate authority to the selection panel to select their preferred candidates with a bulletin report to come to the next Council meeting on the 13 May 2015;
- Note the process to be followed by Sport Aberdeen for appointment of the new Board member; and
- Otherwise note the contents of this report.

3. FINANCIAL IMPLICATIONS

There are no direct financial implications as a result of this report.

4. OTHER IMPLICATIONS

Legal Implications

The Articles of Association of Aberdeen Sports Village and Sport Aberdeen each sets out how Directors will be appointed to and removed from the Board.

5. BACKGROUND/MAIN ISSUES

5.1 **Aberdeen Sports Village**

Aberdeen Sports Village was set up in 2009 and is a partnership between Aberdeen City Council and the University of Aberdeen (the major share-holders) and **sport**scotland. The facilities are run by ASV Limited, with activity overseen by a Board of Directors. The ASV Board consists of representatives of the two major shareholders.

With the opening of the ASV's Aquatics Centre in 2014, the facility now includes a 50m pool and a diving pool alongside a full size indoor football pitch, indoor and outdoor athletics facilities, and a large games hall. These extensive facilities provide high-quality venues across a wide-range of sporting activity, serving a customer base that includes the general public, sports clubs, students and elite athletes.

5.1.1 Aberdeen Sports Village Board of Directors

Under the terms of the Articles of Association the number of Directors shall not be less than two and there shall be no maximum number provided that there are always an equal number of Aberdeen City Council and The University of Aberdeen representatives.

There are currently four Directors appointed to represent each of the shareholders. The current Council vacancy has arisen due to the recent resignation of Nick Dalgarno from the ASV board.

The other current council nominated Directors are Cllr David Cameron, Cllr Willie Young and Dave MacDermid.

Aberdeen Sports Village has completed a skills matrix for the existing Directors in order to assist with the recruitment process.

5.2 **Sport Aberdeen**

5.2.1 Sport Aberdeen was set up in 2010, to deliver some of the council sports facilities and sports development services. Sport Aberdeen is wholly owned by the Council and is run by a Board of Directors.

5.2.2 Sport Aberdeen Board of Directors

Under the terms of the Articles of Association, Sport Aberdeen can have up to 11 directors. Sport Aberdeen currently has 10 directors:

Fred Dalgarno (Chair)
Colin Taylor (Vice Chair)
Cllr Graeme Lawrence
Cllr Graham Dickson
Cllr Marie Boulton
Anthony Dawson
Gordon Edwards
Moyra Cowie
Stephen Wilson
Alistair Robertson (Chief Executive)

6.0 **FILLING OF VACANT DIRECTOR POSITIONS**

6.1 **Process to be undertaken for Aberdeen Sports Village**

The proposed timeline for these positions is detailed below:

Date	Task
4th March 2015	Aberdeen City Council Committee approval – Full Council
w/c 9th March 2015	Board Vacancy advertised
20th March 2015	Closing date for expressions of interest
w/c 23rd March 2015	Selection Panel meet to shortlist
Early April 2015	Interviews to take place
13th May 2015	Bulletin report to Full Council to update Council Director representatives

6.1.2 The University of Aberdeen has also had a recent resignation from the ASV board. During a joint partnership meeting it was suggested that in order to recruit to the ASV board vacancies that the shareholders advertise these positions jointly with a separate selection process taking place.

6.2 **Process to be undertaken by Sport Aberdeen**

6.2.1 Under the Articles of Association, the Board of Sport Aberdeen undertakes its own recruitment and selection process and has done this on the last two occasions when vacancies have arisen. Following

interview and selection, the preferred candidate is then presented to the for Council approval.

6.2.2 The last time Sport Aberdeen had a need to fill vacancies in September 2013, there was a very good response to the advert and in addition to the candidates selected, three highly capable individuals who were unable to be accommodated agreed instead to be co-opted to support the Board's Committee work. Each has made a very strong contribution during the last 18 months and it is the Sport Aberdeen Boards intention that the vacancy would be filled, subject to Council approval, by one of the co-optees.

7. IMPACT

Corporate – This report relates to Aberdeen – the Smarter City

- We will work with our partners to seek to reduce the levels of inequality in the city.
- We will enhance the physical and emotional wellbeing of all our citizens by offering support and activities which promote independence, resilience, confidence and self-esteem.
- Working with our third, public and private sector partners, we will provide opportunities for lifelong learning which will develop knowledge, skills and attributes of our citizens to enable them to meet the changing demands of the 21st century.
- We will embrace the distinctive pride the people of Aberdeen take in their city and work with them to enhance the sense of well-being here, building strong communities which look out for, and look after one another.

This report also relates to the Combined Community Plan and Single Outcome Agreement as follows:

- Children and young people access positive learning environments and develop their skills, confidence and self esteem to the fullest potential
- Children, young people and their families/carers are involved in decisions that affect them. Their voices heard and they play an active and responsible role in their communities
- Children and young people actively participate in their communities and have optimum involvement in decision making
- All children, young people and their families have access to high quality services when required and services provide timely, proportionate and appropriate response that meeting the needs of children and young people within Getting it Right for Every Child, (GIRFEC) requirements
- Improve the quality of life in our most deprived areas
- Citizens are increasingly more active in their communities regardless of age, gender, sexual orientation, ethnic origin, where they live, disability or faith/religion/belief and contribute to active citizenship.

- Develop pathways to participation which enhance the diversity of local representation at and engagement with regional, national and international arts, heritage and sporting events
- Our public services are consistently high quality, continually improving, efficient and responsive to local people's needs

8. MANAGEMENT OF RISK

An appropriately skilled mix of Directors on the Aberdeen Sports Village and Sport Aberdeen boards will improve governance practices in each organisation.

9. BACKGROUND PAPERS

None

10. REPORT AUTHOR DETAILS

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