
Report to: Clackmannanshire Council

Date of Meeting: 5 March, 2015

Subject: Health & Social Care Integration Scheme

Report by: Chief Executive

1.0 Purpose

- 1.1. The purpose of this paper is to seek Council's approval of the draft Scheme for Health & Social Care Integration so that it can be submitted to the Scottish Government by the required deadline.

2.0 Recommendations

- 2.1. It is recommended that Council:
- a) approves the draft Integration Scheme for submission to the Scottish Government (the draft Scheme is attached as the Appendix to this report);
 - b) notes the position in respect of the recruitment of the Chief Officer;
 - c) notes the work programme of the Integration Board in the coming year.

3.0 Considerations

- 3.1. A report updating Council on progress on health and social care integration was considered in December of 2014 and then in January of this year the Council's Housing, Health & Care Committee considered a draft of the integration scheme.
- 3.2. Further to a meeting held on 17 February, 2015, the Transitional Integration Board (on which there are representatives of Clackmannanshire and Stirling councils and NHS Forth Valley) agreed the final draft Scheme and that it be recommended to each of the three partners for approval.
- 3.3. The final draft Scheme follows the guidance set out by the Scottish Government and reflects the requirements set out in the various regulations which accompany the legislation on integration.
- 3.4. There is a requirement to consult on the Integration Scheme and defined consultees are:
- Health and social care professionals;

- Users of health and/or social care;
- Carers of users of health and/or social care;
- Non-commercial and commercial providers of health and/or care;
- Non-commercial providers of social housing;
- Third Sector bodies carrying out activities related to health or social care;
- Staff of the Local Authority and Health Board likely to be affected by the Integration Scheme

3.5 The draft Integration Scheme was widely consulted on throughout January 2015. A full copy of the draft Scheme was available online and consultation was carried out through online surveys and a number of planned consultation events. There were a total of 1200 views of the website pages which were promoted using direct email, Facebook and twitter; 51 responses were received via the online survey and 151 people were consulted via face to face sessions at carers forums, service user reference groups and strategy groups.

3.6 In addition, a staff briefing was issued in January with information on integration and how it will likely impact staff, along with a reference to the website which contains a frequently asked questions document.

3.7 Feedback on the consultation and an updated draft of the Integration Scheme further to that feedback were considered by the Transitional Integration Board at its meeting on 17 February, 2015.

3.8 As previously advised to Council, each integration authority is required to appoint a Chief Officer. The Transitional Integration Board carried out short-leeting at a meeting on 17 February and assessment of the short-leeted candidates, including an interview with the Board's appointments' panel, will take place in March. Councillors Sharp and Cadenhead will represent the Council on that panel.

3.9 Once the draft Scheme is submitted to the Scottish Government, it will be reviewed and, hopefully, approved. Until that time, the integration authority is not legally constituted. In the interim, the Transitional Integration Board will continue to meet, with key items for discussion in the next couple of months including:

- Development of Board Standing Orders
- Organisational Development for the Board (voting members)
- Appointment to Board of non-voting members (staff, third sector, service users, carers)
- Development of strategic plan
- Financial and funding arrangements
- Performance framework

4.0 Sustainability Implications

4.1. N/A

5.0 Resource Implications

5.1. *Financial Details*

- 5.2. The Council will have to contribute to the employee costs of the chief officer and any other officers (such as Finance Officer and business support) and a demand pressure was included in the Council's budget for that. There will be a transfer of resources from the Council and the other two partners to the Integration Board in due course. The level of this and the methodology for the transfer has not yet been agreed and will form part of the Transitional Board's ongoing discussions.
- 5.3. Finance have been consulted and have agreed the financial implications as set out in the report.
- 5.4. *Staffing* - there is no impact on the Council's establishment as a result of this report.

6.0 **Exempt Reports**

- 6.1. Is this report exempt? No

7.0 **Declarations**

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities**

Our communities are more cohesive and inclusive
Vulnerable people and families are supported
Substance misuse and its effects are reduced
Health is improving and health inequalities are reducing
The environment is protected and enhanced for all
The Council is effective, efficient and recognised for excellence

8.0 **Equalities Impact**

- 8.1 Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations? N/A for this report.

9.0 **Legality**

- 9.1 It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes

10.0 **Appendices**

- 10.1 Draft Integration Scheme for Clackmannanshire & Stirling

11.0 **Background Papers**

- 11.1 Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)

Report to Transition Board of 3 February, 2015, entitled: Health & Care Integration Update

Author(s)

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Elaine McPherson	Chief Executive	2002

Approved by

NAME	DESIGNATION	SIGNATURE
Elaine McPherson	Chief Executive	Signed: Elaine McPherson



**Clackmannanshire
Council**



Clackmannanshire & Stirling Health and Social Care Integration Scheme

DRAFT

**Endorsed by the Transitional Board
17/02/15**

1. Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) ("the primary legislation" requires Health Boards and Local Authorities ("The Parties") to integrate planning for, and delivery of, certain adult health and social care services. The Parties can also choose to integrate planning and delivery of other services such as additional adult health and social care services beyond the minimum prescribed by Ministers, and children's health and social care services. The Act requires the Parties to prepare jointly an integration scheme setting out how this joint working is to be achieved. There is a choice of ways in which they may do this.

The Parties have agreed that they will adopt the "body corporate" arrangement (i.e. the model set out in s1(4)(a) of the Act) and this document sets out the detail as to how the Health Board and Local Authorities will integrate services. Section 7 of the Act requires the Parties to submit jointly an integration scheme for approval by Scottish Ministers. The integration scheme should follow the format of the model scheme and must include, as a minimum, the matters prescribed in Regulations. References to obligations on the Parties and/or the established body corporate ("The Integration Joint Board") under the primary legislation or the other regulations flowing there from have been included to ensure that all Parties and the integrated joint Board have a clear and coherent understanding of their respective roles, duties and powers.

It should be noted that Clackmannanshire and Stirling Councils operate a shared service arrangement for the delivery of their social care functions. At present, the Councils share a management structure but work is underway to develop the business case for a lead authority model. To complement this the Councils have elected to form a single body corporate with NHS Forth Valley.

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

As a separate legal entity the Integration Joint Board has full autonomy and capacity to act on its own behalf and can, accordingly, make decisions about the exercise of its functions and responsibilities as it sees fit. However, the legislation that underpins the Integration Joint Board requires that its voting members are appointed by the Health Board and the Local Authority, and is made up of councillors, NHS non-executive directors, and other members of the Health Board where there are insufficient NHS non-executive directors. Whilst serving on the Integration Joint Board its members carry out their functions under the Act on behalf of the Integration Joint Board itself, and not as delegates of their respective Health Board or Local Authority. This is in line with what happened under the previous joint working arrangements. Because the same individuals will sit on the Integration Joint Board and the Health Board or Local Authority, accurate record-keeping and minute-taking will be essential for transparency and accountability purposes.

The Integration Joint Board is responsible for the Strategic Planning of the functions delegated to it and for ensuring the delivery of its functions through the locally agreed operational arrangements set out within the integration scheme in Section 4. Further, the Act gives the Health Board and the Local Authority, acting jointly, the ability to require that the Integration Joint Board replaces their Strategic Plan in certain circumstances. In these ways, the Health Board and the Local Authority together have significant influence over the Integration Joint Board, and they are jointly accountable for its actions.

2. Aims and Outcomes of the Integration Scheme

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

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, 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 service users.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
8. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
9. Resources are used effectively in the provision of health and social care services, without waste.

Our vision is to enable individuals in the Clackmannanshire and Stirling Partnership to live full and positive lives within supportive communities.

We want to see:

- **Self Management** - Individuals, their carers and families are enabled to manage their own health, care and well-being;
- **Community Focused Supports** – Supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community;

- **Safety** - Health and social care support systems help to keep people safe and live well for longer;
- **Decision Making** - Individuals, their carers and families are involved in and are supported to manage decisions about their care and wellbeing;
- **Experience** – Individuals will have a fair and positive experience of health and social care

Having regard to the integration planning principles we will be:

- Placing communities and individuals at the centre of planning and delivery of services
- Putting individuals, their carers and families at the centre of their own care pathway by prioritising the most appropriate care
- Working effectively with voluntary and commercial organisations (e.g. Charities, Businesses, Social Enterprises, and Groups of Volunteers)
- Provide joined up services to improve quality of lives
- Building on the strengths of our communities
- Recognising the importance of encouraging independence by focusing on re-ablement, rehabilitation and recovery;
- Ensuring that all communication is clear, accessible and understandable and ensures a two way conversation
- Encouraging continuous improvement by supporting and developing our workforce.
- Reducing avoidable admissions to hospital
- Ensuring that information is shared appropriately to ensure a safe transition between all services
- Providing timely access to services, based on assessed need and best use of available resources
- Identifying and addressing inequalities

Integration Scheme

The Parties:

Clackmannanshire Council, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at Kilncraigs, Alloa FK21EB

and

Stirling Council, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at Viewforth Stirling FK8 2ET

and

Forth Valley Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as “NHS Forth Valley”) and having its principal offices at Carseview House, Castle Business Park, Stirling, FK9 4SW hereinafter referred to as “**NHS FV**”

(together referred to as “**the Parties**”)

1. Definitions and Interpretation

- 1.1 For the purpose of this agreement the undernoted terms and expressions have the following meaning:-

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

"Appointing Period" means the period, not exceeding three years, for which a Party is to be entitled to appoint the Chairperson or Vice Chairperson of the Integration Joint Board;

"Chief Officer" means the individual appointed to the Integration Joint Board by virtue of Section 9 of the Act;

"Consultee Regulations" means the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014;

"Integration Functions" are the functions of the Parties which require to be delegated to the Integration Joint Board by virtue of the Act as set out in Appendices 1 and 2 attached hereto and any such other functions as the Parties may lawfully agree to delegate;

"Integration Joint Board Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

"Integration Planning Principles" are as defined in section 4 of the Act;

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

"Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Act;

"The Parties" means the Clackmannanshire and Stirling Councils and NHS FV;

"The Scheme" means this Integration Scheme;

"Service Users" means persons to whom or in relation to whom services in respect of the integrated functions are provided;

"Shadow Year" means the year ending 31 March 2016;

"Strategic Plan" means the plan with 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;

"Strategic Planning Group" means the group established under Section 32 of the Act;

"Third Sector Bodies" includes non-commercial providers of health and social care, representative groups, interest groups, social enterprises and community organisations;

"Unpaid Carer" means someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support and the expression "persons who provide unpaid care" and similar expressions shall be construed accordingly.

Words denoting the singular shall include the plural where the context so admits and vice versa.

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

In accordance with section 2(4) 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 Clackmannanshire & Stirling Health and Social Care Integration Authority namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This Scheme comes into effect on the date the Parliamentary Order to establish the Integration Joint Board comes into force.

2. Local Governance Arrangements

Having regard to the requirements contained in the Integration Scheme Regulations, the Parties require to supply the detail of the voting membership, the Chair and Vice Chair of the Integration Joint Board. The Integration Joint Board and the Parties must communicate with each other and interact in order to contribute to the Outcomes however the Integration Joint Board does have a distinct legal personality and the consequent autonomy to manage itself and make decisions. The Parties have no power to independently sanction or veto decisions of the Integration Joint Board.

- 2.1 The composition of the voting membership of the Integration Joint Board shall be as follows:-
- I. Three Councillors nominated by Clackmannanshire Council
 - II. Three Councillors nominated by Stirling Council
 - III. Six members nominated by NHS Forth Valley
- 2.2 The Parties have agreed that the NHS FV voting membership shall comprise four Non-Executive Directors and two Executive Directors; furthermore shall be able to on occasion where necessary substitute one further Non - Executive Director with an Executive Director.
- 2.3 The non-voting membership of the Integration Joint Board shall be as follows:-
- I. The joint Chief Social Work Officer for Clackmannanshire and Stirling failing which the Chief Social Work Officer of one of the constituent Local Authorities
 - II. The Chief Officer of the Integration Joint Board
 - III. The proper officer of the Integration Joint Board appointed under Section 95 of the Local Government (Scotland) Act 1973
 - IV. 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
 - V. 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
 - VI. and a registered medical practitioner employed by the Health Board and not providing primary medical services
- 2.4 In addition the Integration Joint Board shall appoint at least one member in respect of each of the following groups:-

- I. a representative of staff of the Parties engaged in the provision of services provided under the Integration Functions
 - II. Third Sector Bodies carrying out activities related to health and social care for the areas of the constituent authorities
 - III. Service Users residing in the areas of the constituent authorities; and
 - IV. persons providing unpaid care in the areas of the constituent authorities
- 2.5 The Integration Joint Board may appoint such additional members in a non-voting capacity as it sees fit but such members shall not include a Councillor or Non - Executive Director of the NHS.
- 2.6 In accordance with Article 7 of the Integration Joint Board Order and subject to Article 8 and para 2.10 below, members of the Integration Joint Board will be appointed for a period of three years and may be eligible for reappointment thereafter for one further term of office.
- 2.7 Non-voting members as detailed in clause 2.6 I - III above shall remain a member of the Integration Joint Board for as long as they hold the office in respect of which they were appointed.
- 2.8 Voting Board Members will be deemed to have their appointment to the Integration Joint Board withdrawn if they no longer meet the criteria set out in clause 2.4 above and the appointing Party will be able to remove that member by giving notice under Regulation 14 of the Integration Joint Board Order.
- 2.9 Should a Voting Board Member resign from the Integration Joint Board, the appointing Party will be entitled to appoint another representative to the Integration Joint Board pursuant to clause 2.4 and 2.7 as applicable.
- 2.10 Removal of a Voting Board Member shall be in accordance with Article 14 of the integration Joint Board Order.

- 2.11 The initial Appointing Period for the Chairperson and Vice-Chairperson shall be until 31 March 2016 when the Chairperson shall be appointed by NHS FV. Thereafter the Appointing Period shall be two years.
- 2.12 The Parties have agreed that the first Chairperson from 1 April 2016 shall be nominated by one of the local authorities.
- 2.13 The Parties have agreed that the first Vice-Chairperson shall be nominated by NHS FV.
- 2.14 If NHS FV nominate the Chairperson, the Vice Chair must be nominated by one of the constituent Local Authorities and vice versa in accordance with Article 6 of the Integrated Joint Board Order.
- 2.15 The appointment of the Chairperson and consequently the Vice Chairperson must alternate between NHS FV and a constituent local authority.
- 2.16 Nominations for Chairperson and Vice Chairperson can only come from the voting membership of the Integration Joint Board and subject to the further proviso that NHS FV may only nominate a voting member who is a Non-Executive Director.
- 2.17 A Party may change the person appointed by that Party as Chairperson or Vice-Chairperson during the Appointing Period.
- 2.18 The business and procedures of the Integration Joint Board meetings shall be set out in the Integration Joint Board's Standing Orders.
- 2.19 The Integration Joint Board may enter into a contract with any other person in relation to the provision to the Board of goods and services for the purpose of carrying out functions conferred on it by the Act.

3. Delegation of Functions

- 3.1 The functions that are to be delegated by the NHS Forth Valley to the Integration Joint Board are set out in Part 1 of Annex 1. The services to which these functions relate, which are currently provided by the Health Board and which are to be integrated, are set out in Part 2 of Annex 1.
- 3.2 The functions that are to be delegated by the each of the constituent Local Authorities to the Integration Joint Board are set out in Part 1 of Annex 2. The services to which these functions relate, which are currently provided by each of the constituent Local Authorities and which are to be integrated, are set out in Part 2 of Annex 2.

4. Local Operational Delivery Arrangements

- 4.1 The Integration Joint Board shall strategically plan for discharge of the integrated functions as specified in the legislation and shall oversee the implementation of the plan and operational delivery of these functions by the Parties.
- 4.2 The Integration Joint Board shall instruct and direct the operational delivery of the integrated functions by issuing written directions to the Parties in accordance with Section 26 of the Act.
- 4.3 The Integration Joint Board shall appoint a Chief Officer in accordance with Section 10 of the Act. The specific provisions relating to the role are as detailed in section 6 of this Scheme.
- 4.4 Corporate Service Support
- 4.4.1 In the Shadow Year, the Parties will identify the corporate resources currently utilised to carry out the Integration Functions and agree (a) how any or all of those will be provided to the Integration Joint Board to

support it to discharge its duties under the Act, and (b) how this resource will be funded.

4.4.2 Prior to the establishment of the Integration Joint Board, the Parties will identify any corporate services required to allow the Integration Joint Board to discharge its functions and will agree (a) how any or all of those will be provided to the Integration Joint Board to support it to discharge its duties under the Act, and (b) how this resource will be funded.

4.4.3 Any such agreement will be reviewed annually by the Parties and Integration Joint Board to ensure that the necessary support is provided to the Integration Joint Board.

4.5 Support for Strategic Planning

4.5.1 The Integration Joint Board shall establish a Strategic Planning Group in accordance with Section 32 of the Act before preparing its first Strategic Plan.

4.5.2 The Strategic Plan shall be prepared in accordance with Section 33 of the Act.

4.5.3 The Parties will provide the Integration Joint Board with such information and support as may reasonably be required to assist the Integration Joint Board to comply with its obligation to prepare a Strategic Plan. In particular it shall:-

- I. The Parties will share the necessary activity and financial data for services, facilities or resources that relate to the planned use by their residents.
- II. The Parties will advise the Integration Joint Board as soon as practicable where they intend to change non-integrated

service provision that will have a resultant impact on the Strategic Plan.

4.5.4 The Integration Joint Board shall have regard to the effect which any arrangements which it is considering setting out in the Strategic Plan may have on services, facilities or resources which are used, or may be used, by another integration authority and the Parties shall provide the Integration Joint Board with the appropriate information to determine this. In particular;-

- I. NHS FV will provide the necessary activity and financial data for services, facilities or resources that relate to the planned use, by people who live within the Clackmannanshire and Stirling areas, of services provided by other Health Boards ;and
- II. The Councils will provide the necessary activity and financial data for services, facilities or resources that relate to the planned use of services within other local authority areas by people who live within the Clackmannanshire and Stirling areas.

4.6 The Integration Joint Board shall publish its Strategic Plan and statement of action taken, in accordance with Section 35 of the Act.

4.7 The Integration Joint Board shall publish an Annual Financial Statement in accordance with Section 39 of the Act.

4.8 Targets and performance measurement

4.8.1 The Integration Joint Board will be responsible for monitoring and reporting on the delivery of services included in the Integration Functions on behalf of the Parties.

4.8.2 The Integration Joint Board shall prepare and publish an annual Performance Report and provide each Party with a copy.

4.8.3 The Parties shall provide the Integration Joint Board with such information as may reasonably be required to prepare the Performance Report.

4.8.4 The Parties shall provide corporate services support, particularly data analysis, to the Integration Joint Board to ensure the effective monitoring and reporting of targets and measures relating to the delivery of the integrated functions.

4.8.5 The Parties shall agree shared principles based on best practice for the development of relevant targets and measures.

4.8.6 In addition the Parties shall provide the following to the Integration Joint Board:-

I. A list of all relevant targets, measures and arrangements which relate to the Integration Functions and for which responsibility is to transfer, in full or in part, to the Board ("**Integration Functions Performance Target List**").

II. A statement of the extent to which responsibility for each target, measure or arrangement is to transfer to the Integration Joint Board or remains with the relevant party.

III. A list of all targets that are shared and a statement as to the degree of responsibility and accountability of each party.

IV. A list of all targets, measures and arrangements which relate to the functions of NHS FV or the Councils which are not Integration Functions but which are to be taken account of by the Integration

Joint Board when it is preparing the Strategic Plan (“**Non-integration Functions Performance Target List**”).

4.8.7 In developing the Performance Target Lists the Parties shall take into account the national guidance on the core indicators for integration.

4.8.8 The Integration Functions Performance List shall be prepared by 31 March 2016.

4.8.9 Non-Integration Functions Performance Target List will be prepared by 31 March 2016.

4.8.10 The Integration Functions Performance Target List will be developed alongside the Strategic Plan in two stages:

I. All of the existing targets, measures and arrangements currently in place in respect of the integrated functions will be identified and consolidated in one document together with a statement of the extent to which responsibility for each target, measure or arrangement is to transfer and to whom.

II. Those targets, measures and arrangements will be reviewed to ensure that:-

- a) they continue to be appropriate under the Integration Joint Board; and
- b) any gaps are identified and appropriate targets, measures or arrangements recommended for approval of the Integration Joint Board.
- c) that they continue to reflect guidance in respect of the national Health & Wellbeing Outcomes and the associated core suite of indicators for integration

4.8.11 The Lists will be reviewed annually by the Parties to ensure that they remain relevant.

4.8.12 The Integration Joint Board will provide such available performance information as is required to satisfy the relevant scrutiny and audit requirements of the Parties.

5.0 Clinical and Care Governance

5.1 In this section, the following terms have the following meanings:

“Clinical Governance” means a framework through which NHS Forth Valley is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

“Care Governance” means a robust system for assuring high standards in the delivery of safe, personalised and effective health and social care services (together, **“Clinical and Care Governance”**)

[The following two definitions will be completed after confirmation from Central Legal Office.]

“NHS Medical Director” means

“NHS Nursing Director” means

5.2 General Clinical and Care Governance Arrangements

5.2.1 The Parties and the Integration Joint Board are accountable for ensuring appropriate Clinical and Care Governance for their duties under the Act.

5.2.2 It will remain the responsibility of the Parties to assure the quality and safety of services commissioned from the third and independent sectors in line with the requirements set out in the Strategic Plan.

5.2.3 The Integration Joint Board will be responsible for ensuring that a framework for Clinical and Care Governance is in place for the services to be delivered in relation to the Integration Functions (**“the CCG Framework”**).

5.2.4 The Chief Social Work Officer, the NHS Medical Director and the NHS Nursing Director (together, **“the CCG Leads”**) will take the lead role in relation to Clinical and Care Governance. The NHS Medical and Nursing Directors will have arrangements in place for co-ordinating these functions across clinical groups; the Chief Social Work Officer will have arrangements in place for co-ordinating these functions across social care groups.

5.2.5 The CCG Leads will develop the CCG Framework by the end of the Shadow Year for the approval of the Integration Joint Board. The CCG Framework will include the following:

- i. details of each of the roles and responsibilities of each of the CCG Leads and how these will be delivered individually and collectively in relation to services which will be delivered in respect of the Integration Functions;
- ii. details of how those roles and responsibilities will be fulfilled within the Integration Joint Board, the Councils and NHS Forth Valley. In particular, it will contain statements about how the role of the Chief Social Work Officer should be reflected in

Council management arrangements. Arrangements in relation to the role of NHS Medical Director and the NHS Nursing Director are already explicitly articulated in NHS Forth Valley arrangements and will remain intact;

- iii. an agreed approach to measuring, and reporting to the Integration Joint Board, the quality of service delivery, addressing organisational and individual care risks, promoting continuous improvement and ensuring that all professional and clinical standards, legislation and guidance are met;
- iv. arrangements for suitable Service User and carer feedback/complaint handling processes;
- v. arrangements to ensure that the Parties' staff working in integrated services have the appropriate skills and knowledge to provide the right standard of care;
- vi. arrangements to ensure that appropriate staff supervision and support policies are in place;
- vii. arrangements to ensure, and evidence, effective information sharing systems;
- viii. details of the role and relationship of the Integration Joint Board, the Chief Officer, and the CCG Leads to the Community Planning Partnership, particularly in relation to public protection (to include adult support and protection, child protection, MAPPA arrangements, the alcohol and drug partnership, and domestic violence); and
- ix. provision for the oversight and governance of mental health officers and practice and governance in relation to the Adults with Incapacity, Adult Support and Protection, and Mental Health

Care and Treatment statutory framework. This will include clear delineation of responsibility/accountability around the roles and interdependencies of the Chief Officer and the Chief Social Work Officer.

5.3 Interaction with the Integration Joint Board, Strategic Planning Group and localities

- 5.3.1 The CCG Leads will advise the Integration Joint Board on best practice in Clinical and Care Governance.
- 5.3.2 The CCG Leads will be consulted on any proposal relating to the Integration Functions which is to be made to the Integration Joint Board and any views expressed and/or advice offered, will be incorporated into any reports to the Integration Joint Board on any such proposal.
- 5.3.3 The CCG Leads will be given the opportunity to comment on the Strategic Plan before it is formally consulted upon.
- 5.3.4 The CCG Leads may bring reports to the Integration Joint Board on matters relating to Clinical and Care Governance.
- 5.3.5 The CCG Leads will ensure that any professional groups established with regard to localities feed into, and are part of, the wider system of Clinical and Care Governance.
- 5.3.6 The CCG Leads will ensure that relevant Service User groups and fora feed into, and are part of the wider system of, Clinical and Care Governance.
- 5.3.7 The CCG Leads will produce an annual report for the Integration Joint Board.

- 5.3.8 Where appropriate, in advising the Integration Joint Board, the CCG Leads will seek input from the relevant professional groups or committees (for example, the Adult Support and Protection Committee).

5.4 Relationship between CCG arrangements for integrated and non-integrated health and social care services

5.4.1 The Chief Social Work Officer reports annually to a meeting of each of the Councils on the discharge of his/her duties as Chief Social Work Officer. This will continue and relate both to the Integration Functions and non-integrated functions/services. In addition to the annual report, the Chief Social Work Officer is entitled to advise the Council on all matters relating to social work functions. The Chief Social Work Officer's annual report will be made available to the Integration Joint Board.

5.4.2 Clinical Governance reports are considered by the NHS FV Clinical Governance Committee. This will continue and relate both to the Integration Functions and non-integrated functions/services. The Clinical Governance annual report will be made available to the Integration Joint Board.

6.0 Chief Officer

6.1 The Integration Joint Board shall appoint a Chief Officer in accordance with section 10 of the Act.

6.3 The Chief Officer shall be employed by one of the Parties and seconded to the Integration Joint Board to who s/he will be accountable.

6.4 The key functions of the Chief Officer are to;-

- I. oversee the development and implementation of the Strategic Plan;

II. direct and oversee the operational delivery of the integrated functions;

III. monitor and report performance in respect of the same to the Integration Joint Board and the Parties

6.5 The Chief Officer shall be jointly managed by the Chief Executives of the Parties.

6.6 The Chief Officer shall sit as a member of the Executive Management Team of each of the Parties and as such shall use the existing governance and management structures of the Parties to direct, monitor and report upon implementation of the Strategic Plan and delivery of the integrated functions.

6.7 The Chief Officer shall not hold position of Chief Social Work Officer, NHS Medical Director or NHS Nursing Director.

6.8 Where the Chief Officer is absent or otherwise unable to carry out their responsibilities for an extended period, the Parties will jointly propose an appropriate interim arrangement for approval by the Integration Joint Board Chair and Vice-Chair. If the Chief Officer's absence is expected to be more than 4 weeks, a formal secondment or recruitment process will be put in place by the Integration Joint Board.

7.0 Workforce and Organisational Development

7.1 The Parties will jointly develop and put in place for their employees delivering integrated services [and where appropriate for any employees of the Integration Joint Board]

- i. a joint workforce development and support plan (which will cover the learning and development of staff, their engagement and the development of a healthy organisational structure); and
- ii. an organisational development strategy (together “**the Workforce Plans**”).)

7.2 The Parties will commit the necessary resources to ensure the development and implementation of the Workforce Plans and will, where appropriate, consult with stakeholders.

7.3 The Workforce Plans will be developed alongside the Strategic Plan.

8.0 Finance

8.1. Definitions

"Integrated Budget" means the Budget for the delegated resources for the Integrated Functions comprising:-

- I. The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services; and
- II. The payment made to the Integration Joint Board by the Health Board for primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer.

"Notional Budget" (also referred to as the amount "set aside") means the amount required to be set aside by the NHS Forth Valley under Section 14(3) of the Act for direction from the Integration Joint Board through the Strategic Plan in respect of those delegated functions which are provided in large hospitals.

"Large hospital" means a hospital serving two or more local authority areas.

"Strategic Plan Budget" means the total amount of the Integrated Budget plus the Notional Budget.

"Payment" means the contribution made by the Parties to the Integration Joint Board in respect of the integrated functions or similarly the amount directed by the Integration Joint Board to the Parties for the operational discharge of the directed functions. Payment does not mean an actual cash transaction but a representative allocation for the delivery of the integrated functions in accordance with the Strategic Plan.

8.2 Payment in the first year [16/17] to the Integrated Joint Board for delegated functions

8.2.1 The method for determining the amount to be paid by the Health Board and Local Authorities to the Integration Joint Board in respect of each of the functions delegated by them to the Integration Joint Board [other than those to which section 8.2.2 below applies] (the "Integrated Budget") will be based on and take account of the following:-

- I. The financial element in the emergent Strategic Plan.
- II. A transparent analysis of actuals v budget for financial years 2013/14. and 14/15.
- III. A transparent ongoing analysis of projections v budget for financial year 2015/16.
- IV. The analysis as specified in III above may require appropriate budget re-profiling between services in scope and also between services in scope and those that are not.

- V. The requirement of the partners to produce balanced budgets in 2015/16 with constrained resources and a recognition that partners are likely to use different budget assumptions e.g. on inflation and pay awards.
- VI. Recognition that a degree of flexibility and pragmatism will be required in the first year, in particular, to implement change of this magnitude and complexity.
- 8.2.2 The process for determining the notional budget (i.e. the sum to be set aside and made available by the NHS Forth Valley to the Integration Joint Board in respect of those delegated functions which are carried out in a large hospital will be based initially on activity and direct cost information for the preceding three year period. In due course this will be benchmarked against NRAC (National Resource Allocation Committee) methodology for relevant elements.
- 8.2.3 The detailed methodologies for determining the amount to be paid by the Parties to the Integration Joint Board and the sum to be set aside will take into account all relevant guidance on financial planning and will be formally agreed by all Parties by 31st July 2015.
- 8.2.4 Due diligence will require to be carried out by the Local Authority Chief Finance Officer, the Accountable officer of NHS Forth Valley and the Integration Joint Board Financial Officer to assess the adequacy of the Payment made in respect of the Integrated Budget and the sum set aside in terms of the Notional Budget.
- 8.2.5 In the first year the allocated Payments including the Notional Budget set aside for large hospitals shall be tested against actual demand and delivery and adjusted if necessary.
- 8.2.6 The Parties shall determine and agree their respective Payment to the Integration Joint Board for the delivery of the integrated functions in advance of the start of each financial year and shall formally advise the Integration

Joint Board by no later than 28 February each year, subject to Scottish Government confirmation of NHS funding for the forthcoming year.

8.3 Payment in subsequent years

8.3.1 The method for determining the amount to be paid by the Health Board and the Local Authorities to the Integration Joint Board in respect of each of the functions delegated by them to the Integration Joint Board (other than those to which section 8.2.2 above applies) (the "Integrated Budget") shall be based on and take account of the following :-

- I. The indicative three year financial element in the Strategic Plan, subject to annual approval through the Parties' respective budget setting processes.
- II. The Integration Joint Board business case which shall be presented to the Health Board and Local Authorities for consideration against their other priorities and negotiation of their contributions.
- III. The business case should be evidence based with full transparency on its assumptions and take account of the factors listed at para 4.2.8 (as adjusted) of the IRAG Professional Guidance.
- IV. Regard should continue to be directed to the implications of actual and projections relative to budget for recent financial years.
- V. Recognition that a degree of flexibility and pragmatism will be required.

8.3.2 The method for determining the Notional Budget shall be as described in 8.2.2 above.

8.3.3 If the Strategic Plan identifies a change in hospital utilisation the resource implications for the Notional Budget will be determined through a detailed business case to be approved by all Parties.

8.3.4 Due diligence will require to be carried out by the Local Authority Chief Finance Officer, the Accountable officer of NHS Forth Valley and the Integration Joint Board Financial Officer to assess the adequacy of the Payment made in respect of the Integrated Budget and the sum set aside in terms of the Notional Budget.

8.4 In-year variances

8.4.1 The Integration Joint Board will allocate resources it receives from the Parties in line with the Strategic Plan. In doing this it will be able to use its power to hold reserves, so that in some years it may plan for an under spend to build up reserve balances and in others to breakeven or to use a contribution from reserves in line with the reserve policy. This will be integral to the medium term rolling financial plan. The reserves held by the Integration Joint Board should be accounted for in the books of the Integration Joint Board.

8.4.2 The level of reserves required and their purpose will be agreed as part of the annual budget setting and reflected in the Strategic Plan agreed by the Integration Joint Board. The Parties will be able to review the levels of reserves held by the Integration Joint Board as part of the annual budget setting process.

8.4.3 The Chief Officer will manage the respective operational budgets so as to deliver the agreed outcomes within the Operational Budget viewed as a whole.

8.4.4 The Chief Officer will be responsible for the management of in-year pressures and will be expected to take remedial action to mitigate any net variances and deliver the planned outturn.

8.4.5 Where resources allocated to the partner Health Board or Local Authority are ring-fenced, i.e. resources are not permitted to be transferred from these

areas to cover other budgets, the same ring-fencing shall apply when resources are transferred to the Integration Joint Board.

8.5 In-year overspend on the Operational Integrated Budget;-

8.5.1 Where there is a projected overspend against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the Integration Joint Board and the relevant finance officer and operational manager of the constituent authority must agree a recovery plan to balance the overspending budget.

8.5.2 In addition, the Integration Joint Board may increase the payment to the affected body, by either:

- I. Utilising an under spend on another arm of the operational Integrated Budget to reduce the payment to that body; and/or
- II. Utilising the balance of the general fund, if available, of the Integration Joint Board in line with the reserve policy.

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

- I. Make additional one-off payments to the Integration Joint Board, based on an agreed cost sharing model; or
- II. Provide additional resources to the Integration Joint Board which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan to address this; or
- III. Access the reserves of the Integration Joint Board to help recover the overspend position.

8.5.4 The exception is for overspends that arise due to material differences between assumptions used in setting the payments to the Integration Joint Board and actual events, e.g. pay inflation. Unplanned overspends effectively represent underfunding by the Local Authorities or Health Board with respect to planned outcomes and the cost should be met by the relevant Local Authorities or Health Board, subject to the financial capacity of the relevant partners.

8.6 In-year under spend on the operational Integrated Budget;-

8.6.1 Under spends on either arm of the operational integrated budget should be returned from the Local Authorities and Health Board to the Integration Joint Board and carried forward through the general fund. This will require adjustments to the allocations from the Integration Joint Board to these bodies for the sum of the under spend.

8.6.2 The exception is for under spends that arise due to material differences between assumptions used in setting the payments to the Integration Joint Board and actual events e.g. where the actual savings accruing from the substitution of a branded drug with a generic drug are greater than planned because the date of the drug coming off patent is earlier than assumed when setting the payments to the Integration Joint Board. Unplanned under spends effectively represent overfunding by the Local Authorities or Health Board with respect to planned outcomes and should either be returned to the Local Authorities or Health Board in-year through adjustments to their respective contributions to the Integration Joint Board.

8.6.3 What constitutes an exception will be decided by the Chief Officer and Chief Financial Officer of the Integration Joint Board in consultation with Chief Executives and Chief Finance Officers of the Parties. However over time it may become more difficult to identify unplanned under spends as the resources lose their identity in the Integrated Budget.

8.7 Contribution to the management of in-year overspends on non-integrated budgets in the Local Authorities or Health Board:-

- 8.7.1 In the event of a projected in-year overspend in respect of the Parties' non-integrated budgets, they should contain the overspend within their respective non-integrated resources.
- 8.7.2 In exceptional circumstances the Integration Joint Board may be required to contribute resources to offset the overspend, in which case the contributions to the Integration Joint Board will be amended. This will only be used in extreme cases with agreement from the Chief Officer and Chief Finance Officer of the Integration Joint Board and the Parties. The Chief Officer will determine the actions required to be taken to deliver the necessary savings or to fund the reduction in contributions, which actions require to be approved by the Integration Joint Board and all Parties.
- 8.7.3 The Integration Joint Board does not have responsibility for overspends in other Integration Authorities. This responsibility lies with the overspending Integration Authority.

8.8 Virements

- 8.8.1 The Chief Officer will be able to transfer resources between the arms of the operational Integrated Budget. This will require in-year balancing adjustments to the allocations from the Integration Joint Board to the Local Authorities and the Health Board, i.e. a reduction in the allocation to the body with the under spend and a corresponding increase in the allocation to the body with the overspend.
- 8.8.2 The Chief Officer will not be able to vire between the operational Integrated Budget and those budgets that are managed by the Chief Officer, but are outside of the scope of the Strategic Plan, unless agreed by the Parties.

8.8.3 The arrangements for the virement of budgets is specified in the scheme of delegation of the Parties and virement levels will be agreed in the Strategic Plan.

8.9 Risk sharing

8.9.1 Financial risk shall be managed through the financial management process noted above and the use of reserves.

8.10 Financial Management and Financial Reporting Arrangements

8.10.1 The importance of the Integration Joint Board receiving accurate and timeous financial information together with the necessary financial support is well recognised. It is also recognised that in reality the appointments of Chief Officer and Chief Finance Officer will influence the future arrangements for delivery of these financial support services.

8.10.2 Consequently, pending these appointments and confirmation of longer term arrangements, the Health Board and the Local Authority will retain responsibility for recording their respective in-scope services and agree consolidation protocols for preparation of:-

- I. Annual Accounts
- II. Financial Statements
- III. Financial element of the Strategic Plan
- IV. Regular financial reports to the Integration Joint Board
- V. Regular budgetary control reports to the Chief Officer

8.10.3 It is not expected that there will be a schedule of cash payments, but rather annual accounting entries for the agreed budgets. Under normal circumstances, variations will also be managed by accounting entries and exceptionally any proposal for different procedures would require agreement between the Health Board, Local Authorities and Integration Joint Board.

8.11 Capital and Asset management

8.11.1 The Chief Officer will consult with Local Authorities and the Health Board to make best use of existing asset resources.

8.11.2 The Integration Joint Board will have a duty to ensure best value in the use of the capital assets and ensure that they are used efficiently in implementing the Strategic Plan.

8.11.3 The Integration Joint Board will identify the asset requirements to support the Strategic Plan and to allow the Chief Officer to identify capital investment projects or business cases to submit to the Health Board and Local Authorities for consideration as part of their Capital Planning process. The existing procedures in the Health Board and Local Authorities should be used to consider capital bids and business cases.

8.11.4 The Integration Joint Board, NHS Board and the Local Authorities will undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan.

8.11.5 The Integration Joint Board will not receive any capital allocations, grants or have power to borrow for capital expenditure. The Health Board and the Local Authorities will continue to own their property and assets.

8.11.6 Where the Chief Officer identifies as part of the Strategic Plan new capital investment, a business case should be developed for all Parties to consider. Options may include one or more of the Parties approving the project from its capital budget or where appropriate, using the hub initiative.

8.11.7 The integrated budget may include payments from the Local Authorities and Health Board to cover the revenue costs of assets (rents, repairs, cleaning etc). This should be agreed as part of the budget negotiations.

9.0 Participation and Engagement

- 9.1 The Parties shall as a minimum consult those persons, groups or bodies prescribed in the Consultee Regulations in relation to the Integration Scheme.
- 9.2 The Parties and the Integration Joint Board shall employ a variety of methods and participation tools to ensure full and far reaching consultation with stakeholders including those people, groups and communities who are considered hard to reach.
- 9.3 The Parties shall agree and approach and a set of shared principles in respect of engagement and participation for use by the Integration Joint Board pending development of its own strategy.
- 9.4 The Integration Joint Board shall produce a strategy for engagement and participation in line with the principles and practice endorsed by the Scottish Health Council and those set out in the National Standards for Community Engagement.
- 9.5 The Integration Joint Board will participate as a partner in the Community Planning Partnership in line with local arrangements.
- 9.6 The Integration Joint Board shall have access to any relevant stakeholder and interest groups that the Parties have established or maintained for the purposes of engagement, participation and consultation.
- 9.7 The Parties shall provide or make available appropriate and adequate communications support to enable the Integration Joint Board to participate, consult and engage.
- 9.8 The Parties shall support the Integration Joint Board to produce its participation and engagement strategy.
- 9.9 The agreed approach to participation and engagement is attached at Annex 4

10. Information-Sharing and data handling

- 10.1 The Parties are already party to the Forth Valley Accord on the Sharing of Personal Information (known as “**SASPI**”).
- 10.2 The Parties will review SASPI to ensure it is fit for purpose for adoption by the Integration Joint Board and, if so, recommend that the Integration Joint Board become party to it.
- 10.3 If the Parties do not consider SASPI is fit for purpose, they will propose new information sharing arrangements for adoption by the Integration Joint Board and the Parties.
- 10.4 Where personal information is to be shared by or with the Integration Joint Board in the carrying out of the Functions and/or the delivery of integrated services, the Parties, and where relevant the Integration Joint Board, shall enter into an information sharing protocol pursuant to the procedure, and in line with the template documentation, established under SASPI (or any new arrangements set up pursuant to paragraph 10.3 above).

11. Complaints

- 11.1 In this part:

“**a Health Complaint**” means a complaint relating to a service provided to an adult included in Part 2 of Annex 1;

“**a Social Care Complaint**” means a complaint relating to a service provided to an adult included in Part 2 of Annex 2 (other than Housing Support Services);

“a Housing Support Services Complaint” means a complaint relating to a service provided to an adult which is an aspect of housing support services included in Part 2 of Annex 2, including aids and adaptation.

- 11.2 A complaint which is a Health Complaint will be dealt with by NHS Forth Valley pursuant to the health complaint procedure.
- 11.3 A complaint which is a Social Care Complaint will be dealt with by the Council pursuant to the social care complaint procedure.
- 11.4 A complaint which is a Housing Support Services Complaint will be dealt with by the Council pursuant to the Council’s complaint procedure.
- 11.5 Where a complaint is predominantly a Health Complaint but includes a Social Care Complaint and/or a Housing Support Services complaint, it will be dealt with by NHS Forth Valley, with input as necessary from the Council, pursuant to the health complaint procedure. The complainant will be advised of any appeal procedure which is available pursuant to the social care complaint procedure and/or the Council’s complaint procedure in respect of those elements of the complaint.
- 11.6 Where a complaint is predominantly a Social Care Complaint and/or a Housing Support Services Complaint but includes a Health Complaint, it will be dealt with by the Council, with input as necessary from NHS Forth Valley, pursuant to the Social Care complaint procedure and/or the Council’s complaint procedure (as the case may be). The complainant will be advised of any appeal procedure which is available pursuant to the health complaint procedure in respect of that element of the complaint.
- 11.7 Where a complaint is equally a Health Complaint and a Social Care/Housing Support Services Complaint, the Chief Officer will ensure either that (a) each Party will respond separately or (b) the Parties will respond jointly, depending on the complexity and interaction of the issues raised by the complaint.

- 11.8 The Parties will cooperate with each other to the fullest extent possible to ensure that complaints are dealt with fully and promptly in the best interests of the complainant.

12. Claims Handling, Liability & Indemnity

- 12.1 The Parties agree that they will manage and settle claims arising out of the provision of integrated services in accordance with legal principles of liability under common law or statute.
- 12.2 Any Party at fault will indemnify the Integration Joint Board in respect of any claims against it arising from the provision of integrated services.

13. Risk Management

- 13.1 The Parties will review the existing risk management strategies to agree commonalities and harmonise disparities, so as to develop a shared risk management strategy for the Parties and the Integration Joint Board for the significant risks that impact on integrated service provision ("**RM Strategy**"). Where practicable, the RM Strategy will take account of the RM Strategy of the Falkirk Integration Joint Board insofar as it relates to services which are to be delivered across the Forth Valley area.
- 13.2 The Parties will commit the necessary resources to support risk management by the Integration Joint Board, including the time to develop the RM strategy, provide professional advice, run workshops, support training and ensure appropriate monitoring arrangements are in place.
- 13.3 The RM Strategy will be developed in the Shadow Year alongside the Strategic Plan, and with regard to any performance targets, improvement measures and reporting arrangements for which the Integration Joint Board is to be responsible pursuant to section 4 of this Scheme.

- 13.4 The Parties will support the Integration Joint Board to assess its risk and develop a risk register which will list the risks to be reported under the RM Strategy ("**Risk Register**"). The RM Strategy will make provision for the format and content (other than the actual risks) of the Risk Register and the means by which it can be amended. The Risk Register will be developed alongside the Strategic Plan, and will take account of any performance targets, improvement measures and reporting arrangements for which the Integration Joint Board is to be responsible pursuant to section 4 of this Scheme.
- 13.5 The Chief Officer will be responsible for maintaining the Risk Register.
- 13.6 The RM Strategy will make provision for the timescale and frequency within which the list of risks in the Risk Register must be reported and to whom, including, where relevant, to the Parties.
- 13.7 The RM Strategy will include a risk monitoring framework ("**RM Framework**"). The RM Framework will be aligned with the broader governance arrangements for the Integration Joint Board, including the framework for monitoring performance and audit.
- 13.8 The Risk Register will set out any risks that should be reported on from the date of delegation of Integration Functions.
- 13.9 Any changes to the above Risk Management provisions must be subject to consultation and must be agreed amongst the Parties and the Integration Joint Board in writing.
- 13.10 The Integration Joint Board will:
- (a) establish risk monitoring and reporting as set out in the RM framework; and

- (b) maintain the risk information and share with the Parties within the timescales specified.

14.0 Dispute resolution mechanism

14.1 Where any of the Parties fails to agree with the others or with the Integration Joint Board on any issue related to this Scheme, then they will follow this process:

- I. The Chief Executives of the Health Board and the Local Authorities, and the Chief Officer, will meet to resolve the issue within 14 days of either of the Parties or the Integration Joint Board giving written notice to the others of the issue.
- II. If unresolved, the Health Board, the Local Authority and the Integration Joint Board will each prepare a written note of their position on the issue and exchange it with the others within 14 days of the meeting.
- III. Each party must respond to the others in writing within 14 days.
- IV. In the event that the issue remains unresolved, representatives of the Health Board, the Local Authorities and the Integration Joint Board will proceed to mediation with a view to resolving the issue.
- V. The mediator shall be selected within 14 days by agreement amongst the Parties, failing which, by the Director of the Scottish Mediation Network after consultation with the Parties. The mediation shall commence no later than 42 days after the selection of the mediator.
- VI. If there is any issue about the conduct of the mediation upon which the Parties cannot agree, then the mediator selected in accordance with paragraph V above shall, at the request of any Party, decide that issue after consultation with the Parties.

- VII. Unless they agree otherwise, the Parties shall share equally the fees, costs and expenses relating to the mediation and each Party shall pay its own expenses of preparation for, and participation and representation in, the mediation.
- VIII. If the Parties are unable to resolve the issue within 28 days of the mediation commencing, and only if the mediator and the Parties agree, the mediator may produce for the Parties a non-binding recommendation of terms of settlement.
- IX. Any settlement agreement reached in the mediation shall not be legally binding until it has been reduced to writing and signed by, or on behalf of, the Parties.
- X. The mediation will terminate when:
- i. a party withdraws from the mediation
 - ii. the Parties resolve the issue; or
 - iii. a written agreement is concluded.
- XI. Where the issue remains unresolved, the Parties agree to notify Scottish Ministers within 14 days of the unsuccessful mediation terminating, that agreement cannot be reached and to seek a direction pursuant to section 52 of the 2014 Act.
- XII. The Parties agree to be bound by any direction of the Scottish Ministers in relation to the issue.

Annex 1

Part 1

Functions delegated by the Health Board to the Integration Joint Board

Set out below is the list of functions that must be delegated by the Health Board to the Integration Joint Board as set out in the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. Further health functions can be delegated as long as they fall within the functions set out in Schedule One of the same instrument;

SCHEDULE 1 Regulation 3

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

<i>Column A</i>	<i>Column B</i>
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 2CA() (Functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS Contracts); section 17C (personal medical or dental services); section 17I() (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38() (care of mothers and young children); section 38A() (breastfeeding); section 39() (medical and dental inspection, supervision and treatment of pupils and young persons); section 48 (provision of residential and practice accommodation);

section 55() (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);

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

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

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

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

section 79 (purchase of land and moveable property);

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

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

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

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

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);

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

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

and functions conferred by—

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

The Health Boards (Membership and Procedure) (Scotland) 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;

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().

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7

(Persons discharged from hospital)

Community Care and Health (Scotland) Act 2002

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

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

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.

Except functions conferred by—

section 22 (Approved medical practitioners);

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

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

section 46 (Hospital managers' duties: notification)();

section 124 (Transfer to other hospital);

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

section 230 (Appointment of 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() (Correspondence of certain persons detained in hospital);

and functions conferred by—

The Mental Health (Safety and Security) (Scotland) Regulations 2005();

The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005();

The Mental Health (Use of Telephones) (Scotland) Regulations 2005(); and

The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008().

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

Section 23

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

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010

Except functions conferred by—

section 31(Public functions: duties to provide information on certain expenditure etc.); and

section 32 (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011

Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland)

Part 2

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

Set out below is the list of services that the minimum list of delegable functions is exercisable in relation to. Further services can be added as they relate to the functions delegated.

SCHEDULE 2 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(); and

“the public dental service” means services provided by dentists and dental staff employed by a health Board under the public dental service contract.

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().
13. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978().
14. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978().
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().

- 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.
- 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.

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Annex 2

Part 1

Functions delegated by the Local Authority to the Integration Joint Board

Set out below is the list of functions that must be delegated by the local authority to the Integration Joint Board as set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014. Further local authority functions can be delegated as long as they fall within the relevant sections of the Acts set out in the Schedule to the Public Bodies (Joint Working) (Scotland) Act 2014;

SCHEDULE Regulation 2

PART 1

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

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
National Assistance Act 1948()	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958()	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968()	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
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 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.)	

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982()	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986()	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000()	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
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

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001()	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002()	
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()	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006()	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007()	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013()	
Section 3 (Support for adult carers.)	Only in relation to assessments carried out under integration functions.
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
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

<i>Column A</i> <i>Enactment conferring function</i>	<i>Column B</i> <i>Limitation</i>
The Community Care and Health (Scotland) Act 2002	
Section 4() The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002()	

Part 2

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

Scottish Ministers have set out in guidance that the services set out below must be integrated. Further services can be added where they relate to delegated functions;

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services

- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

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Annex 3

Hosted Services

Where a Health Board spans more than one Integration Joint Board, one of them might manage a service on behalf of the other(s). This Annex sets out those arrangements which the Parties wish to put in place. Such arrangements are subject to the approval of the Integration Joint Board but will not be subject to Ministerial approval.

This would include –

The hosting of services by one Integration Authority on behalf of others within the same Health Board areas.

The hosting of services by on Health Board on behalf of one or more Integration Authority.

Additional duties or responsibilities of the Chief Officer.

Annex 4

Partnership Approach to Participation & Engagement

Context

Robust mechanisms which support communication, participation and engagement are critical to the success of health and social care integration. The Parties recognise that a shared set of values, clarity of purpose and a consistent approach in line with the national standards are crucial to effective participation and engagement.

Currently there are variations within the legislation, policies, standards and practice for public involvement between the NHS and local authorities.

NHS Boards have specific duties to involve both patients and the public in the planning and delivery of health services, this is generally known as Patient Focus and Public Involvement (PFPI).

There is a national Participation Standard for NHS Boards which involves carrying out an annual self-assessment against the national standards.

NHS Boards are required to set up Public Partnership Forums linked to Community Health Partnerships.

Local Authorities have a general statutory duty to engage with local communities.

Local Authorities have lead responsibility for Community Planning, a key objective of which is to strengthen community engagement and participation.

First steps

Develop and review/evaluate current involvement structures

The importance of involving and listening to those who use our services has been a long-standing theme in the delivery of health and social care services. National policy developments have increasingly focussed on the importance of working collaboratively with service users, carers, third and independent sector partners to design and plan the delivery of health and social care services.

Meaningful participation and involvement is a core tenet of the Government's policy on Integration of Health and Social Care. The Public Bodies (Joint Working) (Scotland) Act 2014 introduces a statutory duty to involve those who receive health and social care services, carers, local communities and providers of both commercial and non-commercial social care services in their design. The draft regulations relating to the Act prescribe the minimal requirements for membership of the Integration Joint Board and the Strategic Planning Group. There is agreement to scope the resources available across the agencies in order to determine the most effective and efficient approaches that will support participation and engagement and also ensure more joined up arrangements for the future. It is recognised that new

structures should build on the success of current arrangements, as well as taking forward areas identified for improvement. This will involve mapping out the structures, processes and strategies that are currently in place to support public engagement as well as identifying associated resources such as staffing and support arrangements. Reviewing the efficacy of current arrangements and gathering the views of wider stakeholders will be a fundamental element of the review, the results of which will be used to inform structural requirements which will in turn support participation and engagement.

The Parties recognise the benefits of adopting a joined up approach to support participation and engagement. Integration presents opportunities to pool resources and skills, strengthen existing joint planning mechanisms and work more closely with third and independent sector partners to support public engagement activities. In order to support this shared protocols will be required prior to the introduction of more formalised joint arrangements. A key requirement will be to ensure the involvement and engagement of representatives for the key committees and groups as prescribed by secondary legislation.

The Parties have agreed to develop a common shared database incorporating details of all of the relevant stakeholders, key contacts and agreed communication methods. For example, there are existing locally based community groups and communities of interest and user led organisations across NHS Forth Valley that are well established and can be used as channels to support engagement.

Recent examples of collaboration by the Parties, for example the communication and consultation that took place to support the delivery of the Re-shaping Older People's Care agenda and the associated Commissioning Strategies, will be used to inform engagement and consultation in relation to future health and social care strategies and plans.

Arrangements for involving seldom heard groups

Health and Social Care services need to be accessible, appropriate and responsive to meet a diversity of needs. The current strategies and initiatives to engage and involve local minority and potentially disadvantaged groups or communities will be identified by the partners with a view to establishing a more integrated approach.

Accurate data about the population and the groups within it including those who may be seldom heard, is a necessary pre-requisite. The current methods used to collate this type of information and identify groups that may be seldom heard will be reviewed and evaluated by the partners. Actions will be progressed to address any deficits in the arrangements for the collation, analysis and reporting of data in relation to age, ethnicity, gender, religion etc. Greater understanding of the population profile will provide a sound basis for planning and service delivery and will help to identify what arrangements may be required to engage and involve those who are seldom heard.

Specific mechanisms will be developed to guarantee the involvement of seldom heard groups as health and social care integration is progressed. The Parties acknowledge that the arrangements for ensuring the views of minority groups are

fully taken into account need to be strengthened. Existing arrangements and mechanisms will be reviewed to identify what works well and areas where improvements are needed. Several user-led organisations are engaged in a range of activities such as service planning, staff recruitment, training, commissioning and consultation events. User-led approaches have been shown to support effective engagement and ongoing dialogue and to enhance engagement with seldom heard groups. Where initiatives have evaluated well and brought added benefits, the services will share what has worked to support developments across service user groupings.

A range of innovative methods and diverse methods are used to gather views and involve seldom heard groups in service planning activities e.g. presentations to existing community groups or communities of interest, citizen panels, focus groups, questionnaires (including web based surveys), public meetings, consultation events and on-line consultations. There is scope for working more closely with third sector and community groups where there are established links with seldom heard groups e.g. with Gypsy traveller communities, Carers organisations, LGBT groups.

The Parties will identify and address barriers to participation. On-line approaches often enable a higher number of people to comment, respond and receive information, however it is recognised that these also create limitations and barriers for some groups or individuals. For example, some people with disabilities, those living in isolated or rural communities, those who do not use English as a first language and those who are homeless may find it particularly difficult to use these methods of engagement. Similarly where face to face communication is planned, it is necessary to take into account the accessibility of venues and any assistance, specialist tools or support that individuals may require.

To maximise opportunities for engagement the language used in all communications will be jargon-free. A wide range of communication methods will be used. This will also require mechanisms to ensure that the views, feedback and opinions provided by front-line health and social care practitioners on a day to day basis are taken into account in the planning process. The data gathered as a matter of course through direct contact with those who use services should be collated for planning purposes. One way of achieving this will be to ensure that information about personal outcomes is recorded and collated in a way that can inform planning arrangements.

Arrangements for communication with the public

The partner organisations already have wide range of established communication tools and channels to communicate effectively with staff, service users, the general public and other key stakeholders.

It is agreed that, wherever possible, use should continue to be made of these existing tools and channels which will be further developed, reviewed and adapted to ensure they continue to meet the evolving needs of the HSCPs.

The main aim of any public communications will be to raise awareness of service outcomes and highlight the benefits and improvements of integration for service users and their families.

A joint communication protocol will also be developed to support effective, consistent and joined up public communications across the new HSCPs. This will include details of arrangements for managing and responding to media enquiries and promoting joint service developments, improvements and events.

In addition, the communication leads from the partner organisations will work together to develop and agree communication plans to support specific projects, initiatives and consultations undertaken by the Partnership.

Reporting on outcomes (and progress in integration) to the public

Work to develop common performance frameworks that will enable integrated reporting arrangements for a range of audiences is already underway. This will be progressed to include agreed mechanisms and approaches for reporting on the progress of integration and the delivery of outcomes.

The performance framework will incorporate data about resource use, progress against agreed outcomes measures and customer perception. This will require the collation and sharing of both qualitative and quantitative data which will be aligned to the national outcomes for integration and the locally agreed outcomes. The framework will incorporate the range, nature and frequency of joint reporting arrangements. The framework will be developed and presented to the joint board (or shadow board) for sign off.

The framework will identify the ways in which reports will be made available to the public. Reports on performance will be published on relevant websites and arrangements will be made for specific information about outcomes and progress to be visible in key sites and service areas. Reports will be made available, on request, in different formats that are accessible and easily understood.

The Parties are committed to providing feedback to the public about actions that have been taken in response to feedback. Joint mechanisms will be put in place to report on consultations and engagement activities and to give information to respondents and the wider public about changes and improvements that have been made.

Training and on-going support for user/public members of the Board

Training and on-going support will be available for service users, carers and members of the public who are represented on the Integration Board and the strategic group. This will be through the delivery of formal training and other learning opportunities e.g. job shadowing. The Parties will agree how representatives will be identified, the resources to be used in providing appropriate support arrangements and procedures for accessing training. Partnerships will take a collaborative approach in order to ensure that training needs are met in a cost effective way.

How feedback from users/public feeds into governance arrangements

The Parties will agree how the information gathered from those who use services and the wider public will feed in to the governance arrangements for the partnership. This will include collating information received from both compliments and

complaints, outputs from surveys and questionnaires as well as feedback from consultation events. This data will form a key element of the joint performance framework and associated reporting arrangements thus ensuring that service user and public feedback informs and effects service change, service improvement and decision-making for future investment. Arrangements will be put in place at individual service levels and across the partnership to support this.

Information for how people can get involved

Information will be available to ensure that the public, those who use health and social care services and their carers have access to information about how they can become involved in service planning, policy development or providing feedback. This will build on existing information which will be reviewed and updated to reflect the new structures for participation and involvement. A range of communication channels, including social and local media, will continue to be used, as appropriate, to distribute information about events and opportunities to become involved in and engage with service developments.

