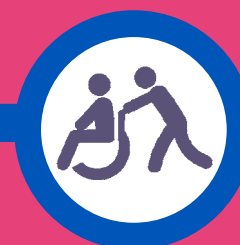
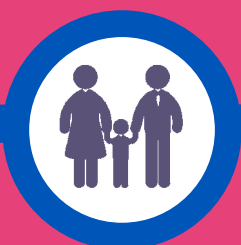
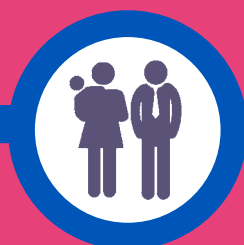




The Scottish
Government
Riaghaltas na h-Alba

Finance Guidance

Integrated Resources Advisory Group guidance and advice
on financial matters for Health Boards and Local Authorities



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Executive Summary

1 BACKGROUND AND INTRODUCTION

- 1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal assent in April. It establishes the framework for the integration of health and social care in Scotland.
- 1.2 The Scottish Government established the Integrated Resources Advisory Group (IRAG) to consider the financial implications of integrating health and social care, and to help develop professional guidance. This guidance and advice addresses financial matters and is being issued to assist Health Boards and Local Authorities in preparing for integration.
- 1.3 A summary of the key financial issues and recommendations covered in this guidance is set out below. Both models of integration – delegation to an integration joint board, and delegation to a lead agency – are covered.

2 DELEGATION TO AN INTEGRATION JOINT BOARD

- 2.0.1 The Integration Joint Board is a legal entity in its own right, created by Parliamentary Order, following Ministerial approval of an Integration Scheme. It will operate under public sector good practice governance arrangements which are proportionate to its transactions and responsibilities.
- 2.0.2 The Integration Scheme sets out the detail of the integration arrangement, as agreed by the Health Board and Local Authority; its content is specified in regulations and these including several provisions on finance related matters.
- 2.0.3 The Health Board and Local Authority will delegate functions and make payments to the Integration Joint Board in respect of those functions. Additionally, the Health Board will also, where appropriate, set aside amounts in respect of large hospital functions for use by the Integration Joint Board.
- 2.0.4 The Integration Joint Board has responsibility for the planning, resourcing and operational delivery of all integrated services. Decisions on integrated services are made by the Integration Joint Board, which produces the Strategic Plan.
- 2.0.5 The Integration Joint Board gives direction and makes payment, where relevant, to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan. The Integration Scheme sets out how the managerial arrangements across the integrated arrangements flow back to the Integration Joint Board and the Chief Officer.
- 2.0.6 The legislation uses the term payment for the transfer of resources by the Health Board and Local Authority to the Integration Joint Board and for the allocation back from the Integration Joint Board to the Health Board and Local Authority for operational delivery. This term does not necessitate cash transactions and it is recommended that the majority of the accounting for

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these should be via book entries within the ledgers of the Health Board and Local Authority, one of which should host the accounts of the Integration Joint Board.

- 2.0.7 The Integration Joint Board will lead the preparation of the Strategic Plan with other stakeholders, in line with the principles and duties set out in the legislation. The resources in the Strategic Plan will comprise:
- a) The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services;
 - b) The payment made to the Integration Joint Board by the Health Board for delegated healthcare services; and
 - c) The amount set aside by the Health Board for any delegated services provided in large hospitals for the population of the Integration Joint Board.
- 2.0.8 The Integration Joint Board will be able to allocate resources between these three components (a) to (c), above in line with the Strategic Plan.
- 2.09 The Integration Joint Board will devolve appropriate responsibility and accountability for resources to localities so that they are empowered to make decisions that achieve shifts in outcomes in line with the Strategic Plan.

2.1 Financial governance

- 2.1.1 When established, the Integration Joint Board is required to appoint a Chief Officer and a financial officer responsible for its financial administration. It is recommended that the latter is a joint appointment from the senior finance team of either the Health Board or Local Authority. The Chief Officer can be appointed to this role, and should this be the case and he/she does not hold a professional accounting qualification, it is recommended that arrangements are put in place to provide him/her and the Integration Joint Board with financial advice from a suitably qualified person; the arrangement should be included in the annual governance statement.
- 2.1.2 The Health Board accountable officer and the Local Authority Section 95 Officer discharge their responsibility, as it relates to the resources that are delegated to the Integration Joint Board, by the provisions in the Integration Scheme.
- 2.1.3 The Integration Joint Board financial officer is responsible for the administration of the financial resources delegated to it and will discharge this duty by:
- Establishing financial governance systems for the proper use of the delegated resources;
 - Ensuring that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board's financial resources; and

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- Ensuring that the directions to the Health Board and Local Authority require that the financial are spent according to the allocations in the Strategic Plan.

2.1.4 The financial resources allocated to the Health Board and the Local Authority by the Integration Joint Board for the delivery of services are the responsibility of the Health Board accountable officer and the Local Authority Section 95 Officer; and the Chief Officer is accountable to them for the use of financial resources in his/her operational role in the Health Board and Local Authority.

2.2 Financial assurance and reporting

2.2.1 The Integration Joint Board will need to put in place systems to establish good governance arrangements, including proportionate:

- Financial regulations;
- Risk management and insurance provision; and
- Internal audit arrangements.

2.2.2 The equivalent arrangements in the Health Board and Local Authority will need to be reviewed and revised to incorporate any changes brought about by the integration arrangements.

2.2.3 The legislation requires that the Integration Joint Board is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973. This determines that the Integration Joint Board will produce audited accounts, that the external audit will be undertaken by auditors appointed by the Accounts Commission and that the financial statements will be prepared according the Code of Practice in Local Authority Accounting in the UK.

2.2.4 The financial statements (including an annual governance statement) will be proportionate to the limited volume of transactions undertaken by the Integration Joint Board; a set of illustrative statements are included in this guidance.

2.2.5 The Integration Joint Board will be required to produce accounts for 2015/16 covering the period from the date of its establishment to the end of March 2016.

2.2.6 The Local Authority and Health Board will need to produce group accounts on the basis that the Integration Joint Board is a joint venture.

2.2.7 The Integration Joint Board will publish an Annual Performance Report which will include provisions on financial performance and Best Value.

2.3 Financial planning

- 2.3.1 The Strategic Plan will incorporate a medium term financial plan for the resources within the scope of the Strategic Plan. The Integration Joint Board will publish an Annual Financial Statement setting out the total resources included in each year of the plan.
- 2.3.2 It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole.
- 2.3.3 The resources in the first year should be based on the due diligence carried out during the shadow period. The due diligence process is vitally important and it is recommended that it should be based on the existing financial plans of the Local Authority and Health Board, including planned efficiencies, on the financial performance during the shadow period and on past financial performance in recent years. In subsequent years the Chief Officer and the Integration Joint Board financial officer will develop a business case for its resources in line with the method set out in the Integration Scheme.

2.4 VAT status

- 2.4.1 HMRC have confirmed that the Integration Joint Board is not a taxable person under the VAT Act 1994 as it will not provide services directly.

2.5 Capital and asset management

- 2.5.1 In preparing the Strategic Plan the Chief Officer will consider all of the resources which are required to deliver the integration outcomes including the relevant non-current assets owned by the Health Board and Local Authority. It is recommended that the Chief Officer develops business cases for capital investment for consideration as part of their respective capital planning processes.

3 DELEGATION BETWEEN PARTNERS – LEAD AGENCY

- 3.0.1 The Integration Scheme will set out the detail of the integration arrangement, including which body will be the lead agency, as agreed by the Health Board and Local Authority. Its content is specified in regulations including several provisions on finance related matters.
- 3.0.2 When the Integration Scheme is approved, the Scottish Ministers will inform the Health Board and Local Authority that they can proceed with the arrangement. The Chief Executive of the lead agency becomes responsible for developing the Strategic Plan according to the arrangements set out in the legislation.

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- 3.0.3 The Health Board or Local Authority will delegate functions and make payments to the lead agency in respect of those functions. Where the Local Authority is the lead agency, the Health Board will also set aside amounts in respect of large hospital functions for use under the scope of the Strategic Plan.
- 3.0.4 The lead agency will produce the Strategic Plan for the use of these resources. Where the Local Authority is the lead agency it will give direction to the Health Board for use of the resources set aside for services provided in large hospitals.
- 3.0.5 The lead agency will lead the preparation of the Strategic Plan with other stakeholders, in line with the principles and duties set out in the legislation. The resources in the Strategic Plan will comprise:
- a) Payment made to the lead agency by the delegating body;
 - b) Budgets in the lead agency for the services to be managed in conjunction with the delegated services; and
 - c) Where the Local Authority is the lead agency, the amount set aside by the Health Board for services provided in large hospitals used by the partnership population.
- 3.0.6 The lead agency will be able to vire resources between the three components (a) – (c) above in line with the Strategic Plan.
- 3.0.7 The lead agency will devolve appropriate responsibility and accountability for resources to localities so that they are empowered to make decisions that achieve shifts in outcomes in line with the strategic Plan.

3.1 Financial governance

- 3.1.1 The Financial governance systems of the lead agency will apply to the integrated resources.

3.2 Financial assurance and reporting

- 3.2.1 The accountable officer of the lead agency is responsible for financial matters relating to the integrated resources. It will be necessary to review and revise the:

- Financial regulations;
- Risk management and insurance provision; and
- Internal audit arrangements.

To include the delegated services.

- 3.2.2 The reporting in the financial statements of the Local Authority and Health Board should follow the existing accounting treatments and will include appropriate disclosure of the lead agency arrangement.

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3.2.3 The Lead agency will publish an Annual Performance Report which will include provisions on financial performance and Best Value.

3.3 Financial planning

3.3.1 The Strategic Plan will incorporate a medium term financial plan for the resources within the scope of the Strategic Plan. An Annual Financial Statement will be published setting out the total resources included in each year of the plan.

3.3.2 The Chief Executive for the lead agency will develop a business case for its resources in line with the method set out in the Integration Scheme. The resources in the first year should be based on the due diligence carried out during the shadow period. The due diligence process is vitally important and it is recommended that it should be based on the existing financial plans of the Local Authority and Health Board, including planned efficiencies, on the financial performance during the shadow period and on past financial performance in recent years.

3.4 VAT status

3.4.1 HMRC guidance will apply to Scotland which will allow a VAT neutral outcome. Worked examples are included in the guidance.

3.5 Capital and asset management

3.5.1 The capital assets owned (or leased) by the delegating body will be used to provide the integrated services together with the lead agency's capital assets.

3.5.2 This can be achieved by the transfer of assets between the Health Board or Local Authority, but where assets are not transferred, a number of options are available to facilitate the use of capital assets by the lead agency; each of these options has different financial implications.

3.5.3 It is recommended that the capital investment needed to deliver the Strategic Plan is included in the lead agency's capital plan. If funding is required from the delegating body, the Chief Executive of the lead agency should prepare a business case as required by the delegating body.

3.6 Accounting treatments

3.6.1 There are a number of budgetary issues that arise under lead agency arrangements due to statutory mitigations being available to Local Authorities which are not available to Health Boards. The main areas where statutory mitigations may make an impact are:

- Where there are proposals for the transfer of staff from Local Authority to Health Board employment, in the accounting for employee benefits under International Accounting Standard 19; and
- Asset transfers.

3.6.2 It is recommended that both the Health Board and Local Authority consider the implications of these matters during the shadow period.

4 Conclusion

4.1 Further information on all of the above matters is provided in the detailed guidance in the sections which follow. In addition advice may be obtained from the contacts listed in section E or through the integration mailbox irc@scotland.gsi.gov.uk

4.2 The Scottish Government would like to thank members of IRAG, the five finance workstreams¹ and the LASAAC/TAG short life working group for their input and advice throughout the preparation of the guidance.

¹ Membership of IRAG and the finance workstreams is listed in Section E

SECTION A

Introduction and Purpose

A INTRODUCTION AND PURPOSE

1 Background

1.0.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) establishes the legislative framework for the integration of health and social care in Scotland². The Act and regulations have a significant impact on the financial governance of Health Boards and Local Authorities and the Scottish Government recognised that there was the need for objective financial guidance to assist and support health and local authority finance leaders in implementing the provisions.

1.0.2 The Scottish Government established the Integrated Resources Advisory Group (the Group) to provide advice on the financial implications of the legislation and on the requirements for statutory and professional guidance. The membership of the IRAG was drawn from a wide range of financial stakeholders within local government, health and central government³. The work of the Group was allocated to five financial workstreams, each chaired by a Director of Finance from either a Health Board or Local Authority and supported by functional experts and the Scottish Government. The workstreams⁴ covered the following areas:

- Accounting treatment and VAT;
- Financial recording and reporting;
- Financial controls, assurance and risk;
- Financial planning and financial performance management; and
- Capital and assets

1.0.3 Each workstream reviewed the financial implications of the legislation and developed principles to be used as a basis for the development of professional guidance initially for the shadow arrangements. The principles were reviewed and agreed by the Group and guidance drafted from the principles was subsequently reviewed and agreed by the Group.

2 Scope and purpose

2.0.1 This guidance is based on the provisions of the Act and regulations; it specifically does not address the potential future situation of the Integration Joint Board being empowered under Section 12. It aims to provide a basis for the development of the local financial arrangements required to support the implementation of the integration of health and social care. In preparing the guidance, the approach has been to achieve proportionality balanced against the need to show openness, integrity and accountability of the public finances.

² Policy Memorandum, Public Bodies (Joint Working) (Scotland) Bill as introduced to the Scottish Parliament 28 May 2013

³ Membership of the Integrated Advisory Group is listed in section E

⁴ Membership of the workstreams is listed in section E

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- 2.0.2 The Act was passed by the Scottish Parliament on 25th February 2014; it received Royal Assent in April and regulations were passed in December 2014, with the duties required to be implemented in the year commencing April 2015.
- 2.0.3 This second and final draft of the guidance builds on the earlier draft issued in April 2014.
- 2.0.4 Further support will be available during implementation as set out in section E.

3 Status

- 3.0.1 This is statutory guidance and it should be used with reference to the legislation.
- 3.0.2 Section 53 of the Act requires that Health Boards, Local Authorities and Integration Authorities must have regard to guidance issued by Ministers in relation to their functions under the legislation; having had regard to the guidance, they may determine that an alternative is more appropriate, in which case they will need to be able to justify the decision.
- 3.0.3 Where the guidance relates to mandatory requirements reference is made to the legislation through the relevant section number as set out in the Act or regulations.

4 Format of the guidance

- 4.0.1 The guidance has been designed to provide an easily accessible and practical format for finance practitioners. It follows the anticipated order of decision making likely to be followed in preparing for and implementing the financial integration arrangements, with information provided in a question and answer format.
- 4.0.2 General information is provided in sections D, E, F, G and H and guidance relevant to each of the two models of integration prescribed in the legislation is in sections B and C. The sections on each model follow a common structure of:
- General introduction;
 - Assurance and governance;
 - Financial reporting;
 - Financial planning and financial performance management;
 - VAT;
 - Capital and asset management; and
 - Accounting standards.

5 Terms and definitions

Accountable Officer (Health Board): this role is the responsibility of the Chief Executive in Health Boards. The financial governance duties are specified in the Public Finance and Accountability (Scotland) Act 2000.

AME: Annually Managed Expenditure. Expenditure outside the revenue and capital resource limits which is managed annually because it cannot reasonably be subject to firm multi-year limits. This budget is restricted to property impairments, movement in pension valuations, provisions and depreciation on donated assets.

ASD: Analytical Services Division (Scottish Government).

Block Grant (Local Authority): Grant from the Scottish Government which funds approximately 85% of the net revenue expenditure of local authorities and consists of the revenue support grant, income from non-domestic rates and specific grants. The balance is funded from local taxation (e.g. Council Tax).

Chief Officer: Officer appointed by the Integration Joint Board in consultation with the relevant Local Authority and Health Board. The legislation prescribes that the Chief Officer is seconded to the Integration Joint Board from the constituent authorities. The Chief Officer is employed by the Health Board or Local Authority party to the Integration Scheme by which the Integration Joint Board was established.

CNORIS: A not-for-profit risk sharing scheme that is in place to meet the cost of clinical and non-clinical negligence claims, which has mandatory membership for Health Boards⁵.

The Code: The Code of Practice on Local Authority Accounting in the United Kingdom. It constitutes proper accounting practice under section 12 of the Local Government (Scotland) Act 2003 and applies to all local authorities, joint committee and joint boards of principle authorities unless directed otherwise in legislation.

CRL: Capital Resource Limit. Capital budget allocation for Health Boards. Health Boards are required to break-even against their CRL on a year to year basis.

Direction (from an Integration Authority): A written instruction from the Integration Authority that an integration function must be carried out by a particular person, e.g. the Local Authority or Health Board which is binding on the recipient.

FReM: Government Financial Reporting Manual.

HSCDIIP: The Health and Social Care Data Integration and Intelligence Project commissioned by The Scottish Government from ISD to work with Health Boards, Local Authorities, Integration Joint Boards, and others to develop a longitudinal health and social care dataset which links health and social care data at individual patient/service user level. It's purpose is to support Strategic Planning

⁵ Section B 2.3 and C 2.3

Host Local Authority: The Local Authority which hosts services on behalf of other local authorities within the Health Board area.

Host Partner: The Local Authority or Health Board which receives and delivers the delegated functions in the lead agency model of integration.

Integration Authority: The lead body or bodies for the integration arrangements which are determined by the model of integration, i.e. the Integration Joint Board, or Health Board, Local Authority or both as the lead agency.

Integrated Budget: Budget⁶ for the delegated resources for the functions set out in the Integration Scheme as specified in legislation (See “notional budget”).

ISD: Information Services Division (Scottish Government).

Integration Models: The two models for integration prescribed in the legislation, which are:

- Delegation of functions to an Integration Joint Board (“body corporate”); and
- Delegation of functions to one or both of the partners (lead agency).

Integration Scheme: The jointly prepared plan between the Local Authority and Health Board covering the Local Authority boundary (or more than one Local Authority and the Health Board) which defines the integration arrangements. Legislation (**Section 1, 2 and 3**) will prescribe that it includes the:

- Model of integration;
- The functions to be delegated; and any functions to be delegated in conjunction with those arrangements in a lead agency arrangement; and
- The method for determining the initial and subsequent payment from the delegating to the receiving authority and certain other financial arrangements.

The legislation also provides for the Scottish Ministers to prescribe other matters that may be included in the Integration Scheme (**Section 1 (3)(f)**).

Integration Joint Board: Body corporate established by order of the Scottish Ministers as a consequence of an approved Integration Scheme (delegation of functions to a body corporate) (**Section 9(2)**).

Integration Joint Monitoring Committee (the joint committee): Joint committee of the Local Authority and Health Board established to monitor and scrutinise the delivery of the Strategic Plan (delegation of functions between partners).

LASAAC: Local Authority Accounts Scotland Advisory Committee

⁶ See sections B1.3.1-1.3.2 and C1.2.1 -1.2.2

Large hospital services: This term refers to services which are provided in the exercise of the functions that a Health Board delegates under an integration scheme which are carried out in the area of the Health Board and are provided for the populations of two or more local authorities (**as described in Section 1 (14)**). Note that services provided in community hospitals **do not** ordinarily fall under this definition, but that exceptions are possible in cases where a material proportion of care is provided for the populations of two or more local authorities. This flexibility is provided for the administrative convenience of the Health Board and leaves unchanged the Integration Joint Board's authority to direct hospital spend and activity for the functions and services delegated to it. These must include the minimum list of inpatient specialities provided in Regulations, which it should be noted make no distinction in terms of place of care; hospital services included on the "must delegated list" in the Regulations are subject to the direction of the Integration Joint Board whether they are provided in a community hospital or any other kind of hospital.

Sum Set aside/Set aside budget: Activity based budget for commissioned hospital services used by the Integration Authority population as set out in the Strategic Plan. This is the amount required to be set aside by the Health Board for use by the Integration Authority (**Section 13(3)**).

ONS: Office for National Statistics responsible for classifying the Integration Joint Board for Accounts purposes.

Payment: Term used in the legislation to describe the Integrated Budget contribution to the Integration Joint Board and does not require that a bank transaction is made. In addition the term used to describe the resources paid by the Integration Joint Board to the Health Board and the Local Authority for carrying out the directed functions.

PAS data: Patient Administration System data.

PLICS: Patient Level Information and Costing System.

Prudential Code: The professional code of practice that informs Local Authority decisions on the funding of proposed capital investments.

RRL: Revenue Resource Limit. Health Boards are required to at least break-even against their RRL on a year to year basis. The RRL is determined by the NHS Scotland Resource Allocation Committee formula and is allocated to Health Boards through their opening revenue budget. Health Boards receive additional funding throughout the year relating to specific priorities and services.

Section 95 Officer: Statutory post under the Local Government (Scotland) Act 1973. The post holder is the Accountable (Proper) Officer for the administration and governance of the financial affairs of the Local Authority.

Strategic Plan: The document setting out the arrangements for carrying out the integration functions and how these are intended to achieve or contribute to the achievement of the relevant national health and wellbeing outcomes for the

population of the Integration Authority. Where there are more than one Integration Authority within the Health Board area consideration will be given to the impact of the individual Strategic Plans on each other.

Statutory Mitigation: Statutory guidance issued by Scottish Ministers for the accounting treatment for specified transactions or types of transactions undertaken by a Local Authority. It may be issued where the accounting practice under the Code has been determined to result in an improper charge against the general fund in the Local Authority financial statements and thus has a consequential impact on the funding available for the provision of local services⁷.

Unified Board Accounts Manual: Manual prepared by the NHS Technical Accounting Group and is intended to compliment the guidance contained in the FReM and assist Health Boards in the preparation of their annual accounts; but does not supersede the requirements of FReM.

TAG: NHS Scotland Technical Accounting Group

VAT: Health Boards and Local Authorities have a different VAT status under the VAT Act 1994. Local Authorities have Section 33 status whereby they can recover VAT on non-business activities; and Health Boards have Section 41 status, whereby they can typically only recover VAT incurred on services (in accordance with contracted out services regulations). Local Authorities typically recover a greater proportion of VAT than Health Boards.

⁷www.scotland.gov.uk/Topics/Government/local-government/17999/LAacc/LAaccguid

SECTION B

Delegation to an Integration Joint Board

B DELEGATION TO AN INTEGRATION JOINT BOARD

1 Introduction

1.0.1 Under this model of integration, the Health Board and Local Authority delegate functions and resources to the Integration Joint Board.

1.1 Integration scheme, Strategic Plan, Annual Financial Statement and Annual Performance Report

1.1.1 The Integration Scheme sets out the detail of the integration arrangement, as agreed by the Local Authority and Health Board and submitted to Scottish Ministers for approval (**Section 7(1)**). Regulations require that it covers a number of finance related matters:

- Functions which are to be delegated to the Integration Joint Board by the Health Board and Local Authority;
- The method for the determination of the resources to be made available by the Local Authority and Health Board to the Integration Joint Board for the delegated functions;
- Reporting arrangements between the Integration Joint Board, Health Board and Local Authority; and
- Arrangements for providing financial services to the Integration Joint Board;
- Financial management arrangements for variances and redetermination of payments and amounts set aside; and
- Arrangements for the use of capital assets in relation to the integration functions.

1.1.2 It is recommended that the Integration Scheme should also define those services which are not delegated to the Integration Joint Board but are managed by the Chief Officer on behalf on the partner Local Authority and Health Board.

1.1.3 The Integration Joint Board will lead the preparation of the Strategic Plan with other stakeholders, in line with the principles and duties set out in the legislation (**Sections 29-39**); the Strategic Plan will describe the capacity required by the partnership population along the spectrum of care and the resources available to deliver the outcomes.

1.1.4 The Integration Joint Board will publish an Annual Financial Statement (**Section 39**) which will set out the amount that will be spent in each year of the strategic plan. Guidance on the content of the Annual Financial Statement is included the [Statutory Guidance](#) for Strategic Planning.

1.1.5 The Integration Joint Board will publish an Annual Performance Report (**Section 42**) within four months of the year end with an assessment of its performance in planning and carrying out the integration functions. Regulations require that it contains financial information for the reporting year on the following:

- Service type and the balance of care;
- Key care groups;
- Localities; and
- Assessment of performance in achieving best value.

1.1.6 [Statutory Guidance](#) on the content of the Annual Performance Report will be published by Scottish Government separately.

1.2 Chief Officer

1.2.1 The Chief Officer will be the accountable officer of the Integration Joint Board in all matters except finance. The Integration Joint Board must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility, (the Integration Joint Board financial officer) (**Section 13(a)**). The Chief Officer may be appointed to this role if the joint board deems it appropriate. (See Section 1.4.2 for financial accountability).

1.2.2 It is recommended that in appointing a financial officer the Integration Joint Board has regard to the CIPFA guide on The Role of the Chief Financial Officer in Local Government⁸.

1.2.3 The Chief Officer will also hold an operational role in the Health Board and Local Authority, for the management of the operational delivery of the services as directed by the Integration Joint Board. This will involve a delegation of budgets from the Health Boards and Local Authorities following their established procedures. She/he should receive support and advice in this role from the Finance Director in the Health Board and Section 95 Officer in the Local Authority (See section 2.1).

1.3 Financial model

1.3.0.1 The Health Board and Local Authority will delegate functions (**Section 1**) and make payments to the Integration Joint Board in respect of the delegated functions (**Section 14**); and the Health Board will also set aside amounts in respect of large hospitals for use by the Integration Joint Board. The Integration Joint Board will produce the Strategic Plan for the use of these resources and give direction and make payment where relevant (**Sections 26 and 27**) to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan.

⁸ http://www.cipfa.org/-/media/Files/Publications/Reports/role_of_CFO_in_LG_2010_WR.pdf

1.3.0.2 The legislation uses the term payment for the transfer of resources by the partner Health Board and Local Authority to the Integration Joint Board and for the allocation back from the Integration Joint Board to the Health Board and Local Authority for operational delivery. This term does not necessitate cash transactions and it is recommended that the majority of the accounting for these be via book entries within the ledgers of the Health Board and Local Authority, one of which should host the accounts of the Integration Joint Board.

1.3.1 Resources within the scope of the Strategic Plan

1.3.1.1 These will comprise:

- The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services **(A)**;
- The payment made to the Integration Joint Board by the Health Board for delegated primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer **(B)**; and
- The amount set aside by the Health Board for delegated services provided in large hospitals for the population of the Integration Joint Board **(C)**.

1.3.1.2 The Integrated Budget comprises of parts **(A)** and **(B)**. The minimum scope of services **(Section 1 (7) and (8))** to be included in each of **(A)**, **(B)** and **(C)** is set out in regulations. The Local Authority and Health Board may include other services, beyond the minimum requirement, within the scope of the plan. The legislation takes powers for Ministers to set this out in regulations and also to specify those services that may not be delegated to the Integration Joint Board **(Section 1 (10) and (11))**.

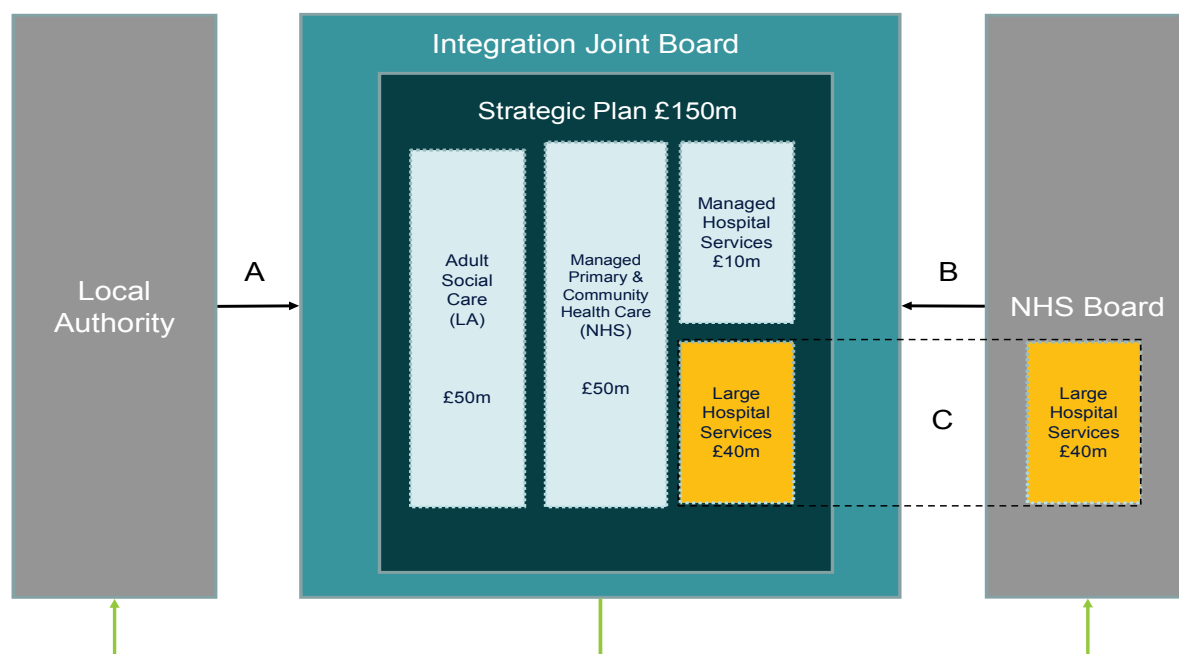
1.3.2 Resources outside the scope of the Strategic Plan

1.3.2.1 In addition to the services within scope of the Strategic Plan and managed by the Chief Officer, the Local Authority and Health Board may request that the Chief Officer manage services that are outside of the scope of the Strategic Plan.

E.g. Children's community health services, children's social work services, or other ex-Community Health Partnership (CHP) services that fall outside the scope of the plan.

1.3.2.2 The resource model for delegation to an Integration Joint Board is shown in figure 1 below. In this example the resources within scope of the Strategic Plan total £150m, comprising £110m in the Integrated Budget allocated to the Integration Joint Board and £40m notional budget for large hospital services managed by the Health Board.

Figure 1: Delegation to an Integration Joint Board.



1.4 Financial governance

1.4.1 Statutory reporting

1.4.1.1 The Integration Joint Board will be required to produce its own statutory accounts as a body under Section 106 of the Local Government (Scotland) Act 1973. **(Section 13)** Legislation specifies the minimum reporting requirements for the annual accounts **(Section 12 of the Local Government Act in Scotland Act 2003 and regulations under Section 105 of the Local Government Scotland Act 1973)**.

1.4.1.2 The Local Authority and Health Board will be required to include additional disclosures and group accounts as part of their financial statements which reflect their relationship with the Integration Joint Board.

1.4.2 Financial accountability

1.4.2.1 The Integration Joint Board must appoint an officer to be responsible for the administration of its financial affairs, referred to in this guidance as the Integration Joint Board financial officer. It is recommended that in appointing the financial officer the Integration Joint Board has regard to the CIPFA⁹ guidance on the role of the Chief Financial Officer in Local Government⁹.

1.4.2.2 The legislation allows for the Chief Officer to be appointed to this post if the Integration Joint Board deems it appropriate. In the event that the Chief

⁹ http://www.cipfa.org/-/media/Files/Publications/Reports/role_of_CFO_in_LG_2010_WR.pdf

Officer is appointed as the Integration Joint Board financial officer but does not hold a professional finance qualification, it is recommended that arrangements are put in place to provide him/her and the Integration Joint Board with financial advice from a suitably qualified person. For example, from the Director of Finance of the Health Board and the Section 95 Officer in the Local Authority (or their delegates). This is a matter for local determination and the arrangement will be included in the annual governance statement. Where the role is not fulfilled by the Chief Officer, it is recommended that it should be carried out by a joint appointment from the senior finance team of either the Health Board or Local Authority.

- 1.4.2.3 The Health Board and Local Authority may make use of non-current assets, owned or otherwise, to deliver the services in scope of the Strategic Plan. Ownership of the assets and the associated liabilities will be unchanged and remain with the partner Local Authority and Health Board.

1.4.3 Risk management

- 1.4.3.1 The Integration Joint Board should establish a system of risk management arrangements for the functions delegated to it. The operational delivery of services by the Local Authority and Health Board, as directed by the Integration Joint Board, will be subject to their respective governance and risk management arrangements.

2 Assurance and governance

2.1 Financial assurance

What will be the respective responsibilities of the Integration Joint Board financial officer, the Health Board accountable officer and the Local Authority Section 95 Officer?

- 2.1.1 The Health Board accountable officer and the Local Authority Section 95 Officer discharge their responsibility, as it relates to the resources that are delegated to the Integration Joint Board, by setting out in the Integration Scheme - the purpose for which resources are used - and the systems and monitoring arrangements for financial performance management. It is their responsibility to ensure that the provisions of the Integration Scheme enable them to discharge their responsibilities in this respect. (See “following the public pound” at 2.7)
- 2.1.2 The Integration Joint Board financial officer will discharge her/his duties in respect of the delegated resources by:
- Establishing financial governance systems for the proper use of the delegated resources;
 - Ensuring that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board’s resources; and
 - Ensuring that the directions to the Health Board and Local Authority provide for the resources that are allocated in respect of the directions are spent according to the plan; it is the responsibility of the Integration Joint Board financial officer to ensure that the provisions of the directions enable them to discharge their responsibilities in this respect. (See “following the public pound” at 2.7);
- 2.1.3 The Health Board accountable officer and the Local Authority Section 95 Officer are responsible for the resources that are paid by the Integration Joint Board to the Health Board and Local Authority in support of the Directions for operational delivery. In his or her operational role within the Health Board and Local Authority, the Chief Officer is:
- Accountable to the Chief Executive of the Health Board for financial management of the operational budget, and is advised by the Health Board Director of Finance;
 - Accountable to the Section 95 Officer of the Local Authority for financial management of the operational budget; and
 - Accountable to the Chief Executive of the Local Authority and Chief Executive of the Health Board for the operational performance of the services managed by the Chief Officer.

Will the Integration Joint Board require its own financial regulations?

- 2.1.4 Yes; financial regulations should be developed by its financial officer and incorporate a minimum set of controls. It is recommended that the financial regulations are approved by the Integration Joint Board.
- 2.1.5 The financial regulations of the Health Board and Local Authority should be revised, if necessary, to incorporate changes resulting from the financial integration arrangements including the arrangements for virement associated with the Integrated Budget (Section 4.3.1).

2.2 Risk management

- 2.2.1 The Chief Officer will be responsible for establishing the Integration Joint Board's risk strategy and profile and developing the risk reporting arrangements. There should be regular reporting on risk management to the Integration Joint Board.
- 2.2.2 The participating authorities should identify and manage within their own risk management arrangements any risks they consider to have retained under the integration arrangements. The Health Board and Local Authority should continue to report risk management to the existing committees, including the impact of the integration arrangements.

What risks will be considered in developing the Integration Scheme?

- 2.2.3 Regulations require that the risk management arrangements for the Integration Joint Board are set out in the Integration Scheme. It is recommended that the risk register includes the key risks inherent in integration and include:
- Governance, management and strategy;
 - Financial management;
 - Asset management;
 - Information management;
 - Performance management; and
 - Customer management.

2.3 Insurance

- 2.3.1 Integration Joint Boards should make appropriate provision for insurance according to the risk management strategy. The Act (**Section 45(2)(b)**) enables, but does not require, Integration Joint Boards to become members of CNORIS, a joint risk sharing scheme.
- 2.3.2 The Act (**Section 65(2)(b)**) also enables, but does not require Local Authorities to become members of CNORIS. Health Boards will remain mandatory members of the scheme. Additional information on liability and

insurance is included in the [Statutory Guidance](#) statutory guidance on the establishment and operation of Integration Joint Boards.

Will the scheme cover all insurable risks?

2.3.3 No. The scheme currently covers Health Boards for:

- Clinical negligence claims and actions which arise in connection with the acts and omissions of their employees; and
- Non-clinical claims and actions which arise following loss or bodily injury affecting Third Parties or Employees or certain other pecuniary risks.

2.3.4 The Act widens the scope of the scheme (**Section 65(3)**) to include social care functions but does not extend to other functions in the Local Authority, for example, housing services. Further information on the scope of functions within CNORIS can be obtained from the Scottish Government Health Directorate.

How will the payments to the scheme be calculated?

2.3.5 Members will make payments towards the accumulated cost of paying the agreed claims for each financial year based on the assessed risk of the functions which they bring to the scheme. The contribution is calculated annually, with the claims initially being funded by the Scottish Government Health and Social Care Directorate.

Will there be a threshold for paying claims by the scheme?

2.3.6 Yes. Under current arrangements, scheme members are required to meet claims of £25,000 or under from their own budgets. Further information on CNORIS may be obtained [here](#).

2.4 Internal audit

2.4.1 It is the responsibility of the Integration Joint Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. This will include determining who will provide the internal audit service for the Integration Joint Board and nominating a Chief Internal Auditor.

2.4.2 The operational delivery of services within the Health Board and Local Authority on behalf of the Integration Joint Board will be covered by their respective internal audit arrangements as at present.

- 2.4.3 The internal audit service should undertake its work in compliance with the Public Sector Internal Audit Standards¹⁰.
- 2.4.4 To ensure that the risk based audit plans for the Integration Joint Board, Local Authority and Health Board are co-ordinated to ensure proper coverage, avoid duplication of efforts and determine areas of reliance from the work of each team, it is recommended that the Chief Internal Auditors for each of the respective bodies share information, co-ordinate activities with each other and with other external providers of assurance and consulting services.

Will there be a separate internal audit plan for the Integration Joint Board?

- 2.4.5 Yes; it is recommended that there should be a risk based internal audit plan. Until the Integration Joint Board is empowered to provide services (**Section 12 (1)(c)(d)**), the Chief Internal Auditor of the Integration Joint Board, in developing the audit plan, would be expected to consider the risks associated with:
- The Strategic Plan and planning process;
 - Financial plan underpinning the Strategic Plan; and
 - Relevant issues raised from the partner Health Board and Local Authority internal auditors
- 2.4.6 The risk based audit plan should be developed by the Chief Internal Auditor of the Integration Joint Board and approved by the Integration Joint Board or other committee (see 2.6 Audit Committees). It is recommended that it is shared with the relevant committees of the Health Board and Local Authority.

Who will provide the internal audit service?

- 2.4.7 It is recommended that internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority. It is recommended that the arrangements for the internal audit service provided to the Integration Joint Board should be set out in a service level agreement.
- 2.4.8 It is recommended that the Chief Internal Auditor from either of the Health Board or Local Authority fulfil this role in the Integration Joint Board in addition to their role as Chief Internal Auditor of their respective Authority.

How will the internal audit be reported?

- 2.4.9 The Integration Joint Board Chief Internal Auditor should report to the Integration Joint Board on the annual audit plan, delivery of the plan and recommendations and should provide an annual internal audit report including the audit opinion.

¹⁰ Relevant internal audit standard setters adopted set of common internal audit standards from 1 April 2013

2.4.10 It is recommended that the Integration Joint Board annual internal audit report is shared with the partner Health Board and Local Authority through the reporting arrangements in those bodies for internal audit.

2.4.11 Reports on each internal audit engagement will be reported to the Chief Officer. The IJB should determine any other reporting arrangements it requires from the Chief Internal Officer Auditor.

2.5 External Audit

Will the Integration Joint Board require an external audit?

2.5.1 Yes; this will be specified in the legislation (**Section 13**).

Who will carry out the external audit?

2.5.2 The Accounts Commission will appoint the auditors to the Integration Joint Board. (**Section 13**).

2.6 Audit Committee

Will the Integration Joint Board be required to have an audit committee?

2.6.1 The Integration Joint Board should make appropriate and proportionate arrangements, for consideration of the audit provision and annual financial statements, which are compliant with regulations and good practice governance standards in the public sector. This should include any reports from internal audit, external audit and the annual accounts (see section 3). For example this may be an audit committee which meets before the main Integration Joint Board meeting two or three times per year.

Who may be the members of the audit committee?

2.6.2 It will be the responsibility of the Integration Joint Board to agree the membership having regard to the agreed remit, skills and good practice for a public sector audit committee¹¹. It is anticipated that members of the Integration Joint Board will serve in this capacity.

¹¹ On Board: A Guide for Board Members on Public Bodies in Scotland, 2006, section 4.8 Audit Committees www.gov.scot/Topics/Government/public-bodies/On-Board

2.7 Following the public pound

2.7.1 Current guidance for Local Authorities¹² where funding is provided by one partner to another body to deliver services which would otherwise be provided by the funder, requires arrangements to be in place to maintain control and clear public accountability over the public funds. This will apply in respect of:

- the resources delegated to the Integration Joint Board by the Local Authority and Health Board; and
- the resources paid to the Local Authority and Health Board by the Integration Joint Board for use as directed and set out in the Strategic Plan.

2.7.2 It is recommended that the best practice principles as set out in the Code of Guidance on Funding External Bodies and Following the Public Pound¹² should be incorporated into both the Integration Scheme and the directions made by the Integration Joint Board to allow the Integration Joint Board financial officer, the Health Board accountable officer and Local Authority Section 95 Officer to discharge the duties noted at 2.1.1 and 2.1.2 above.

¹² Code of Guidance on Funding External Bodies and Following the Public Pound, Convention of Scottish Local Authorities/Accounts Commission

3 Financial reporting

3.1 Statutory accounts

3.1.0.1 This section includes advice produced by a short life working group with members drawn from LASAAC/TAG; a copy of the full guidance is included at Section D.

3.1.0.2 The legislation requires that the Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. (**Section 13**). This will require audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (**Section 12 of the Local Government in Scotland Act 2003 and regulations under section 105 of the Local Government (Scotland) Act 1973**). These will be proportionate to the limited number of transactions of the Integration Joint Board whilst complying with the requirement for transparency¹³ and true and fair reporting in the public sector.

3.1.0.2 The Local Authority and Health Board should include additional disclosures in their statutory accounts which reflect their formal relationship with the Integration Joint Board.

3.1.1 Financial statements of the Integration Joint Board

What individual reporting statements will be required for the Integration Joint Board?

3.1.1.1 The reporting requirements for the annual accounts are set out in legislation and regulations and will be prepared following the Local Authority Code of Practice. It is anticipated that they will include:

- Management commentary;
- Statement of responsibilities;
- Annual governance statement;
- Remuneration report;
- Balance sheet;
- Statement of income and expenditure;
- Statement of accounting policies and notes to the accounts; and
- Audit report.

¹³ Audit Scotland, Developing Financial Reporting in Scotland, July 2013
http://www.audit-scotland.gov.uk/docs/central/2013/nr_130704_financial_reporting.pdf

Who will be responsible for signing the annual accounts?

3.1.1.2 The overall governance arrangements for the Integration Joint Board will determine who is responsible for signing the financial statements and will be specified in regulations (**Regulations under section 105 of the Local Government (Scotland) Act 1973**). It is anticipated that the statements will be signed as follows:

- Management commentary: Chief Officer, Chair, Integration Joint Board financial officer
- Statement of responsibilities: Integration Joint Board financial officer.
- Annual governance statement: Chief Officer, Chair
- Remuneration report: Chief Officer and Chair.
- Balance sheet: Integration Joint Board financial officer.

3.1.1.3 Guidance on financial assurance can be found in section 2.1.

What is the timetable for preparing the annual accounts?

3.1.1.4 The Integration Joint Board financial statements must be completed to meet the audit and publication timetable specified in regulations (**Regulations under section 105 of the Local Government (Scotland) Act 1973**). The timetable should also ensure that the Health Board and Local Authority can meet their statutory audit and publication requirements for their individual and group financial statements as appropriate.

3.1.1.5 The Health Board will follow a different time line to the Local Authority and the Integration joint Board, with audited accounts required by 30 June. By this date, the regulations require the Integration Joint Board to have prepared and submitted accounts to the appointed auditor. The minimum information required by the Health board to prepare its accounts and group accounts by the 30th June statutory deadline is:

- The balances held at the year-end;
- The transactions in the year;
- A schedule of other information including assurances needed for the governance statement.

3.1.1.6 It is recommended that arrangements are established to review and agree balances and transactions on a regular basis during the financial year and not as a one-off exercise at the year end. This process should be set out in the Integration Scheme.

3.1.1.7 Undertaking this activity should be regarded as a key responsibility for the Chief Financial Officer of the IJB, the Local Authority s95 officer and the Health Board Director of Finance.

3.1.8 A proposed timetable is set out in table 1. It is recommended that the timetable is agreed in advance with the external auditors of the Local Authority, Health Board and the Integration Joint Board.

Table 1: Proposed timetable for audit and publication of the Integration Joint Board annual accounts

Milestone	Deadline
Agreement of in year transactions and year end balances with Local Authority and Health Board	30 April
Draft annual accounts produced and submitted for audit.	30 th June
Inspection of accounts and lodging of objections.	Completed by 29 July
Accounts Signed.	30 th September
Publication of audited annual accounts	30 th October

What should be included in the management commentary?

3.1.1.9 The management commentary should be prepared using proper accounting practice¹⁴. The Scottish Government anticipates that guidance, applicable to all Scottish local government bodies, will be developed regarding the management commentary. Until such guidance is developed it is recommended that the minimum content includes:

- Purpose and objective of the Integration Joint Board referring to the Integration Scheme and Strategic Plan; and
- A High level operating review, referring to the performance report.

What should be included in the Integration Joint Board annual governance statement?

3.1.1.10 The Integration Joint Board governance statement will be prepared as required by the Code of Practice with the detailed content determined by local arrangements including:

- The governance framework including the operation of the board or sub-committees if relevant;
- Assessment of the corporate governance arrangements with reference to compliance with generally accepted best practice principles;
- Assessment of the risk management arrangements and risk profile; and
- Assessment of the system of internal control;

See appendix 1 to section B.

¹⁴ Reporting statement: Operating and Financial Review, Accounting Standards Board, January 2006. <http://www.frc.org.uk/Our-Work/Publications/ASB/Reporting-Statement-Operating-and-Financial-Review.aspx>

3.1.1.11 Where the Health Board and Local Authority are delivering services on behalf of the Integration Joint Board these will be included in the reporting of their own annual governance statements.

Who will provide assurance to the Health Board, Local Authority and the Integration Joint Board?

3.1.1.12 The Chief Officer must provide any relevant information required by the Health Board and Local Authority to enable their statements to be prepared within the statutory timetable for the preparation and publication of the financial statements. Similarly the Health Board and Local Authority should report to the Integration Joint Board annually on matters for inclusion in the Integration Joint Board governance statement.

What is expected to be included in the accounting policies?

3.1.1.13 It will be responsibility of the financial officer to determine the appropriate accounting policies for the Integration Joint Board. It is expected that the following polices would be included:

- Accounting convention and basis of preparation;
- Going concern;
- VAT status;
- Related parties;
- Post balance sheet events;
- Debtors and creditors; and
- Reserves

What are the financial reporting requirements for the non-integrated budgets managed by the Chief Officer such as children's services?

3.1.1.14 The non-integrated budgets are not required to be reported in the annual accounts where there is no payment to the Integration Joint Board and they are not included in the scope of the Strategic Plan. An explanation of the arrangement may be included where appropriate.

Will there be a template available for preparation of the annual accounts?

3.1.1.15 Illustrative annual accounts are provided as an appendix to this section. More detailed advice may be issued by LASAAC in due course in advising on Local government accounting.

Will annual accounts be required in the first year?

3.1.1.16 Yes; accounts will be required for the period from the date of establishment of the Integration Joint Board, on the basis that there will be relevant transactions, such as Integration Joint Board operating costs.

- 3.1.1.17 In cases where the commencement date for delegation of functions and resources (published in the strategic plan) is during 2015/16, the accounts should include the part year contributions from the Health Board and Local Authority and the part year payments from the Integration Joint Board for carrying out its directions; and the Integration joint Board operating costs.
- 3.1.1.18 In cases where the commencement date for delegation of functions and resources (published in the strategic plan) is April 2016, the accounts should include the Integration joint Board operating costs.
- 3.1.1.19 Note that support services provided to the Integration Joint Board by the Health Board and Local Authority under a Service Level Agreement should be included in the operating costs only where the Integration Joint Board has control over the support services; this may be via either:
- Consideration paid by the Integration Joint Board to the Health Board/Local Authority; and/or
 - Provisions in the Service Level Agreements; and/or
 - Compensation through a reduction in Health Board/Local Authority contributions to the Integration Joint Board.
- 3.1.1.20 Where support services are not included in the operating costs, this should be explained in the notes to the accounts.

3.1.2 Reporting in the Health Board and Local Authority annual accounts

- 3.1.2.1 The two primary transactions with the Integration Joint Board (i.e. the Health Board and Local Authority contribution to the Integration Joint Board; and the payments in support of the directions made by the Integration Joint Board to the Local Authority and Health Board) are distinct and separate transactions.

How should the contribution to the Integration Joint Board be reported?

- 3.1.2.2 The payment to the Integration Joint Board and the amount set aside for hospital services should be recorded as a separate line within the relevant expenditure analysis in the note to the accounts of the Health Board and Local Authority.

How will the payments in support of the directions made by the Integration Joint Board to the Local Authority and Health Board and the associated expenditure be reported?

- 3.1.2.3 The allocation from the Integration Joint Board including the amount set aside, should be disclosed as income from the Integration Joint Board in the income analysis and the corresponding expenditure in the expenditure analysis in the notes to the accounts.

3.1.2.4 The Comprehensive Income and Expenditure Statement / Statement of Comprehensive Net Expenditure should include:

	£m
Contributions to IJB (including sum set aside)	a,aaa
Expenditure on IJB Services	<u>b,bbb</u>
Gross Expenditure	<u>c,ccc</u>
Income from IJB for Commissioned Services (including sum set aside)	(d,ddd)
Gross Income	<u>(d,ddd)</u>
Net Expenditure	<u>e,eee</u>

3.1.2.5 The change in the trend analysis for the gross expenditure of the Health Board and Local Authority should be clearly explained and presented each partner's financial statements. LASAAC and TAG will, either separately or jointly, provide further guidance in this respect.

Is there a need to prepare group accounts?

3.1.2.6 Yes; it is anticipated that the default classification of an Integration Joint Board will be as a 'Joint Venture' under IFRS 11.

3.1.2.7 This assessment is finely balanced and practitioners and auditors will take into account the operation of the Integration Joint Board in forming their opinion; consequently it is possible that some Integration Joint Boards may be classed as Joint Operations.

3.1.2.8 Joint Venture treatment of Integration Joint Boards will require each partner to consolidate its interest in the Integration Joint Board into group accounts.

3.1.2.9 In cases where functions and resources are not delegated until 1 April 2016 consolidation in 2015/16 may not be necessary on the basis of materiality. Relevant disclosure notes will be required, irrespective of whether group accounts are presented.

Are there any other reporting requirements?

3.1.2.10 Yes; disclosure of the related party interest under IAS24 will be required.

3.2 Central returns

3.2.1 The Health Board (SFR) and the Local Authority (LRF3) currently submit returns to the Scottish Government relating to health and social care services. Proposals will be developed by the Scottish Government to revise the returns to reflect the integration arrangements. Information on the revised arrangements for the LRF3 will be issued by Scottish Government.

Guidance on the SFR will continue to be provided in Unified Board Accounts Manual.

3.3 Whole of Government Accounts

- 3.3.1 The ONS classification of the Integration Joint Board will determine the requirements for submission for the Whole of Government Accounts. The provisional view by HM Treasury is that the Integration Joint Board is a local government public body. Formal classification will follow after the establishment of the first wave of Integration Joint Boards.
- 3.3.2 For Health Boards, the interest in the Integration Joint Board will be ignored by the Scottish Government in preparing Whole of Government Accounts (i.e. only the parent 'single entity' Health Board will be consolidated by the Scottish Government).

4 Financial planning and financial management

4.1 Resources within scope of the Strategic Plan

4.1.1 The legislation requires that the Integration Joint Board produce a Strategic Plan, which sets out the services for their population over the medium term (3 years) (**Sections 29 & 33**); see [Statutory Guidance](#) on strategic planning.

4.1.2 The Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan which will comprise:

- the Integrated Budget, i.e. the sum of the payments to the Integration Joint Board (see 4.2); plus
- the amount set aside by the Health Board, for large hospital services used by the Integration Joint Board population (see 4.4).

It will be important for there to be full transparency of the use of these resources by the Integration Joint Board population and the Integration Authority will be required to publish an annual financial statement setting this out (**Section 39**).

4.1.3 The ability to plan with the overall resource for defined populations and user groups and to use budgets flexibly is one of the hallmarks of integrated care. A premise underlying the legislation is that the Integration Joint Board will, through the Strategic Plan, be able to allocate resources within the Integrated Budget and to plan and agree transfers between the notional budget and the Integrated Budget. It will be for the Integration Joint Board, through the strategic planning process and having regard to the duties in the legislation for consultation, co-production with stakeholders and co-operation with other Integration Authorities (**Section 32**), to decide what capacity is required from Local Authority and Health Board in order to deliver the agreed performance on outcomes. In developing the Strategic Plan, the Integration Joint Board must have regard to the existing constraints on the use of resources by the Local Authority and Health Board arising from legislation or directions; for example resources ring-fenced for specific purposes e.g. allocations to Health Boards for Alcohol and Drug Partnerships (ADP).

4.1.4 Accordingly, the relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be directed by the Integration Joint Board through the Strategic Plan, although it is likely that in the first years they will be similar.

Will the Integration Joint Board be required to co-ordinate the development of its Strategic Plan with other Integration Authorities for cross system services?

4.1.5 Yes; the legislation will place this duty on Integration Joint Boards (**Section 30 (3)**). It is recommended that Health Boards facilitate the co-ordination of the development of strategic planning for cross-system services.

4.2 The Integrated Budget

- 4.2.1 The legislation requires that Health Boards and Local Authorities make payments to the integration joint board for the delegated functions and that the method for determining the value of the payments is included in the Integration Scheme (**Section 1(3)**).
- 4.2.2 The legislation also requires that where the Integration Joint Board gives direction for the partner Local Authority and Health Board for the operational delivery of services, that the value of the payment or the method of agreeing the value of the payment be included in the direction (**Section 27**).

What process should be used to determine the initial payments to the Integration Joint Board?

- 4.2.3 The initial sums should be determined on the basis of existing Health Board and Local Authority budgets, actual spend and financial plans for the delegated services. It is important that the plans are tested against recent actual expenditure and that the assumptions used in developing the plans and the associated risks are fully transparent:
- The budget in the financial plan should be assessed against actual expenditure reported in the management accounts for the most recent two/three years. Ideally, the roll forward of the budget for the delegated services and the actual expenditure over this period should be understood;
 - Material non-recurrent funding and expenditure budgets for the delegated services and the associated risks are identified and assessed;
 - The medium term financial forecast for the delegated services and associated assumptions and risks should be reviewed;
 - Savings and efficiency targets and any schemes identified should be clearly identified and the assumptions and risks understood by all partners;
 - All risks should be quantified where possible and mitigating measures identified.
- 4.2.4 It is recommended that the first year/period is treated as transitional period and that partners agree to a risk sharing arrangement with adjustments being made through subsequent year's allocations; where it is used this provision should be incorporated in the Integration Scheme.
- 4.2.5 The integration authorities should carry out a process of financial assurance for the initial sums to be delegated to the Integration Joint Board. It is recommended that Health Board and Local Authority Directors of Finance and the shadow Chief Officer and shadow Chief Financial Officer of the Integration Joint Board foster an assurance process based on mutual trust

and confidence involving an open-book approach and an honest sharing and discussion of the assumptions and risks associated with the delegated services.

- 4.2.6 IRAG has published detailed supplementary [Statutory Guidance](#) on financial assurance.

What process should be used to calculate subsequent payments to the Integration Joint Board?

- 4.2.7 The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. They should aim to be able to give **indicative** three year allocations to the integration joint board, subject to annual approval through the respective budget setting processes. This should be in line with the three year Strategic Plan.

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

- **Activity Changes.** The impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes;
- **Cost inflation.** Pay and supplies cost increases;
- **Efficiencies.** All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Integration Joint Board, Local Authority and Health Board as part of the annual rolling financial planning process to ensure transparency;
- **Performance on outcomes.** The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Local Authority and Health Board;
- **Legal requirements.** Legislation may entail expenditure commitments that should be taken into account in adjusting the payment;
- **Transfers to/from the notional budget for hospital services** set out in the Strategic Plan. See section 4.3.1
- **Adjustments to address equity.** The Local Authority and Health Boards may choose to adjust contributions to smooth the variation in weighted capita resource allocations across partnerships; information to support this will be provided by ISD¹⁵ and ASD.

- 4.2.9 The partner Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate their respective contributions accordingly. The allocations will be a

¹⁵ <http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/>

negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority. The method for determining the contributions is required to be included in the Integration Scheme (**Section 1(3)**).

What process should be used by the Integration Joint Board to determine the payments to be made to the Local Authority and Health Board for operational delivery of services?

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

What format will the direction take?

4.2.11 The legislation will require that a direction should be in writing and must include information on (**Section 26**):

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

4.2.12 It is anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction (**Section 27 (5)**).

How should resource transfer be treated?

4.2.14 Some social work expenditure budgets will be funded by resource transfer payments. It is recommended that partners identify these and adopt a transparent and consistent approach to their inclusion in the payment to the Integration Joint Board. The options for this are:

- For the Health Board to stop paying resource transfer to the Local Authority and instead to include it in its payment to the Integration Joint Board. The Local Authority would need to make a corresponding reduction in its payment to the Integration Joint Board to cover the loss of resource transfer income from the Health Board; or
- For the Health Board to continue paying resource transfer to the Local Authority and to exclude it from its payment to the Integration Joint Board. The Local Authority would include in its payment to the Integration Joint Board the social work services funded by the resource transfer.

- 4.2.15 It is recommended that the local decision on treatment of resource transfer be set out in the Integration Scheme.

Should overheads be included in the allocations to the Integration Joint Board?

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

Should hosted services be included in the allocations to the Integration Joint Board?

- 4.2.17 Yes; the resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget of each Integration Joint Board. Each Integration Joint Board will be required to include in its strategic plan the capacity required from the hosted service by its population. It is recommended that the Chief Officer responsible for managing the hosted service take the lead in coordinating the Integration Joint Boards in development of their strategic plans for that service.

4.3 Managing financial performance

- 4.3.0.1 The partners should include in the Integration Scheme provisions for managing in-year financial performance of the Integrated Budget. The legislation takes powers for Ministers to set this out in regulations (**Section 1(3)(f)**). This will require that the Chief Officer receive financial performance information for both her/his operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.

- 4.3.0.2 It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole. It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person carry out both this role and the role of financial officer for the joint board (1.4.2.1), but this is a matter for local determination.

- 4.3.0.3 It is recommended that the Health Board and Local Authority agree a consistent basis for the preparation of management accounts, i.e. accruals vs. cash basis; this is a matter for local decision.

Will the Integration Joint Board be expected to break-even?

4.3.0.4 The Integration Joint Board will allocate the resources it receives from the partner Health Board and Local Authority in line with the Strategic Plan; in doing this it will be able to use its power to hold reserves (see 4.3.0.6) so that in some years it may plan for an underspend to build up reserve balances and in others to break even or to use a contribution from reserves in line with the reserve policy. This will be integral to the medium term rolling financial plan.

4.3.0.5 In her/his operational role, the Chief Officer will manage the respective operational budgets so as to deliver the agreed outcomes within the operational budget viewed as a whole. 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, in line with the process noted at 4.3.1. *etal*

Will the Integration Joint Board be able to hold reserves?

4.3.0.6 Yes; the legislation empowers the Integration Joint Board to hold reserves (**Section 13**) and these should be accounted for in the books of the Integration Joint Board.

How will they be used?

4.3.0.7 It is recommended that the Integration Joint Board has a reserves policy and reserves strategy, which include the level of reserves required and their purpose. This should be agreed as part of annual budget setting and reflected in the Strategic Plan agreed by the Integration Joint Board.

Will the Chief Officer be able to vire between the two arms of the operational budget?

4.3.0.8 Yes; the Chief Officer will be able to transfer resources between the two arms of the operational Integrated Budget. This will require in-year balancing adjustments to the allocations from the Integration Joint Board to the Local Authority and Health Board (**Section 27(3)**): 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.

4.3.0.9 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 partner Local Authority and Health Board.

4.3.0.10 The arrangements for the virement of budgets should be specified in the scheme of delegation within the partner authorities.

4.3.1 Budget variances

4.3.1.1 Regulations require that the Integration Scheme should include provisions for the treatment of in-year under and overspends. The following (paragraphs 4.3.1.2 to 4.3.1.10) provide advice for these provisions.

What will happen in the event of an in-year overspend on the operational Integrated Budget?

4.3.1.2 It is recommended that if an overspend is forecast on either arm of the operational Integrated Budget, the Chief Officer and the relevant finance officer (See section 1.2.2) should agree a recovery plan to balance the overspending budget.

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

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

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

- Make additional one-off payments to the Integration Joint Board; or
- 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 in place to address this.

It is advised that the provision in the integration scheme should be clear how the partners will share out the additional contributions, if required; it is also recommended that the proportion of their allocations is used as a default position.

Will the Integration Joint Board be able to retain in-year underspends?

4.3.1.5 Yes; in-year underspends on either arm of the operational integrated budget should be returned from the Local Authority 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 underspend.

- 4.3.1.6 The exception is for unplanned underspends that arise due to *material* differences between the assumptions used in setting the payments (under the process at 4.2.10) 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. This does not undermine the policy set out in 4.2.10. Unplanned underspends effectively represent overfunding by the Local Authority or Health Board with respect to planned outcomes and should either be: returned to the Local Authority or Health Board in-year through adjustments to their respective contributions to the Integration Joint Board and recurrently through the process for subsequent year adjustments noted above.
- 4.3.1.7 Over time, it may become more difficult to identify unplanned underspends as the resources lose their identity in the Integrated Budget.

Will the Integration Joint Board be required to contribute to the management of in-year overspends on non-integrated budgets in the Local Authority or Health Board?

- 4.3.1.8 Ordinarily no. In the event of a projected in-year overspend elsewhere across the Local Authority or Health Board non-integrated budgets, they should contain the overspend within their respective non-integrated resources.
- 4.3.1.9 In exceptional circumstances should they require the Integration Joint Board to contribute resources to offset the overspend, they must do this by amending their contributions to the Integration Joint Board. It is recommended that this provision should only be used in extremis. The Chief Officer will determine the actions required to be taken to deliver the necessary savings, to fund the reduction in contributions and should be approved by the Integration Joint Board as advised by the Integration Joint Board financial officer, where such is appointed separately.

Will the Integration Joint Board be required to contribute to overspends in other Integration Authorities?

- 4.3.1.10 No; the responsibility for this lies with the overspending Integration Authority who should apply the process noted above within their own authority for in-year overspends. This also applies to hosted services.

4.3.2 Risk sharing

- 4.3.2.1 It is advised that financial risk should be managed through the financial management process noted above and the use of reserves. It is further advised that Integration Joint Boards consider the use of risk pooling arrangements for high risk services, such as prescribing. This is a matter for local determination.

4.4 Amount set aside for directed hospital services

- 4.4.0.1 Integration Authorities will be responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care.
- 4.4.0.2 The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.
- 4.4.0.3 Fundamental to this will be a clear understanding of how “large hospital” services are being consumed and how that pattern of consumption and demand can be changed by whole system redesign. As a first step it is critical that there is transparency for Partnerships and localities on how resources are being used. As a second step, there needs to be clarity about the financial impact of changes agreed through the strategic planning process.
- 4.4.0.4 Where more than one partnership exists within a Health Board area, the change programme for hospital services will have to be coherent across individual strategic plans (under S30 (3) of the Act). Consequently, there should be an overarching strategic plan for the hospital services delegated to Integration Authorities that is a consolidation of the individual partnership plans and this should be coordinated and held by the Health Board hospital sector.
- 4.4.0.5 The strategic plans produced by the Integration Authority/ies must in turn be consistent with the strategic context set by the Health Board and Local Authority. The hospital capacity and hosted services included in the strategic plan should evolve from the existing capacity and plans for those services. Strategic plans will reflect locality planning in due course.
- 4.4.0.6 It is recognised that this is a complex journey and supplementary [Statutory Guidance](#) has been jointly produced by IRAG and the Joint Commissioning Steering on which the following is based.
- 4.4.0.7 The legislation provides a choice for how the Health Board resources for delegated functions that are provided in large hospitals are to be treated in the integration arrangements (**Section 1(3)**, **Section 14**). The Health Board may either:
- Exclude the resources from the payment to the Integration Joint Board and instead retain and set them aside for direction by the Integration Joint Board through the Strategic Plan; or
 - Include them in the payment to the Integration Joint Board.

How should the set aside budget be determined?

4.4.0.8 Legislation requires that the method for determining the amount to be set aside by the Health Board should be included in the Integration Scheme **(Section 1(3))**.

4.4.0.9 It is recommended that the consumption of hospital services by partnership populations should be determined by analysis of hospital activity and cost information; this approach should also be used for hosted services that are provided in hospital and for hosted community based services where the data is available.

4.4.0.10 *Activity*

Hospital activity is recorded on Health Board hospital patient administration systems (PAS), which are based on the individual record of each inpatient hospital episode. This data, aggregated to locality and partnership level, should be used to identify the hospital activity and capacity used by patients for each partnership; the data can be obtained from either:

- Local Health Board information teams; or
- National Services Scotland (NSS), which produce these datasets for each partnership through the Health and Social Care Data Integration & Intelligence Project (HSCDIIP).

4.4.0.11 It is recommended that an average of three years of activity is used to scope partnership consumption for the first year of the strategic plan.

4.4.0.12 *Cost*

Attaching a £ value to activity can be achieved in a number of ways, for example:

- Blue book admission or bed day rates;
- Local Costing methodologies;
- NSS patient level costing (PLICS) available through HSCDIIP.

4.4.0.13 It is a local decision as to which method is used, however it is recommended that a consistent method is used for all partnerships in a Health Board area.

Should cross boundary functions be included in the set aside budget?

4.4.0.14 Yes; where material; the set aside budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.

4.4.0.15 Alternatively, the respective cross boundary flow budget may be included in the payments to the Integration Joint Board.

How should 'fair share' information be used?

- 4.4.0.16 Using historical consumption as a starting point inevitably builds in any existing inequity of resource use in the historic position. It is difficult to avoid this without causing immediate destabilisation. Over time, issues of equity can be considered by Health Boards and may be addressed through their subsequent allocations to partnerships.
- 4.4.0.17 It is recommended that partnerships use fair share information based on the National Resource Allocation Committee (NRAC) methodology available from NSS (through the HSCDIIP project) for benchmarking partnership expenditure.

How should the financial consequences of planned changes in capacity be determined?

- 4.4.0.18 Strategic Planning will be a cyclical process of Analyse, Plan, Do and Review and this will likely involve a two stage process for developing cases for change: from considering initial proposals to full inclusion in locality and strategic plans. This will require cost and activity information at different levels of detail, depending on whether consideration is of an outline case or a full case proposal.
- 4.4.0.19 It is recommended that practical and easily used cost information is made available to stakeholders to enable outline cases to be developed.
- 4.4.1.20 It is recommended that detailed estimates of the effect of change proposals should be developed for each by a group comprising the hospital sector director (or similar post-holder) and the Chief Officers of the Integration Authorities whose populations use the hospital services (including those with a material level of cross boundary flow). A financial plan should be developed and agreed that sets out the capacity and resource levels required for the set aside budget for each Integration Authority and for the hospital sector, for each year. This should be based on an agreed implementation plan with assumptions for:
- Activity changes based on demographic change;
 - Agreed activity changes from new interventions;
 - Cost behaviour;
 - Hospital efficiency and productivity targets;
 - An agreed schedule for timing of resource released/additional resource.
- 4.4.0.21 It is recommended that the approach to producing detailed financial plans based on the agreed changes should be similar to those previously used for Learning Difficulty Same As You (SAY) and other major redesign exercises.

How will overheads in directed hospital services be treated?

4.4.0.22 It is a matter for local determination. It is recommended that a consistent approach is adopted for Integration Joint Boards in partnership with the same Health Board.

How will the Integration Joint Board direct use of this resource?

4.4.0.23 The legislation requires that this will be via a direction (**Section 28**), which will refer to the allocation of resources as agreed and set out within the Strategic Plan (developed through a co-production process involving all stakeholders, including the hospital sector).

Will resource be able to be transferred between the Integrated Budget and the set aside budget for directed hospital services?

4.4.0.24 Yes, where a planned change is delivered. In the case of an increase in consumption, the Integration Authority will need to consider how to fund the additional capacity through the Strategic Plan. Similarly, where resource is released, the Integration Authority will be able to consider how to use this resource through the Strategic Plan.

4.4.1 Reporting Performance against Plan

4.4.1.1 Partnerships and the hospital sector will require information on their performance against the plan for hospital capacity in order to flex the strategic plan and also to take remedial action if necessary. This information will need to be available at two levels: for each partnership; and for the overarching hospital plan.

4.4.1.2 It is recommended that the group comprising the Chief Officers and Health Board hospital sector director receive regular activity reports comparing the expected capacity set out in the strategic plan, for each integration authority, with actual capacity used.

4.4.1.3 Actual activity and expected activity will be available from ISD HSCDIIP reports or alternatively from local Health Board information teams.

Will there be in-year virement between the Integrated Budget and the notional budget?

4.4.1.4 The legislation enables this (**Section 28**). However, it is recommended that in-year resource adjustments should be avoided and that changes be made through annual adjustments to the Strategic Plan.

4.4.1.5 If partners consider that in-year resource adjustments should be made, it is recommended that minimum thresholds for activity variances are agreed, below which no resource adjustments will be required.

4.4.1.6 It is recommended that the process for making adjustments to the set aside resource to reflect variances in performance against the plan are agreed and clearly set out. This should explicitly deal with cases of offsetting variances between Integration Authorities.

4.4.2 Accountability Framework

4.4.2.1 It is recommended that there is a clear understanding of where the balance of risk lies, between each Integration Authority and the Health Board hospital sector, for delivering planned hospital capacity. There are two main risks:

- Activity and case mix: i.e. the agreed capacity set out in the plan is not delivered or not delivered on the agreed schedule; and
- Resources: i.e. the capacity set out in the plan is delivered, but the resource required is different to that agreed.

4.4.2.2 Ultimately these risks are shared between the Integration Authorities and the Health Board hospital sector (or host organisation in the case of hosted services); however, it is recommended that the *primary* responsibility for delivering capacity (i.e. activity and case mix) should lie with each Integration Authority; and that for providing the capacity within agreed resources should lie with the Health Board hospital sector.

4.4.2.3 It is recommended that these respective responsibilities are set out in the Strategic Plan.

4.4.2.4 The basis of the accountability framework should be a local decision.

5 VAT

5.1 Revenue

5.1.1 A written submission was made to HMRC seeking confirmation that the Integration Joint Board would have no requirement to register for VAT under the VAT Act 1994. HMRC have confirmed in writing that there is no VAT registration requirement for the Integration Joint Board. This is on the basis that the Integration Joint Board is not delivering any supplies that fall within the scope of VAT and as there is no consideration received by the Integration Joint Board for the production of the plan this will not alter the VAT registration position.

Will there be VAT leakage if the Integration Joint Board changes the balance of services through the Strategic Plan?

5.1.2 Yes; the Integration Joint Board, Local Authority and Health Board should be aware that, due to their different VAT status, the total VAT reclaimed by them will change over time as the profile of services provided by the Health Board and Local Authority respectively, changes in line with the Strategic Plan. There are two cases to consider:

- The Integration Joint Board directs a shift in spend that results in the Health Board and Local Authority spending more/less on the services they already deliver (i.e. the Health Board on health functions and the Local Authority on social care functions). In this case, the Health Board and Local Authority will recover VAT on their supplies in the usual way, which may result in an overall VAT leakage or a VAT gain depending on the direction of the shift in spend.
- The Integration Joint Board directs the Health Board to provide some social care functions and/or the Local Authority to provide some health care functions. In this case the Health Board and Local Authority should recover VAT using the method set out Section C 5.1.1.

What will be the VAT status of the Integration Joint Board if it is empowered to provide services?

5.1.5 HMRC have confirmed that the Integration Joint Board may effectively ignore their independent VAT status and be treated as lead agents on behalf of the Local Authority or Health Board as principals. This scenario would effectively replicate the VAT solution for delegation between partners, (but with the Integration Joint Boards as the host body and the Local Authority and Health Board as delegating partners) and the method set out at section C 5.1.1 should be used to recover VAT.

5.1.6 This outcome should ensure a VAT neutral position.

5.1.7 It is not expected that the Integration Joint Board would have any need to VAT register as it will be delivering services as a lead agent of the Health Board and Local Authority. However, should the Integration Joint Board receive payment for this service then the VAT registration position should be considered as it may have a compulsory obligation to register for VAT.

5.2 VAT implications associated with provision of support services to the Integration Joint Board

5.2.1 The Health Board and/or Local Authority will provide the Integration Joint Board with a range of support services in order to allow it to carry out its functions. The support services will include;

- a) Provision of staff;
 - Chief Officer and Chief Financial Officer employed by the Health Board or Local Authority

- b) Back office support services including;
 - Financial services (e.g. ledger services, member expenses and allowances)
 - Financial planning and financial management services
 - Planning services (e.g. data and analysis to support development of the strategic plan)
 - HR advice (for the two staff)
 - Communications support (to support the communication of the strategy)
 - Participation and engagement facilitation (support to engage with the public)
 - Administrative support (provision of accommodation, printing, records management etc)

5.2.2 Where the Local Authority/Health Board provides support services to the Integration Joint Board it will need to consider whether the transaction falls within the scope of VAT and should be treated as a 'supply' for VAT purposes.

5.2.3 The key determinant will be whether the Local Authority/Health Board receives anything from the Integration Joint Board in return for providing these services.

Supply of services in return for consideration

5.2.4 Where the Local Authority/Health Board receives payment from the Integration Joint Board in return for the provision of support services, it will be treated as making a business supply for VAT purposes. The VAT treatment of staff secondments and back office services will be as follows:

(a) Provision of Staff

5.2.5 Staff secondments are treated as a supply of staff and are usually subject to VAT, unless the supply involves;

- Secondments between and by government departments which require specialist knowledge that cannot be obtained from the private sector;
- Secondments between National Health bodies; and
- Some secondments between local authorities and by local authorities where they have a statutory obligation or monopoly.

5.2.6 The arrangements for Chief officer and Integration Joint Board financial officer are unlikely fall under the above exclusions and therefore where the Local Authority/Health Board is treated as making a supply of staff to the Integration Joint Board it will be required to account for 20% VAT on the consideration received from the Integration Joint Board. As the Integration Joint Board is not registered for VAT, the VAT charge will form an irrecoverable cost to the Integration Joint Board or may reduce the level of funding received by the Local Authority/Health Board.

5.2.7 Note that the consideration for a supply of staff does not necessarily need to be a fee but can constitute charges by the Local Authority/Health Board to the Integration Joint Board of wages, national insurance and similar employment costs it incurs while the employee is on secondment.

5.2.8 It may be possible to avoid an irrecoverable VAT cost to the Integration Joint Board through the use of joint employment contracts.

- This arrangement involves the Chief Officer and Integration Joint Board financial officer being employed under a joint contract of employment with the Local Authority/Health Board and Integration Joint Board. HMRC accept that where an individual is jointly employed by two parties, it is not possible for one of the employers to make a taxable supply of the staff to the other, even where it may charge part of the wages/costs of the staff to the other party. Where the members of staff are employed under a joint employment contract, any payment made by the Integration Joint Board (to either the Local Authority/Health Board or employee) for the use of the staff would therefore be outside the scope of VAT.

5.2.9 Partners should obtain advice when implementing joint contract arrangements to ensure that the employment status is supported by appropriate contracts that meet HMRC criteria; and also that they meet the requirements of S10 of the Act.

(b) Back office support services

5.2.10 The provision of back office support services in return for consideration is a taxable supply for VAT purposes and therefore the Local Authority/Health Board would be required to account for VAT on any payments received from the Integration Joint Board in return for the provision of these services.

5.2.11 Where the Local Authority/Health Board supplies the Integration Joint Board with a right to occupy defined areas such as office space, for example, it will be treated as making a supply of property for VAT purposes. The supply of land and property is generally exempt, subject to an option to tax and the Local Authority/Health Board will need to consider whether it is making an exempt or taxable supply of office space.

Provision of services for no consideration

5.2.12 As part of their roles in the public sector, it is generally accepted that Local Authorities and Health Boards will often provide goods and services free of charge. Should the Local Authority/Health Board not receive any consideration from the Integration Joint Board in return for the provision of support services (including staff secondments), it will be treated as making a non-business supply for VAT purposes and will not be required to account for VAT on the provision of its services.

5.2.13 Where the Local Authority/Health Board provides support services as a non-business supply it will need to consider its VAT recovery position in respect of any costs it incurs in the provision of those services. A Local Authority can usually recover VAT incurred on non-business activities under Section 33. This isn't the case for Health Boards and they will need to consider whether any VAT incurred on expenditure related to the provision of support services is recoverable under the COS headings; however, on the basis that most of the costs of providing these services will be staff, any non-recoverable VAT should be minimal.

5.2.14 Where the Local Authority/Health Board intends to treat the provision of support services as a non-business activity it will be important to ensure that the provision of services are not linked to the payments made by the Integration Joint Board to the partners. Should they be deemed to be linked, HMRC may determine that part of the funding should be treated as consideration for a supply of services by the Local Authority/Health Board to the Integration Joint Board. This is unlikely given the requirements of the Act and Statutory Guidance for development of the Strategic Plan.

5.2.15 Similarly with the payments made to the Integration Joint Board by the Health Board and Local Authority for the delegated functions, where there should be no explicit netting off from the sums delegated to the Integration Joint Board to cover the cost of providing the support services.

5.2.16 It is recommended that where the provision of support services is treated as a non-business activity, Service Level Agreements are carefully drafted to avoid the risk of HMRC deeming that there has been receipt of

consideration. Partners may obtain comfort on this point by approaching their local HMRC officer in a written submission.

- 5.2.17 In 2011, HMRC introduced VAT legislation that encouraged bodies, primarily in the public sector, to share costs. The intention of the legislation was to deal with the situation where bodies that could buy in services from another body refused to do so as a result of the additional cost of irrecoverable VAT; and instead chose to employ their own staff rather than use the resources available in other public bodies.
- 5.2.18 The HM Treasury viewed this as inefficient and introduced legislation that allowed for the establishment of a legal cost sharing group to deliver services and to allow them to be exempt for VAT purposes. As the main cost for the supplying body was salaries then there is little or no impact on the partial exemption position of that body.
- 5.2.19 The Integration Joint Board, Local Authority and Health Board could form a cost sharing group, for VAT purposes which would allow the Integration Joint Board to draw down services, VAT free.
- 5.2.20 Whilst there are a number of conditions that must be met, a cost sharing group may well be a feasible structure to allow the Local Authority and Health Board to deliver services (consisting mainly of staff time) to the Integration Joint Board.

5.3 Capital

- 5.3.1 In the medium term it is unlikely that the Integration Joint Board will be empowered to own capital assets and the VAT regimes of the Local Authority and Health Board will apply to capital assets used to provide the delegated services.
- 5.3.2 Should the Integration Joint Board be empowered in due course, for VAT purposes it will be acting as a lead agent for the Health Board and Local Authority and not making any vatable supplies in its own right. Consequently it will not be entitled to recover VAT on capital expenditure incurred on assets used to provide those services and it is likely to be more efficient from a VAT recovery perspective for capital expenditure to be undertaken by the Local Authority or Health Board.

6 Capital and asset management

6.0.1 The Strategic Plan considers all of the resources available to deliver the objectives approved within the Integration Scheme including non-current assets owned by the Health Board and Local Authority. One of the policy objectives of the legislation is to make more effective use of the resources, including non-current assets for the delivery of health and social care integration.

6.1 Asset management planning

How will the Integration Joint Board consider the property and assets required to deliver the Strategic Plan?

6.1.1 The Chief Officer of the Integration Joint Board is recommended to consult with the Local Authority and Health Board partners to make best use of existing resources and develop capital programmes. The Integration Joint Board should identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to the Health Board and Local Authority for consideration as part of the capital planning processes, recognising that partnership discussion would be required at an early stage if a project was jointly funded.

6.1.2 In developing the Strategic Plan the Chief Officer is advised to consider the CIPFA guidance on place based asset management¹⁶. The CIPFA guidance explains the main concepts of the approach and aims to help senior decision-makers in local public services to understand the drivers for collaboration on public property assets, evaluate benefits and implement a “one public estate” model of delivery.

What should the Integration Joint Board and partners consider before the start of the first year of operation?

6.1.3 The Integration Joint Board, Health Board and Local Authority are recommended to undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan. This will allow all the partner authorities to identify non-current assets within localities and their revenue and future capital liabilities.

¹⁶ One public estate – Getting more from less public sector property using place-based asset management, CIPFA, 2011
www.cipfaproperty.net/fileupload/upload/one%20public%20estate_v2112201111519.pdf

6.2 Capital funding, budgets and allocations

What funding for capital investments will be available to the Integration Joint Board?

- 6.2.1 The Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure. The Health Board and Local Authority will continue to own any property and assets used by the Integration Joint Board and have access to sources of funding for capital expenditure.

How should the Integration Joint Board access resources for the capital investment identified in the Strategic Plan?

- 6.2.2 The Chief Officer is recommended to consult with partner Local Authority and Health Board to identify the need for improvements to assets owned by either partner. Where capital investment is identified the Chief Officer should submit a business case to the appropriate partner. The existing procedures within the Health Board^{17 18 19} and Local Authority²⁰ should be used to consider the capital bids and business cases by the Chief Officer as part of their overall capital planning arrangements.
- 6.2.3 Where the Chief Officer identifies as part of the Strategic Plan new capital investment a business case should be developed for the proposal for both partners to consider. Options may include one or both of the partners approving the project from its capital budget or where appropriate using the hub initiative, as the procurement route, to deliver the capital investment. This is a matter for local agreement.

Is there advice available on the hub initiative?

- 6.2.4 The hub initiative which is led by Scottish Futures Trust is a national approach to the delivery of new community infrastructure. Scottish Futures Trust is supporting the Scottish Government increasing value-for-money by implementing innovative financing structures and improving its Non-Profit Distributing (NPD) model. The NPD model was developed and introduced as an alternative to and has since superseded the traditional Private Finance Initiative (PFI) model in Scotland. More information about the hub initiative, the five hub territories and contract documentation can be found on the Scottish Futures Trust website (www.scottishfuturestrust.org.uk).

¹⁷ NHS Property Transactions Handbook 2011 www.pcpd.scot.nhs.uk/PropTRans/PTHome.htm

¹⁸ Scottish Capital Investments Manual, Scottish Government Health Directorate, 2009
www.scim.scot.nhs.uk

¹⁹ A Policy for Property and Asset Management in NHS Scotland, CEL 35

²⁰ A Guide to Asset Management and Capital Planning in Local Authorities, CIPFA Local Government Directors of Finance Scotland, October 2008

www.aces.org.uk/uploads/Asset_Management_Guide_in_LAs_Scottish_DoFs.pdf

6.3 Repairs and maintenance

What are the property revenue expenditure and budgets incurred by the Integration Joint Board?

- 6.3.1 The Integrated Budget may include payments from the Local Authority and Health Board to cover the revenue costs of assets e.g. rents, repairs and maintenance, rates, cleaning, property insurance etc. This should be agreed as part of the budget negotiations.

7 Accounting standards

7.1 Overview

- 7.1.1 The accounting standards as adapted for the public sector will apply to the Integration Joint Board and it is anticipated that the Code of Practice on Local Authority Accounting in the UK will be the applicable guidance for their interpretation.
- 7.1.2 The Local Authorities and Health Boards will continue to use the existing guidance in the preparation of their financial statements as well as consolidate the Integration Joint Board as a joint arrangement. Further guidance on the reporting requirements is in section 3.1.2.

7.2 Draft IFRS

- 7.2.1 Guidance relating to future changes to the reporting standards will be through the existing arrangements for the amendment of the Local Authority Code of Practice and Unified Board Accounts Manual.

APPENDIX 1

ILLUSTRATIVE INTEGRATION JOINT BOARD ANNUAL ACCOUNTS

All figures and text are for illustrative purposes only

MANAGEMENT COMMENTARY

1 Purpose and objectives

Integration Joint Board was established as a body corporate by order of Scottish Ministers.....

Its purpose is to*refer to the Integration Scheme for detail*

Objective is to*refer to the Strategic Plan for detail*

2 Financial review

High level review of financial outcome and any issuesreference to financial element of Strategic Plan, forward plans to address any issues arising.

3 Operational review

Highlights of the outcomes achieved in the year*refer to the performance report for more information*

Chief Officer

Chair

Financial Officer

Date

Date

Date

STATEMENT OF RESPONSIBILITIES FOR THE STATEMENTS OF ACCOUNT

The Integration Joint Board is required:

- To make arrangements for the proper administration of its financial affairs and to secure that it has an officer responsible for the administration of those affairs. In this Integration Joint Board, that officer is the.....;
- To manage its affairs to achieve best value in the use of its resources and safeguard its assets; and
- To approve the statement of accounts

Responsibilities of the financial officer

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

In preparing the financial statements I am responsible for:

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

I am also required to:

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

Statement of Accounts

The Statement of Accounts presents a true and fair view of the financial position of the xxxxxxxx Integration Joint Board as at 31 March 20xx, and its income and expenditure for the year then ended.

Financial Officer

Date

REMUNERATION REPORT

1 Integration Joint Board

The members of the Integration Joint Board are appointed by.....

2 Senior officers

The Chief Officer is appointed by the Integration Joint Board on consultation with the Health Board and Local Authority. The Chief Officer is employed by x.....and seconded to the Integration Joint Board. The financial officer is appointed by the Integration Joint Board and is*per the local arrangements.*

3 Remuneration policy

The board members are*whatever the arrangement is for the board members re expenses etc..*

The remuneration of the senior officer is set by

4 Remuneration

The board members and senior officers received the following remuneration in the year:

			2016-17	2015-16
	Salary, fees and allowances	Taxable expenses	Total remuneration	Total remuneration
	£	£	£	£
A Another	Bands of £5k	Actual		

5 Pension benefits

The senior officers are members of.....which is a

Costs of the pension scheme contributions for the year to 31 March 2017 are shown in the table below:

	To 31 March 2017	To 31 March 2016
A Another	£	£
In-year pension contributions		
Accrued pension benefits		
Movement in accrued pension benefits		

The information sectionsis subject to the audit.

Chief Officer

Chair

Date

Date

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

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

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

Governance framework

The system of internal control is based on a framework of.....*description of the governance framework to include:*

- *Membership of the Integration Joint Board, committees (if relevant), and their role*
- *Management information*
- *Internal and external audit scrutiny*
- *Sources of reliance*
- *System of risk management*

Review of Effectiveness

We have responsibility for reviewing the effectiveness of the governance arrangements including the system of internal control. *Review to cover relevant areas as set out in the CIPFA guidance Good Governance Framework in Local Government.*

Our review is informed by.....as per local arrangements and may include:

- *Assurance from the Integration Joint Board financial officer on financial matters*
- *Assurance from partner Health Board and Local Authority*
- *Internal and external audit reports*
- *Scrutiny by Integration Joint Board/committee through meetings*

Description of any issues from the review and action taken.

Certification

It is our opinion that reasonable assurance, *subject to the matters noted above*, can be placed upon the adequacy and effectiveness of the xxx Integration Joint Board's systems of governance.

Chief Officer

Chair

Date

Date

STATEMENT OF INCOME AND EXPENDITURE

	2015-16				2016-17		
Gross expenditure	Gross income	Net		Gross expenditure	Gross income	Net	
£000	£000	£000		£000	£000	£000	
109,950	(109,950)	0	Health and social care	109,900	(109,950)	(50)	
50	(50)	0	Corporate services	50	(50)	0	
110,000	(110,000)	0	(Surplus)/ deficit on provision of services	109,900	(110,000)	(50)	
110,000	(110,000)	0	Net income and expenditure	109,900	(110,000)	(50)	

BALANCE SHEET

	Notes	31 March 2017	31 March 2016
		£000	£000
Current assets			
Short term debtors	3	60	10
Current liabilities			
Short term creditors	4	(10)	(10)
Net assets		0	0
Usable reserves	5	50	0
Unusable reserves			
Total reserves		50	0

The Statement of Accounts present a true and fair view of the financial position of the Integration Joint Board as at 31 March 20xx and its income and expenditure for the year then ended.

The unaudited financial statements were authorised for issue on ww June 2017 and the audited financial statements were authorised for issue on vv September 2017

Financial Officer

Date

NOTES TO THE FINANCIAL STATEMENTS

1 Accounting policies

1.1 General principles

The financial statements summarise the transaction of the Integration Joint Board for the 20yy-zz financial year and its position at the year end. The Integration Joint Board is required to prepare annual financial statements by theand section.....of the.....regulations

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

1.2 Accruals of income and expenditure

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

1.3 VAT status

The Integration Joint Board is a non-taxable person and does not charge or recover VAT on its functions.

1.4 Provisions, contingent liabilities and assets

1.5 Events after the reporting period

Events occurring after the.....

1.6 Debtors and creditors

1.7 Reserves

The reserves are.....

2 Related party transactions

The xxx Integration Joint Board was established..... as abetween..... In the year the following financial transactions were made with the xxx Health Board and yyy Local Authority relating to integrated health and social care functions:

Income – payments for integrated functions

	2016-17	2015-16
	£000	£000
NHS Board	60,000	60,000
Local Authority	50,000	50,000
Total	110,000	110,000

Expenditure - payments for delivery of integrated functions

	31 March 2017	31 March 2016
	£000	£000
NHS Board	59,950	60,000
Local Authority	50,000	50,000
Total	109,950	110,000

A further £40 million of budget for certain hospital services were refer to being part of integration arrangements and the Strategic Plan.

3 Corporate expenditure

	31 March 2017	31 March 2016
	£000	£000
<i>Staff costs</i>	45	45
<i>Administrative costs</i>		
<i>Audit fees</i>	5	5
Total	50	50

4 Short Term Debtors

	31 March 2017	31 March 2016
	£000	£000
Central government bodies	50	0
Other local authorities	10	10
Total	60	10

5 Short Term Creditors

	31 March 2017	31 March 2016
	£000	£000
Central government bodies	0	5
Other local authorities	10	5
Total	10	10

6 Movement in reserves

Usable reserves – general fund	31 March 2017	31 March 2016
	£000	£000
Balance at 31 March brought forward	0	0
Surplus/(deficit) on provision of services	50	0
Other comprehensive expenditure and income	0	0
Total comprehensive expenditure and income	50	0
Balance at 31 March carried forward	50	0

7 Post balance sheet events

8 Contingent liabilities

SECTION C

Delegation between Partners – Lead Agency

C DELEGATION BETWEEN PARTNERS – LEAD AGENCY

1 Introduction

1.0.1 Under this model the partners will delegate functions and resources between each other. Before the functions are delegated, the Local Authority and the Health Board must jointly establish an integration joint monitoring committee for the purpose of monitoring the carrying out of the integration functions **(Section 15)**.

1.0.2 The integration joint monitoring committee may issue reports to the host partner on any aspect of the carrying out of the integration functions, including recommendations as to how those integration functions should be carried out in future **(Section 43)**.

1.1 Integration Scheme and Strategic Plan, Annual Financial Statement and Annual Performance Report

1.1.1 The Integration Scheme sets out the detail of the integration arrangement, as agreed by the Local Authority and Health Board and submitted to Scottish Ministers for approval **(Section 7(1))**. It covers a number of finance related matters **(Section 1)**:

- Functions which are to be delegated to the Integration Authority;
- Functions of the host partner that will be used in conjunctions with the delegated functions;
- The method for the determination of the resources to be made available to the Integration Authority for the delegated functions;
- Reporting arrangements between the Integration Authority and the delegating partner;
- Financial management arrangements for variances and redetermination of payments and amounts set aside; and
- Arrangements for the use of capital assets in relation to the integration functions.

1.1.2 The host partner will lead the preparation of the Strategic Plan with other stakeholders, in line with the principles and duties set out in the legislation **(Sections 29-39)**; the Strategic Plan will describe the capacity required by the partnership population along the spectrum of care and the resources available to deliver the outcomes.

1.1.3 The host partner will publish an Annual Financial Statement **(Section 39)** which will set out the amount that will be spent in each year of the strategic plan. Guidance on the content of the Annual Financial Statement is included in the [Statutory Guidance](#) for Strategic Planning.

1.1.4 The host partner will also publish an Annual Performance Report **(Section 42)** within four months of the year end with an assessment of its performance in planning and carrying out the integration functions. This will contain financial information for the reporting year on the following:

- Service type and the balance of care;
- Key care groups;
- Localities; and
- Assessment of performance in achieving best value.

1.1.5 [Statutory Guidance](#) on the content of the Annual Performance Report will be published by The Scottish Government separately.

1.2 Financial model

1.2.1 Resources within scope of the Strategic Plan

1.2.1.1 These will comprise the:

- Payment made to the host partner by the delegating partner **(A)**;
- Budgets in the host partner for the services to be managed in conjunction with the delegated services **(B)**; and
- Budget for services provided in large hospitals used by the partnership population **(C)**.

1.2.1.2 The services in **(A)** and **(B)** will depend on which partner is the host and **(C)**, may be included within the Integrated Budget when the Health Board is the host partner.

e.g. Where the Health Board is the host partner, **(A)** will be the budgets for adult social care services, **(B)** will be the budgets for primary and community healthcare services and community hospital services and **(C)** will be the Health Board budget for services in large hospitals within scope of the plan.

1.2.1.3 The minimum scope of services to be included in each of **(A)**, **(B)** and **(C)** is set out in the legislation (**Section 1**). The Health Board and Local Authority may include other services, beyond the minimum requirement, within the scope of the plan and legislation takes powers for Ministers to set these out in regulations as well as the services which may not be delegated between partners.

1.2.1.4 The host partner may direct and make payment to the delegating partner to carry out the operational delivery of services; the direction must include the method for agreeing the value of the payment (**Section 18**).

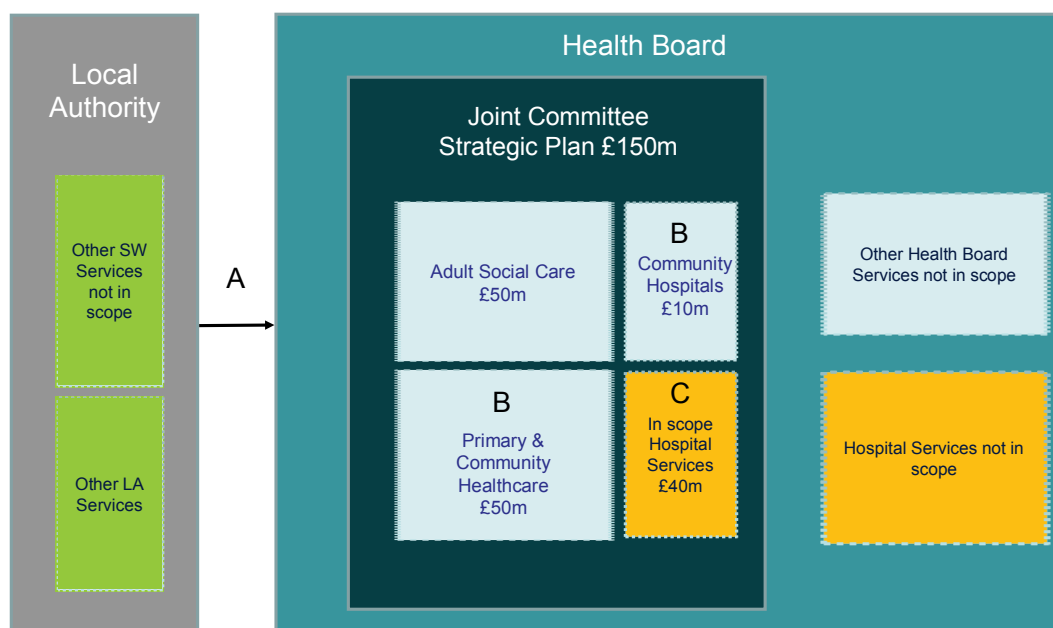
1.2.2 Resources outside scope of the Strategic Plan

1.2.2.1 In addition to the services within scope of the Strategic Plan and overseen by the joint committee, the Health Board and Local Authority may delegate oversight of services that are outside of the scope of the Strategic Plan to the joint committee.

e.g. Children’s community health services, children’s social work services or other ex-Community Health Partnership (CHP) services that are outside the scope of the Strategic Plan.

1.2.2.2 The resource model is shown in figure 3 below. In this example, the Health Board is the host partner and the resources within scope of the Strategic Plan total £150m comprising £50m delegated from the Local Authority and £100m of Health Board budgets.

Figure 3: Delegation between partners.



1.3 Financial governance

1.3.0.1 The delegated resources will be subject to the financial governance processes of the host partner.

1.3.0.2 The host partner will be a “lead agent” for the delegating partner. The Health Boards and Local Authorities will be accountable to Scottish Ministers for the national outcomes for health and wellbeing

1.3.1 Financial accountability

1.3.1.1 The Chief Executive of the host partner will be jointly accountable to the Health Board and Local Authority for the management of the integrated services.

Integrated Resources Advisory Group Finance Guidance

- 1.3.1.2 The accountable officers²¹ of the delegating partner discharge their responsibility, as it relates to the resources that are delegated to the host partner, by setting out in the Integration Scheme how the money is to be used in the integrated arrangement and the systems and monitoring arrangements for financial performance management. It is the responsibility of the accountable officer of the delegating partner to ensure that the provisions of the Integration Scheme enable them to discharge their responsibilities in this respect. (See “following the public pound” at 2.6)
- 1.3.1.3 The Integrated Budget will be managed using the financial regulations and controls of the host partner.

²¹ Chief Executive of the Health Board and Section 95 Officer in the Local Authority

2 Assurance

2.1 Financial assurance

2.1.1 Role of Directors of Finance

Who are the officers that are accountable for the financial governance in the Local Authority and Health Board?

- 2.1.1.1 The accountable officer for financial management is different between Health Boards and Local Authorities. Within Health Boards the Chief Executive is the accountable officer and is responsible for financial stewardship and governance. Within Local Authorities the accountable officer for financial governance is the Section 95 Officer; usually the Director of Finance, Head of Finance, or a chief officer with a recognised accountancy qualification.

Who will be the accountable officer for financial management?

- 2.1.1.2 The accountable officer will not change in a lead agency arrangement (although there will be financial accountability for new services) and will be the existing officer in the host authority. The accountable officer of the delegating partner discharges their accountability in respect of the delegated resources through the provisions of the Integration Scheme.

Will the host partner governance arrangements change?

- 2.1.1.3 Yes. It is recommended that the governance arrangements are revised to include the areas specified under the Integration Scheme. This should include extending the annual governance statement to include reporting on the delegated services. Also, where required, assurances should be provided to the delegating authority.

Will the Directors of Finance of the Health Board and Local Authority be members of the integration joint monitoring committee?

- 2.1.1.4 Yes; regulations require that the Director of Finance of the host partner is a member of the integration joint monitoring committee; they also permit the integration joint monitoring committee to appoint additional members as it sees fit and it is recommended that the Finance Director from the delegating partner is also appointed.

2.1.2 Financial regulations

What financial regulations will be used?

- 2.1.2.1 The financial regulations, amended to include the integration arrangements, of the host partner should be used under this model. They should be reviewed and approved following the existing procedures for update.

2.2 Risk management

- 2.2.1 The risk management arrangements of the host partner should be used and it is recommended that they are updated to reflect the revised risk profile associated with the delegated functions according to the established procedures. The host partner should provide regular reports for assurance and scrutiny purposes to the appropriate committee within the host authority and also to the joint committee.
- 2.2.2 It is recommended that the delegating partner reviews and amends their own risk management arrangements to include any residual risks they consider to have retained on implementation of the integration arrangements.

What risks should be considered in developing the Integration Scheme?

- 2.2.3 Regulations require that the Integration Scheme sets out the risk management arrangements for the integration functions. The host partner's existing risk management arrangements should apply to the delegated functions.

2.3 Insurance

- 2.3.1 The host partner should make appropriate provision for insurance according to the risk management strategy. The Act (**Section 65(2)(b)**) enables, but does not require Local Authorities to become members of CNORIS; Health Boards will remain mandatory members of the scheme.
- 2.3.2 Additional information on liability and insurance is included in the statutory guidance on the establishment and operation of Integration Joint Monitoring Committees.

Will the scheme cover all insurable risks?

- 2.3.3 No. The scheme currently covers Health Boards for:
- Clinical negligence claims and actions which arise in connection with the acts and omissions of their employees; and
 - Non-clinical claims and actions which arise following loss or bodily injury affecting third parties or employees or certain other pecuniary risks
- 2.3.4 The Act widens the scope of the scheme (**Section 65(3)**) to include social care functions but does not extend to other functions in the Local Authority, for example, housing services. Further information on the scope of functions within CNORIS can be obtained from the Scottish Government Health Directorate.

How will the payments to the scheme be calculated?

- 2.3.5 Members make payments towards the accumulated cost of paying the agreed claims for each financial year based on the assessed risk of the functions which they bring to the scheme. The contribution is calculated annually, with the claims initially being funded by the Scottish Government Health and Social Care Directorate.

Will there be a threshold for paying claims by the scheme?

- 2.3.5 Yes. Under current arrangements, scheme members are required to meet claims of £25,000 or under from their own budgets. Further information may be found [here](#).

2.4 Internal audit

- 2.4.1 The assurance and control systems of the host partner will apply to the delegated resources.

Who will provide the internal audit service?

- 2.4.2 It is recommended that the host partner should review and revise the scope of the existing internal audit arrangements to include the delegated functions. The delegating partners internal audit team should provide information to the host partner as required to develop the arrangements.

Will there be an audit plan for the Integration Authority?

- 2.4.3 No the internal audit plan of the host partner will be revised to include the new delegated services.

How will the Chief Internal Auditor report on the integration arrangements?

- 2.4.4 The Chief Internal Auditor will report on the integration arrangements to the Chief Executive of the host authority and the relevant committee in line with agreed governance arrangements of the host partner. Also it is recommended that the Chief Internal Auditor should report to the integration joint monitoring committee on those parts of the internal audit plan relevant to the integration arrangements. The Chief Internal Auditor should also present an annual report to the integration joint monitoring committee.

2.5 External audit

Who will carry out the external audit of the partnership?

- 2.5.1 The external auditor of the host partner will be responsible for the audit of the delegated services as part of the statutory audit of the authority.

2.6 Following the public pound

- 2.6.1 Current guidance for Local Authorities²² where funding is provided by one partner to another to deliver services which would otherwise be provided by the funder, requires arrangements to be in place to maintain control and accountability over the public funds. This applies to the resources delegated to the host partner. The best practice principles are set out in the Code of Guidance on Funding External Bodies and Following the Public Pound²⁵ should be incorporated into the Integration Scheme (see 1.3.1) to allow the accountable officer of the delegating partner to discharge this duty.

²² Code of Guidance on Funding External Bodies and Following the Public Pound, Convention of Scottish Local Authorities/Accounts Commission

3 Financial reporting

3.1 Reporting in the partner financial statements

- 3.1.1 The reporting in the financial statements of the Local Authority and Health Board should follow the existing treatments. The payment from the delegating partner should be shown as expenditure in its accounts and will be shown as income in the lead partner accounts together with the associated expenditure.

Will the arrangement be treated as a business combination under IFRS3?

- 3.1.2 No; the model is a delegation of function and not a transfer of function and responsibility between two parts of the public sector.

How should the integration arrangement be reported?

- 3.1.3 The integration arrangement should be disclosed under related parties as required under IAS24, including disclosure of the value of the delegated resources in the Integrated Budget.

How will over/underspends against the Integrated Budget be reported?

- 3.1.4 In-year variances are the responsibility of the host partner and guidance on its management and associated treatment is in section 4.3.1.

Will the partners need to include a note analysing how the Integrated Budget has been spent in their financial statements?

- 3.1.5 Not in their financial statements, but information will be required for LFR3 and SFR returns as noted below.

3.2 Central returns

- 3.2.1 The Health Board (SFR) and the Local Authority (LRF3) currently submit returns to the Scottish Government relating to health and social care. Proposals will be developed by the Scottish Government to revise the returns to reflect the integration arrangements. Information on the revised arrangements for the LFR3 will be issued by Scottish Government. Guidance on the SFR will continue to be provided in Unified Board Accounts Manual.

3.3 Whole of Government Accounts (WGA)

- 3.3.1 The partner authorities will continue to use the existing guidance for their submissions to the WGA process, noting that there will be additional adjusting entries in respect of the payment to the host authority.

4 Financial planning and financial management

4.1 Resources within scope of the Strategic Plan

- 4.1.1 The legislation requires that the Integration Authority produce a Strategic Plan (**Sections 29 & 33**), which sets out the services for their area over the medium term (3 years), see [Statutory Guidance](#) on strategic planning. Further, the role of clinicians and care professionals, along with the full involvement of the third and independent sectors, service users and carers, will be embedded as a mandatory feature of the commissioning and planning process, through the requirement for the Integration Authority to set up a strategic planning group (**Section 32**).
- 4.1.2 The Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan which comprises the Integrated Budget (see 4.2) plus the amount set aside by the Health Board (see 4.4) for commissioned services in large hospitals. It will be important for there to be full transparency of the use of these resources by the Integration Joint Board population and it will be required to publish an annual financial statement setting this out (**Section 39**). The Strategic Plan will set out the level of capacity required each year in all of the sectors on the care pathway and the allocation of the resource within scope of the plan across the sectors.
- 4.1.3 The ability to plan with the overall resource for defined populations and user groups and to use budgets flexibly is one of the hallmarks of integrated care. A premise of the policy is that the host partner will, through the Strategic Plan, be able to allocate resources within the Integrated Budget and to plan and agree transfers between the notional budget and the Integrated Budget. It will be for the host partner, through the strategic planning process and having regard to the duties in the legislation for consultation, co-production and co-operation with other Integration Authorities (**Section 32**), to decide what capacity is required in order to deliver the agreed performance on outcomes.
- 4.1.4 Accordingly, the relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be commissioned through the plan, although it is likely that in the first years they will be similar.

Will the host partner be required to co-ordinate the development of the Strategic Plan with other Integration Authorities for cross system services?

- 4.1.5 Yes; this duty is specified in the legislation (**Section 30(3)**).

4.2 Integrated Budget

- 4.2.1 The legislation requires that a method for calculating the payment made to the host partner is included in the Integration Scheme (**Section 1 (3)**). The

Integrated Budget will comprise this payment and the budget in the host partner for the services that will be managed in conjunction with the delegated services i.e. **(A)** and **(B)** in the financial model noted above.

- 4.2.2 Where the host partner is the Health Board, the budget for hospital services for the minimum scope of specialties will be included within the Integrated Budget.

What process should be used to determine the initial payment to the host partner?

- 4.2.3 The initial sums should be determined on the basis of the existing Health delegating partner budgets, actual spend and financial plans for the delegated services. It is important that the plans are tested against recent actual expenditure and that the assumptions used in developing the plans and the associated risks are fully transparent:
- The budget in the financial plan should be assessed against actual expenditure reported in the management accounts for the most recent two/three years. Ideally, the roll forward of the budget for the delegated services and the actual expenditure over this period should be understood;
 - Material non-recurrent funding and expenditure budgets for the delegated services and the associated risks are identified and assessed;
 - The medium term financial forecast for the delegated services and associated assumptions and risks should be reviewed;
 - Savings and efficiency targets and any schemes identified should be clearly identified and the assumptions and risks understood by all partners;
 - All risks should be quantified where possible and mitigating measures identified.
- 4.2.4 It is recommended that the first year/period is treated as transitional period and that partners agree to a risk sharing arrangement with adjustments being made through subsequent year's allocations; where it is used this provision should be incorporated in the Integration Scheme.
- 4.2.5 The integration authorities should carry out a process of financial assurance for the initial sums to be delegated. It is recommended that Health Board and Local Authority Directors of Finance foster an assurance process based on mutual trust and confidence involving an open-book approach and an honest sharing and discussion of the assumptions and risks associated with the delegated services.

4.2.6 IRAG has published detailed supplementary [Statutory Guidance](#) on financial assurance.

What process should be used to calculate payments to the host partner in subsequent years?

4.2.12 The process for agreeing the allocations to the Host Partner in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. The delegating partner should aim to give indicative three year allocations to the host partner, subject to annual approval through the respective budget setting processes.

4.2.13 The Chief Executive of the host partner will develop a case for the resources required for the delegated functions, based on the Strategic Plan and present it to the Delegating Partner for consideration and agreement as part of the annual budget setting process. This case should take account of:

- **Activity changes.** The impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes;
- **Cost inflation.** Pay and supplies cost increases;
- **Efficiencies.** All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Local Authority and Health Board as part of the annual rolling financial planning process to ensure transparency;
- **Performance on outcomes.** The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the partner Local Authority and Health Board;
- **Legal requirements.** Legislation may entail expenditure commitments that should be taken into account in adjusting the payment;
- **Transfers to/from the notional budget for hospital services** set out in the Strategic Plan. Where the Local Authority is the host partner, the budget for hospital services will remain in the Health Board with the corresponding notional budget within scope of the plan. The resources delegated to the Local Authority will be adjusted for changes in the resource needed for hospital capacity agreed through the plan. Where the Health Board is the host partner, this will be an internal budget adjustment within the Health Board. See 4.4 below.
- **Adjustments to address equity.** The Local Authority or Health Board may choose to adjust contributions to smooth the variation in use of weighted capita resource allocations across partnerships. This will apply when the Local Authority is host partner and the Health Board is the delegating partner. It will be an internal budget adjustment within the Health Board in cases where it is the host partner. Information to support this will be provided by ISD²³ and ASD.

²³ <http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/>

4.2.14 The delegating partner will evaluate the case relative to its other priorities and negotiate the payment to the host partner. This will be a discretionary process and it cannot be assumed that the payment will be adjusted in line with national uplifts. This process should be included in the Integration Scheme.

How should resource transfer be treated?

4.2.15 Some social work expenditure budgets will be funded by resource transfer payments. It is important that partners identify these and adopt a consistent approach to their inclusion in the resources delegated between each other. Partners have the option to:

- Continue the current arrangement with the Health Board making the resource transfer payment to the Local Authority and the Local Authority including the services funded by resource transfer in the resources that are included in the integrated arrangements ; or
- Adjust the resource transfer payment from the Health Board to the Local Authority for the services that are being integrated and either add this sum to the payment to the Local Authority (where the Local Authority is the host partner) or use the resource transfer budget to fund social work services (where the Health Board is the host partner).

4.2.16 It is recommended that the local decision on treatment of resources transfer is set out in the Integration Scheme.

Should hosted services be included in the integrated budget?

4.2.17 Yes; some health services that are used by multiple partnership populations are hosted and operationally managed by one partnership on behalf of the others. The resources used by the population of a partnership for services that are managed on a hosted arrangement, should be included in the Integrated Budget for each partnership. The legislation takes powers for Ministers to set this out in regulations. Each partnership will be required to include in its Strategic Plan the planned use of the hosted service by its population. It is recommended that the officer responsible for managing the hosted service take the lead in coordinating the partnerships in development of their Strategic Plans for hosted services.

4.3 Managing financial performance

4.3.0.1 The Local Authority and Health Board should set out in their Integration Scheme the process for managing in-year financial performance for the Integrated Budget, including treatment of under/overspends. The legislation takes powers for Ministers to set this out in regulations.

How will the Directors of Finance of the Health Board and Local Authority ensure financial management of the Integrated Budget?

4.3.0.2 The financial management process of the host partner will apply to the delegated resources. Within a short period, it is likely that the delegated services will be integrated with host partner services and will not be separately reported in the host partner accounts.

4.3.1 Budget variances

Will the host partner be expected to break even on the Integrated Budget?

4.3.1.1 Yes; the joint committee should ensure that the Integrated Budget at least breaks even.

Will the host partner be able to vire between operational budgets?

4.3.1.2 Yes; It is recommended that the host partner vire resources within the Integrated Budget but not between the Integrated Budget and those budgets that are outside of the scope of the Strategic Plan, unless agreed by the Chief Executives and Directors of Finance of both organisations.

Where the host partner is the Health Board, will a variance on the Integrated Budget affect the RRL?

4.3.1.3 Yes; the Health Board will be required to deliver the RRL on its total budget i.e. including the budget for hosted delegated functions.

Will the host partner be able to hold reserves?

4.3.1.4 This depends on the identity of the host partner. Local Authorities can hold reserves including an earmarked reserve in the General Fund. Health Boards cannot hold reserves, so where the Health Board is the host partner, the Local Authority would need to carry forward resources on behalf of the Health Board through its reserves. Partners should ensure a clear audit trail for transfers between the Health Board and Local Authority for reserves.

How will they be used?

4.3.1.5 The use of reserves by Local Authorities is set out in the Code and CIPFA guidance^{24 25}. It is recommended that the Local Authority reserves strategy is amended to include the Integration Authority reserve where the Local

²⁴ Local Authority Reserves and Balances, LAAP Bulletin 77, CIPFA, November 2008
www.cipfa.org/-/media/files/policy%20and%20guidance/laap%20bulletins/laap77.pdf

²⁵ The Statutory Basis for Accounting and Disclosing Reserves in Local Authorities in Scotland. LASAAC 2005.
www.cipfa.org/-/media/files/regions/scotland/lasaac/3l%20lasaac%20reserves.pdf

Authority is the host partner and to facilitate a reserve where the Health Board is the host partner.

What will happen in the event of an in-year overspend on the Integrated Budget?

- 4.3.1.6 Over time it will not be possible to disaggregate variances within the Integrated Budget between those attributable to the delegated resources and those attributable to host partner resources.
- 4.3.1.7 If, following remedial management actions, an overspend is still forecast for the Integrated Budget, the Chief Executives and Directors of Finance of the host partner and delegating partner, will consider additional expenditure reductions on targeted areas and/or use reserves.
- 4.3.1.8 If savings are unsuccessful and there are insufficient reserves to fund the forecast overspend, then the Local Authority and Health Board will make additional in-year allocations to the Integrated Budget. This method should be set out in the Integration Scheme and be clear as to how the Local Authority and Health Board will share the additional contributions, if required. The legislation takes powers for Ministers to set this out in regulations.

Will the host partner be able to retain in-year underspends?

- 4.3.1.9 Yes; It is recommended that an underspend on the Integrated Budget is retained and carried forward to the next year. The exception is for underspends that arise due to fortuitous material differences in the assumptions used in setting the respective contributions to the Integrated Budget. In these cases, the Directors of Finance and Chief Executives of the Health Board and Local Authority may make adjustment to the payment and the host partner contribution.

Will the host partner be able to use the Integrated Budget to contribute to the management of in-year overspends on other host partner budgets?

- 4.3.1.10 Ordinarily, no. In the event of a projected in-year overspend elsewhere in the host partner's non-integrated budgets, it is recommended that the host partner should contain the overspend within the non-integrated resources and would normally not require the use the Integrated Budget to contribute to any remedial action.
- 4.3.1.11 However, in exceptional circumstances it may be necessary for the host partner to re-direct resources to their non-integrated budgets. This provision should only be used in extremis and with agreement of the delegating partner Chief Executive and Director of Finance; the process should be clearly set out on the Integration Scheme.
- 4.3.1.12 The Chief Executives and the Director of Finance of both organisations will determine the actions required to be taken to deliver the necessary savings in the Integrated Budget.

Will the delegating partner be able to reduce the payment to the host partner to contribute to the management of in-year overspends on other delegating partner budgets?

- 4.3.1.13 Ordinarily, no. In the event of a projected in-year overspend elsewhere in the delegating partner's budgets, it is recommended that the delegating partner should contain the overspend within the non-integrated resources and would normally not require to reduce the payment to contribute to any remedial action.
- 4.3.1.14 However, in exceptional circumstances it may be necessary for the delegating partner to reduce the payment and re-direct resources to their non-integrated budgets. This provision should only be used in extremis and with agreement of the Chief Executive and Director of Finance of the Local Authority and Health Board; the process should be clearly set out on the Integration Scheme.
- 4.3.1.15 The Chief Executives and the Directors of Finance of both organisations will determine the actions required to be taken to deliver the necessary savings in the Integrated Budget to fund the reduction in the payment.

Will the host partner be required to contribute to overspends in other Integration Authorities?

- 4.3.1.16 No; it is recommended that the responsibility for this lies with the overspending Integration Authority and the process noted above should apply.

4.3.2 Financial risk

- 4.3.2.1 Financial risk will be managed through the use of reserves and the financial management process noted above. In addition, some parts of the Integrated Budget that are subject to high risk or uncertainty (e.g. Prescribing) may require separate risk pooling arrangements. These should be subject to local consideration.

4.4 Amount set aside for directed hospital services

- 4.4.0.1 The Act and regulations require that the budget for hospital services used by the partnership population are included within scope of the Strategic Plan.
- 4.4.0.2 Where the host partner is the Local Authority, these resources are likely to be retained by the Health Board and set aside for use by the host partner. . Where the Health Board is the host partner, the resources will be included (as conjunction functions) in the integrated Budget within the Health Board.
- 4.4.0.3 The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

- 4.4.0.4 Fundamental to this will be a clear understanding of how “large hospital” services are being consumed and how that pattern of consumption and demand can be changed by whole system redesign. As a first step it is critical that there is transparency for Partnerships and localities on how resources are being used. As a second step, there needs to be clarity about the financial impact of changes agreed through the strategic planning process.
- 4.4.0.5 Where more than one partnership exists within a Health Board area, the change programme for hospital services will have to be coherent across individual strategic plans (under S30 (3) of the Act). Consequently, there should be an overarching strategic plan for the hospital services delegated to Integration Authorities that is a consolidation of the individual partnership plans and this should be coordinated and held by the Health Board hospital sector.
- 4.4.0.6 The strategic plans produced by the Integration Authority/ies must in turn be consistent with the strategic context set by the Health Board and Local Authority. The hospital capacity and hosted services included in the strategic plan should evolve from the existing capacity and plans for those services. Strategic plans will reflect locality planning in due course.
- 4.4.0.7 It is recognised that this is a complex journey and detailed [Statutory Guidance](#) has been the jointly produced by IAG and the Joint Commissioning Steering Group on which the following is based.

How should the set aside budget be determined?

- 4.4.0.8 Legislation requires that the method for determining the amount to be set aside by the Health Board should be included in the Integration Scheme **(Section 1(3))**.
- 4.4.0.9 It is recommended that the consumption of hospital services by partnership populations should be determined by analysis of hospital activity and cost information.
- 4.4.0.10 *Activity*
Hospital activity is recorded on Health Board hospital patient administration systems (PAS) which are based on the individual record of each inpatient hospital episode. This data, aggregated to locality and partnership level, should be used to identify the hospital activity and capacity used by patients for each partnership; the data can be obtained from either:
- Local Health Board information teams; or
 - National Services Scotland (NSS), which produce these datasets for each partnership through the Health and Social Care Data Integration & Intelligence Project (HSCDIIP).
- 4.4.0.11 It is recommended that an average of three years of activity is used to scope partnership consumption for the first year of the strategic plan.

4.4.0.12 Cost

Attaching a £ value to activity can be achieved in a number of ways, for example:

- Blue book admission or bed day rates;
- Local Costing methodologies;
- NSS patient level costing (PLICS) available through HSCDIIP.

4.4.0.13 It is a local decision as to which method is used, however it is recommended that a consistent method is used for all partnerships in a HealthBoard area.

Should cross boundary functions be included in the set aside budget?

4.4.0.14 Yes; where material; the set aside budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.

4.4.0.15 Alternatively, where the Local Authority is the host partner, the respective cross boundary flow budget may be included in the payments to the Local authority.

How should 'fair share' information be used?

4.4.0.16 Using historical consumption as a starting point inevitably builds in any existing inequity of resource use in the historic position. It is difficult to avoid this without causing immediate destabilisation. Over time, issues of equity can be considered by Health Boards and may be addressed through their subsequent allocations to partnerships.

4.4.0.17 It is recommended that partnerships use fair share information based on the National Resource Allocation Committee (NRAC) methodology available from NSS (through the HSCDIIP project) for benchmarking partnership expenditure.

How should the financial consequences of planned changes in capacity be determined?

4.4.0.18 Strategic Planning will be a cyclical process of Analyse, Plan, Do and Review and this will likely involve a two stage process for developing cases for change: from considering initial proposals to full inclusion in locality and strategic plans. This will require cost and activity information at different levels of detail, depending on whether consideration is of an outline case or a full case proposal.

4.4.0.19 It is recommended that practical and easily used cost information is made available to stakeholders to enable outline cases to be developed.

4.4.1.20 It is recommended that detailed estimates of the effect of change proposals should be developed and reflected in the financial plan underpinning the Strategic Plan. This should set out the capacity and

resource levels required for the set aside budget for the partnership/locality populations. This should be based on an agreed implementation plan with assumptions for:

- Activity changes based on demographic change;
- Agreed activity changes from new interventions;
- Cost behaviour;
- Hospital efficiency and productivity targets;
- An agreed schedule for timing of resource released/additional resource.

4.4.0.21 It is recommended that the approach to producing detailed financial plans based on the agreed changes should be similar to those previously used for Learning Difficulty Same As You (SAY) and other major redesign exercises.

How will overheads in directed hospital services be treated?

4.4.0.22 It is a matter for local determination. It is recommended that a consistent approach is adopted for Integration Authorities in partnership with the same Health Board.

Will resource be able to be transferred between the Integrated Budget and the set aside budget for directed hospital services?

4.4.0.23 Yes, where there is a planned increase in consumption, the Integration Authority will need to consider how to fund the additional capacity through the Strategic Plan. Similarly, where resource is released, the Integration Authority will be able to consider how to use this resource through the Strategic Plan.

4.4.1 Reporting Performance against Plan

4.4.1.1 Partnerships, Localities and the hospital sector will require information on their performance against the plan for hospital capacity in order to flex the strategic plan and also to take remedial action if necessary. This information will need to be available at two levels: for each partnership; and for the overarching hospital plan.

4.4.1.2 The Local Authority and Health Board should establish a process for the manager of the integrated services and the hospital sector to jointly receive regular activity reports comparing the expected capacity set out in the strategic plan with actual capacity used. Where the host partner is the Health Board, this will be an internal process and it is recommended that reports are at locality level.

4.4.1.3 Actual activity and expected activity information will be available from ISD HSCDIIP reports or alternatively from local Health Board information teams.

Will there be in-year virement between the Integrated Budget and the notional budget?

4.4.1.4 The legislation enables this (**Section 28**). However, it is recommended that in-year resource adjustments should be avoided and that changes be made through annual adjustments to the Strategic Plan.

4.4.1.5 If partners consider that in-year resource adjustments should be made, it is recommended that minimum thresholds for activity variances are agreed, below which no resource adjustments will be required. Where the host partner is the Health Board, the virement would be an internal budget adjustment.

4.4.1.6 It is recommended that the process for making adjustments to the set aside resource to reflect variances in performance against the plan are agreed and clearly set out. This should explicitly deal with cases of offsetting variances between Integration Authorities.

4.4.2 Accountability Framework

4.4.2.1 It is recommended that there is a clear understanding of where the balance of risk lies, between each Integration Authority and the Health Board hospital sector, for delivering planned hospital capacity. There are two main risks:

- Activity and case mix: i.e. the agreed capacity set out in the plan is not delivered or not delivered on the agreed schedule; and
- Resources: i.e. the capacity set out in the plan is delivered, but the resource required is different to that agreed.

4.4.2.2 The balance of the financial risks for planned changes in hospital capacity depends on the identity of the host partner. Where this is the Local Authority these risks are ultimately shared between the Local Authority and the Health Board; however, it is recommended that the *primary* responsibility for delivering capacity (i.e. activity and case mix) should lie with the Local Authority; and that for providing the capacity within agreed resources should lie with the Health Board hospital sector.

4.4.2.3 Where the host partner is the Health Board, clearly both risks will lie with the Health Board, in which case it is recommended that the primary responsibility for delivering capacity should lie with localities.

4.4.2.4 It is recommended that these respective responsibilities are set out in the Strategic Plan.

4.4.2.5 The basis of the accountability framework should be a local decision.

5 VAT

5.1 Revenue

- 5.1.0.1 Scottish Government has concluded discussions HMRC on a method to determine the correct levels of VAT recovery for the delegating partner and host partner. The method of apportionment to calculate the VAT is based on existing 2002 HMRC/DoH guidance and that used by the Highland partnership that specifically deals with “lead agency” arrangements. This is based on the fact that the ultimate legal responsibility for delivery of the services still resides with the delegating partner and that, for VAT purposes, it remains the principal in respect of the supply, with the host partner acting as an agent in delivering the services.
- 5.1.0.2 In this method, the host partner invoices the delegating partner for their element of the VAT which would have been recovered by the delegating partner, if the functions had not been delegated. Worked examples and a sample invoice are included at the end of this section.
- 5.1.0.3 HMRC have been clear that the alternative model in the 2002 HMRC/DoH guidance, in which the host partner acts as principal, is not applicable to the lead agency integration arrangements under the Act.
- 5.1.0.4 The 2002 guidance allows for any reasonable method to be used to determine the proportions of VAT recoverable by the different partners.

5.1.1 Proposed apportionment method

Health Board host partner

- 5.1.1.1 It is proposed that all input VAT incurred by the Health Board, including that which relates either directly or indirectly to the delegated services, is processed under the Contracted Out Services (COS) rules normally operated by NHS. The VAT is recovered under section 41(2), VAT Act 1994. It is acknowledged that this VAT regime will not allow full VAT recovery on associated costs, for example VAT incurred on goods/consumables will not be recoverable and the VAT on certain services that do not fall within the COS headings.
- 5.1.1.2 In order to avoid the VAT leakage on other costs which would previously have been recovered by the Local Authority under the section 33 rules, a monthly memorandum VAT invoice would be raised by the NHS to the Local Authority setting out the additional VAT to be recovered. This will include goods/consumables and services.
- 5.1.1.3 In order to establish the amount of VAT to be charged, the partners will analyse the Local Authority’s expenditure for the year prior to integration and split the input VAT incurred by the Local Authority on the delegated adult services between:

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- Value of VATable expenditure which would have been recoverable had the COS rules been applied; and
- Value of expenditure on which VAT was incurred which would not have been recoverable under COS.

5.1.1.4 The value of none COS expenditure at (b) is then expressed as a percentage of the total outturn for the delegated adult services for the year. An example summary of the analysis of the 2012 expenditure which can be undertaken has been provided below:

	Value of Expenditure £	Percentage £
Local Authority social care budget transferred to NHS	[65,000,000]	
Expenditure which qualifies as eligible services for COS	2,486,465	
Non-COS expenditure on which VAT is incurred	3,299,545	5.07%

5.1.1.5 The annual value of VAT to be invoiced to, and recovered by, the LA would be calculated by:

- Applying 5.07% to the annual budget transferred to the Health Board; and
- Applying the current VAT rate to this calculated value.

5.1.1.6 The recoverable VAT would be notified to the Local Authority on a monthly basis for inclusion in the Local Authority's VAT return. This approach would:

- Be administratively easy for NHS to operate as staff processing input VAT would continue to operate the existing rules and procedures;
- Reflect the increased input VAT which would result from increased budgets;
- Reflect any future changes in the VAT rate;
- Ensure that there is no double counting of VAT which would have qualified for recovery under COS; and
- Be easy to verify by HMRC officers reviewing the arrangements.

Local Authority host partner

5.1.1.7 If the Local Authority is the host partner, the Local Authority may act as agent for the delegated services and the apportionment method noted above used to recover VAT under s33 VAT Act 1994.

5.1.1.8 This is likely to result in the Local Authority recovering more VAT through its normal Accounts Payable process. The law only permits VAT recovery in accordance with the rules applicable to the delegating partner (ie the Health Board in this case) and in the circumstances HMRC have agreed that the most appropriate method of correcting over recovery by the Local Authority is for the Local Authority to issue a memorandum credit note which will

reduce the input VAT recovered. Worked examples and a sample credit note are included at the end of this section.

5.1.2 Implementation

5.1.2.1 Each partnership will have to go through the exercise to establish the recovery percentage which applies to their arrangements. The calculation will need to be revised periodically and the Scottish Government is negotiating with HMRC on the likely/reasonable review period.

5.1.2.2 If the standard approach agreed with HMRC and outlined above is not used then individual partners will be required to use actual expenditure and perform the calculation on an annual basis; partners will not be permitted to switch back and forth between the standard approach and actual basis.

5.2 Capital

5.2.1 There is a fundamental difference in the VAT recovery position of Health Boards and Local Authorities in respect of property expenditure. Health Boards are not allowed VAT recovery on the purchase of goods or property assets. Local Authorities will typically be allowed full VAT recovery on all capital and revenue expenditure on both new construction and repairs/extension/maintenance of property. Health Boards are not allowed VAT recovery on new construction and limited recovery in other scenarios. New build using an NPD model via Scottish Futures Trust or the HUB initiative will typically lead to VAT recovery under Section 41, VAT Act 1994 as the supply is of services rather than goods. HMRC are currently considering the VAT position of the HUB initiative and this guidance will be updated accordingly.

5.2.2 In the submission to HMRC regarding VAT recovery on delegated budgets it has been considered that on-going revenue expenditure in respect of property assets used to deliver delegated services should be calculated on the same basis as all revenue expenditure i.e. if the VAT recovery is not allowed under Section 41 rules but would have been permitted under Section 33 rules then the VAT will be identified on the memorandum invoice to allow VAT recovery under Section 33. This is on the basis that there is no supply of the property asset by the Local Authority to the Health Board, rather a license to operate from facilities and deliver the delegated services.

5.2.3 The VAT implications for each of the of the options for use of capital assets by the host partner in providing the delegated services, set out in section 6, need to be considered by partners.

5.3 VAT Worked Examples

Worked Example (1)

Local Authority acting as Lead Agency.

HM Health Board delegates £ 220,565,924 to ABC Council.

Step 1

LA will automatically recover all VAT (s33).

Identify the amount of net expenditure related to the delegated services.

Analysis of Expenditure by HMHB Subject to VAT	£
Care Expenditure	361,763
Equipment	3,505,824
Goods, consumable etc	670,898
Professional Fees	3,848,626
Other Services	126,777
Property Costs	158,829
Repair and Maintenance	39,680
Staff Costs	5,697,615
Transport/ Travel Costs	434,613
Utilities	1,511,798
Total	<u><u>16,356,423</u></u>

Step 2

Analyse the total expenditure in step 1.

Value of expenditure	£
Total Expenditure by HMHB	220,565,924
Expenditure which qualifies as eligible services for COS	6,546,948

Non-Cos expenditure on which VAT is incurred 9,809,475

Step 3

Calculate non COS expenditure on which VAT is incurred as a percentage of the total budget which has been delegated between the partners in respect of the services to be provided.

i.e.

$$\frac{\text{Non-Cos expenditure on which VAT is incurred}}{\text{Total delegated Health Budget}}$$

Calculation :

$$\frac{\text{£ } 9,809,475}{220,565,924} = 4.45\%$$

Step 4 (on a monthly basis)

Using the calculated percentage of 4.45%, determine the amount to be included in the monthly memorandum credit. To do this, calculate:

$$4.45\% * \text{£}220,565,924/12 \text{ (budget transferred on a monthly basis)}$$
$$= \text{£ } 817,931$$

VAT should then be charged at the standard rate, multiply the amount by 20%

$$\text{£}817,931 * 20\% = \text{£}163,586$$

Step 5

Finally a VAT credit note should be raised stating this amount (£163,586) by Local Authority to the NHS board.

The LA should adjust its VAT recovery or not deduct this VAT on its VAT return.

The effect of this procedure should ensure that both parties are put in the same position from a VAT perspective as they would have been if they had provided the services directly, thereby regularising the VAT position.

Worked Example (2)

NHS Board acting as Lead Agent

ABC Council delegates £65,000,000 to HMHB.

Step 1

Identify the amount of net expenditure related to the delegated services.

Analysis of Expenditure Subject to VAT	£
Expenditure recoverable under COS	2,486,465
Expenditure irrecoverable under COS	3,299,545
Total	<u><u>5,786,010</u></u>

Step 2

Analyse the total expenditure in step 1.

Value of expenditure	£
Local Authority social care budget transferred to NHS	65,000,000
Expenditure which qualifies as eligible services for COS	2,486,465
Non-COS expenditure on which VAT is incurred	3,299,545

Step 3

Calculate as a percentage of the total budget which has been delegated between the partners in respect of the services to be provided.

i.e.

Non-COS expenditure on which VAT is incurred	
<hr/>	
Total Health and Social Care budget delegated	

Calculation:
$$\frac{3,299,545}{65,000,000} = 5.07\%$$

Step 4 (on a monthly basis)

Using the calculated percentage of 5.07%, you can determine the amount to be included in the monthly memorandum invoice.

To do this, you would calculate:

$$\mathbf{5.07\% * \pounds 65,000,000/12 \text{ (budget transferred on a monthly basis)}} \\ \mathbf{= 274,625}$$

VAT should then be charged at the standard rate. Multiply the amount by 20%.

$$\mathbf{\pounds 274,625 * 20\% = \pounds 54,925}$$

Step 5

Finally a monthly memorandum should be issued stating this amount (£54,925) by the NHS Board to the Local Authority in order to account for the local Authority to recover this VAT.

The NHS Board does not have to account for this VAT to HMRC.

The effect of this procedure should ensure that both parties are put in the same position from a VAT perspective as they would have been if they had provided the services directly, thereby regularising the VAT position.

6 Capital and asset management

- 6.0.1 The capital assets owned (or leased) by the delegating partner will be used to provide the integrated services together with the host partner's capital assets.

6.1 Capital funding, budgets and allocations

What funding will be available for future capital investments?

- 6.1.1 The two partners will continue to provide the funding for capital assets, either through capital expenditure or from revenue. This will be funded from a number of sources. The main source of funding for a Health Board will be the annual capital grant allocation from the Scottish Government Health Directorate, while the majority of capital investment required by a Local Authority will be met by additional borrowing under the Prudential Code to supplement the general block capital grant from the Scottish Government.

What is the process for approval of capital investment required to deliver the Strategic Plan?

- 6.1.2 It is recommended that the investment needed to deliver the Strategic Plan is included as part of the host partner's capital plan. If funding is required from the delegating partner the Chief Executive of the host partner should prepare a business case as required by the delegating partner.
- 6.1.3 In developing the Strategic Plan the Chief Executive of the host partner should consider CIPFA guidance²⁶ on place-based asset management and a "one public estate" model of delivery.
- 6.1.4 The Local Authority, Health Board and Scottish Government Health Directorate will continue to approve their own capital budgets and approve capital projects.
- 6.1.5 For health capital investment the Scottish Capital Investment Manual must be followed²⁷.

6.2 Use of assets

Will the delegating partner transfer assets to the host partner?

- 6.2.0.1 In delivering the integrated services the host partner will require the use of non-current assets owned or leased by the delegating partner to deliver the outcomes specified in the Strategic Plan. A number of options are available to the partners to facilitate the use of resources.

²⁶ One public estate – Getting more from less public sector property using place-based asset management, CIPFA, 2011

www.cipfaproperty.net/fileupload/upload/one%20public%20estate_v2112201111519.pdf

²⁷ The use of SCIM in respect of all infrastructure investment by NHSScotland bodies is mandated through NHS CEL Q9 (2009).

6.2.0.2 Where assets being considered for transfer are subject to PFI/PPP arrangements, it is recommended that professional advice is sought on a scheme by scheme basis as VAT will be chargeable on the regular facilities/unitary charge and it is important that this is recovered as it could be significant.

6.2.1 Host partner purchases asset from delegating partner (Health Board is the host partner)

6.2.1.1 The Local Authority transfers, at market value, or at a value which is determined to be best value, assets to the Health Board. The assets transferred may include residential care homes and day centres.

6.2.1.2 The sale of relevant residential property (RRP) is likely to be exempt for VAT purposes or potentially zero-rated, so VAT will not be due on the supply. If the supply is exempt then there may be a “claw-back” of VAT previously recovered required by the Local Authority. This is a complex area and the VAT treatment will depend on certain factors as outlined below:

- Was VAT incurred on the initial construction?
- Was the use certified as RRP by the local authority?
- When was the RRP completed?
- Was the use all Local Authority non-business use or is there an element of business activity use, e.g. private charges?
- Is the RRP property more than 10 years old as this is important to establish if there is a self-supply?

6.2.1.3 Each case should be considered individually and advice sought if necessary.

6.2.1.4 Typically the sale of day care centres will also be exempt for VAT purposes unless the Local Authority has made an Option To Tax (OTT) in respect of the property. Where the supply is exempt the Local Authority will need to consider the impact on its VAT recovery position.

6.2.1.5 Where the Local Authority has made an OTT on relevant property then VAT will be due on the supply and the Health Board is unlikely to be able to recover this VAT under contracted out services (COS). The main benefit to the Local Authority of making a taxable supply of the property is that there will be no “claw-back” of VAT previously recovered. However Local Authorities enjoy a very favourable partial exemption position and each case should be looked at individually to establish if an OTT is required to protect the Local Authorities VAT recovery.

6.2.1.6 The freehold sale of new non-residential property (e.g. less than 3 years old) is mandatorily standard-rated irrespective of an OTT having been made. This must be considered if property is being sold to the Health Board.

6.2.1.7 The Health Board has two options to fund the capital purchase:

- From its annual capital allocation, but this may be fully committed and the overall funding is capped; or
- With a capital grant received from the Local Authority. It may be possible for the Local Authority to provide a capital grant from recycling the capital receipt from the sale. However, the value of the available grant may be reduced due to irrecoverable VAT on the sale and repayment of borrowings on the asset, and therefore there may be insufficient capital grant available to cover the cost of purchase of the asset.

6.2.1.8 In addition an annual depreciation charge would be incurred by the Health Board, resulting in an additional burden to the Integration Budget. The Local Authority does not have a budget for depreciation due to the accounting treatment prescribed in the statutory mitigation for capital accounting which could meet this annual cost.

6.2.1.9 Therefore, the purchase of assets from the Local Authority is likely to result in a significant capital shortfall and recurring unfunded revenue cost making the arrangement financially unviable.

6.2.2 Host partner purchases asset from delegating partner (Local Authority is the host partner)

6.2.2.1 It is mandatory for a Health Board to ensure the disposal of assets at market value. Therefore the Local Authority would require capital funding to purchase the asset. Examples of the type of assets which may transfer from a Health Board to a Local Authority include community hospitals and specialist equipment.

6.2.2.2 There are two options for capital funding for the Local Authority:

- **Loan funding:** Any borrowing undertaken by the Local Authority is subject to the conditions specified in the Prudential regime. In this case it would require the Local Authority to evidence that the it is financially viable for the additional borrowing to be funded from savings delivered by the new integration proposals and the Health Board would require to vire to the Local Authority the savings from transferring the assets so that they could be used to meet the additional borrowing costs. Alternatively the loan charges may be funded by transfer of the depreciation budget associated with the transferred asset. However, the depreciation budget is “ring fenced” within the Health Board and is not available to be transferred.
- **Capital grant from the Health Board:** The Health Board may be able to provide a capital grant from the proceeds of the sale to meet the purchase cost of the asset by the Local Authority. However, capital grants cannot be guaranteed by a Health Board as the current policy by the Scottish Government Health Directorate (SGHD) is that capital

receipts will accrue to the SGHD to support overall capital program priorities. Unless this policy is changed it is unlikely that a capital grant would be approved for this purpose.

6.2.2.3 Therefore, it is unlikely that a Local Authority would be able to develop a viable case under the regulations using either of these funding methods for the purchase of assets from a Health Board.

6.2.2.4 Typically the sale of any property asset by a Health Board will be a business activity and potentially subject to VAT. It is not envisaged that the Local Authority will suffer this VAT as a cost, however the use of the property will need to be considered in detail. If the use by the Local Authority is non-business then any VAT incurred on the supply from the Health Board would be recoverable under Section 33, VAT Act 1994.

6.2.2.5 Typically it will be advantageous for the Health Board to make a supply subject to VAT and this is achieved by making an option to tax on the relevant property. The option to tax is disregarded on certain types of property, e.g. residential. Advice should be sought when considering making the option to tax to establish if it is valid.

6.2.3 Host partner leases asset from the delegating partner

6.2.3.1 It is possible for a host partner to enter into an operating lease arrangement for the use of non-current assets. The income and expenditure associated with the operating lease in the partner authorities should be adjusted through the partner contributions to the Integrated Budget.

6.2.3.2 Where the leasing arrangement is considered to be a finance lease the asset would need to be capitalised and the financial implications for the partners are similar to out-right purchase of the asset. Therefore, in entering into the leasing arrangement consideration should be given to the main terms which determine whether the lease is a finance or operating lease. For example:

- Does the lease transfer ownership to the lessee by the end of the lease term?
- Does the lessee have the option to purchase the asset at a price that is expected to be significantly lower than the fair value at the end of the lease term?
- Is the lease term for the major part of the economic life of the asset?
- Does the present value of the minimum lease payments amount to substantially all the fair value of the asset?
- Are the leased assets so specialised that the lessee is the only user without major modification, but not so specialised that other bodies cannot use them?

6.2.3.3 Each arrangement should be assessed on its own merit and agreement reached with the partners and the external auditors on the accounting treatment under IAS17.

6.2.3.4 From a VAT perspective the individual lease arrangements should be considered in each scenario. The VAT treatment may differ where there is a supply of property, for example where there is a lease of a RRP property HMRC tend to view a lease as not triggering a self-supply charge, whereas an outright sale of property is likely to do so. Non-residential property leases would be exempt unless the property was subject to an option to tax (which would make the supply taxable at the standard rate).

What are the financial implications if the lease is a finance lease?

6.2.3.5 Where the host partner is the Local Authority the financial impact is minimal. The accounting treatment for a finance lease would have a similar impact as purchasing the asset. A Local Authority would have the value of the asset in the balance sheet with additional depreciation charges incurred annually. However, statutory mitigation would be available to offset any implications.

6.2.3.6 The leased property will appear as an asset within the Local Authority balance sheet and a corresponding liability will be recognised in respect of the minimum lease payments due over the term of the lease. The property will be subject to revaluation and impairments tests, and a corresponding depreciation charge will be calculated annually; however statutory mitigation ensures that revaluation and/or impairment losses, together with the annual depreciation charge are reversed through the Movement in Reserves and do not impact upon the taxpayer.

6.2.3.7 The Health Board will derecognise the asset in its balance sheet and instead recognise a long term debtor in respect of the minimum lease payments (the principal element of which will be treated as a capital receipt.)

6.2.3.8 Where the Health Board is the host partner the capital cost of the leased assets are charged against their annual capital resource limit, which may be fully committed. As the Local Authority has not sold the asset there is no capital receipt available to provide the funding for a capital grant to the Health Board. In addition an annual depreciation charge would be incurred by the Health Board, which cannot be funded by the Local Authority as a consequence of the statutory mitigation for capital explained in 6.2.2. Therefore, a finance lease where the host partner is a health board is likely to result in unfunded capital and recurring revenue cost for the health board.

What are the financial implications for an operating lease?

6.2.3.9 Where the Local Authority is the host partner there are no net financial implications. The cost of the lease payments should be adjusted through the partner contributions to the Integrated Budget. The VAT charge can be recovered by the Local Authority.

6.2.3.10 Where the Health Board is the host partner, similarly the cost of the lease payments can be adjusted through the partner contributions to the Integrated Budget. However, the VAT element cannot be recovered by the Health Board and would not be offset in the adjustment to contributions to the Integrated Budget.

Can the lease charge be a nominal sum?

6.2.3.11 This depends on the host authority. A Local Authority is permitted to charge peppercorn rents, but a Health Board is not permitted to enter into concessionary leases with a Local Authority²⁸.

6.2.3.12 Where the Local Authority does grant an interest in property to the Health Board and this is for a “peppercorn” rental this is regarded by HMRC as a “non-business” supply and the Local Authority is not required to account for VAT on the transaction but is still entitled to full VAT recovery on any associated costs. It is common in this sector, because of this position, for a Local authority to grant an interest in property for a “peppercorn” as it will always allow full VAT recovery on any property related costs.

6.2.3.13 For VAT recovery to be allowed the expenditure on the property must be incurred by the Local Authority and this might realistically mean that the transfer of delegated budget is reassessed to leave a proportion with the Local Authority to cover any property expenditure.

6.2.4 Partners agree a right of access or service level agreement

6.2.4.1 The host partner may enter into a service level agreement (SLA) which specifies the right of access to use the assets owned or leased by the delegating partner for the delivery of the services specified in the Strategic Plan. The ownership rights and control of the long term future of the assets remain with the delegating authority. The agreement should cover the right to use the assets and services relating to its operation e.g. maintenance, utilities, etc. and include the costs for these. The agreement should be prepared with relevant professional advice and the interpretation of leasing arrangements given in IFRIC 4²⁹. A SLA is not a lease and is not subject to the accounting treatment specified under IAS 19.

6.2.4.2 The costs resulting from the SLA should be adjusted through the partner contributions to the Integrated Budget.

6.2.4.3 Typically an SLA can give a variety of rights as part of the agreement. This can include a right over property and the VAT implications are outlined above.

²⁸ NHS Scotland Property Transactions Handbook, 2011
www.pcpd.scot.nhs.uk/PropTrans/PTHome.htm

²⁹ IFRIC 4 Determining whether an arrangement contains a lease, International Accounting Standards Board, December 2004

6.2.4.4 Alternatively an SLA can give the “customer” certain rights to operate that fall short of any interest in land and in the circumstances such a supply would be subject to VAT at the standard rate of VAT as the supply tends to be categorised as a supply of facilities services. HMRC do look closely at this sort of structure to ensure the nature of the supply is correctly categorised and treated as a right over land or not. Care should be taken when drafting the SLA to ensure the legal position is accurately reflected. For these SLAs where there is no interest in land:

- Where the Health Board is the host partner with an SLA for use of Local Authority property, and VAT is charged to the Health Board, then there could be scope to recover the VAT under Section 41, VA94 if the costs are able to be treated as contracted out services.
- Where the Local Authority is the host with an SLA for use of a Health Board property then VAT recovery will be determined by Section 33, VA94 and it is likely to be recoverable.

What is the preferred option for the use of assets?

6.2.4.5 Where the Local Authority is the host partner a service level agreement or operating leasing arrangements result in minimal financial impact.

6.2.4.6 Where the Health Board is the host partner the preferred option is the service level agreement specifying the right of use.

What are the implications of future proposals to the accounting treatment of leases?

6.2.4.7 The ISA consulting further on its approach for the treatment of leases (IASB ED/2013/6/Leases). It outlines proposals for the recognition of a liability and a right of use asset for all leases dependant on the classification. The proposals include recognition on lessee balance sheets of all leases of more than 12 months, based on discounted value of committed rental payments. This would have the impact of having all leases accounted for as financial leases, causing potential significant costs.

6.2.4.8 These changes, if approved in the future would not have a material impact on our recommendations. The proposed rental value of £1 per annum and the type of service level agreement developed would create a very low value in the local authority balance sheet, and a similar low monetary value on the partners income and expenditure account. The proposals would not be applicable for a service agreement when it does not meet the definition of a lease.

6.3 Repairs and maintenance

What property revenue costs of non-current assets will be met by the host?

- 6.3.1 The delegating partner should identify the running costs of the properties transferring as part of the payment into the Integration Budget e.g. rents, repairs and maintenance, rates, cleaning, property insurance etc.
- 6.3.2 The service agreement between the partners should determine the costs to be met by the host and the delegating partners. Revenue property costs which are deemed landlord costs will remain with the delegating partner. Revenue costs of the host should be met from the Integrated Budget.

6.4 Due diligence

- 6.4.1 The Health Board and Local Authority should undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan. This will allow the partners to identify non-current assets within localities and their revenue and future capital liabilities.
- 6.4.2 Due diligence should also be carried out in respect of current asset balances, e.g. for client and patients funds and petty cash.

7 Accounting standards

7.1 Scope

- 7.1.1 The partner authorities will continue to use the existing guidance for the preparation of their financial statements. However, depending whether the lead authority is the Local Authority or the Health Board certain accounting treatments may lead to issues under the integration arrangements. The main areas where this is an issue is the in availability of certain budgets for transfer as result of the statutory mitigation available to Local Authorities. Guidance has been prepared to address these issues.

What is a statutory mitigation?

- 7.1.2 A statutory mitigation will determine the accounting treatment for specified transactions or types of transactions undertaken by Local Authority and is issued as statutory guidance by Scottish Ministers. Such guidance is issued where the accounting practice under the Code of Practice has been determined to result in an improper charge against the general fund in the Local Authority financial statements and thus has a consequential impact on the funding available for the provision of local services. The statutory mitigation reverses the financial impact on the general fund. E.g. the impact of IAS19.

What is the impact on the Integration Authority?

- 7.1.3 The statutory mitigation affects the budget which is available to the Local Authority to transfer to the Health Board under the integration arrangements. Therefore, there is a risk that an asset or liability which is planned to be transferred does not have full budget cover.

What other differences may have an impact on the Integration Authority?

- 7.1.4 The treatment and funding of the respective public sector pension schemes and the budget arrangements for capital and depreciation.

Which areas are affected?

- 7.1.5 The areas where this may be an issue for the Integration Authority are capital and depreciation, and employee benefits including pensions, holiday and flexi leave.

7.2 IAS 19 – Employee benefits including holiday pay and flexi leave

- 7.2.1 IAS19 requires employee benefits, including untaken annual and flexi leave, to be valued and accrued at the year end. Health Boards and Local Authorities apply this policy, but Local Authorities have a statutory mitigation. This directs the Local Authority to reverse the accrual included in the in Comprehensive Income and Expenditure Statement through the unusable reserves, which means that there is no requirement to fund the accrual by the Local Authority.

Why is this an issue?

- 7.2.2 Under the provisions of the legislation the employee liability for untaken annual and flexi leave will transfer with staff under the integration arrangement (**Section 21**). Staff transferring from the Health Board to the Local Authority may have accrued annual and flexi leave which is accrued in the Local Authority accounts but subsequently reversed under the statutory mitigation for funding purposes. The statutory mitigation for Local Authority means that the funding for the liability is not required under the integration arrangements.
- 7.2.3 Where staff transfer from the Local Authority to the Health Board the reverse position arises and there is a one-off budget requirement to meet the accrued employee benefit costs which is unfunded in the Local Authority.

When staff transfer from the Local Authority to the Health Board will there be additional funding made available to meet the liability in the first year?

- 7.2.4 There is no specific provision in the financial memorandum to provide additional funding for the cost of the employee benefits. The cost of the accrual should be considered as part of the implementation budget of the Integration Authority, noting that there is no material recurring impact.

Who will benefit from the additional funding when staff transfer from the Health Board to the Local Authority?

- 7.2.5 The funding made available from the accounting treatment should be considered as part of the overall budget requirements for the Integration Authority, noting that there is no material recurring impact.

Is there any action which should be undertaken now?

- 7.2.6 The budget implications for transferred staff should be part of the wider planning for integration³⁰. This should include consideration of how to make effective use within the Integration Authority of the one-off funding available by the integration arrangements and mitigation of potential additional costs. Therefore, it is recommended that there is an early assessment of the potential budget commitment/gain and its constituent parts. This may include:
- Impact of the timing of different leave years;
 - Levels of outstanding holiday pay; and
 - Levels of outstanding flexi leave

³⁰ Workforce implications for integration are being considered by the HR Working Group on Integration.

and a review of specific actions which may be taken to reduce the liability including:

- Potential to align leave years to 31 March; and
- Management of annual and flexi leave levels within existing policies and guidelines.

7.3 IAS 19 – Pension accounting

7.3.1 IAS19 specifies the reporting requirements of defined benefit and defined contribution pension schemes. Local Authorities and Health Boards both apply this standard but are subject to public sector adaptations which are different for each authority. The relevant adaptations for Health Boards^{31 32} are:

- NHS Superannuation Scheme - a defined benefit scheme (final salary, multi-employer, unfunded scheme) is to be treated as a defined contribution scheme;
- The period between actuarial valuations is four years with estimations made in the intervening period for the calculation of defined benefit obligations and the fair value of the assets;
- Funded schemes should use a discount rate in accordance with IAS19 advised by the scheme actuary; and
- Where the Health Board has a share of a local government (or other) pension scheme liability on its statement of financial position, that that entity will use a discount rate determined by the appropriate authority in valuing its share and not the rate advised annually by HM Treasury.

7.3.2 Local Authority apply IAS19 in full but have a statutory mitigation which directs the Local Authority to reverse the IAS19 pension charges against the general fund through the unusable reserves. The actual cost of the pension contributions is charged against the balance required to be funded by the Local Authority. Similarly there is a statutory adjustment for the share of the scheme historic funding deficit.

³¹ NHS Scotland Unified Board Accounts Manual issued by Scottish Government Health Directorate. www.isdscotland.org/Health-Topics/Finance

³² Government Financial Reporting Manual 2013 to 2014, HM Treasury www.gov.uk/government/publications/government-financial-reporting-manual

What are the IAS19 implications for pension accounting when staff transfer?

7.3.3 The accounting treatment and associated financial implications of the pension arrangements of staff transferring under integration is dependent on the transfer terms and conditions agreed e.g. TUPE. Three possible options for the pension arrangements on staff transfer have been considered. These are:

- Staff remain in their existing pension scheme **(A)**;
- Staff transfer to the host partner scheme **(B)**; and
- Staff freeze their pension rights in their existing scheme to the date of transfer and then join the new employee partner scheme **(C)**

7.3.4 However, options **(B)** and **(C)** may not meet the requirements for TUPE and/or be approved by Government Actuaries Department (GAD). Current advice from Scottish Public Pensions Agency is that options **(B)** and **(C)** are unlikely to meet the comparability test without additional budget to protect existing accrued pension rights and may require legislative change to implement.

7.3.5 It is not recommended that options **(B)** and **(C)** are used for staff transfers under the integration arrangements.

7.3.6 Option **(A)** would meet the TUPE requirements and any budgetary impact may be mitigated using the accounting arrangements described below. This is the recommended option.

What is required to adopt option (A)?

7.3.7 Where NHS staff transfer to the Local Authority but remain in the NHS pension scheme, partners need to apply for a direction to allow Local Authority staff to be members of the NHS superannuation scheme. General information may be found at [here](#) and where such arrangement is being considered early discussions should be held with the authority's main contact for NHS Superannuation Scheme (Scotland) at the Scottish Public Pensions Agency.

7.3.8 Where Local Authority staff transfer to the Health Board, but wish to remain with the Local Government Pension Scheme, the Health Board should apply to be an Admitted Member of the relevant Local Authority pension scheme under the new regulations. Each scheme publishes guidance how to apply and it is recommended that early discussions are held with the pension scheme manager where this arrangement is being considered.

Are there any accounting issues when the Local Authority is the host partner?

- 7.3.9 No. The Local Authority will need to disclose its membership of the NHS superannuation scheme as a defined benefit scheme in its financial statements as permitted under the application of IAS19 for the public sector.

Are there any accounting issues when the Health Board is the host partner?

- 7.3.10 Yes. The Health Board will be required to recognise in its accounts the share of any deficit/surplus on the Local Authority pension fund that is attributable to the transferred staff and that arises after the date of transfer (**Section 21(4)**). This will be a non-recurrent provision in the first year with subsequent annual adjustments based on actuarial estimates.
- 7.3.11 The Local Authority statutory mitigation directs that the IAS19 pension charges against the general fund are reversed and charged against unusable reserves. For funding purposes the general fund is charged with the cost of the pension contributions. Consequentially there is no budget available in the Local Authority to transfer to the health board to meet the cost of the share of any deficit for the transferred staff.

What is the accounting treatment for the Health Board share of the annual valuation changes of the pension scheme?

- 7.3.12 The valuation changes from the point of transfer are accounted for by the Health Board as required under IAS19. This requires that the relevant proportion of the assets and liabilities of the scheme are included in the financial statements. The resultant asset or liability should be charged against the AME budget. This requires:
- Health Boards to bid for AME budget in November each year to cover the estimated annual year end valuation.
 - Estimates of the IAS19 valuations of the pension scheme in November each year to inform the AME bid
 - Valuations to be rolled forward to the year-end date by the actuaries to provide the figures for the Health Board accounts by 30 April each year
 - Discussion with Scottish Government health finance regarding the potential new budget requirement.
 - Disclosure in the Health Board financial statements of the pension scheme under IAS19.

What are the accounting arrangements for the historic pension deficit for transferred staff?

7.3.13 The historic pension scheme deficit liability to the date of transfer has accrued during service prior to the transfer and is a liability of the Local Authority. The Local Authority should continue to recognise the liability and related scheme assets within its financial statements on the basis that it will be met by the future actuarial approved pension contributions. This requires:

- Pension scheme actuarial valuation at the date of transfer for the relevant values at the point of transfer.
- Local Authority to pay the proportion of the pension scheme contributions for transferred staff which is attributable to the historic deficit to the point of transfer. There is no budget impact as the integration budget will only include the proportion of the pension contributions due to be paid by the Health Board.
- Actuarial advice and relevant figures for the proportion of the contributions which are related to the historic deficit.

What are the risks?

7.3.14 The main risks are:

- Insufficient budget is available to meet the liability of the historic scheme deficit relating to the pension liabilities of the transferred staff.
- Insufficient AME budget to meet the cost of the annual pension scheme valuations allocated to the Health Board.
- Scottish Government has insufficient total AME budget to meet the annual pension provision due to UK budgetary constraints.

Does IAS19 affect the arrangements for voluntary staff transfer?

7.3.15 The issue discussed above relates to the bulk transfer of staff under the integration arrangements in the legislation. The current arrangements and any associated issues for individual/voluntary staff transfers are unchanged. However, there may be further changes to the operation of the Public Service Pension Schemes following the Public Sector Pension Act including possible changes to the “fair deal” policy, operation of the public transfer club and “wider access” policies. Further specific guidance will be issued where changes will uniquely affect the integration arrangements.

7.4 Capital and depreciation

7.4.1 The integration arrangements will lead to changes in the occupation of and use of assets by the partner authorities. Guidance on asset management and the associated accounting treatment issues are in section 6.2.

7.5 Draft IFRS

7.5.1 Although guidance has been prepared based on the accounting standards and treatments which apply for accounting periods beginning after 1 January 2012, the potential implications of the adoption of new and amended accounting standards has been considered.

What new or revised financial reporting standards are expected to impact on the accounting treatment for the Integration Authority?

7.5.2 In the longer term ED/2013/6 leasing.

What will be the impact?

7.5.3 The consultation on ED/2013/6 leasing ended 13 September 2013 and until the standard is agreed the full impact cannot be assessed for the integration authorities and the public sector as a whole and as such is outwith the scope of this guidance. However, it is noted that the following matters within the proposals may impact on the future treatment of the leasing arrangements in the Integration Authority:

- The treatment of property leases (Type B leases) and their inclusion in the balance sheet as “right of use assets”; and
- The agreed treatment to be applied retrospectively.

Will new guidance be issued the following adoption of the reporting standards?

7.5.4 Additional guidance will be issued if there are specific issues to be addressed unique to the Integration Authority in the initial transitional stage. It is envisaged that guidance relating to other and future changes to the reporting standards will be through the existing arrangements.

SECTION D

LASAAC/TAG

Guidance

Source of Guidance

1. This section of guidance was drafted for IRAG approval by representatives, including Scottish Government and Audit Scotland staff, of LASAAC and TAG as the relevant accounting advisory committees for Scottish local government and the Scottish NHS respectively.

True and Fair View

2. Both the Local Authority Code of Practice and the FReM require that the financial statements provide 'a true and fair view'. This is an overriding requirement and this guidance does not abrogate that responsibility.
3. This guidance provides an indication of the anticipated principles that should apply. LASAAC and TAG may separately issue guidance, for local government and Health Boards respectively, in order to more fully inform the presentation of a true and fair view.

Materiality

4. Both the Local Authority Code of Practice and the FReM address the characteristic of materiality in relation to the annual accounts. This guidance does not prevent the application of judgement when determining materiality.

Integration Joint Board Accounts for 2015/16

5. Integration Joint Boards (IJBs) will be established during 2015/16. Some IJBs may not commence joint service delivery until 1 April 2016. It is considered that:
 - IJB annual accounts will be required for 2015/16 regardless of the date of commencement of joint service delivery. This is on the presumption that the IJB will have reportable transactions, such as operating costs, during 2015/16.
 - As local government bodies IJBs will need to comply with the Local Authority Accounts (Scotland) Regulations (SSI 2014/200; see also Local Government Finance Circular 7/2014). This includes requirements relating to internal control and governance; the submission of the annual accounts for audit; the public inspection process; provision of a Remuneration Report; the approval of the audited accounts and their publication.
 - IJB annual accounts for 2015/16 will be expected to present the partner contributions (gross), IJB operating costs and the cost of commissioned services (if any). It is anticipated, unless there are grounds for rebuttal, that IJB operating costs will include the cost of support services provided by the partners.

Arrangements for Agreeing Final Balances and Transactions

6. It is anticipated that partners will include financial information regarding the IJB in their annual accounts. Local government and Health Boards have different timetable arrangements for the closure and audit of their financial statements. Consequentially, in the interests of collaborative working, it is considered that:
- The necessary financial and non-financial information will be required by a mutually agreed date that allows Health Boards to meet their statutory obligations.
 - All the parties involved will need to ensure that arrangements are made to provide and agree this information by the agreed date. This should include the confirmation of inter-party transactions, balances and accounting treatment.
 - Undertaking this activity should be regarded as a key responsibility for all the CFOs of the relevant parties.
 - It is recommended that arrangements are implemented to review and agree balances and transactions on a regular basis during the financial year, not just at the year end.

Presumption of Applicability of IFRS 11 *Joint Arrangements*

7. It is considered that where an IJB comprises one Local Authority and one Health Board that IFRS 11 *Joint Arrangements* applies. This is based on the default presumption that the arrangement satisfies the requirement that 'joint control' exists, which is defined in IFRS 11 as:
- "The contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control."
8. The 'contractually agreed sharing of control' is presumed by default to be evidenced by the formally approved Integration Scheme and the statutory framework and responsibilities of the partners.
9. The requirement for 'unanimous' consent is presumed by default to be met if the IJB comprises one local authority and one Health Board.
10. The default presumptions are open to rebuttal. For instance if the dispute resolution procedure provides one party with an override which negates the need for unanimous consent the definition of a joint arrangement would not be met.

11. Where an IJB involves more than one local authority it is considered less likely that the 'unanimous consent' requirement would be achieved, and therefore IFRS 11 would not be expected to apply. In that event application of the normal accounting judgements regarding control, and consequently classification as a subsidiary or an associate, would be anticipated.

Presumption of 'Joint Venture' Treatment (where IFRS 11 applies)

12. IFRS 11 requires that a joint arrangement is classified as either :

- A 'Joint Operation' where "the parties that have joint control have rights to the assets, and obligations for the liabilities, relating to the arrangement"
- A 'Joint Venture': where "the parties that have control of the arrangement have rights to the net assets of the arrangement"

13. For IJBs this assessment is finely balanced. It is considered however that the presumed default classification of an IJB should be as a 'Joint Venture'³³. This is based on the following:

- There is no clear specification in the legislation as to the share of individual assets or obligations for liabilities that each partner has.
- Partners do not have an automatic right of return of unused funds (available reserves), rather the partners have 50% / 50% control over the utilisation, within the IJB remit, of any carried forward reserves.
- This suggests that the partners have control/ rights to the residual 'net assets' rather than specified rights to specific assets and obligations for liabilities.
- It is not expected that any Integration Scheme will specify partner rights to IJB assets or obligations for IJB liabilities.
- The IJB has been established as a statutory body with its own statutory responsibilities, including strategic planning, service commissioning and

³³ In this respect the IFRS11 'Basis for Conclusions' was examined. Para BC43 includes:

"The Board believes that the accounting for joint arrangements should faithfully reflect the rights and obligations that the parties have in respect of the assets and liabilities relating to the arrangement."... "the economic substance of the arrangements does not depend exclusively on whether the activities undertaken through joint arrangements are closely related to the activities undertaken by the parties on their own"... "instead the economic substance of the arrangements depends on the rights and obligations assumed by the parties when carrying out such activities. It is those rights and obligations that the accounting for joint arrangements should reflect."

service performance. Joint Venture treatment aligns the financial reporting and statutory responsibilities.

- Scottish Government legal advice is that the *proximate* statutory responsibility for service provision is vested in the IJB itself.

14. The presumed default of Joint Venture treatment may be rebutted in favour of Joint Operation treatment where this is necessary to provide a true and fair view. Where Joint Operation presentation is adopted this may potentially indicate that that the policy objectives of integration are at risk of not being achieved in the longer term.

Local Authority and Health Board Accounts

15. Joint Venture treatment of IJBs will require each partner to consolidate its interest in the IJB into group accounts. Where joint service delivery does not commence until 1 April 2016 partners may wish to consider the materiality of the consolidation in 2015/16. Relevant disclosure notes are anticipated to be required, irrespective of whether group accounts are presented.

16. IJBs are expected to be classified by the ONS as local government bodies. Consequently for Health Boards it should be noted that the interest in the IJB is expected to be ignored by the Scottish Government when the Scottish Government prepares its own consolidated annual accounts i.e. only the parent 'single entity' health board is expected to be consolidated by the Scottish Government.

17. It is considered that in adopting a Joint Venture treatment the IJB should be regarded as acting as principal in its own right. This implies that the 'gross expenditure' of each parent (i.e. in the local authority and health board 'single entity' accounts) will be affected. This is because the two primary transactions with the IJB (1. Partner contribution to the IJB and 2. IJB commissioning of services from the partner) are regarded as distinct and separate transactions.

18. The parent Comprehensive Income and Expenditure Statement / Statement of Comprehensive Net Expenditure would therefore be anticipated to include:

	£m
Contributions to IJB (incl set aside)	a.aaa
Expenditure on IJB Services (as commissioned by IJB)	b.bbb
Gross Expenditure	c.ccc
Income from IJB for Commissioned Services (incl set aside resources)	(d.ddd)
Gross Income	(d.ddd)
Net Expenditure	e.eee

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19. This change in the trend analysis for the gross expenditure of each parent partner will require clear explanation and attention to presentation in each partner's financial statements. It is anticipated that LASAAC and TAG will, either separately or jointly, provide further guidance in this respect.

SECTION E

Future Developments and where to get Help

E FUTURE DEVELOPMENTS AND WHERE TO GET HELP

1 Help with Strategic planning data sets

To support the development of Locality and Strategic Planning competencies, The Scottish Government has established a programme to:

- Improve the data and information available to partnerships; and
- Develop the analytical capacity and skills available to partnerships.

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2 Finance Learning and development

A programme for finance team development will be taken forward by NHS Education for Scotland and CIPFA, in collaboration with colleagues from The Scottish Government. Its objective is to increase awareness of the transformation agenda and provide opportunities for practitioners to access professional development networks with the aim of learn from each other and share good practice

Further information will be available from elaine.lawther@nes.scot.nhs.uk and paul.leak@scotland.gsi.gov.uk

3 Capital planning

Hub Initiative – contact the Scottish Futures Trust
www.scottishfuturestrust.org.uk

CIPFA

Scottish Government Health Finance Directorate

Health and social care circulars and guidance for capital planning and investment at www.pcdc.scot.nhs.uk/Capital/Gidance.html

Scottish Capital Investment manual www.scim.scot.nhs.uk/

4 Implementation support

An online tool for integration finance leads has been set up to allow sharing integration materials and access SG information. All NHS Boards and Local Authorities should be able to access this facility without any difficulty or IT security blocks. For access to the facility, contact Ruksana.Sarwar@scotland.gsi.gov.uk

5 Help with CNORIS for integration

Contact:

Stuart Aitken: stuart.aitken@scotland.gsi.gov.uk

SECTION F

Summary of Substantive Changes from First Version

F SUMMARY OF SUBSTANTIVE CHANGES FROM FIRST VERSION

The key changes to the first version of IRAG Guidance are as follows:

Section A Executive Summary

Section 2.2.4: amended to include reference to the Annual Governance Statement.

Section 2.3.3: amended to emphasise the need for due diligence.

Section 3.4: amended to include reference to VAT worked examples.

Section A Introduction

A3 Status

Sections 3.01 & 3.02: amended to clarify statutory guidance.

Section B Integration Joint Board

B1 Introduction

Sections 1.1.1 & 1.1.4-1.1.6: to include a section on the Annual Financial Statement and finance provisions of the Annual Performance Report.

B2 Assurance and Governance.

Sections 2.2.3: the risk management section updated to reflect regulations.

Section 2.3.2: update to the insurance section.

Section 2.7.2 amended to clarify the “following the public pound”.

Section 2.4.2.1, 2.4.4, 2.4.5, 2.4.6 and 2.4.11: amended to reflect advice from Scottish Local Authority Chief Internal Auditors Group (SLACIAG) on the internal audit arrangements..

B3 Financial reporting

Sections 3.1.1.5-3.1.1.8: amended to include detail on the Accounts Timetable.

Section 3.1.1.9: to amended to note that future guidance on the management commentary may be issued by Local Government finance in SG.

Section 3.1.1.15: amended to note that advice on the financial statements may be issued by LASAAC in due course.

Sections 3.1.1.16-3.1.1.18: amended to clarify the requirement for accounts in the first year.

Sections 3.1.2.1-3.1.2.5: guidance on reporting in the Health Board and Local Authority accounts amended to reflect advice from a short life working group drawn from Local Authority Accounts Scotland Advisory Committee (LASAAC) and NHS Technical Accounting group (TAG) (included in full at Section D).

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Sections 3.1.2.6-3.1.2.9: guidance on group accounts amended to reflect advice from LASAAC/TAG short life working group.

Sections 3.3.1 & 3.3.2: guidance on Whole of Government accounts updated for provisional classification.

B4 Financial planning and management

Sections 4.2.3-4.2.6: guidance on determining the initial payment amended to include material from, and reference, the financial assurance guidance.

Section 4.4: this whole section has been replaced by material from the “financial planning for large hospitals” joint guidance.

B5 VAT

Section 5.1.2: amended to include VAT treatment in cases where the Integration Joint Board directs the Health Board to provide social care services; and vice versa for the Local Authority.

Sections 5.1.5-5.1.7: updated to reflect agreement with HMRC on VAT treatment of Integration Joint Board if it is empowered to provide services.

Section 5.2: a new section with advice for VAT treatment of support services provided to the Integration joint Board.

Section 5.3.2: updated to include VAT treatment on capital expenditure should Integration Joint Board be empowered to provide services.

B7 Accounting Standards

Sections 7.1 & 7.2 amended to update the position on Accounting Standards.

Section C Lead Agency

C1 Introduction

Section 1.01 and 1.02: amended to reflect the role of the Integration Joint Monitoring Committee.

Sections 1.11-1.115: amended to include a section on the Annual Financial Statement and finance provisions of the Annual Performance Report.

Section 1.3.0.1 amended to clarify host partner role in financial governance.

C2 Assurance and Governance.

Section 2.1.1.4: amended to reflect regulations on membership of the Integration Joint Monitoring Committee.

Section 2.2.3 risk management section update to reflect regulations.

Sections 2.3.1, 2.3.2 & 2.3.4: amended to update the Insurance section.

Section 2.4.1: amended to clarify the role of host partner internal audit arrangements for delegated resources.

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C4 Financial planning and management

Section 4.1.1: amended to refer to Strategic Planning guidance.

Section 4.2.2: amended to clarify that hospital services are conjunction functions where the Health Board is the host partner.

Sections 4.2.3-4.2.6: guidance on determining the initial payment amended to include material from, and to reference, the financial assurance guidance.

Section 4.4: this whole section has been replaced by material from the “financial planning for large hospitals” joint guidance.

C5 VAT

Sections 5.1.0.1-5.1.0.3: amended to clarify final agreement with HMRC on VAT treatment for lead agency arrangements, including worked examples.

Sections 5.1.1.7 and 5.1.1.8: updated to include final agreement with HMRC for the VAT treatment where the Local Authority is the host partner.

Section 5.3: a new section with worked examples for the lead agency VAT treatment.

Section D LASAAC/TAG guidance

To include advice in full.

Section E Where to get help

Section 1: updated for HSCDIIP contacts.

Section 2: amended for contact details for finance team learning and development.

Section 4: amended to include details of on-line facility for integration finance leads.

SECTION G

Acknowledgements

G ACKNOWLEDGEMENTS

The Scottish Government would like to thank members of the Integrated Resources Advisory Group (IRAG), the five finance workstreams and members of the TAG/LASAAC short life working group, for their input and advice throughout the preparation of the professional guidance.

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SECTION H

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This publication is available at www.scotland.gov.uk

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The Scottish Government
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ISBN: 978-1-78544-334-3 (web only)

Published by The Scottish Government, May 2015

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS49399 (05/15)