Bevan Brittan

Dated: XXX day of March 2015

Hillingdon London Borough Council

and

NHS Hillingdon

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES UNDER THE BETTER CARE FUND

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THIS AGREEMENT is made on day of March 2015

PARTIES

(1) **Hillingdon London Borough Council** of Civic Centre, High Street, Uxbridge UB8 1UW (the **"Council"**)

(2) **NHS Hillingdon** (the "**CCG**") of 2nd Floor, Boundary House, Cricketfield Road, Uxbridge, UB8 IQC

BACKGROUND

(A) The Council is a Local Authority established under the London Government Act 1963 (as amended) and by virtue of Part 1 of the Care Act 2014 the Council is responsible for ensuring access to, commissioning and/or providing social care services on behalf of the population of the London borough of Hillingdon.

(B) The CCG is established under Chapter A2 of Part 2 of the National Health Service Act 2006 as amended by section 25(1) of the Health and Social Care Act 2012 and is responsible for commissioning services to meet the health needs of persons who are patients of the providers of primary medical services in the London borough of Hillingdon.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services. It is also means through which the Partners wish to pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services;

d) to provide the Partners with the experience of developing a much closer working relationship that will engender a trusting and confident relationship between the Partners to create a platform for increased ambition and expectation from the BCF Plan in 2016/17; and

e) The following aims and objectives have been agreed with service users and stakeholders:

I. We will build on our present initiatives around admissions avoidance and supported discharge;
II. Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and social care;
III. Residents will be able to access the services appropriate to their needs on each day of the week;
IV. Health and care providers will persist with a health and care problem until a solution is found, or another provider has taken on responsibility for finding it;
V. Our workforce will be better equipped and better skilled to face this challenge: to residents they will appear as a single system with an open culture that celebrates success;
VI. We will work together to proactively identify the health and care needs of frail older residents and will aim to manage the care needs of younger people who may be susceptible to frailty as they get older;
VII. We will aim to reduce levels of health inequalities in Hillingdon; and
VIII. We will be better at predicting future health and care needs – both across the population and for individual residents.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(I) The Council and the CCG have approved the terms and conditions of this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules, Annexes and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund (BCF) means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 5 setting out the Partners' plan for the use of the Better Care Fund.

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on the 1st April 2015.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liability *means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.*

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:
(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and
(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions set out in Schedule 2.

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which are set out in Schedule 1.

Host Partner means the Partner that will host the Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2 (1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Description and Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether

arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Better Care Fund Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in Schedule 1.

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 8.4.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the 'joint committee' established in accordance with paragraph 10 (2) of the Regulations, which will be responsible for the review of performance and oversight of this Agreement as set out in the governance arrangements in Schedule 3, where it is described as the 'Core Officer Group'.

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means the Section 151 (Local Government Act, 1972) officer of the Council, who is the Corporate Director of Finance.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SoSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

- 1 April to 30 June
- 1 July to 30 September
- 1 October to 31 December
- 1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations mean the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Description and Specification means the description of an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Description and Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SoSH means the Secretary of State for Health.

Term refers to the period of the Agreement as described in clause 2 of this Agreement.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until the 31st March 2016 or in accordance with Clause 21.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open and transparent with information about the performance and financial status of each scheme set out in Schedule 1; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish a single pooled budget.

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions as described in Schedule 2.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions as described in Schedule 2.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Description and Specification for each Individual Scheme shall be in the form set out in Schedule 1 and shall be completed and agreed between the Partners. The initial Scheme Description and Specifications are set out in Schedule 1.

5.4 The Partners shall not enter into a Scheme Description and Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to approval in accordance with the governance process set out in Schedule 3.

5.6 The table below summarises the delegation of functions described in the Individual Schemes set out in Schedule 1.

Summary of Delegated Functions	
Scheme	**Functions Delegated**
Scheme 1	None
Scheme 2	None
Scheme 3	a. Delegation to the CCG by the Council authority to undertake assessment and prescription of community equipment to meet social care needs. b. Delegation to the Council by the CCG authority to undertake assessment and prescription of community equipment to meet health needs.
Scheme 4	None
Scheme 5	a. Delegation to the CCG, or agents acting on its behalf, by the Council authority to undertake assessment and prescription of community equipment to meet social care needs. b. Delegation to the Council by the CCG authority to undertake assessment and prescription of community equipment to meet health needs.
Scheme 6	None
Scheme 7	Delegation to the Council by the CCG to provide to the CCG or agents acting on its behalf training, advice and support on Safeguarding Adults.

6 COMMISSIONING ARRANGEMENTS

6.1 For the duration of the Term each Partner shall retain Lead Commissioner responsibility for the Services within the Schemes described in Schedule 1 for which they had Lead Commissioner responsibility prior to the Commencement Date. This shall include performance management and contract monitoring of all relevant Service Contracts and payment of the Provider of a Services Contract.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Description and Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 Each Partner shall keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in the Pooled Fund.

6.5 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain a pooled fund for revenue and capital expenditure as set out in Schedule 1.

7.2 The Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Partners are to be the Providers as shall be described in Schedule 1A, the Permitted Budget;

7.3.3 Third Party Costs;

7.3.4 Approved Expenditure

This shall be "Permitted Expenditure".

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue or capital expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint the Council as Host for Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 Managing and accounting for all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 The Partners agree that the Council shall act as host for the purposes of Regulations 7(4) and 7(5) and the Council shall appoint an officer to act as the Pooled Fund Manager for the purposes of Regulation 7 (4).

8.2 The Pooled Fund Manager shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Description and Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Description and Specification;

8.2.6 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.7 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall deliver the recommendations of the Partnership Board and shall be accountable to the Partners through the Partnership Board.

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the CCG and the Council to the Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the Schedule 1.

9.2 Financial Contributions will be paid as set out in the each Scheme Description and Specification.

9.3 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

10 NON FINANCIAL CONTRIBUTIONS

10.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 4.

Overspends in Pooled Fund

11.2 For the Term of the Agreement overspends in the Pooled Fund shall be managed as set out in Schedule 4.

Underspends

11.3 For the Term of the Agreement underspends in the Pooled Fund shall be managed as set out in Schedule 4.

Benefits

11.4 In the event cash savings are delivered, these will be retained by the partner generating the said saving.

12 CAPITAL EXPENDITURE

13.1 The Pooled Fund shall not be applied towards any one-off expenditure on goods and/or services outside of the remit of Scheme 5 of Schedule 1, specifically the use of Disabled Facilities Grants and application of Social Care Capital Grant, without prior approval of the Partnership Board.

13 VAT

13.1 The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund in accordance with Section 7 of the Local Audit and Accountability Act, 2014.

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 16.2, and 163, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

15.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partner will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

17 CONFLICTS OF INTEREST

17.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 7.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established a Partnership Board to undertake responsibility for management of the pooled fund.

18.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 3.

18.4 The terms of reference of the Partnership Board shall be as set out in Schedule 3.

18.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.6 The Health and Wellbeing Board shall be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund, in accordance with the process set out in Schedule 3.

19 REVIEW

19.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 19. The annual report shall be subject to approval by the Health and Wellbeing Board.

19.3 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England, the Partners shall provide full co-operation with NHS England to agree a recovery plan.

20 COMPLAINTS

20.1 During the term of the Agreement, the Partners will explore establishing a joint complaints system. The application of a joint complaints system will be without prejudice to a complainant's right to use either of the Partners' statutory complaints procedures where applicable.

20.2 Prior to the development of a joint complaints system or after the failure or suspension of any such joint complaints system the following will apply:

20.2.1 where a complaint wholly relates to one or more of the Council's Health Related Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council;

20.2.2 where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the CCG;

20.2.3 where a complaint relates partly to one or more of the Council's Health Related Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the relevant NHS organisation, in line with local joint protocol;

20.2.4 where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Partnership Board will set up a complaints subgroup to examine the complaint and recommend remedies. All complaints shall be reported to the Partnership Board.

21 TERMINATION & DEFAULT

21.1 The termination and default provisions as set out in clauses 21.2 to 21.8 of this Agreement shall apply.

21.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Description and Specification (where applicable) provided that the Partners ensure that the Better Care Fund requirements continue to be met.

21.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach.

21.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

21.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

21.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.6.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

21.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

22.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

22.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.3 If the dispute remains after the meeting detailed in Clause 22.2 has taken place, the matter shall be referred in writing to the Chairman of the CCG Board and the Leader of the Council in his capacity as chairman of the Health and Wellbeing Board. The Chairman of the CCG Board and the Leader of the Council shall meet within fourteen (14) days of the date of the referral for the purpose of resolving the dispute.

22.4 The decision of the Chairman of the CCG Board and the Leader of the Council as described in clause 22.3 shall be final and binding on both Partners.

22.5 Nothing in the procedure set out in this Clause 22 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

23.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser’s prior written consent provided that:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

24.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24;

24.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

24.4 Information provided in accordance with the Partners' respective Whistleblowing Policy shall not constitute a breach of this Clause 24.

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

25.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

25.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 24 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

26 OMBUDSMEN AND INVESTIGATIONS BY REGULATORY BODIES

26.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) or any other regulatory body in connection with this Agreement.

27 INFORMATION SHARING

27.1 The Partners will follow the Information Governance Protocol set out in schedule 7, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act.

28 NOTICES

28.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in this Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

28.1.2 sent by facsimile, at the time of transmission;

28.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

28.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

28.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was

properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

28.3 The address for service of notices as referred to in Clause 28.1 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the **Corporate Director of Adult Social Care**;

Tel: 01895 250506
E.Mail: tzaman@hillingdon.gov.uk

and

28.3.2 if to the CCG, addressed to **Chief Operating Officer**;

Tel: 01895 203005
E.Mail: c.jacob@nhs.net

29 VARIATION

29.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

30 CHANGE IN LAW

30.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

30.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

30.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

31 WAIVER

31.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

32 SEVERANCE

32.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

33 ASSIGNMENT AND SUB CONTRACTING

33.1 The Partners shall not sub-contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be

unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

34 EXCLUSION OF PARTNERSHIP AND AGENCY

34.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

34.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

34.2.1 act as an agent of the other;

34.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

34.2.3 bind the other in any way.

35 THIRD PARTY RIGHTS

35.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

36 ENTIRE AGREEMENT

36.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

36.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

37 COUNTERPARTS

37.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

38 GOVERNING LAW AND JURISDICTION

38.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

38.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **THE LONDON BOROUGH COUNCIL OF HILLINGDON**)
was hereunto affixed in the presence of:)

Signed for on behalf of **HILLINGDON CLINICAL COMMISSIONING GROUP**

____

Authorised Signatory

SCHEDULE 1 – BETTER CARE FUND SCHEME DESCRIPTIONS AND SPECIFICATION

Unless the context otherwise requires, the defined terms used in this Scheme Description and Specification shall have the meanings set out in the Agreement.

Scheme 1: Proactive early identification of people with susceptibility to falls, dementia and social isolation

What is the strategic objective of this scheme?

1.1 The primary aim of the scheme will be to reduce the movement from lower tiers of risk into higher tiers of risk through education, training and early proactive identification.

Overview of the scheme

1.2 People living with dementia, people susceptible to falls and/or who are socially isolated are disproportionately represented in our non-elective admissions and admissions to long term residential care. Too many of these factors are identified when people reach a complex stage. There is a loss of opportunity in not being able to identify people with these conditions early on in their development and to intervene sooner. The potential impact on outcomes in the medium to long term could be significant.

1.3 Key initiatives include:

a) Development of frontline workforce: brief intervention training to frontline workers for them to identify people who are susceptible. For example: carers/social workers/GPs/district nursing and other staff who visit people in their own homes need to understand the key signs of when a person might be becoming socially isolated or susceptible to falling (history of recurrent falls without getting hurt) and/or dementia to *make every visit count* in the drive to prevent a loss of independence which is avoidable and in so doing reduce demand on the resources of the statutory services;

b) Supporting and developing the role of third sector providers to work with people in their own homes and communities;

c) Supporting GP Networks to increase dementia diagnosis rates;

d) Increased support to carers and caring families, including the provision of respite care and personalised support to carers. This links with scheme 7: *Care Act Implementation;*

e) Defining a system-wide response to these issues: setting out what to do when we identify people with these susceptibilities. A number of initiatives such as a centralised falls service (with multi-factorial assessment and management), assisted discharge from hospital for people who have fallen and a community based falls prevention service are operational but will be built on;

f) Building on existing partnerships between Public Health, the Library Service, the Sports and Leisure Service and the third sector to keep people active, both mentally and physically.

g) The work that has already been done in using assistive technology in the form of telecare to support older people and people living with dementia, which will be expanded further in partnership with the third sector;

h) Defining risk factors for each condition, who does it and how we respond to that.

Commissioning Arrangements

1.4 Pooled budget.

The delivery chain

1.5 The Council will be the lead for this scheme. Adult Social Care and Public Health will develop an appropriate training programme for identified staff.

1.6 The current falls specific prevention and treatment services are commissioned by the CCG and provided by CNWL, Age UK and THH.

1.7 Support for people with dementia will come from a range of providers including GP Networks, NHS community services, direct Council provision, e.g. TeleCareLine, and the third sector.

1.8 Public Health, the Library Service and Sports and Leisure Service will work in partnership with the third sector to support older residents to become or remain mentally and physically active.

Scheme Investment Total	**£180,000**
CCG Contribution	**Council Contribution**
£180,000	0

Contracts within the scheme

Contract	Provider	Value	Owner
a) Fall Prevention Service	Age UK	£130K	HCCG
b) Primary Care	GP Networks	£50k	HCCG

Impact of Scheme (success factors)

1.9 The scheme will lead to:

a) Falls treatment and prevention services continuing from 2014/15 to deliver a 10% reduction in falls related emergency admissions to acute care during 2015/16 (a reduction of 175)
b) Increase in number of referrals to voluntary and community organisations.
c) Satisfaction rates with third sector provided services.
d) Training programme evaluation
e) Increase in dementia diagnosis rates (10 more people with a dementia diagnosis)

Contribution to BCF metrics

1.10 The contribution to the metrics will be as follows:

a) Contribution to NEL (-388) metric: 175

Delegation of Functions

1.11 The functions for the Council and the CCG shall be as described in Schedule 2.

1.12 There is no delegation of functions or granting of permissions required under this scheme.
Benefits Recipients
1.13 The CCG will be the beneficiary of the reduction in emergency admissions.

Scheme 2: Better care for people at the end of their life			
What is the strategic objective of this scheme?			
2.1 To realign and better integrate the services provided to people towards the end of their life. To develop the ethos of 'a good death' for people and for their family and carers within the provision of adult services, particularly those for older people.			
Overview of the scheme			
2.2 The key components of this scheme will include: a) Shared care plans utilising Coordinate my Care (CMC) and planning for anticipated care needs involving the person at end of life, family and carers; b) Alignment of budgets and joint development of the model of care; c) Development of processes and the workforce to enable seamless care provision between health and social care staff working in partnership with the third sector, providing the necessary support to patients, their families and carers; d) Development of a fast track pathway to enable patients to achieve their preferred place of care; e) Developing access to integrated sources of information for people in hospital and in the community, including availability of psychological services and practical support post death.			
Commissioning Arrangements			
2.4 Pooled budget.			
The delivery chain			
2.5 The providers will be a combination of primary care, community NHS services, acute, social care, London Ambulance Service and voluntary and community sector providers.			
Scheme Investment Total		**£100,000**	
CCG Contribution		**Council Contribution**	
£100,000		0	
Contracts within the scheme			
Contract	**Provider**	**Value**	**Owner**
a) Community	CNWL	£100K	HCCG
Impact of scheme (success factors)			
2.6 The scheme will lead to: a) Increased coordination of care between agencies; b) Utilisation of CMC across agencies; c) 80% of people at end of life with advanced care plans on CMC. d) Establishing a baseline of people aged 65 + on CMC dying in their preferred place of care.			

Contribution to BCF Metrics

2.7 The contribution to the metrics will be as follows:

a) Service user experience: 1% increase in the number of service users who have generally found it easy to find information and advice about support services or benefits.

Delegation of Functions

2.8 The functions for the Council and the CCG shall be as described in Schedule 2.

2.9 There is no delegation of functions or granting of permissions required under this scheme.

Benefits Recipients

2.10 This scheme will not deliver cashable benefits.

Scheme 3: Rapid response and joined up intermediate care

What is the strategic objective of this scheme?

3.1 Prevention of admission to acute care following an event or exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.

Overview of the scheme

3.2 Existing crisis response services for adults (aged 18 years and above) with both health and mental health conditions are provided in the community and in-reach to the emergency department (ED) at The Hillingdon Hospital (THH). They also link with the psychiatric liaison service in the ED. The Rapid Response service provides nursing, therapeutic and care needs for up to 10 days and has a fast track referral process to the LBH to establish packages of care or reablement. For people with more severe mental health conditions, including dementia, home treatment is available for up to 14 weeks. There is also access to night carers for up to 3 nights and a service which will escort people home from the ED.

3.3 There is appropriate onward referral to community based intermediate care services for, typically, up to six weeks. The intermediate care provision is made up of community rehabilitation, reablement, community equipment, telecare services and voluntary sector providers for low social care needs.

3.4 The existing service provision remains fragmented and there is potential to improve efficiency and quality of service delivery by virtually integrating services in a new way.

3.5 It is anticipated that the majority of service users will be older people, including people with complex physical, mental health and social care needs and their carers. Services will be delivered in their usual place of residence.

Commissioning Arrangements

3.6 Pooled budget.

The delivery chain
3.7 Crisis response and home treatment services are provided by CNWL commissioned by the CCG. They link with reablement and home care which are provided and commissioned respectively, by LBH. Telecare services are also provided by LBH and the ED and home from hospital (up to 6 weeks for people with low care needs) service is jointly commissioned by the CCG and LBH, as is the community equipment provision. The night carer service is provided by Harlington Hospice and commissioned by the CCG. 3.8 The enhanced service model is in the process of being developed by a multidisciplinary and multiagency group, which is seeking to prevent admission to hospital and supporting safe discharge from acute care. The group is mainly made up of front line staff who are best placed to inform the new model of care. 3.9 There are designated project managers in THH and the CCG who lead the separate schemes and a community provider lead responsible for the combined work stream and supported by the project leads.

Scheme Investment Total	£4,785,000
CCG Contribution	**Council Contribution**
£4,099k	£686k

Contracts within the scheme

Contract	Provider	Value	Owner
Rapid Response	CNWL	£1,685k	HCCG
Hawthorn Intermediate Care Unit	CNWL	£1,346k	HCCG
Community Rehab	CNWL	£808k	HCCG
Pressure Relieving Mattresses	Talley Group Ltd	£260k	HCCG
	CCG TOTAL	**£4,099K**	
Spot purchased intermediate care beds	Various P & V providers	£341.1k	LBH
Cottesmore Reablement Flats	Paradigm Housing Group	£38k	LBH
Hospital Social Workers	LBH	£250k	LBH
Packages of Care: maintaining eligibility criteria	Various P & V providers	£56.9K	LBH
	LBH TOTAL	**£686k**	

Impact of scheme (success factors)
3.10 The scheme will lead to: a) Identification of Carers b) Carers being referred for a carer's assessment c) 50% of service users completing reablement in less than 4 weeks d) 80% of service users take up at least the minimum telecare offer e) Service users with a self-managed personal budget f) A readmission rate during a period of reablement of 19.5% or less.

Contribution to BCF Metrics
3.11 The contribution to the metrics will be as follows: a) A reduction of 1,060 non-elective admissions producing a saving of £1,580k b) Prevention of 5 permanent admissions to care homes. c) A reduction in Delayed Transfers of Care (DTOCs) by 246 days. d) 85% of people entering the reablement service still living at home 91 days after leaving the service generating an 8% improvement on the 2014/15 position. e) Impact on service user experience metric (Adult Social Care survey) f) Impact on social care-related quality of life metric (Adult Social Care survey)
Delegation of Functions
3.12 The functions of the Council and the CCG shall be as described in Schedule 2. 3.13 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, assessment of residents and prescription of equipment to meet social care need in accordance with the criteria in Annex 1. 3.14 The CCG delegates to the Council and the Council agrees to exercise, on the CCG's behalf, assessment of residents and prescription of equipment to meet health need in accordance with the criteria in Annex 1. 3.15 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, assessment of residents and prescription of minor adaptations to meet social care need in accordance with the criteria in Annex 1. 3.16 HCCG agrees that employees of the Council within the Reablement Team may make referrals to the Rapid Response Service.
Benefits Recipients
3.14 The benefit recipients of the following metrics will be as identified below: a) A reduction of 1,060 non-elective admissions producing a saving of £1,580k - **CCG** b) Prevention of 5 permanent admissions to care homes - **LBH** c) A reduction in Delayed Transfers of Care (DTOCs) by 246 days - **LBH/CCG** d) 85% of people entering the reablement service still living at home 91 days after leaving the service generating an 8% improvement on the 2014/15 position - **LBH/CCG** g) 50% of service users completing reablement in less than 4 weeks - **LBH**

Scheme 4: Seven day working initiative
What is the strategic objective of this scheme?
4.1 To improve quality and patient safety by reducing inconsistent care provision by:- a) Enabling discharge from the acute trust seven days a week. b) Enabling access to community support seven days a week thereby preventing unnecessary emergency department attendance and hospital admission

Overview of the scheme
4.2 The local Hillingdon health and care economy is working to implement the national out of hospital standards for seven day services. 4.3 The trust has established the multi-disciplinary 7-Day Working Group, which is clinically led, to deliver 7 day priorities, reporting through the 'Improving Inpatient Care' and 7 Day Executive Group' that will agree the strategic direction. 4.4 A task and finish group has been established will: a) Review what is already being done in terms of 7 day services (a Directory of Services) and what the cost would be to provide to provide remaining services on a 7–day basis if not already. b) Map what services would be available along the 'ideal' 7 day non-elective pathway c) Prioritise the commissioning/delivery of services to close identified gaps based on potential impact, achievability and cost –high priority items will be included in this year's System Resilience Plan for Winter 2014/15 d) Develop an action plan and implement 4.5 The Task and Finish Group action plan to deliver a 7-day non elective care pathway in the community to enable transfer will be aligned as part of the wider Hillingdon plan to achieve the full set of clinical standards, including the delivery of daily Consultant – led ward rounds. 4.6 The work of the Task and Finish Group will also include the development of the BCF plans related to 7-day working in social care, to align with the rest of the 7-day non- elective pathway.
Commissioning Arrangements
4.7 Pooled budget.
The delivery chain
4.8 The Task and Finish group is multi-agency in response to the system wide changes required to implement 7-day working. The group includes representation from The Hillingdon Hospital Foundation Trust, Central North West London Community Health and Mental Health Services, Hillingdon CCG, Primary Care General Practitioner, Adult Social Care and Hillingdon Voluntary Sector

Scheme Investment Total		£754,000	
CCG Contribution		**Council Contribution**	
0		£754k	
Contracts within the scheme			
Contract	**Provider**	**Value**	**Owner**
Reablement Team	LBH	£654K	LBH
Mental Health Social Workers	LBH	£100K	LBH
	TOTAL	**£754K**	

Impact of scheme (success factors)
4.9 The scheme will lead to: a) Parity in mortality rates across the week, with a whole week mortality rate to be below the London average. The baseline to be agreed in Q4 2014/15. b) The achievement of a readmission rate of 19.5% or less.

c) A reduction in the variation in service provision between weekdays and weekends.
d) Improvements in patient experience of A & E services

Contribution to BCF metrics

4.10 The contribution to the metrics will be as follows:
a) A reduction of emergency admissions equivalent to the reduction in readmissions.
b) A reduction in Delayed Transfers of Care (DTOCs) by 246 days.

Delegation of Functions

4.11 The functions of the Council and the CCG shall be as described in Schedule 2.

4.12 There are no additional functions that require delegation or permissions that need to be provided.

Benefits Recipients

4.13 The benefit recipients of the following metrics will be as identified below:
a) A reduction of emergency admissions equivalent to the reduction in readmissions - **CCG**
b) A reduction in Delayed Transfers of Care (DTOCs) by 246 days - **LBH/CCG**

Scheme 5: Review and realignment of community services to emerging GP networks

What is the strategic objective of this scheme?

5.1 To ensure that community based resources work as effectively and as efficiently as possible within primary care, for the benefit of patients.

Overview of the scheme

5.2 There has been a review and improvement in efficiency of the local community health services. More work needs to be done however, to ensure that there is the best value for money from existing services and that they are better integrated between health, social care and voluntary sector providers.

5.3 The scheme will;
a) Review current community service configuration and realign resources around the emerging GP networks.

b) Integrate teams based around primary care teams focused on older people. This will aim to streamline access to services by ensuring a co-ordinated response to needs at any point of entry into the service system with integrated service provision.

c) Develop programmes to support step down from core community services to less intensive care (care bundles).

d) Short term assessment followed by signposting to services for target groups e.g. older people and populations with highest needs. Multi-agency signposting including health, housing, social care and benefits.

e) Mainstream individual care planning and the development of personalised care planning and

patient participation with all professionals.

Commissioning Arrangements

5.4 Pooled budget.

The delivery chain

5.5 The detail of this scheme needs to be further developed but will involve primary care providers, community health services, social care and departments within the local authority such as housing and benefits, voluntary sector providers.

Scheme Investment Total		**£8,877,000**	
CCG Contribution		**Council Contribution**	
£5,605k		£3,272k	
Contracts included in scheme			
Contract	**Provider**	**Value**	**Owner**
Community Equipment (CCG)	Medequip Assistive Technology LTD	£664k	HCCG
Continence Service	CNWL	£493k	HCCG
Community Matrons	CNWL	£574k	HCCG
District Nursing	CNWL	£3,092k	HCCG
Twilight Service	CNWL	£158k	HCCG
Tissue Viability	CNWL	£531k	HCCG
Care Home Prescriber	HCCG	£30k	HCCG
Care plan coordination	GP Network	£63K	HCCG
	HCCG TOTAL	**£5,605k**	
Community Equipment (LBH)	Medequip Assistive Technology LTD	£125k	LBH
Reablement Team	LBH	£1,960k	LBH
Telecare	LBH	£682k	LBH
Packages of Care: maintaining eligibility criteria	Various P & V providers	£354.3k	
Care Home Project	LBH	£150K	LBH
	LBH TOTAL	**£3,272**	

Impact of scheme (success factors)

5.6 The scheme will lead to:

a) An increase in the number of people with long-term conditions with an active support plan.
b) People identified as a Carer being referred for a Carer's assessment.
c) Carers being sign-posted to information and advice.

Contribution to BCF metrics

5.7 The contribution to the metrics will be as follows:

a) A reduction of 102 non-elective admissions at a saving of £142,000.

Delegation of Functions

5.8 The functions of the Council and the CCG shall be as described in Schedule 2.

5.9 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, assessment of residents and prescription of equipment to meet social care need in accordance with the criteria in *Annex 1*.

5.10 The CCG delegates to the Council and the Council agrees to exercise, on the CCG's behalf, assessment of residents and prescription of equipment to meet health need in accordance with the criteria in *Annex 1*.

5.11 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, assessment of residents and prescription of minor adaptations to meet social care need in accordance with the criteria in *Annex 1*.

Benefits Recipients

5.10 The CCG will be the beneficiary of the reduction in emergency admissions.

Scheme 6: Care home initiative

What is the strategic objective of this scheme?

6.1 To support care home staff in residential and nursing care homes for older people, to improve quality in the provision of care within the homes and to enable staff to be better able to manage a health care exacerbation or crisis and to make appropriate use of local community based crisis response services.

Overview of the scheme

6.2 Key aspects of the scheme are as follows:

a) Focus on learning and development of staff within care homes through an integrated community team consisting of case managers (nurse), contracting leads, social care and care co-ordinator.

b) Support from specialist clinical staff and nursing teams as appropriate and aligned input from social care teams.

c) Support in monitoring improvements in care to people admitted to these care homes and ensure homes understand and implement robust environmental risk assessments and dignity challenge.

d) Focus on managing people optimally in care homes and reduce inappropriate emergency admissions from care homes to secondary care.

e) Establishment of an escalation process between health and social care providers and commissioners, linking with the CQC and the means of following through in relation to any incidents or concerns identified and in line with national minimum standards.

6.3 The first phase of implementation will commence in 2014/15 and will focus on care / nursing homes with the highest rates of admission with an objective to undertake risk assessments of complex care home residents, identify those patients in need of an advanced care plan, provide clinical support and training to manage conditions in the care home setting, identify the areas where staff require skills development.

Commissioning Arrangements			
6.4 Pooled budget.			
The delivery chain			
6.5 Care Home specific front line staff will be the FTE of two community matrons working within the locality teams, a FTE care home pharmacist, a FTE RMN working within the Rapid Response service also providing specific in-reach to care homes. All are commissioned by the CCG. They will link to the LBH Inspection team and social worker team. 6.6 The project will be co-ordinated by a multiagency group and project manager.			
Scheme Investment Total		**£48,000**	
CCG Contribution		**Council Contribution**	
£48k		0	
Contracts within scheme			
Contract	**Provider**	**Value**	**Owner**
Community matrons	CNWL	£48k	CCG
Impact of scheme (success factors)			
6.7 The scheme will lead to: a) Establishing a baseline for the number of 65 + population dying within first week of admission to hospital from a care home and a setting a reduction target. b) Effective engagement of care home providers. c) Increased use of advocacy where there are complaints about service provision and/or safeguarding issues.			
Contribution to BCF metrics			
6.8 The contribution to the metrics will be as follows: a) A reduction in emergency hospital admissions from the 28 nursing and residential care homes for the elderly in Hillingdon by 5%. b) 1% improvement in quality of life metric result.			
Delegation of functions			
6.9 The functions of the Council and the CCG shall be as described in Schedule 2. 6.10 There are no additional functions that require delegation or permissions that need to be provided.			
Benefits Recipients			
6.11 The CCG will be the beneficiary of reduction in emergency hospital admissions from nursing and residential care homes.			

Scheme 7: Care Act Implementation
What is the strategic objective of this scheme?
7.1 The Care Act 2014 sets out new responsibilities and duties for the Council to deliver from April 2015, including:

a) increasing preventative services;
b) developing integration and partnerships with other bodies;
c) providing quality information, advice and advocacy to residents;
d) ensuring market oversight and diversity of provision; and
e) strengthening the approach to safeguarding adults.

7.2 The objective of this scheme is to implement these aspects of the new duties, primarily in respect of carers.

Overview of the scheme

7.3 The duties set out above including prevention, integration and partnerships and adult safeguard will help to support the delivery of the vision underpinning the BCF.

7.4 The prevention duty requires the council to arrange services and take steps to prevent, reduce or delay people's need for care and support, which includes new responsibilities to strengthen the rights and recognition of carers through the following activities:

a) Improved access to information and advocacy to make it easier for carers to access support and plan for their future needs;
b) The emphasis on prevention will mean that carers should receive support early on and before reaching crisis point;
c) Access to an assessment of need;
d) Meeting needs identified as a result of an assessment as set out in a support plan.

7.5 The integration and partnership duty places a requirement on the council to collaborate and cooperate with other public authorities including a duty to promote integration with NHS and other services. The BCF provides a vehicle to help deliver this duty.

7.6 There is a new statutory framework for protecting adults from neglect and abuse, with a duty to investigate suspected abuse or neglect past or present experienced by adults still living and deceased. This will require a newly constituted Adults Safeguarding Board within which the council and the CCG will key partners.

7.7 Linked to the safeguarding duty is the new duty on local authorities regarding market shaping and promoting quality. The council and the CCG will work the third sector and other providers to develop the market to ensure that required services are available.

7.8 A new Care Governance Board has been created to coordinate the council's approach to market value and provider quality and through this scheme it is intended to include CCG representation to facilitate the more coordinated approach.

Commissioning Arrangements

7.9 Pooled budget.

The delivery chain

7.10 A workstream has been created to dovetail with the Council's project delivery team to oversee the implementation of all the duties and responsibilities under the Care Act in the timescales required.

7.11 Delivery of the assessment aspects of the Care Act responsibilities will be undertaken by the Council in partnership with the appropriate health professionals. Generic information and advice services will be provided by third sector organisations. Services to meet the assessed needs of carers (including respite services) will be provided by a combination of third sector and private

providers.

Scheme Investment Total	£838,000
CCG Contribution	**Council Contribution**
0	£838k

Contracts within the scheme

Contract	Provider	Value	Owner
Carers' assessments and review	LBH	£271k	LBH
Services to Carers (inc respite opportunities)	Spot purchased from P & V providers	£500k	LBH
ICT	Shop4Support (?)	£50k	LBH
Adult Safeguarding	LBH	£17k	LBH

Impact of scheme (success factors)

7.12 The scheme will result in the following:

a) Carers will have access to effective information, advice and advocacy services.
b) A broader range of people caring for another adult having access to a timely assessment of their health and social needs.
c) The needs of carers identified from an assessment of need will be met.
d) The care and support market will be managed to ensure that there is a range of quality providers available.
e) Statutory safeguarding arrangements to address abuse of adults will be put in place.
f) A more coordinated approach between the Council and the CCG to the management of provider quality and safeguarding adults.

BCF scheme metrics

7.13 The scheme metrics shall be as follows:

a) Improvements against the results of the 2014 Carers Survey in the following domains:
   i. *Control*: how much control the carer has over their daily life;
   ii. *Personal care*: whether the carer feels that they have enough time to look after themselves in terms of getting enough sleep and/or eating well;
   iii. *Social participation*: whether the carer feels that they have enough social contact with people they want to be with;
   iv. *Encouragement and support*: whether the carer considers that they have enough support in their caring role.

Delegation of functions

7.14 The functions of the Council and the CCG shall be as described in Schedule 2.

7.15 The Council will provide training, advice and support to the CCG on Safeguarding Adults

Benefits Recipients

7.16 The Council will benefit from compliance with legal requirements under the Act.

7.17 The Council and CCG will share benefits from more carers being supported.

ANNEX 1

ELIGIBILITY CRITERIA FOR ACCESS TO SERVICES UNDER THE EQUIPMENT LOANS SERVICE

1. The person must be deemed to be ordinarily resident in the London Borough of Hillingdon to which they have applied for assistance or, in the case of District Nurses, they are registered with a GP practice within the London Borough of Hillingdon.

And

2. The person has a permanent and substantial disability.

Or

3. The person has a medical need due to a short-term illness or long-term illness or disability where not providing equipment would place the person at critical or substantial risk or lead to Hospital admission.

Or

4. Be in the final stages of illness that will not improve significantly, or undergoing palliative care and provision of equipment will enable care to be safely managed in the home.

Or

5. If equipment is being provided for Carers to meet their assessed needs in accordance with Part 1 of the Care Act, 2014.

And

6. Meets eligibility criteria set out below.

Category 1
Critical risk to independence

- Critical – when
  - life is, or will be, threatened; and / or
  - significant health problems have developed or will develop; and / or
  - there is, or will be, little or no choice and control over vital aspects of the immediate environment; and / or
  - serious abuse or neglect has occurred or will occur; and / or
  - there is, or will be, an inability to carry out vital personal care or domestic routines; and / or
  - vital involvement in work, education or learning cannot or will not be sustained; and / or
  - vital social support systems and relationships cannot or will not be sustained; and / or
  - vital family and other social roles and responsibilities cannot or will not be undertaken.

Example situations
Older person unable to toilet independently without equipment.

Main carer for someone with high needs, who is unable to continue to provide care without provision of equipment.

An Adult with rapidly deterioration MS, cannot move in or out of bed without a hoist

A child with minimal sitting balance requiring a high level of postural support to enable toileting.

A person at high risk of skin breakdown.

Person is housebound and needs nursing care equipment.

CATEGORY 2
Substantial risk of loss of independence

- Substantial – when
    - there is, or will be, only partial choice or control over the immediate environment; and / or
    - abuse or neglect has occurred or will occur; and / or
    - there is, or will be, an inability to carry out the majority of personal care or domestic routines; and / or
    - involvement in many aspects of work, education or learning cannot or will not be sustained; and / or
    - the majority of social support systems and relationships cannot or will not be sustained; and / or
    - the majority of family and other social roles and responsibilities cannot or will not be sustained; and / or
    - the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Example situations
Older person at risk of serious self-neglect i.e. weight loss or no personal hygiene.

An adult with chronic breathing problems needing help with transfers, whose carer cannot continue support.

A child with functional difficulties or disability requiring care and equipment to maintain safety, comfort, prevents deformity and deterioration, maintaining developmental age appropriate independence wherever possible.

CATEGORY 3
Moderate risk to independence

- Moderate – when
    - there is, or will be, an inability to carry out several personal care or domestic routines; and / or
    - involvement in several aspects of work, education or learning cannot or will not be sustained; and / or
    - several social support systems and relationships cannot or will not be sustained; and / or
    - several family and other social roles and responsibilities cannot or will not be undertaken.

Example situations
Older person with increasing difficulty with meals due to arthritis such that diet is inadequate

Older person with an infection unable to carry out personal care, or other support tasks.

An adult following a stroke has difficulty on stairs and is at risk of falling.

A child with reduced mobility unable to enter the home due to stepped access.
An adult who is unsteady mobilising on their feet.

CATEGORY 4
Low risk to independence

- Low – when
    - there is, or will be, an inability to carry out one or two personal care or domestic routines; and / or
    - involvement in one or two aspects of work, education or learning cannot or will not be sustained; and / or
    - one or two social support systems and relationships cannot or will not be sustained; and / or
    - one or two family and other social roles and responsibilities cannot or will not be undertaken.

Example situations:
Person unable to carry some daily tasks due to arthritis

Older person has difficulty in using bath, but can strip wash

The Council does not meet adult needs falling within level 4 (low) except where a need falling within level 4 will become, within a very short time, level 3,2 or 1 if not met.

<u>GENERAL CONSIDERATIONS</u>

- A Therapist, Nurse or trained member of staff, as agreed by the Hillingdon local Health Trusts or the London Borough of Hillingdon, may supply equipment following an assessment.
- Where appropriate the first choice is for the disabled person is to receive rehabilitation or training in alternative techniques to carry out a daily living activity rather than rely on equipment/minor adaptation.
- Equipment/minor adaptation provision needs to follow the process mapping as for that equipment type detailed below.
- Identified equipment/minor adaptation must focus on minimising risk and enabling independence to the Service User.
- Plans must be made by the prescriber to review the equipment/minor adaptation and to ensure its safe usage.
- Staff must be aware which pieces of equipment require an annual review.
- The Service User must be informed at the time of assessment that the equipment provided through the Equipment Loan Service (excluding Minor Adaptations), is on loan for their and their carer’s exclusive use. All equipment should be looked after and used as instructed by the practitioners and information contained in manufacturers publications as provided at the time of issue.
- Managers should ensure that the equipment and services prescribed does not exceed the annual budget allocation.
- Carer’s needs should be assessed at the same time as the disabled person. Equipment may be issued with the primary aim of meeting the carer’s needs e.g. transfer belt to prevent back injury.
- Individual items can be prescribed to Service Users living in residential homes. Communal equipment and furniture will be funded by the residential home.
- Equipment is not provided to nursing homes.

Bathing Equipment

Bathing equipment provision is based on safety and need and not on preference. Following assessment, the most straight forward cost-effective solution should be recommended to meet the identified need moving through the levels of standard bath equipment, swivel bather, manual bath lift, powered bath lift, over bath shower, shower adaptation.

Beds

Ordinary domestic beds are not supplied.
The first option is to consider bed raising or bed accessories prior to the prescription of a profiling bed.
Profiling beds are supplied following assessment for persons whose bed is unsuitable due to their medical condition or disability and need for ongoing care and/or nursing needs.
Bed raising or bed accessories should be considered prior to the prescription of a profiling bed.
A risk assessment must be carried out by a qualified worker prior to issuing bed cotsides and profiling beds due to the risk of entrapment.
NB. Padded infills must be supplied with cotside provision.

Chairs

Ordinary domestic chairs are not supplied.
Following assessment, the most straight forward cost-effective solution should be recommended to meet the identified need moving through the levels of chair raise, high back chair on short term loan, footstools, riser chair, riser recliner.
Chairs must not be issued to people on the grounds of financial difficulty, comfort or poor repair.
A risk assessment must be carried out prior to issuing riser recliners due to the risk of entrapment.
A riser recliner should only be ordered for persons with reduced strength and mobility or would enable the person to become independent with transfers or carer's health is at risk due to lifting or the person needs to sleep in the chair because of an inability to transfer in and out of bed or to enable the Service User to alter the resting/seating position to alleviate pressure areas. Please note that a person not requiring full riser recliner functions must not be prescribed such an item.

Domestic Equipment (trolley, perching stool, cantilever table)

The person has an assessed need for equipment to enable them to carry out necessary personal or domestic activities safely and independently.
Equipment issued will have been especially designed to meet needs arising from a disability, which an able bodied person would not need to use.

Mobility Equipment

Equipment will be provided to ensure safe mobilisation around the home environment and community. To enable, access to food and drink, toileting and washing, contribute to safe transfers and reduce the risk of falls.

Manual Handling

Practitioners must have a current manual handling certificate before assessing or providing equipment.
When the Service User is having difficulty with one or more basic transfers and needs assistance, the risks to the carer are minimal and a safe transfer can be achieved.

Hoists

Hoists should only be ordered by qualified practitioners who have experience in manual handling. The Practitioner must assess the person and their home situation and be confident of the person and/or carer's ability to use a hoist safely. This includes selection of an appropriate hoist and compatible slings, choice of sling size, correct positioning and fitting of the sling, correct use of the controls and re-assurance of the person during the hoisting process.

Practitioners must leave written instructions for the use of the hoist. Demonstration in the use of the hoist is essential. Informal carers should be offered training.

Electric Hoists
To enable the carer (single/informal) to be independent in using the hoist within their capabilities

Or

If the carer needs to be close to the person as a result of their physical (e.g. involuntary tremor), psychological or mental state

Or

The carer needs to be actively involved in the positioning of the person during the manoeuvre where the use of the mobile electric control would facilitate this (carers should be aware of the initial movement of the hoist)

And

When a manual hoist has been considered and/or tried and deemed to be inappropriate.
Space implications must be considered.
Practitioners need to be aware of person’s weight.

Portable Ramps
Where there is an urgent need for access, the need is temporary or interim awaiting a more permanent solution.
These ramps are predominantly for use by carers. Unsuitable for self-propelling and electric wheelchair users without the supervision of a carer. An assessment of the carer’s ability to manage the portable ramps is required.
The long-term provision of a fixed or permanent ramp should always be considered.
Portable ramps should not be left in situ where they could create a hazard for ambulant people or those with poor mobility or visual impairment accessing the property.

Toilet equipment
To be provided to enable a person to transfer safely and independently as possible and/or to assist the carer to reduce manual handling risk.
Consideration will be given to provision of a second set of toileting equipment if essential e.g. upstairs and downstairs.

Sensory Impairment Equipment
The Service User has been assessed as needing to wear a hearing aid or is so severely/profoundly deaf that a hearing aid would not benefit them.
The Service User has significant sight loss that cannot be corrected sufficiently by wearing glasses.

Children’s equipment
Ordinary children’s seats and car seats are not supplied.
Children’s equipment is provided for children with a permanent and or substantial disability from birth to 18 unless still in full time education.
The assessment considers the home environment, safety for the child and carer, the need for supervision, the postural needs of the child, the risk of entrapment.
The simplest solution to meet the child’s needs will be considered, whilst allowing for the maximum growth.

Specials (Non stock equipment)
Special pieces of equipment should only be provided if standard stock equipment does not meet the assessed need.
Items over £1000-00 need to be presented to the Operational Management Group, which meets on a monthly basis.
Equipment under £25-00 must not be ordered.
All specials must be authorised by the Line Manager.

Minor adaptations
For Service Users experiencing difficulty due to poor mobility, loss of balance, pain, shortness of breath, sensory loss.
To improve safety in the home and prevent the risk of falls.
Prescribers must attend the Minor Adaptations Course prior to ordering any rails or minor adaptations.
Any special minor adaptation will require two quotes unless not available.

Door Entry
Door entry system needs to be considered first to allow client choice on who they allow entry to their property. If the client cannot reliably use a door entry system because, for example, cognitive problems, a keysafe will need to be considered. However, a keysafe must not be installed on the grounds of convenience for Service Providers going into the home.

A door entry system should only be considered if a person is left alone for significant periods of the day or lives alone and is not able to get out of bed independently or has severely restricted mobility and is unable to reach the front door safely within a reasonable length of time.

SCHEDULE 1A - FINANCAL CONTRIBUTIONS SUMMARY

Table 1: Funding Summary 2015/16 (£,000)	
Funding transferred to HCCG from NHSE:	**£15,642**
Funding to be transferred to LBH:	**£15,642**
Funding to repaid to HCCG to cover contract/service obligations shown in Table 2 below.	**£10,032**

Table 2: Contract/Service Spend 2015/16			
Contract/Expenditure	**Provider**	**Value (£,000)**	**Owner**
Scheme 1: Proactive early identification of people with susceptibility to falls, dementia and social isolation			
a) Falls Prevention Service	Age UK	130	HCCG
b) Primary Care	Network	50	HCCG
SCHEME TOTAL		**180**	
Scheme 2: Better care for people at the end of their life			
Community	CNWL	100	HCCG
SCHEME TOTAL		**100**	
Scheme 3: Rapid response and joined up intermediate care			
a) Rapid Response	CNWL	1,660	HCCG
b) Hawthorn Intermediate Care Unit	CNWL	1,354	HCCG
c) Community Rehab	CNWL	807	HCCG
d) Pressure relieving mattresses	Talley Group	278	HCCG
CCG TOTAL		4,099	
a) Spot purchased intermediate care beds	Various P & V	341	LBH
b) Cottesmore Reablement Flats	Paradigm Housing Group	38	LBH
c) Hospital Social Workers	LBH	250	LBH
d) Packages of care: maintaining eligibility criteria	Various P & V	57	LBH
LBH TOTAL		**686**	
SCHEME TOTAL		**4,785**	
Scheme 4: Seven Day Working			

a) Reablement Team	LBH	654	LBH
b) Mental Health Social Workers	LBH	100	LBH
SCHEME TOTAL		**754**	
Scheme 5: Review and realignment of community services to emerging GP networks			
a) Community equipment	Medequip	664	HCCG
b) Continence service	CNWL	493	HCCG
c) Community matrons	CNWL	574	HCCG
d) District Nursing	CNWL	3,092	HCCG
e) Twilight Service	CNWL	158	HCCG
f) Tissue Viability	CNWL	531	HCCG
g) Care Home Prescriber	HCCG	30	HCCG
h) Care Plan coordination	Network	63	HCCG
CCG TOTAL		5,605	
a) Community equipment	Medequip	125	LBH
b) Reablement Team	LBH	1,961	LBH
c) Telecare	LBH	682	LBH
d) Packages of Care: maintaining eligibility criteria	LBH	354	LBH
e) Care home project	LBH	150	LBH
LBH TOTAL		**3,272**	
SCHEME TOTAL		**8,877**	
Scheme 6: Care Home Initiative			
Community matrons	CNWL	48	HCCG
SCHEME TOTAL		**48**	
Scheme 7: Care Act Implementation			
a) Carers' assessments and review	LBH	271	LBH
b) Services to carers (inc respite)	LBH	500	LBH
c) ICT	Shop 4 Support	50	LBH
d) Adult safeguarding	LBH	17	LBH
SCHEME TOTAL		**838**	
CAPITAL			
a) DFG	LBH	1,769	LBH
b) Social Care Capital Grant	LBH	580	LBH
TOTAL CAPITAL		**2,349**	
PROGRAMME MANAGEMENT TOTAL			
Project Manager	LBH	60	LBH
PROJECT MANAGEMENT TOTAL		**60**	
CONTRIBUTION			
HCCG CONTRIBUTION	HCCG	**10,032**	

LBH CONTRIBUTION	LBH	**7,959**	
BCF TOTAL		**17,991**	

SCHEDULE 2 - FUNCTIONS

1. Functions of NHS Bodies included in the Section 75 are:

a) The functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the 2006 National Health Service Act, including rehabilitation services and services intended to avoid admission to hospital;

b) The functions of making direct payments under:
   i. Section 12A (1) of the National Health Service Act, 2006 (direct payments for health care)
   ii. The National Health Service (Direct Payments) Regulations, 2013

2. Excluded NHS functions are:

a) Surgery, radiotherapy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services.

3. Health-related responsibilities of the Council included in the BCF Plan are:

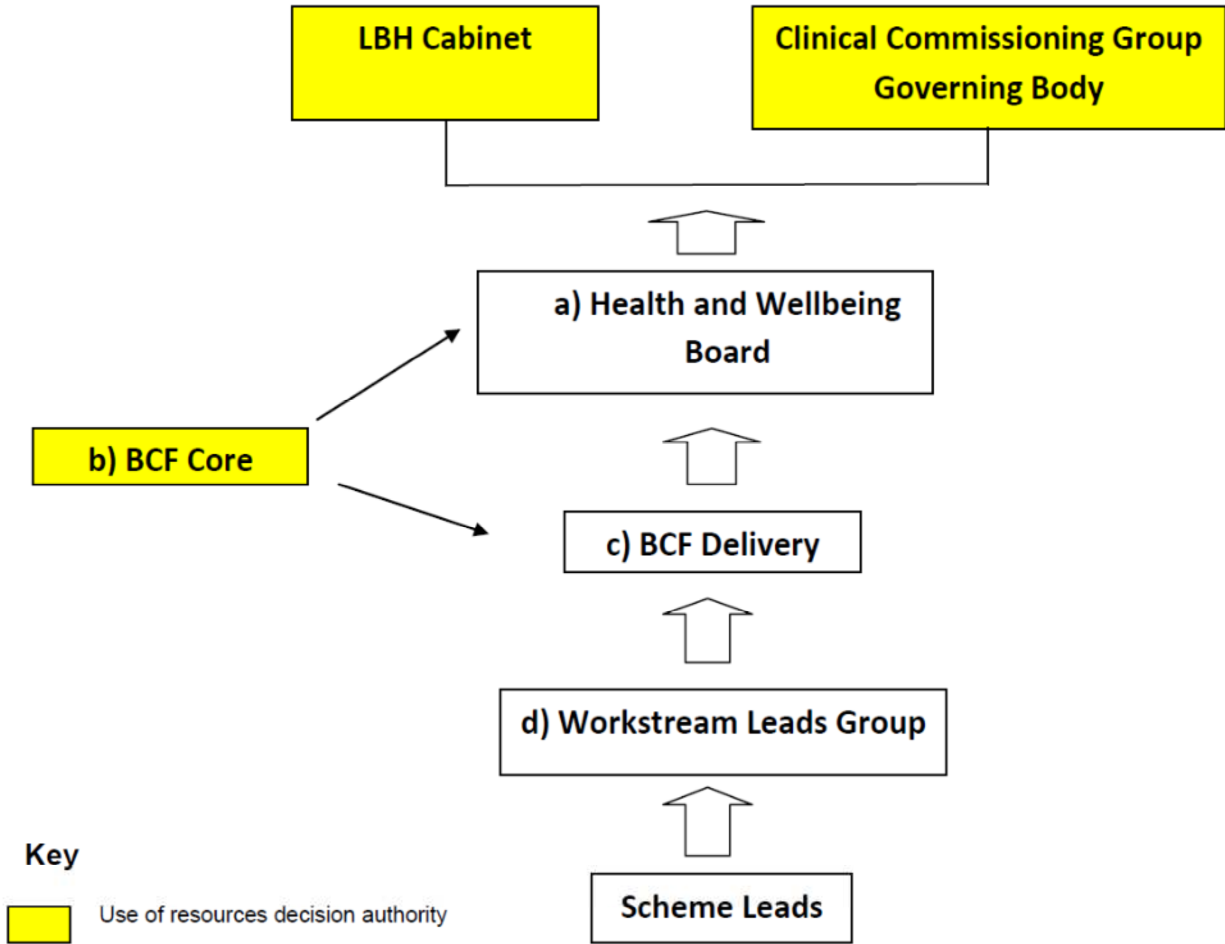
a) Functions under Part 1 of the Care Act, 2014.
b) Functions under Schedule 1 of the Local Authority Social Services Act, 1970 (as amended).
c) Functions under Part 1 of the Housing Grants, Construction and Regeneration Act, 1996, specifically the provision of Disabled Facilities Grants.

4. Excluded Council functions include:

a) Functions under sections 4 (providing information and advice), 5 (promoting diversity and equality in provision of services), 14 to 17 (charging and assessing financial resources), 34 to 36 (deferred payment agreements), 42 to 47 (safeguarding adults), 48 to 52 (provider failure) and 69 to 70 (enforcement of debts) of the Care Act, 2014.

SCHEDULE 3 - BETTER CARE FUND GOVERNANCE ARRANGEMENTS

1. Better Care Fund Governance Structure Summary



2. Better Care Fund Governance Structures Terms of Reference

a) Health and Wellbeing Board

2.1 The key purpose of the Health and Wellbeing Board is to fulfil statutory requirements under the 2012 Health and Social Care Act to improve the health and wellbeing of the local population.

2.2 It is specifically required to:

a) Lead on the duty to assess and publish information about the needs of the local population in the form of the Joint Strategic Needs Assessment (JSNA);

b) Deliver the duty to prepare and publish a Joint Health and Wellbeing strategy based on the JSNA, to consider Health and Social Care Act flexibilities, e.g. partnership arrangements, lead commissioner arrangements and/or pooled budgets, in developing the strategy and involve local residents and others as appropriate;

c) Promote integrated and partnership working across areas, including through the promotion of joined up commissioning plans across the NHS, social care and public health; and

d) Support, be involved in and provide opinion on joint commissioning plans and the review of how well the Health and Wellbeing strategy is meeting needs. This includes providing an opinion on how well the Clinical Commissioning Group (CCG) contributes to the delivery of the joint Health and Wellbeing strategy.

2.3 The Board is also responsible for:

a) Providing leadership in developing a strategic approach for health and wellbeing in Hillingdon;

b) Developing the statutory Health and Wellbeing Strategy;

c) Ensuring that the Health and Wellbeing Strategy is informed and underpinned by the JSNA and is focused upon:
   - Improving the health and wellbeing of the residents of Hillingdon;
   - The continuous improvement of health and social care services;
   - The reduction of health inequalities;
   - The involvement of service users and patients in service design and monitoring; and
   - Integrated working across health and social care where this would improve quality;

d) Reviewing performance on delivering the Health and Wellbeing Strategy and other key strategic targets;

e) Holding partner agencies to account for performance on agreed priorities in conjunction with the External Services Scrutiny Committee of the Council;

f) Influencing and approving the Clinical Commissioning Group (CCG) commissioning plan and annual update;

g) Collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance;

h) Agreeing and monitoring delivery of the BCF plan (as shown in governance structure summary); and

i) Monitoring the performance of Public Health and reviewing services in conjunction with the External Services Scrutiny Committee.

Board Membership

2.4 The Chairman of the Board is the Leader of the Council and the Vice-Chairman is the Cabinet Member for Social Services, Health & Housing.

2.5 Statutory members of the Board include:

- Cabinet Members from the London Borough of Hillingdon
- A representative from Hillingdon Clinical Commissioning Group
- A representative from Healthwatch Hillingdon
- The statutory Director of Adult Social Services
- The statutory Director of Children's Services
- The statutory Director of Public Health

Frequency of Meetings

2.6 The Board meets in public every two months and its agenda and reports are published on the Council's website a week before its meetings. Dates of meetings are also published on the Council's website and can be found by following this link http://modgov.hillingdon.gov.uk/ieListMeetings.aspx?CId=322&Year=0

2.7 Although the public can attend meetings, there is no public right to speak.

b) Better Care Fund Core Officer Group

2.8 The key purpose of the Core Group is to:

a. Provide day to day management of the BCF pooled budget established under Section 75 of the National Health Service Act, 2006, in accordance with delegated authority provided by the Council's Cabinet and the CCG's Governing Body;
b. Undertake the role of '*Partnership Board'* as described in the Section 75 Agreement; and
c. Act as the executive arm of the BCF Delivery Forum.

2.9 The Core Officer Group will be responsible for:

a. Considering the development of the BCF within the context of the priorities of the democratically elected administration of the Council and also of the statutory CCG Board;

b. Making decisions on financial expenditure in accordance with the agreed BCF Plan and agreement of both Partners;

c. Considering the strategic issues arising from the delivery of the Plan and consulting with the Delivery Forum accordingly;

d. Taking directions from the elected administration of the Council and the statutory CCG Board where required in order to make informed recommendations to the Delivery Forum;

e. Translating recommendations from the Delivery Forum into action;

f. Relaying recommendations from the Delivery Forum to the Health and Wellbeing Board and/or CCG Board, as required.

2.10 The Core Officer Group will also:

a. Be the escalation point for performance issues requiring urgent remedial intervention;
b. Report on issues arising from the management of the pooled budget to the Health and Wellbeing Board;
c. Consider opportunities for joint commissioning that may be reflected in the future scope of the BCF and section 75 agreement, subject to approval by the Health and Wellbeing Board, the Council's Cabinet and the HCCG Board.

Group Membership

2.11 The BCF Core Group is chaired jointly by the Council's Director of Adult Social Services and the CCG's Chief Operating Officer.

2.12 Other members include:

- Corporate Director of Finance – LBH
- Chief Finance Officer – HCCG
- Head of Policy and Partnerships – Chief Executive's Office, LBH
- Others by invitation or cooption

Accountability

2.13 The BCF Core Group is accountable to the Health and Wellbeing Board and informs the BCF Delivery Group.

2.14 Council officers who are members of the Core Group will be accountable to the Council's Cabinet and CCG officers will be accountable to the CCG's Governing Body.

Frequency of Meetings

2.15 The BCF Core Group meets fortnightly. Its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.16 The Core Group has no authority to commit resources to the BCF other than those approved by either the Council's Cabinet or the CCG's Governing Body.

c) Better Care Fund Delivery Forum

2.17 The key purpose of the BCF Delivery Forum is to have oversight over the delivery of the vision and deliverables within the Better Care Fund Plan. Its key role is consultative.

2.18 The Delivery Forum will be responsible for:

a. Receiving progress reports on the delivery of schemes under the BCF, including performance against KPIs and achievement of the BCF Plan benefits;

b. Assessing the strengths, opportunities, risks and challenges that present through options for a more holistic and potentially integrated health and social care service in Hillingdon;

c. Identifying solutions to identified risks and blockages;

d. Making recommendations to the Health and Wellbeing Board and the HCCG Board via the Core Officer Group where options have resource implications. The Delivery Forum can only make recommendations; it has no authority to instruct commissioning or provider organisations in how they use their resources or to commit the use of their resources;

2.19 The Delivery Forum must be consulted on any changes to the Plan, its metrics or benefits that may occur during the lifetime of the Plan.

<u>Delivery Forum Membership</u>

2.20 The Delivery Forum is chaired jointly by the Council's Director of Adult Social Services and the CCG's Chief Operating Officer.

2.21 Other members include:

- A director of the CCG Board
- A non-executive director of the CCG Board
- Two representatives from the GP Networks
- Statutory Director of Public Health - LBH
- Chief Operating Officer, The Hillingdon Hospital (THH) or representative
- Divisional Director, Mental Health and Community Services – Central and North West London Foundation Trust (CNWL)
- Chief Finance Manager – HCCG
- Adult Social Care Finance Manager – LBH
- 5 BCF workstream leads
- Hillingdon4All representative
- Hillingdon Healthwatch representative
- Others by invitation or cooption

2.22 Delivery Forum members are expected to cascade the information obtained from meetings to appropriate people within their organisations to maximise awareness and understanding of progress with Plan delivery.

Accountability

2.23 The BCF Delivery Forum is accountable to the Health and Wellbeing Board.

Frequency of Meetings

2.24 The BCF Delivery Forum meets on a monthly basis. Its meetings are not held in public due to the confidential and sensitive nature of the information discussed.

d) Workstream Leads Group

2.25 The key purpose of the Workstream Leads Group is to:

a. Monitor in detail the delivery of the workstream action plans and the programme plan;
b. Identify risks and mitigation;
c. Escalate blockages or risks that require more strategic intervention to the Delivery Group.

Group Membership

2.26 The Workstream Leads Group is chaired jointly by the CCG's Director of Integrated Care and the Council's Head of Safeguarding, Quality and Partnerships.

2.27 Its membership includes:

- The five Workstream Leads
- The BCF Programme Manager
- The Older People's Commissioner, HCCG
- Others by invitation or cooption

Accountability

2.28 The Workstream Leads Group is accountable to the BCF Delivery Group.

Frequency of Meetings

2.29 The Workstream Leads Group meets monthly. Its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

3. Roles and Responsibilities: Programme Manager, Workstream Leads and Scheme Leads

a) Programme Manager

3.1 Identify, analyse and communicate to the Core Officer Group and/or Delivery Forum and other key stakeholders all interdependencies between the different workstreams and schemes in the BCF programme, plus any external dependencies and how they will be managed.

3.2 Monitor progress of the workstreams and take action to deal with any exceptional situations that might jeopardise achievement of the plan and its benefits.

3.3 Actively manage identified risks and issues arising from workstreams.

3.4 Provide direct support to Workstream and/or scheme leads as required.

3.5 Escalate to the Core Officer Group or Delivery Forum risks or issues that cannot otherwise be managed and recommend mitigation.

3.6 Meet with workstream leads (actually or virtually) on a weekly basis to keep track of progress against workstream plans.

3.7 Produce monthly status reports to the Delivery Forum that identify progress, risks and mitigation and benefits realisation.

3.8 Manage the delivery of the stakeholder engagement strategy.

b) Workstream Leads

3.9 Monitor the delivery of scheme plans that are delivering BCF benefits within agreed timescales, identify risks and recommend mitigation.

3.10 Provide monthly updates on the delivery of scheme to the Programme Manager.

3.11 Attend monthly Delivery Forum meetings

3.12 Meet weekly (actually or virtually) with the Programme Manager to discuss progress, risks, mitigation and items that require escalation.

c) Scheme Leads

3.13 Establish and lead a project group of relevant stakeholders.

3.14 Define and agree with relevant stakeholders best practice pathways for individual schemes that will contribute to the delivery of BCF benefits.

3.15 Identify baseline position and identify gaps against best practice standards.

3.16 Undertake a risk analysis of pathway options, identify mitigation and recommend preferred option that will deliver BCF objectives and contribute to the delivery of BCF benefits.

3.17 Develop an implementation plan and provide monthly updates to Workstream Lead highlighting delivery risks.

3.18 Update the performance management system PM3 on a monthly basis.

4. Review

4.1 These governance arrangements are subject to approval by the Health and Wellbeing Board and will be subject to review annually from the date of approval.

SCHEDULE 4 – RISK SHARE AND OVERSPENDS

Risk Share

1. The Partners have agreed that they will each manage their own risks under this Agreement.

2. For avoidance of doubt, risks arising from non-payment of the performance element of the Better Care Fund shall be managed by the CCG.

Overspends

3. The Partners in their capacity as Lead Commissioners for the Service Contracts at the Commencement Date shall be responsible for managing any overspends in those Service Contracts that may occur during the Term.

4. The Partners shall inform the Partnership Board in accordance with clause 8 where the remedial actions to address any overspend may impact on one or more of the Individual Schemes set out in Schedule 1.

5. The Partnership Board shall use its best endeavours to preserve the integrity of Individual Schemes.

6. Where remedial action is proposed to address an overspend that may jeopardise the integrity of an Individual Scheme, a report shall be provided to the Health and Wellbeing Board before any such action is implemented.

Underspends

7. In the event that expenditure from any Pooled Fund is less than the aggregate value of the Financial Contributions made the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners.

8. Any underspends shall be retained for the delivery of the Better Care Fund Plan and the use of any underspend shall be subject to established governance processes.

SCHEDULE 5 – BETTER CARE FUND PLAN

Adobe Acrobat Document

SCHEDULE 6 – CONFLICTS OF INTEREST

Definition of a conflict of interest

A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.

Principles for managing conflicts of interest

Conflicts of interest can be managed by:

- **Doing business properly.** If commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid or deal with, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

- **Being proactive not reactive.** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible stage, for instance by considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making roles, and by ensuring individuals receive proper induction and understand their obligations to declare conflicts of interest. They should establish and maintain registers of interests, and agree in advance how a range of different situations and scenarios will be handled, rather than waiting until they arise;

- **Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest.** Most individuals involved in commissioning will seek to do the right thing for the right reasons. However, they may not always do it the right way because of lack of awareness of rules and procedures, insufficient information about a particular situation, or lack of insight into the nature of a conflict. Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this;

- **Being balanced and proportionate.** Rules should be clear and robust but not overly prescriptive or restrictive. They should protect and empower people by ensuring decision making is efficient as well as transparent and fair, not constrain people by making it overly complex or slow.

The Partners shall manage conflicts of interest as follows:

- HCCG - as set out in the *Managing conflicts of interests: Guidance for clinical commissioning groups* (NHS England March 2013)
- LBH – as set out in the *Code of Conduct for Council Employees* (LBH March 2010)

SCHEDULE 7 – INFORMATION GOVERNANCE PROTOCOL

INFORMATION SHARING PROTOCOL

(A) The purpose of this Protocol is to facilitate the secure sharing of information amongst key public sector, private and voluntary organisations in the London Borough of Hillingdon to support the provision of effective and efficient health and social care services to the populations of the local area.

(B) This Protocol sets out general principles, standards and governance agreed between the identified Partner Organisations to provide a secure framework for the sharing of information between the Partner Organisations within which they can all operate.

(C) By signing this document, each Partner Organisation undertakes to implement and adhere to the principles, standards and governance set out in this Protocol, reassuring the other Partner Organisations that patient information will be used and managed only in agreed and appropriate ways.

(D) This Protocol will be underpinned by service specific Information Sharing Agreements between the Partner Organisations that are designed to meet the specific requirements for the sharing of specific information for specific purposes using specific systems.

A glossary of terms can be found in **Annex 1**.

Parties to this PROTOCOL

We the undersigned agree that each organisation that we represent will adopt and adhere to the principles, standards and governance set out in this Protocol, and are prepared to sign Information Sharing Agreements for the sharing of specific information for specific purposes, using specific systems:

(Please see next page and the list of Partner Organisations in **Annex 2**)

Agency Name	NHS HILLINGDON CLINICAL COMMISSIONING GROUP
Address	Boundary House Cricket Field Road Uxbridge Middlesex UB8 1QG
Responsible Manager	**Email Address-** ian.goodman@gp-E86001.nhs.uk
Authorised Signatory- Chair of Hillingdon CCG	Signature Date

Agency Name	LONDON BOROUGH OF HILLINGDON
Address	Civic Centre High Street Uxbridge UB8 1UW
Responsible Manager	**Email Address-** tzaman@hillingdon.gov.uk
Authorised Signatory- Director of Adult Social Care	Signature Date

This page must be completed by the Caldicott Guardian:

Organisation Name	Brent, Harrow and Hillingdon Clinical Commissioning Groups
Address	3rd Floor 59-65 Lowlands Road Harrow on the hill HA1 3AW
Contact Details	**Email Address-** ursula.gallagher@nhs.net
Authorised Signatory- Caldicott Guardian for Brent, Harrow and Hillingdon CCGs	Signature: …………………………. Date:

Each of the above listed organisations shall be a **Partner** and together they shall be the **Partner Organisations**.

1. OVERARCHING PRINCIPLES

1.1 The Partner Organisations recognise that many services cannot be effectively delivered without the exchange of Personal Confidential Data across key public sector, private and voluntary organisations. This Protocol sets out the principles by which the Partner Organisations agree to exchange information, in a manner which is compliant with their legal responsibilities. The Partner Organisations will ensure the accurate, timely, secure and confidential sharing of information where such information sharing is essential for the provision of health and social care to the local population in North West London.

1.2 Each Partner Organisation is responsible for ensuring that robust technical and organisational measures and information governance arrangements are in place to protect the security and integrity of information to ensure a trusted sharing environment.

1.3 Information shared pursuant to this Protocol may not be shared with any other organisation not a signatory to this Protocol without the prior consent of the relevant Partner Organisation and/or patient/client.

1.4 The Partner Organisations recognise that there must be a legal basis for any sharing of Personal Confidential Data.

1.5 The Partner Organisations recognise that where Personal Confidential Data is shared because it is necessary for Direct Care, the patient's consent may usually be implied, providing a legal basis for such sharing.

1.6 The specific purpose for use and sharing information will be defined in the Information Sharing Agreements, however the following principles should form the basis of such Information Sharing Agreements relevant to its type:

1.7 Provided any disclosure is in accordance with this Protocol, Partner Organisations should share Personal Confidential Data when it is needed for the safe and effective care of an individual.

1.8 Where Personal Confidential Data is shared for Indirect Care, consent may not be implied. The Partner Organisations agree to anonymise such data before sharing where possible. Any Personal Confidential Data should only be shared for Indirect Care if:

a. the Data Subject has given consent;

b. the data sharing is required by law;

c. the recipient has approval to receive it under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 (otherwise known as Section 251 support).

1.9 The Partner Organisations agree to respect an individual's right to object to the sharing of Personal Confidential Data about them.

Key Legislation and Guidance

1.10 The Partner Organisations are subject to a variety of legal obligations, and statutory and other guidance in relation to the sharing and disclosure of information, including (without limitation):

- Data Protection Act 1998

- Human Rights Act 1998
- Common Law Duty of Confidence
- Caldicott Principles
- ICO Data Sharing Code of Practice
- Confidentiality: NHS Code of Practice
- HSCIC: A guide to confidentiality in health and social care
- NHS England Information Governance and Risk Stratification: Advice and Options for CCGs and GPs
- Department of Health: Information Security: NHS Code of Practice

1.11 This is not an exhaustive list and other legislation applies in specific circumstances.

1.12 Each Partner Organisation must have documented policies and procedures to ensure compliance with the national requirements for data protection, information security and confidentiality and committed to ensuring that any information is shared in accordance with its legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

1.13 As part of each Information Sharing Agreement each Partner Organisation shall specify how it meets its legal obligations and the legal basis under which information can be shared.

2. INFORMATION GOVERNANCE REQUIREMENTS

2.1 Subject to clause 2.3, each Partner Organisation is required to comply with the then current NHS Information Governance Toolkit as appropriate to its organisation type and adhere to robust information governance management and accountability arrangements, including effective security event reporting and management.

2.2 Subject to clause 2.3, each Partner Organisation must comply with the IGT assessment, reporting and audit requirements relevant to its organisation type. Each Partner Organisation will provide evidence of compliance to the Governing Group or the other Partner Organisations on written request.

2.3 Any Partner Organisation which is a non-NHS organisation and unable to comply with the IGT must obtain prior written approval from the Governing Group to adopt an alternative, but equivalent standard to the IGT for NHS organisations. For the avoidance of doubt, the Governing Group reserves the right to reject/amend any proposed standard at its sole discretion.

2.4 Each Partner Organisation must ensure and maintain its registration with the Information Commissioner under the Data Protection Act 1998.

2.5 In the event of a Security Incident, the responsible Partner Organisation should immediately inform the Governing Group and all other affected Partner Organisations (usually the disclosing Partner Organisation(s)) with as many details as known at that time and regularly update the relevant Partner Organisations and Governing Group thereafter, including any subsequent investigation report or remedial actions. Any affected Partner Organisation will then pass on the information in accordance with incident reporting procedures within their own organisation if appropriate.

2.6 If any Partner Organisation cannot or may not be able to comply with the requirements in this Clause, the partner should inform the Governing Group immediately. The Governing Group will undertake an urgent review and has the discretion to authorise derogation from or amendment to the requirements of this clause, on such terms as the Governing Group considers appropriate, as long as the derogation or amendment is lawful.

3. PERSONAL CONFIDENTIAL DATA: COMMUNICATION AND CONSENT

Communication

3.1 Each Partner Organisation must:

- Effectively inform patients about the ways the information they have provided may be used, who it may be shared with, what will be shared and for what purpose;
- Effectively inform patients that they have the right to opt out of sharing their information or select/restrict which elements of their information may or may not be shared and that any consent can be changed in the future;
- Effectively inform patients of the implications for the provision of care or treatment, such as the potential risks involved if their full record is not made available to health professionals involved in their Direct Care; and
- Ensure fair processing notices are always in place.

3.2 Any Partner Organisation which does not have the ability to mark part of a record as private, must notify the Governing Group and inform the patient that they must decide whether all or none of their record should be shared.

3.3 Each Partner Organisation must ensure that technical and organisational measures are in place to obtain and record consent from patients and allow patients to select which elements of their information may not be shared. These measures must also allow for the patient to withdraw consent and include a process for ceasing processing of such information immediately and give notice to affected Partner Organisations.

3.4 Each Partner Organisation should employ a variety of channels to communicate with its patients regarding information sharing, such as information leaflets, posters, at the point of care, during the patient registration process or when referring into other services.

Consent

3.5 Patient consent must be obtained in line with NHS guidance then in force. Consent can be Explicit Consent or Implied Consent. Each Partner Organisation recognises that different consent arrangements are needed in respect of sharing information for Direct Care and Indirect Care purposes.

3.6 Obtaining Explicit Consent for information sharing is best practice and ideally should be obtained when the patient first accesses the service.

3.7 Partner Organisations must make arrangements for the systematic obtaining of consent.

3.8 Consent must be informed. Each Partner Organisation must ensure that the patient has the capacity to give consent and if not, follow the relevant guidance to obtain the appropriate consent.

3.9 Each Partner Organisation must ensure that technical and organisational measures are in place to obtain and record consent from patients and allow patients to select which elements of their information may not be shared. These measures must also allow for the patient to withdraw consent and include a process for ceasing processing of such information immediately and give notice to affected Partner Organisations.

3.10 Each Partner Organisation will, as a matter of good practice, seek fresh consent if there are significant changes in the circumstances of the individual or the work being undertaken with them.

3.11 Each Partner Organisation must ensure that where required, consent is recorded and a full audit trail retained of who obtained consent.

3.12 Partner Organisations have authority to seek consent only on behalf of their own organisation.

4. DECIDING WHETHER TO SHARE PERSONAL CONFIDENTIAL DATA

4.1 Partner Organisations will follow the decision tree at Annex 3, adapted from the guidance given by the HSCIC in its *Guide to confidentiality in health and social care*.

4.2 Information relating to a deceased person is not subject to the Data Protection Act 1998, however careful consideration should be given and further advice sought before any such information is released. Duties of confidence still apply.

4.3 If a Partner Organisation decides not to disclose some or all of the Personal Confidential Data, the requesting Partner Organisation must be informed why in so far is as permitted by law. For example, if the Partner Organisation is relying on an exemption or on the inability to obtain consent from the patient.

5. SYSTEM SUPPLIER STANDARDS

5.1 Each system operated by any Partner Organisation for sharing clinical information should have NHS Interoperability Toolkit accreditation, thus assuring its system specifications and standards meet the agreed interoperability standards for the NHS. Partner Organisations that operate such systems will provide evidence of compliance to the Governing Group or other Partner Organisations on written request.

5.2 Any proposed non-compliance must be explained, documented and agreed in advance by the Governing Group.

5.3 If any Partner Organisation cannot or may not be able to comply with the requirements in this Clause, the partner should inform the Governing Group immediately. The Governing Group will undertake a review and may in its discretion authorise derogation from the above requirements subject to such conditions as it deems appropriate.

5.4 All partner organisations' systems under this Protocol must have user authentication mechanisms to ensure that all instances of access are auditable against an individual, including the following information:

- Job role and name of staff member accessing the system;
- Organisation name;
- What actions were performed; and
- The date and time the information was viewed.

5.5 The systems and technical measures used by each Partner Organisation for the sharing of Direct Care and Indirect Care must be specified in any Information Sharing Agreement.

6. KEY CONTACTS

6.1 Each Partner Organisation will nominate a person as a key contact to deal with queries and requests for information under this Protocol. This person shall also represent the Partner Organisation in the Governing Group. It is advisable that such appointed contact shall usually be the Partner's Caldicott Guardian or data protection officer or equivalent.

6.2 A Partner Organisation may change its appointed contact at any time on written notice to all Partner Organisations.

6.4 The key contact for each Partner Organisation will ensure dissemination of this Protocol in line with each Partner Organisation's internal arrangements for the distribution of policies, procedures and guidelines and monitor the implementation and compliance of this Protocol within their own Partner Organisation.

7. GOVERNING GROUP

7.1 The purpose of the Governing Group is to oversee, support and maintain the secure sharing of information under this Protocol.

7.2 Each Partner Organisation will have a representative on the Governing Group which in accordance with clause 6 will be each Partner Organisation's key contact under this Protocol.

7.3 Patient representation on the Governing Group will be nominated by Partner Organisations

7.4 The Governing Group will meet at least annually.

7.5 The Governing Group shall have the following powers and responsibilities:

a. to approve ISAs and additional Partner Organisations to this agreement;

b. to administer membership of this Protocol

c. to determine whether a Partner Organisation should cease to be a party to this Protocol for a specific period of time or permanently for non-compliance;

d. to determine whether a Partner Organisation may derogate from or amend any requirement under this Protocol;

e. to maintain an information conduit between the Partner Organisations;

f. to maintain a channel of liaison with pan-London personal information sharing initiatives and relevant NHS and local authority national initiatives;

g. to investigate breaches of the Protocol and require Partner Organisations to take remedial actions;

h. to monitor each Partner Organisation's compliance with this Protocol or any ISA. The Governing Group may request evidence of compliance with this Protocol on written request to any Partner Organisation;

i. to approve common patient communication materials; and

j. to develop, review and maintain the Protocol to ensure that it reflects any legal and statutory obligations and any other related best practice guidance in relation to information governance.

7.6 The Governance Group may regulate its own procedure subject to the provisions of this Information Sharing Protocol.

7.7 It is noted that there may be specific information sharing protocols already in place between some Partner Organisations, which must be taken into consideration.

7.8 In accordance with clause 6, any Partner Organisation wishing to amend the details of its representative must notify, in writing, the Governing Group, providing details of the newly appointed representative as soon as is practicably possible.

8. DATA RETENTION STANDARDS

8.1 Each Partner Organisation must have a written policy for the retention and disposal of information in accordance with NHS Best Practice guidance.

8.2 No Partner Organisation should retain information for longer than is necessary to achieve the objectives for which the information was obtained.

9. ASSURANCE

9.1 Each Partner Organisation must, so far as possible, ensure the accuracy of the information (correct, complete and up-to-date) which it is sharing under this Protocol and must have in place appropriate systems to update any information if subsequently discovered to be inaccurate.

9.2 If a Partner Organisation is aware of a material inaccuracy or omission in information that it shares under an Information Sharing Agreement, the Partner Organisation must inform the recipient of that inaccuracy or omission.

9.3 Where possible, the NHS number must be used as the unique patient identifier and systems used by the Partner Organisations should connect to the Connecting for Health Personal Demographic Service to ensure the NHS numbers are accurate and demographic data synchronised.

10. STAFF

10.1 Each Partner Organisation is responsible for ensuring that access to shared information is documented and restricted to those staff who have a legitimate and appropriately approved reason to access it and those staff who are properly trained to discharge any relevant obligations in accordance with this Protocol.

10.2 Each Partner Organisation shall provide staff with training on the principles and legal requirements for information sharing and the appropriate tools to enable them to comply with the obligations under this Protocol.

10.3 Each Partner Organisation shall ensure that shared information can only be accessed via username and password and other such methods as shall be appropriate given the sensitive nature of the information.

10.4 Each Partner Organisation shall make it a condition of employment that all employees, agents or contractors will abide by the rules and policies of that Partner Organisation in relation to information governance. This condition should be written into employment and other contracts and each Partner Organisation shall make staff aware that any failure to comply with the requirements outlined in this Protocol is likely to be subject to disciplinary action.

11. SUBJECT ACCESS AND COMPLAINTS

11.1 Each Partner Organisation is responsible for putting into place effective procedures to address complaints about data sharing and subject access requests relating directly to this Protocol. Information about these procedures should be made available to patients.

11.2 Each Partner Organisation must have a designated Data Protection Officer or Information Governance Manager who is responsible for subject access requests and complaints.

11.3 Subject access requests from third parties for data available to organisations under this Protocol are to be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

11.4 Any complaints about data sharing relating directly to this Protocol should be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

12. FREEDOM OF INFORMATION

12.1 The Partner Organisations recognise that public bodies are subject to the requirements of the Freedom of Information Act 2000 (as amended) ("FOIA") and the Environmental Information Regulations ("EIR"). Any such requests relating to information governed by this Protocol should be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

12.2 The Partner Organisations shall process any such requests in accordance with their own policies and shall cooperate with each other to ensure compliance with statutory obligations.

13. AUDIT

13.1 Each Partner Organisation accepts responsibility for independently or jointly auditing its own compliance with this Protocol and any Information Sharing Agreements in which it is involved on a regular basis (at least annually).

13.2 Each Partner Organisation is required to keep and maintain records of all requests for information sharing received and track the flow of Personal Confidential Data.

13.3 This Protocol will be formally reviewed annually by the Governing Group, unless in the Governing Body's opinion new or revised legislation or national guidance necessitates an earlier review.

13.4 Following each review the Governing Group will confirm whether this Protocol remains fit for purpose, or whether to recommend amendments to the Partner Organisations.

ANNEX 1 - GLOSSARY

In this Protocol unless the context otherwise requires the following words and expressions shall have the following meanings:

"Anonymised Data" means data in a form where the identity of the individual cannot be recognised i.e. when:

- Reference to any data item that could lead to an individual being identified has been removed;
- The data cannot be combined with any data sources held by a Partner with access to it to produce personal identifiable data;

"Data Controller" A company, organisation or person who decides what data is collected, the purposes for which it is used and how that data is handled;

"Direct Care" means clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals (all activities that directly contribute to the diagnosis, care and treatment of an individual);

"Explicit Consent" means articulated patient agreement which gives a clear and voluntary indication of preference or choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear, and in relation to data sharing, the consent covers the specific details of processing; the data to be processed; and the purpose for processing;

"Governing Group" means as defined in paragraph 7 of this Schedule 7 (Governing Group).

"Implied Consent" means patient agreement that has been signalled by behaviour of an informed patient;

"Indirect Care" means activities that contribute to the overall provision of services to a population as a whole or a group of patients with a particular condition, but which fall outside the scope of direct care. It covers health services management, preventative medicine, and medical research;

"Information Sharing Agreement(s)" means the agreement to be entered into between Partner Organisations prior to sharing information that is designed to meet the specific requirements for the sharing of specific information for specific purposes using specific systems and based on the attached template in Appendix 3;

"NHS Information Governance Toolkit" "IGT" means the set of information governance requirements produced by the Department of Health and now hosted by the Health and Social Care Information Centre. It is a tool with which health and social care organisations can assess their compliance with current legislation and national guidance;

"Partner"

"Partner means the organisation(s) party to this Protocol, or automatically added as a signatory to this Protocol by way of

Organisations"	entering an approved specific Information Sharing Agreement;
"Personal Confidential Data"	means personal information about identified or identifiable individuals, which should be kept private or secret. For the purposes of this Protocol 'personal' includes the definition of 'Personal Data', but it is adapted to include dead as well as living people. 'Confidential' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'Sensitive Personal Data' as defined in this Protocol;
"Personal Data"	has the meaning given to it in the Data Protection Act 1998, namely: data which relate to a living individual who can be identified: (a) from those data; or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the Data Controller, and includes any expression of opinion about the individual and any indication of the intentions of the Data Controller or any other person in respect of the individual. Typical examples of this type of data could include a Name, Address, Full Postcode, Date-of-Birth, Email Address, and Telephone Number or a photograph or CCTV image. A unique number such as an employee number or NHS number could be considered as personal data if the organisation holds the identifying data relating to the unique identifier;
"Security Incident"	means an actual, suspected or threatened unauthorised exposure, access, disclosure, use, communication, deletion, revision, encryption, reproduction or transmission of any component of Personal Data and/or Sensitive Personal Data or unauthorised access or attempted access to any Personal Data and/or Sensitive Personal Data;
"Sensitive Personal Data"	means Personal Data consisting of information as to - (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or other beliefs of a similar nature, (d) whether he is a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings,

ANNEX 2 - RESPONSIBILITIES OF PARTNER ORGANISATIONS

Partner Organisation	Responsibility
Federation of Brent, Harrow and Hillingdon CCGs	Governing Group (Informatics Sub-Committee)
NHS Hillingdon Clinical Commissioning Group	Host of Protocol

The table below sets out the Partner Organisations for Hillingdon.

Partner Organisation	Responsibility
GP Practices within NHS Hillingdon CCG	Primary Healthcare provision – direct care
Hillingdon Hospitals NHS Foundation Trust	Secondary Healthcare provision – direct care
Central and North West London NHS Foundation Trust	Community and mental healthcare provision – direct care
London Borough of Hillingdon	Social Services – direct care Telecare services – direct care
Greenbrook Healthcare Ltd – Urgent Care Centre at Hillingdon Hospital	Urgent care services – direct care
Harmoni Ltd – Out of Hours and 111 services	OOH and 111 services – direct care
Imperial College Healthcare NHS Trust – including West London Breast Screening	Secondary Healthcare provision – direct care and screening services
North West London Hospitals NHS Trust (Northwick Park Hospital) – Accident and Emergency Service	Secondary Healthcare provision – direct care and screening services
Ealing Hospital NHS Trust	Secondary Healthcare provision – direct care
Royal Brompton and Harefield NHS Foundation Trust (Harefield Hospital)	Secondary Healthcare provision – direct care
West Hertfordshire Hospitals NHS Trust (Watford General Hospital)	Secondary Healthcare provision – direct care
Heatherwood and Wexham Park Hospital NHS Foundation Trust	Secondary Healthcare provision – direct care
West Middlesex University Hospital NHS Trust	Secondary Healthcare provision – direct care
London Ambulance Service	Emergency care services – direct care
North West London Commissioning Support Unit	Clinical Quality and Patient Safety – clinical audit and/or investigation; recording, monitoring and analysing serious incidents; supporting the CCG in its statutory responsibilities for clinical quality and patient safety in all elements of the commissioning cycle
Age UK - Hillingdon	Support services as per agreed care

	pathways – direct care
Royal Marsden – Host of the Co-ordinate My Care (CMC) Programme	Host of shared electronic healthcare record created with patient consent
Healthcare Gateway Ltd - Medical Interoperability Gateway	Host of Information Technology solution that enables the sharing of electronic patient records

ANNEX 3 - DECIDING WHETHER TO SHARE PATIENT/RESIDENT CONFIDENTIAL INFORMATION