Dated: **day of June 2016**

Hillingdon London Borough Council

and

NHS Hillingdon

2016/17

NHS
Hillingdon
Clinical Commissioning Group

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES UNDER THE BETTER CARE FUND UNDER SECTION 75 NATIONAL HEATH SERVICE ACT, 2006

Contents

Acknowledgement: This agreement is based on a template developed by Bevan Brittan LLP
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THIS AGREEMENT is made on day of June 2016

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 and capital expenditure on the Services;

d) to provide the Partners with further 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 that will be reflected in a 2017 to 2020 BCF Plan in accordance with National Conditions; 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. **04437**.

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 2016.

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 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 2017 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	None
Scheme 4	None
Scheme 5	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. c. Delegation to the Council by the CCG to act as lead commissioner on behalf of the CCG for the community equipment service as described in **Schedule 1B**. d. 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. e. Delegation to the CCG, or agents acting on its behalf, by the Council authority to undertake assessment and prescription of standard minor adaptations **(**as defined in Paragraph 1.1 **Schedule 1B** of this Agreement) to meet social care need. f. Delegation to the CCG, or agents acting on its behalf, by the Council authority to undertake assessments for non-standard minor adaptations (as defined in Paragraph 1.1 **Schedule 1B** of this Agreement) to meet social care need.
Scheme 6	Delegation to the Council by the CCG to undertake the brokerage function for nursing home placements for older people on behalf of the CCG.
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.
Scheme 8	None

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 For avoidance of doubt, the Council shall undertake Lead Commissioner responsibility for the Community Equipment Service as described in **Schedule 1** and **Schedule 1B**.

6.3 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.

6.4 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.

6.5 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.

6.6 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, 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 16.3, 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:

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

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 and Children and Young People's Services**;

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: cmorison@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 One: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation

Scheme Strategic Objectives

1.1 This scheme seeks to manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.

Scheme Overview

1.2 This scheme builds on the work undertaken under Hillingdon's 2015/16 BCF plan to take forward the anticipatory model of care and apply a more preventative approach to addressing health and social care need. The scheme's focus is people whose current level of need is low and as a result their risk factors would not be identified through the risk stratification process being undertaken in primary care. See scheme 5: *Integrated Community-based Care and Support* for details of the utilisation of risk stratification as part of the delivery of better anticipatory care in Hillingdon. Identification of this cohort of people will enable early engagement in self-directed care and support and facilitate access to preventative pathways.

1.3 People living with dementia, people susceptibility to falls and/or who are socially isolated are disproportionately represented in our non-elective admissions and admissions to long term residential care. In addition, stroke is one of the main causes of disability in the 55 and over population and one of the main causes of death in the 75 and over population. Susceptibility to stroke increases as people age and there are factors that can contribute to a person being particularly at risk. As stroke is a largely preventable condition, early identification of people at risk can help to prevent this life changing condition from occurring.

1.4 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.

1.5 Key initiatives include:

a) *Promotion and further development of an online citizen portal* - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. The Connect to Support portal established in 2015/16 will be promoted further in 2016/17 to make it the go-to place for information and advice, including about activities and services to support the health and wellbeing of Hillingdon's residents.

b) *Making every contact count (MECC)* - Training delivered to frontline staff in Q4 about how to identify people who may be at risk of dementia, falls and/or social isolation and how to respond will be evaluated. This will shape the content of any further training to staff who visit people in their own homes. The extent to which this is rolled out further will depend on the readiness of the response to issues raised following staff contact with residents at risk;

c) *Delivering a system-wide response* - This entails setting out what to do when we identify

people with these susceptibilities. It could include a referral to the pilot Hillingdon Health and Wellbeing Service provided by the third sector consortium H4All, which will provide support to older people with one or more long-term condition who need assistance to manage their condition. People referred to this service can also benefit from an assessment using the Patient Activation Measures (PAM). This assessment is intended to identify people needing support to engage more actively in the management of their own condition. People identified as needing support to engage with self-care plans are at greatest risk of increased health and care need and will receive a programme of direct support from the service. Other people will be advised about the options available to address their needs, including being sign-posted to services provided by third sector organisations.

d) *Reviewing the falls strategy* - A centralised falls service (with multi-factorial assessment management), assisted discharge from hospital for people who have fallen and a community based falls prevention service were established prior to 2015/16 and have proved successful in preventing emergency admissions. Hillingdon's strategy for supporting people at risk of falling as well as those who have fallen will be reviewed in 2016/17. This will take a comprehensive view of the respective Council and CCG functions and funded services and how collectively with partners falls prevention can be supported.

e) *Supporting and developing the role of the third sector* - The evaluation of the impact of the Health and Wellbeing Service pilot will include patterns of utilisation of services provided by Hillingdon's third sector. This will inform how best to target current third sector capacity funded by the Council and/or CCG in order to maximise the outcomes of supporting people to be independent in the community and preventing or delaying escalation and subsequent demand on statutory services. This will help inform commissioning decisions about the appropriate configuration of services to meet local need in the period up to 2020 as part of an integrated model community based care for older people, which links to scheme 5: *Integrated community-based Care and Support*.

f) *Stroke prevention*: There are four components to a stroke prevention strategy and these are: increasing physical activity, addressing excess weight issues, smoking cessation and early detection. During the 2016/17 the following initiatives will be undertaken:

I. *Increasing physical activity* - There is an existing physical activity programme and targeting this at people aged 55 and over carrying excess weight is expected to have a beneficial outcome.

II. *Addressing excess weight issues* - In 2015/16 a weight management project working with 200 residents has been piloted. The results of this will inform the development of a business cases for a tier 2 weight management service directed at obese or overweight people who need personal, time-limited interventions in the community to support them in managing lifestyle changes;

III. *Smoking cessation* - The Council, through its public health function, already provides a successful smoking cessation service and this will continue. It will be reviewed during 2016/17 to explore how its effectiveness can be maximised;

IV. *Early detection* - A key method for detecting at an early stage susceptibility to stroke is through the NHS health check programme. We currently have an active programme but at 12% of the eligible population being targeted per annum the rates are lower than is ideal and aiming for 20% would be more effective in disease prevention. Hypertension and high cholesterol (both important in causing stroke) are already tested for in NHS health checks. Atrial fibrillation (AF), a

disturbance of heart rhythm, is a major cause of stroke and is not tested as part of the health check programme. During 2016/17 options to increase the rate of health checks (as well as extending them to cover AF) will be explored.

g) *Delivering older people's wellbeing initiatives* - The Council will implement the reorganisation of its Health Promotion and Sports Development Services into a Wellbeing Service, which will be able to develop more comprehensive initiatives in partnership with the third sector to improve health and wellbeing by helping to keep people active, both mentally and physically.

h) *Preventing dementia* – The actions set out above to prevent stroke and promote the wellbeing of older people will also help to prevent or delay the onset of dementia. This links with scheme 8: *People living well with dementia*.

i) *Identification of carers* - Many people who provide care for loved ones free of charge are not aware that they are carers. The work undertaken under this scheme provides an opportunity to identify carers and refer them to the Council for a carer's assessment and/or the third sector for information, advice and appropriate support. This links with scheme 7: *Supporting carers.*

j) *Making best use of assistive technology* - The work undertaken under this scheme provides an opportunity to identify people who may benefit from assistive technology, e.g. telecare and telehealth, and to make referrals. This technology can help to provide the residents/patients and their families with greater confidence about them remaining in their own home.

Commissioning Arrangements

1.6 Pooled budget.

The Delivery Chain

Scheme Lead Role

1.7 The Council shall be the lead for this scheme.

Scheme Delivery

1.8 The online resident portal, Connect to Support, is commissioned by the Council;

1.9 A multi-agency, multi-disciplinary clinical working group (CWG) co-ordinates the development of falls and falls prevention services in Hillingdon. The current falls-specific prevention and treatment services are commissioned by the CCG and provided by CNWL, Age UK and THH;

1.10 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;

1.11 The current screening programme is undertaken in primary care;

1.12 The new Wellbeing Team will work in partnership with the Library Service and the third sector to support older residents to become or remain mentally and physically active. This will help to prevent or delay the onset of dementia, as well as help to prevent stroke;

1.13 The Council provides telecare through its in-house TeleCareLine Service, which includes a response service for those without a family responder or where the family responder is not contactable in the event of an emergency. Telecare equipment is supplied by a private provider.

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Health and Wellbeing Service	H4All	543	195	738
b) Connect to Support	Shop4Support	45	0	45
c) Online Services Coordinator	LBH	44	0	44
d) Atrial Fibrillation screening equipment	P & V	5	0	5
e) Older People Wellbeing initiatives	LBH	20	0	20
f) Falls Prevention Service	Age UK	0	140	140
	Primary Care	0	55	55
TOTALS		**657**	**390**	**1,047**

Contribution to BCF Metrics

1.14 This scheme will contribute to the following key BCF metric:

a) Reduction in non-elective admissions

Other Success Measures

1.15 The following measures will be used to identify whether the scheme is working:

a) Increase in utilisation rates for Connect to Support (new and repeat users) – Baseline to be established in Q4 2015/16.

b) % of users of Adult Social Care who have found it easy or difficult to access information and advice about services and/or benefits (Test through the Adult Social Care Survey).

c) Reduction in falls-related emergency admissions (83 admissions prevented).

d) Proportion of residents/patients who have an improved PAM scoring where there is tangible improvement in engagement in self-directed support.

e) Number of people assessed through the Health and Wellbeing Service receiving active support from a support coordinator.

f) Number of people supported by the Health and Wellbeing Service who receive appropriate information or signposting to local groups through the service's triage assessment. This will require a separate survey of service users.

g) Number of successful referrals to voluntary and community organisations from the H4A Service and the referral outcomes. This will require a system to be put in place to monitor user feedback and identify delivery of intended outcomes.

h) Numbers of people aged 55 and over participating in stroke prevention activities. Activities that help to prevent stroke will also contribute to reducing the risk of dementia.

i) % of people aged 55 and over participating in screening programmes.

j) Evaluation of the training programme for frontline staff who visit residents in their own homes.

Scheme Two: Better care for people at the end of their life

Scheme Strategic Objectives

2.1 This scheme seeks to realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' This is intended to maximise the dignity of the person at end of life, ensure that they receive the right services at the right time and relieve as much as is possible the stress for them and their carers and/or family.

Scheme Overview

2.2 This scheme builds on the work undertaken in 2015/16. The main goals of the scheme are to ensure that people at end of life are able to be cared for and die in their preferred place and to ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.

2.3 To achieve these goals the key initiatives under this scheme will include:

a) *Identification of people at end of life* - The process for identifying people at end of life resulting from work undertaken in 2015/16 will be implemented. This will ensure that key professionals are supported in diagnosing people with advanced disease who are in the last months/year of life and who are in need of supportive and palliative care. This will support appropriate anticipatory planning being undertaken. This action links with scheme 8: *Living well with dementia*.

b) *Delivering a communications plan for professionals* - The communications plan developed in 2015/16 setting out Hillingdon's end of life pathway, including the support available to residents/patients and their carers and/or families will be delivered. This will help to raise awareness of the support available to people at end of life whose preferred place of care is at home and help to prevent hospital admissions that are inappropriate in the context of expressed resident/patient wishes.

c) *Increasing utilisation of multi-disciplinary care and support planning* – During 2016/17 partners will be increasing the utilisation of Co-ordinate My Care (CMC) as the advance care planning tool for people at end of life, which is in line with practice across London. This will include exploration of access to Adult Social Care staff and the provision of appropriate training to facilitate this. Increasing the utilisation of CMC will link in to the expansion of the care information exchange (CIE) platform, subject to the success of the pilot which will be undertaken early in 2016/17.

d) *Facilitating seamless care provision between health and social care* – The Council will bring its social care spend for people at end of life within the pooled budget to ensure that a

disruption in care is not caused by a transition in funding responsibility between health and social care. The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only having six months to live whose needs are primarily social care. This would help to avoid the complexities and potential disputes that can arise when trying to determine at what point a person's care should be health funded.

e) *Implementing results of market testing of end of life services* – In order to reduce the fragmentation of end of life services and avoid the disruption that can arise from a change of provider resulting from a person's needs transitioning from being primarily social care to health care at critical time, the Council and CCG will move towards single or lead provider arrangements.

f) *Developing appropriate training for providers* - 'Difficult conversations' training will be delivered to health and social care providers to assist with planning for anticipatory care needs, which will help to avoid crisis situations leading to hospital attendances and admissions, especially where the latter is not the preferred place of care.

g) *Implementing outcome of review of support for carers of people at end of life* – Any gaps in service provision to support carers of people at end of life will be considered as part of the work undertaken in scheme 7: *Supporting Carers*. Where additional funding is required appropriate business cases will be developed for consideration by the Council and/or CCG.

h) *Reviewing available information* – Access to good, up to date information is critical to support residents/patients and their Carers and families. For residents/patients this will be promoted through the resident online portal Connect for Support. For professionals the additional route is the NHS Directory of Services. The range of services advertised and accuracy of the data will be monitored by the End of Life Forum.

Commissioning Arrangements

2.4 Pooled budget.

The Delivery Chain

Scheme Lead Role

2.5 HCCG shall lead on this scheme, the implementation of which will be overseen by the multi-agency End of Life Forum.

Scheme Delivery

2.6 The providers will be a combination of primary care, community NHS services, acute, social care, London Ambulance Service and voluntary and community sector providers.

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Community Palliative Team	CNWL	0	106	106
b) Specialist Palliative Personal Care Service	Third Sector	50	0	50

TOTALS		50	106	156

Contribution to BCF Metrics

2.7 This scheme will contribute to the following key BCF metric:
a) Reduction in non-elective admissions.

Other Success Measures

2.8 The following measures will be used to identify whether the scheme is working:
a) To achieve 90% of people at end of life with an advanced care plan on CMC.
b) >50% of people with an advanced care plan on CMC dying in their preferred place of care.
c) Positive family/carer experience of the quality of care and support provided at end of life. Securing this information will require a separate survey to be undertaken the sensitive nature of which is likely to necessitate one to one support.

Scheme Three: Rapid Response and Integrated Intermediate Care

Scheme Strategic Objectives

3.1 Prevention of admission and readmission to acute care following an event or a health 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.

Scheme Overview

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, the Home Treatment Service 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 This scheme is aligned with the early supported discharge HomeSafe Service, which is clinically led by Hillingdon Hospital through the Care of the Elderly Team (COTE). The service entails older people aged 65 and over who are admitted through the ED being screened for a comprehensive geriatric assessment (CGA). Patients who receive a CGA will be managed on the HomeSafe pathway. Health and care needs identified are met by community based providers for up to 10 days to facilitate clinically appropriate and timely discharge from acute care. Appropriate onward referrals to address on-going needs are then made.

3.4 The intermediate care provision is made up of the 22 bed Hawthorn Intermediate Care Unit (HICU) on the Hillingdon Hospital site, the Community Rehabilitation Team, Reablement Team, community equipment, telecare services and Prevention and Admission to Hospital Service provided by Age UK for people with low social care needs. 5 step-down beds are provided at Franklin House Nursing Home for people who are medically stable and are a) on a rehabilitation pathway, need a bed-based service but unable to weight bear for 3 weeks or more; or b) are undergoing an assessment for continuing health care (CHC) which has not yet been completed. There is also a flat at the Cottesmore House extracare sheltered housing scheme that is used to meet step-up or step-down needs and supported by private sector care provider with in-reach support from the Reablement Team.

3.5 During 2015/16 an integrated discharge team has been set up in the Acute Medical Unit (AMU) to identify adults with care needs as soon as they are admitted to hospital and to take a more proactive and joint approach between health and social care to discharge management. This will continue into 2016/17.

3.6 Although there has been greater functional alignment between services during 2015/16 they still remain fragmented. During 2016/17 work will take place to explore integration options, including possible incentivisation of providers, that will deliver the following outcomes:

- Reduction in the number of hand-offs between different organisations.
- Resident/patient needs being addressed by the most suitably qualified professional first time.
- Reduction in the number of points of access.
- Reduction in length of stay in intermediate care services.
- Improved resident/patient experience of care.
- Value for money.

3.7Service options development will also include consideration of procurement routes.

The Delivery Chain

Scheme Lead Role

3.8 HCCG will lead on this scheme, the implementation of which will be overseen by the Systems Resilience Group.

Scheme Delivery

3.9 Crisis response and home treatment services are provided by CNWL and commissioned by the CCG. They link with the Reablement Team which is provided by LBH. They also link into private sector provided homecare commissioned by LBH.

3.10 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.

3.11 It is expected that delivery options during 2016/17 will be shaped by the emerging Accountable Care Partnership (ACP).

Commissioning Arrangements

3.12 Pooled budget

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Rapid Response	CNWL	0	1,546	1,546
b) Hawthorn Intermediate Care Unit	CNWL	0	1,614	1,614
c) Community Rehab	CNWL	0	1,094	1,094
d) Prevention of Admission/Readmission to Hospital (PATH)	Age UK	29	91	120

e) Take Home & Settle	Age UK	0	63	63
f) Reablement Team	LBH	2,211	0	2,211
g) Reablement Physio	CNWL	51	0	51
e) Community Homesafe	CNWL	0	688	688
f) Spot purchased intermediate care beds	Various P & V	341	0	341
g) Step-down beds (Franklin House)	Care Uk	0	198	198
h) Support to step-down beds	CNWL	0	53	53
i) Cottesmore Reablement Flats	Paradigm Housing Group	38	0	38
j) Hospital Social Workers	LBH	210	0	210
k) Mental Health Nurse in Rapid Response	CNWL	40	0	40
TOTAL		**2,920**	**5,347**	**8,267**

Contribution to BCF Metrics

3.13 This scheme will impact on the following BCF metrics:

a) Reduction in the number of non-elective admissions.
b) Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population from 2015/16 baseline.
c) Increase in % of older people aged 65 years and over who are still at home 91 days post hospital discharge into reablement service from 2015/16 baseline.

Other Success Measures

3.14 The following measures will be used to identify whether the scheme is working:

- 7 admissions a day avoided following referral to Rapid Response by Hillingdon Hospital's Emergency Department and 1 admission per day avoided following referrals from other routes.
- Average number of discharges supported home from Hillingdon Hospital wards by HomeSafe per day.
- Reduction in admissions resulting in a length of stay (LOS) of between 0 and 2 days.
- 78 admissions avoided as a result of the availability of the Rapid Access Care of the Elderly (COTE) clinics.
- Average of 80 referrals to Reablement per month.
- % of new clients who received Reablement where no further request was made for long-term support.
- Number of reablement cases closed within 6 weeks.
- Number of people readmitted to hospital whilst receiving reablement.

3.15 Qualitative feedback will be sought through surveys of residents/patients to capture their feedback about their experience.

3.16 Baselines will be established in Q4 2015/16 against which progress in 2016/17 can be measured.

Scheme Four: Seven Day Working

Scheme Strategic Objectives

4.1 To improve quality and patient safety through reducing inconsistent care provision by:-

a) Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures;

b) Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission and reducing length of stay for people admitted to hospital for either planned or unplanned procedures;

c) Reducing the uneven rate of hospital discharge across the week.

Scheme Overview

4.2 This scheme is intended to deliver standard 9 of the 10 Seven Day Working Clinical Standards.

4.3 There are a number of interdependencies with other schemes that are critical to the delivery of standard 9 and these include:

a) *Placements for people with challenging behaviour needs* - Securing suitable local placements for people with challenging behaviour needs is a key cause of delayed transfers of care and this piece of work falls within the remit of scheme 6: *Care Home and Supported Living Market Development;*

b) *Seven day assessments in nursing homes* - The availability of suitably qualified staff in nursing homes to undertake assessments of people who have been admitted to hospital and are medically fit for discharge will contribute to delivering a more even spread of discharges across the week. This requirement will be included as a condition of the Dynamic Purchasing System (DPS) tender for care homes that the Council is undertaking with the West London Alliance (WLA) of local authorities. This piece of work falls within the remit of scheme 6: *Care Home and Supported Living Market Development.*

c) *Palliative & hospice bed provision* - The ability of the Hospital to discharge people who are at end of life is impacted by available service provision and this will also be addressed under scheme 6: *Care Home and Supported Living Market Development.* This also links with scheme 2: *Better care at end of life*.

4.4 Improvements in managing the discharge process from Hillingdon Hospital introduced in 2015/16 will be carried forward into 2016/17. Essential components of this will be earlier planning and this will be assisted by the following:

a) *Advanced discharge planning on wards* - Hospital wards will be set specific targets to facilitate advanced discharge planning to ensure that key enablers such as medication and transport are available. Opportunities for standardising the MDT process on wards on the Hillingdon Hospitals sites will be explored. The objective of this work will be to apply the most effective MDT model consistently to achieve a better experience of care for patients and expedite the discharge of people who no longer need to be in hospital.

b) *Embedding earlier referrals to Hospital transport* - The Hospital has transport available 24/7 365 days a year but earlier planning will assist in enabling referrals to be made earlier in the day in order to avoid a glut of activity around 4pm. This will also help to

improve the experience of care by preventing patients being taken back home late at night.

c) *Developing the Integrated Discharge Team* (IDT) - The continuation of the IDT into 2016/17 is subject to the outcome of an evaluation into its effectiveness that will take place in Q4 2015/16. However, the practice of Adult Social Care proactively engaging with the wards to facilitate advanced discharge planning will continue in one form or another. Subject to the availability of accommodation on the Hospital site, there will be an increased social care presence to ensure a prompt response to addressing social care needs, which will contribute to a more even seven day flow out of the Hospital. This links into scheme 3: *Rapid Response and Integrated Intermediate Care*.

4.5 Other required components of the work to improve the discharge process will include:

a) *Addressing needs of people with acute mental health needs* - Caring for people admitted to the Emergency Department with acute health needs in addition to severe mental health needs can be very resource intensive and this can impact on the delivery of a smooth discharge pathway for other patients. Through joint working between the CCG, Hillingdon Hospital, CNWL and the UK Border Agency the intention is to release acute mental health beds to ensure that people with acute mental health needs are cared for in the most appropriate setting to support their recovery.

b) *Earlier referrals to Psychiatric Liaison Service* (PLS) - Changing practice to ensure early referral of patients showing signs of mental distress are referred to the PLS prior to discharge will also assist in preventing readmission that is avoidable.

c) *Developing the role of the third sector* - Linking into scheme 3: *Rapid Response and Integrated Intermediate*, the support from the third sector to people at the point of discharge and in the first few weeks after they have returned home will be considered. The purpose of this will be to ensure that maximum benefit can be obtained from the unique skills available from the third sector to support the independence of residents and prevent readmissions that are avoidable.

d) *Developing a common functional assessment in hospitals in North West London (excluding Hillingdon Hospitals)* - Assessment of patient need and function occurs within the hospital and is carried out by the hospital Multi-disciplinary Team (MDT) however, decision-making about which community service(s) is most appropriate is undertaken by the community team. The development of a common tool for assessing a patient's needs and function in hospitals other than Hillingdon Hospital would assist in supporting the discharge process where Hillingdon residents are admitted to other hospitals in north west London.

Commissioning Arrangements

4.6 Pooled budget.

The Delivery Chain

Scheme Lead Role

4.7 Hillingdon Hospital will continue as the lead for this scheme, which will be overseen by the System Resilience Group (SRG). The SRG has responsibility for monitoring delivery of all the clinical standards mandated by NHSE.

Scheme Delivery

4.8 The services required to deliver a more even hospital discharge process across the week will be provided by a combination of the following providers: The Hillingdon Hospital Foundation Trust, Central North West London Community Health and Mental Health Services, Hillingdon's four GP networks, Adult Social Care, Hillingdon's third sector and the private sector.

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Mental Health Social Workers	LBH	100	0	100
TOTALS		**100**	**0**	**100**

Contribution to BCF Metrics

4.9 The scheme will impact on the following BCF metrics:
a) Reduction in non-elective admissions through a reduction in readmissions
b) % of people supported at home 91 days post discharge into reablement by reducing the number of readmissions related to the cause of the original admission.

Other Success Measures

4.10 The following measures will be used to identify whether the scheme is working:
a) 35% of discharges should occur before midday 7/7.
b) Weekend discharges are 80% of weekday rates.
c) Number of people discharged at weekends.
d) % of people supported at home 91 days post discharge into reablement.
e) Reduction in differential mortality rates between weekdays and weekends.
f) Reduction in readmissions within 30 days.
g) Resident/patient feedback
h) Carer feedback

4.11 With the exception of the last two measures, this data is collected automatically. The last two qualitative measures will require new surveys to be undertaken of patients and carers.

Scheme Five: Integrated Community-based Care and Support

Scheme Strategic Objectives

5.1 To ensure that community based care and support works as effectively and as efficiently as possible and is aligned across primary care and community services to deliver anticipatory care in community settings that achieves the best outcomes for patients/residents and delivers value for money.

Scheme Overview

5.2 There has been a review and improvement in efficiency of a range of community health services to ensure that value for money from existing services is being achieved. An integrated model of care for older people will be extended where integrated care and support planning approaches facilitate closer integration between health, social care and third sector providers and delivers improved outcomes.

5.3 This scheme will contribute to this through the following actions:

a) *Expanding the use of risk stratification tools* - The Metrohealth GP network in the north of the borough has been using a combination of multi-provider risk stratification tools, informed GP practice intelligence and informed provider intelligence to detect early signs of frailty to trigger earlier support. During 2016/17 risk stratification tools will be refined and this learning will be rolled out across the borough to all practices.

b) *Mainstreaming personalised care planning* - Care planning processes and outcomes have been reviewed in 2015/16. This will enable work the undertaken in 2015/16 and linked to the application of risk stratification tools to be fully embedded in GP networks across the borough to support a reduction in avoidable emergency admissions to hospital. This will be supported by the development of the co-produced Integrated Care and Support Record (ICSR) and, subject to the outcome of the pilot, the further scale up of the care information exchange (CIE) platform.

c) *Embed a multi-disciplinary team (MDT) approach to addressing the needs of residents/patients with complex needs* - GP networks will be supported to embed the MDT approach as a cost effective tool for maximising the health and wellbeing of residents/patients living with long-term conditions. This will include training for MDT chairs as well as practical support for the administration of meetings.

d) *Scaling up the integrated model of care for older people across the borough* - Building on integrated care planning in primary care, an enhanced model of integrated care provision for older people is currently being piloted with Metrohealth GP network in the north of the borough. This will inform commissioning a system wide integrated model of care for older people in shadow form in 2016/17 and will enable the involvement of other networks as maturity builds. This approach requires new contractual relationships with primary care, community health, acute and the third sector and the development of enablers to drive better outcomes.

e) *Raise awareness within primary care of community service provision and access routes* - Training will be provided to staff within primary care about the range of services provided by the Council to support the health and wellbeing of residents/patients in their own homes, including the provision of Disabled Facilities Grants (DFGs). Training will include promotion of the online resident portal Connect to Support and how to access information about the range of services provided by the voluntary and community sector.

f) *Deliver an integrated community equipment service* - Community equipment is critical to supporting people with physical disabilities and/or sensory impairments in their own home. People of all ages often have a variety of equipment needs, ranging from daily living equipment such as bath board, hoists, electric beds, etc, to more medical equipment, e.g. pressure relieving mattresses and/or oxygen. To avoid the coordination difficulties posed by having different providers delivering different types of equipment, the community equipment service will be retendered in 2016/17 under a model that brings together as many types of equipment as possible to improve efficiency in meeting the equipment needs of residents/patients. This provision will apply to all adults and children.

g) *Relaunch the retail model for community equipment* - The purpose of the retail model is to give residents greater choice by enabling them to access more personalised equipment than is available from the standard catalogue available to the Council and the NHS. Under this model they can pay a top-up if the cost of the equipment item is greater than the equipment prescription value.

h) *Develop an integrated approach to home care market development and management* - This will bring together health and social care to ensure better management of medication in the community. A key intended outcome would be to prevent residents/patients needing to

change provider to address their respective health or social care needs unless this was necessary for clinical reasons. Another outcome would be to ensure service availability to support people who had care needs but who did not meet the national eligibility criteria for social care. As part of the joint approach to the management of the homecare market is ensuring the availability of provision to support people in the community living with dementia, which links with scheme 8: *People living well with dementia*.

i) *Expansion of Personal Health Budgets (PHB)* – A local offer for PHBs will be developed for residents/patients living with one or more long-term conditions and also children with special educational needs. The PHB offer will not be restricted to people who are eligible for NHS funded Continuing Healthcare. During 2016/17 a three year plan to expand the take-up of PHBs will be developed and this will include joint PHBs and Direct Payments where an adult meets the national eligibility criteria for a financial contribution from the local authority to meet their social care needs. The plan will also address market development issues.

Commissioning Arrangements

5.4 LBH to be lead commissioner for community equipment service.

5.5 Pooled budget.

The Delivery Chain

Scheme Lead Role

5.6 HCCG will lead for this scheme, which will be overseen by the multi-agency Integrated Care Steering Group.

Scheme Delivery

5.7 An Accountable Care Partnership (ACP) is HCCG's preferred model of delivery for integrated care. An ACP is where a group of providers agree to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Under this model providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target. In Hillingdon the ACP comprises of The Hillingdon Hospitals Foundation Trust, Central North West London Foundation Trust (CNWL), Metrohealth GP network and the H4All third sector consortium.

5.8 Commissioning integrated care from the ACP will initially be for older people with long term conditions, but will progress in scope to all older people and other population groups with long term conditions. This is not expected to occur in 2016/17, which will be a shadow year before the ACP becomes fully operational in 2017/18. The ACP will deliver services under the current contracts held by its constituent organisations and a shadow capitated budget will be developed in 2016/17. A capitated budget is a sum of money based on the estimated needs of a population group and for 2016/17 this will initially be older people with long-term conditions. Both the CCG and the ACP will monitor the cost of the model of care and outcomes in readiness for moving to a full capitated model after April 2017.

5.9 The Council will commission care and support provision in extra care schemes from an independent sector provider and the CCG will commission community health services either from the existing community provider or an independent sector provider following a procurement process. Primary care services will be co-commissioned between the CCG and NHSE from the appropriate GP networks.

5.10 Community equipment is commissioned by the Council on its own behalf and that of the

CCG and the service is provided by a private company. Hillingdon is part of a consortium comprising of 16 London boroughs and CCGs that is led by Hammersmith and Fulham. See **Schedule 1C** for detailed local operation of this service.

5.11 The success of the retail model for community equipment is dependent on there being a range of approved providers. There are currently 16 participating pharmacists and expanding this coverage will be a task for 2016/17.

5.12 Both the Council and the CCG commission homecare providers from a range of private and independent sector companies.

5.13 Individual residents/patients will commission services directly from a range of third sector or private sector providers.

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Community equipment contract	Medequip Assistive Technology LTD	756	685	1,441
b) Pressure relieving mattresses	DHS	0	200	200
c) Telecare	Tunstall/LBH	262	0	262
d) Continence service	CNWL	0	529	529
e) Community matrons	CNWL	0	677	677
f) District Nursing	CNWL	0	3,287	3,287
g) Twilight Service	CNWL	0	167	167
h) Tissue Viability	CNWL	0	386	386
i) Disabled Facilities Grants	LBH	3,457	0	3,457
j) Packages of care: maintaining eligibility criteria	Various P & V	655	0	655
k) Medication Administration Record (MAR chart) provision	Community Pharmacists	0	8	8
l) Medication administration training	Opus	0	16	16
m) Homecare provider care standards training	Independent Sector	15	0	15
n) Adult Safeguarding	LBH	260	0	260
TOTALS		**5,412**	**5,973**	**11,385**

Contribution to BCF Metrics

5.14 This scheme will impact on the following BCF metrics:
a) Reduction in non-elective admissions
b) Reduction in permanent admissions to care homes of 65 + population.
c) Reduction in delayed transfers of care.
d) Social care quality of life.

Other Success Measures

5.15 The following measures will be used to identify whether the scheme is working:
a) Proportion of residents identified as in need of preventative care who have been offered a care plan.
b) Proportion of patients who have care planning where there is a tangible improvement in quality of life and level of independence.
c) Proportion of patients who have achieved jointly agreed goals in 6 months or have shown a very positive progression towards achievement of their goals.
d) Improved patient experience tested by part of patient survey.
e) Number of people in receipt of a Personal Health Budget.

Scheme Six: Care Home and Supported Living Market Development

Scheme Strategic Objectives

6.1 Through market reshaping secure:
a. A vibrant, quality care home market that meets current and future local need; and

b. An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.

Scheme Overview

6.2 This scheme is focused on two areas:
a) The care home (residential and nursing) primarily for older people but also for younger adults with physical disabilities; and
b) The supported living markets for all adults and not just older people.

6.3 The scheme will include the following actions:

a) *Launch of market position statements (MPSs)* - Through MPSs developers and providers of care homes for older people and other population groups and developers and providers of supported living schemes for older people and other population groups will be advised of LBH/HCCG needs over the next 3 - 5 years to address health and care needs of the population;

b) Securing suitable care home provision for people with challenging behaviour needs - Securing suitable local placements for people with challenging behaviour needs, including those associated with dementias, is a key cause of delayed transfers of care. This will be accomplished through providing appropriate wrap-around support for care homes that includes access to medical and clinical expertise to existing providers as well as facilitating new supply, where appropriate. This links with scheme 4: *Seven day working;*

c) *Palliative & hospice bed provision* - A review of bed based services will consider the need for additional palliative and bed-based hospice provision. Delivery of the outcomes of the review will start in 2016/17 but any new locally based services may take up to two years to come on

stream. This links with scheme 2: *Better care at end of life* and scheme 4: *Seven day working*;

d) *Monitoring quality of service provision*: A jointly agreed process for encouraging and monitoring quality of provision within the care home and supported living markets will be embedded;

e) *Managing business failure* - A jointly agreed process for identifying and responding to provider business failure that will ensure continuity of service provision will be embedded;

f) *Agreed price for care tool implementation* - Implementing an agreed tool for establishing a fair price for care will provide a transparent basis for determining care home fees that allow for market stability and are affordable and provide value for money for commissioners;

g) *Securing agreement on integrated brokerage options* – Options for integration of nursing care home brokerage placements following work undertaken in 2015/16 will be considered jointly by the Council and CCG alongside options for joint contracting arrangements;

h) *Implementing preferred contracting options for care homes* - Development of a joint care home specification that employs appropriate contractual levers to implement national policy priorities, e.g. seven day working. This will also include partnership working with the West London Alliance (WLA) of local authorities to tender for a Dynamic Purchasing System (DPS) for care homes. A DPS is a fully-electronic process used by public sector bodies to award contracts for works or services and it ensures that the end-to-end procurement process is competitive, fair and transparent.

i) *Development of a menu of in-reach support for care homes and supported living schemes* - This would include medical and other clinical advice that will prevent hospital admissions that are avoidable;

j) *Developing the model of care and support for extra care* - The development of wrap-around services to ensure that the health and care needs of older people in existing extra care sheltered schemes, Cottesmore House and Triscott House, are met as well as those in two new schemes (Grassy Meadow and Parkview) to be opened in 2018. The intention will be to minimise the circumstances where it is necessary for people living in these schemes to be admitted to care homes to address their needs.

Commissioning Arrangements

6.4 Pooled budget.

The Delivery Chain

Scheme Lead Role

6.5 The Council will lead on this scheme and will be supported by a multi-agency task and finish group.

Scheme Delivery

6.6 The Council and CCG currently commission care home placements separately and often from the same private providers. The need for care home provision will be met by the private or independent sector market and through this scheme different commissioning options will be considered, including lead commissioning arrangements.

6.7 In-reach support from community matrons to care homes is commissioned by the CCG from CNWL. Any enhancement to this service to include other clinical and medical support and also to include supported living schemes would be subject to approval of proposed business cases and could be further developed within the emerging ACP.

6.8 The Council currently commissions a private provider to deliver care to the tenants of two existing extra care schemes, Cottesmore House and Triscott House. Housing-related support is provided directly to tenants by the Council. The Council will continue to be the lead commissioner for the service provided to tenants at these schemes and the new ones due to open in 2018. It is expected that core care and support hours, e.g. the level of care required for the safe running of the schemes, will be delivered by a private or independent sector

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Quality Assurance Team	LBH	150	0	150
b) Care Home Prescriber	HCCG	0	32	32
TOTAL		**150**	**32**	**182**

Contribution to BCF Metrics

6.9 This scheme will impact on the following BCF metrics:
a) Reduction in non-elective admissions
b) Reduction in permanent admissions to care homes of 65 + population.
c) Reduction in delayed transfers of care (mental health).
d) Social care quality of life.

Other Success Measures

6.10 The following measures will be used to identify whether the scheme is working:
a) Reduction in non-elective admissions from care homes.
b) Reduction in non-elective admissions from supported living schemes, including extra care.
c) Reduction in number of people aged 65 + dying in hospital within seven, fourteen and twenty-one days of admission from a care home where the hospital is not their preferred place of care. This links to scheme 2: *Better care at end of life*.

Scheme Seven: Supporting Carers

Scheme Strategic Objective

7.1 This strategic objective of this scheme is that carers are able to say:
• "I am physically and mentally well and treated with dignity"
• "I am not forced into financial hardship by my caring role"
• "I enjoy a life outside of caring"
• "I am recognised, supported and listened to as an experienced carer"

Scheme Overvew

7.2 The 2014 Care Act increased the responsibilities of local authorities towards adult carers. The Act changed the definition of who is a carer so that any adult providing unpaid care to another adult is legally regarded as a carer whether or not they regard themselves as such. Any

carer within this definition has a right to a carer's assessment and also to have their own care and support needs identified from the assessment met by the local authority. This scheme seeks to support the health and wellbeing of carers, both adults and young carers and this will be achieved through the following actions:

a) *Deliver a communications campaign to increase awareness and take up of carers' support/services* - The campaign will include identifying "hidden", e.g. people who do not necessarily identify themselves as carers. It will also include a *'What would you do? Where would you go?*' initiative to raise awareness for all residents who could become carers at any time.

b) *Reviewing assessment capacity across the borough to provide additional support to carers* - The expectation is that as the population ages the number of carers will increase and there consequently needs to be sufficient capacity within the system to permit timely carers' assessments to take place. Some demand may be absorbed by the online self-assessment facility through Connect to Support but the Council will ensure sufficient capacity through its contracts with the third sector. From the autumn of 2016 this flexible response to demand for carers' assessments would come within the carers' hub contract.

c) *Implement the carers' hub contract* - Following a tender for an integrated support service for carers in 2015/16 the new contract will be implemented in the autumn of 2016.

d) *Deliver GP annual health checks and flu jab programmes for carers* - GP practices will be supported by the Communications Team to proactively identify carers and to register them as carers. Where feasible each practice will identify someone as a carers' champion and the definition of this role will be agreed in consultation with teh GP networks. A mechanism for referring carers for a health check following a carer's assessment will also be developed.

e) *Deliver options to extend services for carers -* e.g. weekend carers cafes, more activities in winter months and condition specific cafes e.g. dementia, MH, autism and provide access to appropriate and improved 7 day health care services

f) *Delivery of an integrated engagement framework for carers* - This is being developed in 2015/16 and is intended to enhance the voice of carers in service planning and delivery, across all providers. It will include use of technology to enable carers to give their views online in a way that is least disruptive to them. Subject to the outcome of a feasibility study, it may also include establishing a Carers' Assembly.

g) *Support for carers of people at end of life* – The results of the review of the needs of carers of people at end of life undertaken as part of the work of the End of Life Forum under scheme 2: *Better care at end of life*, will be implemented. Where additional funding is required appropriate business cases will be developed for consideration by the Council and/or CCG.

Commissioning Arrangements

7.3 Pooled budget.

The Delivery Chain

Scheme Lead Role

7.4 The Council shall lead on this scheme and will be supported by the multi-agency Carers Strategy Group.

Scheme Delivery

7.5 Carers' assessments are undertaken by the Council with additional capacity commissioned from Hillingdon Carers by the borough. This will continue during 2016/17.

7.6 Information and advice for carers is commissioned by the Council from a range of third sector providers and these include Hillingdon Carers, Rethink and the Alzheimers' Society. It is intended that the new carers' hub service being tendered during 2015/16 will be delivered by a third sector organisation and provide a single point of access to services for carers. This will include information and advice to young carers and a range of support services, including some therapeutic services.

7.7 The Council has commissioned the Carers' Trust to provide a sitting service for carers of people who do not meet eligibility criteria. This enables carers to take a break of four hours a week. A carers' assessment is not required for them to be able to access this service and any carer requiring more support may be able to receive this following an assessment. This service will be part of the new Carers' Hub Service that will operational from 1st October 2016.
Local GP networks are responsible for delivering health checks for carers. Where appropriate, Personal Health Budgets will be made available during 2016/17 to address the specific healthcare needs of carers identified from the health check process. See scheme 5: *Integrated Community-based Care and Support*.

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Carers' hub, assessments and review	Third sector	600	0	600
b) Services to carers (inc respite)	Various P & V	209	0	209
c) Support to Hillingdon Social Care Direct	LBH	70	0	70
d) Training	Third sector	20	0	20
e) Carer Support Worker	Hillingdon Carers	0	18	18
TOTALS		**899**	**18**	**917**

Contribution to BCF Metrics

7.8 This scheme will impact on the following BCF metrics:

a) Reduction in non-elective admissions.
b) Reduction in permanent admissions to care homes of 65 + population.

Other Success Measures

7.9 The following measures will be used to identify whether the scheme is working:

a) Number of carers' assessments completed.
b) Number of carers receiving respite or a carer specific service following an assessment.
c) Through the national carers' survey:

I. Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
II. Carer quality of life questions about:

- Getting enough sleep and eating well
- Having sufficient social contact
- Receiving encouragement and support.

d) Number of carers on GP Carers' Registers.
e) Number of Carers in receipt of a Personal Health Budget. Links with scheme 5: *Integrated Community-based Care and Support*.

Scheme Eight: People living well with Dementia

Scheme Strategic Objective

8.1 The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia.

Scheme Overview

8.2 Hillingdon's ageing population means that dementia, a condition primarily associated with old age, is going to have a significant impact on the local health and care economy for the foreseeable future. Through more integrated working across health and social care it is intended that this scheme will contribute to people affected by dementia being able to say:

- I was diagnosed in a timely way.
- I know what I can do to help myself and who else can help me.
- Those around me and looking after me are well supported.
- I get the treatment and support, best for my dementia, and for my life.
- I feel included as part of society.
- I understand so I am able to make decisions.
- I am treated with dignity and respect.
- I am confident my end of life wishes will be respected. I can expect a good death.

8.3 To achieve this the following actions will be taken:

a) *Preventing or delaying the onset of dementia* - This action links in with the work being undertaken under scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation*, as the actions intended to prevent stroke will also assist in preventing or delaying the onset of dementia, e.g. promoting physical activity, nutrition guidance, smoking cessation and early detection of conditions such as hypertension and high cholesterol.

b) *Implementing a single point of access (SPA) for crisis care* - Building on a single point of access to urgent and crisis care in 2015/16, the service will be developed in 2016/17 so that people with urgent mental health needs, including dementia, are able to receive multi-disciplinary assessments of need and onward referral as appropriate. It is envisaged that referrals into the SPA would come from professionals and voluntary and community organisations as well as residents themselves and/or their carers.

c) *Completion of Integrated Multi-disciplinary Team business case* - Following modelling work undertaken in 2015/16, a business case will be developed in 2016/17 for a multi-disciplinary service model encompassing Memory Assessment, older people mental health beds and community home treatment services to provide a more integrated service for older people with dementia requiring diagnosis and post-diagnosis support. This will include case management approaches for people living with dementia and other long-term physical health needs. This links into existing integrated care planning for older people and specifically with scheme 5: *Integrated Community-based Care and Support.*

d) *Developing a local dementia resource centre model* - A dementia resource centre will be included in the 88 flat Grassy Meadow extra care scheme due to open in early 2018. This resource is primarily intended to meet the social care needs of people living with dementia in the community with family carers, but during 2016/17 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

e) *Developing standardised training for providers* - The multi-agency Dementia Working Group will develop a training framework for health and social care staff that will address the following three tiers:

- Tier 1: Dementia Awareness ('Essential information') that highlights the basic, essential competencies relevant to all sections of workforce and society.
- Tier 2: 'Enhanced' builds on tier 1 and highlights competencies needed for those working in general health or social care settings and for those working with people with dementia.
- Tier 3: 'Specialist' builds on tiers 1 & 2 and is relevant to those working in a more specialist and intensive way with people with dementia.

8.4 It is envisaged that tier 1 and 2 would be available as an e-learning modules.

a) *Securing care home provision for people living with dementia with challenging behaviours* – The current limited availability of this provision is the cause of people with dementia staying in inappropriate care settings for longer than is desirable and can contribute to delayed transfers of care. The work being undertaken under scheme 6: *Care Home and Supported Living Market Development* is intended to address this gap in provision.

b) *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

Commissioning Arrangements

8.5 Pooled budget.

The Delivery Chain

Scheme Lead Role

8.6 HCCG shall lead on this scheme, which will be overseen by the multi-agency Dementia Working Group task and finish project group.

Scheme Delivery

8.7 Information and advice about dementia is commissioned by the Council from the Alzheimer's Society, who also provide an advice centre at the Templeton Centre in Northwood. The CCG commissions CNWL to provide a memory assessment service which is based at the Woodland Centre on the main Hillingdon Hospital site. In-patient provision is also based at the Woodland Centre, which is commissioned by the CCG. Both the Council and the CCG commission CNWL to provide an Admiral Nurse service, which supports carers of people living with dementia.
8.8 There are 29 care homes in Hillingdon that support older people and 26 of these are registered to support people with dementia. The direction for national and local policy is to support people living with dementia in their own homes or in as least restrictive environment as possible for as long as possible, which is one of the reasons for the development of extra care schemes. The commissioning of care homes and care and support provision is addressed within scheme 6: *Care Home and Supported Living Market Development.* This includes provision to address the needs of people living with dementia with challenging behaviours.

8.9 Both the Council and the CCG commission homecare provision from private and independent sector providers to support people in their own homes with their personal care and health needs. The availability of a service to address the care needs of people living with dementia will be addressed under scheme 5: *Integrated Community-based Care and Support.*

8.10 The Council's Wellbeing Team, in partnership with the Libraries Service, provides a range of activities to keep people living with dementia mentally and physically active. This links with scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.*

Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
Wren Centre	LBH	300	0	300
Staff & provider training	Third sector	5	0	5
	Totals	**305**	**0**	**305**

Contribution to BCF Metrics

8.11 This scheme will impact on the following BCF metrics:
a) Reduction in permanent admissions to care homes of 65 + population.
b) Social care quality of life.

Other Success Measures

8.12 The following measures will be used to identify whether the scheme is working:
a) Diagnosis rate as a percentage of projected prevalence of dementia within the Hillingdon population.
b) Proportion of residents identified as in need of preventative care who have been offered a care plan.
c) Number of people in receipt of a Personal Health Budget.
d) Evaluation of training delivered to providers.

SCHEDULE 1A - FINANCAL CONTRIBUTIONS SUMMARY

Table 1: Funding Summary 2016/17 (£,000)	
Source of Funds:	
HCCG BCF Grant	16,558
LBH DFG Grant	3,457
HCCG Voluntary Contribution	1,344
LBH Voluntary Contribution	1,172
Total	**22,531**

Allocation of Funds:	
Hillingdon CCG	11,965
LB Hillingdon	10,566
Total	**22,531**

Table 1A: Payment Arrangements Summary	
Funding to be transferred to LBH from HCCG	17,902
Funding to repaid to HCCG to cover contract/service obligations shown in Table 2 below.	11,965
Funding retained by LBH to cover contract/service obligations shown in Table 2 below.	5,937

Table 2: Contract and Provider Breakdown 2016/17					
Contract/Expenditure	**Provider**	**Lead Partner**	**Funding Partner**		**TOTAL**
			LBH	**HCCG**	
Scheme 1: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation					
a) Health and Wellbeing Service	H4All	HCCG	543	195	738

b) Connect to Support	Shop4Support	LBH	45	0	45
c) Online Services Coordinator	LBH	LBH	44	0	44
d) Equipment Provision- Atrial Fibrillation screening	LBH	LBH	5	0	5
e) Wellbeing initiatives for older people	LBH	LBH	20	0	20
f) Falls Prevention Service	Age UK	HCCG	0	140	140
g) Primary Care	GP Networks	HCCG	0	55	55
SCHEME 1 TOTAL			**657**	**390**	**1,047**
Scheme 2: Better care for people at the end of their life					
a) Community Palliative Team	CNWL	HCCG	0	106	106
b) Palliative Personal Care Service	Third sector	LBH	50	0	50
SCHEME 2 TOTAL			**50**	**106**	**156**
Scheme 3: Rapid response and Integrated Intermediate Care					
a) Prevention of Admission/Readmission to Hospital (PATH)	Age UK	HCCG	29	91	100
b) Take Home and Settle	Age UK	HCCG	0	63	63
c) Reablement Team	LBH	LBH	2,262	0	2,262
d) Spot purchased intermediate care beds	Various P & V	LBH	341	0	341
e) Cottesmore Reablement Flats	Paradigm Housing Group	LBH	38	0	38
f) Hospital Social Workers	LBH	LBH	210	0	210
g) Mental Health Nurse	CNWL	LBH	40	0	40
h) Rapid Response	CNWL	HCCG	0	1,546	1,546
i) Hawthorn Intermediate Care Unit (HICU)	CNWL	HCCG	0	1,614	1,614
j) Community Rehab	CNWL	HCCG	0	1,094	1,094
k) Step Down Beds (Franklin House)	Care UK	HCCG	0	198	198
l) Community Rehab Support to Step-down beds	CNWL	HCCG		53	53
m) Community Homesafe	CNWL	HCCG	0	688	688

SCHEME 3 TOTAL			**2,920**	**5,347**	**8,267**
Scheme 4: Seven Day Working					
a) Mental Health Social Workers	LBH	LBH	100	0	100
SCHEME 4 TOTAL			**100**	**0**	**100**
Scheme 5: Integrated Community-based Care and Support					
a) Community Equipment	LBH	LBH	756	685	1,441
b) Pressure Relieving Mattresses	DHS		0	200	200
c) Telecare	Tunstall/LBH	LBH	262	0	262
d) Training for Home Care Providers	LBH	LBH	15	0	15
e) Medication Administration Training (Homecare Providers)	OPUS	HCCG	0	16	16
f) Medication Administration (MAR)	Community Pharmacies	HCCG	0	8	8
g) Continence Service	CNWL	HCCG	0	529	529
h) Community Matrons	CNWL	HCCG	0	677	677
i) District Nursing	CNWL	HCCG	0	3,287	3,287
j) Twilight Service	CNWL	HCCG	0	167	167
k) Tissue Viability	CNWL	HCCG	0	386	386
l) Care Plan Coordination	Primary Care	HCCG	0	67	67
m) Packages of Care: Maintaining Eligibility Criteria	LBH	LBH	655	0	655
n) Disabled Facilities Grants	LBH	LBH	3,457	0	3,457
o) Adult Safeguarding	LBH	LBH	260	0	260
SCHEME 5 TOTAL			**5,405**	**6,021**	**11,426**
Scheme 6: Care Home and Supported Living Market Development					
a) Quality Assurance Team	LBH	LBH	150	0	150
b) Community Matrons	CNWL	HCCG	0	51	51
c) Care Home Prescriber	HCCG	HCCG	0	32	32
SCHEME 6 TOTAL			**150**	**83**	**233**
Scheme 7: Supporting Carers					

a) Carers' hub, assessments and review	Third sector	LBH	600	0	600
b) Services to carers (inc respite)	Various P & V	LBH	209	0	209
c) Support to HSCD	LBH	LBH	70	0	70
d) Training	Third sector	LBH	20	0	20
e) Carer Support Worker					
SCHEME 7 TOTAL			**899**	**0**	**899**
Scheme 8: People Living with Dementia					
a) Wren Centre	LBH	LBH	300	0	300
b) Training for staff/providers	Third sector	LBH	5	0	5
SCHEME 8 TOTAL			**305**	**0**	**305**
PROGRAMME MANAGEMENT TOTAL					
a) Programme Manager	LBH	LBH	80	0	80
PROGRAMME MANAGER TOTAL			**80**	**0**	**80**
TOTAL PLAN VALUE 2016/17			**10,566**	**11,965**	**22,531**

SCHEDULE 1B - OPERATION OF THE COMMUNITY EQUIPMENT LOANS AND MINOR ADAPTATIONS SERVICE

1. Definitions Specific to this Schedule 1B

1.1 Defined terms and interpretation for this Schedule 1B shall be as described in Clause 1.1 of this Agreement unless otherwise stated below:

a) **Community Services Quality Assurance Manager** means the person appointed by the Council to oversee the day to day operation of the Contract.

b) ***Contract*** means the contract with the Service Provider.

c) ***Door entry systems*** refer to systems that facilitate authorised access to the homes of Hillingdon residents where the resident is unable to directly open their front door because of a disability.

d) ***Eligibility criteria*** means the criteria agreed between the Partners to determine access to the Service as described in **Annex A** of this Schedule.

e) ***Minor adaptations*** refer to adaptations costing under £1k.

f) ***Standard minor adaptations*** refer to minor adaptations available through the Service Provider's equipment catalogue.

g) ***Non-standard minor adaptations*** refer to minor adaptations that are not available through the Service Provider's equipment catalogue and for which a procurement process is required to be undertaken.

h) ***Prescribers*** refer to qualified staff from all Stakeholder Teams who are authorised to prescribe equipment.

i) ***Prescribing Teams*** refer to teams across Social Care and the NHS who have prescribers authorised to prescribe equipment to people who are residents of the borough or who are registered with a Hillingdon GP.

j) ***Service*** means either the Equipment Loans Service under Part 1 of this Schedule or the minor adaptations and door entry systems services under Part 2 of this Schedule.

k) ***Service Provider*** means Medequip Assistive Technology Ltd

Part 1 - Equipment Loans Service

1. Services under Part 1 of this Schedule

1.1 The Service that is subject to this Agreement is daily living equipment provided from the Equipment Loans Service under the Contract with the Service Provider.

1.2 Access to the Services funded under Parts 1 and 2 of this Schedule of the Agreement shall be based on the Eligibility Criteria set out in **Annex A** of this Schedule.

2. Service Aim

2.1 The Hillingdon Community Equipment Service (HCES) shall provide value for money by being a high quality, well co-ordinated, cost effective loan equipment service for Service Users registered

with General Practitioners based in Hillingdon who are contracted with NHS England to provide general medical services in Hillingdon or to people resident in the London Borough of Hillingdon who may not be registered with a GP in Hillingdon.

3. Contract

3.1 The Council shall hold the Contract with the Service Provider for the delivery of the Services set out in **Annex B**.

3.2 The Service Provider will carry out the day-to-day requirements of the Services as outlined in **Annex B**. As Host Authority the Council shall have the responsibility for managing the Contract.

3.3 This Agreement includes those current budgets identified under the following headings for Hillingdon Community Equipment Services:

- the Council's equipment staffing and non staff budgets for the Equipment Loans Service
- the CCG's Equipment Loans purchasing budgets

3.4 Resources allocated for 2016/2017 are as follows:

Council	£611,750
HCCG	£611,750
TOTAL	£1,223,500

3.5 A detailed breakdown of the 2016/17 budget can be found in **Annex C**.

3.6 Services will be provided in line with the Eligibility Criteria for services as set out in **Annex A**.

3.7 Ownership of equipment loaned to Service Users for use in their homes rests jointly with the Partners. At the point of termination of the Agreement, separate negotiations will be undertaken regarding the distribution of ownership of loaned equipment provided.

3.8 Where there are issues of service costs rising beyond the additional contributions of each Partner, (e.g. due to differences in pay settlements, failure of budgets to be centrally uplifted, or any other factors), these will be addressed within the CCG and the Council in the first instance, and an attempt made to resolve them within the overall budgetary framework. Ongoing budget monitoring is expected to pay close attention to issues such as staff pay awards, superannuation agreements, registration requirements, legislative changes and any other factors that might potentially lead to cost pressures, and to plan accordingly wherever foreseeable. Where the contributions of each Partner are insufficient to meet the service requirements, agreement will be reached by the Core Officer Group to either increase funding or offer different, less costly options to ensure financial probity and that the Services are delivered within the budgetary constraints.

3.9 Definition of management costs and any shared overheads shall be as agreed between the Partners.

4. Budget Setting

4.1 The budget for the Equipment Loans Service for 2016/17 shall be as set out in Clause 3.4 above.

4.2 The Council shall propose a base budget for consideration by the Partners by end of Q3 2016/17 and a proposed base budget for 2017/18 shall be determined by the end of February 2017 and Stakeholder Teams funded from the Pooled Budget shall be notified of their allocation.

4.3 The amount to be provided will cover service developments, inflation and cost pressures.

4.4 The VAT regime of the Council will apply as laid out in the CIPFA guidance on Pooled Funds.

5. Monitoring Arrangements

5.1 The Council shall employ a Community Services Quality Assurance Manager who shall manage the relationships between Prescribing Teams, the Service Provider and the Partners.

5.2 Activity, expenditure and quality of service delivery of the Services under this **Schedule 1B** shall be overseen by the Joint Services Efficiency Group, the role and responsibility of which is set out in **Annex D**.

5.3 The Community Services Quality Assurance Manager shall provide monthly updates of activity information, expenditure and projected year-end expenditure as directed by the Equipment Joint Efficiency Group or the Partnership Board.

5.4 Prescribing teams shall be given notional budgets against which they will prescribe and their activity will be monitored.

5.5 The Council shall provide quarterly financial monitoring reports and year-end accounts showing funds received, funds spent, funds committed and any unspent resources, to the Partnership Board. The Council shall also provide such other reports as deemed necessary to ensure compliance with Audit requirements.

5.5 The pooled budget shall not pay the Service Provider for any expenditure above, or different from that previously agreed unless so authorised in advance by the Partners.

6. Changes to Financial Contributions to the Equipment Loans Service

6.1 The contributions to the pooled budget arrangements shall be based on the following ratios:

A.	Council	a) Equipment	50%
		b) Activity	50%
B.	HCCG	a) Equipment	50%
		b) Activity	50%

7. Over and underspends

7.1 Provisions concerning over and under-spends are addressed in **Schedule 4** of this Agreement.

8. Audit Arrangements

8.1 In addition to the provisions in Clause 14 of this Agreement, the Council may in respect of this **Schedule 1C** arrange for an audit of assessments for equipment and the application of the Eligibility Criteria. The costs arising from this audit shall be shared equally by the Partners.

9. Prescribing Authority

9.1 The Project Manager shall enable Prescribers to prescribe equipment under this **Schedule 1B** up to a value as directed by the appropriate team manager or service leads from the Partners. Team managers and service leads shall have authority to remove prescribing authority or alter the value to which a Prescriber can prescribe equipment under the Whole Agreement.

9.2 The Pool Manager may, in consultation with the Chair of the Partnership Board, remove the authority of any prescribing team to prescribe equipment under this **Schedule 1B**. This may only take place where there has been persistent and demonstrable failure to comply with the Eligibility Criteria and that has not been remedied following written notice.

Part 2 - Minor Adaptations and Door Entry Systems

10. Services under Part 2 of this Schedule

10.1 The Services that are under Part 2 of this **Schedule 1B** shall be minor adaptations and door entry systems.

11. Funding Responsibility

11.1 The Council shall contribute the funding for the minor adaptations and door entry systems services to the Pooled Budget for 2016/17 as follows:

Minor adaptations	£90,150
Door entry systems	£54,100

11.2 Only prescribers within the Council shall have authority to prescribe minor adaptations and door entry systems.

ANNEX A - 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 they are registered with a GP practice that is a member of NHS Hillingdon CCG.

And

2. The adult's needs arise from or are related to a physical or mental impairment or illness.

And

3. The person is eligible under the Care Act 2014, Chronically Sick and Disabled Persons Act 1970, National Health Service Act 2006 with consideration as needed to the Human Rights Act 1998, Equalities Act 2010, Moving and Handling Operations Regulations 1992 and Lifting Operations, and Lifting Equipment Regulations 1998.

GENERAL CONSIDERATIONS

4. A Therapist, Nurse or trained member of staff, as agreed by the NHS Hillingdon CCG or the London Borough of Hillingdon, may supply equipment following an assessment.

5. Where appropriate the first choice is for the person is to receive rehabilitation or training in alternative techniques to carry out a daily living activity rather than rely on equipment/minor adaptation.

6. Equipment/minor adaptation provision needs to follow the process mapping as for that equipment type detailed below.

7. Identified equipment/minor adaptation must focus on minimising risk to and maximising independence of the Service User.

8. Plans must be made by the prescriber to undertake an appropriate review the equipment/minor adaptation and to ensure its safe usage by the service user and their carers.

9. Staff must be aware which pieces of equipment require an annual review and make arrangements for this.

10. The Service User must be informed at the time of assessment that the equipment provided through the Loan Model (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. Conditions of Loan document to be issued and recorded in case notes.

11. Managers should ensure that the equipment and services prescribed do not exceed the annual budget allocation and work within their budget limits.

12. Carer's needs should be assessed at the same time as the person. Equipment may be issued with the primary aim of meeting the carer's needs e.g. transfer belt to prevent back injury.

13. Equipment should be provided by residential and nursing care homes if it is the type of equipment required by its residents as part of its statement of purpose /registration. The issue of special equipment to individuals will be considered and if prescribed must not be used by any other resident.

ANNEX B - CONTRACT WITH THE SERVICE PROVIDER

CE Contract_Spec and Addtnl Extension

ANNEX C - EQUIPMENT LOANS SERVICE DETAILED BUDGET BREAKDOWN 2016/17

2016/17 EQUIPMENT LOANS SERVICE BUDGET BREAKDOWN			
	TOTAL	**LBH**	**HCCG**
Equipment purchase	755,900	377,950	377,950
Delivery Charges	368,000	184,000	184,000
Staff	50,100	25,050	25,050
Equipment Maintenance	9,000	4,500	4,500
Water Closet Emptying Service	13,000	6,500	6,500
Lead authority role RBK &C	19,500	9,750	9,750
Overheads - Directly attributable	8000	4,000	4,000
Net cost/Budget	**1,223,500**	**611,750**	**611,750**

ANNEX D - JOINT SERVICES EFFICIENCY GROUP TERMS OF REFERENCE

ANNEX D JSEG ToR.docx

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:

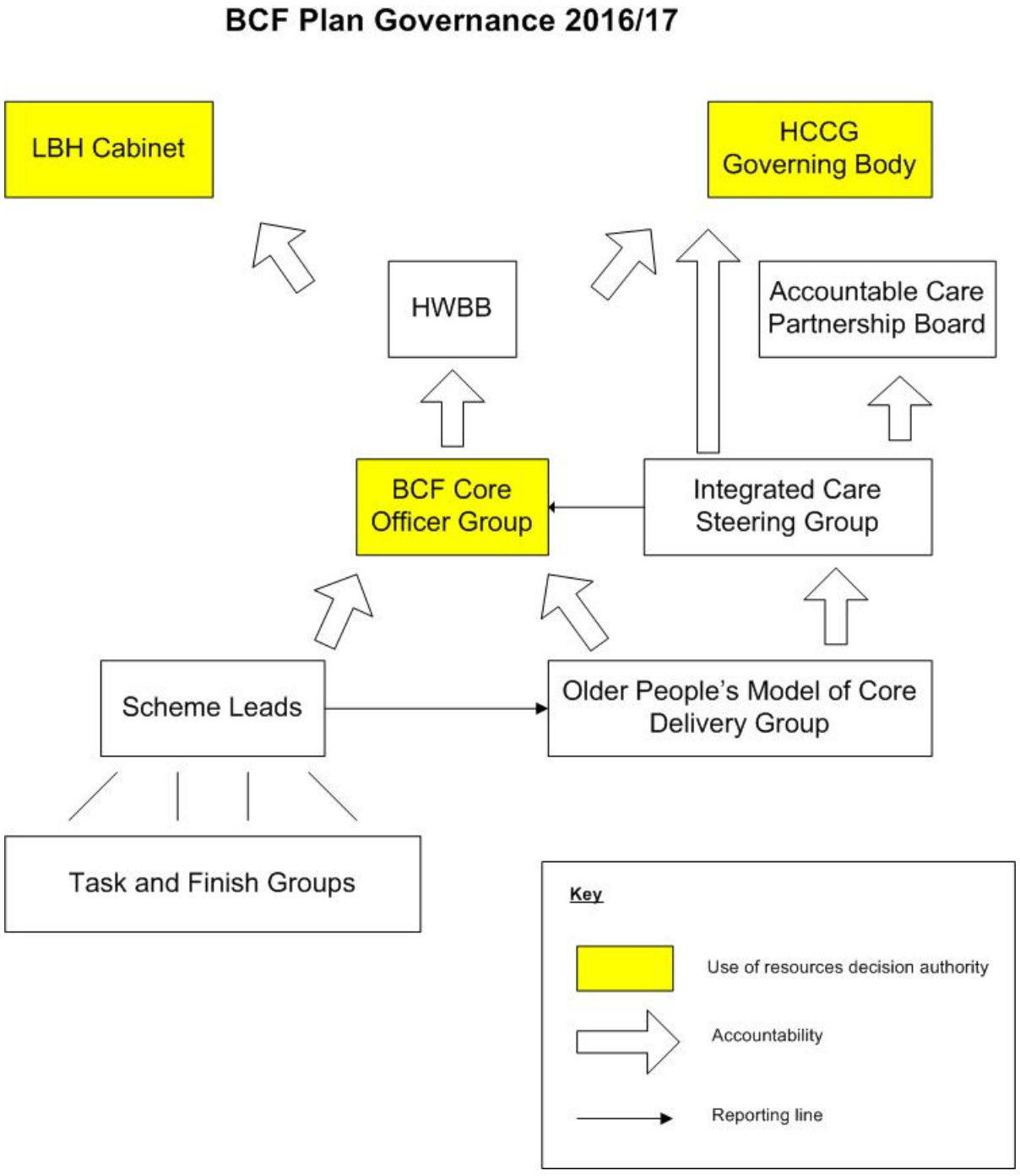
a) Functions under Part 1 of the Care Act, 2014.
b) Functions under Schedule 1 of the Local Authority Social Services Act, 1970 (as amended).
c) Functions under Part 1 of the Housing Grants, Construction and Regeneration Act, 1996, specifically the provision of Disabled Facilities Grants.

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 Older People's Model of Care Delivery Group 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 Older People's Model of Care Delivery Group;

e. Translating recommendations from the Older People's Model of Care Delivery Group into action;
f. Relaying recommendations from the Older People's Model of Care Delivery Group 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 Older People's Model of Care 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 monthly. 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) Older People's Model of Care Delivery Group

2.17 The key purpose of the Older People's Model of Care Delivery Group is provide partner input into the successful delivery of integration priorities, including the Better Care Fund, and also provides oversight and alignment of the existing plans, strategies and work steams for older people.

2.18 The Delivery Group will be responsible for:

a) Ensure alignment of programmes and initiatives intended to support the health and wellbeing of Hillingdon's 65 and over population or where this group will be the main beneficiaries, including:
   - Better Care Fund Plan
   - End of Life care strategy
   - Dementia Pathway
   - Urgent Care Plan
   - Long-term Conditions
   - Primary Care Plan
   - Carers strategy

b) Assess strengths, opportunities, risks and challenges of options for integrating health and social care with regard to delivering service for older people in Hillingdon

c) Identify solutions to identified risks and unlock blockages.

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

Older People's Model of Care Delivery Group Membership

2.20 The Older People's Model of Care Delivery Group is chaired jointly by the Council's Head of Social Work and Occupational Therapy and the CCG's clinical lead for integration.

2.21 Other members include:

- Deputy Chief Operating Officer, HCCG
- A non-executive director of the HCCG Board
- GP Network leads
- Director of Integration, The Hillingdon Hospital (THH) or representative
- Head of Adult Services, Central and North West London Foundation Trust (CNWL)
- Head of Mental Health Services, Central and North West London Foundation Trust (CNWL)
- Managing Director, Accountable Care Partnership (ACP)
- Access Team Service Manager, LBH
- Older People's Commissioner, HCCG
- BCF scheme leads
- Hillingdon4All representative
- Hillingdon Healthwatch representative
- Others by invitation or cooption

2.22 Older People's Model of Care Delivery Group 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 Older People's Model of Care Delivery Group is accountable to the BCF Core Officer Group and the Integrated Care Steering Group.

Frequency of Meetings

2.24 The Older People's Model of Care Delivery Group meets on a monthly basis. Its meetings are not held in public due to the confidential and sensitive nature of the information discussed.

d) Integrated Care Steering Group

2.25 The key purpose of the Integrated Care Steering Group is to ensure a programme of work is developed and delivered which will deliver the whole systems integration plan. It will provide operational direction to the shadow board for the Accountable Care Partnership.

2.26 The Integrated Care Steering Group will be responsible for:

- Identify key workstreams and mechanisms are in place for delivery of the agreed programme.
- Oversee delivery and monitor progress of the overall whole system integration work streams taking any appropriate corrective or remedial actions
- identification of any additional support/resource required to deliver integration plan
- Continuous assessment of the risks relating to the integration plan and impact health and social care system as a whole
- Ensure effective communications and engagement plans are in place across all partners specifically relating to model of care and new ways of working .
- To ensure the detailed plans align with other transformation initiatives particularly BCF and primary care model of care, and is cognisant of the inter-dependencies, including the financial commitments.
- To ensure learning from being an Early Adopter is shared, providing knowledge, information and tools that can be accessed by others eg local GP networks allowing them to develop in parallel.

Group Membership

2.27 The Group is chaired jointly by HCCG's Chief Operating Officer and the Programme Director for the Accountable Care Partnership

2.28 Other members include:

- HCCG integration clinical lead
- Model of care clinical lead, GP network
- Head of Primary Care, HCCG
- GP network Chief Operating Officer
- Deputy Chief Finance Officer, HCCG
- Head of Communications, HCCG
- IT implementation workstream lead, GP network
- Model of Care Delivery Group lead, CNWLI
- BCF Programme Lead, LBH
- Lay representative

Accountability

2.29 The Integrated Care Steering Group is accountable to the CCG's Governing Body and the Accountable Care Partnership Board.

2.30 The Group also reports into the BCF Core Officer Group but is not accountable to it.

Frequency of Meetings

2.31 The Integrated Care Steering Group meets monthly. Its meetings are not held in public due to the confidential and sensitive nature of the information discussed.

e) Accountable Care Partnership Board

2.32 The Accountable Care Partnership Board will be the legally constituted board of trustees for the Accountable Care Partnership (ACP). It will operate in shadow form during 2016/17 pending formal incorporation.

2.33 The Accountable Care Partnership Board will be responsible for the conduct and operation of the Accountable Care Partnership and compliance with its legal obligations.

Board Membership

2.34 Whilst in shadow form the Board will be chaired by the Managing Director of the ACP and other members will include:

- Chief Officers, leads or their representatives from the constituent parts of the ACP, e.g. GP networks, The Hillingdon Hospitals Foundation Trust, Central and North West London Foundation Trust and H4All.
- Lay representation

Accountability

2.35 The Board is accountable to itself.

Frequency of Meetings

2.36 The Board meets monthly. Its meetings during 2016/17 are not held in public due to the confidential and sensitive nature of the information discussed.

3. Roles and Responsibilities: Programme Manager and Scheme Leads

a) Programme Manager

3.1 Identify, analyse and communicate to the Core Officer Group and/or Older People's Model of Care Delivery Group and other key stakeholders all interdependencies between the different schemes in the BCF programme, plus any external dependencies and how they will be managed.

3.2 Monitor progress of the schemes 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 schemes.

3.4 Provide direct support to scheme leads as required.

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

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

3.7 Produce monthly status reports to the Core Officer Group and Older People's Model of Care Delivery Group that identify progress, risks and mitigation and benefits realisation.

3.8 Produce performance reports on a quarterly basis for the Health and Wellbeing Board and HCCG's Governing Body.

3.9 Manage the delivery of the stakeholder engagement strategy.

b) Scheme Leads

3.10 Establish and lead a project group of relevant stakeholders.

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

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

3.13 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.

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

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 OVER AND UNDER PERFORMANCE

Risk Share

1. The Partners have agreed that they shall each manage their own risks under this Agreement unless otherwise stated in this **Schedule 4**.

Overspends

2. 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.

3. Liability for any overspends for the service described in **Schedule 1B** (Equipment Loans Service) shall be on the following basis:

    a. Where an overspend is incurred because of budget maladministration, the liability for this will rest with the Council. Maladministration is defined as expenditure outside the terms of this Agreement and without proper authorisation.

    b. Where over expenditure occurs as a result of failure of one or more of the Partners to abide by the terms of the Agreement, or an action by one or more of the Partners which is prohibited or against the terms of this Agreement, the liability shall rest with that Partner, (for example, unauthorised capital expenditure; failure to meet contractual obligations to an employee resulting in a claim for compensation; agreement to a particular placement for which formal funding through the right process has not yet been agreed: etc). In these cases it is expected that individual agencies shall already have indemnity or other arrangements for meeting expenditure arising from such failures.

    c. Where overspends occurs due to unforeseen circumstances that are not due to maladministration, or as a result of failure of one or more of the Partners to abide by the terms of the Agreement, or an action by one or more of the Partners which is prohibited or against the terms of this Agreement, liability shall be shared in proportion to the Partners individual contributions to the pooled budget for the service that is the subject of **Schedule 1B**.

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 over performance 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 underspend shall be retained for the delivery of the Better Care Fund Plan and the use

of any underperformance shall be subject to established governance processes.

SCHEDULE 5 – BETTER CARE FUND PLAN

Insert BCF Plan

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

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