Appendix 1

Dated: **day of December 2017**

Hillingdon London Borough Council

and

NHS Hillingdon

2017/19

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

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Acknowledgement: This agreement is based on a template developed by Bevan Brittan LLP
Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

THIS AGREEMENT is made on day of December 2017

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) progress towards closer integration between health and social care where this is demonstrably the most effective mechanism for delivering better outcomes for Service Users and the Partners.

c) meet the National Conditions and Local Objectives;

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

e) ensure that by 2019/20 we have in place a model of care and supporting enablers:

i. Where residents have easy access to information and advice about services, including care and support services;

ii. That have a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;

iii. Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;

iv. Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social care;

v. Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;

vi. Enablement of self-care and preventative services and promotion of independence for as long as possible

vii. Where people are only admitted to Hillingdon Hospital when they are acutely ill;

viii. Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;

ix. That enables people to be treated at or close to their home wherever possible;

x. A reduction in the number of people living in residential care;

xi. The most effective use of health and care resources is made to achieve best value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and

xii. IT interoperability and development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

(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 2017.

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 Description.

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 either the CCG or 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'.

Patients means the same as **Service Users**.

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.

Personal Health Budgets means an amount of money to support a person's identified health and wellbeing needs the application of which is planned and agreed between the individual, their representative, or, in the case of children, their families or Carers and the local NHS Continuing Healthcare Team.

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).

Residents means people who live within the geographical boundaries of the London Borough of Hillingdon.

Scheme Description 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 2019 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 Description.

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 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 describes the delegation of functions attributed to the delivery of the Individual Schemes set out in **Schedule 1**.

Summary of Delegated Functions	
Scheme	**Functions Delegated**
Scheme 1	None
Scheme 2	None
Scheme 3	Delegation to the Council by the CCG to act as lead commissioner on behalf of the CCG for the provision of homecare for people at end of life as described in **Schedule 1E** of this Agreement.
Scheme 4	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 5	a) Delegation to the Council by the CCG to undertake the brokerage function for homecare placements for adults and children on behalf of the CCG as described in **Schedule 1C** of this Agreement. b) Delegation by the Council to the CCG to undertake the brokerage function for homecare placements for adults and children on behalf of the Council as described in **Schedule 1C** of this Agreement. c) Delegation to the Council by the CCG to manage the process for people registered with Hillingdon GPs to access Personal Health Budgets as described in **Schedule 1D** of this Agreement. d) Delegation to the Council by the CCG to act as lead commissioner on behalf of the CCG for homecare as described in **Schedule 1E** of this Agreement.
Scheme 6	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 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

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

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

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

7 ESTABLISHMENT OF A POOLED FUND

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

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

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

7.3.1 the Contract Price*;*

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

7.3.3 Third Party Costs*;*

7.3.4 Approved Expenditure

This shall be "Permitted Expenditure".

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

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

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

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

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

7.6.3 Appointing the Pooled Fund Manager;

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

8 POOLED FUND MANAGEMENT

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

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

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

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

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

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

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

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

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

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

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the CCG and the Council to the Pooled Fund for each 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.

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

12.1 The Pooled Fund shall not be applied towards any one-off expenditure on goods and/or services outside of the remit of Schemes 1 and 4 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 co-operate with NHS England to agree a recovery plan.

19.4 Any review undertaken in accordance with this Clause 19 shall reflect an intention to deliver the aims and benefits identified in Clause (F) of this Agreement.

20 COMPLAINTS

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

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

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

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

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

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

21 TERMINATION & DEFAULT

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

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

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

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

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

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

21.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the

separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

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

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

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

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

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

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

22 DISPUTE RESOLUTION

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

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

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

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

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

23 FORCE MAJEURE

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

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

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

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

24 CONFIDENTIALITY

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

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

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

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

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

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

24.3 Each Partner:

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

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

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

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

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

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

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

26 OMBUDSMEN AND INVESTIGATIONS BY REGULATORY BODIES

26.1 The Partners shall 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 shall follow the Information Sharing Agreement set out in **schedule 7** as may be amended from time to time, and in so doing shall 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 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

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

Scheme 1: Early Intervention and Prevention

a) Strategic Objectives

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, that includes a focus on promoting self-care. It builds on the work undertaken under Hillingdon's 2015/16 and 2016/17 BCF plans and also the broader programme of integration to taking forward the anticipatory model of care and applies a more preventative approach to addressing health and social care need.

b) Scheme Overview

As with previous iterations of the Hillingdon's BCF plan, the focus of this scheme will be people living with dementia, people susceptible to falls and/or who are socially isolated and also people at risk of stroke as these long-term conditions are disproportionately represented in our non-elective admissions and admissions to long term residential care.

Initiatives under this scheme include:

- *Access to information and advice* - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. Over the last two years the Council has developed and promoted the online resident portal called Connect to Support. In 2017/18 platform supplier arrangements will be subject to competitive tender and service specification development will include accessibility through portable technology options. Partners will work on the links between the resident portal and the development of a directory of services to support the hospital discharge process referred to further in scheme 4: *Integrated Hospital Discharge*. A key objective here is to reflect synergies and avoid unnecessary duplication.

- *Risk stratification* - Much work has taken place over the last two years in applying risk stratification tools within primary care, e.g. Qadmissions, PAR30, the Electronic Frailty Index (EFI) and the Patient Activation Measure (PAM), as a means of early identification of people at risk of escalated needs. The development of fifteen Care Connection Teams (CCTs) across the borough comprising of a guided care matron and care coordinator working alongside GPs, will support more proactive interventions to prevent or delay what might otherwise be an inevitable trajectory towards escalated need. Proactive work between social care and, initially, CCTs in the north of the borough to identify people receiving both social care and health support and explore opportunities for a more efficient and effective means of addressing need will be explored. Involvement of Adult Social Care in multi-disciplinary team (MDT) meetings: the weekly *'huddles'*, where appropriate will ensure a multi-agency approach to addressing the needs of people on the cusp of escalated needs. The allocation of social care resources to support CCTs that have extra care schemes and a concentration of care homes within their catchment area will be explored. See scheme: 5: *Improving care market management and development.*

- *Developing the preventative role of third sector* - 2016/17 has seen the successful implementation of the Wellbeing Service provided by the third sector consortium H4All. People referred to this service have benefitted 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(s). During 2017/18 the model of investment in the third sector by both the Council and CCG will be reviewed with voluntary and community sector partners to see

how the successes of the H4All Wellbeing Service can be built on to most effectively support Hillingdon's older residents, e.g. by improving access to information, addressing social isolation and keeping people active, through the creation of a single point of access for older people. Any enhancements to the model will be implemented in 2018/19, subject to approval through governance processes.

- *Keeping older people physically active* - Keeping people active is a contributory factor in preventing stroke and preventing or delaying the onset of dementia. During 2017/18 the Council and ACP partners will work together to develop a physical activity strategy, ensuring integration with existing services and the Council's new Sport and Physical Activity Team will continue to deliver a range of activities to keep older people physically active and also prevent social isolation, e.g. tea dances, chair exercise classes and healthy walks.

- *Stroke prevention*: As set out in the 2016/17 plan, the key components of a stroke prevention strategy are: increasing physical activity, addressing excess weight issues and early detection. During 2017/19 the following initiatives will be undertaken:

  - *Increasing physical activity* - Alluded to above, an existing physical activity programme targeted at people aged 55 and over carrying excess weight will continue due to the beneficial outcomes for this group of people.

  - *Early detection* - 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. In late 2016/17 a pilot started using detection equipment in six community pharmacies in the borough. The results from this will be used to inform possible expansion of screening programmes in 2017/18.

  - *Stroke risk and stroke prevention campaign* - During 2017/18 the Council's Communications Team will develop a proposal for a campaign intended to promote the uptake of the health checks programme for people most at risk of stroke and also signpost residents to physical activities and groups, social engagement activities, and facilities such as leisure centres, green spaces, and libraries.

- *Making best use of assistive technology* - The work of the CCTs referred to above, as well as the integrated approach to hospital discharge described in scheme 4: *Integrated Hospital Discharge,* provide opportunities 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.

- *Flexible use of Disabled Facilities Grants* - A business case will be developed for a six month early intervention pilot to provide a non-means-tested grant to people aged 75 and over for installation of a level-access shower where they have disability/medical condition that significantly restricts their mobility; they have reported difficulty with getting in and out of the bath; and they have no intention of leaving the property for at least 5 years. This is about proactively anticipating needs.

c) Intended Outcomes/Success Measures

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

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Increase in utilisation rates for Connect to Support (new and repeat users);

- Contributing towards a 5% reduction in falls-related non-elective admissions on 2016/17 outturn;

- % 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);
- Proportion of patients (among all those with a PAM score) whose PAM score has improved in the last 12 months.
- % of people aged 55 and over participating in screening programmes.

Scheme 2: An integrated approach to supporting Carers.

a) Strategic Objectives

The strategic objective of this scheme is to maximise the amount of time that Carers are willing and able to undertake a caring role. This will be contributed to by Carers being 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*"

b) Scheme Overview

This scheme continues the priority given in 2016/17 to support Carers and reflects the implementation of legal duties on local authorities under the Care Act, 2014 and the Children and Familes Act, 2014 respectively to support Adult and Young Carers. It also reflects policy directives on NHS bodies as directed by NHSE. The health and wellbeing of Carers will be supported through the following actions:

- *Maintaining capacity to deliver Carer's assessments through the Carers in Hillingdon contract that provides a single point of access for Carers in the borough* - Under this contract a triage assessment will continue to be promoted so that Carers can make informed decisions about whether to go through the full assessment process. In addition the online self-assessment facility through Connect to Support will be promoted and supported by Hillingdon Carers.
- *Implementation of NHS England's integrated approach to assessing Carer health and wellbeing* - This will entail the development of a Memorandum of Understanding (MoU) between the Council and Health partners, which will set out how partners will work together to support Carers.
- *Identifying "hidden" and "young" Carers* - This will entail using existing networks and materials e.g. Hillingdon People, social media, local press, street champions newsletter, Public Health initiatives and voluntary sector promotional event, etc, to identify people who do not necessarily consider themselves to be Carers. It will also entail the development of a consistent mechanism for identifying and recording Carers in primary care.
- *Developing the remit of the Young Carers Strategy Group* - This group was launched in 2016/17 to embed Young Carer initiatives at a strategic level, e.g. Healthy Schools Strategy; developing an early intervention and prevention strategy. A key role for the group in 2017/18 will be to develop a Young Carers Plus programme for Young Carers affected by parental drug, alcohol or mental health issues;
- *Health checks and flu prevention* - GP Health Checks and Flu Jab programmes for Carers will be promoted;

- *Hospital admissions and discharge* - Partners will work together to ensure that Carers are supported throughout the hospital admission and discharge care planning processes;

- *Personalisation for Carers* - Awareness of and access to Carer Personal Budgets and the individual's Personal Health Budgets will be maximised;

- *Social activities for Young Carers* - A range of social activities for Young Carers will be developed;

- *Extending availability of services for Adult Carers* - Options to extend services for Adult Carers, particularly working Carers who cannot access weekday provision, will be explored;

- *Social Worker drop-in sessions* - Social Worker drop-in sessions at the Hillingdon Carers Partnership Carers' Centre will be delivered.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following BCF national metrics:
b) Reduction in non-elective admissions.
c) Reduction in permanent admissions to care homes of 65 + population.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Number of Carers' assessments completed.
- Number of Carers' self-assessment completed.
- Number of Carers receiving respite or a carer specific service following an assessment.
- Through the National Carers' survey in 2018/19:
  - Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
  - Carer quality of life questions about:
    - Getting enough sleep and eating well
    - Having sufficient social contact
    - Receiving encouragement and support.
- Increasing the number of Carers identified and registered on the Hillingdon Carers' Carers' Register.

- Number of Carers in receipt of a Direct Payment or an individual with Personal Health Budget to contribute to the local trajectory by 2021 (303 to 607).

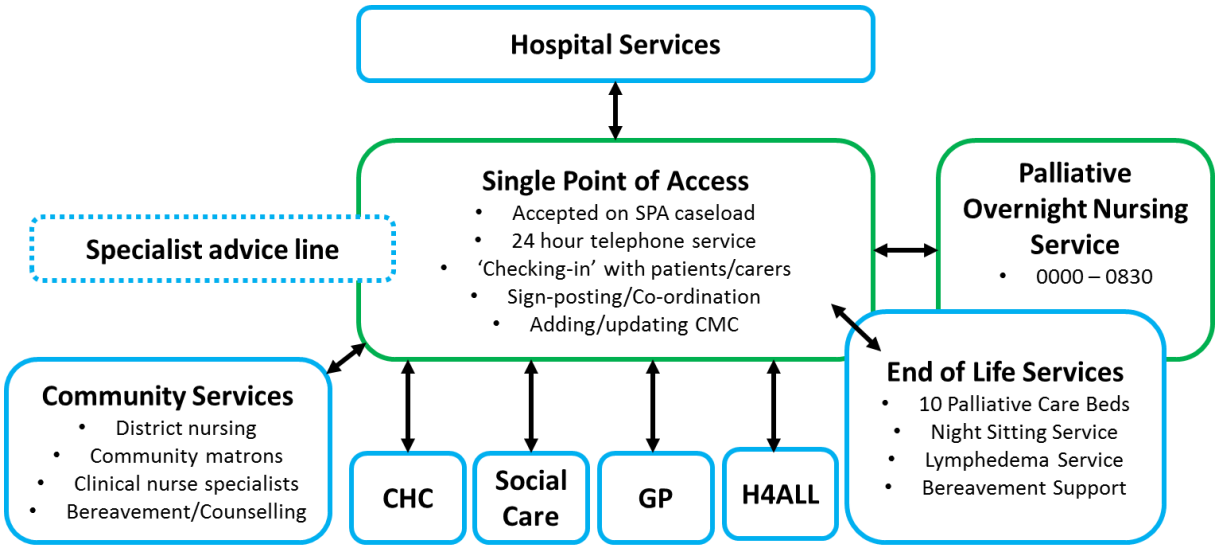
Scheme 3: Better care at end of life

a) Strategic Objectives

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.' 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 of care; 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.

b) Scheme Overview

Building on work undertaken during 2016/17, activity under this scheme will be aligned to the development of a new single point of access for people diagnosed as being within their last year of life. The SPA will act as a central information and advice hub for end of life/palliative care patients and services, whilst providing a co-ordination on behalf of patients, Carers and staff and giving the wider generalist workforce 24/7 access to specialist palliative advice. This will be supported by the palliative overnight nursing function (PONS) which, in addition to telephone advice will be able to assess and provide hands on care and support at the patient's place of residence if required. The intended model is shown below.



The key initiatives under this scheme intended to deliver better outcomes for people at end of life are:

- *Facilitating seamless care provision between health and social care* - The specialist homecare needs of people at end of life will be reflected in the integrated homecare service model tender referred to in scheme 5: *Improving care market management and development.* The intention behind this and a clear benefit of having the BCF pooled budget in place is to remove the possibility of disruption in care being caused by a transition in funding responsibility between health and social care, except in cases where the existing provider is unable to meet the escalating needs of the person at end of life.

- *Reviewing charges for Council funded services* - The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only six months to live and 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.

- *Utilisation of multi-disciplinary care and support planning* - In 2016/17 Adult Social Care gained read and write access to Coordinate My Care (CMC), an advanced care planning tool used in London primarily to support people at end of life. The intention and expectation is that there will be increased use of this tool by social care staff in line with the expected increase in use by other professionals and service providers across the borough.

- *Reviewing hospice bed provision requirements* - This is linked into the bed-based services requirements review action contained outlined in scheme 5: *Improving care market management and development.* The intention would be to identify future requirements and provision options.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions.

The following measure that links to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

Scheme 4: Integrated hospital discharge

a) Strategic Objectives

This scheme seeks to prevent 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.

A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.

b) Scheme Overview

This scheme seeks to consolidate the move to a discharge home to assess model that expedites the flow out of hospital of people whose medical needs no longer require them to be there. This assumes that most people will recover more quickly from the cause of their admission in their usual home environment. The scheme is also seeking to establish an integrated hospital discharge service with a single point of referral to eliminate the existing fragmentation that exists between services and organisations.

Under Hillingdon's Discharge to Assess model there are three pathways:

- *Pathway 0 (Simple Discharges)* - This is for people whose needs can safely be met at home and need no additional assessment. The patient is functionally fit or at functional baseline when they are declared medically optimised. The patient can go directly home either without care or with a care package restart. The patients for this pathway are identified and their discharges managed by ward staff. It is envisaged that the majority of patients will be discharged on this pathway.

- *Pathway 1 (Home to Assess)* - This is for people who are not at their functional baseline when they are declared medically optimised. Following a risk assessment, their needs can be safely met at home (including a residential or nursing care home), where an assessment will be undertaken. Any care, equipment or rehabilitation will be provided at home, including a Continuing Healthcare assessment where appropriate. The discharge will be managed by the Discharge Coordinators or the Integrated Discharge Team (IDT) when required. At present needs are met either by the Council's Reablement Service for up to six weeks or Community Homesafe provided by CNWL for up to 10 days for people who have had a Comprehensive Geriatric Assessment (CGA). The intention is to get to a point where there is a community-based single point of referral and discharge coordinated by community-based staff, including arranging transport and community equipment. The assessment to determine ongoing care needs would then take place in the person's usual place of residence.

- *Pathway 2 (Cannot return home)* - This is for people who are unable to return home as they require a period of further rehabilitation, their care needs are not able to be safely met in their usual place of residence or their home needs preparation or adaptation. It is intended that people will be identified by ward staff and the discharge managed by the Discharge Coordinators or the IDT. The onward route from hospital will either be to the 22 bed Hawthorne Intermediate Care Unit (HICU) for people who require rehabilitation, the 5 step-down beds in a private nursing home commissioned by the CCG for people who require a bed based service on discharge and will be non-weight-bearing for more than 3 weeks or require a full continuing healthcare (CHC) assessment. The Council also has a step-down flat available in an extra care scheme where a person's home is unsuitable to meet their immediate needs.

Improvements to hospital discharge processes, including early identification of people with complex needs likely to impact on timely discharge and transport and medication issues are captured within the Urgent and Emergency Care Work Plan and the Delayed Transfers of Care (DTOC) action plan.

Other actions that will be taking place under this scheme include:

- *Reviewing the Integrated Discharge Team (IDT)* - Within the context of the Discharge to Assess model, the role and function of a multi-agency IDT will be undertaken by the Leadership Centre, an independent organisation that supports the public sector to address complex issues.

- *Emergency Care Improvement Programme (ECIP) undertaking a review of mental health discharges processes and causes of delay* - Delayed discharges of people with mental health needs represent the largest proportion of delayed transfers of care in Hillingdon.

- *Establishing regular liaison meetings between Mental Health and Housing* - Housing-related issues present one of key causes of delays in supporting the discharge from hospital of people with mental health needs. The Council and the community mental health provider, CNWL, will establish more structured referral routes and escalation pathways to ensure early identification of people with complex needs.

- *Developing a business case for establishing a Hospital Discharge Grant* - A business case will be developed to use flexibilities in the use of the Disabled Facilities Grant permitted under the Regulatory Reform Orders to establish a non-means tested grant of up to £4k to pay for the following in order to expedite a resident's discharge from hospital:
  - Home/garden clearance.
  - Home deep cleaning.
  - Home fumigation.
  - Furniture removals to establish a micro-environment.
  - Heating repairs, e.g. repairing or replacing boilers.
  - Repairs to, or replacement of, essential appliances, e.g. cooker, refrigerator/freezer.

c) Intended Outcomes/Success Measures

This scheme will impact on the following BCF metrics:
- Reduction in the number of non-elective admissions.
- Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population.
- 88% of older people aged 65 years and over who are still at home 91 days after discharge from hospital into reablement
- % reduction in delayed transfers of care (delayed days), including:
  - % reduction in delays attributed to the NHS
  - % reduction in delays attributed to Adult Social Care

The following measure will also be used:

- 85% of new clients who received reablement where no further request was made for ongoing long term support;
- Less than 15% of Continuing Healthcare assessments completed in a hospital.

Scheme 5: Improving care market management and development

a) **Strategic Objectives**

This scheme is intended to contribute to the STP 2020/21 outcomes of achieving:

- A market capable of meeting the health and care needs of the local population within financial constraints; and

- A diverse market of quality providers maximising choice for local people.

b) **Scheme Overview**

The focus of this scheme is the following areas:

- Pilot of an integrated brokerage;
- Integrated homecare for adults and young people;
- Care home market development; and
- Support for extra care sheltered housing.

The scheme represents both a logical progression from work undertaken in 2016/17 and also step-change in the integration between health and social care, which can be seen with the establishing of lead organisation/commissioner arrangements in respect to tendering of homecare and the potential to develop this further for nursing care home provision. By taking the step on the road to integration between health and social care this scheme seeks to address private provider market capacity and service quality issues that have a significant impact on Hillingdon's health and care system. This scheme is therefore also critical to the delivery of the objectives of several other schemes within the BCF plan, e.g. scheme 3: *Better care at end of life*, scheme 4: *Integrated hospital discharge* and scheme 6: *Living well with dementia*.

The key objectives of this scheme will be achieved through the following initiatives:

Integrated Brokerage

- Expanding utilisation of e-brokerage facility in Connect to Support to include nursing care home and homecare placements for Continuing Healthcare patients.

- Trial of co-locating both Council and CCG brokerage teams from September 2017.

- Developing affordable options for Council and CCG approval to expand scope of joint brokerage to include self-funders.

- Expanding take-up of Personal Health Budgets (PHBs) and integrated budgets, e.g. combination of Direct Payments (DPs) and PHBs in order to achieve the defined trajectory by 2021.

- Reviewing the impact of the brokerage pilot and consequent closer alignment of teams to inform a decision about any structural integration in 2018/19.

Integrated homecare for adults, children and young people

- The Council will lead for itself and the CCG in the tendering for an integrated, tiered service model of homecare through a Dynamic Purchasing System (DPS), e.g. a type of framework agreement that allows new providers to the market place to enter at any time if certain specified criteria are met. The DPS will become operational in October 2017 for two years. For the Council the tender will provide coverage for a part of the borough where a contract is currently not in place; it will also provide additional capacity in other parts of the borough. The model is intended to address NHS capacity requirements in all parts of the borough.

- Homecare placements will be made through the piloted integrated brokerage team through an electronic process.

- The integrated homecare model will include specialist palliative provision for people whose final preferred place of care is at home. The investment element for this provision is reflected in scheme 3: *Better care at end of life*, although delivery will be through work undertaken as part of this scheme 5.

- A review of the impact of the model in 2018/19 will inform the approach taken by both the Council and the CCG to respond to the expiry of the Council's other homecare contracts at the end of 2019.

Care home market development

- Developing and launching a market position statement following a joint health and social care bed based services demand exercise to advise the market of Council and NHS supply requirements over the next 10 years.

- Exploring with providers increasing local capacity for residential dementia and nursing (inc dementia) care home capacity through conversion of spot purchases to block arrangements and seeking approval for other affordable options to meet supply needs.

- Developing an integrated nursing care home specification, e.g. to meet social care and CHC requirements.

- Determining the agreed procurement route for delivery in 2019/20, including the possibility of the Council being included within the NHS Any Qualified Provider (AQP) contract.

- Expanding the existing weekend GP advice and visiting service across the Borough and establish a Monday to Friday GP with specialist interest pilot to provide an emergency response, e.g. advice and/or visits as appropriate, for a defined number of care homes from October 2017 to March 2018.

- Based on the outcomes of the pilot, commission a GP advice and visiting service in an integrated way with existing and planned services in community/primary care through the ACP to support care homes.

- Developing a range of training opportunities for care home staff supported through the ACP and Council, e.g. falls prevention, deprivation of liberty and mental capacity assessments, prevention of pressure ulcers, continence care, palliative care and respiratory conditions.

- Developing a business case for additional community dietician to specifically work with care homes.

- Exploring the development of a career pathway for nursing care home staff through the ACP to contribute to addressing shortage of qualified nurses in this setting.

- Developing a '*Red Bag'* scheme pilot scheme with local care homes. The '*Red Bag*' keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff. contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.

- Developing a care home dashboard to be shared with care home managers that shows the number of hospital attendances and admissions from care homes and also London Ambulance call outs to care homes and conveyances to hospital.

Support for extra care sheltered housing schemes

- Developing a model of in-reach health and social care support for extra care schemes linked to Care Connection Teams. This will include dedicated social work support and it is proposed will entail the reallocation of Protecting Adult Social funding from contributing to the mental health nurse in Rapid Response to resourcing a dedicated social work post to support extra care.

- Delivering a new care and wellbeing service at Cottesmore House and Triscott House in 2017/18 and at two new schemes called Grassy Meadow Court and Park View Court in 2018.

- Delivering a model of primary care, e.g. GP, support for extra care schemes. This links into the proposed service for care homes referred to above.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following national BCF metrics:

d) Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care and specifically for those attributed to the lack of care home placement or package of care reasons.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:
- Reduction in non-elective admissions from care homes.
- Reduction in inappropriate non-elective admissions from extra care sheltered housing schemes.
- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

The following targets will be set for people in receipt of a combination of PHBs, integrated health and social care budgets, e.g. a combination of PHBs and Direct Payments, and people with a managed Personal Health Budget, which is where the actual sum of money allocated is identified but it is managed on behalf of the individual by the CCG:

PHB Target by Quarter 2017/19 (Cumulative)				
	Q1	**Q2**	**Q3**	**Q4**
2017/18	38	58	83	113
2018/19	148	183	223	263

Scheme 6: Living well with dementia

a) **Strategic Objective**

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

b) **Scheme Overview**

Dementia is primarily a condition associated with old age and as Hillingdon's population ages the numbers of people living with this condition is likely to increase significantly, with a consequential impact on the local health and social care economy. This scheme represents a continuation of work undertaken in 2016/17 and many of the key actions required to support people living with dementia and their families are addressed within other schemes in the plan. These include the following actions:

- *Preventing or delaying the onset of dementia* - This action links in with the work being undertaken under scheme 1: *Early intervention and prevention*, 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.

- *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 5: *Improving care market management and development is* intended to address this gap in provision.

- *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Improving care market management and development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

- *Developing dementia-friendly alternatives to care home settings* - Linked to scheme 5: *Improving care market management and development,* two extra care sheltered housing schemes that have been built to the University of Stirling's Gold Standard, an internationally renowned design standard for dementia-friendly environments, will open in 2018. These are Grassy Meadow Court with 88 self-contained flats and Park View Court with 60 flats. Both schemes are intended as a realistic alternative to residential care for older residents and tenants will have access to 24/7 on site care and support provision.

The following action is specific to this scheme:

- *Developing a local dementia resource centre model* - A dementia resource centre will be included in the Grassy Meadow Court extra care scheme referred to above that is 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 2017/18 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- Reduction in permanent admissions to care homes.

SCHEDULE 1A - FINANCAL CONTRIBUTIONS SUMMARY

Table 1: BCF Funding Summary 2017/19			
	2016/17	2017/18	2018/19
	£,000s	£,000s	£,000s
Protecting Social Care	5,937	6,085	6,201
CCG Share of Minimum Contribution	10,619	10,769	10,974
TOTAL MINIMUM LEVEL OF BCF POOLED FUNDING	**16,556**	**16,854**	**17,175**
Disabled Facilities Grant	3,457	3,815	4,174
Additional Council Contribution	1,172	5,702	11,646
IBCF Section 31 Grant	0	4,054	5,258
Additional CCG Contribution	1,346	6,639	15,796
TOTAL BCF FUNDING 2017/19	**22,531**	**36,814**	**54,049**

Table 1A: Payment Arrangements Summary		
	2017/18	2018/19
Funding to be transferred to LBH from HCCG	23,243	33,971
Funding to be repaid to HCCG to cover contract/service obligations shown in Table 2 below.	17,158	26,770
Funding retained by LBH to cover contract/service obligations shown in Table 2 below.	6,085	6,201

Table 2: Contract and Provider Breakdown								
Scheme 1: Early intervention and prevention								
Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			
		LBH £000's	**HCCG £000's**	**Total £000's**	**LBH £000's**	**HCCG £000's**	**Total £000's**	**Total 2017/19 £000's**
a) Connect to Support	Shop-4-Support	45	-	45	46	-	46	91
b) Online Service Co-ordinator	LBH	49	-	49	50	-	50	99
c) Wellbeing Service	H4All	543	334	877	543	334	877	1,754
d) Information Advice Welfare and Benefits Service	Age UK	150	-	150	150	-	150	300
e)Social Wellbeing Service	Age UK	100	-	100	100	-	100	200

f) Practical Support Service	Age UK	76	-	76	76	-	76	152
g) Falls Prevention Service	Age UK	-	143	143	-	143	143	285
h) Older People Wellbeing Initiatives	LBH	20	-	20	20	-	20	40
i) Telecare	LBH	262	-	262	267	-	267	529
j) Disabled Facilities Grant	LBH	3,815	-	3,815	4,174	-	4,174	7,989
k) Integrated Care Programme	CCG	-	1,062	1,062	-	1,062	1,062	2,124
l) Care Connection Team	CCG	-	759	759	-	759	759	1,518
j) Primary Care		-	56	56	-	56	56	112
SCHEME 1 TOTAL		**5,060**	**2,353**	**7,413**	**5,426**	**2,353**	**7,779**	**15,193**

Scheme 2: An integrated approach to supporting Carers								
Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			**TOTAL 2017/19** £,000
		LBH £,000	**HCCG** £,000	**TOTAL** £,000	**LBH** £,000	**CCG** £,000	**TOTAL** £,000	
a) Carers' hub, assessments and review	Hillingdon Carers (lead)	649	0	*649*	661	0	*661*	*1,310*
b) Services to Carers (inc respite)	Various P & V	213	0	*213*	217	0	*217*	*430*
c) Carer Support Worker	Hillingdon Carers	0	18	*18*	0	18	*18*	*36*
SCHEME 2 TOTAL		**862**	**18**	***880***	**878**	**18**	***896***	***1,776***

Scheme 3: Better care at end of life								
Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			**TOTAL 2017/19** £,000
		LBH £,000	**HCCG** £,000	**TOTAL** £,000	**LBH** £,000	**CCG** £,000	**TOTAL** £,000	
a) Palliative home care.	Various P & V	50	884	*934*	51	884	*935*	*1,869*
b) Community Palliative Team.	CNWL	0	108	*108*	0	108	*108*	*216*
SCHEME 3 TOTAL		**50**	**992**	***1,042***	**51**	**992**	***1,043***	***2,085***

Scheme 4: Integrated hospital discharge								
Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			
		LBH £000's	**HCCG £000's**	**Total £000's**	**LBH £000's**	**HCCG £000's**	**Total £000's**	**Total 2017/19** £000's
a) Rapid Response	CNWL	-	1,669	1,669	-	1,669	1,669	3,338
b) Hawthorn Intermediate care Unit	CNWL	-	1,603	1,603	-	1,603	1,603	3,206
c) Community Rehab	CNWL	-	1,198	1,198	-	1,198	1,198	2,396
d) Prevention of Admissions and Readmission (PATH)	Age UK	29	74	103	29	74	103	206
e) Take Home and Settle	Age UK	-	63	63	-	63	63	126
f) Reablement and Hospital Assessments	LBH	2,638	-	2,638	2,689	-	2,689	5,327
g) Reablement Physio	CNWL	51	-	51	51	-	51	102
h) Community Equipment	Medequip	756	715	1,471	761	715	1,476	2,947
i) Community Homesafe	CNWL	0	688	688	0	688	688	1,376
j) Packages of care	Various P&V	1,044	0	1,044	1,064	0	1,064	2,108
k) Step Down beds (Franklin House)	Care UK	0	198	198	0	198	198	396
l) Pressure Mattresses	CCG	0	206	206	0	206	206	412
m) Continence Service	CNWL	0	582	582	0	582	582	1,164

n) Community Matrons	CNWL	0	599	599	0	599	599	1,198
o) District Nursing	CNWL	0	3,346	3,346	0	3,346	3,346	6,692
p)Twilight Service	CNWL	0	124	124	0	124	124	248
q) Tissue Viability	CNWL	0	288	288	0	288	288	576
r) Support to step down Beds	CNWL	0	53	53	0	53	53	106
s) Cottesmore Reablement Flat	Paradigm Housing Group	49	0	49	50	0	50	99
t) Mental Health Nurse in Rapid Response	CNWL	40	0	40	0	0	-0	40
SCHEME 4 TOTAL		**4,607**	**11,406**	**16,013**	**4,643**	**11,406**	**16,049**	**32,062**

Scheme 5: Improving care market management and development								
Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			**Total 2017/19 £000's**
		LBH £000's	**HCCG £000's**	**Total £000's**	**LBH £000's**	**HCCG £000's**	**Total £000's**	
a) Quality Assurance team	LBH	168	-	168	171	-	171	339
b) Adult Safeguarding	LBH	260	-	260	265	-	265	525
c) Brokerage Team	LBH	315	62	377	315	62	377	754
d) Home Care	Various P&V	7,952	251	8,203	7,952	251	8,203	16,406
e) Care Home Prescriber	HCCG	0	32	32	0	32	32	64
f) Older peoples care Home	Various P&V	0	1,968	1,968	7,149	1,968	9,117	11,085
g) EMI over 65 Residential	Various P&V	0	0	-	0	2,913	2,913	2,913
h) EMI over 65 Domicillary	Various P&V	0	0	-	0	199	199	199
i) Physical Disability (Under 65)	Various P&V	0	0	-	0	2,370	2,370	2,370

j) Pallative Care - Residential	Various P&V	0	0	-	0	509	509	509
k) Pallative Care - Domicilliary	Various P&V	0	0	-	0	596	596	596
l) Funded Nursing Care	Various P&V	0	0	-	0	3,025	3,025	3,025
m) Extra Care Social Work Post	LBH	0	0	-	41	0	41	41
n) Medication Admin		0	24	24	0	24	24	48
o) Community Matron	CNWL	0	52	52	0	52	52	103
SCHEME 5 TOTAL		**8,695**	**2,389**	**11,084**	**15,893**	**12,001**	**27,894**	**38,978**

Scheme 6: Living well with dementia								
Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			**TOTAL 2017/19** £,000
		LBH £,000	**HCCG** £,000	**TOTAL** £,000	**LBH** £,000	**CCG** £,000	**TOTAL** £,000	
Wren Centre (dementia resource centre)	LBH	300	0	300	306	0	306	606
SCHEME 6 TOTAL		**300**	**0**	**300**	**306**	**0**	**306**	**606**
PROGRAMME MANAGEMENT TOTAL								
a) Programme Manager	LBH	82	0	***82***	81	0	***82***	***164***
PROGRAMME MANAGEMENT TOTAL		82	0	***82***	81	0	***82***	***164***
TOTAL PLAN VALUE 2017/19		***19,656***	***17,158***	***36,814***	***27,279***	***26,770***	***54,049***	***90,864***

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

2. SERVICES UNDER PART 1 OF THIS SCHEDULE 1B

1.1 The Service that is the subject of this **Schedule 1B** 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 the 2017/2019 period are as follows:

	2017/18	2018/19	TOTAL
Council	756	761	1,517
HCCG	715	715	1,430
TOTAL	1,471	1,476	2,947

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 2017/19 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 2018/19 and a proposed base budget for 2019/20 shall be determined by the end of February 2019 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 Integrated 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 UNDER SPENDS

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 2017/19 as follows:

	2017/18	**2018/19**
Minor adaptations	£50,000	£50,000
Door entry systems	£37,000	£37,000

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 (adults), the Chronically Sick and Disabled Persons Act 1970 (children and young people, 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 a proportionate and appropriate 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. In addition, equipment and minor adaptations must be considered to prevent, delay or reduce the needs of adults for care and support as outlined in the Care Act 2014.

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, e.g. manual handling equipment 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. The Conditions of Loan document must be issued to each service user (family member) and a record of this made against the service user's file/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. It is expected that nursing and residential care homes will provide their residents with a range of equipment to meet the variety of care needs that is appropriate to their registration status with the Care Quality Commission, including variations in height, weight and size. The Council and CCG are not responsible for the general provision of equipment unless there is an emergency whereby a temporary item can be supplied for a short period time, for example, to facilitate an urgent hospital discharge or where there is a safeguarding concern. Standard equipment should not be supplied to residential or nursing care homes; however, standard special and bespoke special equipment will be considered on a case by case basis following the special equipment request process.

14. A hospital bed for a Service User in residential care homes will be allowed where their needs have escalated to the extent that they require nursing care and the provision of this type of bed will allow them to remain in their current care setting.

ANNEX B - CONTRACT WITH THE SERVICE PROVIDER

Call Off Contract - Medequip.pdf

Service Specification.docx

ANNEX C - EQUIPMENT LOANS SERVICE DETAILED BUDGET BREAKDOWN 2017/19

EQUIPMENT LOANS SERVICE BUDGET BREAKDOWN 2017/19		
Item	**2017/18 (£,000)**	**2018/19 (£,000)**
Equipment purchase	1,113	1,113
Staff	52.5	52.5
Equipment Maintenance	52	52
Lead authority role LB H & F	19.5	19.5
Overheads - Directly attributable	19.1	19.1
Net Cost/Budget	**1,250**	**1,256**

ANNEX D - JOINT SERVICES EFFICIENCY GROUP TERMS OF REFERENCE

ANNEX D JSEG ToR.docx

SCHEDULE 1C - OPERATION OF INTEGRATED BROKERAGE SERVICE

1. BACKGROUND

1.1 The Service that is the subject of this **Schedule 1C** is Integrated Brokerage Service.

1.2 The Council and CCG are seeking to bring together the expertise developed within existing health and social care brokerage teams under a pilot that will see the co-location of teams. The ultimate remit of an integrated brokerage service will include:

1.2.1 All age homecare placements
1.2.2 Nursing home placements
1.2.3 Short-term placements, e.g. respite, step-down/step-up
1.2.4 Management of Personal Health Budgets

2. PILOT SCOPE

2.1 The scope of the pilot shall include Personal Health Budgets as described in **Schedule 1D** of this Agreement and Integrated Homecare as described in **Schedule 1E** of this Agreement.

3. INTENDED OBJECTIVES

3.1 The intended objectives of the integrated brokerage service:

3.1.1 Improving market intelligence, including about capacity, capability, standards and price;

3.1.2 Supporting the delivery of more consistent quality standards and improving the approach to the management of provider risk, including provider failure;

3.1.3 Making it easier for providers to navigate the local health and care landscape by creating a single point of access;

3.1.4 Supporting a more integrated approach to addressing need as people's needs escalate from being primarily a social care responsibility to an NHS responsibility, thus improving the experience of care.

4. SERVICE DELIVERY

Referrals

4.1 Referrals into the brokerage service will come either via social care teams for Council funded services or through the CHC Team for NHS funded services. The clinical and professional staff making the referrals will determine the service required or, in the case of Direct Payments (Council or NHS) determine the level of the personal or notional budget.

4.2 Any amendment or variation to the details of a referral shall only be made following consultation with the referrer.

Nursing Home Placements

4.3 For the duration of this Agreement the Council and HCCG shall secure nursing home placements to meet both short and long-term need through separate commissioning frameworks. For the Council this shall be through the West London Alliance Dynamic Purchasing System or other spot purchases as may from time to time be required. For HCCG this shall be through the London Any Qualified Provider framework or other spot purchases as may from time to time be required. This

practice shall continue unless both Parties agree alternative arrangements, in which case this Agreement shall be amended in accordance with Clause 29 (Variations) of this Agreement.

4.4 The Council and HCCG shall collaborate in the monitoring and maintenance of quality standards within the care home market and HCCG's CHC Lead Nurse and Safeguarding Nurse shall be a member of the Council's Provider Risk Panel. This is intended to help secure the safety of people admitted to care homes through early identification of interventions required to support providers. It is also intended to assist in the early identification of potential provider failure and notification to neighbouring boroughs and/or CCGs of provider concerns..

PHBs

4.5 The support provided by the Council to HCCG for the administration of PHBs shall be as described in **Schedule 1D** of this Agreement.

Homecare

4.6 The operation of the integrated homecare dynamic purchasing system, including care at home for people at end of life, shall be as described in **Schedule 1E** of this Agreement.

5. STAFFING

5.1 The intention is to co-locate staff from both brokerage teams. However, at the start of the pilot one member of CCG brokerage team will be based with the Council brokerage team three days a week. A target date for co-locating all staff will be set in accordance with the governance and review arrangements for this Schedule 1C (see Clauses 9 and 11).

5.2 There shall be no transfer of staff for the duration of the Agreement and for the avoidance of doubt, management of Council brokerage staff will remain the responsibility of the Council and management of HCCG brokerage staff will remain the responsibility of HCCG. This is subject to any changes agreed in accordance with Clause 29 (Variation) of the Agreement.

5.3 The HCCG CHC Lead Nurse shall notify the Council's Service Manager, Early Intervention & Prevention, in the event that a CHC Team brokerage officer is unable to attend the Civic Centre as scheduled for whatever reason. This is to comply with health and safety requirements. A defined roster will also be available for both the Council and HCCG.

5.4 It is intended that in order to maximise the effectiveness of an integrated brokerage service staff from the respective brokerage teams will be able to broker access to appropriate providers for either health or local authority referrals and a target date for achieving this will be set in accordance with the governance and review arrangements for this Schedule 1C (see Clauses 9 and 11).

6. IT

6.1 The Council shall arrange for HCCG brokerage team staff to have access free of charge to the Council's care management database system called Protocol and also the online brokerage facility within Connect to Support.

6.2 HCCG shall arrange for Council brokerage team staff to have access free of charge to HCCG's case management database called Caretrak.

7. TRAINING

7.1 The Council shall provide training to HCCG brokerage team staff in the use of Protocol and the Connect to Support online brokerage facility.

7.2 HCCG shall provide training to Council brokerage team staff in the use of Caretrak.

7.3 The training needs of staff within the respective Council and HCCG brokerage teams shall be identified through the application of good staff management practice. Both the Council and HCCG shall cooperate to ensure that the training needs of the respective staff members are met in order to deliver the objectives of the Service.

8. METRICS

8.1 The following measure shall be used to determine the value of the integrated brokerage pilot:

8.1.1 *Positive use of market intelligence:* Identification of what shared market intelligence has enabled partners to do that was either not possible or was more difficult before;

8.1.2 *Positive experience of a single point of access for providers:* Following the establishment of a SPA, the views of providers will be canvassed to test their experience and judgement about value;

8.1.3 *Period between referral and placement:* The number of days between a referral for a homecare placement and it being secured will be measured;

8.1.4 *Positive experience for Service Users:* The views of Service Users and/or their families will be tested to confirm their experience of care.

9. GOVERNANCE

9.1 There shall be monthly meetings between the HCCG CHC Team Lead Nurse and the Council's Service Manager, Early Intervention and Prevention. The purpose of the meetings shall be to review progress and outcomes and identify issues.

9.2 The delivery of the integrated brokerage pilot shall be overseen by the BCF Core Officer Group and Transformation Group as described in **Schedule 3** (Governance) of this Agreement.

10. FINANCIAL ARRANGEMENTS

10.1 Any change in the financial contribution by HCCG to the Council's on-costs for supporting HCCG staff based at the Civic Centre shall be subject to the governance arrangements set out in Schedule 3 (Governance) of this Agreement.

10.2 The Council shall provide to HCCG brokerage staff access to a desk, telephone, computer and software at no cost.

11. REVIEW

11.1 The pilot shall be reviewed on a two monthly basis by HCCG's Deputy Director Quality & Safety and the Council's Assistant Director, Provided and Commissioned Services and the outcomes reported to the groups as described in Clause 9.2 above.

SCHEDULE 1D - OPERATION OF THE PERSONAL HEALTH BUDGETS SERVICE

1. BACKGROUND

1.1 The Service that is the subject of this **Schedule 1D** is the Personal Health Budgets Service for Adults and Children.

1.2 A Personal Health Budget (PHB) is an amount of money spent to meet the health and well-being needs of Hillingdon people eligible for NHS CHC or those with a defined long-term condition. PHBs centre on a care plan, which sets out the service user's health outcomes, the amount of money in the budget, and how the money will be used. The support plan will be developed by the individual with support from a support worker additional to the Continuing Healthcare Team, employed by Hillingdon Clinical Commissioning Group (HCCG).

1.3 Personal health budgets can take three forms:

1.3.1 *A notional budget* - This is the identification of the amount of money that the NHS will contribute to meeting a person's assessed healthcare needs;

1.3.2 *A budget held by a third party* - Where the sum of money determined by the NHS to fund service provision to meet assessed health need is paid to another person at the direction of the Service User. This may be the Carer, another family member or another individual. In Hillingdon our preferred option is to administer Direct Payments via a prepaid card, however other options can be explored on a case by case basis; or

1.3.3 *A Direct Payment (DP)* - Where the sum of money determined by the NHS to fund service provision to meet assessed health need is paid to the individual. As described in Clause 1.2.2 above, the preferred method of payment in Hillingdon is through a pre-paid card.

1.4 Budgets will be approved by the Continuing Healthcare Commissioning Lead for Hillingdon CCG. PHBs may be used for the purchase of care in a person's own home or in a nursing care home setting.

2. COMMISSIONING ARRANGEMENTS

2.1 The Council is being commissioned by HCCG to provide the administration, financial monitoring and on-going direct payment support for service users of all ages entitled to be offered a PHB and request a direct payment, a notional budget, a budget held by a third party, or a mixed budget (e.g. notional and direct payment).

2.2 Funding the full cost of care packages for the people eligible for PHBs remains the statutory responsibility of HCCG. The funding of an integrated PHB will be a joint responsibility between the Council and HCCG.

3. KEY SERVICE ELEMENTS, PHILOSOPHY AND BUDGET

3.1 The Service to be provided by the Council to people eligible for a PHB shall:

3.1.1 Access to creative support planning;

3.1.2 Access to the Approved Provider List of Personal Budget Support Services for managing a PHB DP, payroll services, recruitment services for Personal Assistants (Pas) and ongoing support and advice on DPs;

3.1.3 Support to case managers to aid creative care planning;

3.1.4 Support to case managers and/or service users and/or Carers once budgets and care plans are agreed by HCCG and the CHC Case Managers to explain prepaid cards;

3.1.5 Arrangement and implementation of prepaid cards for service users/carers;

3.1.6 Financial monitoring of Service User/Carer spending

3.1.7 Reporting to HCCG of Service User/Carer spending

3.2 The Service provided by the Council shall not include the following functions:

3.2.1 Assessment of financial contributions, as the NHS will fully fund the services required to meet health needs following a CHC assessment or Children's Continuing Care assessment or review of an individual with a long-term condition;

3.2.2 Clinical case management and reviews;

3.2.3 Support to people receiving a PHB through an HCCG notional budget; and

3.2.3 Assessment of the continued eligibility for NHS CHC.

3.3 The Service shall be offered and delivered based on an 'enabling' model and philosophy, the emphasis will be on facilitation to encourage confidence and creativity in choice of support. Service Users shall be assisted to access services and community networks through the online resident portal Connect to Support or other such similar system.

3.4 The Council shall support case managers to encourage take up of PHBs by eligible adults and children.

4. SERVICE PROCESS AND RESPONSE TIMES

4.1 The referral process is summarised in **Annex A** to this **Schedule 1D**. Referrals will come via the CHC Commissioning Lead for HCCG and can be either a new or existing Service User.

4.2 If the Service User is known to the Council and in receipt of Direct Payments from the Council:

4.2.1. Referral from CHC Commissioning Lead to Direct Payments Team via secure email including a care plan and indicative budget signed off through HCCG Expenditure Control Procedures;

4.2.2 Referral reviewed by LBH Direct Payments team - Target time: 2 days;

4.2.3 Budget adjusted and documented by the Council - Target time: 2 days;

4.2.4 The Council shall provide on-going financial monitoring and reporting;

4.3 If a Service User is not known to the Council and has never received Direct Payments:

4.3.1 Referral from CHC Commissioning Lead to the Direct Payments Team via email including a care plan and indicative budget signed off through Hillingdon CCG Expenditure Control Procedures;

4.3.2 Referral to be reviewed by the Council's Direct Payment's Team Leader - Target time: 2 working days);

4.3.3 Service User details documented by the Council on Protocol - Target time: 10 working days;

4.3.4 The Council's Direct Payments Team Leader will allocate the case to a Direct Payments Worker and they will make contact with Service User confirming referral. They will initiate the discussion about creating a support plan and explain direct payment financial monitoring and employment set up and on-going support;

4.3.5 The Council will make a referral through the Council's Direct Payments Support Framework Agreement where the Service User requires employment support, for example with employing a personal assistance - Target time: 1 working day;

4.3.6 The Council's Direct Payments Team will set up a pre-paid care for the Service User/Carer.

4.4 Where during financial monitoring processes the Council identifies any anomalies such as no spend or evidence to suggest misuse of funds, HCCG shall be notified immediately and all relevant information shall be provided to HCCG to undertake further investigations as to NHS Fraud guidance. In such circumstances HCCG shall advise the Council on what action to take in regards to the continued payment and administration of the Direct Payment

4.5 The CHC Commissioning Lead shall notify the Direct Payments Team via secure email where there are changes to NHS CHC funding or long-term conditions funding or where this eligibility ends, which may result from a reduction in the Service User's health needs or their death.

5. SERVICE QUALITY AND OUTCOMES

5.1 Quality assurance and monitoring will be built into individual service delivery, monitored and tracked through existing Hillingdon CCG systems and technology. This will include:

5.1.1 Identifying the number of service users receiving a personal health budget through direct payments;

5.1.2 Identifying the number of service users using a pre-paid card; and

5.1.3 Equality and diversity profiling

5.2 HCCG shall retain responsibility for clinical care, through its Continuing Care Case management team based at Harefield Health Centre or as notified to the Council by HCCG.

6. INFORMATION SHARING

6.1 Arrangements for the sharing of information as required for the delivery of the Service under this **Schedule 1D** shall be governed by the provisions of **Schedule 7** of this Agreement.

7. FUNDING

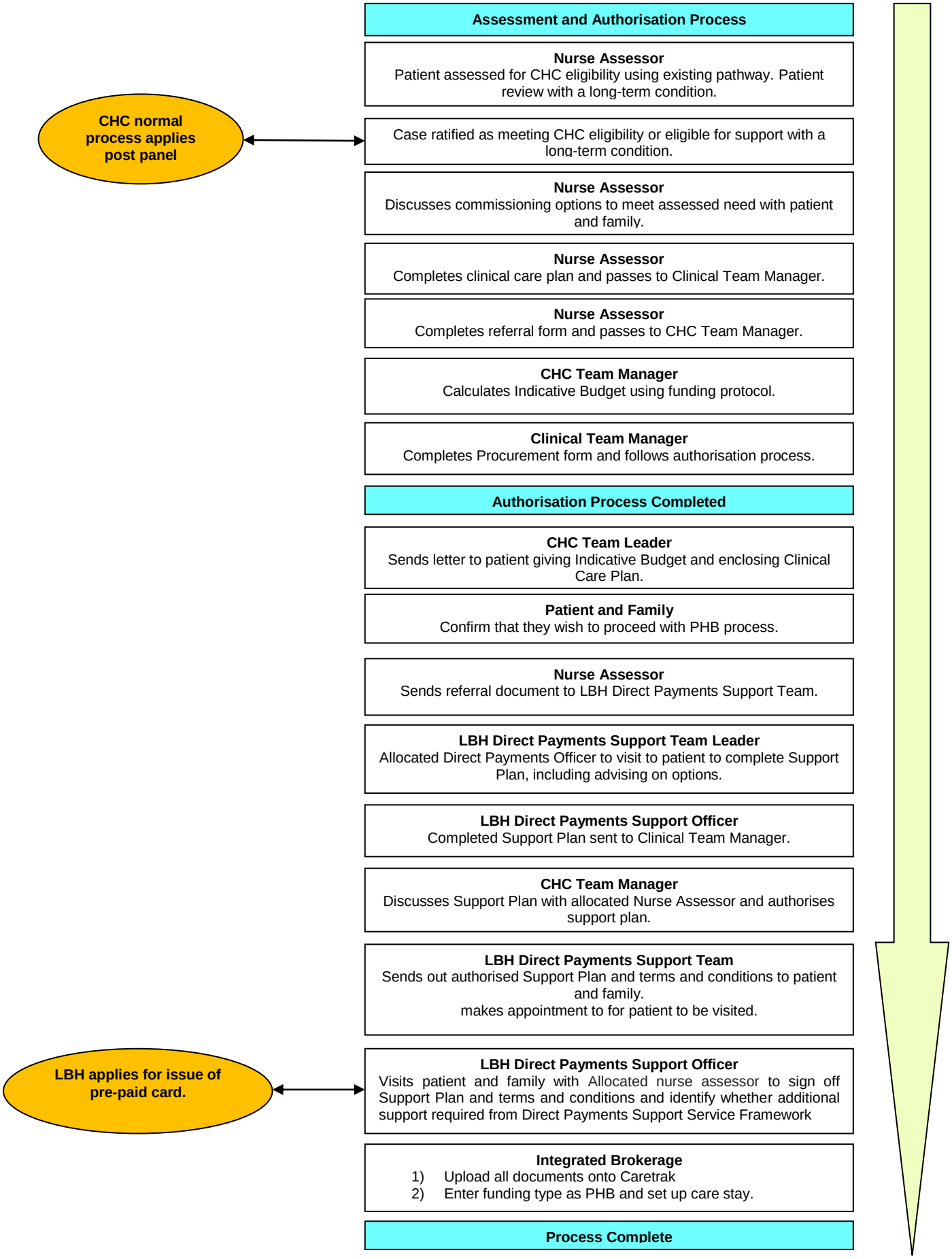
7.1 HCCG shall pay a fixed rate per case to the Council for the administration of PHBs for the duration of the Agreement. The fixed rate per new case for 2017/18 and 2018/19 shall be £765 with an annual support cost charge of £260 per case thereafter.

7.2 The estimated number of new Service Users to be supported by the Council is 24 in 2017/18 and 24 in 2018/19.

7.3 Service Users will be set up on the Council's case management database called Protocol and an estimate of the value of business for HCCG commissioned packages that will be paid directly by the Council, as well as the related support charges, will be made at the beginning of each year. This estimate will be incorporated into the amount HCCG pays to the Council as part of the quarterly billing for the whole BCF. This value will be regularly reviewed and adjusted as necessary during the course of the pilot project.

7.4 Monthly reports of actual spend on NHS commissioned packages will be provided to HCCG to enable HCCG to monitor the costs of the Service.

ANNEX A - PERSONAL HEALTH BUDGET PATHWAY TO DIRECT PAYMENTS



SCHEDULE 1E - OPERATION OF THE INTEGRATED HOMECARE SERVICE FOR ADULTS AND CHILDREN

1. BACKGROUND

1.1 The Service that is the subject of this **Schedule 1E** is the Integrated Homecare Service for Adults and Children. The Council shall commission the Service in accordance with the delegation of functions described in Clause 5.6 of this Agreement.

1.2 The Integrated Homecare Service for Adults and Children is intended as a pilot to operate for a period of two years from October 2017 but with the option to extend for a period of up to two further years. The pilot is intended to assist in informing the longer term model of homecare provision to be implemented from October 2019, subject to any decision about the extension of the pilot.

1.3 Home Care is the provision of person centred, personal care, enabling care and/or other services that are necessary to maintain a Service User's quality of life, enabling them to remain living in their own home and achieve their specified outcomes. Home Care is not about doing things for people in a way that increases dependency, but about supporting people to do things for themselves as far as they are able.

2. SERVICE AIM

2.1 The integrated homecare model is intended to support the sustainability of a fragile but increasingly critical area of care provision that will assist in ensuring the availability of quality services to meet the needs of Residents and Patients through the following:

- A single, joint specification.
- A single point of contact for providers.
- Common and consistent quality assurance process.
- Common key performance indicators.
- A single contract management process.

2.2 The Service will achieve a primary objective of enabling Service Users to remain living at home safely for as long as possible and maintaining a good quality of life which meets the Service User's identified outcomes.

3. SERVICE SCOPE

3.1 For the duration of the pilot the Service is intended to address demand for homecare provision:

a) For Adults referred by a Social Care professional within the central zone shown in **Annex A** to this **Schedule 1E**;

b) For Adults referred by a Social Care professional in all other parts of the borough where current lead providers lack capacity;

c) For Children referred by a Social Care professional in all areas of the borough;

d) For all Adults and Children referred by an NHS clinician in all areas of the borough.

e) For Adults and Children across the borough at end of life who have been referred either by a Social Care professional or an NHS clinician.

4. SERVICE DELIVERY

Homecare Model

4.1 The Integrated Homecare pilot is based on a Dynamic Purchasing System (DPS) model. A DPS is like a framework agreement with the exception that new providers can join at any time if they satisfy admission criteria. For admission to the DPS a Service Provider must have:

a) A CQC rating which is of a minimum standard of *Requires Improvement* and a demonstrable commitment to achieving a *Good* or *Outstanding* Rating;

b) A commitment to having in place an Electronic Call Monitoring System (ECMS) to monitor care hours delivered that is linked to the Council's electronic system by 31st March 2018. Payment will be based on information from ECMS and will be for actual care delivered.

c) A local office for the management of Service Provision which must be within approximately five miles of the borough boundary.

d) A commitment to a pay rate of at least £9.75 per hour for Care Workers.

4.2 The Hillingdon DPS will be an entirely electronic process and as such all call-offs will be made through the Council's Connect to Support e-brokerage solution. There will be a phased implementation of the e-brokerage solution which is not anticipated to be fully operational until January 2018.

4.3 There is no limit on the number of Service Providers who can be admitted to the DPS.

Care Tiers

4.4 Service Providers admitted to the DPS have been required to identify which levels of care they are qualified and able to deliver against four tiers of care. The Service Specifications for Adults and Children are appended to this **Schedule 1E** as **Annex B and** describe the tiers in detail**.** However, the tiers can be summarised as follows:

a) ***Home Care Tier 1: Non-specialist Care*** - This includes basic tasks such as prompting to take medication, assistance with personal care tasks, meal preparation and assistance with eating/ drinking;

b) ***Home Care Tier 2: Non-specialist Care*** - In addition to the above, this includes administration of medication, use of feeding tubes, more complex moving and handling;

c) ***Home Care Tier 3: Specialist Care*** - In addition to tier 1 and 2 this would include administration of medication using specialist techniques, care for people with ventilator dependency; and

d) ***Home Care Tier 4: Registered Nursing Specialist Care*** - This applies where care must be provided by a registered nurse and delegated care workers.

Call-off Process

4.5 The electronic call-offs against the DPS through Connect to Support will be made against the following domains:

a) ***Domain 1: Meeting the requirements of the care package as per the referral*** - Service Provider confirmation that the Service can be provided in accordance with the commissioned tasks and outcomes.

b) ***Domain 2: Urgency*** - Service Provider confirmation that Services can be commenced in accordance with the proposed start date.

c) ***Domain 3: Duration/Time Critical*** - Service Provider confirmation that it has available capacity to meet the commissioned times and durations of each call.

d) ***Domain 4: CQC Rating*** - Service Provider's current CQC rating will be referenced for evaluation purposes.

e) ***Domain 5: Quality Rating*** - This relates to the Council/CCG appointed quality rating arising from the contract management process as described in **Annex C** of this **Schedule 1E**.

f) ***Domain 6: The Price*** - This relates to the price for the specific tiers provided as part of the process of admission to the DPS.

g) ***Domain 7: Continuity of Care Requirements*** - Continuity of care is considered where there may be risks to the Service User by changing agency, disruption and other risk based factors.

h) ***Domain 8: Location/Geographical Area*** - Service Provider confirmation of available capacity in the required location.

i) ***Domain 9: Gender or Age Specific Requirements*** - Service Provider confirmation that Care Workers are available to meet these requirements.

j) ***Domain 10: Service User Choice*** - Where Service Providers equally meet all of the Call-off requirements for the package of care being commissioned, the Service User will be given the option of choosing the preferred Service Provider.

5. CONTRACT

5.1 Contracts with Service Providers will be held by the Council.

6. MONITORING ARRANGEMENTS

6.1 Monitoring and management of homecare providers shall be undertaken by the Council in partnership with the HCCG in accordance with the homecare DPS contract management arrangements described in **Annex C** of this **Schedule 1E**.

7. FINANCIAL ARRANGEMENTS

7.1 An estimate of the value of business for HCCG commissioned packages that will be paid directly by the Council will be made at the beginning of each year. This estimate will be incorporated into the amount HCCG pay to the Council as part of the quarterly billing for the whole BCF. This value will be regularly reviewed and adjusted as necessary during the course of the pilot project.

7.2 Monthly reports of actual spend on NHS commissioned packages will be provided to HCCG to enable HCCG to monitor the costs of the service.

ANNEX A - HOMECARE ZONES

Schedule 1E Annex A - Homecare Zones.pd

ANNEX B - HOMECARE SPECIFICATIONS FOR ADULTS AND CHILDREN

Schedule 1E Annex B - Home Care Spec Ad

Schedule 1E Annex B - Home Care Spec Ch

ANNEX C - HOMECARE DPS CONTRACT MANAGEMENT

SCEDULE 1E ANNEX C - DPS CONTRACT M

ANNEX D - HOMECARE DPS SPOT CONTRACT

SCHEDULE 1E ANNEX D SPOT DPS HOMECA

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.

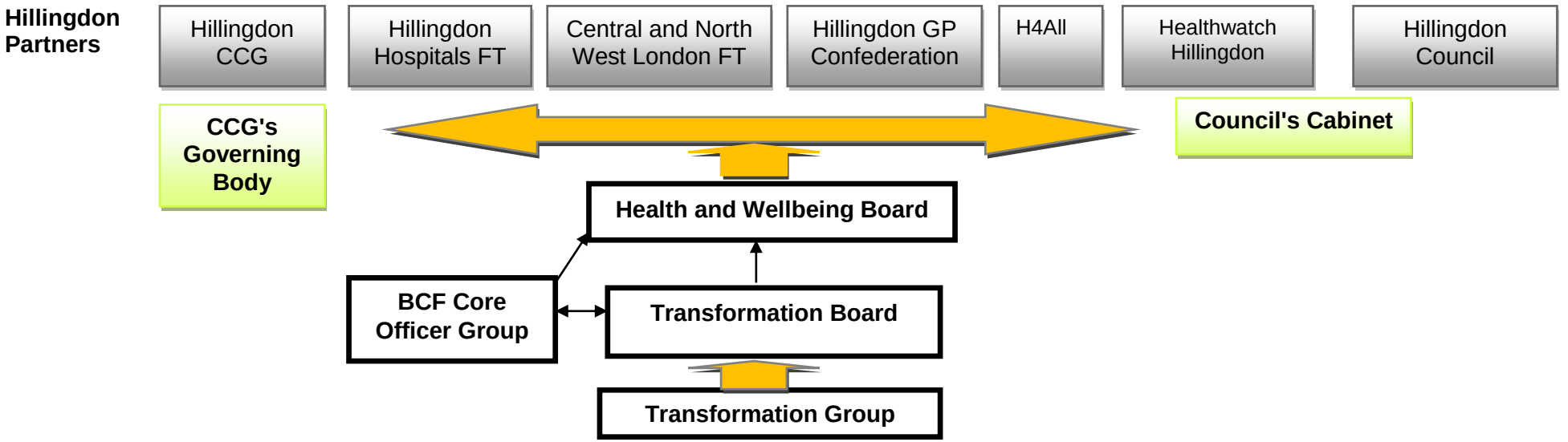
3. Health-related responsibilities of the Council included in the BCF Plan are:

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



STP Delivery Areas	DA1 Prevention & Wellbeing				DA2 Long-term Conditions		DA3 Older People		DA4 Mental Health	DA5 Sustainable Acute Services		Enablers
Supporting Groups & Scheme Delivery Responsibility (BCF Scheme Number)	Prevention Group **(1)**	Primary Care	Children & Young People Mothers & Babies	Carers Strategy Group **(2)**	Long-Term Conditions	Cancer	Clinical Design & Delivery Group	End of Life Forum **(3)**	Mental Health & Learning Disabilities	Planned Care	A & E Delivery Board	• Digital. • Estates. • Workforce. • Provider market **(5)**. • Medicines. • Statutory targets.
							Dementia Working Group **(6)**			Integrated Hospital Discharge Group **(4)**		

SCHEDULE 3 - BETTER CARE FUND GOVERNANCE ARRANGEMENTS

1. BETTER CARE FUND GOVERNANCE STRUCTURE SUMMARY

Key to Summary of Governance Arrangements	
	*Use of resources decision authority*
	*Line of accountability*
	Reporting line

2. BETTER CARE FUND GOVERNANCE STRUCTURES TERMS OF REFERENCEe

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 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 Joint Strategic Needs Assessment (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

2.3 The Chairman of the Board is the Cabinet Member for Social Services, Housing, Health & Wellbeing.

2.4 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

2.5 In addition there are co-opted members from three NHS provider trusts and these are:

- The Hillingdon Hospitals Foundation Trust
- Central and North West London Foundation Trust
- The Royal Brompton and Harefield Foundation Trust

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 Transformation Board 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 Transformation Board;
e. Translating recommendations from the Transformation Board into action.

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 and Children and Young People's Services and the CCG's Chief Operating Officer.

2.12 Other members include:

- Corporate Director of Finance – LBH
- Chief Finance Officer – HCCG
- Head of Health Integration and Voluntary Sector Partnerships – LBH
- Others by invitation or cooption

Accountability

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

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) Transformation Board

2.17 The key purpose of the Transformation Board is to:

- To transform how local health and care services are commissioned and delivered to achieve care services that are integrated around the needs of the patient / resident in a manner that also delivers financial stability and resilience in the local health and care economy.

2.18 The Transformation Board will be responsible for:

a) Developing transformation programmes across partners to benefit the local health and social care system and therefore Hillingdon residents / patients, acknowledging that transformation programmes may be led by different member organisations;

b) Ensuring that all programmes are aligned;

c) Sourcing relevant external resources to support transformation programmes;

d) Monitoring the Hillingdon Transformation Board's achievements and accounting for its collective actions;

e) Ensuring integration between health and social care where it adds benefit to patients/residents and contributes to the delivery of value for money;

f) Ensuring that pathway plans are supported by workforce redesign, optimum use of IT and estate rationalisation plans;

2.19 The Board will also be responsible for:

a. Developing and delivering a system-wide financial recovery plan and transformation programmes.

b. Identifying any additional support/resource required to deliver the plan.

c. To ensure appropriate communication with stakeholders, including consultation issues.

d. To ensure robust clinical engagement within primary, community, secondary, mental health and social care, as well as with the third sector, is in place to support the delivery of the Hillingdon recovery plan and transformation programmes.

Membership

2.20 The Transformation Board will be chaired by the Chair of HCCG's Governing Body.

2.21 Membership of the Board will include the following:

- **HCCG**: Accountable Officer, Chief Operating Officer, Chief Financial Officer.
- **THH:** Chief Executive, Medical Director/Director of Patient Experience and Nursing, Chief Operating Officer, Director of Finance
- **CNWL:** Chief Executive, Medical Director, Managing Director, Director of Finance.
- **Primary Care:** Chair, Hillingdon GP Confederation, Managing Director, Hillingdon GP Confederation.
- **Council**: Cabinet Member for Social Services, Housing, Health & Wellbeing, Director of Adults and Children and Young People's Services, Director of Finance, Director of Public Health
- **Others**: by invitation.

Accountability

2.22 Each member of the Board shall be accountable through the governance structures of their respective organisations.

Frequency of Meetings

2.23 The Board meets every two months and its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.24 The Board 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.

d) Transformation Group

2.25 The key purpose of the Transformation Group is to:

- Be the vehicle for driving delivery of transformation projects and programmes required to deliver the aspects of the North West London Sustainability and Transformation Plan (NWL STP) reflected in Hillingdon's Joint Health and Wellbeing Strategy.

2.26 The Transformation Group aims to:

a) Support the Hillingdon Transformation Board in delivering the vision set out in the NWL STP and the local priorities for Hillingdon as described in the Joint Health and Wellbeing Strategy; and

b) Work closely with Hillingdon health and care commissioning and provider partners to deliver a whole systems approach to health and care planning in Hillingdon.

2.27 The Transformation is responsible for:

a) Providing regular progress and update reports to the Hillingdon Transformation Board and to other committees and boards as required;

b) Ensuring a whole-system perspective, communication, engagement and alignment to delivering health and care transformation in Hillingdon;

c) Oversee the production of needs assessments and business cases which will inform priority service developments, guide service redesign, and support decisions to invest in new models of care;

d) Monitoring the delivery of the Better Care Fund Plan;

e) Overseeing the production of workforce needs assessment to inform education and training opportunities;

f) Support the development and delivery of ‘at scale’ primary care and out of hospital care closer to home;

g) Drive the development of accountable care in Hillingdon;

h) Overseeing implementation of an estates strategy;

i) Overseeing the implementation of an IT strategy.

Membership

2.28 The Transformation Group will be chaired by the Chair of HCCG's Governing Body.

2.29 Membership of the Transformation Group will include:

- *HCCG*: Chief Operating Officer, Chief Finance Officer, Associate Director of QIPP, Transformation & Planning, Commissioning and Governing BodyTransformation Leads.

- *LBH*: Director of Public Health, Head of Health Integration and Voluntary Sector Partnerships, Health and Social Care Integration Manager.

2.30 Occasional members of the Transformation Group will include:

- NHS provider trust representatives.
- NWL Primary Care Strategy and Transformation Team.
- NHS England Primary Care Contracting Team.
- Local Medical Committee Representative.
- NHS Property Services.

Accountability

2.31 The Group is accountable to the Transformation Board.

Frequency of Meetings

2.32 The Transformation Group meets monthly and its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.33 The 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.

3. Roles and Responsibilities: Programme Manager and Scheme Leads

a) Programme Manager

3.1 The responsibilities of the Programme Manager will be to:

a) Identify, analyse and communicate to the Core Officer Group and/or the Transformation 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.

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

c) Actively manage identified risks and issues arising from schemes.

d) Provide direct support to scheme leads as required.

e) Escalate to the Transformation Group and/or Core Officer Group risks or issues that cannot otherwise be managed and recommend mitigation.

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

g) Manage the delivery of the stakeholder engagement strategy.

b) Scheme Leads

3.2 The responsibilities of Scheme Leads will be to:

a) Establish and lead a project group of relevant stakeholders.

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

c) Identify baseline positions and identify gaps against best practice standards.

d) 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.

e) Develop implementation plans and provide updates to the Programme Manager highlighting delivery risks.

SCHEDULE 4 – RISK SHARE AND OVER AND UNDER PERFORMANCE

1. RISK SHARE

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

1.2 During the period of the integrated homecare shadow arrangements shall be put in place whereby HCCG and the Council are responsible for the costs of meeting the needs of their own referrals. This will help to determine the appropriateness of contributions by each organisation, which will then help to inform risk share arrangements as part of the agreed commissioning model from October 2019.

2. OVERSPENDS

2.1 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.

2.2 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 this 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**.

2.3 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**.

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

2.5 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.

3. UNDERSPENDS

3.1 Each Partner shall have regard to the aims of this Agreement as set out in Clause F of this Agreement in determining how any such underspend on their contribution to the Pooled Fund

shall be spent. In any event, the value of the plan approved by NHSE shall not be reduced during the lifetime of this Agreement.

SCHEDULE 5 – BETTER CARE FUND PLAN


BCF Supporting Narrative 2017-19 v1


Annex 1 DTOC Action Plan 17-18 v9


BCF Planning Template Master FIN

SCHEDULE 6 – CONFLICTS OF INTEREST

1. DEFINITION OF A CONFLICT OF INTEREST

1.1 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.

2. PRINCIPLES FOR MANAGING CONFLICTS OF INTEREST

2.1 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.

2.2 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 SHARING AGREEMENT

1. NORTH WEST LONDON INFORMATION SHARING AGREEMENT

1.1 The Partners shall be signatories to the North West London Integrated Care Digital Information Governance Agreement (NWL ISA) as set out in **Annex A** of this **Schedule 7** and as may be amended from time to time with agreement of the Partners.

1.2 The purpose of the information sharing agreement shown in **Annex A** of this Schedule is to support integrated care and care planning. The Council became a signatory to the NWL ISA on 14th July 2017. The other signatories to the NWL ISA are set out in **Annex A** of this Schedule.

2. ENTERING INTO SEPARATE INFORMATION SHARING AGREEMENTS

2.1 It is acknowledged that it may be necessary during the term of this Agreement for the Partners to enter into information sharing agreements that are separate and external to the NWL ISA. This may be required in order to comply with the requirements of the 1998 Act in circumstances where it is required to use electronic systems that are outside of the scope of the NWL ISA.

2.2 In the circumstances described in Clause 2.1 of this Schedule, the Partners shall follow their respective governance processes in order to seek approval for any such agreements.

ANNEX A - NORTH WEST LONDON INFORMATION SHARING AGREEMENT

North West London Information Sharing A

NWL ISA TZ Signature 14.07.17.p