Appendix 2

Dated: day of December 2022

London Borough of Hillingdon

and

North West London Integrated Care Board

2022/23

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

CONTENTS

Acknowledgement: This agreement is based on a template developed by Bevan Brittan LLP
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THIS AGREEMENT is made on day of **December** 2022

PARTIES

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

(2) **North West London Integrated Care Board** (the "***ICB***") of 15 Marylebone Rd, London NW1 5JD

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 adult population of the London borough of Hillingdon.

B. The ICB is established under Chapter A3 of Part 2 of the National Health Service Act, 2006 and shall from the 1st July 2022 be the successor organisation to North West London Clinical Commissioning Group 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. The ICB shall be 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 as described in the 2006 Act.

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 ICB 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 provides the means through which the Partners can pool funds and align budgets as agreed between the Partners.

F. The aims and benefits of the Partners in entering into 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 2025/26 improvement in the health and wellbeing of all residents can be demonstrated as well as a reduction in disparities in health and care across Hillingdon's communities.

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 ICB 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:

1983 Act means the Mental Health Act, 1983.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act, 2006.

2014 Act means the Care Act, 2014 unless otherwise stated.

2018 Act means the Data Protection Act, 2018.

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 Approval Ref. No. PAR1296.

Better Care Fund Plan means for 2022/23 the schemes described in **Schedule 1**.

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 4th April 2022.

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.

Core Officer Group has the same meaning as Partnership Board defined below.

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 that 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.

ICB Statutory Duties means the duties of the ICB pursuant to Chapter A3 of Part 2 of the 2006 Act.

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 in **Schedule 1** of this Agreement.

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 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

(c) 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 ICB as are relevant to the commissioning of the Services and further described in **Schedule 2**.

NHS NWL means the North West London Integrated Care Board.

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 ICB 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 2018 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 or the Accountable Officer of the ICB or their authorised representative, dependent on context.

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

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

- *Quarter 1*: 1 April to 30 June
- *Quarter 2*: 1 July to 30 September
- *Quarter 3*: 1 October to 31 December
- *Quarter 4*: 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 mean 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 as described in **Schedule 1**.

Section 117 (s117) refers to the duties on local authorities and ICBs to provide aftercare to people previously detained under section 3 of the 1983 Act.

Sensitive Personal Data means Sensitive Personal Data as defined in the 2018 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 individuals for whom the Partners have a responsibility to commission the Services.

SoSHSC means the Secretary of State for Health and Social Care.

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 Subject to compliance with the terms and conditions of this Agreement, this Agreement shall remain in force with respect to each party and their obligations unless terminated in accordance with the relevant clauses, provisions or sections of the Agreement or it is replaced by a successor agreement.

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 ICB and the ICB 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 ICB delegates to the Council and the Council agrees to exercise on the ICB'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 will include such functions as will 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.

5.4 The Partners will 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 For the purposes of implementing the Schemes in **Schedule 1**, the ICB delegates to the Council its functions below:

5.6.1 section 3(1)(b) of the 2006 Act of arranging for the provision of other accommodation for the purpose of any service provided under the 2006 Act;

5.6.2 section 3(1)(e) of the 2006 Act of arranging for the provision of such other services or facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness as are appropriate as part of the health service.

5.7 Table 1 below shall describe the form that the delegation provided for in Clause 5.6 above shall take.

Table 1: Summary of Form of Delegated Functions: ICB to Council	
Scheme	**Functions Delegated**

Scheme 1	None
Scheme 2	None
Scheme 3	None
	a) Delegation by the ICB to the Council to enter into contractual arrangements with homecare providers on behalf of the ICB.
	b) Delegation by the ICB to the Council to procure the provision of beds for use as intermediate care or short-term placements on behalf of the ICB as described in **Schedule** 1**D** of this Agreement.
	c) Delegation by the ICB to the Council authority to act as lead commissioner on behalf of the ICB for the Bridging Care Service described in **Schedule 1D**.
	d) Delegation by the ICB to the Council to undertake the brokerage function for nursing care home placements on behalf of the ICB as described in **Schedule 1D** of this Agreement.
	e) Delegation by the ICB to the Council to act as lead commissioner on behalf of the ICB for the community equipment service as described in **Schedule 1B**.
	f) Delegation by the ICB to the Council authority to undertake assessments and prescriptions for community equipment to meet health needs.
Scheme 5	Delegation by the ICB to the Council to manage the process for people registered with Hillingdon GPs to access Personal Health Budgets as described in **Schedule 1C** of this Agreement.
Scheme 6	None
Scheme 7	a) Delegation by the ICB to the Council to exercise on its behalf lead commissioning functions for the Children and Young People's Integrated Therapy Service as described in **Schedule 1E** of this Agreement.

	b) Delegation by the ICB to the Council to undertake all necessary steps for the implementation of Scheme 7 in accordance with the terms of **Schedule 1E** and the agreed contract for the provision of the Service.
Scheme 8	a) Delegation to the Council by the ICB the case management function for people with a learning disability and/or autism assessed as being eligible for NHS Continuing Healthcare (CHC) funding as described in **Schedule 1F** of this Agreement. b) Delegation to the Council by the ICB to act as lead commissioner in securing care and support to meet the assessed needs of people with a learning disability and/or autism eligible for CHC funding.

5.8 For the purposes of implementing the Schemes as described in **Schedule 1** the Council delegates its functions under section 2 (1) of the Care Act, 2014, to the ICB as follows:

5.8.1 Arrangements for the provision of services, facilities or resources, or take other steps that will:

a) Contribute towards preventing or delaying the development by adults in its area of needs for care and support;

b) Contribute towards preventing or delaying the development by carers in its area of needs for support;

c) Reduce the needs for care and support of adults in its area;

d) Reduce the needs for support of carers in its area.

5.9 Table 2 below shall describe the form that the delegation provided for in Clause 5.8 shall take.

Table 2: Summary of Form of Delegated Functions: Council to ICB	
Scheme	**Functions Delegated**
Scheme 1	None
Scheme 2	None
Scheme 3	None

Scheme 4	Delegation to the ICB by the Council authority to undertake assessment and prescription of community equipment to meet social care needs.

5.10 The Partners agree that the delegation of functions under this Clause 5 will:

5.10.1 Likely lead to an improvement in the way in which these functions are discharged; and

5.10.2 Will improve health and wellbeing.

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 Pooled Funds 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 Funds 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 the Pooled Fund as set out in the Scheme Specifications. The Host Partner shall be 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) in respect of Pooled Fund 1 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 ICB and the Council to the Pooled Fund for each Financial Year of operation of each Individual Scheme will be as set out in the **Schedule 1A**.

9.2 With the exception of Clause 12, 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 15.2, and 15.3, 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 15.1 will 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 15, 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 always 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 always 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 ICB is subject to the ICB 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 ICB 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 6**.

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 18 and **Schedule 3**.

18.4 The terms of reference of the Partnership Board will 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 will 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 must 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 must 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 will 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 ICB's NHS Functions, it will be dealt with in accordance with the statutory complaints procedure of the ICB;

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 ICB'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 must 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 will 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 22.

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 (or any part thereof) for any reason whatsoever the following will 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 will 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 will not be required to make any payments to the Provider for such amendment or termination unless the Partners will 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 will 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 will 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 ICB Clinical Lead for Hillingdon and the Co-chairmen of the Health and Wellbeing Board. The ICB Clinical Lead for Hillingdon

and the Co-chairmen of the Health and Wellbeing Board will meet within fourteen (14) days of the date of the referral for the purpose of resolving the dispute.

22.4 The decision of the ICB Clinical Lead for Hillingdon and the Co-chairmen of the Health and Wellbeing Board as described in Clause 22.3 will be final and binding on both Partners.

22.5 Nothing in the procedure set out in this Clause 22 will 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 will 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 will 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 will 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 will 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 will 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 will not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient will 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 will 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 will 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 will 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 will 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 will be subject to their duties under the 2000 Act and 2004 Act. No Partner will be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

26 DATA PROTECTION AND INFORMATION SHARING

26.1 The Partners must comply with the provisions of the Data Protection Laws and any other relevant data protection law in force so far as applicable to this Agreement and the Services and must indemnify each other against all actions, costs, expenses, claims, proceedings and demands which may be brought against the other Party for breach of statutory duty under these statutes which arises from the use, disclosure or transfer of Personal Data by the other Party or its servants or agents.

26.2 For the purposes of this Clause 26, the terms "*Data Controller*", "*Data Processor*", "*Data Subject*", "*Data*" and "*Processing*" will have the meaning prescribed under the Data Protection Laws.

27 OMBUDSMEN AND INVESTIGATIONS BY REGULATORY BODIES

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

28 NOTICES

28.1 Any notice to be given under this Agreement must 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 must 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 will 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 **Executive Director for Adult Services and Health**;

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

and

28.3.2 if to the ICB, addressed to the **Borough Director**;

Tel: 01895 203005

E.Mail: sean.bidewell@nhs.net/richard.ellis9@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 **NORTH WEST LONDON INTEGRATED CARE BOARD**

_____

Authorised Signatory

Schedule 1 - Scheme Descriptions

Scheme 1: Neighbourhood Development

a) **Scheme Aim(s)**

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.

b) **2022/23 Priorities**

The 2022/23 priorities under this scheme include:

- Embedding population health management and addressing areas of inequality (including those identified in the NHS Core20Plus5 model) to determine operating model for integrated neighbourhood teams.
- Delivering national and NWL enhanced services to national/NWL targets.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following key BCF metric:

- ***Admission avoidance metric***: Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2022/23 is 874.

Scheme 2: Supporting Carers

a) **Scheme Aim(s)**

This scheme seeks 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) **2022/23 Priorities**

The 2022/23 priorities under this scheme are:

- Developing a refreshed all age Joint Carers Strategy, 2023 – 2028.
- Completing the *'Are you a carer?* leaflet.
- Restoring carer leads in GP surgeries.
- Ensure that the electronic patient record (EPR) system is developed so that asking if a patient has a carer or is a carer is a mandatory aspect of assessment at Hillingdon Hospital.
- Reviewing the Carer Support Service delivery model prior to retendering.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following BCF national metrics:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2022/23 is 874.

- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. The target for 2022/23 is 93.2%.

- ***Permanent admissions to care homes metric:*** Reduction in permanent admissions to care homes per 100,000 65 + population. The ceiling for 2022/23 is 776.3.

- ***Still at home 91 days after discharge metric:*** An increase in the percentage of people aged 65 + still at home 91 days after discharge. The 2022/23 target is 90.5%.

Scheme 3: Better care at end of life

a) **Scheme Aim(s)**

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 aims 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) **2022/23 Priorities**

The 2022/23 priorities under this scheme are:

- Establishing a coordination hub for patients, carers and health professionals to access specialist care and support

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following key BCF metric:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2022/23 is 874.

- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. The target for 2022/23 is 93.2%.

Scheme 4: Urgent and Emergency Care

a) **Scheme Aims**

The aims of this scheme are:

- To prevent admission and readmission to acute care following an event or a health exacerbation;
- To enable recovery through intermediate care interventions to maximise a person's independence, ability to self-care and remain in their usual place of residence for as long as possible;
- To facilitate rapid discharge of people who are clinically suitable for discharge from hospitals but are unable to return to their usual place or residence or care setting;
- To support discharge from mental health community beds

b) **2022/23 Priorities**

The 2022/23 priorities for this Scheme include:

- Increasing capacity for same day emergency care (SDEC), including establishing intravenous antibiotic administration in the community.
- Piloting an integrated neuro-rehab community service.
- Establishing a frailty virtual ward model to reduce admissions and length of stay.
- Roll out falls training package for care homes and ongoing falls population health work.
- Ensuring availability of community capacity to respond to winter demand surge.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. The target for 2021/22 is 91%.
- ***Permanent admissions to care homes metric:*** Reduction in permanent admissions to care homes per 100,000 65 + population. The ceiling for 2022/23 is 776.3.
- ***Still at home 91 days after discharge metric:*** An increase in the percentage of people aged 65 + still at home 91 days after discharge. The 2022/23 target is 90.5%.

Other success measures include:

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The bed occupancy rate should be at no more than 90%.
- ***Length of stay of seven days or more (Hillingdon Hospital):*** Percentage of people in hospital with a length of stay of seven days or more (known as '*stranded patients'*) should be no more than 30% of the bed base, i.e., 90 based on 315 core beds.
- ***Out of hospital capacity:*** Health and social care capacity at no more than 90% utilisation.

Scheme 5: Improving care market management and development

a) **Scheme Aim(s)**

This enabling scheme supports other schemes within the BCF and aims to achieve:

- 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) **2022/23 Priorities**

The 2022/23 priorities under this scheme are:

- Implementing a coordinated approach to supporting the sustainability of the regulated care market.
- Undertaking a fair cost of care exercise and developing a Market Sustainability Plan.
- Embedding integrated brokerage arrangements to expedite hospital discharge**.**
- Establishing care home block contracts to support discharge.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following national BCF metrics:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2022/23 is 874.
- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. The target for 2022/23 is 93.2%.
- ***Permanent admissions to care homes metric:*** Reduction in permanent admissions to care homes per 100,000 65 + population. The ceiling for 2022/23 is 776.3.

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

- Number of CQC registered care providers that experience business failure.
- 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.

Scheme 6: Living well with dementia

a) **Scheme Aim(s)**

The main aim 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) **2022/23 Priorities**

The 2022/23 priorities under this scheme are:

- Improving dementia diagnosis rates.
- Developing and maintaining alternative solutions to institutional care for people living with dementia.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2022/23 is 874.
- ***Permanent admissions to care homes metric:*** Reduction in permanent admissions to care homes per 100,000 65 + population. The ceiling for 2022/23 is 776.3.

Scheme 7: Integrated Care and Support for Children and Young People

a) **Scheme Aims**

This Scheme aims to:

- To provide a high quality service for children and young people with physical, occupational and speech and language difficulties in accordance with national guidance and best practice.
- To improve the quality of life and the ability of children and young people with physical, occupational and speech and language difficulties to live independently or with support within the community and participate in mainstream services including education.

b) **2022/23 Priorities**

The 2022/23 priority under this scheme is:

- Delivering integrated family hub services.

- Developing 0-19 services focussed on needs of local population.
- Establishing mental health support roles in neighbourhood teams.
- Establishing a dynamic support register (DSR) for CYP with LD and /or Autism to enable partners to identify CYP at risk and consider community solutions.

c) **Intended Outcomes/Success Measures**

This scheme will not contribute to the BCF metrics.

The measures that will be used to identify whether the scheme is working include:

- % of referrals acknowledged within 2 days of receipt (by email or text).
- % of referrals (reviewed by the MDT Panel) with referral decision communicated to the referrer within 2 weeks.
- % of EHC needs assessment reports provided within 6 weeks (statutory) by therapy type: SaLT, OT & physiotherapy.
- % of parents / carers satisfied with the timeliness of the identification of their child's needs.
- % of parent / carers who report that the pathway process is clear and that they feel involved in agreeing their child's intervention outcomes.
- *Youth Justice SaLT*: 100% of young people are offered a SaLT assessment within 2 weeks of referral being accepted.
- *Youth Justice SaLT*: 100% of all Pre-sentence Reports and Breach reports have SaLT contribution.
- *Youth Justice SaLT*: 100% of young people are provided with a report and communication profile outlining their strengths, needs and adaptations.

Scheme 8: Integrated care and support for people with learning disabilities and/or autism

a) **Scheme Aims**

The intended aims of this Scheme are to:

- To improve the quality of care for people with a learning disability and/or autism;
- To improve quality of life for people with a learning disability and/or autism;
- To support people with a learning disability and/or autism down pathways of care to the least restrictive setting;
- To ensure that services are user focused and responsive to identified needs;
- To ensure Value for Money and efficient use of resources, maximising income where at all possible and avoiding duplication.

b) **2022/23 Priorities**

The 2022/23 priorities under this scheme are:

- Developing crisis pathways for people with learning disabilities and/or autistic people.
- Developing an all-age Joint Autism Strategy, 2023 – 2026.
- Completion of Joint Strategic Needs Assessment for autism.

- Delivery of LD health checks to national target.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2022/23 is 874.

- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. The target for 2022/23 is 93.2%.

The following measures will be used to identify whether the scheme is working:
- % of people with learning disabilities known to services in paid employment.
- % of people with learning disabilities known to services in settled accommodation.
- % of people with learning disabilities known to services receiving an annual health check.
- % of Service Users with an up to date Health Action Plan.

SCHEDULE 1A - FINANCAL CONTRIBUTIONS SUMMARY AND BREAKDOWN

1. Figures in the tables within this Schedule are subject to rounding and therefore totals given may not be the sum of the numbers provided.

FINANCIAL CONTRIBUTIONS SUMMARY

2. Table 1 summarises the total contribution by organisations by organisation in 2022/23 compared with 2021/22.

Table 1: Financial Contributions by Organisation 2021/22 and 2022/23 Compared		
Organisation	**2021/22** ***(£,000s)***	**2022/23** ***(£,000s)***
NHS	49,127	51,047
LBH	57,327	58,033
TOTAL	**106,454**	**109,080**

3. Table 2 below provides a breakdown of the mandated financial requirements for 2022/23 compared with 2021/22.

Table 2: BCF FUNDING SUMMARY 2021/23			
Funding Breakdown	**2021/22 (£,000)**	**2022/23** ***(£,000s)***	**% Difference**
MINIMUM NHS CONTRIBUTION	**20,485**	**21,664**	**5.8**
Required Spend			
• Protecting Social Care	7,470	7,892	5.6
• Out of Hospital	5,821	6,150	5.7
• Other minimum spend	7,194	7,622	5.9
MINIMUM LBH CONTRIBUTION	**12,359**	**12,578**	**1.8**
Required Spend			
• Disabled Facilities Grant (DFG)	5,111	5,111	0
• Improved Better Care Fund (iBCF)	7,248	7,467	3
MINIMUM BCF VALUE	**32,844**	**34,223**	**4.2**
• Additional NHS Contribution	28,642	29,402	2.5
• Additional LBH Contribution	44,968	45,454	1
TOTAL BCF VALUE	**106,454**	**109,080**	**2.4**

4. Table 3 below summarises the Council and ICB contributions for 2022/23 by scheme and compares these with the 2021/22 position.

Table 3: NHS and LBH Financial Contribution by Scheme Summary							
Scheme		**2021/22**			**2022/23**		
		LBH (£,000)	**NHS (£,000)**	**TOTAL**	**LBH (£,000)**	**NHS (£,000)**	**TOTAL (£,000)**
1.	Neighbourhood development	4,015	3,053	**7,068**	4,134	3,100	**7,234**
2.	Supporting carers	864	101	**965**	854	99	**953**
3.	Better care at end of life	0	1,983	**1,983**	0	1,972	**1,972**
4.	Urgent and emergency care	4,120	17,772	**21,892**	4,251	18,950	**23,201**
5.	Improving care market management and development.	7,598	13,875	**21,473**	7,609	14,389	**21,998**
6.	Living well with dementia	0	2,836	**2,836**	0	2,925	**2,925**
7.	Integrated care and support for children and young people.	2,567	2,384	**4,951**	2,537	2,387	**4,924**
8.	Integrated care and support for people with learning disabilities and/or autistic people.	38,163	7,034	**5,197**	38,648	7,133	**45,782**
	Programme Management	0	89	**89**	0	92	**92**
	TOTAL	**57,327**	**49,127**	**106,454**	**58,033**	**51,047**	**109,080**

5. Table 4 summarises the funding to be paid by the NHS to the Council for its retention.

Table 4: NHS Funding to the Council to be Retained				
Item	**Minimum NHS Contribution (Protecting Social Care)**	**Minimum NHS Contribution (Out of Hospital Services)**	**Additional NHS Contribution**	**TOTAL**
Scheme 1: Neighourhood development				
Market Place	45	0	0	**45**
Online Services Coordinator	51	0	0	**51**
Scheme 2: Supporting carers				
Services to carers (inc respite)	79	0	0	**79**
Carer Support Worker	0	0	19	**19**
New carers' leaflet	1	0	0	**1**
Scheme 4: Urgent and emergency care				
Prevention of Admission/Readmission to Hospital (PATH)	31	0	0	**31**
Reablement Team	371	0	963	**1,334**
Hospital Discharge Social Work Team	1,256	0	0	**1,256**
Reablement Physiotherapist	72	0	0	**72**
Continuing Healthcare Social Work post	0	0	47	**47**
Park View Court IMC.	32	0	175	**207**
Block beds to support discharge 04/04/22 – 02/04/23	58	15	172	**245**
Residential Homes (65+)	90	0	0	**90**
Nursing Homes (65+)	59	0	0	**59**
Integrated Homecare (65+)	71	0	0	**71**
D2A Bridging Care	0	0	641	**641**
Scheme 5: Improving care market management and development				
Quality Assurance Team	304	0	0	**304**
Adult Safeguarding	402	0	0	**402**
Social Care Review (Provider Concerns) Post	60	0	0	**60**
Extra Care Team Manager Post	58	0	0	**58**
Extra Care Social Work Post	67	0	0	**67**
Residential Homes (65+)	458	0	0	**458**
Nursing Homes (65+)	1,867	0	0	**1,867**
Integrated Homecare (65+)	1,597	0	0	**1,597**
Scheme 6: Living well with dementia				
Dementia Resource Centre	366	0	0	**366**
Scheme 7: Integrated care and support for children and young people.				
Children's Safeguarding	0	0	64	**64**
Speech & Language Therapist in Youth Justice Service	0	0	37	**37**
Designated Clinical Officer in Special Educational Need and Disability (SEND)	0	0	31	**31**
Scheme 8: Integrated care and support for people with learning disabilities and/or autistic people.				
Homecare	176	0	0	**176**
Placements	67	0	282	**349**
Supported living	0	0	282	**282**

Respite Care Placements	165	0	0	**165**
LBH Learning Disabilities Case Management Service	0	0	129	**129**
Programme Management				
Programme Manager	91	0	0	**91**
TOTALS	**7,893**	**15**	**2,842**	**10,749**

2022/23 FUNDING BREAKDOWN

6. **Annex A** to this **Schedule 1A** of the Agreement provides a detailed breakdown of services, related funding and funding source reflected within the 2022/23 BCF plan.

ANNEX A: 2022/23 BCF SUBMISSION TEMPLATE EXPENDITURE TAB

Annex%20A%20Schedule%201A%20-Sul

SCHEDULE 1B - OPERATION OF THE COMMUNITY EQUIPMENT SERVICE

1. BACKGROUND

1.1 The subject of this **Schedule 1B** of the Agreement is the operation of the Community Equipment Service (CES), which will be referred to in this Schedule as the Service.

1.2 The Community Equipment Service includes:

1.2.1 The Equipment Loans Service (ELS) which provides daily living equipment to people who meet the eligibility criteria described in **Annex A** of this Schedule.

1.2.2 Standard and non-standard minor adaptations and door entry systems as defined in Clause 1.3 below and provided to people who meet the eligibility criteria described in **Annex A** of this Schedule.

1.2.3 Equipment Prescription Service as defined in Clause 1.3 below.

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

1.3.1 ***Contract Operations Officer*** means the person appointed by the Council to oversee the day to day operation of the Contract.

1.3.2 ***Contract*** means the contract with the Service Provider.

1.3.3 ***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.

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

1.3.5 ***Equipment Prescription Service*** means a prescription for equipment to meet assessed need that reflects the value of the local statutory sector financial contribution to meeting that need. The prescription provides the opportunity to the Service User/Patient to '*top-up'* the statutory sector contribution should they wish to do so. Prescriptions can be redeemed in retail outlets approved by the Council. People electing to use the Prescription Service do so as an alternative to the equipment available through the standard ELS catalogue.

1.3.6 ***Minor adaptations*** refer to adaptations costing under £1k.

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

1.3.8 **NHS NWL** means the North West London Integrated Care Board.

1.3.9 ***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. These are adaptations that require the services of a building.

1.3.10 ***Prescribers*** refer to qualified staff from all Prescriber Teams who are authorised to prescribe equipment.

1.3.11 ***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 an NHS NWL GP who is located in the London Borough of Hillingdon.

1.3.12 ***Service Provider*** means Medequip Assistive Technology Ltd.

2. SERVICE AIM

2.1 The aim of the Community Equipment Service is to maximise the independence of Hillingdon's residents and other people who meet the eligibility criteria shown in **Annex A** thereby reducing the pressure on the borough's health and care system. This will be achieved by enabling people to carry out day-to-day tasks and activities of daily living that they would otherwise be unable to do without support.

3. MONITORING ARRANGEMENTS

3.1 The Council will employ a Contract Operations Officer who will manage the relationships between Prescribing Teams, the Service Provider and the Partners.

3.2 Activity, expenditure and quality of service delivery of the Services under this **Schedule 1B** will be overseen by the Budget Monitoring Group, the role and responsibility of which is set out in **Annex B**.

3.3 The Contract Operations Officer will provide monthly updates of activity information, expenditure and projected year-end expenditure as directed by the Budget Monitoring Group or the Partnership Board.

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

3.5 The Council will 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 will also provide such other reports as deemed necessary to ensure compliance with Audit requirements.

3.6 The pooled budget will not pay the Service Provider for any expenditure above (or different from) that previously agreed unless so authorised in advance by the Partners.

4. PRESCRIBING AUTHORITY

4.1 The Contract Operations Officer will 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 will have authority to remove prescribing authority or alter the value to which a Prescriber can prescribe equipment under this **Schedule 1B**.

4.2 The Contract Operations Officer 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.

5. CONTRACT

5.1 The Council will hold the Contract with the Service Provider for the delivery of the Services set out in **Annex C**.

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

5.3 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.

6. FINANCIAL ARRANGEMENTS

Financial Contributions

6.1 The contributions of the Partners to the CES will be based on the principle that each Partner pays for what they use.

2022/23 Budget

6.2 The breakdown of the 2021/23 budget for the Service is shown in table 1 below.

Table 1: Integrated Community Equipment Service Budgets 2021/23						
Equipment Service	**2021/22 Budget**			**2022/23 Budget**		
	NHS *(£)*	**LBH *(£)***	**TOTAL *(£)***	**NHS *(£)***	**LBH *(£)***	**TOTAL *(£)***
Equipment Loans	1,223,000	420,000	**1,643,000**	1,312,814	440,341	**1,753,155**
Minor Adaptations	36,000	14,000	**50,000**	41,416	11,241	**52,657**
Door Entry Systems	24,000	13,000	**37,000**	25,486	13,487	**38,973**
Equipment Prescription Service	29,000	1,000	**30,000**	11,946	504	**12,450**
TOTAL	**1,312,000**	**448,000**	**1,760,000**	**1,391,662**	**465,573**	**1,857,235**

6.3 Table 2 provides a breakdown of the ELS budget for 2021/23.

Table 2: Equipment Loans Service Budget Breakdown 2021-2023		
Item	**2021/22 *(£,000)***	**2022/23 *(£,000)***
Equipment purchase	1,515	1,621
Staff	56	58
Equipment Maintenance	51	53
Lead authority role RBKC	10	10
Overheads – TCES System	11	11
Net Cost/Budget	**1,643**	**1,753**

Budget Setting

6.4 The Council will propose a base ELS budget for consideration by the Partners by end of Q3 2022/23 and a proposed base budget for 2023/24 will be determined by the end of February 2023. Prescribing Teams funded from the Pooled Budget will be notified of their allocation.

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

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

6.7 Definition of management costs and any shared overheads will be as agreed between the Partners.

Over and Under-spends

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

7. AUDIT ARRANGEMENTS

7.1 In addition to the provisions in Clause 14 (*Audit and Right of Access*) of this Agreement, the Council may in respect of this **Schedule 1B** arrange for an audit of assessments for equipment and the application of the Eligibility Criteria. The costs arising from this audit will be shared equally by the Partners.

8. TERMINATION

8.1 The arrangements under this Schedule may be terminated by either Partner giving **six calendar months'** notice to the other.

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 NHS NWL GP practice that is located in the London Borough of Hillingdon.

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 NWL 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. The Prescriber must undertake a follow up telephone call and/or visit to ensure that the Service User and/or their Carer are able to use the equipment or minor adaptation safely.

9. Staff must be aware which pieces of equipment require an annual review, e.g. specialist seating for children and some 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 NHS NWL 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.

15. Each Prescribing Team must make service appropriate arrangements to ensure that equipment no longer needed is collected.

ANNEX B - BUDGET MONITORING GROUP

Annex B Schedule 1B.docx

ANNEX C - CONTRACT WITH THE SERVICE PROVIDER

Call Off Contract - Medequip.pdf

Service Specification.docx

SCHEDULE 1C - OPERATION OF THE PERSONAL HEALTH BUDGETS SERVICE

1. BACKGROUND

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

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 the ICB. 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 the ICB 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 the ICB. The funding of an integrated PHB will be a joint responsibility between the Council and the ICB.

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 the ICB 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 the ICB 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 ICB 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 1C**. Referrals will come via the CHC Commissioning Lead for the ICB 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 ICB 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 ICB 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, the ICB will be notified immediately and all relevant information will be provided to the ICB to undertake further investigations as to NHS Fraud guidance. In such circumstances the ICB will advise the Council on what action to take in regard 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 ICB 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 The ICB will retain responsibility for clinical care, through its Continuing Care Case management team or as notified to the Council by the ICB.

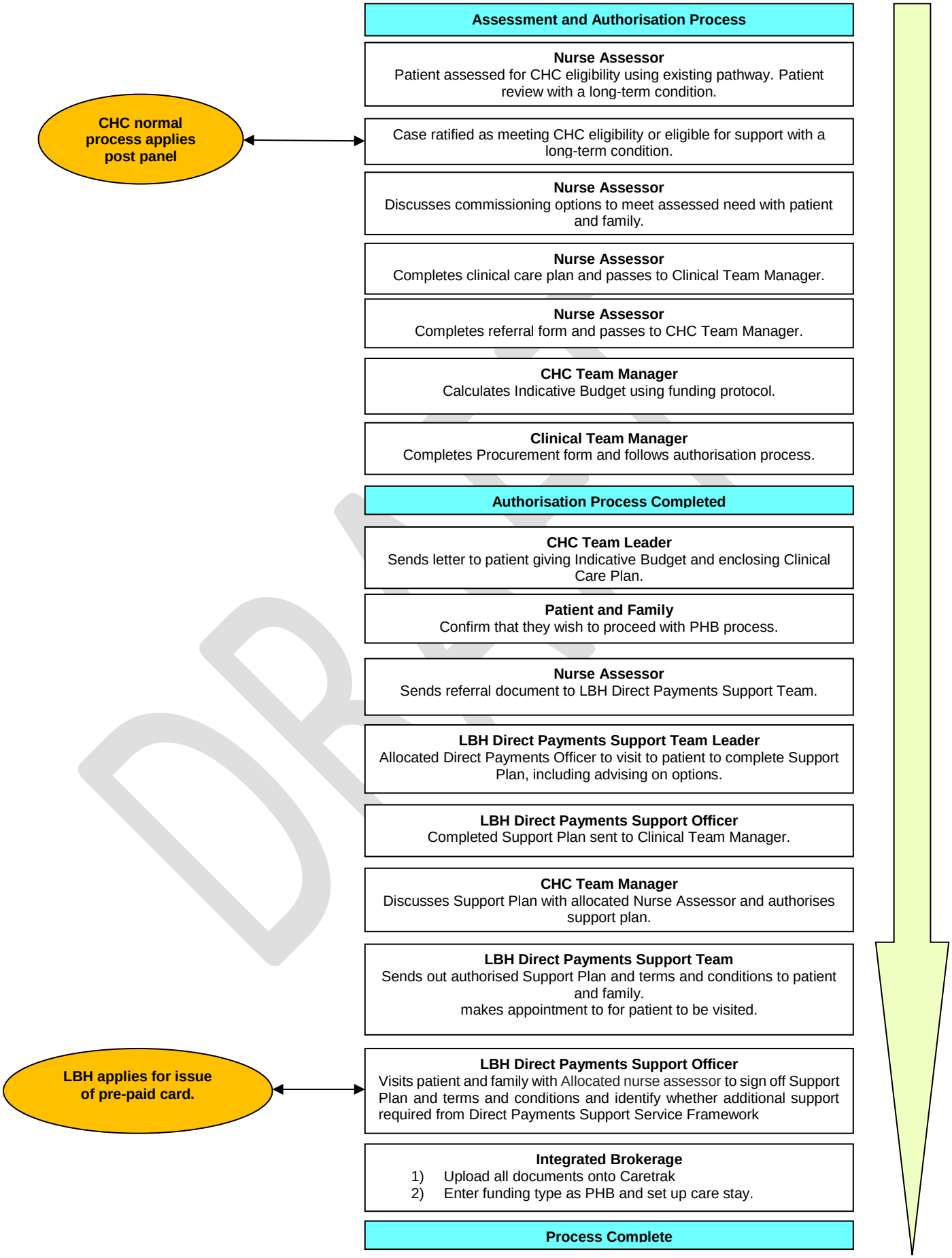
6. FUNDING

6.1 The ICB will 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 2022/23 will be £1,040 with an annual support cost charge of £440 per case thereafter.

6.2 Service Users will be set up on the Council's case management database called Protocol and an estimate of the value of business for ICB 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 the ICB 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.

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

ANNEX A - PERSONAL HEALTH BUDGET PATHWAY TO DIRECT PAYMENTS



Schedule 1D: Hospital Discharge Funding Arrangements

1. BACKGROUND AND OVERVIEW

1.1 The subject of this **Schedule** of the Agreement is the operation of hospital discharge funding arrangements for 2022/23. The Schedule links into Scheme 4: *Urgent and emergency care*.

1.2 This Schedule describes financial contributions by the NHS to meeting Council costs for supporting hospital discharge.

1.3 This **Schedule** details funding included within the Pooled Fund as well as funds transferred to the Council by the NHS in 2021/22 that are being used to support hospital discharge in 2022/23.

1.4 Unless the context otherwise requires, the defined terms used in this **Schedule** will have the meanings set out in the Partnership Agreement.

2. FUNDING WITHIN THE POOLED BUDGET

2.1 Table 1 describes the funding to support hospital discharge contained within the Pooled Fund that entails payment to the Council by the ICB that will be retained by the Council.

Table 1: 2022/23 Intermediate Tier Business as Usual Services Summary

Service	Provider	Start Date	End Date	NHS Contribution (£,000s)	LBH Contribution (£,000s)	Total Cost 2022/23 (£,000s)
A. Bridging Care	Comfort Care Services	04/04/22	02/04/23	641	0	**641**
B. Short-term placement block contracts	HC-One & Seymour House	04/04/22	02/04/23	245	0	**245**
C. Park View Court IMC	Comfort Care Services	04/04/22	02/10/22	207	0	**207**
D. Care home spot placements 65 +	Independent Sector	04/04/22	02/04/23	149	1,436	**1,585**
E. Homecare	Independent Sector	04/04/22	02/04/23	71	948	**1,019**
			TOTAL	**1,313**	**2,384**	**3,697**

Intermediate Tier Services: Exit Arrangements

2.2 The ICB may decommission or reduce capacity of the Bridging Care Service shown in table 1 above by issuing to the Council three calendar months' notice. Should notice not be given three months prior to the end date shown in table 1 above the service will continue until such time as notice is issued under this Clause 2.2.

3. FUNDING OUTSIDE OF THE POOLED FUND

3.1 Table 2 below describes funding arrangements for intermediate tier services for 2022/23 that are external to the Pooled Fund.

Table 2: Intermediate Tier Services Funded Outside of the Pooled Fund						
Service Description	**Provider**	**Start Date**	**End Date**	**2021/22 Winter Pressures Underspend** ***(£,000)***	**Section 256** ***(£,000)***	**TOTAL** ***(£,000)***
1. Bridging Care Additional Capacity	Comfort Care Services	04/04/22	02/04/23	125.6	0	**125.6**
2. Additional Reablement capacity	Comfort Care Services	04/04/22	02/10/22	31.4	0	**31.4**
3. Block beds	Independent Sector	04/04/22	02/10/22	0	225.2	**225.2**
4. Block beds	Independent Sector	03/10/22	02/04/23	38.6	26.7	**65.3**
5. Additional weekend social work capacity	LBH	04/04/22	02/04/23	63.6	0	**63.6**
6. Additional Brokerage capacity	LBH	04/04/22	02/04/23	60.9	0	**60.9**
			TOTALS	**320.1**	**251.9**	**572**

3.2 Subject to receipt of notice in writing from the ICB to the Council at least two months before the end date shown in table 2 above, the intermediate tier services shown in table 2 shall cease from the end date.

SCHEDULE 1E - INTEGRATED THERAPIES FOR CHILDREN AND YOUNG PEOPLE

1. BACKGROUND

1.1 The subject of this **Schedule 1E** of the Agreement is the operation of the integrated therapies service for children and young people (CYP), which will be referred to in this Schedule as the '*Service*'.

1.2 Integrated therapies include:

1.2.1 Speech and Language Therapy (SaLT) for CYP with speech, language and communication needs (SLCN) or eating, drinking and swallowing difficulties (dysphagia);

1.2.1AA A Speech and Language Therapist post to support the Council's Youth Justice Service.

1.2.2 Occupational therapy for CYP with difficulties relating to mobility, gross and fine motor skills, sensory processing and perception; and

1.2.3 Physiotherapy for CYP who have a disability or illness caused by neurological, neuromuscular, musculoskeletal, orthopaedic and cardio-vascular or respiratory conditions.

1.3 For the purposes of this Schedule reference to the Service Provider will mean CNWL.

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

1.4.1 **2014 Act** means the Children and Families Act, 2014;

1.4.2 **Contract** means the contract between the Council and the Service Provider for the provision of the Integrated Therapy Service;

1.4.3 **EHCP** means Education, Health and Care Plans pursuant to section 37 of the 2014 Act;

1.4.4 **OT** means occupational therapy, which aims to maximise the ability of individuals to undertake the activities of daily life;

1.4.5 **SEND** means Special Educational Needs pursuant to section 20 of the 2014 Act;

1.4.6 **TAC** means '*Team Around the Child'* and brings together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family. It places the emphasis firmly on the needs and strengths of the child or young person, rather than on organisations or service providers.

2. SERVICE AIMS AND OBJECTIVES

2.1 The aims of the Service that is the subject of this **Schedule 1E** are:

2.1.1 To provide a high quality service for children and young people with physical, occupational and speech and language difficulties in accordance with national guidance and best practice.

2.1.2 To improve the quality of life and the ability of children and young people with physical, occupational and speech and language difficulties to live independently or with support within the community and participate in mainstream services including education.

2.2 The key objectives of the Services are:

2.2.1 To provide early intervention services, offering early assessment and advice, supporting self-care and reducing dependence on services in future years.

2.2.2 To provide a robust integrated triage process that directs children and young people to the most appropriate therapy and support without delay.

3. SERVICE SCOPE

3.1 The people eligible for the Service will be:

3.1.1 All CYP aged 0-19 years who live within the geographical boundaries of the London Borough of Hillingdon (for local authority services) or are registered with a GP affiliated to the ICB (for health services).

3.1.2 All CYP resident in the London Borough of Hillingdon with a special education need and/or an Education, Health and Care Plan (EHCP) aged 18-25 years attending an education establishment regardless of its geographical location.

3.1.3 Home schooled CYP who live in the London Borough of Hillingdon and/or are registered with an NHS NWL GP located in the London Borough of Hillingdon.

4. SERVICE DESCRIPTION AND DELIVERY

4.1 An equitable and inclusive service will be delivered that is:

4.1.1 *Universal*: for CYP with mild to moderate or transient needs; and
4.1.2 *Targeted*: for CYP with moderate to severe needs.

4.2 High quality support must be provided to CYP who have a need identified or specified in Part F (Education) and Part G (Health) of their EHCP. Therapy needs identified under Part F or Part G are mandatory.

4.3 The Service Provider will deliver the Integrated Therapies Service Model illustrated in **Annex A** of this Schedule. The Service will be delivered in accordance with the requirements of the Service Specification shown in **Annex B**.

4.4 Delivery of the model shown in **Annex A** will lead to the following changes:

4.4.1 Increasing OT provision in schools to provide therapy and training;

4.4.2 Developing a pathway for those without an EHCP using a screening tool called Speech Link;

4.4.3 Delivering a triage facility that ensures that all referrals are reviewed by a qualified therapist within two weeks of a referral;

4.4.4 Introducing and formalising the consultation model for stakeholders involved in the assessment of a CYP;

4.4.5 Increasing the focus on transition to primary school and using a system called Language link to assess and inform therapy provision for children aged 4 to 8.;

4.4.6 Using the support planning document called My Support Plan and the TAC process to inform transition to primary and to secondary school with information shared regarding planned therapy input in schools;

4.4.7 Introducing social skills groups to support CYP and their parents;

4.4.8 Introducing a Development/Facilitator role to build and support cross-agency working through training and sharing best practice, etc.

Access to the Service

4.5 The Service Provider will be required to ensure the provision of the following:

4.5.1 A telephone advice line to enable CYP, their parents, carers, healthcare professionals and education Staff to seek advice regarding how to access the Services and/or given advice on other available support programmes.

4.5.2 Drop-in facility/clinics in Children's Centres, schools and colleges for CYP as well as parents and education staff to seek advice on presenting issues and how to access the most appropriate support.

Referral to the Service

4.6 The following will apply to the referral process:

4.6.1 Referral forms will be accepted from CYP, their parents/carers, healthcare professionals, education staff and the Council's SEND team.

4.6.2 Referrers will be encouraged to include video clips capturing a CYP's difficulties/challenging behaviour.

4.6.3 Referral forms will be accepted via email or post. The advice line will be promoted to assist with queries regarding completion of the referral form.

4.6.4 All referrals will be acknowledged within 2 working days of receipt.

4.6.5 Referrals from the Council's SEND team for assessment as part of the statutory EHC Needs Assessment will be allocated for assessment in all cases.

Service Location

4.7 The Services will be delivered from a range of settings including early years settings, schools and colleges. The hours of operation of the Services will be agreed between the Service Provider and the Council.

5. SERVICE OUTCOMES

5.1 The Integrated Therapies Model shown in **Annex A** is intended to deliver the outcomes shown in table 1 below.

Table 1: Children's Integrated Therapies Service Model Outcomes Framework				
Prevention & Early Intervention	**Identification**	**Triage**	**Assessment & Individual Care Planning**	**Review & Transition**
"A CYP, their families and carers are able to access wellbeing support before it becomes an issue".	"A CYP's needs are identified as early as practically possible".	"A CYP is signposted to the necessary intervention shortly after referral".	"A CYP's needs are assessed and clear recommendations are made around the provision they require".	"Therapy delivery provides targeted intervention that enables CYP to make good progress". "A CYP and their family are clear on the reasons for discharge and understand what future support will look like, if necessary".

5.2 The Service must also deliver the following outcomes from the NHS Outcomes Framework:

5.2.1 *Domain 2*: Enhancing quality of life for people with long-term conditions.

5.2.2 *Domain 3*: Helping people to recover from episodes of ill-health or following injury.

5.2.3 *Domain 4*: Ensuring people have a positive experience of care.

5.2.4 *Domain 5*: Treating and caring for people in a safe environment and protecting them from harm.

6. CONTRACT

6.1 The contract with the Service Provider will be held by the Council.

Contract Duration

6.2 The period of the contract between the Council and the Service Provider will be, subject to the exercise of any provisions for early termination, 1st August 2019 to 31st January 2024.

7. MONITORING ARRANGEMENTS

7.1 Although the contract for the Service will be between the Service Provider and the Council, the contract will be jointly managed by both the Council and the ICB. Management of the contract between the Council and the Service Provider will be undertaken in accordance with the provisions of the contract management schedule shown in **Annex C**.

7.2 Delivery of the Service under this Schedule will be overseen by the Core Officer Group as described in **Schedule 3 (*Governance*)** of the Agreement. This body will provide an escalation route regarding the implementation of the Integrated Therapies Model shown in **Annex A**.

8. FINANCIAL ARRANGEMENTS

8.1 The expectation of both the Council and the ICB is that the implementation of an early intervention and prevention model will assist in the management of demographic growth. The service budget for the period of this Agreement and the Contract is between £2.3m and £2.5m and will remain within these parameters. The respective financial contributions to the Service by the Council and the ICB are set out in **Schedule 1A** of the Agreement. For ease of reference these are summarised in table 2 below:

Table 2: Integrated Therapies Funding Contributions 2021/23 Summary

Service	Funder					
	2021/22					
	LBH	NHS	TOTAL	LBH	NHS	TOTAL
	(£,000)	*(£,000)*	*(£,000)*	*(£,000)*	*(£,000)*	*(£,000)*
Integrated therapies	441	2,246	**2,687**	441	2,246	**2,687**
SaLT in Youth Justice Service	35	35	**70**	37	37	**74**
Designated Clinical Officer in SEND	31	31	**62**	31	31	**62**
TOTAL	**507**	**2,312**	**2,819**	**509**	**2,314**	**2,823**

8.2 For 2022/23 the ICB shall pay the Service Provider directly the ICB's contribution to the Integrated Therapies Service shown in table 2 above.

8.3 Arrangements for managing over and underspends will be managed in accordance with the provisions of **Schedule 4 (*Risk Share and Over and Underspends*)** of the Agreement.

Annex A

Children's Integrated Therapies Service Model

1. Prevention & Early intervention

- Training & development for early years, schools, parents, including parent/adult interaction training support programmes.
- Introduce a development/facilitator role to build and support cross-agency working, e.g. training, sharing best practice, etc.

2. Identification

- Clear access routes for parents, professionals, early years and schools.
- Training & development for early years & schools.
- Advice line for HCPs & Education staff.
- Develop a pathway using Speechlink as the screening tool for people without an EHCP.

3. Triage & MDT

- Weekly triage/MDT panel focusing on need, provision and outcome for all referrals.
- Use of technology to inform diagnosis and intervention, e.g. video clips of child's behaviour/ teleconferencing
- Improved communication of referral outcome and next steps.

4. Assessment & Individual Care Planning

- Lead assessor model.
- Introduce/formalise the consultation model.
- Case worker, e.g. parent, teacher, practitioner.
- Using the My Support Plan/TAC process with information shared.
- Outcome based intervention.
- Increase OT provision in schools to provide therapy and training.
- Therapist attendance at EHCP and SEND panel.

5. Review & Transition

- Scheduled review of progress to inform on-going intervention/next steps.
- Increase the focus on transition, i.e. to primary & secondary school.
- Using the My Support Plan/TAC process with information shared.

Annex B

SCHEDULE 1E - ANNEX B INTEGRATE

Annex C

Schedule 4 - Contract Managemen

SCHEDULE 1F - INTEGRATED CARE AND SUPPORT FOR PEOPLE WITH LEARNING DISABILITIES

1. BACKGROUND

1.1 The subject of this **Schedule 1F** of the Agreement is the delivery of a case management and placement function by the Council on behalf of the ICB for people described in Clause 2 of this Schedule and summarised in Scheme 8 of **Schedule 1** of this Agreement.

1.2 During the period of the Agreement the Partners will review the model of integration for the provision of care and support for people with learning disabilities and associated commissioning arrangements. The objective of the review will be to secure better outcomes for people with learning disabilities and ensure value for money for the Partners.

1.3 The definition of terms used in this Schedule will be as described in Clause 1 of the Agreement unless otherwise stated. For the purposes of this Schedule the following terms will have the meaning described:

1.3.1 ***CNWL*** means the Central and North West London NHS Foundation Trust.

1.3.2 ***The Service*** means a case management and placement service provided by the Council to the ICB.

1.3.3 ***In-house services*** means services directly provided by the Council.

1.3.4 ***Placements*** include care home, supported living (including extra care), domiciliary care (also known as homecare) and day opportunity services. Identification to which of these is referred to at any given time will be determined by context.

1.3.5 ***1983 Act*** means the Mental Health Act, 1983.

1.3.6 ***Independent sector providers*** include providers that are for profit organisations as well not-for-profit voluntary and community sector organisations.

1.3.7 ***Preparing for Adulthood Team*** (PfA) means the team within the Council responsible to managing the transition from children to adult social care and/or health services. This was formerly known as the *'Transition Team'*.

2. SERVICE SCOPE

NHSE Transforming Care Case Management and Placements

2.1 The Service will be delivered by the Council to people aged 18 and over:

2.1.1 Who are included within the Transforming Care Programme, which applies to people who have a diagnosis of a learning disability and/or autism who are in an inpatient hospital setting as well as those who could be at risk of inpatient admission unless support is commissioned to meet their assessed needs; and

2.1.2 Who have been assessed as meeting the eligibility criteria for NHS Continuing Healthcare (CHC) funding and are people with a diagnosed learning disability; or

2.1.3 Are entitled to after care services under s117 of the 1983 Act and are jointly funded by the Partners.

2.2 The following are excluded from the scope of the Service:

2.2.1 People with a learning disability and/or autism aged under 18.

2.2.2 Any actions on behalf of the ICB that are required to be undertaken by a qualified solicitor in accordance with the Solicitors Act, 1974.

3. SERVICE AIMS AND OBJECTIVES

3.1 The intended aims of the Partners are:

3.1.1 To improve the quality of care for people with a learning disability and/or autism;

3.1.2 To improve quality of life for people with a learning disability and/or autism;

3.1.3 To support people with a learning disability and/or autism down pathways of care to the least restrictive setting;

3.1.4 To ensure that services are user focused and responsive to identified needs;

3.1.5 To ensure Value for Money and efficient use of resources, maximising income where at all possible and avoiding duplication.

3.2 The objectives of the Partners in meeting the aims described in Clause 3.1 above are that integrated working will:

3.2.1 Maximise the opportunities for people with a learning disability and/or autism to lead happy and fulfilling lives as independently as possible in the least restrictive environment feasible:

3.2.2 Ensure that people with a learning disability and/or autism have a positive experience of care and support.

4. SERVICE DESCRIPTION

NHSE Transforming Care Case Management and Placements

4.1 The Service provided to the ICB will include:

4.1.1 Liaising with and providing updates to organisations including NHS England and the Department of Health and Social Care. Following are examples (and not an exhaustive list) of the updates that will be required:

4.1.1.1 Information regarding the delivery of social care support services to individuals and groups of people with learning disabilities and/or autism;

4.1.1.2 Responding to data requests and national information requirements;

4.1.1.3 Contributing to audits and reviews in respect of monitoring and improving the care provided to people with learning disabilities and/or autism in Hillingdon, such as the National Autism Statutory Assurance Framework.

4.1.2 The updates referred to in Clause 4.1.1 may be provided to the ICB for onward transmission or provided directly and copied to the ICB. The route chosen will be dependent on the update required and will be determined in consultation with the ICB.

4.1.3 Providing access to the Council's brokerage team to identify suitable placements;

4.1.4 Providing access to the Council's social work team in order to complete risk assessments and support plans.

4.2 The Council will make placements on behalf of the ICB for eligible Service Users as described in Clause 2.1 of this Schedule. The Council will broker these placements and pay the providers.

4.4 Both Partners will work to ensure there is no undue delay when processing reviews and/or CHC Criteria Assessments.

4.5 The timescales to which the CHC Team will be working are:

- Fast-track applications-decisions made: - 2 working days
- Eligibility for CHC against Decision Support Tool (DST): - 28 working days
- Length of time from Panel decision to letter sent to individual advising outcome: - within 10 working days

4.6 Health funding reviews will be managed by the CHC Team according to the following timescales:

- Initial review following allocation of funding: - 3 months
- Review frequency thereafter: - Annually
- Time frame from completion of the review assessment to decision: - 28 working days

4.7 In circumstances where a Service User who is jointly funded under section 117 is placed outside of Hillingdon and then re-sectioned under the 1983 Act, the Council will manage the transfer of care to the host local authority. However, it must be noted that a different set of rules apply with regards the ICB's responsibility in such a situation as set out in the guidance document *'Who Pays? Determining responsibility for payments to providers'* (NHSE August 2013).

4.8 Where the CHC team has not completed an assessment within the 28 days and the Service User either:

4.8.1 *Goes into hospital* - if awarded CHC will be backdated to the 1st referral date (Day 29 from completion of initial checklist) irrespective of hospitalisation; or

4.8.2 *Dies* - ICB will review the case to determine eligibility for CHC where representations are made by the Service User's family. ICB will also undertake a review in circumstances where either the Service User does not have a family or where they have a family who do not wish to request a review and the Council makes representations on the basis that there has been an undue delay.

Referrals to the Service

4.9 Referrals to the Service will come from the following sources:

4.9.1 The Council's Preparing for Adulthoood (PfA) Team;

4.9.2 The ICB's CHC Team; and

4.9.3 The CHLDT.

4.10 The Council's Social Work Team may make referrals to the CHLDT and this process will be guided by a Memorandum of Understanding (MoU) between the Council and CNWL.

Legal Support

4.11 Where a Service User's circumstances require the intervention of a solicitor the Council will make a referral to the ICB's CHC lead, who will make the required arrangements as set out in the ICB's protocol for accessing Legal Advice. This would apply where, for example, a Community Deprivation of Liberty Standards (DOLS) application to the Court of Protection is required.

5. LEGAL LIABILITY

5.1 The ICB acknowledges and accepts that the Council will act appropriately in delivering the Service on its behalf. Accordingly, and for the avoidance of doubt, in the event of legal proceedings being undertaken by a third party regarding any aspect of the Service then Clause 15 (*Liabilities and Insurance and Indemnity*) of the Agreement will apply.

6. CONTRACT

6.1 For avoidance of doubt, the contract for the provision of the CHLDT will be held by the ICB for the duration of the Agreement. The ICB will be the lead commissioner for this service during the term of the Agreement.

6.2 Subject to Clause 29 (*Variations*) of the Agreement, the provider for the CHLDT will be CNWL.

7. MONITORING

7.1 Arrangements for monitoring delivery of the Service will be as described in **Schedule 3 (*Governance*)** of the Agreement.

8. FINANCIAL ARRANGEMENTS

General

8.1 This Clause 8 should be read in conjunction with **Annex A** of this Schedule and also **Schedule 1A** of the Agreement.

8.2 The North West London (NWL) Continuing Healthcare Team will be responsible for the budgets during the period of the Agreement in respect of the eligible Service Users described in Clause 2.1 of this Schedule and must be involved in any decision concerning the provision of care and support to eligible Service Users.

8.2 The ICB will be responsible for meeting 100% of the cost of meeting the care needs of a Service User in the following circumstances:

8.2.1 The Service User has been assessed as being entitled to NHS Continuing Healthcare funding.

8.2.2 The Service User is placed in a hospital setting for assessment and/or treatment.

8.3 For Service Users assessed under s117 of the 1983 Act the ICB will be responsible for contributing a percentage agreed between the Partners. The remaining difference in cost will be paid by the Council. The formal mechanism for agreeing the respective contributions of the Partners will be as described in Schedule 5 of the Agreement.

Process for Agreeing New Placement Costs

8.4 Prior to entering into a contract with a provider the Council must secure written approval the ICB's CHC lead to enter into an agreement at the proposed price.

Process for Agreeing Changes in Placement Costs

8.5 Any additional charges arising from changes to care costs associated with an escalation of need must be authorised by an authorised signatory. The process is outlined below as follows:

8.5.1 Any increase to a care package within an existing placement must be authorised by the CHC lead for the ICB, who will work within their agreed authorisation limits covered by ICB standing financial instructions.

8.5.2 Any change in placement for a Service User who is not a CHC patient and not a recipient of s117 aftercare will be authorised by the Council's Head of Mental Health and Learning Disability Services within the parameters of their authorisation limits. Costs above this will be authorised in accordance with the Council's scheme of delegations.

8.5.3 Any change in a placement for a Service User who is eligible for CHC will be approved by the ICB's CHC lead, who will be working within agreed authorisation limits covered by ICB standing financial instructions.

8.5.4 Any requirement to place a Service User in an inpatient care setting, including mental health hospital inpatient care, must be escalated to the ICB responsible commissioner and referred to the LD clinical psychiatry services (CNWL). The consultant psychiatrist will review the clinical need for in-patient treatment and the care manager will act accordingly. The expectation is that there will be an Multi-disciplinary Team (MDT) meeting (either face to face or via a teleconference) to discuss alternatives to admission to a specialist LD or MH inpatient setting, which would possibly be followed up by a Care and Treatment Review (CTR) under Transforming Care CTR protocols to ensure the Service User's holistic needs are discussed. A robust plan for care and support must also be agreed between all parties, including the Service User's representative and family members. The Service User's details must be added to the risk of admission register if not already included.

8.5.5 The membership of any MDT necessitated by circumstances in which a Service User is at risk of admission to a specialist LD or MH inpatient setting must include a manager with delegated decision making authority, the ICB's responsible commissioner and the CHC clinical lead. Any additional professional representation will be determined by the manager with delegated decision making authority.

8.5.6 Should specialist hospital admission be required, the ICB's CHC lead will request funding approval from the NWL Chief Nursing Officer.

8.5.7 Service Users requiring low secure provision following clinical assessment will be discussed with the NHSE non-acute commissioning team and the Transforming Care lead commissioner at the ICB at an early stage to support and agree the placement.

Inflationary Uplifts

8.6 The Council's process for agreeing inflationary uplifts will apply to services commissioned by the Council on behalf of the ICB.

Cessation of Service

8.7 In the event of the death of a ICB funded patient the ICB will continue to be liable for the cost of that care package as follows:

Residential Placements

8.7.1 For Service Users in placements with independent sector providers the ICB will be liable in accordance with the terms of the contract that the Council has with that provider. This will ordinarily entail 100% of the placement costs for the 24-hour period following the death of the Service User.

8.7.3 Where the placement is an in-house provided service, the ICB will remain liable until the earlier of:

8.7.3.1 The date the relevant vacancy has been filled following the date when the vacancy became available; or

8.7.3.2 Seven days following the date that the vacancy became available.

Day Opportunity Services

8.7.4 For Service Users in placements with independent sector providers the ICB will be liable in accordance with the terms of the contract that the Council has with that provider.

8.7.5 Where the placement is in an in-house service, the ICB will be liable until such time that the relevant vacancy is filled up to a maximum of seven days following last day of service provision to the Service User.

Domiciliary Care

8.7.6 The ICB's liability will cease immediately following the death of the Service User.

Hospital Placements

8.8 Where care is required and commissioned in a non-acute hospital setting for a Service User in order to address physical and mental health needs (including detention under a relevant section of the 1983 Act for assessment/treatment) and/or the Service User has been identified as a ICB funding responsibility prior to admission, then the full cost of that placement for the duration of the Agreement will be the responsibility of the ICB.

8.9 For as long as the Service User's previous residential placement remains open continued funding will be the responsibility of either the ICB or the Council depending on the Service User's status on the date of admission. In such circumstances, there will be an assessment undertaken prior to a planned discharge from the non-acute NHS setting to determine on-going funding responsibility.

8.10 Admission for NHS care in an acute setting will not change the on-going funding status of the Service User unless determined by an assessment in accordance with the Agreement or the 1983 Act.

Change of Supplier

8.11 In the event that a change of supplier should be determined by either Partner as a result of a review of care required in relation to a Service User's needs then the ICB will be liable in accordance with the terms of the contract that the Council has with the relevant provider.

People Aged under 18

8.12 A review (or an assessment) will be undertaken by the CHC Team of people known to the PfA Team prior to them attaining their 18th birthday in order to determine eligibility under the adult CHC criteria. Where it is determined that an individual qualifies for CHC funding then the effective date for this funding will either be the individual's 18th birthday or the date of referral by the PfA Team, whichever is the later.

Out of Borough Placements

8.13 In the case of dispute with another ICB, NWL ICB will be responsible for funding the Service User until a transfer date has been agreed with the other ICB. In these circumstances NWL ICB will recover any back dated costs direct from the other ICB if the dispute is settled in favour of NWL ICB.

Reporting Requirements

8.14 The Council must send a financial schedule to the ICB's Finance Lead on a monthly basis setting out the expenditure for the previous month and future commitment.

Monthly Review

8.15 There will be monthly meetings to review expenditure and commitments. These meetings will include:

8.15.1 The Finance Leads from both the Council and the ICB;

8.15.2 The ICB's Complex Care Lead; and

8.15.3 The Council's Head of Service with responsibility for services for people with learning disabilities and/or autism.

9. ESCALATION PROCESS

9.1 The ICB's CHC lead will be the initial contact point for the Council to secure approval of placement costs in accordance with Clauses 8.4 and 8.5 of this Schedule and also to request that appropriate legal advice be sought in accordance with 4.11. In the event that a response has not been received within a reasonable time period the escalation route shown in table 1 below should be followed. The nature of the decision request and the circumstances of the Service User/Patient will determine what constitutes a *'reasonable time period*'.

Contact Details	Courtesy Copy Destination Details
1. Ian Robinson Associate Director Continuing Healthcare & Complex Care North West London Integrated Care Board Tele: 0203 114 7157 Email: ian.robinson6@nhs.net	Jane Hainstock Head of Joint Commissioning NWL ICB (Hillingdon) Tele:01895 203000 Email: Jane.Hainstock@nhs.net
2. Chief Nursing Officer North West London Integrated Care Board Tele: 0203 114 7168	Sean Bidewell/Richard Ellis Borough Director NWL ICB (Hillingdon) Tele: 01895 203000 Email: sean.bidewell@nhs.net/richard.ellis9@nhs.net

10. FUNDING DISPUTE RESOLUTION

10.1 This Clause 10 will only apply to disputes between the Partners regarding:

10.1.1 Funding responsibility for services provided to any Service User who is the responsibility of either or both of the parties under the "*ordinary residence*" rules or equivalent rules on funding responsibility as they apply to the NHS; or

10.1.2 The outcome of an assessment of needs or eligibility for services to be provided by the ICB under the National Framework for CHC or by the Council; or

10.1.3 The package of services to be offered to a Service User following an assessment;

10.2 The procedure will also cover disagreements between partners over jointly funded care packages.

10.3 There are three stages to this funding dispute resolution process, and these are:

10.3.1 ***Stage 1:*** Escalation to Clinical Care Commissioner

10.3.2 ***Stage 2:*** Escalation to Chief Nurse for the ICB.

10.3.3 ***Stage 3:*** Referral to arbitration.

10.4 ***Stage 1: Escalation to Clinical Care Commissioner***: Where any dispute cannot be resolved by the decision-making practitioners, either party may request that the Service Managers (or equivalents) in the Partners' respective decision-making teams meet within 14 days of being notified of the existence of a dispute to review the decision and/or the process by which the decision was made. The purpose of this meeting is to explore the possibility reaching a consensus decision as to the correct outcome of the decision-making process.

10.5 In the case of disputed eligibility for NHS Continuing Healthcare, either Partner may request that the ICB refers the case, if it has not already been considered by that panel, for consideration at the next meeting of its Continuing Healthcare Panel ("CHC panel"). If the case has already been considered by the CHC panel then a request can be made for reconsideration at the next meeting of the ICB's Continuing Healthcare Review Panel. The Council will always be invited to represent when the case is discussed at the Continuing Care Panel.

10.6 ***Stage 2: Escalation to Chief Nurse:*** Where the procedures set out in Stage 1 do not result in a consensus decision being reached as to the correct outcome of the decision-making process, the matter will be referred to the Chief Nurse and Director of Quality for the ICB and the Council's Head of Learning Disability, Mental Health and Autism Services or officers of equivalent seniority within each body responsible for the decision-making teams referred to in Stage 1.

10.7 Within 14 days of being notified by either party of a dispute which has not been resolved at Stage 1 of this procedure, the Chief Nurse and Head of Learning Disability, Mental Health and Autism Services, or officers of equivalent seniority of the Partners, will hold a meeting to try and resolve the dispute by reaching a consensus decision.

10.8 The relevant officers referred to in Clause 10.7 above may involve other professionals in the meeting to provide guidance and/or advice in specialist areas as they deem to be appropriate.

10.9 ***Stage 3: Referral to arbitration***: If any dispute is not resolved through the procedures outlined in Stages 1 and 2 above, or there is any failure by either party to acknowledge the existence of a dispute or to deal with it in accordance with the procedures outlined above, the Partners will refer the matter to the Executive Director, Adult Services and Health for Social Care and Health and the Hillingdon Borough Director of the ICB or the Accountable Officer for the ICB for arbitration. The outcome of stage 3 will end the local stage of the dispute resolution process.

10.10 The Executive Director, Adult Services and Health and the ICB's Borough Director or Accountable Officer, as appropriate, will hold a meeting within 14 days of being notified by either party of a dispute which has not been resolved at Stage 2 of this procedure.

10.11 Other professionals may be invited to the meeting described in paragraph 10.10 above to provide guidance and/or advice in specialist areas as is deemed appropriate and necessary.

10.12 Where the local resolution procedure has not resulted in an outcome that the Service User finds satisfactory, they have the right to apply to NHSE to establish an independent review of the decision through an Independent Review Panel (IRP).

11. TERMINATION

11.1 Either Partner may terminate the arrangements under this Schedule by issuing six months' written notice to the other.

ANNEX A - FINANCIAL ARRANGEMENTS

1. CALCULATION OF CHARGES

1.1 The Charges are split between Fixed and Variable costs as set out in paragraphs 2 and 3 respectively of this **Annex A**.

2. CHARGES BASED ON A FIXED PRICE

2.1 Charges for 2022/23 based on a fixed cost are as described in table 1 below.

Table 1: LD Case Management Service Costings 2022/23			
Type	**FTE/Service Users**	**Rate**	**2022/23 Cost**
1. Staffing			
• Social Worker (POB grade)	1.5	61,668	**92,502**
2. Accommodation & ICT	1.5	4,500	**6,750**
3. Additional staff support costs, e.g., travel, training, admin, etc.	N/A	6,000	**6,000**
4. Finance cost: payment of providers & recharging ICB	74	320	**23,680**
TOTAL LD CASE MANAGEMENT SERVICE COST			**128,932**

3. VARIABLE COSTS

3.1 The costs of Service User placements will be recharged at cost basis split between externally provided services and in-house services.

3.2 Externally provided services will be recharged to the ICB at the total gross package cost.

3.3 In-house services will be recharged at the rates agreed per the Council Fees and Charges Report agreed at Cabinet when the Council Budget is set.

4. PAYMENT PLAN

4.1 1/12th of the estimated Annual Cost of the service will be billed at the beginning of each month. A review of the estimate will take place in October and bills for the rest of the year will be adjusted to reflect the latest forecast.

5. COUNCIL CONTRIBUTION TO THE POOLED BUDGET

5.1 The Council's contribution to the pooled budget for 2021/22 will be as set out in **Schedule 1A** of the Agreement.

6. FINANCIAL CONTRIBUTIONS

6.1 **Schedule 1A** of the Agreement identifies the respective financial contribution to the Pooled Budget established under this Agreement. For ease of reference, table 2 below outlines the resource contributions of the Partners to the Scheme 8 of the BCF plan that is the subject of this **Schedule 1F**.

Table 2: Scheme 8 Financial Contributions

Service		Provider	Funder 2021/22			Funder 2022/23		
			LBH ***(£,000's)***	**NHS** ***(£000's)***	**TOTAL** ***(£000's)***	**LBH** ***(£,000's)***	**NHS** ***(£000's)***	**TOTAL** ***(£000's)***
8.1	Social Care Staffing	LBH	1,254	0	**1,254**	1,254	0	**1,254**
8.2	Homecare	Various P & V	840	171	**1,007**	865	176	**1,041**
8.3	Community Support	Various P & V	8,093	0	**8,093**	8,094	0	**8,094**
8.4	Supported Living	Various P & V	14,667	282	**14,949**	14,949	0	**14,949**
8.5	Centre for ADHD and Autistic Support (CAAS)	CAAS	15	0	**15**	15	0	**15**
	Hillingdon Autistic Care and Support (HACS)	HACS	40	0	**40**	40	0	**40**
8.5	Residential/Nursing Care Home Placements	Various P & V	11,945	347	**12,292**	12,192	496	**12,688**
8.6	Respite placements	LBH & Various P & V	1,309	64	**1,373**	1,240	165	**1,405**
8.7	CHC Placements	Various P & V	0	3,467	**3,467**	0	3,578	**3,578**
8.8	Non-CHC Placements	Various P & V	0	2,590	**2,590**	0	2,590	**2,590**
8.9	Accommodation & Staffing	LBH	0	115	**115**	0	128	**128**
SCHEME 8 TOTAL			**38,671**	**6,299**	**45,137**	**38,649**	**7,134**	**45,782**

NB: Figures in table subject to rounding and may not sum to total.

SCHEDULE 2 - FUNCTIONS

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

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

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

2. Excluded NHS functions are:

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

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

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

4. Excluded Council functions include:

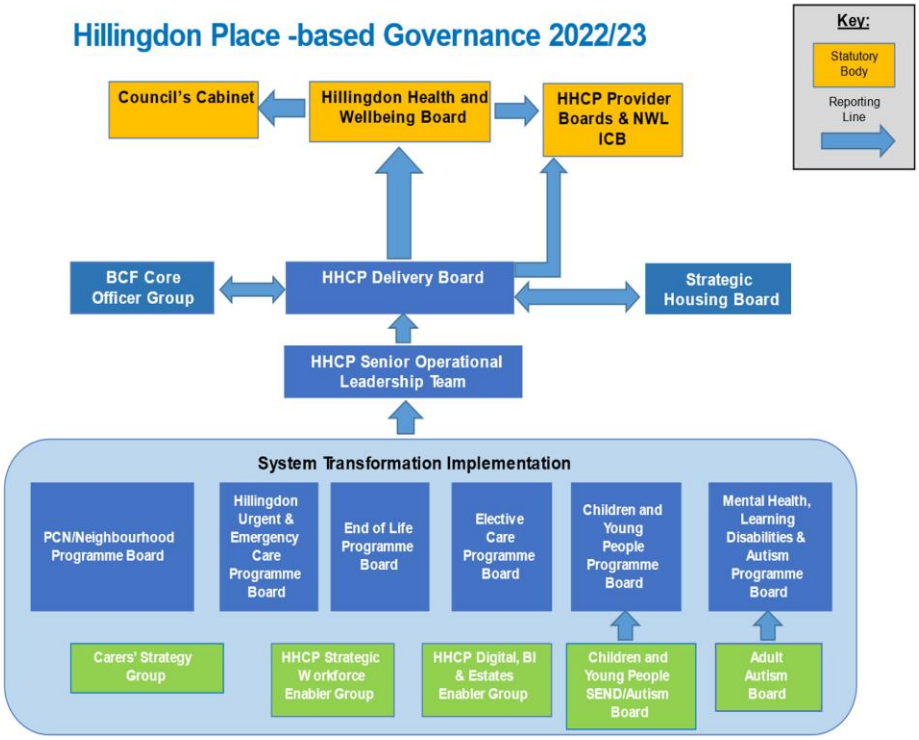
a) Functions under sections 4 (providing information and advice), 5 (promoting diversity and equality in provision of services), 14 to 17 (charging and assessing financial resources), 34 to 36 (deferred payment agreements), 42 to 47 (safeguarding adults), 48 to 52 (provider failure) and 69 to 70 (enforcement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

SCHEDULE 3 - BETTER CARE FUND GOVERNANCE ARRANGEMENTS

1. BETTER CARE FUND GOVERNANCE STRUCTURE SUMMARY

1.1 Figure 1 below summarises how the governance of the BCF fits within the broader placed-based governance arrangements for the health and care system in Hillingdon.

Figure 1.



2. BETTER CARE FUND GOVERNANCE STRUCTURES TERMS OF REFERENCE

a) Health and Wellbeing Board

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

2.2 The Board is also responsible for:

2.2.1 Providing place-based leadership in developing a strategic approach for health and wellbeing in Hillingdon;

2.2.2 Developing the statutory Health and Wellbeing Strategy;

2.2.3 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;

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

2.2.5 Holding partner agencies to account for performance on agreed priorities in conjunction with the Health and Social care Select Committee of the Council;

2.2.6 Influencing and approving the North West London Integrated Care Board (ICB)'s commissioning plan and annual update;

2.2.7 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;

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

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

Board Membership

2.3 The Board is the co-chaired by Cabinet Member for Health and Social Care and the Managing Director of Hillingdon Health and Care Partners, Hillingdon's accountable care partnership.

2.4 Statutory members of the Board include:
- Cabinet Members from the London Borough of Hillingdon
- A representative from North West London Integrated Care Board
- 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 Membership also includes the Council's Chief Executive and representatives from local NHS provider trusts, and these are:
- The Confederation, which represents 43 out of 45 local GP practices.
- 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:

2.8.1 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 ICB's Governing Body;

2.8.2 Undertake the role of '*Partnership Board'* as described in the Section 75 Agreement.

2.9 The Core Officer Group will be responsible for:

2.9.1 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 ICB Board;

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

2.9.3 Considering the strategic issues arising from the delivery of the Plan and consulting with the Transformation Board accordingly;

2.9.4 Taking directions from the elected administration of the Council and the statutory ICB Board where required in order to make informed recommendations to the Transformation Board;

2.9.5 Translating recommendations from the Transformation Board into action.

2.10 The Core Officer Group will also:

2.10.1 Be the escalation point for performance issues requiring urgent remedial intervention;

2.10.2 Report on issues arising from the management of the pooled budget to the Health and Wellbeing Board;

2.10.3 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 ICB.

Group Membership

2.11 The BCF Core Group is chaired by the BCF Programme Manager.

2.12 Other members include:

- Joint Borough Directors – ICB
- Executive Director, Adult Services and Health – LBH
- Managing Director – Hillingdon Health and Care Partners
- Head of Health Integration and Voluntary Sector Partnerships – LBH.

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 ICB officers will be accountable to the Board of the ICB.

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 Board of the ICB.

c) Hillingdon Health and Care Partners Delivery Board

2.17 The key purpose of the HHCP Delivery Board is to:

2.17.1 Develop and deliver an agreed service transformation programme;

2.17.2 Undertake the functions of the A & E Delivery Board.

2.18 The HHCP Board will be responsible for:

2.18.1 Approving and owning the transformation programme governance;

2.18.2 Addressing any issues escalated from the programme that require senior internal or organisation to organisation resolution;

2.18.3 Holding the Senior Responsible Officers to account for delivery;

2.18.4 Ensuring that patients access safe, timely and clinically effective A&E services;

2.18.5 Ensuring that recovery and improvement plans are in place and that agreed priorities are being implemented;

2.18.6 Resolving clinical, managerial and organisational issues which impact on the delivery of A&E services.

Membership

2.19 The Board will be chaired on a rotation basis by the partner representatives shown in clause 2.20 below.

2.20 Membership of the Board will include the following:

- **HHCP:** Managing Director
- **THHs:** Chief Operating Officer
- **CNWL:** Managing Director
- **GP Confederation:** CEO
- **H4All:** CEO
- **ICB**: Borough Director.
- **Healthwatch Hillingdon**: nominated representative
- **SROs**

2.22 The Council will have associate membership and will be represented by the Executive Director, Adult Services and Health or nominated representative (s).

Accountability

2.23 Each member of the Board will be accountable through the governance structures of their respective organisations.

Frequency of Meetings

2.24 The Board 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

2.25 The Board has authority to commit resources in accordance with delegation arrangements between NHS partners within the borough based care partnership. It has no authority to commit Council resources without the approval of the Council's Cabinet.

d) HHCP Senior Operational Leadership Team (SOLT)

2.26 The key purpose of the Senior Operational Leadership Team:

- Manage/utilise resources across system to optimise service delivery;

2.27 The Senior Operational Leadership Team will be responsible for:

- Ensuring operational ownership of transformation projects, ensuring changes become business as usual;
- Overseeing operational implementation of the agreed model of care and related projects;
- Ensuring effective issues and risk management is in place;
- Making recommendations to the HHCP Delivery Board for changes to the plan.

Membership

2.28 Meetings will be chaired by the HHCP Managing Director

2.29 SOLT membership will include:

- GP Confederation: Chief Operating Officer
- CNWL: Borough Director and Assistant Director, Outer London Services
- THH: Directors of Operations for Planned and Unplanned Care
- ICB: Borough Director, Associate Director, Integration and Delivery, Primary Care Commissioner and Mental Health Commissioner.
- H4All: CEO
- HHCP Clinical Directors
- HHCP Finance Lead
- SROs

2.30 The Council will also be represented by the Head of Service – Hospital, Localities, Sensory and Review.

Accountability

2.31 SOLT will be accountable to the HHCP Delivery Board.

Frequency of Meetings

2.32 SOLT 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 SOLT has no authority to commit resources and any such decisions will need to be referred to the Delivery Board for consideration.

e) Programme Manager

2.34 The responsibilities of the Programme Manager will be to:

2.34.1 Identify, analyse and communicate to the Core Officer 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.

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

2.34.3 Actively manage identified risks and issues arising from schemes.

2.34.4 Provide direct support to scheme leads who have responsibility for managing relevant task and finish groups as required.

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

2.34.6 Produce performance reports on a quarterly basis for the Health and Wellbeing Board and such structures within the borough-based care partnership and the Board of the ICB as may be required from time to time.

2.34.7 Manage the delivery of the stakeholder engagement strategy.

SCHEDULE 4 – RISK SHARE AND OVER AND UNDER PERFORMANCE

1. RISK SHARE

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

2. OVERSPENDS

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

2.2 Liability for any overspends during the period of the Agreement for the Service described in **Schedule 1B (Community Equipment Service)** will be on the following basis:

2.2.1 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.

2.2.2 Where over expenditure occurs as a result of failure of one or more of the Partners to abide by the terms of the Agreement, for example, through inappropriate prescribing practice, the relevant Partner shall bear full responsibility for that overspend.

2.2.3 Where overspends occur 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 will be with the Partner whose Prescribing Team incurred the overspend. For avoidance of doubt, for Social Care Teams this will be the Council and NHS Teams this will be the ICB.

2.3 In respect of **Schedule 1E (Integrated Therapies for Children and Young People)**, where it is agreed by Partners through the BCF Core Officer Group that demand cannot be met within the contract value the following arrangements will apply:

2.3.1 *Increased demand attributed to therapy needs identified as part of the EHCP*: The Council would manage this risk in accordance with its duties under the Children and Families Act, 2014.

2.3.2 *Increased demand not attributed to therapy needs identified as part of the EHCP*: ICP would manage this risk in accordance with its processes for approving non-budgeted financial pressures.

2.5 The Partners will inform the Partnership Board in accordance with Clause 8 of the Agreement where the remedial actions to address any overspend may impact on one or more of the Individual Schemes set out in **Schedule 1**.

2.6 The Partnership Board will use its best endeavours to preserve the integrity of Individual Schemes.

2.7 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 will 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.

SCHEDULE 5 – OPERATION OF SECTION 117 AFTERCARE ARRANGEMENTS

1. INTRODUCTION

1.1 This Schedule 5 concerns arrangements under section 117 (s117) of the Mental Health Act, 1983 (the '*Act*') for the successful provision of aftercare support to people within the geographical boundaries of the London Borough of Hillingdon who were previously detained under section 3 of the Act.

1.2 The definition of terms used in this Schedule will be as described in Clause 1 of the Agreement unless otherwise stated.

1.3 This Schedule aims to ensure that local interpretation of s.117 is in line with the legal requirements of the Act and implements the requirements of the Care Act 2014 (the '*2014 Act'*). It also aims to integrate practice and decision making within the ICB and the Council with regard to s.117 of the Act.

1.4 The provisions of this Schedule will be cascaded to staff employed by the Council and ICB.

2. CONTEXT

Statutory Guidance Principles

2.1 The Mental Health Act Code of Practice 2015 ('the Code of Practice') provides a set of five guiding principles which should be considered when decisions are made about a course of action under the Act. It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act. The five guiding principles are:

2.1.1 **Least restrictive option and maximising independence:** Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

2.1.2 **Empowerment and involvement:** Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

2.1.3 **Respect and dignity:** Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

2.1.4 **Purpose and effectiveness:** Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

2.1.5 **Efficiency and equity:** Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2.2 All decisions must be lawful and informed by good professional practice. Lawfulness includes compliance with the Human Rights Act 1998 (the '*1998 Act'*) and the Equality Act 2010. All five sets of principles are of equal importance and should inform any decision made under the Act. Notwithstanding that the principles inform decisions made under the 1998 Act they do not determine them. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Partnership Working

2.3 Hillingdon London Borough Council (the 'Council') and NHS North West London Integrated Care Board (the 'ICB') have jointly adopted the following principles to underpin their joint working on the provision of aftercare services :-

2.3.1 We will put the individual service user at the heart of our decision making.

2.3.2 We need to take into account the needs of carers and the safety of carers and the wider public.

2.3.3 We need to make good decisions at the right time.

2.3.4 We need to act in a spirit of openness and co-operation. We will communicate with each other in order to avoid surprises or issues arising unexpectedly.

2.3.5 We will endeavour to ensure our other partners respect this policy.

When s.117 aftercare arises under the Act

2.4 Under s.117 of the Act, local authorities and clinical commissioning groups have a joint duty to provide mental health aftercare services for people who have been detained in hospital for treatment under certain qualifying provisions of the Act and who require it. The relevant qualifying provisions of the Act for the purposes s.117 aftercare are as follows:

2.4.1 s.3 of the Act (admission for treatment).

2.4.2 s.37 of the Act (hospital order).

2.4.3 s.45A of the Act (a hospital direction and limitation direction)

2.4.4 s.47 of the Act (transfer from prison)

2.4.5 s.48 of the Act (transfer to hospital of prisoners on remand)

2.5 It follows, therefore, that any person that has been treated under sections 3, 37, 45A, 47 or 48 of the Act is entitled to receive aftercare services from the point at which they are discharged from hospital. This applies even if:

2.5.1 The person remains in hospital for a period on a voluntary basis having been discharged from a relevant treatment section of the Act.

2.5.2 The person is released from prison having spent some of their sentence in hospital under a relevant treatment section of the Act.

2.5.3 The person is being discharged under a Supervised Community Treatment Order under the Act.

2.5.4 The person is granted s.17 leave under the Act; s.117 aftercare is relevant during any period of s.17 leave from hospital because the patient is discharged from hospital for the period that the leave is valid.

2.6 The duty to provide aftercare services begins at the point that the person leaves hospital and lasts for as long as the person requires the services.

What constitutes s.117 aftercare under the Act

2.7 A statutory definition of aftercare services is established by s75(4) Care Act 2014. It sets out the following:

"In this section, "after-care services, in relation to a person, means services which have both the following purposes –

(i) meet a need arising from or relating to a person's mental disorder; and

(ii) reducing the risk of a deterioration of a person's mental condition (and accordingly, reduces the risk of the person requiring admission to a hospital again for treatment for the disorder)." (emphasis added)

2.8 The statutory definition has widened the scope of s.117 aftercare services. In particular, the statutory test no longer requires that the need must arise from the mental disorder; it is sufficient that it is related to the mental disorder (a much broader category). This converts the test from a 'but for' test (i.e., "but for" the mental disorder, the person would not require that service) to a less onerous test of relation (i.e., that the need for the service is "related to" the mental disorder). It no longer requires a causal connection. This is significant, as a test based on a simple relation to the mental disorder could include anything which:

2.8.1 impacts on; or

2.8.2 is impacted by the mental disorder.

3. WHAT IS AFTERCARE

3.1 Aftercare is a vital component in a person's overall treatment and care. As well as meeting their immediate needs for health and social care, aftercare should aim to support them in

regaining or enhancing their skills, or learning new skills, in order to cope with life outside of hospital.

3.2 The Department of Health's *Care and Support Statutory Guidance* issued under the Care Act 2014, notes that ICBs and local authorities should interpret the definition of aftercare services broadly, and we recognise that this could be potentially more widely than the core Care Act services . As such, aftercare services could include:

3.2.1 Healthcare (e.g., specialist mental health services or drug treatment services);

3.2.2 Social care (e.g., floating support, aids and adaptations to the person's home, home care services, telecare);

3.2.3 Employment, volunteering and training services;

3.2.4 Supported accommodation

3.2.5 Services to meet the person's wider social, cultural and spiritual needs (e.g. day opportunities and other daytime activities);

3.2.6 Services that support a person in regaining or enhancing their skills, or learning new skills, in order to cope with life outside the hospital.

4. WHO ARE WE RESPONSIBLE FOR

4.1 The Council and the ICB have roles and responsibilities to provide s.117 aftercare to those persons eligible.

4.2 There have been changes over time on the responsibility for NHS bodies. This has been compounded by some confusion in the guidance including the current note published by ADASS. The ICB has followed the guidance and worked on the basis of responsibility following GP registration. Cases will need to be considered on an individual basis where ordinary residence at the time of detention and GP registration might give different answers. This will be subject to review if and when further guidance is issued.

4.3 The Council is responsible for patients who, at the time of their admission, were ordinary resident within its area. It is also responsible for those who were of no settled residence but physically present within its area. In cases where a patient was detained prior to 01 April 2015, the Council is responsible where that patient was resident within its area.

4.4 Where an individual on S117 leave is readmitted under a qualifying section this restarts the process to identify the responsible authorities, in accordance with the Care Act statutory guidance

Hillingdon Council responsibilities

4.5 The Council is jointly responsible with the ICB for the provision of aftercare services under s.117 of the Act and will ensure that any of its social care staff will participate in s.117 aftercare planning

4.6 The Council will provide an adequate mechanism so that those subject to s.117 aftercare are not charged for services provided as s.117 aftercare services for as long as they are deemed to require the services.

4.7 Decisions to end the s.117 aftercare provision to a person are a joint health and social service decision. Reviews of s.117 aftercare provision will always be conducted on a joint basis involving both health and social care staff.

NHS NWL – ICB Responsibilities

4.8 The ICB is jointly responsible with the Council for the provision of aftercare services under s.117 of the Act and will ensure that relevant members of staff will participate in s.117 aftercare planning meetings.

4.9 As noted above, for any patient discharged after 1 April 2016, the ICB will be responsible for that patient's aftercare if the patient was ordinarily resident in the ICB's geographic area immediately prior to the qualifying detention. It is fixed with the ICB and the responsibility will not change or transfer if the patient moves.

4.10 The ICB will ensure that where it is the responsible commissioner for a patient who is detained under a qualifying section it will take steps to convene a care planning meeting with Council and any other relevant body to plan for discharge and maintain a register of all such patients.

Joint Responsibilities

4.11 The ICB and the Council shall jointly maintain a register of all individuals in receipt of S117 after care by either of them, which shall identify any other relevant commissioner, review dates and the care manager for the individual.

5. PROCESS

Managing the discharge from hospital

5.1 Although the duty to provide s.117 aftercare begins when the person is discharged hospital, the planning of s.117 aftercare should start as soon as the person is admitted to hospital. Planning for a person's discharge should be undertaken using the CPA, the CPA approach used by Central and North West London Foundation Trust (CNWL) is under review and this policy will be updated to reflect any changes that emerge from that review; the planning process should be person-centred and recovery focussed. The Code of Practice requires the clear identification of a named individual who has responsibility for co-ordinating the preparation, implementation and evaluation of a person's CPA care plan. It is also incumbent on the Council to undertake an assessment of need in line with s.9 Care Act, 2014.

5.2 An initial CPA should be held close to admission, usually within the first 7 days, to determine any ongoing health, social care or housing needs.

5.3 A discharge planning s.117 aftercare meeting should take place within a minimum of two weeks (10 working days) prior to discharge This is for assessment and planning purposes and should include all of the relevant parties who are or will be actively involved in the

person's care going forward. The planning s.117 aftercare meetings should be convened and managed by the relevant ward staff at the hospital where the person is detained.

5.4 The following must be in attendance at a planning s.117 aftercare meeting:

5.4.1 the individual if they choose to attend;
5.4.2 the Social Worker from the responsible Local Authority;
5.4.3 clinical representative from CNWL (ward staff or Community Mental Health Team)

5.4.4 others to be invited if involved in someone's care include a key worker from a placement, support worker, advocate, family or carer, physical care needs lead e g district nurse. This list is not exhaustive and efforts should be made to ensure that key professionals are involved.

5.5 All individuals with enduring mental illness and complex care needs should be assessed and their care planned with the CPA framework. Prior to discharge, the Council & ICB shall arrange a holistic assessment for the person in order to determine what s.117 aftercare services will be required when the person leaves hospital. This assessment is likely to involve consideration of:

5.5.1 Continuing mental health needs;

5.5.2 The psychological needs of the person and, where appropriate, of their family and carers;

5.5.3 Physical healthcare;

5.5.4 Daytime activities, employment or training;

5.5.5 Appropriate accommodation;

5.5.6 Identified risks and safety issues;

5.5.7 Any specific needs arising from, for example, co-existing physical disability, sensory impairment; learning disability or autistic spectrum disorder;

5.5.8 Any specific needs arising from drug, alcohol or substance misuse (if relevant);

5.5.9 Any parenting or caring needs;

5.5.10 Any social, cultural or spiritual needs;

5.5.11 Assistance in welfare rights and managing finances or in providing counselling and personal support;

5.5.12 Involvement of authorities and agencies in a different area, if the person is not going to live locally to the ICB or the Council;

5.5.13 Involvement of other agencies, for example, the probation service or voluntary organisations;

5.5.14 For a restricted patient the conditions which the Secretary of State for Justice or the tribunal has imposed or is likely to impose on their conditional discharge; and

5.5.15 Contingency plans (should the person's mental health deteriorate) and crisis contact details.

4.5 Based on this assessment, a support plan for s.117 aftercare should be agreed with the person and clearly documented. The plan must include the needs which arise from the person's mental disorder, the services that are required to meet those needs so as to reduce the risk of deterioration, and estimated timescales within which each of the identified needs is to be addressed or reviewed. The s.117 aftercare provision should be recorded on the person's care plan as part of the CPA process. The plan should also seek to indicate whether a need to be met is a health need, a social care need or a joint health and social care and which needs are required to be met as part of the person's s.117 aftercare funding.

Commissioning the Package

4.6 In the range of services which are considered to support a person's discharge from hospital, there may be services which are determined by assessment as those for which the person is eligible under s.117 of the Act. In addition, there may be some services which are commissioned to meet other care needs, such as physical health, which do not fall within s.117 aftercare eligibility. Services may, therefore, be commissioned under s.117 aftercare provision (which are not chargeable to the service user) which run alongside non-s.117 aftercare services for which the Council's usual financial assessment procedure will apply.

4.7 A package of care and support will need to be developed based on a service user's s.117 aftercare support plan. The plan should follow the principles of self-directed support and personalised services and the package should utilise existing universal, free to access services where possible.

4.8 The package of care and support will then be subject to ratification by the weekly ICB and Council validation panel. Care and support plans for service users must clearly document which services are planned under s.117 aftercare provision and which services are not subject to this provision.

4.9 Prior to confirming the s.117 aftercare funding support, the care co-ordinator must request determination of the ICB responsible for commissioning the package of care. All requests must be sent to the ICB Joint Commissioning team. It is expected that they will receive notification with regard to which ICB is responsible for commissioning within 24hrs between Monday and Friday.

Cost Split

4.10 Following an audit undertaken in 2018 the ICB and the Council have agreed a cost split for all cases of 38% NHS funded and 62% Local Authority.

Review of a person's s.117 aftercare

4.11 CNWL Mental Health Services (CMHTs) will advise Hillingdon Social Care Direct that the person's a review of s117 aftercare is required. Care plans for people receiving s.117

aftercare should be regularly reviewed within a timescale determined by their needs. A minimum timeframe for such a review is at least once every six months for any person subject to s.117 aftercare in the first years following their discharge from hospital. The timeframe for individual patient's review dates should be recorded on the s.117 aftercare register held by the ICB and the Council. Occasionally a s.117 aftercare review meeting will need to be brought forward to address issues that cannot wait which require all agencies involved to make an input into the person's aftercare arrangements. However, if changes to a person's after care plan are urgent there should be no delay speaking to relevant parties to agree the changes. Any urgent budgetary changes need to be discussed with the relevant budget managers and recorded on the case notes at the time as well as in the next s.117 meeting. These changes will be reported to the Council and ICB validation panel held weekly.

4.12 The review process should include:

4.12.1 The person's care coordinator arranging the review within the relevant timeframe and then at regular intervals;

4.12.2 The ICB and the Council should maintain an up-to-date register of its service users who are in receipt of s.117 aftercare and of whom both organisations are responsible;

4.12.3 The register must be maintained and regularly updated with notifications of any changes, for example, if a person has been discharged from receiving s.117 aftercare or has been transferred out of area;

4.13 A review of a person's s.117 aftercare provision should follow the CPA and should review the quality of care being provided to the person and address the financial issues arising from outstanding quality markers. It should be a joint process between the Council and the ICB.

4.14 It is important to consider at every review whether it is appropriate for the person's care plan to continue to be provided under s.117 of the Act. If amendments to the person's care plan identifying additional services to address the mental health needs are identified these will be s.117 aftercare services and the relevant paperwork will need to be completed, reviewed and signed off to ensure additional costs are contracted and met.

4.15 Once a review of a person's s.117 aftercare provision has been completed, a copy of the review paperwork must be uploaded to relevant health and social databases (System1 (CNWL), Protocol (Council) and Caretrak (ICB)) However those organisations e.g., placements who provide the care and support needs should get a copy of the care plan. The CPA documentation must identify when the next review will be required; the register must also be updated. The person should receive a copy of their plan.

5. DISCHARGE FROM S117

5.1 The duty to provide s.117 aftercare services exists until both the ICB and the Council are satisfied that the person no longer requires them. Aftercare under s.117 of the Act does not have to continue indefinitely. It is the joint responsibility of the ICB and the Council, in consultation with the person, carers (if indicated) and professionals involved, to decide whether s.117 aftercare should end. Aftercare under s.117 of the Act may be terminated

upon the death of the person or after a review has determined that s.117 aftercare is no longer required.

5.2 An exception to the above duty is where a person is subsequently once more detained in hospital under a qualifying section of the Act. In those circumstances, any existing s.117 aftercare duty owed to that person ceases but a new entitlement would start when the person was discharged from hospital following the new period of detention. The process of identifying the responsible s.117 aftercare bodies and making a s.117 aftercare plan, therefore, would start afresh.

5.3 The circumstances in which it is appropriate to end s.117 aftercare will vary from person to person and according to the nature of the services being provided. For example, in circumstances where a person's mental health has improved to a point where they no longer need services to meet needs arising from or related to their mental disorder, their s.117 aftercare should be brought to an end. Fully involving the person and (if indicated) their care and/or advocate in the decision-making process will play an important part in the successful ending of s.117 aftercare provision.

5.4 As part of their CPA care-coordination, a person's care coordinator has a particular responsibility for considering the question of whether the person is suitable for discharge from s.117 aftercare and bringing it to the attention of the multi-disciplinary team. Any decision to discharge the person from s.117 aftercare can only be made after a lawful multi-disciplinary reassessment of the person's needs has taken place. Certain factors should be considered to establish if discharge from s.117 aftercare is appropriate for a particular person:

5.4.1 What are the person's current assessed mental health needs?

5.4.2 Have the individual's needs changed since their discharge from hospital under s.117 of the Act?

5.4.3 What are the risks of a return to hospital/relapse?

5.4.4 Has the provision of s.117 aftercare services to date served to minimise the risk of the individual being re-admitted to hospital for treatment for mental disorder/experiencing relapse of their mental illness?

5.4.5 Are those services still serving the purpose of reducing the prospect of the individual's re-admission to hospital for treatment for mental disorder/experiencing relapse or has that purpose now been fulfilled?

5.4.6 What services are now required for the person's current mental health needs?

5.4.7 Does the individual still require medication for their mental disorder?

5.4.8 Is there any ongoing need for care under the supervision of a consultant psychiatrist or any ongoing need for involvement of specialist mental health services such as a community mental health team?

5.5 A person should be considered for discharge from s.117 aftercare if care, support or treatment related to their mental disorder is no longer needed to minimise the risk of

deterioration and/or readmission to hospital. This is a measure of recovery and increasing independence.

5.6 The Code of Practice states that services under s.117 of the Act should not be withdrawn solely on the grounds that:

5.6.1 The person has been discharged from the care of specialist mental health services;

5.6.2 An arbitrary period has passed since the care was first provided;

5.6.3 The person is deprived of their liberty under the Mental Capacity Act 2005;

5.6.4 The person has returned to hospital informally or under s.2 of the Act; or

5.6.5 The person is no longer on a Community Treatment Order or utilising s.17 leave under the Act.

5.7 Once a decision has been made to discharge a person from s.117 aftercare, a copy of the discharge paperwork must be sent to and uploaded onto System One, Protocol and Caretrak. A copy must also be sent to the person in receipt of s117 aftercare, the register must also be updated to reflect the discharge.

6. INTERRELATIONSHIP WITH CHC

6.1 The relationship between s.117 of the Act and NHS Continuing Healthcare ('CHC') is clarified within the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, March 2018, at sections 309 – 319.

6.2 Responsibility for the provision of s.117 aftercare services lie jointly with local authorities and the NHS. Where an individual is eligible for services under s.117 of the Act these must be provided under s.117 and not under CHC (National Framework - section 313).

6.3 It is not, therefore, necessary to assess eligibility for CHC if all the services in question are in fact to be provided as aftercare services under s.117 of the Act (National Framework – section 314).

7. DECISION MAKING GOVERNANCE

7.1 The Council and CNWL Team Managers in collaboration with care coordinators and Social Workers are responsible for monitoring the arrangements for the provision of s.117 aftercare services through caseload management and s.117 aftercare planning review meetings. They must ensure that all aspects of this policy are adhered to including training and appraisals of staff and should report any problems or concerns to the CNWL Service Manager and Council Service Manager respectively and inform the ICB via the weekly validation meeting.

7.2 The validation Panel will monitor compliance with the Acts guiding principles, monitoring whether reviews are undertaken on a timely and consistent basis –This will be reported to the ICB's Head of Joint commissioning and the Council's Head of Learning Disability and Mental Health Services on a quarterly basis.

8. DISPUTE RESOLUTION

8.1 If a service user, or their representative, has a complaint regarding the operation of this policy then this should in the first instance be addressed with the respective Council, ICB or CNWL Team Manager

8.2 Disputes must not unreasonably delay a person's discharge from hospital and should be negotiated with the best outcomes of the person in mind.

8.3 The ICB and the Council have developed a Disputes Resolution Procedure that shall operate as follows:

8.3.1 The Council and CNWL staff agree a care plan and discharge destination.

8.3.2 If this is not agreed by both parties then the case will be escalated to the Council and CNWL team managers who will attempt to resolve the issues.

8.3.3 If this is not possible then the case can be reviewed by the validation panel representatives; in usual circumstances it is expected that this group will be able to agree a solution however if this is not possible then the case will be escalated to the ICB Head of Joint Commissioning and Council's Head of Learning Disability and Mental Health Services for review, case that are not resolved at this level are likely to require both parties to seek a legal view as to how to progress.

8.4 With regard to ordinary residence disputes, the local authority that is meeting the needs of the person on the date that the dispute arises must continue to do so until the dispute is resolved. If no local authority is currently meeting the person's needs, then the local authority where the person is living or is physically present must accept responsibility until the dispute is resolved. The Care and Support (Disputes between Local Authorities) Regulations 2014 sets out the specific procedures local authorities must follow when disputes arise between local authorities regarding a person's ordinary residence.

8.5 With regard to resolving disputes between ICBs, NHS England promotes the underlying principle that there should be no gaps in responsibility. For example, no treatment should be refused or delayed due to uncertainty or ambiguity as to which ICB is responsible for funding an individual's healthcare provision. ICBs are expected to act in the best interests of the patient at all times and work together in the spirit of partnership. NHS England expects that all disputes will be resolved locally, ideally at ICB level. In circumstances where resolution cannot be found at ICB level, area teams of NHS England should be consulted and should arbitrate where necessary.

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:

2.1.1 **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;

2.1.2 **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;

2.1.3 **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;

2.1.4 **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 will manage conflicts of interest as follows:

2.2.1 **ICB:** as set out in the ICB *Conflict of Interest Policy* (July 2022)

2.2.2 **LBH:** as set out in the *Code of Conduct for Council Employees* (LBH March 2010).