2025/26 BETTER CARE FUND SECTION 75 AGREEMENT

Cabinet Member & Portfolio	Cllr Jane Palmer Cabinet Member for Health & Social Care
Responsible Officer	Sandra Taylor – Adult Social Care and Health
Report Author & Directorate	Gary Collier – Adult Social Care and Health.
Papers with report	**Appendix 1** – Draft 2025/26 Better Care Fund Section 75 Agreement.

HEADLINES

Summary	This report seeks authority to enter into an agreement with the Northwest London Integrated Care Board (ICB) under section 75 of the National Health Service Act, 2006, to give legal effect to the financial and partnership arrangements within the 2025/26 Better Care Fund (BCF) plan. The Better Care Fund (BCF) is a national initiative that has been in place since 2015 through which Council and Northwest London Integrated Care Board (ICB) budgets are pooled and then reallocated based on an approved plan intended to support the national policy objectives of supporting the shift from sickness to prevention and supporting people to live independently and the shift from hospital to home. The BCF is also a route through which the Government targets funding to support the local health and care systems. The focus of Hillingdon's 2025/26 BCF plan is improving care outcomes for older people, adults living with long-term conditions and people with learning disabilities and/or autism.
Putting our Residents First **Delivering on the Council Strategy 2022-2026**	This report supports our ambition for residents / the Council of: • Live active and healthy lives • Staying independent for as long as they are able. This report supports our commitments to residents of: • Thriving, Healthy Households
Financial Cost	The value of the BCF for 2025/26 is £74,160,938 comprising of a Council contribution of £44,729,879 and an ICB contribution of £29,431,059.

Select Committee	Health and Social Care
Ward(s)	All

RECOMMENDATIONS

That:

1. **the London Borough of Hillingdon enter into an agreement with Northwest London Integrated Care Board (ICB) under section 75 of the National Health Service Act 2006 for the delivery of the Better Care Fund plan as described in the report from the 1st April 2025 to 31st March 2026 at a value of £74,160,937.**

2. **Authority be delegated to the Corporate Director, Adult Social Care and Health, to amend the terms of the agreement with Northwest London Integrated Care Board during 2025/26, in consultation with the Leader of the Council and the Cabinet Member for Health and Social Care.**

Reasons for recommendation(s)

1. **Entering Section 75 agreement:** Using powers under the 2006 National Health Service Act, NHS England makes the release of the £27,145k element of Hillingdon's Better Care Fund (BCF) that is under its control conditional on a pooled budget being established between the Council and North West London Integrated Care Board (ICB) through an agreement established under section 75 (s75) of the National Health Service Act 2006 (NHS Act). Local authorities and ICBs can enter s75 agreements once written notification has been received from NHS England that plans have 'assured' status. Confirmation of assured status was received on 18 June 2025.

2. Multiple factors have contributed to the delay in Cabinet being asked to consider this report. These include the impact on ICB capacity resulting from the NHS reorganisation. This has delayed decisions about ICB requirements. Securing partner agreement on use of discharge funding has also been subject to delays.

3. **Delegated authority to amend s75 agreement in-year**: The recommendation will enable the Council and ICB to respond quickly to any opportunities presented by evolving national policy, such as additional funding.

Alternative options considered / risk management

4. **Not entering into the s75 agreement:** Cabinet could decide not to enter the agreement with the ICB for 2025/26, but this is not recommended as it would impact on the availability of £27,145k in 2025/26 NHS funding to support the local health and care system, including £9,157k to support adult social care. It could also impact on the £6,341k Disabled Facilities Grant that is paid directly to the Council by the Ministry of Housing, Communities and Local Government (MHCLG) and the £9,212k Local Authority Better Care Grant that is also paid directly to the Council by the MHCLG.

In each case, grant conditions require that the Council has an agreed BCF plan in place that meets national conditions.

5. **Not delegated authority to amend s75 agreement in-year:** Cabinet could decide not to approve delegation arrangements or to add some additional requirements. This option is not recommended as the recommendation is intended create agility within the health and care system to respond to evolving circumstances, including new funding opportunities.

Select Committee comments

6. None at this stage.

SUPPORTING INFORMATION

Background

7. The Better Care Fund (BCF) is a national initiative that has been in place since 2015 through which Council and Northwest London Integrated Care Board (ICB) budgets are pooled and then reallocated based on an approved plan intended to support the national policy objectives of supporting the shift from sickness to prevention and supporting people to live independently and the shift from hospital to home. The BCF is also a route through which the Government targets funding to support the local health and care systems.

8. The policy framework that set out broad principles to be followed for the 2025/26 Better Care Fund (BCF) plan was published on the 30 January 2025. The detailed planning requirements for 2025/26 were also published on the same date.

9. The submission date for the 2025/26 plan set out in the January 2025 planning requirements was 31 March 2025. An in-year reduction to NHS additional contribution funding arrangements announced by the Northwest London Integrated Care Board (ICB) on 20th March 2025 meant that it was not possible for Hillingdon Place to be compliant with the national requirement and our local plan was submitted on the 6 May 2025. The planning documents were submitted as drafts pending Health and Wellbeing Board (HWB) formal approval. HWB approval of the plan is a national condition and was granted under delegated arrangements on 5 June 2025.

10. Cabinet may wish to note that the decision to reduce the NHS additional contribution to the BCF in-year followed the national announcement of the requirement for ICBs to reduce their overheads by 50% by December 2025.

11. The 2025/26 BCF plan submission comprises of the following documents:

- Narrative plan
- Planning template
- Intermediate care demand and capacity template

12. The narrative plan and key aspects of the planning template, i.e., income and expenditure, targets for metrics and supporting rationale, and the intermediate care demand and capacity template can be accessed using the following link Better Care Fund - Hillingdon Council.

Funding Stream Changes

13. Cabinet is advised that in 2024/25 there were two discharge funding grants, one of which came directly to local authorities and the other via ICBs. These were ring-fenced grants that could only be used to the support discharge. The ring-fence has been removed in 2025/26 and the ICB Discharge Fund has been included within the NHS minimum contribution to health. The local authority discharge fund has been included within the Local Authority Better Care Grant, which is paid directly to councils. The latter also includes the Improved Better Care Fund (iBCF) grant also previously received by councils as a separate grant. The value of this funding remains at the 2024/25 level. To avoid confusion, in this report funding previously identified as discharge funding will continue to be referred to as such, although it is important to emphasise that the removal of the ring-fence increases flexibility as to how this income can be deployed.

ICB Review of BCF Schemes

14. As a result of the ICB instigated review of BCF schemes undertaken during 2024/25, Hillingdon has amalgamated schemes using common definitions agreed across the sector. BCF funded services have been aligned to four schemes that have aims linked to the national BCF objectives. There has also been an attempt to simplify funding arrangements by reducing the number of different BCF income streams supporting services included in the plan.

15. The schemes and related aims are shown below:
    - ***Scheme 1: Living Well.*** Aim: Maximising independence and preventing unnecessary admission to hospital and residential care - Adults of working age.
    - ***Scheme 2: Ageing Well*****.** Aim: Maximising independence and preventing unnecessary admission to hospital and residential care - People aged 65 +.
    - ***Scheme 3: Active Recovery*****.** Aim: Promoting recovery and independence after acute illness.
    - ***Scheme 4: Infrastructure Enablers*****.** Aim: Providing effective foundations for operational service delivery.

Key Changes from 2024/25 Plan

16. The ICB's decision to reduce its additional contribution to the BCF in 2025/26 by 50% has resulted in savings of £796,619. The expectation is that the NHS additional contribution to the BCF will reduce by a further £718,608 from 2026/27 making a full year saving for 2026/27 of £1,515,227. Within this changed financial context the approach taken has included:
    - Deletion of posts that have not been recruited to or where functions can be delivered outside of the BCF, e.g. P2/3 Bed Coordinator and Online Services Coordinator posts.
    - Moving things out of the BCF that could be funded elsewhere, e.g., Marketplace online directory software licence.
    - Not continuing contracts due to expire in-year or where it is difficult to demonstrate impact.
    - Reducing capacity of services following an eligibility review, e.g. Bridging Care.

17. As part of the process of streamlining the BCF to focus on mandated funded streams and additional that is aligned to them, £26,210k of additional local authority contribution has been removed from the 2025/26 plan. This mainly applies to community services for people with learning disabilities, e.g., supported living, outreach, direct payments, etc. It is important to emphasise that these services continue to be funded but outside of the BCF.

18. Linked to the outcome of the NWL BCF are changes to the risk share arrangements for the community equipment service. In 2024/25 this was 76% NHS and 24% local authority. This will change to 71% NHS and 29% local authority in 2025/26 as part of a transition to a uniform 65% NHS and 35% local authority, which it is proposed to fully implement in 2026/27.

S75 Agreement Key Features

19. The s75 agreement is largely a roll forward from 2023/24; however, this section of the report summarises the main features.

20. **Agreement duration**: Subject to Cabinet approving recommendation 1, the term would be 1st April 2025 until 31st March 2026. No option to extend further has been requested due to uncertainty about the Government's plans for the BCF from April 2026. Cabinet, however, is advised that some schemes include provision for them to continue unless terminated in accordance with the terms of the section 75 Agreement or superseded by a new section 75 Agreement. For example, services supporting hospital discharge reflected in Schedule 1D (Hospital Discharge Funding Arrangements) of **Appendix 1**.

21. **Hosting**: The practice since the inception of the BCF has been for the Council to host the pooled budget, which is the equivalent of a joint bank account.

22. **Hospital discharge arrangements**: Schedule 1D (Hospital Discharge Funding Arrangements) of the s75 agreement in **Appendix 1** sets out financial arrangements supporting hospital discharge. This includes funding for short-term bed-based block contracts as well as financial arrangements for out-of-hospital services that are not bed-based. It sets out services funded from the Discharge Fund as well as other funding streams within the BCF.

23. Agreed use of ICB Discharge Fund rolled forward from 2025/26 is also reflected Schedule 1D of **Appendix 1** to ensure transparency.

24. **Risk share**: It is proposed that the established practice of both partners managing their own risks is extended to the 2025/26 plan. The exception to this is with community equipment as identified in paragraph 12 above and Schedule 3 (Risk Share, Overspends and Underspends) of **Appendix 1**.

25. **Dispute resolution**: The dispute provisions of the agreement have been rolled over from the agreement supporting the 2024/25 BCF plan.

26. **Governance**: The delivery of the successive iterations of Hillingdon's plans has been overseen by the Core Officer Group comprising of the ICB's Joint Borough Directors for Hillingdon, the Council's Corporate Director for Adult Social Care and Health, HHCP's Managing Director, and the BCF Programme Manager. The governance schedule (Schedule 2) within the s75 agreement demonstrates the interrelationship between the Core Officer Group and the Hillingdon Place governance arrangements.

Financial Implications

BCF Value 2025/26

27. The value of the BCF for 2025/26 as shown in table 2 below decreases from **£100,025k** in 2024/25 to **£74,160k** in 2025/26. The expenditure tab from the template submitted to NHSE can be accessed via this link Better Care Fund - Hillingdon Council. This provides Cabinet with a detailed breakdown of investment for 2025/26 that is within the scope of the 2024/25 section 75 agreement.

28. Table 1 below provides a comparison of NHS and Council contributions in 2025/26 compared with 2024/25.

Table 1: Financial Contributions by Organisation 2024/25 and 2025/26

Organisation	2024/25	2025/26
NHS	29,851,857	29.431,059
LBH	70,173,307	44,729,879
TOTAL	**100,025,164**	**74,160,938**

29. Table 2 below provides a comparison of NHS and Council contributions by funding stream in 2025/26 compared with 2024/25. The decrease in the Council's additional contribution is explained in paragraph 11.

Table 2: Financial Contributions by Funding Stream 2024/26		
FUNDING SOURCE	**FUNDING**	
	2024/25	**2025/26**
Minimum NHS Contribution	26,754,890	27,145,109
Additional NHS Contribution	3,096,967	2,285,950
NHS TOTAL	**29,851,857**	**29,431,059**
Minimum LBH Contribution	14,787,649	15,554,753
Additional LBH Contribution	55,385,658	29,175,125
LBH TOTAL	**70,173,307**	**44,729,878**
TOTAL BCF VALUE	**100,025,164**	**74,160,938**

30 Table 3 below provides a comparison in value of the mandated BCF income streams in 2024/25 and 2025/26.

Table 3: BCF Minimum Contributions Summary 2024/26		
Funding Breakdown	**2024/25**	**2025/26**
NHS MINIMUM CONTRIBUTION BREAKDOWN		
➢ Minimum to Adult Social Care	8,811,589	9,157,453
➢ Minimum to Health	15,352,420	15,396,775
➢ ICB Discharge Fund	2,590,881	2,590,881
TOTAL	**26,754,890**	**27,145,109**
LBH MINIMUM CONTRIBUTION BREAKDOWN		
➢ Disabled Facilities Grant (DFG)	5,574,889	6,341,993
➢ Improved Better Care Fund (iBCF)	7,467,803	7,467,803
➢ LA Discharge Fund	1,744,957	1,744,957
TOTAL	**14,787,649**	**15,554,753**
MINIMUM BCF VALUE	**41,787,649**	**42,699,862**

31. Table 4 below summarises the Council and NHS funding contributions for the 2025/26 plan by scheme.

Table 4: Funding Breakdown by Scheme			
Scheme	**NHS**	**LBH**	**TOTAL**
1: Living Well	2,720,577	11,973,563	14,694,140
2: Ageing Well	11,166,206	30,872,950	42,039,156

3: Active Recovery	15,013,481	1,744,957	16,758,438
4: Infrastructure Enablers	530,795	138,409	669,204
TOTAL	**29,431,059**	**44,729,879**	**74,160,938**

Summary of Financial Changes

32. In summary, the main financial changes from the 2024/25 plan are:

32.1 **Additional LBH Contribution:**

- £26,210k of additional local authority contribution has been removed from the 2025/26 plan. This concerns community services for people with learning disabilities, such as supported living, outreach and direct payments services and reflects part of the process of simplifying the BCF and ensuring that additional funding aligns directly to the mandated funding streams.

32.2 **NHS Minimum Contribution to Adult Social Care:**

- *Support for carers***.** There has been a simplification of funding arrangements by bringing together separate carer-related services. This means that in 2025/26 there is a single carer support service activity within this income stream instead of three, which was the case in 2024/25.

- *Reablement***.** The contribution of this income stream to funding Reablement has increased from £407.6k in 2024/25 to £957k. This reflects Government guidance that national funding for reablement is included within the NHS minimum contribution to Adult Social Care and links to the national policy objectives.

32.3 **NHS Additional Contribution to Adult Social Care (Capitalisation):**

- *Long-term residential/nursing care home provision 18* +. The NHS funding contribution to this area of provision, i.e., £787k, has been consolidated into this funding stream. It was spread across the NHS minimum and NHS Additional Contributions to Adult Social Care in 2024/25.

- *Reablement.* The contribution of this income stream (£449k) to the funding of this service has reduced to reflect the increase in the contribution from the NHS minimum contribution.

- *Continuing Healthcare Social Work post*. The funding for this post, i.e., £69k, was split across the NHS minimum and NHS Additional Contributions to Adult Social Care in 2024/25. It is now in one place.

32.4 **Local Authority Better Care Grant (Discharge Component):**

- *Discharge-related placements*. Funding provision, i.e., £1,040k, allows short-term placements to be made and assessments of long-term care needs to be undertaken in an out of hospital setting. Funding covers the first six weeks

after placement and aligns with intermediate care regulations.

- *Discharge-related homecare*. Funding provision, i.e., £435k, covers the first four weeks after the start of the service.

- *Reablement*. This funding stream makes a £96k contribution to the cost of this service. This ensures that there is sufficient funding for the service to support admission prevention, hospital discharge and the out of hours response service for the telecare service, i.e., in circumstances where there is an alert, but the person concerned either does not have a responder or has a responder who cannot be contacted.

Local Authority Better Care Grant

33. Cabinet is advised that the above grant combines what were two separate grants in 2024/25, i.e., Local Authority Discharge Grant and the Improved Better Care Grant. The funding received in 2025/26 reflects the combined value of the two grants in 2024/25, which was £9,212,760. The grant conditions for the Local Authority Better Care Grant are that it must be used to:
    - Meet adult social care needs.
    - Reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready (including supporting the principles of *'Discharge to Assess'*); and/or
    - Ensure that the local social care provider market is supported.

34. Under the agreed BCF plan the total £7,467,803 of this grant that in 2024/25 was the Improved Better Care Grant has been identified to support the provider market. This includes funding commissioning capacity to ensure greater effectiveness in delivering the Council's responsibilities under section 5 of the Care Act, 2014, which was identified as an area for development during the assurance process undertaken by the Care Quality Commission in 2024.

ICB Discharge Fund Roll Forward

35. The hospital discharge funding arrangements schedule in **Appendix 1** also describes the use in 2025/26 of ICB Discharge Funding that was rolled forward into 2025/26, and this is shown in table 5 below. Cabinet is reminded that this funding was subject to a ring-fence, which meant that it could only be used to support hospital discharge. The REST service referred to in the table supports people with mental health needs and addictions.

Table 5: 2024/25 ICB Discharge Fund Carry Forward		
Service	**Provider**	**Cost (£s)**
Extra care step-down extension	LBH/Comfort Care Services	24,685
Block beds 1-2-1 Support	London Quality Care	43,554
Rapid Engagement Support Team (REST) Service	CNWL	53,532
Additional hospice capacity support	Harlington Hospice	19,000
Self-funder Information Advice & Guidance Service	Age UK	48,872
Housing Needs Officer (Discharge)	LBH	37,128
	TOTAL	**226,771**

RESIDENT BENEFIT & CONSULTATION

The benefit or impact upon Hillingdon residents, service users and communities?

36. The Council and ICB will be able to comply with the national BCF requirements for 2025/26.

Consultation & Engagement carried out (or required)

37. The ICB has been consulted in the drafting of this report. The HHCP Finance and Performance Committee considered the provisions of the section 75 agreement at its meeting on 2nd October 2025.

CORPORATE CONSIDERATIONS

Corporate Finance

38. Corporate Finance have reviewed this report and concur with the Financial Implications set out above, noting the recommendation to enter into an agreement with North West London Integrated Care Coard, under Section 75 of the National Health Service Act 2006 for the delivery of the Better Care Fund Plan as described in the main body of the report covering the 1st April 2025 to 31st March 2026.

39. Furthermore, it is noted, the total amount for the Better Care Fund Plan for 2025/26 is £74,161k, made up of Council contribution of £44,730k and an Integrated Care Board contribution of £29,431k.

40. Additionally, it is noted that the 2025/26 Council contribution of £44,730k represents a reduction of £25,443k compared to the 2024/25 contribution. The reduction is in relation to the refocussing of the Better Care Fund on the mandated funding streams, this adjustment primarily affects community services, which will continue to be funded, but outside the scope of the Better Care Fund.

Legal

41. Section 75 of the NHS Act 2006 permits NHS bodies and councils to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning, including of integrated services. When considering entering into a s75 agreement regard must be given to the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 which set out what a s75 Agreement must specify. There are no legal impediments to the recommendations set out within the report.

BACKGROUND PAPERS

Better Care Fund policy framework 2025 to 2026 - GOV.UK
NHS England » Better Care Fund planning requirements 2025-26

Appendix 1

Dated: day of 2025

London Borough of Hillingdon

and

NHS Northwest London Integrated Care Board

FRAMEWORK PARTNERSHIP AGREEMENT PURSUANT TO SECTION 75 NHS ACT 2006 RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES UNDER THE BETTER CARE FUND AND OTHER PARTNERSHIP ARRANGEMENTS

Cabinet – 23 October 2025
(Part 2 - Members' Only)
Strictly Not for Publication

CONTENTS

THIS AGREEMENT is made on day of 2025

PARTIES

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

(2) **NHS Northwest London** (the "***ICB***") of 15 Marylebone Rd, London NW1 5JD

each a "**Partner**" and together the "**Partners**".

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Hillingdon.

(B) The ICB has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Hillingdon.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions. 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 integrated care boards 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 which are the subject of this Agreement through lead or joint commissioning arrangements and through which the Partners will pool funds and/or align budgets as set out in this Agreement.

(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) meet the National Conditions.

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

d) ensure that by 2026/27 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 are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 65Z5 of the 2006 Act as applicable, to the extent that exercise of these powers is required for the Partners to comply with their obligations under 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:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

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 24, 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 and Appendices.

Annual Report means the annual report produced by the Partners in accordance with Clause 20 (Review).

Approved Expenditure means any expenditure approved by the Partners in writing or as set out in the Scheme Specification in relation to an Individual Scheme over and above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

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

BCF Quarterly Report means the quarterly report produced by the Partners and provided to the Health and Wellbeing Board.

Better Care Fund means the Better Care Fund as described at **NHS England » Better Care Fund** as relevant to the Partners.

Better Care Fund Plan means the plan agreed by the Partners for the relevant Financial Year setting out the Partners' plan for the use of the Better Care Fund as attached as Schedule 6.

Better Care Fund Requirements means any and all requirements on the ICB and the Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health and Social Care and NHS England.

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 Commencement Date.

Commencement Date means 00:01 hrs on 1st April 2025.

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 under a Service Contract as consideration for the provision of goods, equipment or services as required as part of the Services and which, for the avoidance of doubt, does not include any Default Liability.

Controller has the meaning given to it in the Data Protection Legislation.

Data Protection Legislation means all applicable data protection and privacy legislation in force from time to time in the UK including the UK GDPR, the 2018 Act and the Privacy and Electronic Communications (EC Directive) Regulations 2003 and any guidance and codes of practice issues by any Regulatory or Supervisory Body from time to time.

Data Subject has the meaning given to it in the Data Protection Legislation.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Service Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a Service 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 Service Contract, liable to the Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund or Non-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; or

(g) any form of contamination or virus outbreak,

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.

Health-Related Functions means those of the health-related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non-Pooled Fund the Partner that will host the Non-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 Sections 14Z32 to 14Z44 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 which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 of the 2006 Act as documented in a Scheme Specification.

Information Commissioner has the meaning given to it in the Data Protection Legislation.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Health-Related 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 of the 2006 Act.

Law means:

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

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

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

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

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

Lead Partner means the Partner responsible for commissioning an Individual Service under a Scheme 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 National Guidance as are amended or replaced from time to time.

National Guidance means any and all guidance in relation to the Better Care Fund as issued from to time to time by NHS England, the Ministry of Housing, Communities and Local Government, the Department of Health and Social Care, and the Local Government Association either collectively or separately.

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 which may be further described in each Scheme Specification.

NHS Standard Contract means the contract published by NHS England which must be used by the ICB when commissioning clinical services.

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 or Non-Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

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

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Clause 19.2 and **Schedule 2**, where it is described as the '*Core Officer Group'*.

Partnership Board Quarterly Reports means the reports that the Pooled Fund Manager shall produce and provide to the Partnership Board on a Quarterly basis.

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 7.4.

Personal Data has the meaning given to it in the Data Protection Legislation.

Personal Data Breach has the meaning given to it in the Data Protection Legislation.

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 such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund as nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

Processing has the meaning given to it in the Data Protection Legislation, and the terms "Process" and "Processed" shall be construed accordingly.

Processor has the meaning given to it in the Data Protection Legislation.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement, including the Council where the Council is a provider of any Services.

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended from time to time).

Regulatory or Supervisory Body means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Partner must comply or to which it must have regard and includes the Information Commissioner.

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

Scheme means Individual Scheme.

Scheme Specification (or description) means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

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.

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 Specification.

Service Contract means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the Services in accordance with the relevant Individual Scheme.

Service Provider means a provider of Services under a Service Contract with one or both Partners.

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

Special Category Personal Data means Personal Data that falls within the scope of special categories of Personal Data specified in Article 9 of the UK GDPR.

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.

UK GDPR has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.

Underspend means any expenditure from the Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.

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 if pounds sterling is replaced as legal tender in the United Kingdom by a different currency, then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

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

2 TERM

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

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification or if not set out, for the duration of this Agreement unless terminated earlier by the Partners in accordance with Clause 22.3.

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 with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission the Services. This may include one or more of the following commissioning mechanisms:

4.1.1 Lead Commissioning Arrangements.

4.1.2 Integrated Commissioning.

4.1.3 Joint (Aligned) Commissioning; and/or

4.1.4 the establishment of one or more Pooled Funds,

in relation to Individual Schemes (the "**Flexibilities**").

4.2 Where there are Lead Commissioning Arrangements and the ICB is Lead Partner 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.

4.3 Where there are Lead Commissioning Arrangements and the Council is Lead Partner, 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.

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

5 FUNCTIONS

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

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Services in accordance with their obligations under this Agreement.

5.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in **Schedule 1** Part 2.

5.4 Where the Partners wish to add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 30 (Variations). Each new Scheme Specification shall be substantially in the form set out in **Schedule 1** Part 1.

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

5.6 For the purposes of implementing 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 aftercare 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**
Schemes 1 and 2	Delegation by the ICB to the Council to enter contractual arrangements with homecare providers on behalf of the ICB.
	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.
	Delegation by the ICB to the Council to commission hospital admission prevention services on behalf of the ICB, subject to the Council's duties under section 22 of the 2014 Act.
Scheme 1	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 1E** of this Agreement.
	Delegation to the Council by the ICB to act as lead commissioner in securing care and support services to meet the assessed needs of people with a learning disability and/or autism eligible for CHC funding.
Scheme 2	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**.
	Delegation by the ICB to the Council authority to undertake assessments

	and prescriptions for community equipment to meet health needs.
Scheme 3	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.
	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**.
Scheme 4	None

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	Delegation to the ICB by the Council authority to undertake assessment and prescription of community equipment to meet social care needs.
Scheme 3	None

Scheme 4	None

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 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.

6.6 Commissioning arrangements in respect of **Schedule 1A** of this Agreement shall be as described in that Schedule.

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 **Schedules 1A** to **1E** inclusive.

7.2 At the Commencement Date there shall be a single Pooled Fund in respect of this Agreement. Financial provisions outside of the Pooled Fund shall be as described in **Schedule 1A**.

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

7.4 Subject to Clause 7.5, it is agreed that the monies held in the Pooled Fund may only be expended on the following:

7.4.1 the Contract Price.

7.4.2 where the Council is to be the Provider, the Permitted Budget.

7.4.3 Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board; and

7.4.4 Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board,

("**Permitted Expenditure**").

7.5 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of the Partnership Board.

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

7.7 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.7.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners.

7.7.2 providing the financial administrative systems for the Pooled Fund.

7.7.3 appointing the Pooled Fund Manager; and

7.7.4 ensuring that the Pooled Fund Manager complies with their obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, the Partners shall agree which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager for each Pooled Fund 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 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 this Agreement and by the Partnership Board.

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement.

8.2.7 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 including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance; and

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as may be required by it and any relevant National Guidance including (without limitation) supplying Quarterly Reports referred to in Clause 8.2.7 above to the Health and Wellbeing Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall:

8.3.1 have regard to National Guidance and the recommendations of the Partnership Board; and

8.3.2 be accountable to the Partners for delivery of those responsibilities.

9 NON-POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non-Pooled Fund will be notionally held in a fund established solely for the purposes agreed by the Partners. For the avoidance of doubt, a Non-Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non-Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund; and

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner of the relevant Non-Pooled Fund will be responsible for establishing the financial and administrative support necessary to enable the

effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that any Services commissioned using a Non-Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the ICB Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health-related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 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** to **1E** inclusive.

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

10.3 Financial arrangements in respect of **Schedule 1A** of this Agreement shall be as described in that Schedule.

11 NON-FINANCIAL CONTRIBUTIONS

11.1 Each 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(s)).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in **Schedule 3**, which provide for risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

Overspends in Pooled Fund

12.2 Overspends in the Pooled fund shall be managed as set out in **Schedule 3** for the Term of the Agreement.

Underspend in Pooled Fund

12.3 Underspends in the Pooled Fund shall be managed as set out in **Schedule 3** for the Term of the Agreement.

Benefits

12.4 In the event that cash savings are delivered in respect of services in the Pooled Fund, these will be retained by the Partner generating the said saving.

Underspends and Overspends of Non-Pooled Funding

12.5 Underspends and overspends of non-pooled funding shall be managed as set out in **Schedule 3**.

13 CAPITAL EXPENDITURE

13.1 The Pooled Fund shall not be applied towards any one-off expenditure on goods and/or services outside of the remit of Schemes 1 and 4 of **Schedule 1**, specifically the use of Disabled Facilities Grants, without prior approval of the Partnership Board.

14 VAT

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

15 AUDIT AND RIGHT OF ACCESS

15.1 The 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 the Regulations and the Local Audit and Accountability Act 2014.

15.2 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 relevant Partner 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.

15.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Nothing in this Agreement shall affect:

16.1.1 the liability of the Council to the Service Users in respect of the Health-Related Functions; or

16.1.2 the liability of the ICB to the Service Users in respect of the NHS Functions.

16.2 Subject to Clause 16.3, and 16.4, if a Partner (the "Indemnified Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner (the "Indemnfiying Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Service Contract then the Indemnifying Partner shall be liable to the Indemnified Partner for that Loss and shall indemnify the First Partner accordingly.

16.3 Clause 16.2 shall only apply to the extent that the acts or omissions of the Indemnifying Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Indemnifying Partner acting in accordance with the instructions or requests of the Indemnified Partner or the Partnership Board.

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

16.4.1 as soon as reasonably practicable give written notice of that matter to the Indemnifying Partner specifying in reasonable detail the nature of the relevant claim.

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

16.4.3 give the Indemnifying 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.

16.5 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 and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement).

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

Conduct of Claims

16.7 In respect of the indemnities given in this Clause 16:

16.7.1 the Indemnified Partner shall give written notice to the Indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity.

16.7.2 the Indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the Indemnified Partner, the Indemnifying Partner shall consult with the Indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the Indemnified Partner informed of all material matters; and

16.7.3 the Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective standing orders and standing financial instructions).

17.2 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 Partners will co-operate with all reasonable requests from the Council which the Council considers necessary to fulfil its Best Value obligations.

17.3 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 Funds are therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

17.4 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 Services.

18 CONFLICTS OF INTEREST

18.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 5.

19 GOVERNANCE

19.1 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.

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

19.3 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 2**.

19.4 The terms of reference of the Partnership Board will be as set out in **Schedule 2**.

19.5 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.

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 2.**

20 REVIEW

20.1 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.

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

20.3 If 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.

20.4 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.

21 COMPLAINTS

21.1 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.

21.2 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:

21.2.1 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.

21.2.2 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.

21.2.3 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.

21.2.4 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.

22 TERMINATION & DEFAULT

22.1 The termination and default provisions as set out in Clauses 22.2 to 22.8 of this Agreement will apply.

22.2 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.

22.3 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 this Clause 22.

22.4 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.

22.5 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.

22.6 Upon termination of this Agreement (or any part thereof) for any reason whatsoever the following will apply:

22.6.1 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;

22.6.2 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.

22.6.3 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.

22.6.4 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.

22.6.5 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

22.6.6 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.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 will apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 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.

23.2 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 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 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.

23.4 The decision of the ICB Clinical Lead for Hillingdon and the Co-chairmen of the Health and Wellbeing Board as described in Clause 23.3 will be final and binding on both Partners.

23.5 Nothing in the procedure set out in this Clause 23 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.

24 FORCE MAJEURE

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

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

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.1 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.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

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

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

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

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

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 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.

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

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

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 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 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

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) in connection with this Agreement.

28 DATA PROTECTION AND INFORMATION SHARING

28.1 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..

28.2 For the purposes of this Clause 28, the terms "*Data Controller*", "*Data Processor*", "*Data Subject*", "*Data*" and "*Processing*" will have the meaning prescribed under the Data Protection Laws

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery.

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

29.1.3 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.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the 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).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.4 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:

29.4.1 if to the Council, addressed to the **Corporate Director for Adult Social Care and Health**.

Tel: 01895 250506
Email: staylor@hillingdon.gov.uk

and

29.4.2 if to the ICB, addressed to the **Borough Director**.

Tel: 01895 203005
Email: sean.bidewell@nhs.net/sue.jeffers@nhs.net

30 VARIATION

30.1 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.

31 CHANGE IN LAW

31.1 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.

31.2 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.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

32.1 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.

33 SEVERANCE

33.1 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.

34 ASSIGNMENT AND SUBCONTRACTING

34.1 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 transfer to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 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.

35.2 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:

35.2.1 act as an agent of the other.

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

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

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

37 ENTIRE AGREEMENT

37.1 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.

37.2 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.

38 COUNTERPARTS

38.1 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.

39 GOVERNING LAW AND JURISDICTION

39.1 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.

39.2 Subject to Clause 23 (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 arise out of, or

in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

EXECUTION OF AGREEMENTS BY THE COUNCIL

CORPORATE SEAL OF THE
LONDON BOROUGH OF
HILLINGDON

_____

EXECUTION OF AGREEMENTS BY NHS NORTHWEST LONDON

NAME:

POSITION:

SIGNATURE:

DATE:

SCHEDULE 1 – SCHEME DESCRIPTIONS

Scheme 1: Living Well
Aim: Maximising independence and preventing unnecessary admission to hospital and residential care - Adults of working age.
Priorities: • Continuing to embed a Population Health Management (PHM) approach across the health and care system. • Strengthen early intervention to prevent or delay long-term conditions. • Develop support for unpaid carers. • Implementing the outcomes of competitive tenders for third sector provided preventative services, e.g., information, advice and guidance, support for carers, and early intervention support for adults with mental health needs.
Metrics: • *Proportion of unpaid carers on the carers register as a proportion of carers identified by the 2021 census.* • *Long-term admissions to residential care homes for people aged 18 to 64 per 100,000 population.*

Scheme 2: Ageing Well
Aim: Maximising independence and preventing unnecessary admission to hospital and residential care - People aged 65 +.
Priorities: • Further developing three Integrated Neighbourhood Teams (INTs) and the neighbourhood working approach to deliver care and support closer to home. • Establishing fewer, larger integrated teams aligned to the INTs that cover seven days and have a single leader. • Expanding a targeted care coordination programme within the INTs that utilises digital innovation and focuses on risk stratification and early intervention, particularly for the 4,400 people who are high users of health services.
Metrics: • *Emergency admissions to hospital for people aged 65+ per 100,000 population.* • *Emergency admissions to hospital related to falls for people aged 65+ per 100,000 population* • *Long-term admissions to residential care homes for people aged 65 + per 100,000 population.*

Scheme 3: Active Recovery
Aim: Promoting recovery and independence after acute illness.
Priorities: • Implementation of a Community Urgent and Emergency Care Service linked to the three super Neighbourhood Hubs previously mentioned. • Implementation of an Integrated Active Recovery Service. • Expansion of the Palliative Integrated Care Hub. • Full implementation of an acute to hospice pathway.
Metrics: • *Average length of discharge delay for all acute adult patients* • *Reduction in number of people in an acute hospital not meeting the Criteria to Reside (CTR).*

Scheme 4:
Aim: Providing effective foundations for operational service delivery.
Priorities: • Implementation of an Adult Social Care commissioning model.
Metrics: • *Increase in the percentage of regulated providers assessed by the Care Quality Commission as 'good' and above.*

SCHEDULE 1A – FINANCIAL CONTRIBUTIONS SUMMARY AND BREAKDOWN

FINANCIAL CONTRIBUTIONS SUMMARY

1.1 Table 1 summarises the total contribution by organisations in 2025/26.

Table 1: Financial Contributions by Organisation 2025/26	
Organisation	**2025/26**
NHS	29,431,059
LBH	44,729,879
TOTAL	**74,160,938**

1.2 Table 2 below provides a breakdown by BCF funding stream for 2025/26.

Table 2: Financial Breakdown by BCF Funding Stream, 2025/26			
Running Balances	**Income**	**Expenditure**	**Balance**
DFG	£6,341,993	£6,341,993	0
NHS Minimum Contribution	£27,145,109	£27,145,109	0
Local Authority Better Care Grant	£9,212,761	£9,212,761	0
Additional LA Contribution	£29,175,125	£29,175,125	0
Additional NHS Contribution	£2,285,950	£2,285,950	0
TOTAL	**£74,160,938**	**£74,160,938**	0

1.3 Table 3 below shows the allocation to Adult Social Care spend from the NHS minimum contribution.

Table 3: Adult Social Care Spend from NHS Minimum 2025/26		
Required Spend	**Planned Spend**	**Balance**
£9,157,453	**£9,157,453**	**0**

1.4 Table 4 below summarises the Council and NHS contributions for 2025/26 by scheme.

Table 4: Council and NHS Contributions by Scheme, 2025/26			
Scheme	**NHS**	**LBH**	**TOTAL**
Living Well	2,720,577	11,973,563	14,694,140
Ageing Well	11,166,206	30,872,950	42,039,156
Active Recovery	15,013,481	1,744,957	16,758,438
Infrastructure Enablers	530,795	138,409	669,204
TOTAL	**29,431,059**	**44,729,879**	**74,160,938**

1.5 **Annex A** to this **Schedule 1A** of the Agreement provides a detailed breakdown of services, related funding and funding source reflected within the 2025/26 BCF plan.

1.6 **Annex B** to this **Schedule 1A** of the Agreement summarises the funding to be paid by the NHS to the Council for its retention.

ANNEX A: FUNDING BREAKDOWN, 2025/26

Annex%20A%20Schedule%201A%20202

ANNEX B: SUMMARY OF NHS FUNDING TO BE RETAINED BY THE COUNCIL 2025/26

Annex%20B%20Schedule%201A%20202

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.

1.3 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*** mean the criteria agreed between the Partners to determine access to the Service as described in **Annex A** of this Schedule.

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

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

1.3.7 **NHS NWL** means the Northwest London Integrated Care Board.

1.3.8 ***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.

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

1.3.10 ***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.

1.3.11 ***Service Provider*** means Medequip Assistive Technology Limited.

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 Operational Advisory 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 secure provision of 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 (or delegated representative), 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.

5.2 The Service Provider will carry out the day-to-day requirements of the Services as outlined in the Contract. 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 following risk share arrangement for 2025/26:

- NHS: 71%
- LBH: 29%

6.2 The Partners acknowledge an intention to move to the following risk share arrangement for 2026/27:

- NHS: 65%
- LBH: 35%

2025/26 Budget

6.3 The breakdown of the 2025/26 budget for the Service is shown in table 1 below

Table 1: Community Equipment Budget 2025/26

Commissioner	Equipment Cost 2025/26	Staffing Cost	TOTAL	% Contribution
ICB	1,516,575	50,767	**1,567,342**	71%
LA	619,446	20,736	**640,182**	29%
TOTAL	**2,136,021**	**71,503**	**2,207,524**	**100%**

6.4 In 2025/26 the Council will capitalise the NHS community equipment contribution shown in table 1 above using Disabled Facilities Grant funding. The ICB agrees to pay to the Council a sum of equivalent value to support Adult Social Care provision. The use of this funding shall be as shown in table 2 below.

Table 2: NHS Additional (Capitalisation) 2025/26		
BCF Scheme Reference	**Spend Item**	**2025/26 ICB Minimum Contribution (£'s)**
		2025/26 Allocation
		1,567,342
Living Well	Continuing Healthcare Social Work post	69,010
Living Well	Mental Health Service Manager post	103,000
Living Well	Long-term residential or nursing care: 18+	787,444
Active Recovery	Additional discharge AMHP capacity	72,258
Active Recovery	MH Discharge Social Worker post	52,403
Active Recovery	Reablement	449,276
Active Recovery	MH Discharge Floating Support Service	33,951
	TOTAL	**1,567,342**
	Balance	**0**

Budget Setting

6.5 The Council will propose a base CES budget for consideration by the Partners by end of Q3 2025/26 and a proposed base budget for 2026/27 will be determined by the end of February 2026. The budget for 2026/27 will be determined by the outcome of an open book analysis. Prescribing Teams funded from the Pooled Budget will be notified of their allocation.

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 Underspends

6.8 Provisions concerning over and under-spends are addressed in **Schedule 3** of this Agreement. Underspend of funds provided as shown in table 2 may be used to support Adult Social Care provision.

7. AUDIT ARRANGEMENTS

7.1 In addition to the provisions in Clause 15 (*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 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 – OPERATIONAL ADVISORY GROUP TERMS OF REFERENCE

Annex%20B%20Schedule%201B%20-%2

SCHEDULE 1C – OPERATIONAL 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 contact the 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 regarding 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.

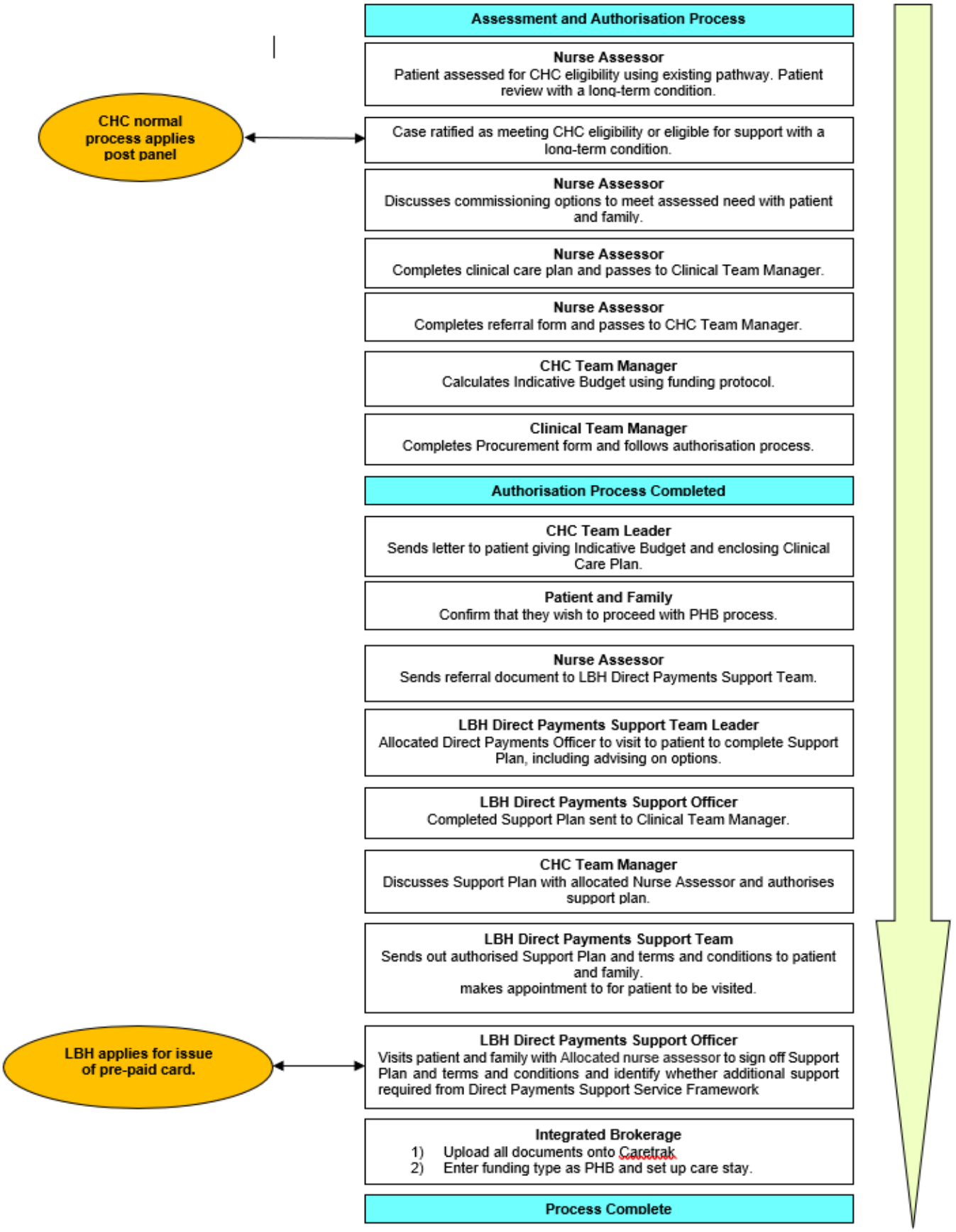
6. FUNDING

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 2025/26 will be £1,229 with an annual support cost charge of £525 per case thereafter. These rates will be subject to review for 2026/27.

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.

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 2025/26. The Schedule links into Scheme 3: *Active Recovery*.

1.2 Unless the context otherwise requires, the defined terms used in this **Schedule 1D** will have the meanings set out in the Partnership Agreement.

2. FUNDING WITHIN THE POOLED BUDGET

Intermediate Tier Services: Step-down Nursing Care Home Beds

2.1 Table 1 below describes the annual funding breakdown from the 1st April 2024. The total cost of block step-down provision in 2024/25 will be **£1,014,000** as described in table 1. The funding reflected in table 1 below will be contained within the Pooled Budget.

2. FUNDING WITHIN THE POOLED BUDGET

Intermediate Tier Services: Step-down Nursing Care Home Beds

2.1 Table 1 below describes the annual funding breakdown from the 1st April 2025. The total cost of block step-down provision in 2025/26 will be **£949,000** as described in table 1. The funding reflected in table 1 below will be contained within the Pooled Budget.

Table 1: Nursing Step-down Beds Breakdown 2025/26			
NHS Minimum Contribution to Adult Social Care	**NHS Minimum Contribution to Health (Discharge)**	**Local Authority Better Care Grant (Discharge)**	**TOTAL**
498,089	406,597	44,314	**949,000**

2.2 The Council has led a procurement process to identify suitable providers to deliver step-down nursing bed provision. Contractual arrangements are summarised in table 2 below. The need addressed from the provision shown in table 2 is general nursing, nursing dementia and non-weight bearing (primarily Parkfield House and Drayton Village as the secondary option).

Table 2: Step-down Nursing Beds Contractual Arrangements Summary						
Setting	**Provider**	**Bed Number**	**Contract Start Date**	**Contract End Date**	**Minimum Annual Cost (£)**	**Minimum Contractual Period Cost**
Parkfield House	Canford Healthcare Ltd	10	01/04/24	01/05/25	676,000	728,000

Parkfield House	Canford Healthcare Ltd	5	02/05/25	31/03/27	338,000	640,900
Drayton Village Care Centre	GCH North London Ltd	5	03/06/24	01/06/27	338,000	1,014,000
Ashwood Care Centre	Bondcare Ltd	4	17/03/25	04/07/27	260,000	565,527
					TOTAL	**2,948,427**

2.3 Contracts with Providers contain a three (3) calendar month break clause that is operable nine (9) months from commencement date. This means that the minimum duration of the contracts will be one calendar year.

2.4 The management of inflationary uplifts will be as set out in the terms of the Council's standard contract, i.e., subject to the provider (s) evidencing increased costs.

Intermediate Tier Services: Other

2.5 Table 3 below provides a summary breakdown of other intermediate tier services in 2025/26 where the Council is the commissioner.

Table 3: Summary of Other Intermediate Tier Funded Services 2025/26						
Service	**Provider**	**Start Date**	**End Date**	**NHS Contribution (£)**	**LBH Contribution (£)**	**Total Cost 2025/26 (£)**
A. Bridging Care	Comfort Care Services	01/04/25	31/03/26	858,343	0	**858,343**
B. Reablement	Comfort Care Services	03/04/20	02/04/26	1,406,316	96,000	**1,502,316**
C. Additional Brokerage capacity	LBH	01/04/25	31/03/26	0	55,500	**55,500**
D. Social work manager 7-day capacity	LBH	01/04/25	31/03/26	0	57,658	**57,658**
E. PATH (Home from Hospital) Service	Age UK	01/04/25	30/09/25	17,104	0	**17,104**
F. Deep clean & house clearance contract.	Telfords Cleaners Ltd/Other independent sector	01/04/24	31/03/26	0	16,000	**16,000**
G. Hospital Discharge AMHP	LBH	01/04/24	31/03/26	72,258	0	**72,258**
H. Mental Health hospital discharge social worker	LBH	01/04/24	31/03/26	52,403	0	**52,403**
I. Mental Health floating support service	Ability Housing and Care	16/01/24	30/11/25	33,951	0	**33,951**
J. Discharge-related care home placements	Independent sector	03/04/25	31/03/26	0	1,040,000	**1,040,000**
K. Discharge-related homecare	Independent sector	03/04/23	31/03/26	0	435,485	**435,485**
			TOTAL	**2,440,375**	**1,700,643**	**4,141,018**

Intermediate Tier Services: Exit Arrangements

2.6 Funding arrangements in respect of services in Clause 2.2 shall continue beyond the term of this Agreement, subject to the terms of any successor agreement or the ICB giving three calendar months' written notice to the Council.

2.7 The ICB may decommission or reduce capacity of the Bridging Care Service shown in table 3 pertaining to Clause 2.5 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 3 above the service will continue until such time as notice is issued under this Clause 2.7.

Discharge Funding

2.8 There have been changes to discharge funding in 2025/26. The local authority allocation has been incorporated into the Local Authority Better Care Grant and the ICB Discharge Fund has been included in the NHS minimum contribution to Health. **Annex A** to this **Schedule 1D** summarises the spending plan for 2025/26.

2.8 There have been changes to discharge funding in 2025/26. The local authority allocation has been incorporated into the Local Authority Better Care Grant and the ICB Discharge Fund has been included in the NHS minimum contribution to Health. **Annex A** to this **Schedule 1D** summarises the spending plan for 2025/26. No ring-fence applies to this funding in 2025/26.

ICB Discharge Fund Schemes: ICB Directed Schemes

2.9 **Bridging Service – Pathway 1:** The Bridging Service provides short-term support for Pathway 1 patients moving from hospital to home. Patients are assessed promptly, discharged safely, and supported for up to five days to help them transition smoothly into longer-term care if needed.

2.9.1 *Reporting requirements: referrals, assessment and discharge times, and patient outcomes.*

2.9.2 *Target: average Pathway 1 discharge delays under 2 days; discharge within 12 hours of readiness.*

2.10 **Strategic Oversight and Programme Management:** Funding is provided for strategic oversight, programme management, and system leadership to improve discharge processes across Northwest London. This includes rolling out OPTICA, supporting weekend discharges, managing the Discharge Grant Fund, and addressing Pathway gaps.

2.10.1 *Reporting requirements: number of WTEs in post.*

2.10.2 *Target: ensure adequate senior leadership and programme management capacity to support effective discharge and system flow.*

2.11 **Gap Commissioning:** Funding for gap / unclear commissioning patients supports those who fall between health and social care responsibilities—typically patients with health needs who do not meet the criteria for Continuing Healthcare. It enables patients to be discharged safely, recover at home, and regain independence. Services are flexible and include care not routinely available in the borough

2.11.1 *Reporting requirements: number of referrals accepted, and type of care provided.*

2.11.2 *Target: reduce hospital delays for unclear commissioning patients; ensure safe discharge and access to necessary community care.*

3. INTERMEDIATE TIER SERVICES FUNDED FROM 2024/25 CARRY FORWARD

3.1 Table 4 below details the funding carried forward from 2024/25 to support services in 2025/26.

Table 4: 2024/25 ICB Discharge Fund Carry Forward		
Service	**Provider**	**Cost (£s)**
Extra care step-down extension	LBH/Comfort Care Services	24,685
Block beds 1-2-1 Support	London Quality Care	43,554
Rapid Engagement Support Team (REST) Service	CNWL	53,532
Additional hospice capacity support	Harlington Hospice	19,000
Self-funder Information Advice & Guidance Service	Age UK	48,872
Housing Needs Officer (Discharge)	LBH	37,128
	TOTAL	**226,771**

ANNEX A: DISCHARGE FUNDING SPENDING PLAN 2025/26

Table 1: 2025/26 Discharge Fund Allocation	
Local Authority Better Care Grant (Discharge) Allocation	1,744,957
NHS Minimum to Health (Discharge) Allocation	2,590,881
TOTAL PROVISIONAL HILLINGDON HWB DF ALLOCATION 2024/25	**4,335,838**

Table 2: Spending Plan	
1. Local Authority Better Care Grant (Discharge) Allocation	**Allocation**
1.1 Reablement Service	96,000
1.2 Block step-down beds	44,314
1.3 Discharge-related placements	1,040,000
1.4 Discharge-related homecare	435,485
1.5 Deep clean & house clearance contract	16,000
1.6 Social work 7-day discharge capacity	57,658
1.7 Additional Brokerage Team capacity	55,500
LBH DIRECT FUNDING TOTAL:	**1,744,957**

2. NHS Minimum to Health (Discharge) Allocation	**Allocation**
2.1 Bridging Care Service	256,380
2.2 Reablement Physio	39,250
2.3 Block step-down beds	406,597
2.4 Home-based Active Recovery Service	785,213
2.5 Home-based Active Recovery Service – Additional weekend capacity	37,642
2.6 Gap commissioning	139,834
2.7 Additional admission prevention schemes	360,631
2.8 Additional discharge support	313,510
2.9 Central ICB support for borough-based teams	33,750
2.10 Mildmay HIV Rehab Unit	87,500
2.11 Personal Health Budget (PHB) purchase cards	10,000
2.12 Rehab beds, Furness Ward, Willesden	120,574
ICB ALLOCATION TOTAL	**2,590,881**
TOTAL HILLINGDON 2025/26 DISCHARGE FUND ALLOCATION	**4,335,838**

1. Table 3 below provides an update on the use of funding against the generic schemes (highlighted) in table 2 above.

Table 3: 2025/26 NHS Minimum (Discharge) Use and Provider Summary					
Original Scheme (Table 2 reference)	**Funding Allocation**	**Scheme**	**Spend**	**Provider**	**TOTAL ADDITIONAL FUNDING BY PROVIDER**
Gap commissioning (2.6)	139,834	Community IV Antibiotics	139,834	**Confed**	**430,000**
Additional admission prevention schemes (2.7)	360,631	Community IV Antibiotics	90,166	**Confed**	
		Same Day Urgent Care Capacity	200,000	**Confed**	
		UCR Capacity	70,465	**CNWL**	**271,000**
Additional discharge support schemes (2.8)	313,510	UCR Capacity	65,035	**CNWL**	
		Homefirst Capacity	135,500	**CNWL**	
		Housing Officer (Discharge)	24,650	**LBH**	**112,975**
		Winter Demand Surge Capacity	88,325	**Independent Sector**	**88,325**
TOTAL	**813,975**		**813,975**	**TOTAL**	**813,975**

SCHEDULE 1E – INTEGRATED CARE AND SUPPORT FOR PEOPLE WITH LEARNING DISABILITIES

1. BACKGROUND

1.1 The subject of this **Schedule 1E** 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 5 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 Northwest London NHS Foundation Trust.

1.3.2 ***Dowry cases*** mean payments made by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. NHS England pays for dowries when the inpatient is being discharged from NHS England-commissioned care, and ICBs will pay for dowries when the individual is being discharged from ICB-commissioned care. Dowries only apply to those people discharged on or after 1 April 2016, and only to people who have been in inpatient care for five years or more on 1 April 2016.

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*** mean 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.

40

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 NWL ICB, 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.

4.9 An annual confirmation of dowry-qualifying individuals will be undertaken by the Council and the ICB. Responsibility for the Council will be with the Assistant Director for Learning Disabilities, Autism and Mental Health Social Work and for the ICB it will be the Head of Joint Commissioning.

4.10 The Partners acknowledge that the number of dowry cases as of 30th September 2025 was five (5).

Referrals to the Service

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

4.11.1 The Council's Preparing for Adulthoood (PfA) Team.

4.11.2 The ICB's CHC Team; and

4.11.3 The CHLDT.

4.12 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

4.13 Where a Service User's circumstances require the intervention of a solicitor the Council will make a referral to the ICB's CHC lead and Head of Joint Commissioning for non CHC cases, 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 2 (*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 **Schedule 1A** of the Agreement.

8.2 The North West London (NWL) Continuing Healthcare Team will be responsible for the budgets of CHC case and Head of Joint Commissioning will be responsible for S117 and Dowry 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 a contract with a provider the Council must secure written approval from the ICB's CHC lead for CHC cases and Head of joint Commissioning for s117 cases 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 or Head of Joint Commissioning 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 Head of Joint Commissioning Team 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 a Local Area Emergency protocol (LAEP) meeting (either face to face or via a MS Teams) 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 Dynamic Support Register (DSR) 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. Any additional professional representation will be determined by the manager with delegated decision-making authority.

8.5.6 Should specialist hospital admission be required funding will need to be approved by the ICB's Head of Joint Commissioning.

8.5.7 Service Users requiring low secure provision following clinical assessment will be discussed with the NWL provider collaborative and ICB Head of Joint Commissioning Team 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 because 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 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 (CHC cases) and Head of Joint Commissioning team (Non CHC case) 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. If 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 Northwest London Integrated Care Board Tele: 0203 114 7157 Email: ian.robinson6@nhs.net	Sean Bidewell/Sue Jeffers Joint Borough Directors NWL ICB (Hillingdon) Tele: 01895 203000 Email: sean.bidewell@nhs.net/ sue.jeffers@nhs.net
2. Chief Nursing Officer Northwest London Integrated Care Board Tele: 0203 114 7168	

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 lead Commissioner

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

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

10.4 ***Stage 1: Escalation to Clinical/Lead 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/Borough Director:*** 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 Assistant Director for Learning Disabilities, Autism and Mental Health Social Work 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 Assistant Director for Learning Disabilities, Autism and Mental Health Social Work, 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 Corporate Director, Adult 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 Corporate Director, Adult Social Care 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 2025/27 based on a fixed cost are as described in table 1 below.

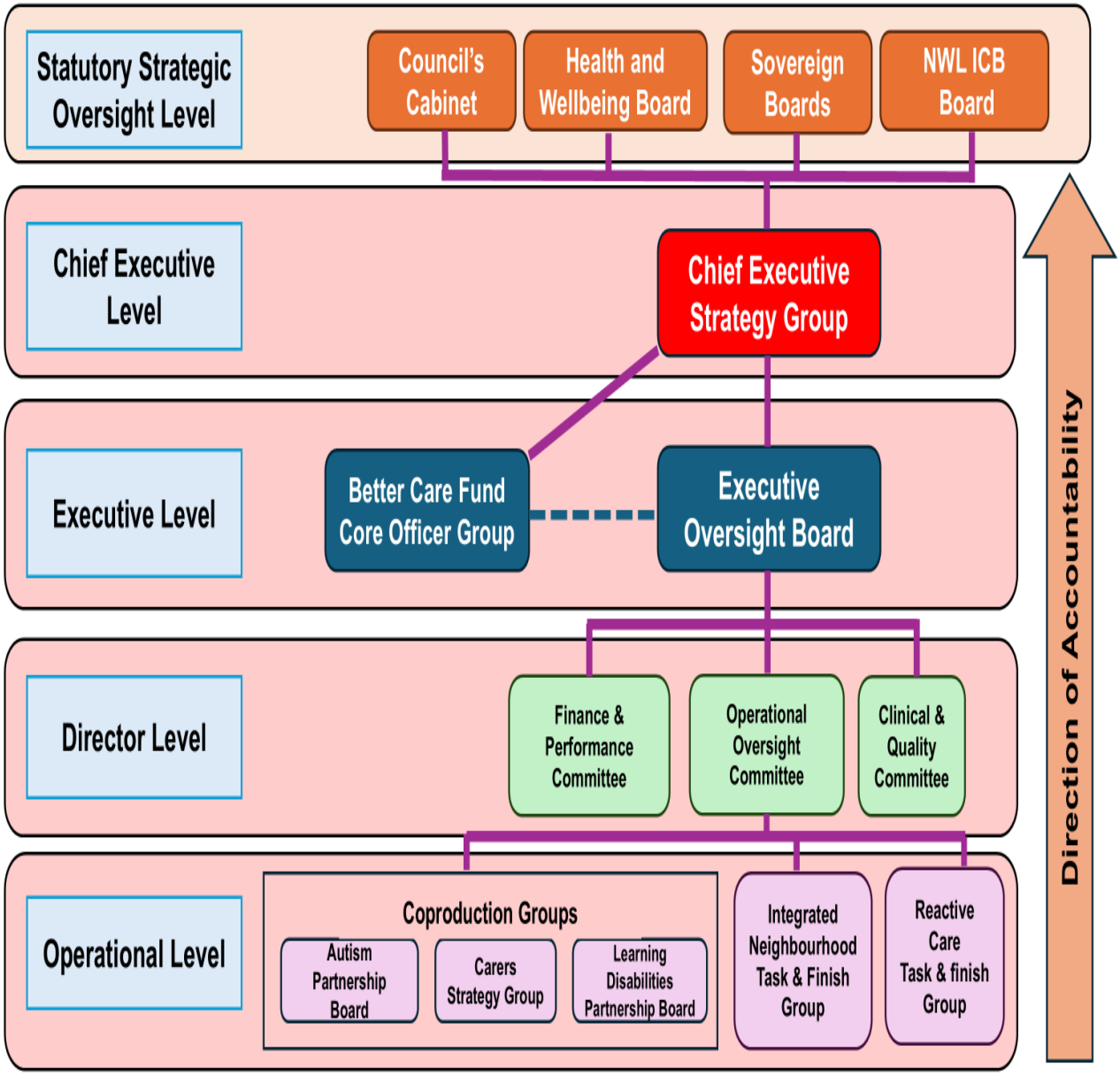
Table 1: LD Case Management Service Costings 2025/26			
Type	**FTE/Service Users**	**Rate**	**2025/26 Cost**
1. Staffing			
• Social Worker (POB grade)	1.5	73,545	**110,318**
2. Accommodation & ICT	1.5	4,500	**6,750**
3. Additional staff support costs, e.g., travel, training, admin, etc.	N/A	7,444	**7,444**
4. Finance cost: payment of providers & recharging ICB	30	320	**9,600**
TOTAL LD CASE MANAGEMENT SERVICE COST			**134,112**
		2025/26 COSTS X 50%	**67,056**

SCHEDULE 2 – 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: Hillingdon Place-based Governance Structure



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 Northwest 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 borough-based partnership.

2.4 Statutory members of the Board include:

- Cabinet Members from the London Borough of Hillingdon
- A representative from Northwest 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 Northwest 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) Chief Executive Strategy Group

2.8 The key purpose of the Chief Executive Strategy Group is to:

2.8.1 Set strategic development of the Place Based Partnership and ensure implementation of integrated care acting under delegated authority from sovereign organisations.

2.8.2 Improve population health outcomes for Hillingdon through collaboration of providers and commissioners.

2.8.3 Ensure alignment of all organisations to the agreed vision and objectives for an integrated care partnership in Hillingdon.

2.8.4 Hold senior responsible officers (SROs) and the Executive Oversight Board to account within their terms of reference.

Group Membership

2.9 The Chief Executive Strategy Group is chaired from among its members on a rotating basis.

2.10 Membership includes chief executive officers of the following organisations:

- The Council
- Hillingdon Hospitals NHS Foundation Trust
- Central and Northwest London NHS Foundation Trust
- H4All
- NHS Northwest London

2.11 The Managing Director for Hillingdon Health and Care Partners is also a member.

2.12 In attendance are also representatives of:

- Healthwatch Hillingdon
- Brunel Partners

Accountability

2.13 The Group is accountable to the Health and Wellbeing Board and their constituent sovereign boards.

Frequency of Meetings

2.14 The Group meets quarterly. Its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.15 The Group may commit resources to the extent of the scheme of delegations within the constituent organisations represented.

c) Executive Oversight Board

2.16 The key purpose of the Executive Oversight Board is to:

2.16.1 Be the overarching decision-making body for the development and implementation of integrated care within delegated authority from sovereign organisations.

2.16.2 Ensure alignment of all organisations to the agreed vision and objectives for an integrate care partnership in Hillingdon.

2.16.3 Lead work at a borough level on delegated primary care co-commissioning.

2.16.4 Coordinate agreed change programmes in line with the NHS Northwest London Integrated Care Strategy and programme of work.

2.16.5 Lead work with the Council on joint commissioning.

2.16.6 Hold committees (see figure 1 to clause 1.1 above) to account.

Membership

2.17 The Board will be chaired on a rotation basis from among its members.

2.18 Membership of the Board will include the following:

- HHCP Managing Director
- Chair (Finance & Performance Ctte)
- Chair (Operational Oversight Ctte)
- Chair (Clinical & Quality Ctte)
- Medical Director, Hillingdon
- Corporate Director, Adult Social Care & Health, LBH
- Director of Public Health, LBH
- Executive Director, Hillingdon Hospitals
- CEO, The Confed
- CEO, H4All
- Chief Strategy & Digital Officer (CNWL)
- Managing Director, CNWL

2.19 In attendance will be a representative from Healthwatch Hillingdon.

Accountability

2.20 The Board will be accountable to the Chief Executive Strategy Group.

Frequency of Meetings

2.21 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

2.22 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) Better Care Fund Core Officer Group

2.23 The key purpose of the Core Group is to:

2.23.1 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.

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

2.24 The Core Officer Group will be responsible for:

2.24.1 Considering the development of the BCF within the context of the priorities of the democratically elected administration of the Council and of the statutory ICB Board.

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

2.24.3 Considering the strategic issues arising from the delivery of the Plan and consulting with the Executive Oversight Board (see clause 2.16) accordingly.

2.24.4 Taking directions from the elected administration of the Council and the statutory ICB Board where required to make informed recommendations to the Executive Oversight Board.

2.24.5 Translating recommendations from the Executive Oversight Board into action.

2.25 The Core Officer Group will also:

2.25.1 Be the escalation point for performance issues requiring urgent remedial intervention.

2.25.2 Report on issues arising from the management of the pooled budget to the Health and Wellbeing Board.

2.25.3 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

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

2.27 Other members include:

- Joint Borough Directors – ICB
- Corporate Director, Adult Social Care and Health – LBH
- Managing Director – Hillingdon Health and Care Partners

Accountability

2.28 The BCF Core Group is accountable to the Chief Executive Strategy Group and informs the Executive Oversight Board.

2.29 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

2.30 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

2.31 The Core Group has no authority to commit resources to the BCF other than those approved by either the Council's Cabinet or the ICB Board.

SCHEDULE 3 – RISK SHARE, OVERSPENDS AND UNDERSPENDS

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 3.**

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 because 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 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.

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

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

3. UNDERSPENDS

3.1 Each Partner 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 4 – 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).