Bevan Brittan

Dated **2015**

LONDON BOROUGH OF TOWER HAMLETS

and

NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES TO DELIVER THE TOWER HAMLETS BETTER CARE FUND PLAN

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THIS AGREEMENT is made on the day of 2015

PARTIES

(1) **LONDON BOROUGH OF TOWER HAMLETS** of the Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG (the **"Council"**)

(2) **NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP** of 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG (the "**CCG"**)

BACKGROUND

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

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Tower Hamlets.

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

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

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

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

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

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

d) support the achievement of the vision for integrated care in the borough for a health and social care Services system that:

i. coordinates care around the patient and delivers care in the most appropriate setting;

ii. empowers patients, users and their carers;

iii. provides more responsive, coordinated and proactive care, including data sharing information between providers to enhance the quality of care; and

iv. ensures consistency and efficiency of care.

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

necessary, and in line with each Partners obligations regarding consultation with affected parties, in respect of any future proposals to vary the plan or individual schemes.

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

1 DEFINED TERMS AND INTERPRETATION

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 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.

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

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

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

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

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

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

Commencement Date means 00:01 hrs on 01 April 2015.

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

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

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

(c) which is a trade secret.

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

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

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

Financial Contributions Proposal means a proposal made by each Partner to a Pooled Fund or Non-Pooled Fund in respect of each Partner's financial contribution for each Individual Scheme subsequent to the first Financial Year's Financial Contributions.

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

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

(g) any form of contamination or virus outbreak; and

(h) any other event,

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

Functions means the NHS Functions and the Health Related Functions

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 each Aligned Fund the Partner that will host the Aligned Fund]

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

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

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

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

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

Law means:

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

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

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

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

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

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

London Living Wage means the hourly rate of pay set by the Mayor of London for residents working in London (as amended from time to time).

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

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

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

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 10.5.

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

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

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2 (for the avoidance of doubt, in Tower Hamlets this is the Integrated Care Board).

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

Permitted Expenditure has the meaning given in Clause 7.3.

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

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

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

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

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

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

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

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

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

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

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

Standing Orders and Standing Financial Instructions (or equivalent) means the Partners' internal constitutional and corporate governance rules detailing the Partners' respective powers and delegations amongst other things.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including but not limited to legal, accounting and auditing costs) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

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

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

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

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

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

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

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

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

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

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

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

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

2 TERM

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

2.2 This Agreement shall continue until 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.

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 establish one or more of the following:

4.1.1 Lead Commissioning Arrangements; and

4.1.2 the establishment of one or more Pooled Fund.

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

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

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

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

5 FUNCTIONS

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

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

5.3 On the Commencement Date of this Agreement the following Individual Schemes will be included in the scope of this Agreement:

5.3.1 Individual Schemes funded from the Better Care Fund:

Scheme	Sub-scheme	Lead Commissioner
Integrated Community Health Team	Integrated Community Health Team Reablement and Rehabilitation Joint Working Pilot Seven day working by the Social Work Team at Royal London Hospital Integrated Health and Social Care Continuing Health Care Assessment	CCG
Mental Health Support and Liaison	RAID Recovery College	CCG
Independent Living	Independent Living	CCG
Integrated Care Incentive Scheme	Integrated Care Incentive Scheme	CCG
Protection of adult social care services (pursuant to Care Act 2014 responsibilities)	Personalisation Carers Information, advice and support Quality Safeguarding Assessment and eligibility Veterans Law reform	Council
Carers	Carers assessments Carers services	Council
Capital funding	Disabled Facilities Grants Social Care Capital Grant	Council

5.3.2 Individual Schemes funded by Tower Hamlets CCG that support the delivery of the Better Care Fund Plan:

Scheme	Lead Commissioner
Social Prescribing	CCG
Additional Community Geriatrician	CCG
Personalisation and Integrated Personal Commissioning	CCG

5.4 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 and shall be completed and agreed between the Partners. The initial Scheme Specification is set out in Schedule 1 part 2 (which may be varied from time to time by the Partners in accordance with the terms of this Agreement).

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 The introduction of any Individual Scheme will be subject to:

5.6.1 a business case (on the respective template of the Partner wishing to propose the same or as otherwise agreed between the Partners); and

5.6.2 approval by the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

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 Specification are commissioned within each Partner's Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

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

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

Appointment of a Lead Commissioner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties (including any Change in Law) and guidance (as amended from time to time) of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts and ensure that effective and timely action to remediate any non-performance is taken;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.7.9 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 a Pooled Fund or Non Pooled Fund.

Responsibilities of the other Partner

6.8 The other Partner, insofar as they are a provider of services under Individual Schemes, shall undertake to provide all necessary performance and financial data necessary to enabling the Lead Commissioner to fulfil the responsibilities at 6.7.

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 such pooled funds for revenue expenditure as set out in the Scheme Specifications.

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

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

7.3.1 the Contract Price*;*

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Third Party Costs;

7.3.5 Approved Expenditure;

7.3.6 any other explicit allowances stipulated in this Agreement; and

7.3.7 subject to Clause 7.4, Permitted Expenditure

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

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

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

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

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

7.6.3 appointing the Pooled Fund Manager;

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

7.7 At the Commencement Date of this Agreement there shall be four (4) Pooled Funds:

POOLED FUND	**LEAD COMMISSIONER**	**HOST PARTNER**
CCG Better Care Fund Core Individual schemes: ➢ Mental Health Support and Liaison ➢ Integrated Care NIS ➢ Integrated Care Community Health Team ➢ Enablers (CCG)	CCG	CCG
LBTH Better Care Fund Core ➢ Mental Health Recovery College ➢ Community Geriatrician ➢ Additional Community Health Teams Investment ➢ 7 day hospital discharge / avoidance and step down ➢ Independent Living ➢ Enablers (LBTH) Specific schemes within core fund for which LBTH is Lead	CCG	Council

Commissioner: ➢ Protection of adult social care services (pursuant to Care Act 2014 responsibilities) ➢ Carers	LBTH LBTH	
Strategy and Development Fund	CCG	Council
Better Care Fund Capital	Council	Council

8 POOLED FUND MANAGEMENT

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

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 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 in respect of each Individual Service where there is a 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 and liaising with Internal and External Auditors as necessary;

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

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.

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

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

8.4 The Partnership Board may agree to the viring of funds between Pooled Funds subject always to the Law and the Partners' Standing Orders and Standing Financial Instructions.

8.5 The Partnership Board may agree to the secondment of employees between Partners for the purposes of managing Pooled Funds or management and delivery of Individual Schemes subject always to the Law, Partners' Standing Orders and Standing Financial Instructions, and the Partners' Human Resource and Managing Organisational Change policies and procedures.

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 for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the 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 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 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 CCG 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 CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 Each Partner shall submit a Financial Contributions Proposal to the Partnership Board not less than 60 Working Days prior to the end of each Financial Year based on a review of the performance of each Individual Scheme from their respective commencement dates.

10.3 The Partnership Board shall submit any Financial Contributions Proposal made by the Partners pursuant to Clause 10.2 to the Health and Wellbeing Board which shall determine the Financial Contribution of each Partner to any Pooled Fund or Non-Pooled Fund for subsequent Financial Year(s) of operation of each Individual Scheme.

10.4 Financial Contributions will be paid as set out in the each Scheme Specification.

10.5 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.

11 NON FINANCIAL CONTRIBUTIONS

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

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 financial risks arising within the commissioning of Services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause 12.3, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.

12.4 Where the Pooled Fund Manager identifies an actual or projected Overspend and notifies the Partnership Board in accordance with Clause 8.9 the provisions of Clause 12.5, 12.6 and Schedule 3 shall apply.

12.5 Subject to Clause 12.6, for twelve (12) months from the Commencement Date of this Agreement the Partners agree that any Overspends occurring in respect of Individual Schemes however such Overspends arise, shall be the responsibility of the Scheme Provider to manage. For the absence of doubt this includes schemes for which the Council is the Service Provider.

12.6 The Partnership Board may agree, in circumstances where an Overspend arises and for which there is a causal relationship to the operation of other Better Care Fund Schemes, to contribute to the mitigation of said Overspend by authorising the virement of funds from elsewhere within the Pooled Fund subject always to there being sufficient capacity within the Pooled Fund to avoid the creation of a consequential Overspend elsewhere.

Overspends in Non Pooled Funds

12.7 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partner's Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

12.8 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund and shall discharge this responsibility in a manner consistent with the responsibilities assigned to the Host Partner by clauses 12.2 to 12.6. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

Underspend

12.9 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the

Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

13.1 With the exception of Pooled Funds covered by clause 13.2, neither Pooled Funds nor Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The elements of the Pooled Funds which relate to Disabled Facilities Grants and to the Social Care Capital Grant shall be treated as capital funds and all expenditure against these funds shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13.3 Any arrangements for the sharing of capital expenditure shall be made separately and in accordance with Section 256 (or Section 76) of the NHS Act 2006 and directions thereunder.

14 VAT

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

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Sections 20 and 21 (whichever is applicable to the relevant Host Partner of the relevant Pooled Fund) of 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 Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("**First Partner**") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("**Other Partner**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

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

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

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

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

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

16.4 Subject to Clause 16.2 and 16.3, if any third party makes a claim against either Partner which gives rise to liability under this Clause 16. and such claim arises from unrecoverable non-performance by a Service Provider which for the avoidance of doubt includes but is not limited to:

16.4.1 a breach of the Provider's obligations under the Services Contract;

16.4.2 a termination event (as defined under the Services Contract) which entitles a third party to terminate the Provider's Services Contract

and all reasonable steps have been taken by the relevant Partner to recover such liabilities, the liability shall be met from the Pooled Funds.

16.5 For the purposes of Clause 16.4, where such action creates an Overspend such expenditure shall be deemed to be Permitted Expenditure under Clause 12.3.

16.6 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.

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

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 in order to fulfil its Best Value obligations.

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

17.4 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful discrimination, harassment and victimisation, and to advance quality of opportunity and foster good relations between different groups and their respective policies. The Partners will maintain and develop these policies as applied to the Services, with the aim of developing a joint strategy for all elements of the Services.

17.5 The Partners acknowledge their respective commitments to the London Living Wage in this Agreement. Where applicable, the Partners shall use their reasonable endeavours to procure that Service Providers commissioned in respect of any Individual Schemes for which the Partners are responsible, accept and agree to the London Living Wage in their Services Contracts.

18 CONFLICTS OF INTEREST

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

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 oversee:

19.2.1 Delivery of commissioned Integrated Care Services provided by the Tower Hamlets Integrated Provider Partnership; and

19.2.2 Development of Integrated Care strategy, including the Better Care 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 19 and Schedule 2.

19.4 The terms of reference of the Partnership Board shall 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.

19.6 The Health and Wellbeing Board shall be responsible for the overall approval of the Individual Scheme, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Partnership Board and Health and Wellbeing Board.

19.8 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Partnership Board and Health and Wellbeing Board.

20 REVIEW

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

20.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 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. A copy of this report shall be provided to the Partnership Board, and subsequently to the Health and Wellbeing Board. 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.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan. The Lead Commissioner will act as the lead Partner in any such engagement with NHS England.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services and shall keep records of all complaints and provide the same for review by the Partnership Board every Quarter of this Agreement (or as otherwise agreed between the Partners).

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification 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 Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

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 and the provisions of Clauses 15 (Audit and Right of Access) 16 (Liabilities and Insurance and Indemnity) 22 (Termination & Default) 25 (Confidentiality) 26 (Freedom of Information and Environmental Protection Regulations) and 28 (Information Sharing).

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

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

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 shall 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 Officers 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 Council's Director of Adult Social Services and the CCG's Chief Officer or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will jointly refer the matter to either (whichever is the sooner):

23.4.1 the next scheduled meeting of the Health and Wellbeing Board for settlement; or

23.4.2 the Partnership Board if the Chair of the Health and Wellbeing Board has agreed to devolve responsibility for settling the dispute to the Partnership Board.

23.5 If the dispute remains after the meeting detailed in Clause 23.4 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

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.

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

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; and

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;

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

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

27 OMBUDSMEN AND PROHIBITED ACTS

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 of them) in connection with this Agreement.

27.2 Neither Partner shall do any of the following:

a) offer, give, or agree to give the other Partner (or any of its officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement or any other contract with the other Partner, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other contract with the other Partner; and

b) in connection with this Agreement, pay or agree to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to the other Partner,

(together "**Prohibited Acts**" for the purposes of Clauses 27.2 to 27.6).

27.3 If either Partner or its employees or agents (or anyone acting on its or their behalf) commits any Prohibited Act or commits any offence under the Bribery Act 2010 with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:

a) to exercise its right to terminate under clause 22 and to recover from the defaulting Partner the amount of any loss resulting from the termination; and

b) to recover from the defaulting Partner the amount or value of any gift, consideration or commission concerned; and

c) to recover from the defaulting Partner any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

27.4 Each Partner must provide the other Partner upon written request with all reasonable assistance to enable that Partner to perform any activity required for the purposes of complying with the Bribery Act 2010. Should either Partner request such assistance the Partner requesting assistance must pay the reasonable expenses of the other Partner arising as a result of such request.

27.5 The Partners must have in place an anti-bribery policy for the purposes of preventing any of their staff from committing a prohibited act under the Bribery Act 2010. If either Partner requests the other Partner's policies to be disclosed then the Partners shall endeavour to do so within a reasonable timescale and in any event within 20 Working Days.

27.6 Should the Partners become aware of or suspect any breach of Clauses 27.2 to 27.6, it will notify the other Partner immediately. Following such notification, the Partner must respond promptly and fully to any enquiries of the other Partner, co-operate with any investigation undertaken by the Partner and allow the Partner to audit any books, records and other relevant documentation.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES AND PUBLICITY

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; and

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) within one (1) Working 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:

29.3.1 if to the Council, addressed to the: Service Head: Commissioning and Health, Education, Social Care and Wellbeing, London Borough of Tower Hamlets, 5th Floor, Mulberry Place, 5 Clove Crescent, London, E14 2BG;

Tel: 020 7364 3131
E.Mail: dorne.kanareck@towerhamlets.gov.uk

and

29.3.2 if to the CCG, addressed to: Deputy Director of Commissioning and Transformation, NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG;

Tel: 020 3688 2518
E.Mail: josh.potter@towerhamletsccg.nhs.uk

29.4 Without prejudice to Clause 26, except with the written consent of the other Partner, (such consent not to be unreasonably withheld or delayed), the Partners must not make any press announcements in relation to this Agreement in any way.

29.5 The Partners must take all reasonable steps to ensure the observance of the provisions of Clause 29.4 by their staff, servants, agents, consultants and sub-contractors.

30 VARIATION

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 subject to the Law and the Partners' Standing Orders and Standing Financial Instructions.

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

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

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 SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

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 Contract 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

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

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

THE CORPORATE SEAL of)
THE LONDON BOROUGH OF)
TOWER HAMLETS)
was hereunto affixed in the presence of:)

Signed for on behalf of NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP

_____

Authorised Signatory

SCHEDULE 1– SCHEME SPECIFICATION

Part 1– Template Services Schedule

TEMPLATE SERVICE SCHEDULE

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

40 OVERVIEW OF SERVICES

40.1 Context and background information

Local Context

Tower Hamlets has a resident population of 242,000 people with an unusually young age profile. Only 7.1% (15,000-18,000) of the population is over 65 with LAPS 1 and 5 having the oldest residents in the area and LAP 8 having a young working population due the presence of Canary Wharf. The population is expected to increase by over 23,000 people up to 2015, an increase of about 10%. The largest growth is expected in LAPs 6 and 8 (over 7,000 people in each, a 28% and 17% increase respectively). The age profile of residents is not anticipated to change dramatically over this time. 50% of the population is classified as white and 33% Bangladeshi although this distribution varies substantially across different age groups. 59% of the 0-20 age range is Bangladeshi, this proportion decreases to 25% of the 20-64 age range (adult) population and just 22% of the 65 years and over population. In contrast, just 21% of the 0-20 age range population is white, rising to 60% of the 20-64 age range population and 65% of 65 years and over population.

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is shorter than national averages (male life expectancy is 75.3 years and female life expectancy is 80.4). Tower Hamlets has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). There are an increasing number of complex patients with co-morbidities, particularly in the 65 years and over age group, and the distribution of these patients varies across the borough. The highest percentages of patients with multiple co morbidities are based in LAPs 1, 6 and 7. Within this there are variances in prevalence of long term conditions across different ethnicities, age groups and genders in Tower Hamlets. Hypertension, depression and asthma are the most common conditions affecting the white population, whereas asthma, diabetes and hypertension are most commonly seen in the Bangladeshi population.

Around 1,140 Tower Hamlets residents will die per year of which around 870 are potentially predictable deaths. The majority of these people will be aged over 65. Tower Hamlets has a higher hospital death rate compared to national (68%) and a significantly lower home death rate (17%) despite people`s preference to die at home. Our aim is that care should focus on reversing/ stabilising or effectively managing deterioration in functional or health status with palliative care as an integral component in line with our shift of focus on palliative care to a wider Last Years of Life perspective.

Integrated Care

The Tower Hamlets integrated care programme is part of the Integration Pioneer WELC integrated care programme. The programme requires that a holistic approach is taken to the management and care of patients. The component services within the programme will be delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes.

The target population for Integrated Care over the next 3-5 years is the same for all providers and is identified as patients who have very high risk, high risk or moderate risk of a hospital admission in the next 12 months and have consented to participate in the programme. Across the borough this makes up the top 20% of the population who is at risk of admission.

Over the year 2014-15, the target population for the Integrated Care programme in Tower Hamlets will be the top 4% of the population who is at risk of admission boroughwide.

40.2 Pooled Funds:

At the Commencement Date of this Agreement there shall be four (4) Pooled Funds:

POOLED FUND	LEAD COMMISSIONER	HOST PARTNER
CCG Better Care Fund Core Individual schemes: ➢ Mental Health Support and Liaison ➢ Integrated Care NIS ➢ Integrated Care Community Health Team ➢ Enablers (CCG) ➢	CCG	CCG
LBTH Better Care Fund Core ➢ Mental Health Recovery College ➢ Community Geriatrician ➢ Additional Community Health Teams Investment ➢ 7 day hospital discharge / avoidance and step down ➢ Independent Living ➢ Enablers (LBTH) Specific schemes within core fund for which LBTH is Lead Commissioner: ➢ Protection of adult social care services (pursuant to Care Act 2014 responsibilities) ➢ Carers	CCG LBTH LBTH	Council
Strategy and Development Fund	CCG	Council
Better Care Fund Capital	Council	Council

40.3 Strategic Objectives

The strategic objectives for each individual scheme are as follows:

40.3.1 Integrated Community Health Teams

The Locality based Community Health Teams will provide an integrated team approach to the care of patients in the community and incorporate the function of the following services:

- Community virtual ward and case managers
- Community rehabilitation and support team (CReST) including the falls team
- Last years of life centre (facilitators and coordinators, service development and MCNS service)
- Adult community nursing (including IV therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hour nursing)

40.3.2 Reablement and Rehabilitation Joint Working Pilot

The service being proposed by two organisations is a joint working process that involves goal planning, interventions and a protocol between the Reablement Service (LBTH) and the Community Health Team therapies (BLT) for the three following user groups :

- Users who present with a physical dysfunction without a diagnostic cause or identified impairment
- User with a cognitive impairment (non-progressive) but who present with potential to improve function
- Users who would benefit from physiotherapy intervention alongside social care / restorative Occupational Therapy input

40.3.3 Social work team 7 day working at Royal London Hospital

The scheme will extend the current hospital discharge team from working Mon – Fri, to a 7 day service. It will have social work staff available to assess and discharge patients on acute wards who are deemed medically fit for discharge at weekends and public holidays. This will free up acute beds within the Royal London Hospital, who otherwise would have to wait until Monday to be assessed and discharged.

40.3.4 Integrated Health and Social Care Continuing Health Care Assessment

This scheme proposes a trial project which introduces joint and coordinated multidisciplinary assessments and care planning which would include CHC checklists, LHNA, DSTs as well Integrated Support Plans (Joint Funded). It would be piloting the concept of joint assessments between community health and social care teams ensuring person centre planning with carers and families from the outset. There is some work to be done about identifying the exact cohort.

40.3.5 Mental Health Liaison (RAID)

The Royal London Hospital Liaison Psychiatry Service is being commissioned to provide a single multi-disciplinary mental health and drug and alcohol assessment service to provide expert advice, support and training to Royal London Hospital clinicians. The Service will be fully integrated into the Royal London Hospital and associated Barts Health sites in Tower Hamlets, and will maintain a very high profile within the hospital.

40.3.6 Re-commissioning of Care Homes and Extra Care Sheltered Housing for people with Dementia

Tower Hamlets Council and CCG are jointly undertaking a review of care homes commissioned for people with dementia in order to improve the quality of the care provided, reduce admission to hospital, and ensure provision is sufficient to sustain future demographic growth.

40.3.7 Recovery College

The Recovery College model complements health and social care specialist assessment and treatment by helping people with mental health problems and/or other long term conditions to understand their problems and learn how to manage these better in pursuit of their aspirations.

By supporting the principle of recovery and progression through course based education and peer support, the Recovery College acts as a bridge to resources already available in the local area (e.g. courses run by local colleges)

40.3.8 **Independent Living**

The strategic objective of the scheme is to develop to better enable vulnerable residents of Tower Hamlets to live independently in their own homes. This will be done primarily by refocusing the Telecare, Community Equipment Service and Assistive Technology services.

The scheme will also consider and evaluate the inclusion of other functions in an integrated service provision model that would provide a single point of contact for service users to access a wide range of services to support their independent living.

40.3.9 **Integrated Care Incentive Scheme**

The introduction of the Integrated Care Network Incentive Scheme aims to incentivise an integrated care approach for patients in the top risk levels in Tower Hamlets.

The Tower Hamlets integrated care programme is part of the Integration Pioneer WELC integrated care programme. The programme requires that a holistic approach is taken to the management and care of patients. The component services within the programme will be delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes.

41 AIMS AND OUTCOMES

41.1 Integrated Community Health Teams

- Provide integrated nursing and therapy care services across the locality ranging from a 2 hour response service to avoid admission to complex case management and promoting self-care
- Systematically identify adults in Tower Hamlets who are most vulnerable/at risk of hospitalisation and provide support and care to these patients which is coordinated and multidisciplinary in approach
- Reduce non-essential use of A&E and unplanned admissions
- Reduce readmission rates within 30 days of discharge from any acute setting
- Assess and support people with Long term conditions in the community, promoting self-management and enabling patients to regain or maintain functional independence and restore confidence within a set timeframe
- Involve patients/service users and carers in planning and providing care;
- Facilitate carer assessment (either by completing the assessment or by referring to other agencies to carry out carer assessment);
- Ensure continuing health care assessment and reviews are completed in line with defined timescales
- Seek to improve health outcomes for the population through strong clinical leadership and governance and ensure productivity, innovation and efficiency are core service deliverables

41.2 Reablement and Rehabilitation Joint Working Pilot

- Better identify the most suitable rehabilitative pathway for service users post discharge from the acute hospital setting
- Reduce 'hand-offs' and changes of key team/worker for the person
- Deliver greater efficiencies for services by getting it right' first time and reducing duplications of effort
- Reduce intervention periods for service users going through health and social care pathways

41.3 Social work team 7 day working at Royal London Hospital

- Demonstrate how a change in working practise in the hospital social work service can deliver better outcomes to patients being discharged from the Royal London hospital.
- Identify potential efficiency savings
- Facilitate and work with any additional Consultants in supporting patients in a timely fashion, who are medically fit for discharge.
- Help reduce any bottle necks occurring over weekends on acute wards, thereby improving patient flow through AAU and A&E.
- Increase availability of beds at weekends by 10%

41.4 Integrated Health and Social Care Continuing Health Care Assessment

- Enhanced quality, choice and control for clients, carers and families.
- Decreased length of stay in hospital wards.
- Greater number of integrated partnerships working across health and social care resulting in a reduction in (re)admissions to hospital, delays in long term care provision and placements in care homes.

41.5 Mental Health Liaison (RAID)

- Improve health outcomes for patients with a mental health or drug or alcohol problem who have been admitted to wards at the Royal London Hospital
- Reduce length of stay for patients with a mental health or drug or alcohol problem who are admitted to wards at the Royal London Hospital
- Reduce readmissions for patients with a mental health or drug or alcohol problem who have been discharged.

41.6 Re-commission Care Homes and Extra Care Sheltered Housing for people with Dementia across LA and NHS

- Deliver an evidence-based framework to explicitly set out our expectations for the care offer to people with dementia living in care homes and ECSH.
- Lever improvements to drive up quality of care provided in Care Homes and Extra Care Sheltered Housing

41.7 Recovery College

- Increased use of scheduled care and decreased use of episodic care
- Decrease or better managed symptoms of mental ill health (anxiety, depression, psychosis)
- Improved mental health well-being
- Reduced social isolation
- Increased Trust roles available for volunteering
- Increased uptake of mainstream adult learning opportunities
- Increased uptake of employment support opportunities
- Increased ability to cope with everyday domestic situations and skills acquired to develop strategies and build resilience
- Increased knowledge of local health care systems and navigation of these (Primary and Secondary care)
- Increased knowledge of local community facilities and the confidence to access them
- Increased uptake of personalisation budgets and choice

41.8 Independent Living Service

- Provision of equipment and a highly responsive service that helps promote safety, peace of mind, security and wellbeing by enabling service users to live more independently in their own homes.
- Provision of equipment and a service that facilitates discharge from hospital.
- Provision of a service that helps support and reassures carers.
- Reduction of preventable hospital admissions
- Provision of an accessible and reliable out of hours referral service.

- Provision of accurate and timely information to Duty Social Workers.

41.9 Integrated Care Incentive Scheme

- Fewer avoidable emergency admissions to hospital [Non elective admissions]
- Shorter admissions and safer discharges with lower readmission rates [Non elective bed days, Non elective readmission within 28 and 90 days, Delayed transfer, Discharge from hospital to residential home]
- Improvement in people dying in the place of their choice
- Impacts on other service utilisation- prescribing costs, planned secondary care, continuing care
- Impact on disease specific care package payment metric performance- we will report metrics for the care packages without frail or complex for payment purposes AND the overall population performance to allow comparison with previous years.
- For those within the integrated care programme who make contact with urgent or emergency care providers/ LAS who have an anticipatory care plan (ACP) the % of people where the ACP is accessed
- People getting the right joined up care at the right time in the right place [SEAs on deaths, audits of unplanned admissions (mandatory for AUA DES target group only)]
- Proportion of local authority spend on nursing and residential care in over 65 yrs
- Quality reviews of care planning outputs

42 THE ARRANGEMENTS

		Sub-scheme	**Lead Commissioner**
1	Integrated Community Health Team	Integrated Community Health Team Reablement and Rehabilitation Joint Working Pilot Seven day working by the Social Work Team at Royal London Hospital Integrated Health and Social Care Continuing Health Care Assessment	CCG
2	Mental Health Support and Liaison	RAID Recovery College	CCG
3	Independent Living	Independent Living	CCG
4	Integrated Care Incentive Scheme	Integrated Care Incentive Scheme	CCG
5	Protection of adult social care services (pursuant to Care Act 2014 responsibilities)	Personalisation Carers Information, advice and support Quality	Council

		Safeguarding Assessment and eligibility Veterans Law reform	
6	Carers	Carers assessments Carers services	Council
7	Capital funding	Disabled Facilities Grants Social Care Capital Grant	Council

	Scheme	**Lead Commissioner**
8	Social Prescribing	CCG
9	Additional Community Geriatrician	CCG
10	Personalisation and Integrated Personal Commissioning	CCG

Pooled Funds:

Pooled Fund	Lead Commissioner	Pooled Fund Manager
Better Care Fund Core (schemes 1,2,3,4) Specific schemes within core fund for which LBTH is Lead Commissioner: ➢ Protection of adult social care services (pursuant to Care Act 2014 responsibilities) (Scheme 5) ➢ Carers (Scheme 6)	CCG LBTH LBTH	CCG CCG CCG
Strategy and Development Fund (Schemes 8,9,10)	CCG	LBTH
Better Care Fund Capital (Scheme 7)	LBTH	LBTH

43 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions)

44 SERVICES

Scheme	*Services*	*Beneficiaries**	*Contracts in place*
Integrated Community Health Teams	Community virtual ward and case managers Community rehabilitation and support team (CReST) including the falls team Last years of life centre (facilitators and coordinators, service development and MCNS service) Adult community nursing (including IV therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hour nursing).	*See**	*Community Health Services Contract with Barts Health*
Reablement and Rehabilitation Joint Working Pilot	- Barts Community Health Team - Tower Hamlets Reablement Service	Users who present with a physical dysfunction without a diagnostic cause or identified impairment Users with a cognitive impairment (non-progressive) but who present with potential to improve function Users who would benefit from physiotherapy intervention alongside social care / restorative Occupational Therapy input	*Community Health Services Contract with Barts Health* *Service Level Agreement in development for Tower Hamlets Reablement Service*
Social Work Team 7 day working Royal London Hospital	*- Social Work Team*	*Patients at the Royal London Hospital who are deemed medically fit at the weekend but require social services support before they can be discharged*	*Service Level Agreement in development for Social Work Team 7 day working*
Integrated Health and		Exact Cohort TBC	

Social Care Continuing Health Care Assessment			
Mental Health Liaision (RAID)	- *Royal London Hospital Liaison Psychiatry Service*	People with a diagnosed mental health condition who present at / are admitted to Barts Health sites. Barts Health Clinical Staff	*Mental Health Contract with East London Foundation Trust*
Recovery College		Stage 1: (Pilot) Mental health service users who have used ELFT (Tower Hamlet) services in the previous 12 months, including those who have been discharged. Stage 2: (Roll Out) Supporters (carers, family, friends) of people using mental health services in Tower Hamlets. ELFT, local authority and voluntary sector staff working within mental health services. Complex co-morbidity – mental health issue and other long term physical condition Groups at risk of emergency hospital admission where effective self-care within a professional/peer supported environment (i.e. recovery college) may reduce preventable admissions.	
Independent Living	- Telecare, Assistive Technology and Community Equipment services	People living with a disability, the elderly or those with a long term illness, who require equipment to help them cope with daily living tasks such as dressing, washing, bathing, or preparing meals.	*Service Level Agreement in development for Social Work Team 7 day working*
Integrated Care Incentive Scheme	- *Integrated Care Incentive Scheme*	All patients who are in the top 4% risk of admission (borough level risk) who are eligible for Level 1 All patients in the four mandatory groups: palliative, heart failure, dementia and	*Network Improved Service Contract with Primary Care Networks*

		nursing home-irrespective of QAdmissions risk. These patients will be eligible for both Level 1 and Level2 All discretionary patients under the previous CC NIS who were identified in the CEG August 2013 baseline search and who were consented into the CC NIS by 31/3/14, irrespective of Q Admissions risk. These patients will be eligible for both Level 1 and Level2 [No further discretionary patients can enter the programme currently]	

***Beneficiaries of services**

All beneficiaries of these services will be residents within Tower Hamlets and graded as being at very high risk of hospital admission, using the Q-admissions rating scale.

Overall inclusion criteria are:

- Patient has a risk score sufficient to qualify them as at least medium risk of admission
- Patient is likely to have at least one long term condition
- Patient has consented to inclusion in the integrated care programme
- Patient is a Tower Hamlet resident (temporary or permanent);
- Over the age of 18 years

45 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

45.1 Commissioning arrangements for each of the schemes are consistent with those set out in the main body of the agreement at, but not limited to, Clause 4: Partnership Flexibilities and Clause 6: Commissioning, Contracting and Access.

45.2 Service Level Agreements will be developed for each of Council's directly provided services that are included in the Individual Schemes.

46 FINANCIAL CONTRIBUTIONS

Contributor	2015/16 (£000s)
LBTH	1629
CCG Mandated	18738
CCG Additional Contribution	183
CCG Strategic Development	852
Total	21402

Deployment of contributions:

Scheme	2015/16 (£000s)
Raid	2106.42
Mental health recovery college	110
Integrated care incentive scheme	1020.746
Integrated community health team	7336.449
7 day working at social work team royal london hopsital	866
7 day hospital discharge	1200
Reablement and rehabilitation	2350
Independent living	1212.187
ENABLERS (see section 7)	198
DFG and CAPITAL	1629
Performance pool	1091.343
Care act implementation	733
Support for carers	697
Strategic development	852
Total	21402.145

47 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund	
Are any amendments required to the Agreement in relation to the management of Pooled Fund	**No**
Have the levels of contributions been agreed? *How will changes to the levels of contributions be implemented?*	**Yes. See S75 for rules on changes**
Have eligibility criteria been established?	**Yes, see scheme descriptors**
What are the rules about access to the pooled budget?	**See S75**
Does the pooled fund manager require training?	**No**
Have the pooled fund managers delegated powers been determined?	**Yes, in line with current SFIs**
Is there a protocol for disputes?	**Yes, see S75**
Audit Arrangements	
What Audit arrangements are needed?	**The current audit arrangements will apply**
Has an internal auditor been appointed?	
Who will liaise with/manage the auditors?	
Whose external audit regime will apply?	
Financial Management	

Which financial systems will be used?	**Existing financial systems in each partner org**
What monitoring arrangements are in place?	**Monthly budget reports** **Monthly provider performance reports**
Who will produce monitoring reports?	**Lead commissioner of that scheme**
Has the scale of contributions to the pool been agreed?	**Yes**
What is the frequency of monitoring reports?	**Monthly**
What are the rules for managing overspends?	**See S75**
Do budget managers have delegated powers to overspend?	**No, see S75**
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?	**See S75**
How will overspends and underspends be treated at year end?	**See S75**
Will there be a facility to carry forward funds?	**See S75**
How will pay and non pay inflation be financed?	**Annual review of budgets in accordance with S75 agreement**
Will a contingency reserve be maintained, and if so by whom?	**Performance pool. See S75**
How will efficiency savings be managed?	**See S75**
How will revenue and capital investment be managed?	**See S75**
Who is responsible for means testing?	**LBTH**
Who will own capital assets?	**NA**
How will capital investments be financed?	**NA**
What management costs can legitimately be charged to pool?	**None, the pool does not currently include management costs**
What re the arrangement for overheads?	**None, the pool does not currently include commissioning overheads**
What will happen to the existing capital programme?	**NA**
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?	**See S75**

48 VAT

VAT arrangements will be in accordance with normal arrangements for the Lead Commissioner

49 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

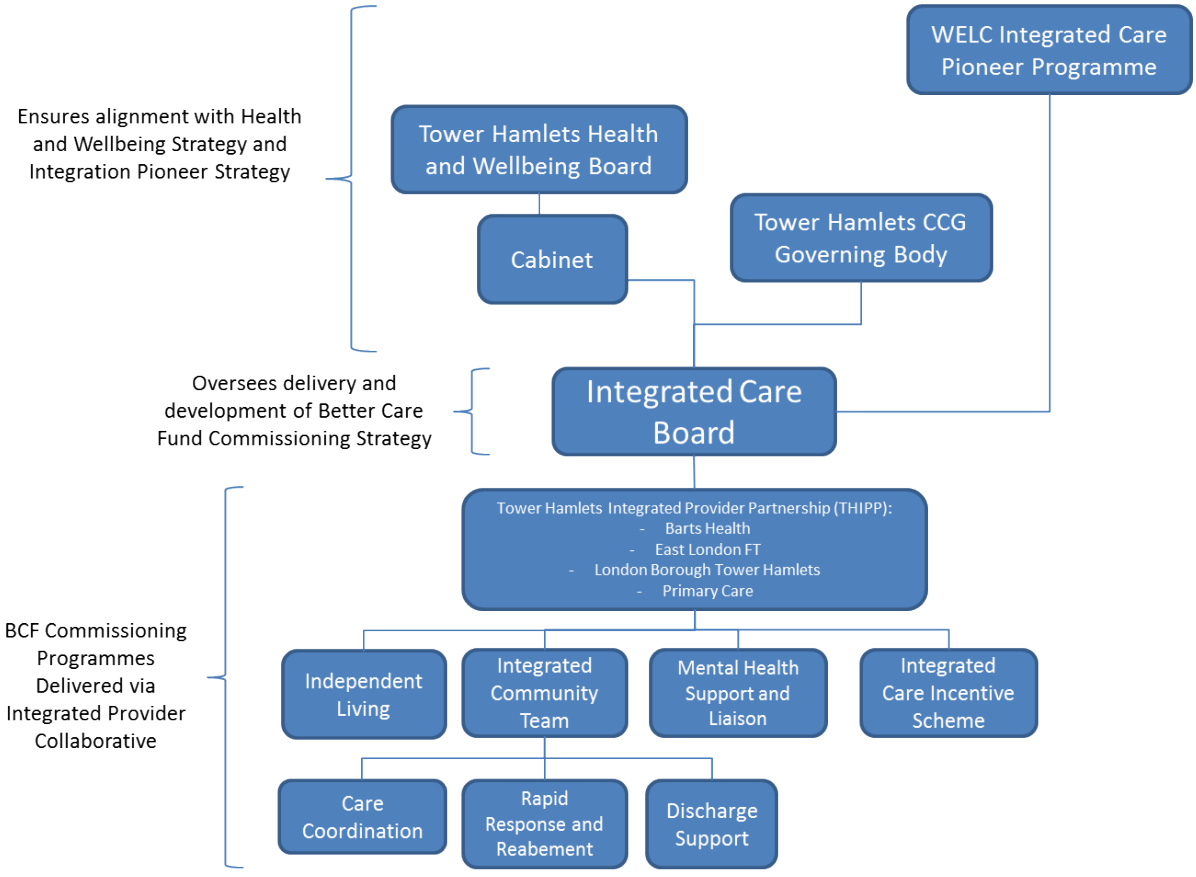
49.1 Integrated Care in Tower Hamlets is overseen and driven by a joint Integrated Care Board (ICB). The ICB includes representatives from:

- CCG and LA commissioners
- Provider colleagues from social care acute, community, mental health and primary care
- Voluntary sector
- Chaired by a provider non Executive director

49.2 The ICB is a formal sub-committee of the Health and Wellbeing Board, as well as being a Tower Hamlets CCG programme board. The Chair of the Integrated Care Board sits on the Health and Wellbeing Board, and Integration is a key strategic priority under the Tower Hamlets Health and Wellbeing Strategy.

49.3 The Integrated Care Board oversees:

- Delivery of commissioned Integrated Care services, provided by the Tower Hamlets Integrated Provider Partnership
- Development of Integrated Care strategy, including the Better Care Fund



50 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

CCG Contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

51 STAFF

To be inserted

52 ASSURANCE AND MONITORING

See Better Care Fund application excel submission

Outcome	Metric	Source	Timeliness
BCF Metrics	See Part 2	See Part 2	Monthly
Emergency admissions for target group	Emergency admissions for target group	Integrated Care Dashboard	Monthly
Readmissions for target group	Readmissions for target group	Integrated Care Dashboard	Monthly
Average length of stay	Average length of stay	Integrated Care Dashboard	Monthly
Total bed days	Total bed days	Integrated Care Dashboard	Monthly
Bed days per 1000 eligible population	Bed days per 1000 eligible population	Integrated Care Dashboard	Monthly
Non-elective admission rate per 1000 eligible population	Non-elective admission rate per 1000 eligible population	Integrated Care Dashboard	Monthly

Number of attendances at A&E	Number of attendances at A&E	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 30 days of discharge	Proportion of patients readmitted to acute hospital within 30 days of discharge	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 91 days of discharge	Proportion of patients readmitted to acute hospital within 91 days of discharge	Integrated Care Dashboard	Monthly
Average acute cost per patient	Average acute cost per patient	Integrated Care Dashboard	Monthly
Avoidable emergency admissions	Avoidable emergency admissions	Integrated Care Dashboard	Monthly

53 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Dorne Kanerack	Education, Social Care and Wellbeing, London Borough of Tower Hamlets, 5th Floor, Mulberry Place, 5 Clove Crescent, London, E14 2BG	020 7364 0497	dorne.kanareck@towerhamlets.gov.uk
CCG	Josh Potter	NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG	020 3688 2518	josh.potter@towerhamletsccg.nhs.uk

54 REGULATORY REQUIREMENTS

See individual service specifications

55 INFORMATION SHARING AND COMMUNICATION

See section 7c in Part One BCF application

SCHEDULE 2 – GOVERNANCE

1 Partnership Board

1.1 The Tower Hamlets Integrated Care Board will act as the Partnership Board defined by this agreement and its Terms of Reference will be amended to encompass the governance arrangements set out in the remainder of this Schedule and elsewhere in this agreement including, but not limited to, Clauses 5,6 and 19.

1.2 The membership of the Partnership Board will be as follows:

Name	Role	ICB function
Alastair Camp	Non-Executive Director, Barts Health	Chair
John Wardell	WELC PMO	CCG Accountable Officer
GP Representative		
Isabel Hodkinson Liliana Risi Victoria Tzortiou-Brown	GP Board lead: IT/Informatics; Last Years of Life Clinical lead:Cancer; Last Years of Life GP Board lead: Integrated Care	Clinical Lead Clinical Lead Clinical Lead
Local Authority Representatives		
Bozena Allen Dorne Karnacek Paul Iggulden Judith Shankleman	Interim Service Head Adult Social Care Service Head: Commission & Health Education, Social Care and Wellbeing (London Borough Tower Hamlets) *London Borough Tower Hamlets -Public Health Department* Associate Director Senior Strategist	Local Authority Social Care Local Authority Public Health Public Health
CCG Representatives		
Josh Potter Julie Dublin Richard Fradgley Danijela Levarda	Deputy Director of Commissioning and Transformation Transformation Manager for ICB Deputy Director of Mental Health and Joint Commissioning Programme Manager (WELC Integrated Care Programme)	Commissioning Commissioning Mental Health Commissioning WELC PMO
NEL CSU Representative		
David Bush	Senior Commissioning Support Manager	CSU Representative
Barts Health Representative		
Steve Ryan Dr Shera Chok Sven Bunn Abigail Jago Fiona Wheeler	Medical Director Director of Primary Care Associate Director of Strategy – Foundation Trust Programme Lead Programme Manager (Integrated Care) – Barts Health Fiona Wheeler	Barts Barts Barts Barts Barts
East London NHS Foundation Trust		
Navina Evans Anna Burnside	Director of Operations Dr Anna Burnside, Consultant Psychiatrist and Clinical Lead Department of Psychological Medicine	East London Foundation Trust East London Foundation Trust
GP Care Group		

Dr Phillip Bennett-Richards	GP Care Group	GP
Tower Hamlets Integrated Provider Partnership		
Dr Phillip Bennett-Richards	GP Care Group	GP
Abigail Jago	Programme Manager (Integrated Care) – Barts Health	Barts
Fiona Wheeler	Fiona Wheeler	Barts
Sven Bunn	Associate Director of Strategy – Foundation Trust Programme Lead	Barts
Navina Evans	Director of Operations	East London Foundation Trust
Bozena Allen	Interim Service Head Adult Social Care	Local Authority Social Care
Navina Evans	Director of Operations	East London Foundation Trust
TH Community Voluntary Sector Representatives		
Zoe Portlock	Director of Services, Bromley By Bow Centre	Community Voluntary Sector
Myra Garrett		Community Voluntary Sector

2 Role of Partnership Board

3 The Partnership Board shall:

3.1.1 Provide strategic direction on the Individual Schemes

3.1.2 receive the financial and activity information;

3.1.3 review the operation of this Agreement and performance manage the Individual Services;

3.1.4 agree such variations to this Agreement from time to time as it thinks fit;

3.1.5 review and agree annually a risk assessment and a Performance Payment protocol;

3.1.6 review and agree annually revised Schedules as necessary;

3.1.7 request such protocols and guidance as it may consider necessary in order to enable teach Pooled Fund Manager to approve expenditure from a Pooled Fund;

3.1.8 provide, at least annually, a report on progress in delivering the Better Care Fund plan to the Health and Wellbeing Board and to the CCG Board. The Partnership Board will report to the same two bodies more frequently by exception in respect of remedial action to address non-performance that it is beyond the delegated authorities of the Partnership Board to resolve.

4 Partnership Board Support

The Partnership Board will be supported by officers from the Partners from time to time.

5 Meetings

5.1 The Partnership Board will meet Quarterly at a time to be agreed within fourteen (14) days following receipt of each Quarterly report of the Pooled Fund Manager.

5.2 The quorum for meetings of the Partnership Board shall be a minimum of one representative (CCG Senior Management Team / LBTH ESCW Directorate Management Team seniority) from each of the Partner organisations.

5.3 Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement at Clause 23.

5.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

5.5 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

6 Delegated Authority

6.1 The Partnership Board is authorised within the limited of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

6.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

6.1.2 authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

7 Information and Reports

Each Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

1. To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund as a result of a failure to fully meet the target for reducing unplanned emergency activity the partners have agreed that the CCG will utilise the withheld Performance Funding as a risk pool to mitigate the direct impact of additional costs incurred in the health system as a result of this failure.

2 The CCG also agrees to give proper consideration to any submission by the Council to the effect that the failure to meet the target for reducing unplanned emergency activity has had a direct and demonstrable impact on the Council's social care budgets by, for example, leading to an increase in permanent admissions to residential care. Where the CCG is satisfied that such an impact is demonstrated the CCG undertakes to give consideration to allocating a suitable proportion of the risk pool to mitigate this impact.

3. The Partners agree that Overspends shall be apportioned in accordance with this Schedule 3.

Pooled Fund Management

4. The Pooled Fund Manager for each scheme within the Better Care Fund Plan will be responsible for quarterly reporting of income and expenditure for each scheme. Clause 8.2.7 of this Agreement defines this responsibility. The income and expenditure reports for each scheme will be incorporated into the Quarterly Performance Report submitted to the Partnership Board.

Overspend

5. Where potential or actual Overspends are reported in respect of any individual scheme the Board shall give consideration to the following options for remediating, subject always to Clause 12.5 of this Agreement:

   - agreeing an action plan to reduce expenditure in the relevant scheme or schemes;
   - identifying Underspends that can be vired from any other Fund maintained under this agreement or outside of this agreement;
   - agreeing additional investment by the respective Partners (in so far as the delegated authorities to Board representatives allow for this);
   - if no suitable investment or reduction in expenditure can be identified, agreeing a plan of action, which may include decommissioning all or any part of the Individual Service to which the Fund relates.

6. The Partnership Board shall act reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints in agreeing appropriate action in relation to Overspends.

7. The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends for which it is not possible or reasonable to identify mitigating action.

8. Overspends which occur in relation to any Performance Payments shall be subject to alternative provisions in the relevant Performance Payment Arrangement, and be apportioned between the Partners pro rata to the value of their respective Financial Contributions (excluding Non-Recurrent Payments) for the Financial Year in respect of which the Overspend occurs.

9. Where there is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates save to the extent that such overspend is not the fault of the other Partner.

10. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2 The Lead Commissioner shall provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 Joint Investigation Reports;

2.6 Service Quality Performance Report;

3 The Lead Commissioner shall consult with the other Partners before attending:

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Commissioner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.2 vary any Provider Plans (excluding Remedial Action Plans);

4.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.4 give any approvals under the Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice;

4.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners acting through the Partnership Board. Such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

7 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3 Each Partner (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

1. The Partners have agreed that the achievement of the benefits it is intended be realised through the successful delivery of the Better Care Fund plan will be measured using three key methods:

   - Monthly activity and progress reporting by Providers to the Partnership Board;
   - Quarterly reporting of the Integrated Care Dashboard, which includes all metrics relevant to Better Care Fund plan delivery, to the Partnership Board; and
   - Use of a Patient Experience Metric being developed for 2015/16 as part of the WELC Integrated Care Pioneer Programme. Quarterly reporting against this metric will be incorporated into the Integrated Care Dashboard for reporting to the Partnership Board.

2. The Partnership Board will use the monthly activity and progress reports for each scheme submitted by Providers as a means of providing early warning of potential non-performance in respect of individual schemes. The Board will be proactive in discussing and implementing remedial actions designed to deal with identified non-performance. A lead Partner or Provider will be identified as being responsible for implementing the necessary remedial actions.

3. Progress in implementing any remedial actions will continue to be reported, by the Lead Partner or Provider, to subsequent meetings of the Partnership Board until such time as the Board is satisfied that the non-performance has been properly addressed and rectified.

4. In circumstances where authority to implement the necessary remedial actions is beyond the delegated powers of the Board or individual Partner or Provider representatives the following escalation procedures shall apply:

4.1 Where the Board as a whole does not have sufficient delegated authority the Chair of the Board will be responsible for escalating to the next meeting of the Health and Wellbeing Board for resolution. In circumstances where this is not practicable, for example because of time constraints, the Authorised Officers for each Partner will seek the necessary authority from their respective organisations.

4.2 Where the issue relates to the delegated authority of an individual Partner or Provider representative, said representative will be responsible for escalating the agreed remedial actions for approval within their own organisation.

5. The Lead Commissioner shall be responsible for presenting the Integrated Care Dashboard, with an accompanying narrative providing an overview of performance against the plan, to the Partnership Board on a quarterly basis. The Board shall use this report to take a more considered and strategic view of progress against the plan as a whole and to consider whether any adjustments across and between individual schemes, additional investment or disinvestment, or other interventions are necessary to maintain the desired level of progress in delivering against the plan.

6. The quarterly report prepared by the Lead Commissioner shall also include the income and expenditure report required by Clause 8.2.7 of this Agreement.

7. Where the wider quarterly review undertaken by the Board identifies potential or actual non-performance against the plan, the process for implementing remedial actions shall be as set out in Clauses 2 to 4 of this Schedule above.

8. The Lead Commissioner shall be responsible for the preparation of the Annual Performance Report to meet the requirements set out in Clause 20 of this Agreement and for presenting it to the Health and Wellbeing Board within the prescribed timescale.

9. As and when directed by the Partnership Board as per Schedule 2, Clause 3.1.8, the Lead Commissioner shall be responsible for preparing exception reports to the Health and Wellbeing Board.

10. The Partners acknowledge that as the WELC Integrated Care Pioneer Programme develops it is likely that the metrics and performance reporting arrangements underpinning the wider Programme

will continue to be refined and developed. The Partners therefore agree to keep the performance arrangements set out in this Schedule and elsewhere in this Agreement under review and to develop them as necessary to maintain continuity with the performance arrangements for the wider Programme.

SCHEDULE 6 – BETTER CARE FUND PLAN

1. The Tower Hamlets Better Care Fund plan, as approved by NHS England on 07 January 2015, can be viewed via the following link: *(Link to be inserted)*

2. The approved plan has the following appendices:

- Appendix A: Integration Function
- Appendix B: WEL 5 Year Strategic Plan "Transforming Services Together"
- Appendix C: Integrated Care Data Analysis (Impact measures)
- Appendix D: NHS & Monitor PILS
- Appendix E: EOI from WELC in co-commissioning primary care
- Appendix F: Specification for Integrated Care Incentive Scheme
- Appendix G: Methodology and rationale for patient experience indicator
- Appendix H: WELC Integrated Care Pioneer Programme
- Appendix I: Summary of the Tower Hamlets Integrated Provider Partnership arrangements.
- Appendix J: Metrics and Key Performance Indicators used in performance managing the RAID service.

3. Each of these appendices can also be viewed via the link at 1. above.

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. The Council and the CCG jointly recognise that each operates in a complex practice, policy and political environment and that from time to time this complexity could give rise to situations where the wider interests of one Partner may create an actual or perceived conflict of interest in respect of delivery of the Better Care Fund plan.

2. Both Partners also recognise that the complexity of the environment in which each operates means that it is incumbent on each Partner to ensure that in planning any investment or disinvestment decisions and/or policy or practice changes any potential impact on Better Care Fund plan delivery is considered and appropriate mitigation sought during the planning of change. In so doing, the Partners wish to reduce the likelihood of conflicts of interest arising inadvertently.

3. The Partners undertake to use best endeavours to minimise the risk of any such conflicts arising, and to minimise the adverse impact should such conflicts (actual or perceived) arise. At all times when addressing any actual or perceived conflicts the Partners will have due regard to the terms of this agreement, and the partnership approach underpinning it, and in particular to the General Principles set out in Clause 3.2 of the Agreement.

4. The Authorised Officers will, in the first instance, seek to resolve any actual or perceived conflict of interest that arises during the term of this Agreement through discussion. While this can be managed informally, a record of the actual or perceived conflict, and of the agreed means of resolving, should be kept by the Authorised Officers and reported to the next available Partnership Board meeting for noting.

5. In circumstances the Authorised Officers are unable to resolve the conflict of interest through informal discussion the Dispute Resolution procedure set out at Clause 23 of the Agreement shall be followed.

6. The Council recognises that its role as both Commissioner and Provider of services means that it is necessary to put additional safeguards in place to ensure transparency of decision making and to assure the CCG that the best interests of the Partnership are the primary consideration with regards to Better Care Fund plan delivery. In order to provide this assurance the Council will:

6.1 Ensure that at all times it is represented on the Partnership Board by at least one senior officer whose job functions are primarily Commissioning based, and who has no line management responsibility (or line management accountability to senior officers) for the delivery of Provider functions;

6.2 Ensure at all times that Commissioning intentions or decisions agreed by the Partners, or made under delegated authority by the Pooled Fund Manager, are not communicated to Provider functions within the Council in advance of their formal communication to the relevant Provider or Providers by the Partnership.

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

1. Information Governance, including assurance of compliance with relevant Laws and the requirements of the Caldicott Guardians for each Partner, is a key component of the WELC Integrated Care Pioneer Programme. Arrangements for ensuring that individually identifiable data is managed securely and in full compliance with all relevant legislative requirements have been or are being put in place via this programme in order to ensure that the sharing of information necessary for delivering properly integrated arrangements can be facilitated. Details of the Information Governance protocols in place to support the Integrated Care Pioneer Programme can be obtained from the WELC Programme Office, currently hosted by NHS Tower Hamlets CCG.

2. The Partners to this Agreement have resolved, therefore, that the Information Governance arrangements to support the delivery of the Better Care Fund plan will be those established for the WELC Integrated Care Pioneer Programme. In particular, NHS numbers will be used as the common identifier for individual recipients of services, and the Council reconfirms its commitment to ensuring that all individual records held pursuant to discharge of its Community Care responsibilities include the individual's NHS number. For the purposes of Better Care Fund plan delivery this commitment extends to individuals aged eighteen (18) and over whose services are being provided under the Children and Families Act 2014 and related legislation and regulation.

3. Each Partner remains at all times responsible, through their own Information Governance arrangements, for assuring themselves that all data sharing and other agreements put in place to facilitate the sharing or transfer of individually identifiable data are compliant with the legislation relevant to that partner and to any internal protocols in place pursuant to ensuring that compliance.