HEALTH & ADULTS SCRUTINY SUB-COMMITTEE

Tuesday, 30 November 2021 at 5.30 p.m.

Committee Room One - Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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Members:
Chair: Councillor Gabriela Salva Macallan
Vice-Chair: Councillor Shah Ameen

Councillor Faroque Ahmed, Councillor Kabir Ahmed, Councillor Shah Ameen, Councillor Denise Jones and Councillor Puru Miah

Substitutes:
Councillor Andrew Wood and Councillor Bex White

Co-opted Members:

David Burbidge	Healthwatch Tower Hamlets Representative
Sue Kenten	Health & Adults Scrutiny Sub-Committee Co-optee

[The quorum for this body is 3 voting Members]

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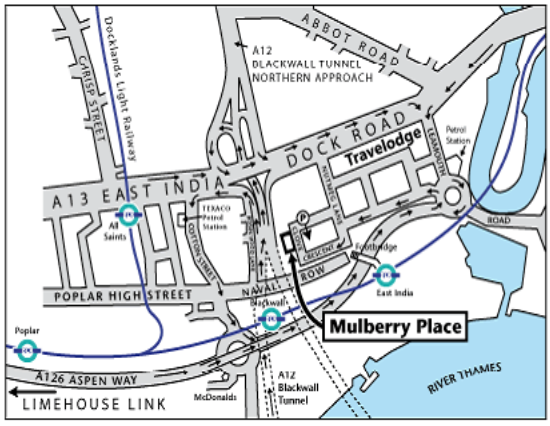

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1.	**DECLARATIONS OF INTERESTS**	**5 - 6**

Members are reminded to consider the categories of interest in the Code of Conduct for Members to determine whether they have an interest in any agenda item and any action they should take. For further details, please see the attached note from the Monitoring Officer.

Members are reminded to declare the nature of the interest and the agenda item it relates to. Please note that ultimately it's the Members' responsibility to declare any interests and to update their register of interest form as required by the Code.

If in doubt as to the nature of your interest, you are advised to seek advice prior to the meeting by contacting the Monitoring Officer or Democratic Services

2.	**PUBLIC QUESTIONS**	

To be notified at the meeting.

3.	**MINUTES OF THE PREVIOUS MEETING**	**7 - 16**
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Next Meeting of the Sub-Committee
The next meeting of the Health Scrutiny Sub-Committee will be held on Tuesday, 8 March 2022 at 6.30 p.m. in Committee Room One - Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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DECLARATIONS OF INTERESTS AT MEETINGS– NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Code of Conduct for Members at Part C, Section 31 of the Council's Constitution

(i) Disclosable Pecuniary Interests (DPI)

You have a DPI in any item of business on the agenda where it relates to the categories listed in **Appendix A** to this guidance. Please note that a DPI includes: (i) Your own relevant interests; (ii)Those of your spouse or civil partner; (iii) A person with whom the Member is living as husband/wife/civil partners. Other individuals, e.g. Children, siblings and flatmates do not need to be considered. Failure to disclose or register a DPI (within 28 days) is a criminal offence.

Members with a DPI, (unless granted a dispensation) must not seek to improperly influence the decision, must declare the nature of the interest and leave the meeting room (including the public gallery) during the consideration and decision on the item – unless exercising their right to address the Committee.

DPI Dispensations and Sensitive Interests. In certain circumstances, Members may make a request to the Monitoring Officer for a dispensation or for an interest to be treated as sensitive.

(ii) Non - DPI Interests that the Council has decided should be registered – (Non - DPIs)

You will have 'Non DPI Interest' in any item on the agenda, where it relates to (i) the offer of gifts or hospitality, (with an estimated value of at least £25) (ii) Council Appointments or nominations to bodies (iii) Membership of any body exercising a function of a public nature, a charitable purpose or aimed at influencing public opinion.

Members must declare the nature of the interest, but may stay in the meeting room and participate in the consideration of the matter and vote on it **unless:**

- A reasonable person would think that your interest is so significant that it would be likely to impair your judgement of the public interest. **If so, you must withdraw and take no part in the consideration or discussion of the matter.**

(iii) Declarations of Interests not included in the Register of Members' Interest.

Occasions may arise where a matter under consideration would, or would be likely to, **affect the wellbeing of you, your family, or close associate(s) more than it would anyone else living in the local area** but which is not required to be included in the Register of Members' Interests. In such matters, Members must consider the information set out in paragraph (ii) above regarding Non DPI - interests and apply the test, set out in this paragraph.

Guidance on Predetermination and Bias

Member's attention is drawn to the guidance on predetermination and bias, particularly the need to consider the merits of the case with an open mind, as set out in the Planning and Licensing Codes of Conduct, (Part C, Section 34 and 35 of the Constitution). For further advice on the possibility of bias or predetermination, you are advised to seek advice prior to the meeting.

Section 106 of the Local Government Finance Act, 1992 - Declarations which restrict Members in Council Tax arrears, for at least a two months from voting

In such circumstances the member may not vote on any reports and motions with respect to the matter.

Further Advice contact: Janet Fasan Head of Legal Services and Monitoring Officer, Tel: 0207 364 4800.

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH & ADULTS SCRUTINY SUB-COMMITTEE

HELD AT 6.32 P.M. ON TUESDAY, 26 OCTOBER 2021

COMMITTEE ROOM ONE - TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Gabriela Salva Macallan (Chair)
Councillor Shah Ameen (Vice-Chair)
Councillor Faroque Ahmed
Councillor Denise Jones
Councillor Andrew Wood

Co-opted Members Present:

David Burbidge	–	Healthwatch Tower Hamlets Representative
Sue Kenten	–	Health & Adults Scrutiny Sub-Committee Co-optee

Apologies:

Councillor Puru Miah

Others Present:

Dr Somen Banerjee	–	(Director of Public Health)
Waleed Fawzi	–	Lead for Mental Healthcare of Older People
Eugene Jones	–	Director of Service Transformation - ELFT
Ellie Kershaw	–	(Tackling Poverty Programme Manager, Benefits)
Carrie Kilpatrick	–	Deputy Director for Mental Health and Joint Commissioning
Joseph Lacey-Holland	–	(Senior Strategy Policy & Performance Officer)
Katie O'Driscoll	–	(Director of Adult Social Care)
Denise Radley	–	(Corporate Director, Health, Adults & Community)
Joanne Starkie	–	(Head of Strategy and Policy - Health Adults and Communities)
David Knight	–	(Democratic Services Officer, Committees, Governance)

1. DECLARATIONS OF INTERESTS

No declarations of interest were received at the meeting.

2. MINUTES OF THE PREVIOUS MEETINGS

3.1 8th June 2021

The Sub-Committee formally confirmed as a correct record the minutes of the last meeting of the Health Scrutiny Sub-Committee held on 8th June 2021. The Chair was authorised to sign.

3.2 16th September 2021

The Sub-Committee formally confirmed as a correct record the minutes of the last meeting of the Health Scrutiny Sub-Committee held on 16th September 2021. The Chair was authorised to sign.

4. MATTERS ARISING

1. **Item 7.3 Health & Adults Scrutiny Sub-Committee - Tuesday, 8th June 2021.** Operation Oak - Departmental and voluntary agency support for asylum seekers.

- The Committee was reminded that there had been discussions on the Home Office housing recovery programme, known as Operation Oak, which is intended to accelerate the movement of asylum seekers out of contingency accommodation into dispersed accommodation across the United Kingdom, in both new and existing dispersal areas.

2. **Item 3.1 Health & Adults Scrutiny Sub-Committee Thursday 16th September 2021** Food Poverty in older people and low-income families.

- The Sub-Committee had considered a report which had summarised what food poverty is and who is affected by it in the London Borough of Tower Hamlets (LBTH). In particular that the food poverty needs of older people and low-income families and the food provision that is in place for these vulnerable groups.

It was **agreed** that these matters would be kept on the action log and the Sub-Committees would receive regular updates.

5. CHAIRS UPDATE

The Chair:

- **Commented** that as one of the Councils representatives on the Inner Northeast London Joint Health Overview and Scrutiny Committee (INEL JHOSC) at the last meeting on Monday 13th of September 2021 there had been a discussion on the Integrated care system (ICS) a substantial change in the way to improve population health and reduces inequalities between diverse groups. The ICS would also be the subject of discussion at the that the Tower Hamlets Health and

Wellbeing Board on 2nd of November 2021. Members of the Sub-Committee will be sent copies of the agenda pack for that Board meeting and have an opportunity to raise formally comments for consideration by the Board.

- **Commented** that (i) she is a Member of the Local Covid Engagement Board that leads on engagement with the public regarding Covid-19 risks and prevention; (ii) she has seen this week an increase in the reported cases of Covid-19; and (iii) she is very happy to take questions from the Sub-Committee on the Board's work.
- **Welcomed** to the meeting Katie O'Driscoll the newly appointed Director of Adult Social Care
- **Reminded** the Sub-Committee that it had been Adult and Social Care Practice week on the 21st of September 2021 and together with a number of other members had undertaken shadowing of Telecare across Adult Social Care.

6. REPORTS FOR CONSIDERATION

6.1 Inpatient dementia assessment services

The Sub-Committee received a presentation from Eugene Jones and Waleed Fawzi East London NHS Foundation Trust (ELFT) and supported by other colleagues who had asked to attend this meeting to outline their proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre. This was originally moved to free up space in Mile End Hospital to make it more Covid secure and to provide existing dementia residents with a step-up offer. The main points of the discussion on the questions raised by the presentation summarised as follows:

The Sub-Committee:

- **Noted** that before the public consultation is launched on the proposals ELFT wanted to check in with Members around their plans and the questions that ELFT were intending to frame around these plans, so as to allow the opportunity to change and reconfigure those as needed before the public consultation commences.
- **Noted** that once this consultation is completed ELFT intend to report back to the Sub-Committee.
- Was **advised** that the Unit is an in-patient dementia assessment unit for older people living in the boroughs of Tower Hamlets, Newham, Hackney and The City of London.
- **Understood** following questions that the Unit provides dementia assessment in the City of London, Hackney, Tower Hamlets and Newham. It is a short-term assessment unit with an average length of stay of six weeks. It provides assessment and treatment for people experiencing complex mental health problems associated with degenerative brain disorders such as dementia.
- Was **informed** that each patient receives a thorough assessment of their needs from a wide range of health professionals. Along with input from families the aim is to provide person centred care by building an

understanding of a person's life history in order to meet their individual needs.

- Was pleased to **note** that in terms of the staff moves to East Ham Care Centre all of the staff that were previously providing the services at Columbia Ward Mile End Hospital would be moved with the patients to the Cazaubon Dementia Assessment Unit.
- **Felt** that the passion of the staff around this care group provides is essential in ensuring a continuity of care given their knowledge of the individuals within this group.
- **Observed** that in terms of the impact on families, ELFT have had positive feedback from service users and the families and ELFT have also put in place a carers questionnaire to identify specific feedback around the nature of travel and any issues that people have experienced.
- Was **told** in response to enquiries that recommended local taxi companies receive vetting in terms of their ability to provide care and support for patients and their families and that ELFT will continue to monitor and to date they have had no negative feedback.
- **Noted** that if service users and carers require support in terms of the journey by their own vehicle ELFT can provide support with that and therefore ELFT has a multi-pronged approach which is not just about taxis but about supporting people so they do not incur any financial hardship as a result of visiting Cazaubon.
- **Understood** that ELFT are having an ongoing dialog with service users and carers on this matter and comments from the carers questionnaire we will be incorporated into the feedback in terms of understanding the impact of the move on carers specifically (**e.g.** in terms of the journeys themselves the focus is primarily carers and family members who are going to visit their family members in Cazaubon).
- **Welcomed** the significant program of capital investment within Casaubon to enhance the area (**e.g.** improve the outside space and garden area to make it more wheelchair friendly and accessible for all and around creating specific clinical space outside of the Unit for people to be isolated away from other patients to prevent cross contamination or infection).
- **Noted** that patients when they are admitted have to be screened for Covid, so as to allow patients to go directly onto the Ward. However, whilst they are waiting for the test results, which can take a few hours and they need to be isolated from other patients. Hence the need for the provision of an isolation area for any new admissions.
- **Understood** that whilst the Unit encourages visitations due to Covid these have had to be curtailed by the restrictions on hospital visits. Although during the pandemic the Unit has adapted its arrangements for contact with friends and family through the digital and technological roots through laptops and arrangements like that so families could still stay in contact with their families' members.
- Following questions raised **observed** that in regard to the carbon emissions ELFT aims to support where carbon neutral.travel.

- **Noted** that ELFT have engaged with Healthwatch to provide support and they have been to visit the Unit and have spoken to service users, carers, and staff. It was noted that all have been complimentary of the service.
- **Noted** that the Care Quality Commission (CQC) the independent regulator of health and social care in England had visited the Unit and stated that **(i)** the staff demonstrated a commitment to the empowerment of the patients by ensuring they were given the appropriate information to understand the different types of support and treatment offered; **(ii)** the patient was at the heart of the process and had been fully involved in assessment and decision making; and **(iii)** the staff were accessible and knowledgeable.
- **Observed** that any consultation material about the Units move needed to be clear, succinct, and easy to understand so as to avoid misunderstandings. It was felt that this was particularly important when the consultation material is about the co-location of medical services.
- **Stated** that it wished to undertake a visit to the Unit at the earliest opportunity and **wanted** to receive the feedback from service users; carers and Healthwatch specifically around travel to help inform future discussions.

In conclusion the Sub-Committee having noted and commented the plans and proposed approach with the public consultation **RESOLVED** that:

1. It wished to undertake a visit to the Unit at the earliest opportunity and receive the feedback from service users; carers and Healthwatch specifically around travel to help inform future discussions.

6.2 Adult Social Care Strategy 2021

The Sub-Committee noted that a new Adult Social Care (ASC) strategy has been developed and will provide clarity of strategic ambitions for the service. It is important that the priorities identified in the strategy reflects the needs of adult social care users and carers and there is space to effectively engage with them. Therefore, the Chair had asked Joanne Starkie and the Health and Social Care Leadership Team to present the strategy and tell the Sub-Committee how it has been developed including next steps. The main points of the discussion on the question raised by the presentation summarised as follows:

The Sub-Committee:

- **Considered** that as health services play a significant part in the life of all local people when they require care is naturally of particular interest to service users, a wide range of individuals, groups, and organisations.
- **Noted** that this Strategy, represents a renewed commitment to engage more effectively within the local community in the future. The Partnership will work to ensure that stakeholders are more aware of the

Partnerships work, successes, and challenges in general on a more regular basis.

- **Noted** that the Partnership will listen and learn from what local people have to say about services and in the development and consideration of options - before change is made or decisions are taken.
- **Noted** that Partners particularly recognise the value and importance of effective stakeholder engagement.
- **Observed** that effective stakeholder engagement requires strong and enduring relationships between the Trust and local people, which continue even in times of challenge or pressure. It relies on having a good understanding of the various perspectives and the respective areas of interest and concern and more lay involvement in the process.
- **Commented** that with regard to the community development it should be better articulated within the Adult Social Care Strategy such as a network of community social work posts which would enable people and groups to be empowered to set up services with the support from the Partnership so that these activities can come to fruition (**e.g.** social services teams and NHS Providers have direct volunteers which is one of the most effective ways to gain meaningful, hands-on experience in the social work field and to help their community).
- In response to questioning was **informed** that in terms of **(i)** how it fits alongside the Adult Social Care Budget the Strategy has been developed with the relevant officers within the Councils Finance Directorate (**e.g.** technology enabled care to provide an opportunity to help relieve some of the financial pressures whilst improving the quality of care); and **(ii)** performance indicators had been one of the main issues raised during the consultation is that it is important to be really clear on what the targets and the measures are within the Strategy (**e.g.** . to develop key performance indicators).
- **Understood** that with regard to the Strategy support is provided to carers through a Carers Support Service (A commissioned service) . and consideration can be given to the design of care services and how they should be shaped going forward. In addition, through engagement and consultation it was noted that more could been done to raise people's understanding of the aims of the Strategy and to explain more about social care packages and how they work.
- **Noted** that there is ongoing pressure on the Adult Social Care Budget that that has continued throughout the Pandemic and development of the Strategy has to be considered in that context and to what is happening with reform of social care on the national agenda over the next two to three years together with the funding uncertainty.
- Following questioning on the workforce issue **noted** there is **(i)** an Ethical Care Charter that applies to home care; **(ii)** a commitment to the London Living wage; and **(iii)** a shared workforce strategy which aims to set out a strategic level the support and improvement with regard to recruitment, retention, and development of staff.
- **Noted** that concerning new technology it should be designed with the needs of the Service in mind to help to meet the agreed objectives
- Was pleased to **note** that **(i)** the significant reliance on agency staff in the past has been reduced dramatically through a very good

recruitment campaign following a restructure; **(ii)** whilst there are one or two hotspot areas that are being worked the work force is broadly stable; and **(iii)** on the commissioned workforce side, there is a stable workforce in the Borough which is obviously a real positive.

- **Noted** that whilst around 67% of the Council adult social care workforce are from Black, Asian and Minority Ethnic Communities LBTH is looking to do improve that diversity picture at the more senior levels within the organisation.
- **Thanked** officers for bringing this to Sub-Committee at short notice and indicated that they would wish to receive **(i)** details of the feedback once receive; **(ii)** and the key performance indicators once they have been aligned; and **(iii)** details of the carers action plan.
- **Indicated** that the Strategy should address improved access to nutritional food and what does that mean.
- **Wanted** to receive details of the **(i)** innovation being undertaken with the alignment of the adult social care budget; **(ii)** the levels of support plans for the innovative technology; and **(iii)** breakdown of the workforce and what is being done to do improve the diversity picture within adult and social care.

In conclusion the Sub-Committee having noted and commented the new Adult Social Care strategy **RESOLVED** that:

1. It would want to receive **(i)** details of the feedback on the Strategy; **(ii)** the key performance indicators once they have been aligned; and **(iii)** details of the carers action plan.
2. the Strategy should address improved access to nutritional food..
3. it should receive details of the **(i)** innovation being undertaken with the alignment of the adult social care budget; **(ii)** the levels of support plans for the innovative technology; and **(iii)** breakdown of the workforce and what is being done to do improve the diversity picture within adult and social care.

6.3 Contain Outbreak Management Fund (COMF)

The Sub-Committee noted that the Contain Outbreak Management Fund (COMF) provides local authorities with financial support to reduce the spread of coronavirus through test, trace and contain activity. Accordingly, the Chair had invited Somen Banerjee, Director of Public Health in Tower Hamlets to set out the use of this fund in the context of the strategic aims of the Local Outbreak Management Plan and help the Sub-Committee explore the wider learning from the approaches that have been taken. The main points arising from consideration of the presentation may be summarised as follows:

The Sub-Committee:

- **Noted** that LBTH is working on the assumption that the Government will ‘clawback’ the Coronavirus (Covid-19) emergency funding given to

local government and that LBTH will need to allocate that funding received before the end of March 2022.

- **Noted** that LBTH is also mindful **(i)** that there are "early signs" that Covid infection levels are increasing; **(ii)** whether there is going to be additional restrictions; and **(iii)** whether funding can be carried over.
- **Noted** that LBTH have in this year has received £11m.
- **Noted** that with the funding there has been a real focus on inequalities and have identified which communities have been particularly at risk so as to develop the outreach that has been commissioned and informed investment in the Community Clinics (CC) and have seen a kind of reversal of inequality.
- **Requested** that the outcome of this activity and good practice developed be shared with the committee.
- **Noted** that the role of the Covid-19 community champions established to empower and support Tower Hamlets residents to stay up to date with the latest advice about Covid-19 is providing information about testing and rapid testing.
- **Noted** LBTH has a real focus on vaccination as whilst over two-thirds of the Boroughs population have been vaccinated there is a challenge around **(i)** uptake of vaccination in the 12- to 15-year-olds; and **(ii)** the Booster Programme which is a major new program that LBTH needs to focus on given the Government's announcement that they wanting to accelerate the booster and the 12- to 15-year-olds vaccination programmes because of the increase in the numbers of Covid cases.
- **Noted** that the improvements around infection control measures in schools; care homes and workplaces which are really critically important for the control of all infectious diseases.
- **Noted** that the vaccination programme for Covid will in the future be the same way as there is for influenza.
- **Noted** that LBTH will continue to support communities addressing inequalities and the impacts of coronavirus which can cause symptoms that last weeks or months after the infection has gone **e.g.** post-Covid syndrome or "long Covid".
- **Noted** that since April 2021 the Council "Call Centre" have had about 28,000 calls of which 90% are vaccine related (**e.g.** booking vaccines for residents).
- **Acknowledged** that whilst the success of the vaccination rollout has paved the way for a gradual lifting of restrictions no vaccine is 100% effective and, like all viruses, Covid can mutate.
- **Noted** that the Councils Call Centre has been able to develop very quickly pathway plans and these plans remain under review.
- **Noted** that the Call Centre Team is continuously working proactively and with the partners and other services to ensure that it is keeping pace to ensure that the residents are getting the most up to date information (**e.g.** for test and trace and referrals on to other services).
- **Agreed** that it wanted feedback on the development of this work to be reported to a future meeting.
- **Noted** that specific expenditure has been transferred to the Call Centre to support specific activities **e.g.** the public helpline, the 3030 number: food support and the local test and trace.

In conclusion the Sub-Committee having noted and commented the Contain Outbreak Management Fund (COMF) **RESOLVED** that:

1. It wished to receive a further report to update on the use of COMF and the development of best practice.

7. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

The Chair:

- Informed the Sub-Committee that subject to consultation with Divisional Director Legal, Governance and Monitoring Officer the next meeting would be held on the 30th of November 2021.
- Reminded Members that the Tower Hamlets Health and Wellbeing Board on 2nd of November 2021 will be considering a report on the Northeast London Integrated Care System (NEL ICS) and that report would be sent to all Sub-Committee Members and they would have the opportunity to raise formally comments for consideration by the Board.
- That the Sub-Committee Work Plan would be circulated for Member's information and comment.
- That officers would be asked to ensure that Members would be informed of all future scrutiny training sessions.

Finally, with no other business to discuss, the Chair called this meeting to a close and thanked the Sub-Committee members, for their attendance and participation.

The meeting ended at 8.23 p.m.

Chair, Councillor Gabriela Salva Macallan
Health & Adults Scrutiny Sub-Committee

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Health and Adults Scrutny sub-committee - Action Log					
Meeting:	**Agenda item:**	**Action:**	**Owner:**	**Deadline:**	**Update:**
16-Sep-21	Operation Oak - Departmental and Voluntary Agency support for asylum seekers	1.0 An update on 'operation oak'. Update should include information on - - what the Council could do to help these asylum seekers with regards to mental health; help for schools in terms of uniform grants; where these individuals will be housed and what access would they have to primary care.	Tracey St Hill / Karen Swift	20 Dec (tbc)	Date: Comment:
	Food poverty - to inform new food poverty strategy	2.1 To review use of community kitchens including schools' kitchens to support families and tackle food security.	Cllr Mufeedah Bustin, Ellie Kershaw and Natalie Lovell	20 Dec (tbc)	Date: Comment:
		2.2 To review benefits of putting food tech/science back on the schools' national curriculum.			Date: Comment:
		2.3 To review the councils' position on the 'right to food' campaign.			Date: Comment:
		2.4 To review how health partners (PCNs, CCG and GPs) support identification of vulnerable people and connect with food hubs.			Date: Comment:
		2.5 To ensure that dashboard holds up to date and accurate data to enable effective targeting of vulnerable people and families.			Date: Comment:

		3.0 To provide a briefing on provisions that have been put in place to support people who used to use Meals on Wheels? (The briefing should include details of any information packs made available to practitioners to use to support older people to look for alternative options. Did we support people who used to use Meals on Wheels with one off payments for white goods such as microwaves etc?)	Katie O'Driscoll	By end of Nov 2021	Date: Comment:
	Impact of covid 19 on Mental Health and mental wellbeing	4.0 Awaiting recommendations	Carrie Kilpatrick	(tba)	Date: Comment:
26-Oct-21	ELFT - Columbia ward (dementia ward) - permanent move to East Ham	5.0 Arrange a visit to Cazabourn ward in East Ham;	Eugene Jones	By Dec 2021	Date: Comment:
		5.1 Share Equalities Analysis with committee;	Eugene Jones		Date: Comment:
		5.2 Provide further details on how service will promote carbon neutral footprint (referring to travel arrangements for patients/families)	Eugene Jones		Date: Comment:
		5.3 Consider suggestions about language in the consultation and provide committee with feedback of consultation outcomes	Eugene Jones		Date: Comment:
	Adult Social Care Strategy	6.0 Provide feedback from the consultation	Joanne Starkie	By Nov 2021	Date: 22.11.2021 Comment: Feedback from consultation has been sent to HASC on 22 Nov.

		6.1 Provide information on strategy KPIs	Joanne Starkie	By Nov 2021	Date: 22.11.2021 Comment: This has now been included in the final strategy. Final Strategy and summary version has been sent to HASC on 22 Nov.
		6.2. Share copy of the Carer Action Plan 2021-22	Shuheda Uddin	By Nov 2021	Date: 22.11.2021 Comment: Carer Action Plan sent to HASC on 22 Nov
		6.3 Provide details of budget	Joanne Starkie	By Nov 2021	Date: 26 Oct 2021 Comment: The budget is £117 million for 2021-22. We spent £118 million in 2020-21. In terms of the strategy: a. Care at home – the spend last year was £25 million; b. Housing with care – the spend last year was £45.1 million on residential and nursing care. There is then additional spend on supported housing and extra-care sheltered housing; c. Direct payments – the spend last year was £10.8 million d. Day time support options – the spend last year was £4.7 million The remainder was spent on staffing costs and a wide variety of preventative support options – these cover work packages 1 and 2 in particular.
		6.4. Information on technology-enabled care in terms of our plans and how to resource these:	Joanne Starkie	By Feb 2022	Date: 22.11.2021 Comment: This information will be shared with the committee by February 2022, as a "diagnostic" review of this topic is currently being carried out.
		6.5 Information on ASC workforce in terms of retention and diversity –	Gianmarco Ciavarro (HR) Ali Kirk (IP team)	By Nov 2021	Date: Comment: Information has been shared with HASC on 22 Nov. Any further queries will be raised with relevant service(s).
	Contain Management Outbreak Fund	7.0 Impact on provision and workforce when COMF funding ends in March 2022?	Somen Banerjee	By Mar 2022 (tba)	Date: Comment:
		7.1 How much of COMF was spent on supporting staff/workforce?	Somen Banerjee		Date: Comment:

	Any Other Business	7.2 What learning and development opportunities are in place for scrutiny members?	Afazul Haque	By Nov 2021	Date: 22.11.2021 Comment: Three training sessions with Centre for Public Scrutiny & Governance have been held for chair and vice chairs. This resource is available to sub-committee members. Any suggestions for training will be considered for future learning and development opportunities programme.

Health & Adults Scrutiny Sub-Committee Tuesday 30 November 2021	
Report of: Jackie O'Sullivan, Chief Executive of the Royal London Hospital, Barts Health NHS Trust	**Classification:** Unrestricted
Restoring elective care and outpatient services at the Royal London Hospital and Barts Health NHS Trust	

Originating Officer(s)	Jackie O'Sullivan, Chief Executive of the Royal London Hospital, Barts Health NHS Trust Kathriona Davison, Director of Operations and Transformation, The Royal London Hospital, Barts Health NHS Trust Ralph Coulbeck, Group Director of Strategy, Barts Health NHS Trust Stephen Edmondson, Consultant Cardiothoracic Surgeon and Chief of Surgery, Barts Health NHS Trust
Wards affected	All wards

REASONS FOR URGENCY

The report was not published five clear days in advance of the meeting. This is due to the additional time required to review the report in order to provide the necessary clearances.

Summary

This report is an update on progress towards recovering elective care and outpatient services at the Royal London Hospital and Barts Health NHS Trust. It also covers the urgent response to dental provision in the London Borough of Tower Hamlets.

Recommendations:

The Health & Adults Scrutiny Sub-Committee is recommended to:

1. Give consideration to this briefing

1 REASONS FOR THE DECISIONS

1.1 This is for information only.

2 ALTERNATIVE OPTIONS

2.1 This is for information only.

3 DETAILS OF THE REPORT

3.1 As a result of the ongoing pandemic we have seen a significant rise in patients waiting for elective outpatient and inpatient care at the Royal London Hospital and across Barts Health NHS Trust.

3.2 Since April 2021, we have been carefully yet speedily restoring patient services that were put on hold during the pandemic. This includes working closely with system partners across north east London and the independent sector to restore levels of service and reduce waiting times in elective surgery, outpatients, and other services. Detailed figures will be included in the appendix titled *'Update on progress towards recovering elective care and outpatient services at the Royal London Hospital and Barts Health NHS Trust'.*

3.3 We are monitoring activity to ensure that services are restored equitably, whilst balancing the need for staff rest and recovery.

3.4 We prioritise patients by the urgency of treatment they require, and the average wait for those needing urgent surgery has reduced significantly.

3.5 In September 2021, the number of patients who were waiting up to one year (52 weeks) for surgery was 8,980. This is a reduction of around 45% from the peak volume we experienced earlier in the year.

3.6 To reduce our non-urgent elective surgery and outpatient appointment waiting lists, we have:

- Established new surgical hubs to treat high-volume, low-complexity cases in the specialities that have the largest waiting lists. These hubs are now open for business and are treating patients.
- Held more outpatients clinics remotely through video and telephone consultations, where appropriate. There has been good uptake and positive feedback from patients for these virtual clinics.
- Introduced 'Super Saturday' clinics, meaning our capacity to see these patients is increased, thanks to more staff working on Saturdays.

- Launched '**Project Tooth Fairy'** in October at the Royal London Hospital. This provides three additional procedure rooms for paediatric dentistry, the specialty that has the most patients who have been waiting up to two years for surgery.
- Ensured that additional Ear, Nose and Throat (ENT) consultants are available across the Trust.
- Secured independent sector capacity in the short term, using our clinicians, but within private premises. We have also been exploring options for mutual aid in specialties with particular capacity challenges.
- Worked with primary care to manage referrals and the optimisation of capacity across the Trust. We have also provided additional advice and guidance to support GP colleagues and manage patient expectations.
- Partnered with Communitas, an NHS provider of specialist community services, to triage and reduce the backlog of ENT patients who are waiting for an outpatients appointment. This will result in approximately 4,000 patients being transferred to this new pathway.

3.7 We are regularly communicating the measures in place across the Trust to ensure people know what they can expect when they come to our hospitals.

3.8 At the Royal London Hospital and Barts Health NHS Trust, we will continue to be flexible over the coming months, particularly as we enter winter and its associated pressures, ready to adjust to changing circumstances as we have been doing over the last 18 months.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Update on progress towards recovering elective care and outpatient services at the Royal London Hospital and Barts Health NHS Trust (**Presentation – tabled**)

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- NONE

Officer contact details for documents:

Lisa Dinh, External Relations Manager, Barts Health NHS Trust
l.dinh@nhs.net

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Health & Adults Scrutiny Sub-Committee Tuesday 30 November 2021	
Report of: Denise Radley, Corporate Director, Health, Adults and Community	**Classification:** Unrestricted
Adult Social Care Budget	

Originating Officer(s)	Denise Radley, Corporate Director, Health, Adults and Community
Wards affected	All wards

REASONS FOR URGENCY

The report was not published five clear days in advance of the meeting. This is due to the additional time required to review the report in order to provide the necessary clearances.

Summary

A presentation is tabled for the meeting which will highlight the overall budget for adult social care, the position at month 6 of the 2021/22 financial year, delivery of savings and pressures/risks going forward and the approach to managing these.

Recommendations:

The Health & Adults Scrutiny Sub-Committee is recommended to:

1. Note the presentation, raise any questions and provide any feedback.

1 REASONS FOR THE DECISIONS

1.1 No decisions required. This is for information only.

2 ALTERNATIVE OPTIONS

2.1 This is for information only.

3 DETAILS OF THE REPORT

3.1 A presentation is tabled for the meeting which will highlight the overall budget for adult social care, the position at month 6 of the 2021/22 financial year, delivery of savings and pressures/risks going forward and the approach to managing these.

3.2 Adult Social Care sits within the Health, Adults & Community directorate and comprises the Adult Social Care division (all of the operational services) and the Integrated Commissioning division. The budgets for these divisions need to be viewed together and the total budgets for 2021/22 are £97,891,358 and £9,090,890 respectively.

3.3 The presentation supplements the Month 6 budget report being presented to the Cabinet on 24 November 2021.

3.4 A report on the Better Care Fund, one element of the adult social care budget, is the subject of a separate report to the Committee on 30 November 2021.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- NONE

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- NONE

Health and Adults Scrutiny Sub-Committee

30th November 2021

Adult Social Care Budgets

Health, Adults & Community Revenue Budget Monitoring Summary Period 6 2021-22

	2021/22 Projected Outturn @ Period 6		
Service	**Current Budget ***	**Projected Outturn Period 6**	**Projected Variance Period 6**
Adult Social Care	97,891,358	101,652,110	+3,760,752
Integrated Commissioning	9,090,890	7,499,082	-1,591,808
Community Safety	5,588,519	5,684,798	+96,279
Public Health	36,350,890	36,350,890	+0
Total HAC	**148,921,657**	**151,186,880**	**+2,265,223**

* Budgets subject to Budget Realignment exercise by December 2021

Savings

Title	Service Area	Savings Achievement Status	2021-22 Savings Target £'000	2022-23 Savings target £'000	2023-24 Savings target £'000
Helping People with Learning Disability live Independently	Adult Social Care	Delivered / On Target	254	-	
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - Hotel in the park	Adult Social Care	Delivered / On Target	20		
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - MHA/Advocacy	Adult Social Care	Delivered / On Target	70		
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - Rethink	Adult Social Care	Delivered / On Target	150		
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - MH Supported Accommodation	Adult Social Care	Delivered / On Target	570	-	
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - Direct payment support	Integrated Commissioning	Delivered / On Target	20		
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - Information and Advice - Advocacy (cross cuttings)	Integrated Commissioning	Delivered / On Target	35		
Efficiencies in Commissioned Services for Adult Social Care (part of the £1m saving) - Information and Advice	Integrated Commissioning	Delivered / On Target	135		
Promoting Independence and in Borough Care for Adults with Disabilities (Split of Saving = £247k CLDS, £200k CMHT, £253k Localities)	Adult Social Care	Slipping but Achievable	700	-	
Accommodation and support for single homeless people	Integrated Commissioning	Delivered / On Target	343	350	

			2021-22	2022-23	2023-24
Title	**Service Area**	**Savings Achievement Status**	**Savings Target £'000**	**Savings target £'000**	**Savings target £'000**
Merging of the physical disability day opportunities service with the Riverside Day Service	Adult Social Care	Delivered / On Target	316	-	
Changes to the adult social care charging policy	Adult Social Care	Delivered / On Target	231	-	
Integration of Tower Hamlets short-term support services - rehabilitation and reablement	Adult Social Care	Delivered / On Target		100	
Technology-enabled care	Adult Social Care			100	
Tenant Activity Pot (TAP) activities programme	Integrated Commissioning	Delivered / On Target	299	-	
Adults Transport savings	Adult Social Care	Delivered / On Target	100	100	
Day Opportunities - day centres redesign	Adult Social Care	Delivered / On Target	252	-	
Integrated Commissioning staffing reductions	Integrated Commissioning	Delivered / On Target	202	-	
Hostels and Substance Misuse	Integrated Commissioning			-	100
Review Telecare model	Adult Social Care	Delivered / On Target	71	71	

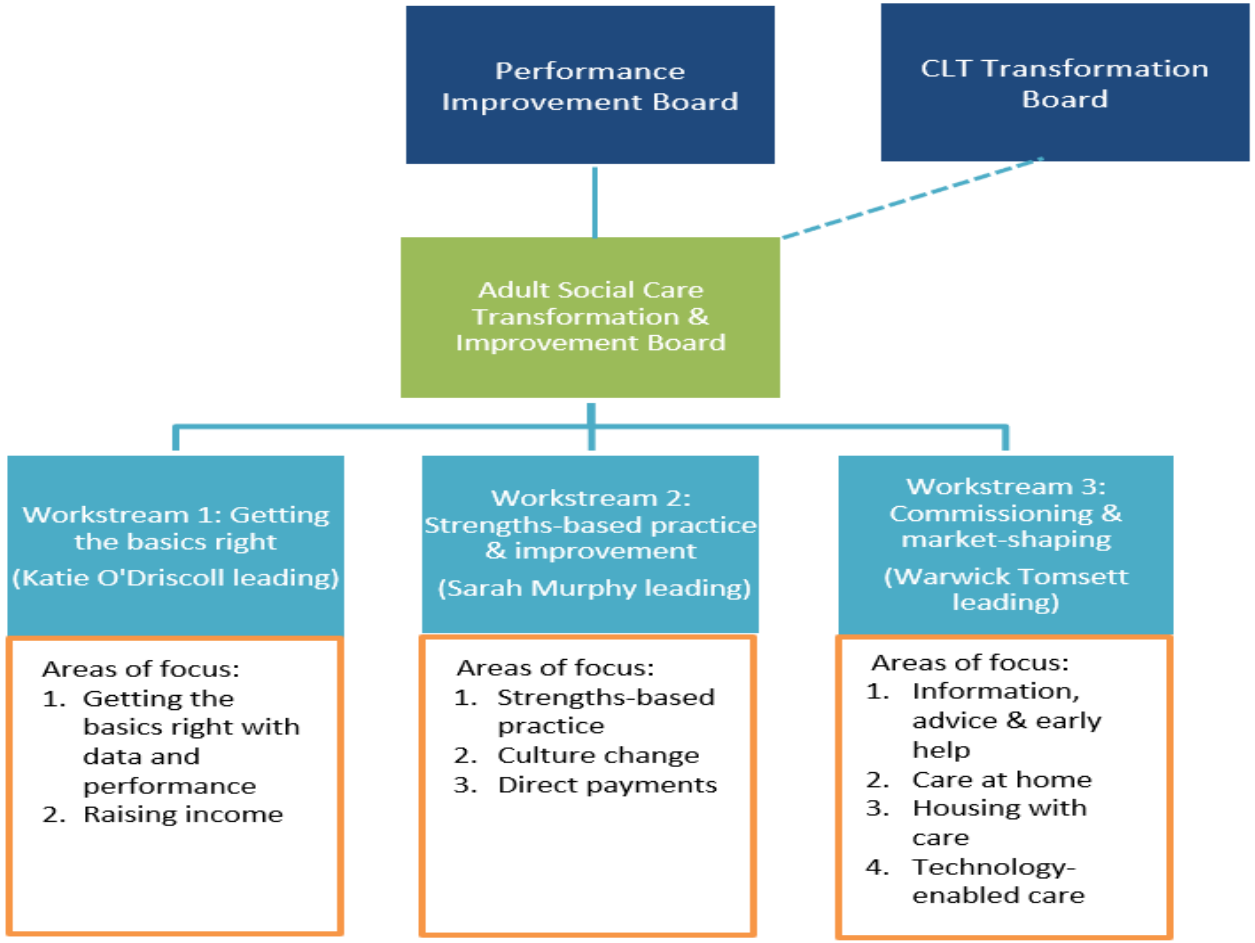
Pressures – Care Packages

- Care and Support Plan Assurance Meetings (CSPAM) data clearly demonstrates the increasing needs and complexities of clients, with additional 1-1 support and 24-hour homecare packages being required to meet growing demand.
- Data from the 1st April to the end of September 2021 shows:
  - 385 care packages increased on review – an additional pressure of £2.829m in full year estimated costs
  - 206 care packages reduced on review - a £3.804m reduction in full year estimated costs
  - 208 care packages unchanged on review
- The net impact of CSPAM to date is a reduction of £0.975m indicting the value of the CSPAM oversight.
- There have been 233 new packages of care totalling £1.979m in full year costs.
- The number of packages that have ceased during the same period is not yet available.

Approach

- Budget realignment
- Working to upskill our budget managers in line with the corporate finance improvement programme
- Data Quality
- Adult Social Care Improvement Programme

Improvement Programme



Winter Funding

Description of the scheme	Key partners	Benefits expected from the scheme	Cost of the scheme
North East London CCG additional clinical resource to support with increase discharge and assessment capacity of patients. Proposal is requesting one nurse and one Social Worker	ELFT and LBTH	*Reduction in number of days for Social Work allocation delay. * Reduction in number of days in the completion on Continuing Health Care Checklist upon discharge. *Improvement of completion rate and timescales for Continuing Health Care assessment upon discharge. *Increase in capacity to support with out of hours and weekend discharges.	£60,000
Social Worker resource in A&E/AAU and to enable extended day coverage up until 8pm Mon-Fri	LBTH	To increase social work capacity to avoid admissions	£25,900
Social Worker resource to Outreach to other North East London Integrated Discharge Hubs to facilitate discharges for Tower Hamlets residents from other out of borough hospital sites	LBTH	Increase social work capacity for Tower Hamlets residents in other hospitals	£25,900
Additional social work capacity in the IDH to respond to surges during winter	LBTH	To increase social work capacity to reduce Length of Stay	£51,800
Social Workers for Initial Assessment Hospital Discharge cluster inc facilitating step-down bed discharges	LBTH	To increase social work capacity to reduce Length of Stay	£52,000
Brokerage Officer Capacity	LBTH	To increase capacity of brokerage to reduce potential delays in social care packages	£11,200
Outpatient Parenteral Antimicrobial Therapy Nursing	ELFT	Reduce Length of Stay by increasing intravenous antibiotic at home capacity in the community	£40,000
Infection Prevention and Control support within the social care system	CCG	Reduction in risk of care home closure to admissions due to outbreaks Reduces risk of spread within social care setting which helps on admission avoidance	£77,633
Trusted Assessor	LBTH	Reduction in Length of Stay for patients to return back home	£80,000
		Total	**£424,433**

Risks

- Overview to Audit Committee – October 2021
- Adult social care pressures are a significant risk to the Council's corporate budget position
- Demography funding is capped within the current MTFS – need to determine future approach – a cap is a risk based approach that recognises uncertainty and complexity
- Covid funding 20/21 and 21/22 mean some atypical income and expenditure patterns
- Significant risk of NHS discharge funding ending
- Uncertainty of social care reform, care cap, White Papers

Total Claimed via NHS Discharge Funding April to October 2021

TOWER HAMLETS

Service	April & May Claim		June Claim		July Claim		August Claim		September Claim		Total Claimed Apr-Sept	
	Cost in Month £'000	No Packages in month	Cost in Month £'000	No Packages in month	Cost in Month £'000	No Packages in month	Cost in Month £'000	No Packages in month	Cost in Month £'000	No Packages in month	Cumm Packages	Cumm Amount £
Pathway 1	465.66	275	208.72	117	178.44	104	98.38	93	102.13	88	677	1,053.33
Pathway 2	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0	0.00
Pathway 3	41.00	11	31.04	18	51.96	21	29.16	17	44.60	17	84	197.76
Designated Care Setting	33.97	10	16.70	5	17.27	5	17.27	5	19.57	5	30	104.78
Hospice	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0	0.00
Other Care Accomodation	3.16	7	4.57	3	2.43	2	0.43	2	0.58	2	16	11.17
Other	2.79	4	0.80	1	4.49	3	0.00	0	1.69	3	11	9.76
Total HDP Claim	**546.57**	**307**	**261.83**	**144**	**254.60**	**135**	**145.23**	**117**	**168.58**	**115**	**818**	**1,376.81**

Service	H1 claim Oct		H2 Claim Oct		Total Oct Claim		
	Cost in Month £'000	No Packages in month	Cost in Month £'000	No Packages in month	Cost in Month £'000	No Packages in month	Cumm Packages
Pathway 1	2.50	8	133.91	100	136.41	108	785
Pathway 2			0.00	0	0.00	0	0
Pathway 3	13.66	5	34.45	11	48.10	16	100
Designated Care Setting			0.00	0	0.00	0	30
Hospice			0.00	0	0.00	0	0
Other Care Accomodation			17.48	3	17.48	3	19
Other			3.81	4	3.81	4	15
Total HDP Claim	**16.16**	**13**	**189.65**	**118**	**205.80**	**131**	**949**

Projected CCG NHS Discharge Funding 2021/22 £3 - £4m

Health & Adults Scrutiny Sub-Committee Tuesday 30th November 2021	
Report of: Warwick Tomsett, Joint Director of Integrated Commissioning	**Classification:** Unrestricted
Better Care Fund 2021-22 update	

Originating Officer(s)	Phil Carr Strategy and Policy Manager Suki Kaur Deputy Director of Partnership Development
Wards affected	All wards

Executive Summary

The Better Care Fund (BCF) is aimed at bringing together heath and social care organisations to plan, fund and commission integrated services.

This presentation seeks to provide a timely update of recent actions relating to the BCF which will include an overview of the considerations and outcome of our internal BCF review, updating on proposed and future changes to the BCF (including areas for future integration) as well as providing an update on changes made to our recently submitted 2021-22 Better Care Fund plan and associated Section 75.

Recommendations:

The Health & Adults Scrutiny Sub-Committee is recommended to:

1. Note the presentation and provide feedback on proposed areas of integration for 2022-23.

1. REASONS FOR THE DECISIONS

1.1 Following the recent submission of our 2021-22 BCF Plan to the national team for assurance it is felt that now is an opportune time to update the Health & Adults Scrutiny Sub-Committee on the current and planned developments of the Better Care Fund.

2. ALTERNATIVE OPTIONS

2.1 N/a

3. DETAILS OF THE REPORT

8.1 The Better Care Fund (BCF) is aimed at bringing together heath and social care organisations to plan, fund and commission integrated services.

8.2 The BCF was introduced in 2016-17 for implementation and has effectively been rolled over year on year while we await the outcome of a national review of the programme. Our local BCF programme was rolled forward into 2020/21 (as advised by our regional BCF team).

8.3 National guidance for 2021-22 Plans was received on the 30th September 2021 with a requirement for local areas to submit returns on the 16th November 2021 (our 2021-22 Plan is attached as an appendix).The key difference in the BCF guidance this year has been the introduction of three new health metrics around 'avoidable admissions', 'length of stay' and 'discharge'. The length of stay metric will be the particular focus of the national assessors.

8.4 We have met all the national conditions set out in the guidance. With the delay in the BCF guidance being issued, in TH we took the initiative earlier in the year to review our BCF and made some changes. These were completed with CCG and LA finance colleagues and have since been updated within our Section 75 and signed off by both CCG and LA legal and finance colleagues. Our Section 75 for 2021-22 has already been signed-off and the key changes were presented at the Health and Wellbeing Board in September 2021.

8.5 Tower Hamlets Together Executive Board (which reports into the Health and Wellbeing Board) provides strategic oversight of the schemes that sit within the BCF. Generally, as the Fund sits within Integrated Commissioning team there is visibility of the range of budgets across the system, and a recognition that these are the areas where resources need to combine in order to deliver our collective priorities.

8.6 Note that funds contributed to the BCF by CCGs are repurposed from existing revenue. The iBCF grant to Local Authorities is the only external funding associated with the BCF. Currently budgets are aligned within the BCF i.e.

CCG and LBTH manage their own schemes and budgets. Service areas have been identified for further pooling or aligning budgets from 2022-23.

4. EQUALITIES IMPLICATIONS

4.1 The Better Care Fund is focussed on integrating health and social care services to better support people with a diverse range of illnesses and conditions. These include people with mental health problems, people at risk of being admitted to hospital and people being discharged from hospital with appropriate support. It also funds Reablement which supports people to learn or relearn skills necessary for daily living following ill-health or disability; the adaptation of the domestic accommodation of people with disabilities to enable them to live at home, and the training of staff in the use of assistive technology.

4.2 As the Better Care Fund is used to fund a number of schemes across health and social care, equalities issues are picked up within each of these individual schemes.

5. OTHER STATUTORY IMPLICATIONS

5.1 Better Care Fund is concerned with achieving best value in the health and social care economy, by ensuring that services are provided most appropriately across the system and that the allocation of resources supports efficiency improvements, as well as better outcomes for service users. It also seeks to reduce the historic problem of financial savings in one sector being achieved at the expense of additional costs in the other, through better joint planning and shared priorities.

Linked Reports, Appendices and Background Documents

Linked Reports

- None

Appendices

- BCF Plan 2021-22 (Planning template and narrative plan)
- Section 75 2021-22

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:
Phil Carr, Strategy and Policy Manager
Phil.carr@towerhamlets.gov.uk

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BCF narrative plan template for Tower Hamlets

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Tower Hamlets

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

Strategic Approval

The 2021-22 BCF plan has been agreed by:

- Denise Radley – Director of Health, Adults and Community for the London Borough of Tower Hamlets. Councillor Rachel Blake who is the lead member for health and Chair of the Health and Wellbeing Board has been briefed on the return.
- Siobhan Harper – Transformational Director for North East London CCGs working specifically with Tower Hamlets, Newham and Waltham Forest.

The Better Care Fund is overseen by the Health and Wellbeing Board and the Tower Hamlets Together Executive Board. Both these Boards are made up of a wider range of stakeholders from across our health and care system including voluntary sector representatives.

Timescales have not allowed the 2021-22 plan to be submitted for approval prior to 16th November. The plan will be considered by the Tower Hamlets Health and Wellbeing Board for approval on the 1st December. The board membership includes the London Borough of Tower Hamlets council officers who manage Adults and Health, Children Services, Public Health, NHS North East London Clinical Commissioning Group (NEL CCG), Royal London Hospital (part of Barts Health NHS Trust), East London Foundation Trust, GP Care Group, Healthwatch and Council for Voluntary Sector (CVS).

The 2021-22 BCF plan is an evolution of the 2020-21 arrangements. The priorities have been developed through the Tower Hamlet Together (THT) Executive Board, the borough based integrated health care partnership, which includes key members from the Health and Wellbeing Board.

Prior to the planning guidance being released, we used the initiative to carry out a local review of the BCF. It was important to take stock on what's been delivered, what's worked, lessons learnt and understand how the scale of ambition for integration will be delivered. In essence, the priority for 2021-22 is to develop a plan for the plan. These conversations have been within health and the council mainly and we will start VCS and resident involvement in the New Year (2022) once the local ICS arrangements gain clarity.

The tight deadlines provided to develop the plan have limited the scale of engagement on the specifics of the 2021-22 BCF Plan.

We have a smaller working group between the Council and the CCG which includes finance leads where we work on the details of the plan.

A joint finance report which includes the BCF is presented to the Tower Hamlets Together Executive Board on a quarterly basis alongside a joint performance report.

For more information about our health and care partnership – Tower Hamlets Together – please visit https://www.towerhamletstogether.com/about/the-board

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

Our priorities and work programme for 2021-22 is below. The programme is overseen by our newly developed Local Delivery Board (LDB) which is chaired by our CEO of the GP Care Group and is attended by key operational leads from across our health and care partnership.

Local Delivery Board – the overall programme management of the 42 individual transformation projects are themed under the following five headings:

1.Care Close to Home - maintaining people's independence in the community
2.Hospital to Home -reducing the time people need to stay in hospital
3.Prevention -building the resilience and wellbeing of our communities
4.Mental Health and Learning Disabilities
5.Children and Young People

The following are the key priorities from our work programme which fall under each of the five headings and are delivered by our integrated lifecourse workstreams:

1. **Children and Young People –Born Well and Growing Well workstream**

•Children's mental health and emotional wellbeing
•Special Education Needs and Disabilities
•Childhood Obesity
•Ways of working –including pathways for long term conditions, a shared practice framework, a shared model of locality and Multi-Disciplinary Team working

2. **Mainly Healthy Adults –Living Well workstream**

•To improve the experience of residents accessing reproductive health services (e.g. sexual health, contraception, termination of pregnancy) through a joint commissioning approach across the CCG and Local Authority.
•Developing and implementing virtual health checks.
•Integration of IT across pharmacy and GP for living well services.
•Implement the local physical activity programme jointly with Public Health and Primary Care
•Deliver the Covid-19 Vaccination Programme across Tower Hamlets
•Integrate the Community Phlebotomy service

3. **Complex Adults –Promoting Independence workstream**

•Develop a plan for wider implementation of Personalisation and Personal Health Budgets.
•Establishing a new model of homecare which includes MDT approaches e.g. working closer with District Nursing.
•Redesign of older people's day centre provision.
•Developing an integrated rehab/reablement service

Whilst the three workstreams continue with delivering against their priority areas for their chosen population segment, the Local Delivery Board agreed it needed to keep a tighter focus on the following 6 and 12 month priority areas as their core focus. These were the areas felt as key to supporting the recovery from the Covid-19 pandemic and preparing for any future waves of the virus.

6 month priorities (April 2021 to Sep 2021)

- Delivering the Covid 19 vaccinations programme
- Implementing the MDT and Care Coordination model to 1) improve MDT identification and care planning for people who are vulnerable which includes providing them with 2) integrated care plans 3) care co ordination and 4) case management approach
- Embedding and improving our integrated discharge pathway to support discharge for patients at the Royal London Hospital who no longer meet the criteria to reside. Ideally within 24 hours.

12 month priorities (April 2021 to March 2022)

- Improving CYP mental health services and access
- Delivery of expanded CAMHS crisis service to meet the 35% access standard for CAMHS services & delivery of CAMHS ED waiting times standard
- Consider adding additional CYP schemes to the BCF and Section 75 (where appropriate and beneficial)
- Establishing a new model of Homecare to ensure that the model of home care responds to the specific needs/aspirations of the population and exploits the opportunities for integration with health, e.g. district nursing and social prescribing
- Reviewing the ASD pathway - all services within the pathway to have a collective understanding of the immediate and long term priorities/objectives in supporting children and families from pre diagnosis through to transition into adult services. All services to have closer dependencies and join up in meeting the agreed objectives
- Enhancing our EOL care offer - work with Primary Care to identify people in the last months/year of their life but are not on the palliative care register; Once identified work with multi-disciplinary teams to undertake holistic needs assessment and then develop a person centred plan for the patients.

The Local Delivery Board (LDB) takes on the operational focus from the Tower Hamlets

Together Executive Board. The programme plan for the LDB includes some of the schemes from the BCF plan such as reablement, discharge and community health and care teams.

Key changes in the BCF Plan for 2021-22
With the delay of the official BCF guidance, we took the decision locally to review our BCF and make changes ahead of the official guidance. The key changes from the 2020-21 BCF are below:

New schemes added for 2021-22
- Brokerage support for hospital discharge (£100,778)
- Adult Learning Disability Services - Lead on Hospital Admission and Discharge (£27,853)
- Initial Assessment Service - Support for Hospital Discharge (£66,327)
- Initial Assessment Service - Support for Safeguarding (£55,706)
- AMHP Service - Support for Hospital Discharge (£66,327)
- Practice Development - OT Joint Practice Lead (£30,000)
- Locality Development Fund (£968,487)

Key changes to the Section 75 for 2021-22
- Community Equipment Service now shown as separate lines split across Medequip contract, contribution to Telecare and Independent Living Hub, Pharmacy Prescription and Wheelchair Service. Allocation from minimum and additional contribution shows 50/50 spilt between LA and CCG.
- Carers Services renamed to Carers Support to better reflect nature of the scheme (Carers Centre and subscriptions)
- Community Outreach Service and Dementia Café combined into one scheme now called 'Dementia Diagnosis and Community Support'
- Two iBCF schemes added to the main BCF 'Shared Lives' and 'Developing Capacity in Learning Disability'
- Local Incentive Scheme renamed to 'Locality Development Fund CCG contribution' and combined with LA contribution to create circa £1M pot to support strategic development of localities (further integration of PCNs into THT for e.g.)

It would be ideal if planning for the future years BCF e.g. 2022-23 onwards could be started prior to the next financial year, so that we can tie this is with the operating frameworks for the CCG and Councils. We would like to better reflect our BCF in future years with our local place based developments in line with the ICS changes. Therefore, timely BCF planning guidance would support this ambition.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Strategic oversight of the Better Care Fund in Tower Hamlets is devolved from the Health and Wellbeing Board to the Tower Hamlets Together (THT) Executive Board.

The Tower Hamlets Together Executive Board

- Oversees joint strategic commissioning of services in Tower Hamlets for children and young people, adults and public health.
- Coordinates the development of joint strategies for the relevant service areas and ensure necessary arrangements are in place to implement strategies and procure service changes.

- Oversees strategic market development and management, and oversee plans to re-commission and de-commission services, aligning this work with joint strategic procurement plans.
- Reports key decisions to the Tower Hamlets Together Executive and related Delivery Boards as well as to relevant executive and governing bodies of the CCG and Council.

The THT Board is based on a joint working group structure and includes members from;

- London Borough of Tower Hamlets (Council)
- North East London Commissioning Alliance (formerly THCCG)
- East London Foundation Trust
- Barts Health
- Tower Hamlets Council for Voluntary Services
- GP Care Group

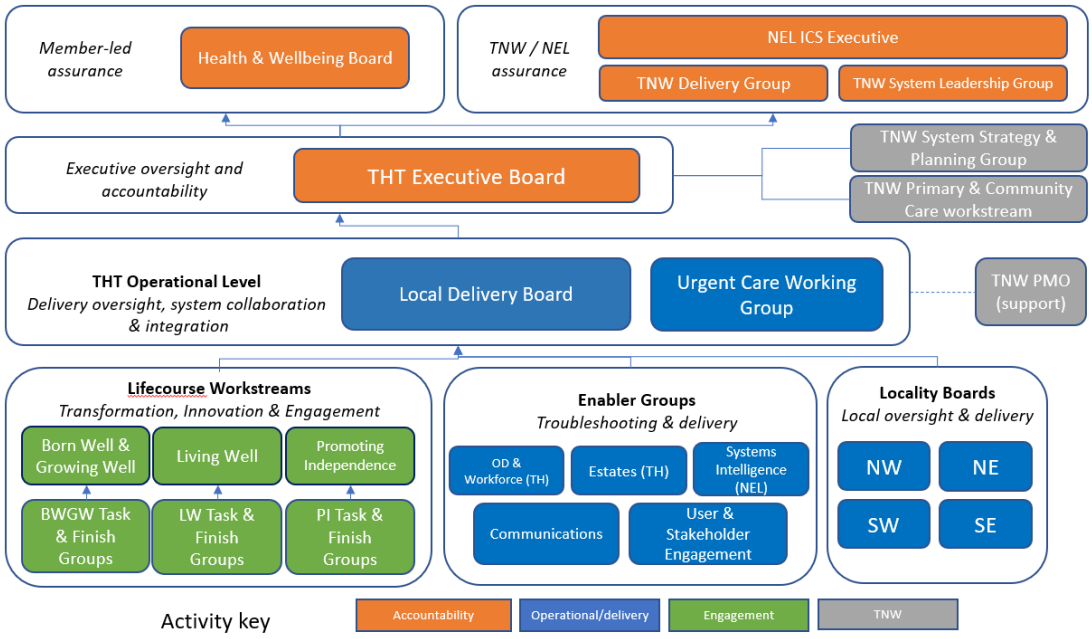
Members have delegated responsibility from the partner employing them to make decisions which enable the THT Executive Board to carry out its objects, roles, duties and functions.

The Tower Hamlets Together Executive Board is responsible for the overall approval of Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

Each Scheme Specification confirms the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Tower Hamlets Together Executive Board.

The Partners produce a Quarterly Finance Report which is presented to the THT Executive Partnership (and Health and Wellbeing Board at least annually) and sets out information as required by national guidance and any additional information required by the Health and Wellbeing Board or relevant partners (for e.g. finance data and updates on metrics).

A copy of the Tower Hamlets Together structure is below.



Note that TNW stands for Tower Hamlets, Newham and Waltham Forest (the Barts Health footprint)

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

For a number of years Tower Hamlets has been on a journey towards integrated, person and community-centred care – from the original integrated care model primarily for over 65s with complex needs leading to attaining Vanguard status; to the decision in 2017 to establish the Alliance Partnership to deliver the Community Health Services (CHS) with greater focus on population health and establishing a lifecourse focus in 2018; and in 2019 to transition from the development stage of the community integration work to delivery at scale focussing on four care models.

All partners have shared how hard this journey has felt, even at the best of times – and in common with systems across England and around the world, never have the challenges for us individually and collectively been greater than in the recent months of the Covid-19 outbreak.

In February 2020 we committed to the next phase of our health and care integration as part of the WEL and NEL ICS developments – with shared priority areas of implementing our Primary Prevention, Complex Care, Urgent and Long Term Conditions Models; transforming

our Community Mental Health Services; mobilising our Community Assets; working with our Voluntary and Community Sector partners; and further strengthening our four localities and Primary Care Networks – no-one could have foreseen what the next phase would fully bring.

Since the beginning of March 2020, when the history of our partnership working currently as Tower Hamlets Together (THT) became the epicentre of our work with local partners on supporting each other in responding to Covid-19 – bringing together, as it has, on a weekly basis senior representatives of the acute, community, mental health, social services, primary care networks, voluntary and community sector, CCG and broader council – we have solidified the foundations of a system that we believe will enable us to drive improvements in health and wellbeing, reductions in inequalities, and the sustainable use of our collective resources to meet current and future demand across these areas and our health and wellbeing priorities as a whole.

Following on from the unprecedented challenges of re-purposing our health and care systems to meet the challenges of Covid-19, the process of continuing to manage safety and risk; capacity and flow; support for both existing and new long-term conditions and care needs; and of accelerating the journey of integration across the partnership; is an even bigger ask of our workforce, our relationships, and all of those who are involved in delivering care in our communities.

As we recognised in February 2020, our four locality Health and Wellbeing Committees covering the eight Primary Care Networks will be critical to the success of this, with primary care at the heart of our borough recovery plan. But it is only by working together as a single team, in support of all of the people of Tower Hamlets, that we will succeed in delivering safe, effective care which harnesses the diverse assets of our organisations and our partnership – enabling all of those we care for to 'Start Well', 'Live Well, Work and Age Well'.

Tower Hamlets Together – System Plan

Overall our partnerships ambition can be explained through the following mission, vision, objectives and priorities for action.

Mission
Transform people's health and lives in Tower Hamlets, reducing inequalities and reorganising services to match people's needs

Vision

- Tower Hamlets residents, whatever their backgrounds and needs, are supported to thrive and achieve their health and life goals, reducing inequalities and isolation

- Health and social care services in Tower Hamlets are high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care

- Service users, carers and residents are active and equal partners in health and care, equipped to work collaboratively with THT partners to plan, deliver and strengthen local service

Objectives

- Transform health and tackle inequalities Achieve better health and wellbeing outcomes for all Tower Hamlets residents, as set out in the THT Outcomes Framework, shaped by local people

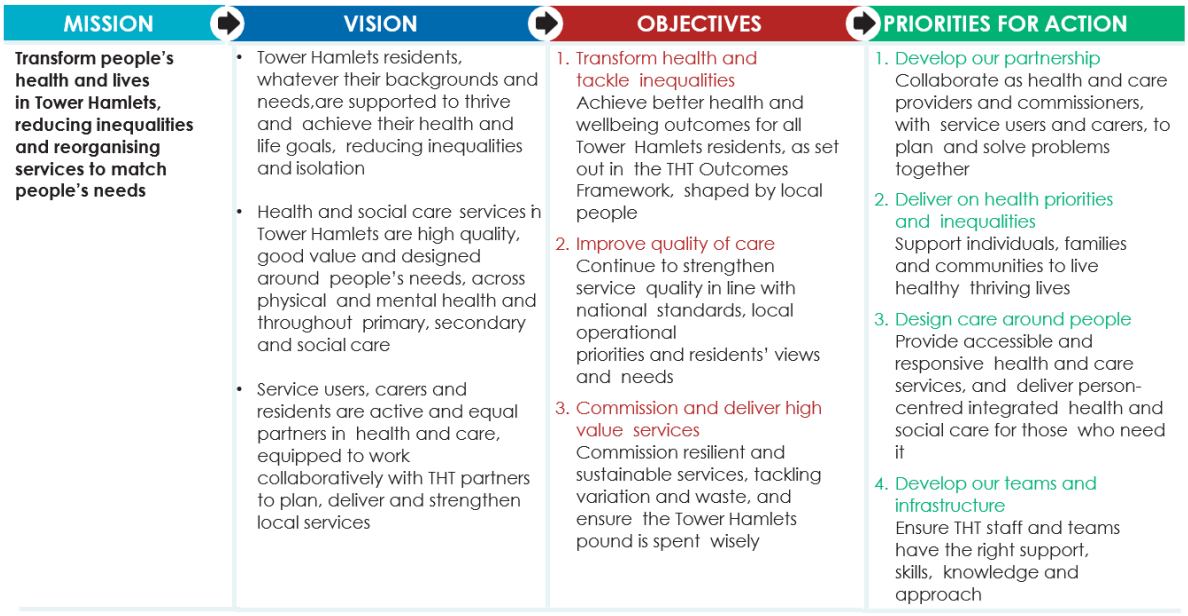
- Improve quality of care Continue to strengthen service quality in line with national standards, local operational priorities and residents' views and needs

- Commission and deliver high value services Commission resilient and sustainable services, tackling variation and waste, and ensure the Tower Hamlets pound is spent wisely

Priorities for Action

1. Develop our partnership Collaborate as health and care providers and commissioners, with service users and carers, to plan and solve problems together
2. Deliver on health priorities and inequalities. Support individuals, families and communities to live healthy thriving lives
3. Design care around people Provide accessible and responsive health and care services, and deliver person-centred integrated health and social care for those who need it
4. Develop our teams and infrastructure. Ensure THT staff and teams have the right support, skills, knowledge and approach

Our system plan on a page



Our Vision Through Our System Wide Outcomes Framework

As a partnership we have co-produced a series of 'I' statements with local residents that articulate their aspirations for improving health and wellbeing, and include statements such as 'I play an active part in my community', 'I feel like services work together to provide me with good care' and 'I have a good level of happiness and wellbeing'.

These statements are broken down across five domains: 'Wider Determinants of Health', 'Healthy Lives', 'Quality of Life', 'Quality of Care & Support', and 'Integrated Health and Care System'. Each domain and statement has a narrative and a set of indicators to measure progress towards the outcome and proposed aspirational indicators that could be adopted across the system and are increasingly being used by colleagues from providers across the partnership develop and plan services, helping to build a consistent, system-wide approach. For example the 'I'-statements have been used by commissioners when designing service

specifications and by policy teams when developing borough-wide strategies.

For more information on our Outcomes Framework, please visit https://www.towerhamletstogether.com/the-challenge/outcomes-framework

Domain	I-Statement			
Integrated health and care system	I feel like services work together to provide me with good care	I believe the trust, confidence and relationships are in place to work together with services to decide the right next steps for us as a whole community		I want to see money being spent in the best way to deliver local services
Wider determinants of health	I am able to support myself and my family financially	I am satisfied with my home and where I live	I am able to breathe cleaner air in the place where I live	I feel safe from harm in my community
Healthy Lives	I am supported to make healthy choices	I understand the ways to live a healthy life		
Quality of Care & Support	Regardless of who I am, I am able to access care services for my physical and mental health	I am able to access safe and high quality services (when I need them)	I am confident that those providing my care are competent, happy and kind	I have a positive experience of the services I access, overall
Quality of Life	I have a good level of happiness and wellbeing	I am supported to live the life I want	My children get the best possible start in life	I play an active part in my community

Key developments since March 2020

At the start of the Covid-19 outbreak in London, a decision was taken to co-ordinate the Tower Hamlets response through the Pandemic Committee, chaired by Tower Hamlets Council's Director of Public Health, with senior representation from all local partners. Reporting to the Pandemic Committee group were various silver operational groups, including a Health & Social Care Operational Group chaired by the Joint Director of Integrated Commissioning. There has been significant learning, with much more to do, but examples of the achievements across the partnership since the beginning of March 2020 include:

- **Collaboration with providers** –we refocused to ensure daily contact with our main providers – care homes, home care agencies and hostels had priority focus but also including our day centres and our mental health and learning disability providers, as well as our carers centre and local link services. We provided high levels of support in terms of public health advice, PPE mutual aid arrangements and testing.
- **Integrated Discharge Hub** - a multi-disciplinary team established from ELFT's Admissions Avoidance Discharge Service, the Councils Hospital Social Work Team, ELFT Continuing Healthcare Team and LBTH Reablement and Brokerage. The team are responsible for all hospital discharges from the Royal London Hospital, including non-Tower Hamlets patients. Between March – May over 300 patients were referred, with just over 50% of these Tower Hamlets residents. 90% of patients were successfully discharged home. 10% were discharged to nursing and residential homes, supported accommodation, and newly commissioned step-down facilities. 25% of patients were discharged the same day, and over 50% within 1 day.
- **Adapting services** – primary care provided staff and patient testing directly in Care homes and GP's provided support for homeless people in the special hostels. GP practices switched swiftly to remote consultation including health checks where possible to limit unnecessary contact/journeys, using video/telephone consultation
- Direct Payments – we put in place a 10% contingency for all residents who receive direct payment and provided PPE for those who needed it. We provided advice and

support across the board and worked closely with our local disabled people's organisation, the local provider of direct payment support and others to produce local advice and guidance. We focused on strong communications to promote this.

- Community mobilisation –supported the co-ordination of the community efforts around wellbeing, befriending etc.
- **Home monitoring service** – provided by General Practice for COVID symptomatic patients to avoid face to face care, reduce conveyances and enable safe discharge home
- **Shielding -** worked closely across the partnership to ensure the most vulnerable in our borough were identified, contacted, and supported. A contact operation was established with GPs, Council and health partners calling vulnerable residents.
- **Travel Assistance** – whilst the number of children requiring home to school travel assistance reduced, the team continued to support those families of key workers and vulnerable children to safely attend school where possible. As well as this the team used their skills and experience to offer a service to Royal London Hospital to increase transport capacity should there be a need for mass discharge of none Covid patients.
- **Homelessness & rough sleeping** - close working with housing meant an effective approach in terms of homelessness, rough sleepers and our large hostel population. This has included additional accommodation for homeless people and linking GPs and health service support around those sites; and ensuring our settings are prepared for managing outbreaks, supporting social distancing and self isolation etc.
- **PPE** –rapidly created a team, a process and a supply chain to ensure we had sufficient PPE for staff and for our commissioned services, and with clear guidance in place about when and how to use this – despite the difficulties nationally with PPE.
- **Placements** –increased the system wide collaboration between the Children's Integrated Commissioning Team, the Children's Placement Team, SEND and Children with Disabilities, utilising existing structures and arrangements, namely the local area risk register meetings to care plan and source placements, using our collective capacity and resources to increase capacity. This approach kept some of the children with the most complex and challenging behaviours safe and at a reduced risk of requiring tier 4 MH services.
- **Financial support and market sustainability**-moved swiftly to change payment and contractual arrangements for our home care providers and commissioned care homes

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The Integrated Discharge Hub (IDH) was established on 30th March 2020, following the publication of the national service requirements on hospital discharge on 19 March 2020

- The requirements set out that all hospitals must have a 8-8/7 day a week discharge service, which is able to facilitate the timely discharge of all medically optimised patients

- In Tower Hamlets the service pulled together in just over a week as a multi-disciplinary team established from ELFT's Admissions Avoidance Discharge Service, the London Borough of Tower Hamlets Hospital Social Work Team, ELFT

Continuing Healthcare Team, as well as LBTH Reablement and Brokerage.

Overall the hub is responsible for coordinating care for all residents on pathways 1, 2 and 3 who are residents of our borough. This includes arranging packages of care, ordering of equipment, arranging reablement or community rehabilitation and supporting those residents who can't return back home by either supporting discharge to a step-down bed or into long term placement. In all cases residents are supported to return home and we work on a home first principle. In Tower Hamlets, we have the Royal London Hospital which includes not only Tower Hamlets patients but many out of borough patients. Therefore the team work closely with other discharge teams across London to ensure patients return home safely.

We take a continuous approach to improvement and have a borough-based Discharge Transformation Group, which reports into the Urgent Care Working Group which in turn reports into the A&E Delivery Board and the Partnership Executive. Our Discharge Transformation Group has a wide membership from partners including Community Health Services, CCG, Local Authority and the Hospital.

In addition, we also meet monthly with other Integrated Discharge Hubs, alongside the Bart's Health site, with the aim to collaborate across borough boundaries, share good practice and improve performance for challenging pathways. The borough-based Discharge Group and the system discharge group have aligned action plans for service improvement, which are reviewed monthly and have identified transformation support.

The borough-based groups and the wider group uses local data to identify trends and areas for service improvement and have a standard data pack supporting discussions. Areas reviewed monthly includes:

- Length of Stay (+7, +14 and +21days)
- Discharge verse referrals to IDH
- Numbers discharged within 24hrs (from referral to IDH)
- Numbers discharged within 48hrs (from referral to IDH)
- Reasons for delay.

Where a trend is identified for improvement we would then undertake a local audit and review of that aspect of the pathway to identify areas of challenge for improvement. A particular focus is how we reduce length of stay for our residents and enable same day or next day discharges through our discharge to assess model.

As per national guidance we use the Hospital Discharge Scheme to fund the first four weeks of care post discharge to enable long term care assessments to take place in the community. We also use the funding to enable our system to have effective step-down bed provision for nursing, residential and intermediate care.

Outcomes

- Over 300 patients have been referred through the service since the service commenced, with just over 50% of these Tower Hamlets residents

- 90% of patients have been successfully discharged home with care and support. The remaining 10% have been discharged to nursing and residential homes, supported accommodation, and newly commissioned step-down facilities.

- 25% of patients have been discharged the same day, and over 50% within 1 day, a big improvement on historical discharge times

- New relationships have been established across historical boundaries (ELFT, LBTH, Barts) and regular team meetings and learning sessions ensure discharge processes are continuing to improve

Supporting Admissions Avoidance

Within Tower Hamlets we have a range of services and approach to reduce attendance and admissions for our residents at acute hospitals. These include:

-Launched a Falls Pick Up service in the borough as part of our Rapid Response Service. The new pathway is available to Primary Care, Ambulance Crews, self-referral, Care Homes, 111 and 999 to refer into. The service will respond within 2 hours. Service went live over the summer.

-Expanded our 2 Hour Response time for Community Services. Rapid Response has been expanded to ensure that they are able to respond appropriately within 2 hours where clinically appropriate. The service has been expanded to include nursing, AHP, Social Workers, Domilicary care and linked to medical advice and support. The service also provided dedicated access to local care homes and an in-reach component to support care homes to better understand what is available and avoid contact London Ambulance.

-Each Care Home in our borough has a dedicated GP Practice attached as per the requirements of the Enhanced Health in Care Homes model. This includes regular ward rounds of the care homes and robust care plans being put in place, they link into existing community services to ensure timely intervention.

-We have expanded the catchment area of the Physician Response Unit, which is a joint initiative between Bart's Health and London Ambulance Service, which is a team which is dispatched to the patient's own home. The service in essence brings the Emergency Department to the patient's location through a senior emergency medicine doctor and ambulance clinician attending. Over 50% of patients seen do not get conveyed to hospital.

-Across the Barts Health sites, the Same Day Emergency Care Gold Standard "in hospital pathways", which are available for Primary Care to refer into as well as manage patients who walk into the acute sites, have been launched which are:

•Abscess
•AKI
•Atrial Fibrillation
•Cellulitis
•DVT
•Fall
•Hyperemesis
•Low Risk Chest Pain
•Pulmonary Embolism
•Pyelonephritis

The next phase of the programme includes implementing the Same Day Emergency Care Symptom Pathways which will be available for 111 and 999 to refer into and finalised for the Barts sites over the coming weeks. The symptom based pathways are:

•Abscess
•Bleeding in early pregnancy

•Dysuria, loin pain and fever
•Falls
•Low risk chest pain
•Palpitations
•Unilateral swollen lower limb
•Vomiting in early pregnancy

In addition, NEL has collaborated to develop pathway for rough sleepers and complex homeless from hospital with the aim to minimise readmissions. This includes a specialist team to work within the IDH and step down accommodation. The pathway will work on a cross borough level to maximise the opportunity. Service users will be able to stay for a maximum of 4 weeks whilst their next steps are identified. This is currently being mobilised. The wider aim is to establish whether this type of model is effective in improving outcomes and reducing system costs.

Reablement

To help people mitigate illness or disability, by learning or re-learning the skills necessary for daily living, following deterioration in health and/or an increase in support needs.

To promote and optimise independent functioning, and help people to do as much for themselves as possible, and in particular:

- Improving their quality of life
- Keeping and regaining skills, especially those enabling people to live independently
- Regaining or improving confidence (e.g. for someone who has had a fall)
- Increasing people's choice, autonomy, and resilience
- Enabling people to be able to continue living at home

The service also seeks to ensure:
- The safe transfer of support between acute care, community health and social care services and to support service users' return to independent living
- The prevention of unnecessary hospital admissions and the facilitation of early supported discharge
- To the provision of information and onward referral to other services, so that users/patients and their carers can make choices about support needs
- The prevention of premature admissions to residential and nursing care.

The service also has the following organisational objectives:
- To reduce admissions and readmissions
- Financial benefits, in the form of reduced support packages required post-reablement
A sustainable reduction in medium-term support packages, 6-12 months post-reablement.

Joint Triage Test and Learn (Reablement)

Since 1st April 2021 we have been piloting a Joint Triage Test and Learn pilot.

Services in scope
- Community rehabilitation Team AADS & Rapid Response
- Social Care Reablement service including the sensory team

Project aim: To introduce a Single point of access and a single referral form

- The service to have a Triage Team –their function is to review referrals and

allocate to the most appropriate pathway
- To have a data entry principle of read all, write in one
- Test and learn for Referral, Triage and allocations

Progress to date including service user story
During the Integrated Triage recently, a Social Worker joined the conversation with AADS (Admission Avoidance and Discharge Service) and Reablement to discuss a potential referral to Reablement, and it was established the patient was currently being seen by an EPCT (Extended Primary Care Team) Physio. The discussion helped the Social Worker to understand the role of EPCT better and what the different services offer and to avoid duplication.

This also helped the Social Worker understand what is involved in terms of rehabilitation and to distinguish between a focus on activities of daily living and on regaining independence in the wider sense, for example working on balance and gait. The EPCT Physio was invited to a further meeting, which resulted in a period of Reablement Officer support, which benefited this resident with regaining some confidence.

Overall, this meant that this resident received care that was planned between providers and professionals rather than being contacted by each provider separately with a similar offer.

Effective Communications
Integrated Triage has also enabled staff to learn about referrals being received by each other's services, and to know whether someone has had recent input from social care or community health services, and whether this was beneficial

Understanding of Services
Staff from the respective services have started to get to know each other and build working relationships

Community Equipment

Community Equipment Services in Tower Hamlets include:

- Community Equipment Service
- Telecare Service
- Independent Living Hub
- Wheelchair service / Pharmacy prescriptions

The Community Equipment Service procures stores, delivers, installs, maintains, collects, cleans and recycles daily living, paediatric, moving & handling and sensory impairment equipment, and carries out minor adaptations and alterations to property.

The Telecare Service provides a range of front-line services that include: Referral processing, Alarm installation, Alarm call monitoring, Emergency Visiting Response and a Regular Visiting Service. The Service operates 24/7 365 days a year.

The service is also the first point of contact for Social Care referrals received Out of Hours, and is responsible for taking referrals relating to Children and Adults Social Care; on behalf of the Out of Hours Emergency Duty Team,

Assistive technology delivers and fits a range of innovative technology to residents which enables them to remain at home and independent with sustained life choices, the focus is

on prevention and a reduction in hospital admission and readmission

The strategy arm of the team raise awareness among health and social care professionals through training and reinforcing of good practice at team level

The Sight and Hearing service helps anyone who is deaf, blind, suffers from hearing loss, visual loss or a dual sensory loss. The service provides social work support, general information and advice, rehabilitation training and equipment to encourage independent living skills. Work is undertaken with individuals apart from the self-assessment which would need to be re-evaluated in light of any changes and the low vision clinic which is external to the contractual arrangements.

7-Day Community Equipment Provision Team

This scheme will permit community equipment services to be provided to people able to leave hospital for longer hours on a 7 days a week basis. Community Equipment Service personnel will be available to receive requisitions for simple aids to living and complex pieces of equipment, such as hoists, special beds, pressure care, hand rails and so on via dedicated secure electronic faxes, telephone calls and secure emailing.

The service will:

- avoid unnecessary admissions and trips to A&E, by providing emergency deliveries, repair and replacement of hoisting, special beds and mattresses and other essential toileting and mobility equipment over extended hours.
- support hospital teams to carry out safer discharges by providing an out of hours service
- minimise and prevent readmissions and Delayed Transfer of Care (DTOC).
- facilitate safe, integrated and seamless transfer of patients between hospital, community health and social care services.

TH Connect (Information, Advice and Guidance service)
Tower Hamlets Connects supports the council to manage demand on its adult social care front door and those of health partners by providing free, quality assured information, advice and advocacy across health, social care and social welfare.

Equipping residents with the correct information and advice support at the right time will enables residents to support themselves, live fulfilling lives and to be as independent as possible.

The service offers early help and support to residents and carers through a digital portal, a help/advice telephone line service and face-to-face support in community and primary care settings.

A key element of the information and advice offer is the Tower Hamlets Together Digital Portal. This website is the digital front door for all residents with or without health or care needs. It provides residents with a suite of information and advice pages, a service directory, and an events calendar.

Linkage Plus
This is a preventative service which will support this vision by providing Tower Hamlets residents aged 50 and over universal access to:
- Community outreach;

- A wide range of physical and social activities;
- Information and low level Advice, including signposting and onward referrals as required; and
- A range of health-related services.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Disabled Facilities Grant (DFG) plays an important part in Tower Hamlets' approach to integrated care however there is recognition that we could be doing more.

The local authority provides services to clients requiring adaptations through its Occupational Therapist service and Home Improvement Agency. It works closely with Registered Providers who own the majority of social housing in the Borough. The tenants of the borough's Registered Providers account for around 75% of DFG expenditure. This spend reflects the relatively low level of owner occupied housing in the borough.

We are currently exploring options for a cross divisional DFG Working Group to be established to review the DFG programme, consider a pathway redesign for DFG and the DFG's integration with assistive technology and other Home Care services with a focus on supporting people to maintain their independence in the community for longer.

The Working Group will also give some consideration to how it can make better use of the flexibility allowed in DFG spending by the Regulatory Reform (Housing Assistance)(England and Wales) Order 2002 to support innovative solutions such as care technology.

In 2018, our Place Directorate carried out a full review of emerging good practice in regards to the wider use of DFG and engaged with Foundations, the Government's appointed advisory agency for best practice in the delivery of DFGs and extended use of the grant allowed under the RRO. In order to create greater flexibility within the fund and address housing issues on a wider preventative basis, it was agreed by the Mayor in Cabinet in to extend the fund on a discretionary basis to allow the use of the grant in the following areas:

- **Relocation Grants -** Relocation grants enable the Council to assist homeowners to move to a more suitable property where an in situ solution cannot be provided. Although they are rarely likely to be used, grants could cover removal costs, reconnection fees and legal costs.

- **Hospital Discharge Grants –** DFG grants are available for fast track works, including deep cleaning; decluttering and minor repairs which can speed up the hospital discharge process.

- **Dementia Grants –** Dementia grants can be used to replace gas, electric cooking facilities with microwaves and specialist assistive technology such as GIS tracking devices where appropriate.

- **Assistive Technology and Equipment** - The Council provides comprehensive assistive technology and equipment services including deaf/blind aids. DFG spend is used to supplement this service where an unmet demand can be identified.

Care technology next steps

We will carry out a care technology-diagnostic to see where we do well with technology-enabled care and where we could do more. The diagnostic will help us decide if and how much we need to invest in this area and identify longer-term potential financial benefits.

As a result of the diagnostic we expect to improve our current offer and introduce new technology including but not limited to -

- Innovative telecare and tech solutions (e.g. smart home sensors, alarms)
- Artificial Intelligence (AI)
- Predictive analytics
- Tools that help us share data between health and social care (e.g. Care Plans, understanding who is involved in a person's care and support)
- Digital directory of services
- Prepaid cards and virtual wallets for people who organise their own care with a direct payment.
- We will support people who are new to technology to start using it.
- Digital directory of services

What difference will it make?

- It will mean more people have more control over their care.
- It will improve people's experience of social care by providing the right care at the right time and providing another way of getting support.
- It will reduce delays in the social care process by staff spending less time on administrative tasks.
- It will support people to remain independent in their own homes for longer.
- It can improve the experience carers have when interacting with staff, giving them more control and access to information.

In order to implement and manage this transformation we intend to establish a Technology Enabled Care Board.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Managing Population Health & Tackling Inequalities

Tower Hamlets has a population of over 319,000 people and is referred to as densely populated. There were 344 confirmed deaths of residents since 1st October 2020 from Covid-19 as of 4th November 2021.

Tower Hamlets has an ethnically diverse population, with White 45%, Asian/Asian British 41% and 7% from Black/African/Caribbean/ decent. The population is relatively young

compared with the rest of the country but people typically start to develop poorer health around ten years earlier. 5.9% of the population are over 65 and already live with a degree of frailty. According to the most recent census data Tower Hamlets population includes 19,356 carers, often looking after older people with Long Term Health conditions who are at higher risk from Covid-19, and needing greater support to recover. During the Covid-19 pandemic there were over 9,000 shielded people living in the borough.

The Covid-19 pandemic has shone a light on inequalities (socio-economic, young people, older people, BAME, women, people with disabilities) and risk is that these will be exacerbated going forward. The Public Health England disparities report (summarised below) highlights the overlapping and interconnected narratives in Tower Hamlets impacting on the pattern of Covid-19 in the borough.

- The public health response to the pandemic adapted to consider digital exclusion. A Covid-19 helpline was set-up to resolve issues and book vaccines, with call handlers who speak community languages. Posters and signs in community languages were placed around the borough in relation to Covid-19. Somali and Bangladeshi community organisations delivered outreach and support and codesigned tailored prevention and protection messages to the life course groups within these communities.

- In Barts Health NHS Trust, work has been undertaken with renal medicine (the largest user of remote access), which included reviewing access to bilingual health advocacy, advocacy staff calling non-English patients prior to video consultations to assess their needs and any concerns. As a result, setting up setting up 3-way consultations when necessary. - Covid-19 vaccine clinics for people who are undocumented or with no recourse to public funds have been organised, explicitly promoted to people who may be worried

- The Tower Hamlets Together (THT) Board has completed an anti-racism leadership development programme provided by the equality charity Brap. This has included a focus on systemic racism and systemic change. - THT partners have agreed a joint Workforce and Occupational Development (OD) Strategy in March 2021 with commitments to tackle Black, Asian, and Minority Ethnic inequality amongst staff. - Barts Health NHS Trust has committed to 3% year on year growth of Black, Asian, and Minority Ethnic staff in senior positions. This has been achieved over the last year, maintaining this growth would allow the trust to achieve representative leadership by 2028. - The Health and Wellbeing Board and Tower Hamlets Together partnership have gathered community insights to support better understanding of causes of health inequalities amongst Black, Asian, and Minority Ethnic communities.

- The Board has used the insights to agree a Health & Wellbeing Strategy for 2021-2025 with key principle of addressing inequalities and being antiracist in everything the partnership does. - The council has developed anti-racism practice in adult social care including establishing a board which aims to ensure the social care workforce has substantial knowledge of anti-racism in practice and that social care has a diverse workforce reflective of the community, who are supported, included and have development opportunities.

The partnership has also committed to a number of key deliverables for 2022 in response to the Tower Hamlets Black, Asian, and Minority Ethnic Inequalities Commission which are set out below

- By March 2022 the partnership will gather and analyse data across the system,

manage an audit of key public information in community languages and organise translations, coordinate 'you said, we did' work related to coproduction. It will also arrange a 'lessons learned' exercise in relation to Covid-19 approaches by April 2022, targeted at Black, Asian and Minority Ethnic communities that we may want to replicate in future for other health issues. The partnership has also developed a digital inclusion action plan with the aim of better coordinating digital inclusion activities across the borough to ensure residents have the tools and skills they need to participate in, contribute to, and benefit from a digital world.

- The Health & Wellbeing Board has commenced work on developing a robust evidence base to form a better understanding of key health inequalities and the impact it has on our Black, Asian and Minority Ethnic communities. As part of this research there will be significant emphasis on engagement with Black, Asian and Minority Ethnic communities to identify key issues and solutions. This will be supported by Healthwatch Tower Hamlets who will gather their own intelligence on the experience and issues for patients at the Royal London Hospital. Both workstreams are expected to be completed by December 2021 and will provide evidenced based solutions to address health inequalities and inform future activities of the partnership.

- The Partnership will better recognise and meet the cultural needs of patients through the development of anti-racist practice. The success of the antiracism leadership programme delivered by BRAP to the Tower Hamlets Together Executive Board, the partnership will invest in an anti-racism leadership programme beyond 2021. This will help to drive deep cultural change and tackle the pervasive racial microaggressions, bias and stereotypes that exist in society and service provision.

- The partnership will continue to support the delivery of the Disparities project which aims to work with Black Asian and Minority Ethnic residents to amplify and sustain the impact and influence achieved during the response to the pandemic. The project will provide a locally driven, co-production support programme targeting Black, Asian and Minority Ethnic communities with an emphasis on prioritising mental health. This will lead to improvement in access to services and better satisfaction amongst local people.

- Through the insights on local inequality the partnership will work as one voice to influence and lobby for further resources for Tower Hamlets. The partnership will support local campaigns to improve access to health services by lobbying against the hostile environment polices and reduce the checking of immigration status of service users and patients.

We have also identified a number of areas for future investment (through the Public Health Reserve - £350k and Contain Outbreak Management Fund - £200k) to achieve the following outcomes on health:

- Improved access to health and care services for Black, Asian and Minority Ethnic residents.
- Leaders in health and social care champion and actively address heath inequalities faced by Black, Asian and Minority Ethnic residents.
- Better representation of Black, Asian and Minority Ethnic staff at all levels in health services.
- Black, Asian and Minority Ethnic residents are meaningfully involved and engaged in design and delivery of health services.
- Health and wellbeing key messages reach Black, Asian and Minority Ethnic

residents and deliver intended outcomes

Case Study, Somali Mental Health (Task and Finish Group)

Purpose
The Somali Mental Health Task and Finish Group was set up to conduct an in-depth review on the impact of mental health and neurological conditions within the Somali community from February 2021 to October 2021.

Why a 'Task and Finish' group focusing on Mental Health for this community?

- Somali Working Group expressed growing concerns (exacerbated by Covid-19) over mental health and its impact on the Somali community
- To build stronger networks between the community and service providers.

What evidence was gathered?
Presentations from and discussions with key internal and external stakeholders including CCG, Adults Social Care Commissioning, Phoenix School, Youth Services, Age UK, THCVS and ELFT.

Engaged with community members of the Mental Health Task and Finish Group for lived experience in this area (Women's Inclusive Team, Somali Citizen's Club, Ashaadibi Centre, Numbi Arts and other local residents who know people in the community affected by mental health or neurological conditions).

Four sessions were held with community members and partners on different mental health themes

Specific issues highlighted by the community

- **Mental health in Somali men** – potentially at higher risk of mental health difficulties due to challenges they face (i.e. racial trauma, exclusion from school, and social deprivation).
    - Heavy representation in the most restrictive parts of mental health services
    - Inaccessibility of mental health services
    - Lack of Somali health workers
    - Timings of assessment and treatment – often in serious crisis before they arrive at services
    - Inadequate data collection
- **Autistic child and family support** – need for effective partnership work across education, health and social care.
    - Need for regular review and evaluation to ensure the quality, type and amount of provision available to meet local need with long term outcomes for individual children.
    - Perceived high proportion of Somali young people with SEND
    - Need for more space and/or opportunities for young people to discuss issues
    - Access to specialist schools for Somali young people
- **Mental health and neurological conditions in older people**:
    - Need for greater sign-posting to support services available for people dealing with dementia
    - Support/care services available for family members with Alzheimer's - dementia befriending.
    - Need for more access to GPs for older people with options for interpreters, varied mobility access and sensory/cognitive impairment
    - Isolation and lack of social contact/stimulation

- **Mental health in young people**:
    - Need for more data and access to youth provision to deal with isolation
    - Need for greater awareness of mental health support services available to them
    - Likelihood of experiencing racism, resulting in anxiety and other mental health issues
    - Increased need for talking therapies for young people

Based on these findings a number of recommendations have been pulled together and these were presented to the THT Executive Board asking them to -

- Take the lead on ensuring the delivery of the recommendations and embedding actions to enable that within existing/emerging THT workstreams
- Commit to how Somali Working Group members will be engaged in shaping mental health services
- Feed back to the Somali Working Group on delivery against recommendations on at least an annual basis

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Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Tower Hamlets
Completed by:	Suki Kaur and Phil Carr
E-mail:	Suki.Kaur1@nhs.net and Phil.Carr@towerhamlets.gov.uk
Contact number:	0207 688 2356

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director of Health, Adults & Community and Transition
Name:	Denise Radley and Siobhan Harper

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 01/12/2022

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Rachel	Blake	Rachel.Blake@towerhamlets.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	NEL CCGs Accountable	Henry	Black	henryblack@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Transitional Director -	Siobhan	Harper	siobhanharper@nhs.net
	Local Authority Chief Executive	Chief Executive	Will	Taylor	Will.Tuckley@towerhamlets.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Corporate Director of	Denise	Radley	Denise.Radley@towerhamlets.gov.uk
	Better Care Fund Lead Official	BCF leads LBTH and NEL	Phil Suki	Carr Kaur	Phil.Carr@towerhamlets.gov.uk and
	LA Section 151 Officer	Corporate Director	Kevin	Bartle	Kevin.Bartle@towerhamlet.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Tower Hamlets

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,320,693	£2,320,693	£0
Minimum CCG Contribution	£23,145,037	£23,145,037	£0
iBCF	£16,316,044	£16,316,044	£0
Additional LA Contribution	£774,839	£774,839	£0
Additional CCG Contribution	£13,404,970	£13,404,970	£0
Total	**£55,961,583**	**£55,961,583**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,577,163
Planned spend	£14,060,501

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£9,098,111
Planned spend	£9,639,946

Scheme Types

Assistive Technologies and Equipment	£2,184,000	(3.9%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£662,000	(1.2%)
Community Based Schemes	£18,290,200	(32.7%)
DFG Related Schemes	£2,320,693	(4.1%)
Enablers for Integration	£276,786	(0.5%)
High Impact Change Model for Managing Transfer of	£3,061,308	(5.5%)
Home Care or Domiciliary Care	£0	(0.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£23,746,297	(42.4%)
Bed based intermediate Care Services	£2,425,271	(4.3%)
Reablement in a persons own home	£2,349,289	(4.2%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£645,739	(1.2%)
Residential Placements	£0	(0.0%)
Other	£0	(0.0%)
Total	**£55,961,583**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	251.3	239.4

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	8.0%	8.1%
	LOS 21+	4.4%	4.4%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	96.5%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	317	350

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.2%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Tower Hamlets

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Tower Hamlets	£2,320,693
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,320,693**

iBCF Contribution	Contribution
Tower Hamlets	£16,316,044
Total iBCF Contribution	**£16,316,044**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Tower Hamlets	£774,839	various schemes as set out in tab 5a. Expenditure
Total Additional Local Authority Contribution	**£774,839**	

CCG Minimum Contribution	Contribution
NHS Tower Hamlets CCG	£23,145,037
Total Minimum CCG Contribution	**£23,145,037**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Tower Hamlets CCG	£13,404,970	various schemes as set out in tab 5a. Expenditure
Total Additional CCG Contribution	**£13,404,970**	
Total CCG Contribution	**£36,550,007**	

	2021-22
Total BCF Pooled Budget	**£55,961,583**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Tower Hamlets

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,320,693	£2,320,693	£0
Minimum CCG Contribution	£23,145,037	£23,145,037	£0
iBCF	£16,316,044	£16,316,044	£0
Additional LA Contribution	£774,839	£774,839	£0
Additional CCG Contribution	£13,404,970	£13,404,970	£0
Total	**£55,961,583**	**£55,961,583**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,577,163	£14,060,501	£0
Adult Social Care services spend from the minimum CCG allocations	£9,098,111	£9,639,946	£0

Checklist

Column complete:

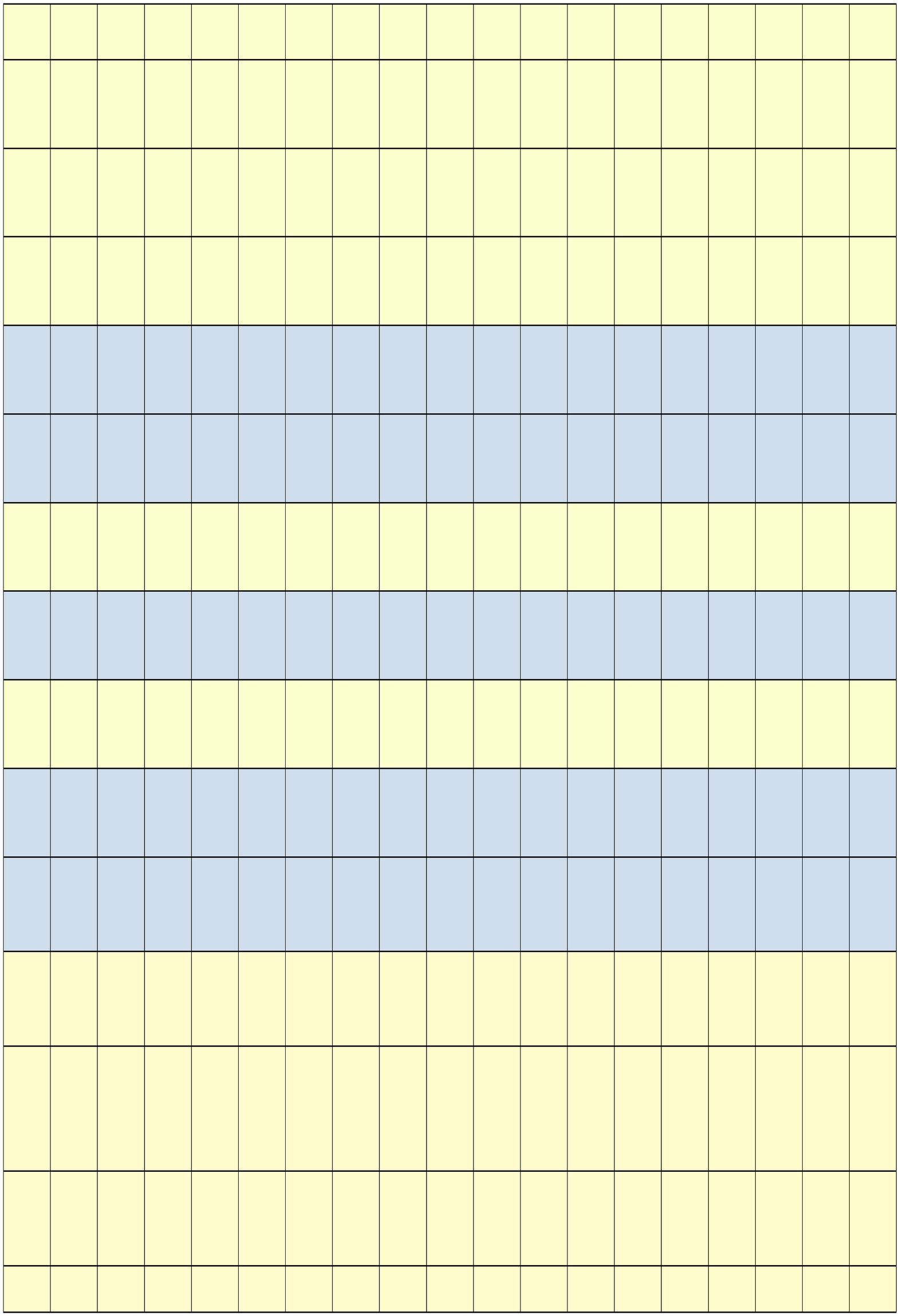
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

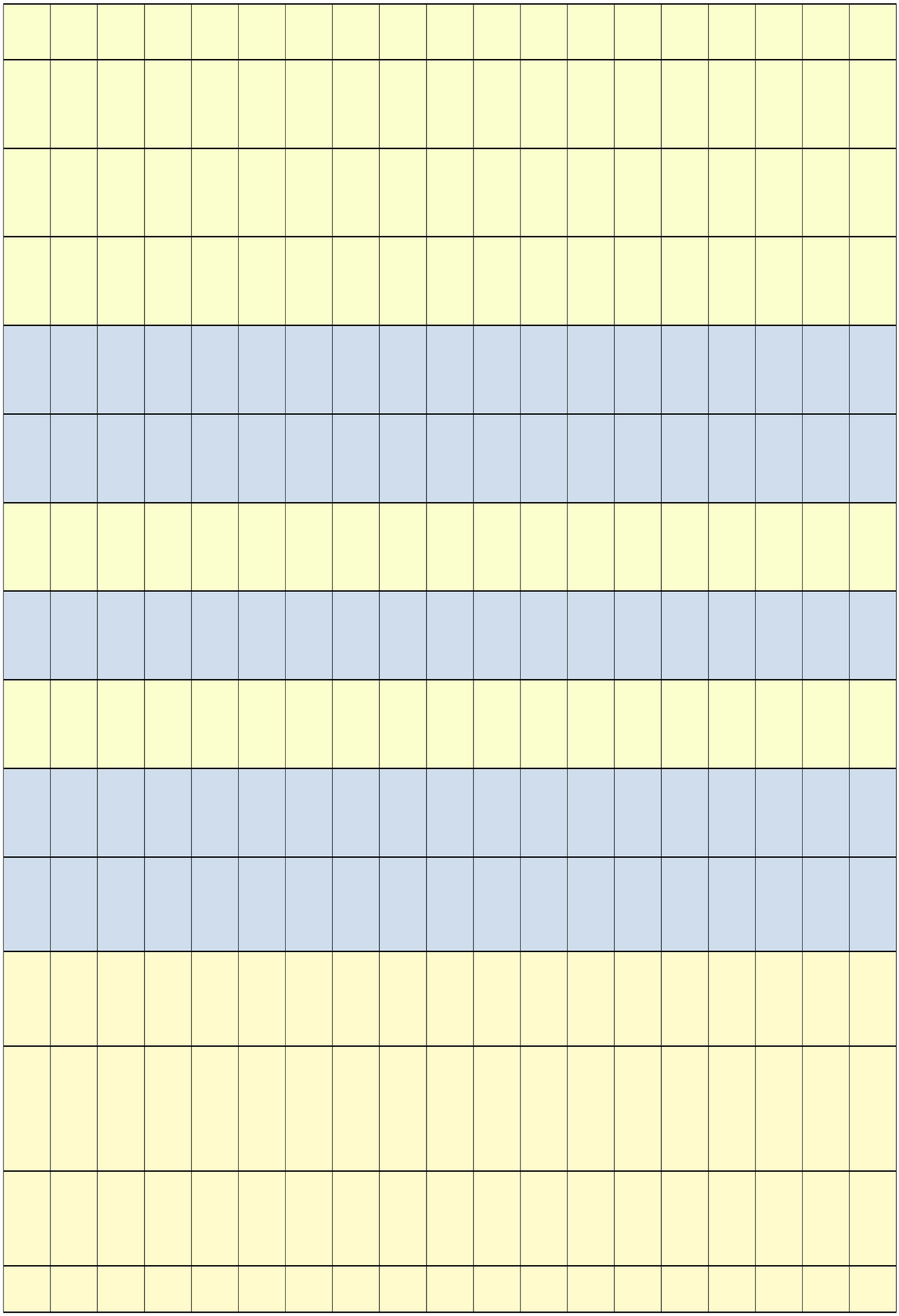
Sheet complete

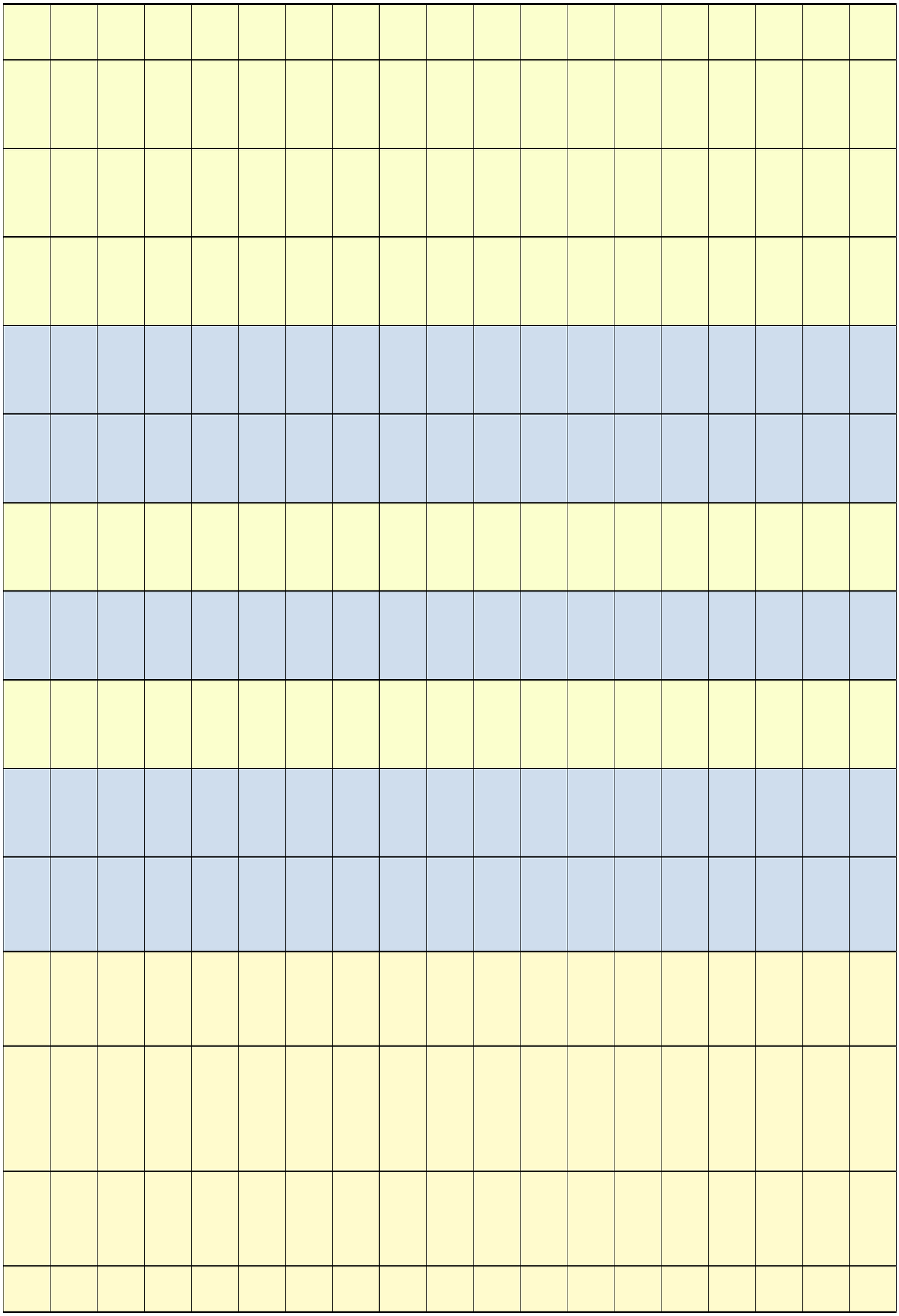
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Reablement	Reablement Team	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,349,289	Existing
2	Community Health Team (Social Care)	Community Health Team - Social Care elements	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,300,378	Existing
3	7 day hospital social work team	hospital social work team	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,665,152	Existing
4	Brokerage service - support for hospital discharge	Brokerage service - support for hospital discharge	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£110,778	Existing
5	Community Equipment Service	Council contribution to Medequip contract	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Additional LA Contribution	£454,100	Existing
6	Community Equipment Service	CCG contribution to Medequip contract	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Additional CCG Contribution	£322,000	Existing
7	Community Equipment Service	CCG & LBTH contribution to Medequip, Telecare,	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,407,900	Existing

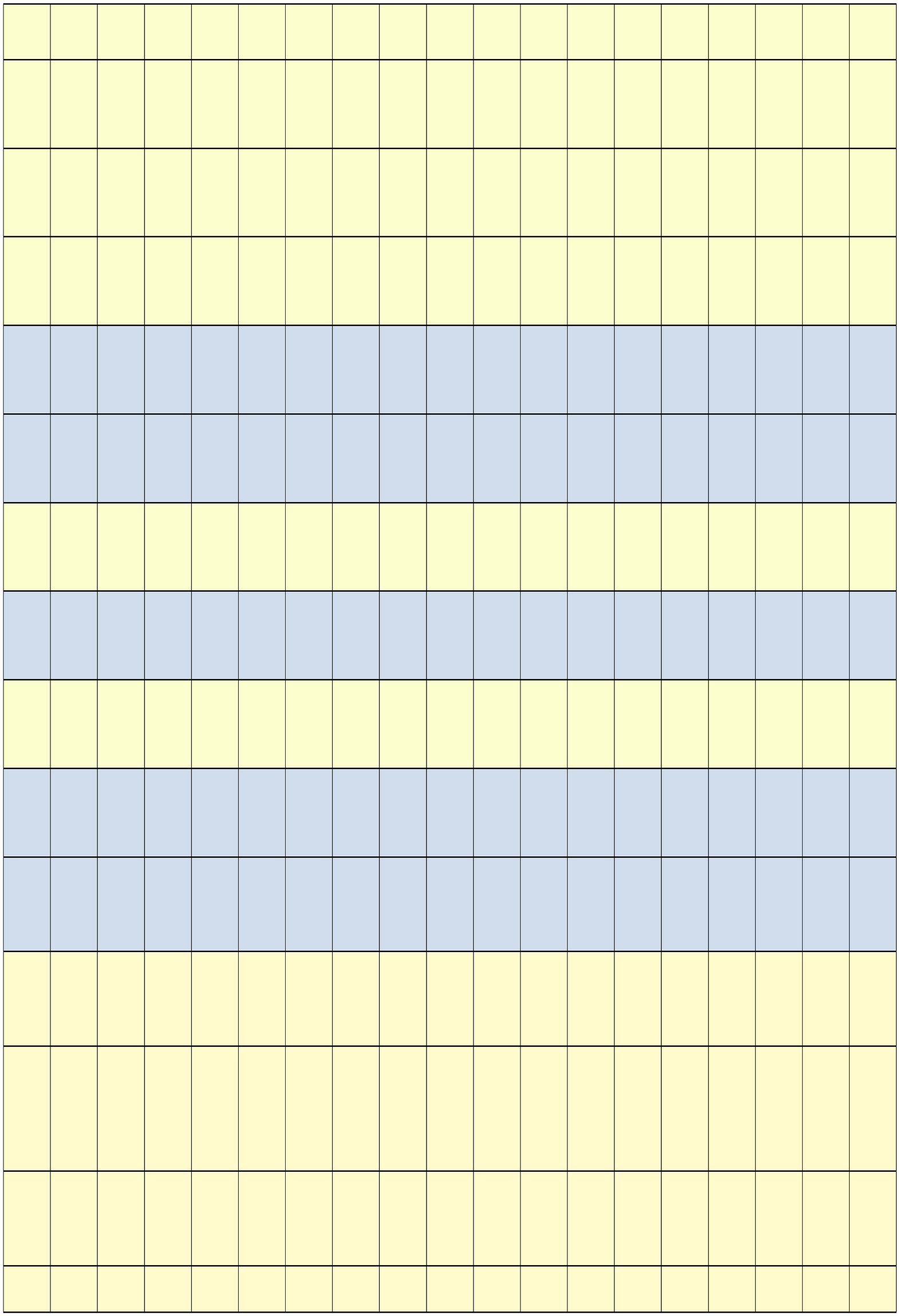
8	Carers support	Support for carers	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£662,000	Existing
9	Local Authority Support for Health and Social Care	Coordination support for integration of health and social care	Enablers for Integration	Programme management		Social Care		LA			Local Authority	Minimum CCG Contribution	£242,253	Existing
10	Dementia Diagnosis and Community	Outreach service for the diagnosis of dementia in the community	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£79,800	Existing
11	Social Work Support for the Memory Clinic	Social worker input to the memory clinic	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£57,028	Existing
12	LinkAge Plus - CCG contribution	community contract	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£325,000	Existing
13	LinkAge Plus - LBTH contribution	community contract	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£320,739	Existing
14	Adult Learning Disability Services	shared lives, developing capacity, lead on hospital admissions &	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	Minimum CCG Contribution	£253,521	New
15	Initial Assessment Service	Support for Hospital Discharge and safeguarding	High Impact Change Model for Managing	Early Discharge Planning		Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£122,033	New
16	AMHP Service	Support for hospital discharge	High Impact Change Model for Managing	Early Discharge Planning		Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£66,327	New
17	Practice Development - OT Joint Practice Lead	Occupational Therapy lead post	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£30,000	New
18	Locality Development Fund	CCG and council contribution to schemes supporting integration at	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£413,077	New
19	Locality Development Fund	CCG and council contribution to schemes supporting integration at	Community Based Schemes	Integrated neighbourhood services		Social Care		CCG			CCG	Minimum CCG Contribution	£555,410	New
20	Disabilties Fund Grant	DFG	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£2,320,693	Existing
21	iBCF	iBCF	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	iBCF	£16,316,044	Existing
22	Out of Borough Social Worker	Social Worker post based in acute hospital to support out of	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Additional CCG Contribution	£61,200	Existing
23	Age UK Last Years of Life	Age UK input to acute hospital supporting discharge pathway	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			CCG	Additional CCG Contribution	£93,641	Existing
24	Extended Primary Care Team	community health services	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£9,414,434	Existing
25	Extended Primary Care Team	community health services	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£4,770,354	Existing
26	Integrated Clinical and Commissioning	primary care based schemes delivered via an incentive scheme to	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			CCG	Minimum CCG Contribution	£1,382,624	Existing

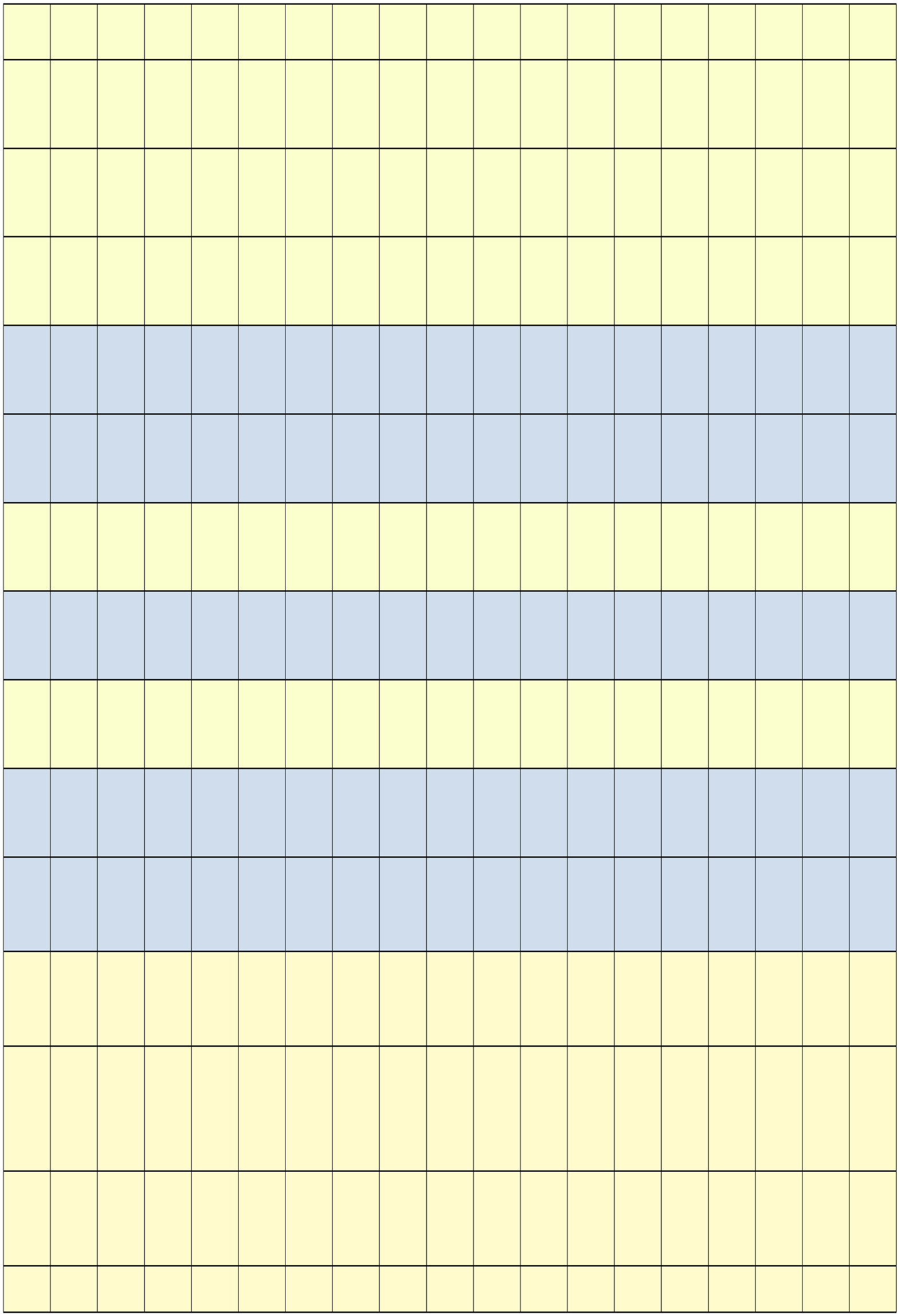
27	Integrated Clinical and Commissioning	primary care based schemes delivered via an incentive scheme to	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			CCG	Additional CCG Contribution	£3,216,625	Existing
28	RAID	Mental health input to acute A&E	Integrated Care Planning and Navigation	Care navigation and planning		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£2,414,259	New
29	Adult Autism and Diagnostic Intervention	mental health	Community Based Schemes	Integrated neighbourhood services		Mental Health		CCG			NHS Mental Health Provider	Additional CCG Contribution	£338,580	New
30	Mental Health Recovery College	mental health support	Community Based Schemes	Integrated neighbourhood services		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£126,740	New
31	Community Geriatrician Team	community Geriatrician	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£132,501	New
32	Psychological Support for People with LTCs	mental health input to primary care	Community Based Schemes	Integrated neighbourhood services		Primary Care		CCG			NHS Mental Health Provider	Additional CCG Contribution	£150,000	New
33	St Joseph's Hospice	end of life	Bed based intermediate Care Services	Other	end of life care	Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£2,425,271	New
34	Barts Acute Palliative Care Team	end of life	Integrated Care Planning and Navigation	Care navigation and planning		Acute		CCG			NHS Acute Provider	Additional CCG Contribution	£974,344	New
35	Admissions Avoidance Discharge Service	supporting discharge	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£850,955	New
36	Age UK Take Home and Settle Service	supporting discharge to community	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£114,000	New
37	Spot Purchase (overseen by CSU)	supporting discharge	High Impact Change Model for Managing	Housing and related services		Acute		CCG			NHS Acute Provider	Additional CCG Contribution	£88,000	New
38	contingency (to be allocated)	part of Locality Development Fund	Enablers for Integration	Integrated models of provision		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£34,533	New

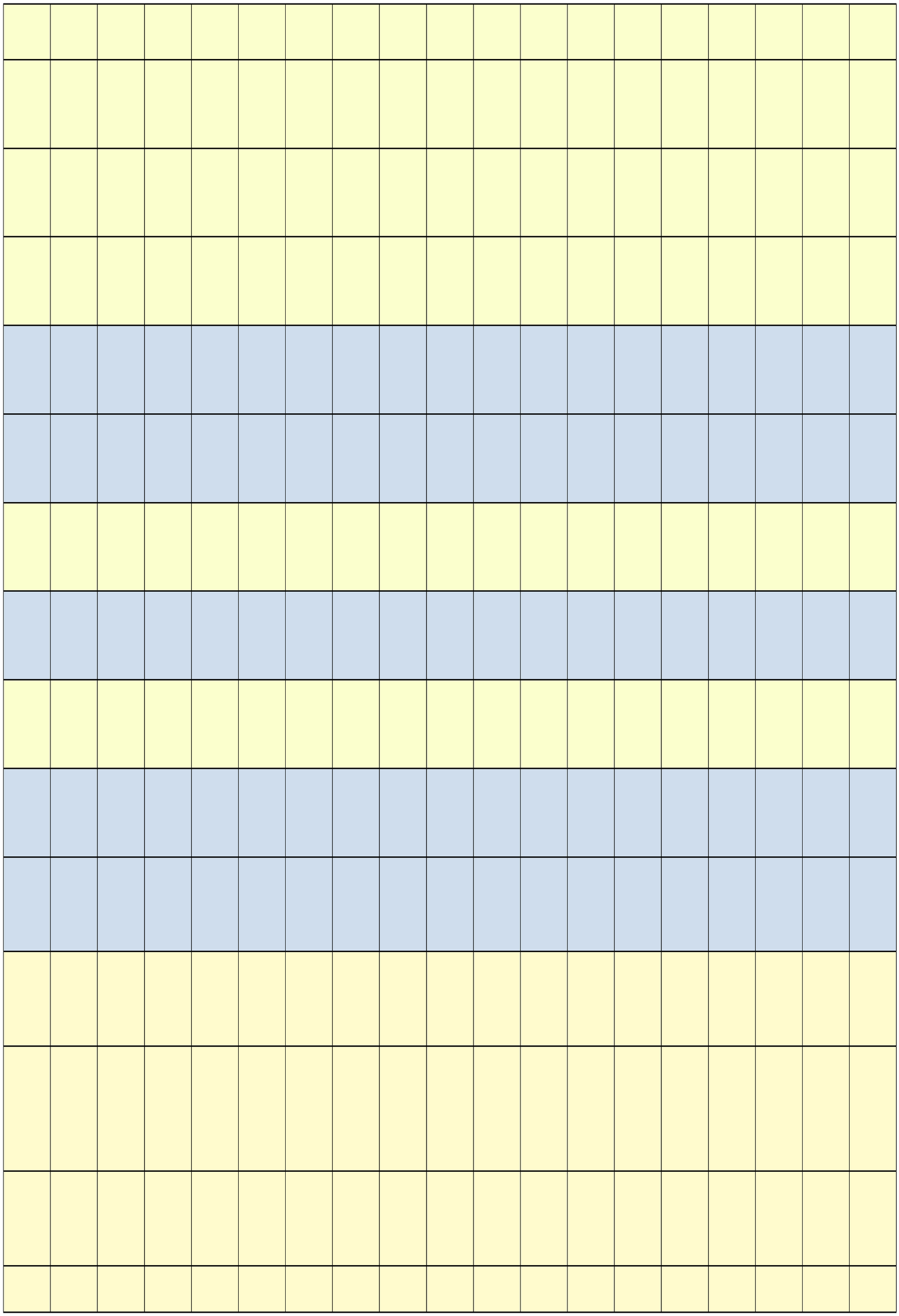


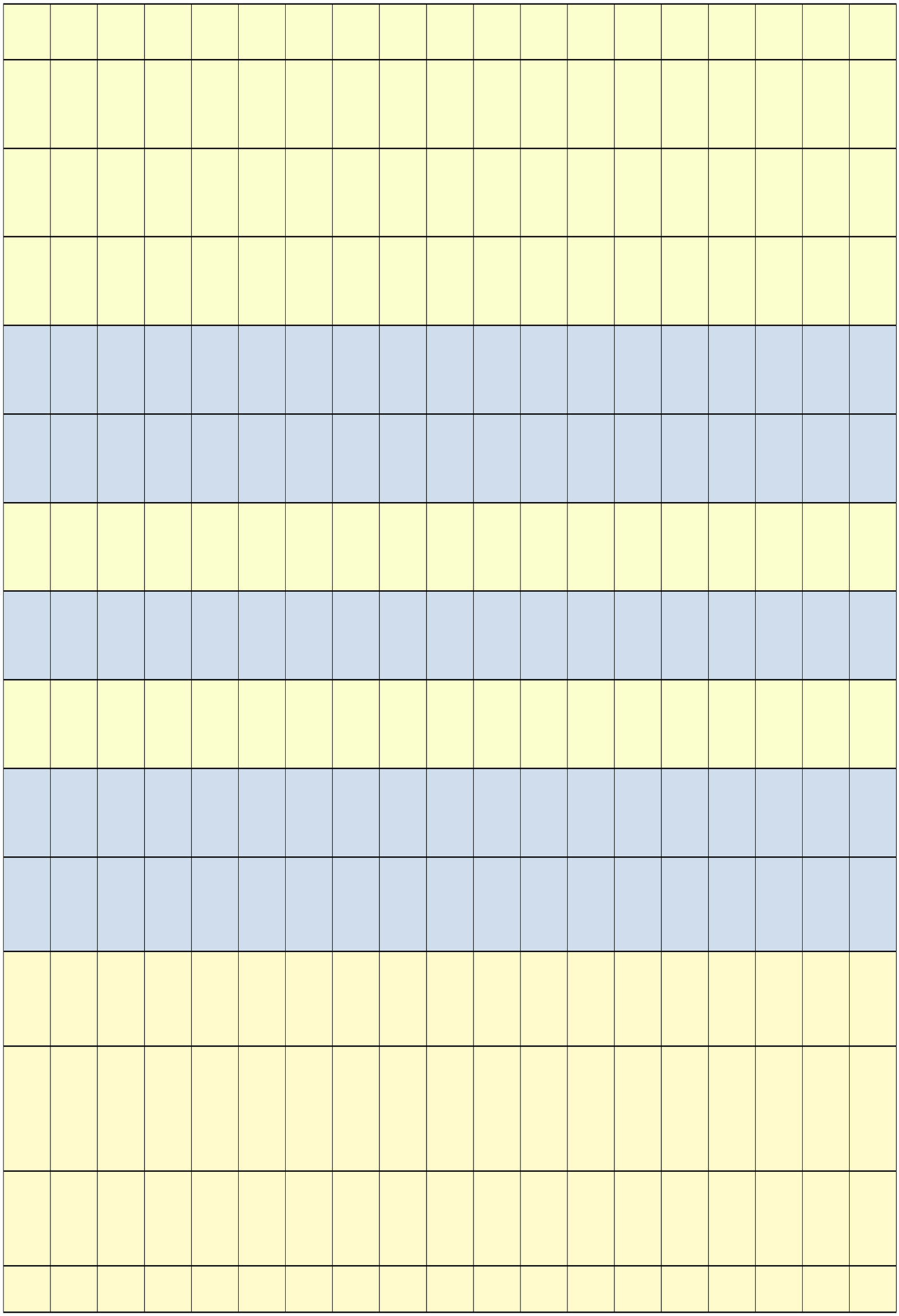


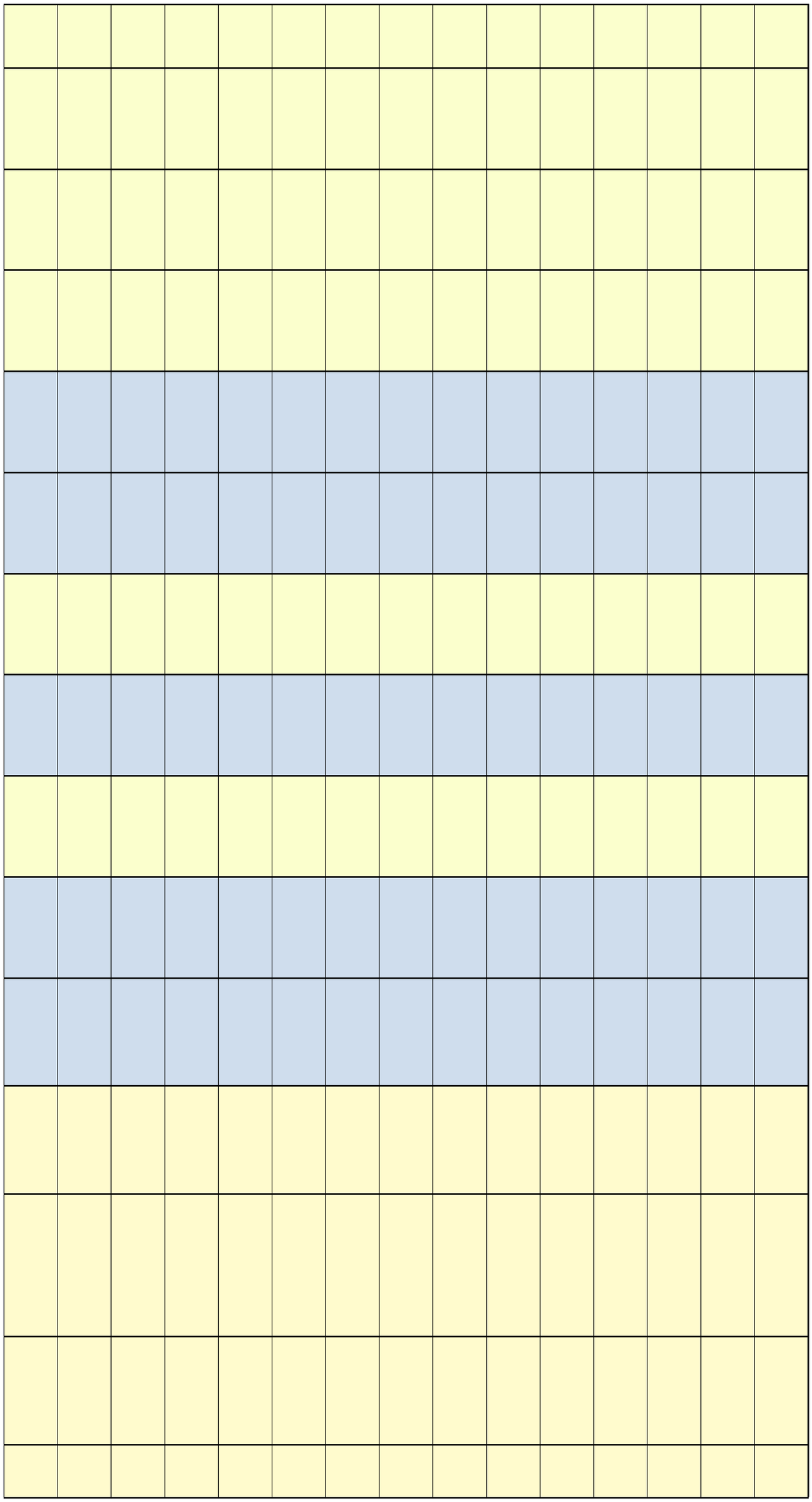












2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of ‘home ward’ for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Tower Hamlets

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		251.3	239.4	Methodology to 2021-22 plan: To develop the 2021-22 plan, we took the average reduction from 2018-19 to 2019-20 across Tower Hamlets and applied this to 2021-22. We have not used 2020-21 as a baseline year as we saw a significant reduction in non-elective admissions and A&E in our dataset, but this	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.0%	8.1%	Methodology to 2021-22 plan: -14 days or more – We took the national data for LoS and used the forecast provided by the BCF national team. By Q4 we are expecting 14 days to be at 8.1%. This is a stretch compared to 2020-21 which was at 8.6% and a stretch against baseline year 2019-20 which was at 8.5% by Q4. Our trajectory is lower than the national average of 12.6% in 2019-20 and 11.8% in 2020-21, and lower than the London average which was at 12.1% in 2019/20	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	4.4%	4.4%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.5%	Methodology to 2021-22 plan: We used the national data and the forecast provided for the 2021-22 plan (sep-21 to mar-22) by the national BCF team which shows our forecasted performance as 96.5%. This is higher compared to the same period in 2019-20 and 2020-21. In 2019-20 the average discharge to normal	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	480	460	317	350	The target rate was exceeded in 20/21 for permanent admissions. A rate of 316.9 was achieved. This year we have set our target rate at 350. We are currently within the target performance range though winter pressures may impact. Hospital occupancy rates remain very high so there are significant pressures on bed spaces and an	**Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	98	96	69	79		
	Denominator	20,354	20,859	21,771	22,590		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	83.1%	67.6%	77.2%	Note that in 2020-21 our reported performance on this metric was 74% (184/248). Usually, only a small number of people are discharged to reablement each month so the numbers fluctuate. In the year to date (1/4/21 to 31/10/21) there are reported to be 202 discharges to reablement and in 156 reported instances, the person	**Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	108	69	267		
	Denominator	130	102	346		

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Tower Hamlets

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

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Bevan Brittan | Lawyers for the public, private and third sectors

Dated **2021**

The London Borough of Tower Hamlets

and

NHS North East London
CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES & THE BETTER CARE FUND

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Contents

THIS AGREEMENT is made on day of 2021

PARTIES

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

(2) **NHS North East London CLINICAL COMMISSIONING GROUP** of 4th Floor Unex Tower, 5 Station Street, London, E15 1DA (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 as well as the City of London, London Borough of Barking and Dagenham, London Borough of Hackney, London Borough of Havering, London Borough of Redbridge, London Borough of Newham, London Borough of Waltham Forest.

(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 funds 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 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 into this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives; and

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

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act.

1 DEFINED TERMS AND INTERPRETATION[1]

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

2018 Act means the Data Protection Act 2018.

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.

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

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

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

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

BCF 2015 Agreement means the agreement between the Parties in respect of the Better Care Fund for the period commencing 1 April 2015

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

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

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 Commencement Date

Commencement Date means 00:01 hrs on 1 April 2021.

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.

[1] Definitions should be finalised once main body of Agreement is finalised.

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

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) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract.

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

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

Force Majeure Event means one or more of the following:

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

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

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

(h) any other event,

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

Functions means the NHS Functions and the Health Related Functions

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

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non Pooled Fund the Partner that will host the Non Pooled Fund

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

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

Individual Scheme means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 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 Health Related Functions.

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

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

Month means a calendar month.

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

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

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the 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 [10.3].

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 Clause 19.2 and Schedule 2 or such other arrangements for governance as the Partners agree.

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

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

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 2018 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 including the Council where the Council is a provider of any Services.

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).

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 2018 Act.

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

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

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

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

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

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

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

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

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

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

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

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

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

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

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

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but 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 or if not set out, for the duration of this Agreement unless terminated earlier by the Partners.

2.4 This Agreement supersedes the BCF 2015 Agreement without prejudice to the rights and liabilities of the Partners under the BCF 2015 Agreement

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

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

4.1.1 Lead Commissioning Arrangements; and

4.1.2 the establishment of one or more Pooled Funds.

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

4.2 Where there is Lead Commissioning Arrangements and the CCG is Lead Partner 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 Where there is Lead Commissioning Arrangements and the Council is Lead Partner, 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.

4.5 At the Commencement Date of this Agreement the following Individual Schemes will be included within its scope:

4.5.1 The following Individual Schemes with Lead Commissioning with Council as Lead Partner:

(a) Reablement Team

(b) Community Health Team (Social Care)

(c) 7 Day Hospital Social Work Team

(d) Brokerage Service – Support for Hospital Discharge

(e) Community Equipment Services (LBTH contribution to Medequip)

(f) Carers support

(g) Local Authority Support for Health and Social Care Integration

(h) Dementia Diagnosis and Community Support

(i) Social Worker Support for the Memory Clinic

(j) LinkAge Plus

(k) Adult Learning Disability Service

(i) Developing capacity
Shared Lives
(ii) Lead on hospital admission and discharge

(l) Initial Assessment Service

(m) AMHP Service

(n) Practice Development

(o) Disabled Facilities Grant (DFG)

(p) Improved Better Care Fund (iBCF)

4.5.2 The following Individual Schemes with Lead Commissioning with CCG as Lead Partner:

(a) Out of Borough Social Worker

(b) Community Equipment Services (CCG contribution)

(c) Age UK Last Years of Life

(d) Integrated Community Health Team (incorporating the Extended Primary Care Team)

(e) Integrated Clinical and Commissioning Quality NIS

(f) RAID

(g) Adult Autism and Diagnostic Intervention Service

(h) Mental Health Recovery College

(i) Community Geriatrician Team

(j) Psychological Support for People with LTCs (MH PC)

(k) Personalisation Programme (IPC)

(l) St Joseph's Hospice

(m) Barts Acute Palliative Care Team

(n) Admissions Avoidance Discharge Service (including D2A)

(o) Age UK Take Home and Settle Service

(p) Locality Development Fund

(q) Spot Purchase (overseen by CSU)

4.5.3 Further schemes may be added to this Agreement, as are agreed by the Partnership Board.

5 FUNCTIONS

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

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

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

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

[2] This will be taken from the Better Care plan; other schemes may be included later. Consideration should be given as to whether existing schemes should be moved under this scheme.

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 business case approval by the Partnership Board[3] in accordance with the variation procedure set out in Clause 30 (Variations).

6 COMMISSIONING ARRANGEMENTS

General

6.1 The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification.

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

6.3 The Partners shall comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned.

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

6.5 Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Services Contract being entered into the Partners shall agree in writing:

6.5.1 how the liability under each Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and

6.5.2 whether the Services Contract should give rights to third parties (and in particular if a Partner is not a party to the Services Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Services Contract should be afforded any rights to enforce any terms of the Services Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Services Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Services Contract and shall establish how liability under the Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme.

6.6 The Partners shall comply with the arrangements in respect of Joint (Aligned) Commissioning as set out in the relevant Scheme Specification, which shall include where applicable arrangements in respect of the Services Contracts.

Integrated Commissioning

6.7 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme:

6.7.1 The Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.7.2 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 Partners Financial Contribution in respect of that particular Service in each Financial Year.

[3] Clause 19 relates to the governance structure including the role of the Health and Wellbeing Board.
See comments below at Clause 30 relating to the inclusion of a procedure for the proposal and approval of Individual Schemes.

Appointment of a Lead Partner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Partner shall:

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

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

6.8.3 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;

6.8.4 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;

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

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

6.8.7 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

6.9 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 agreed by the Partners. At the Commencement Date there shall be two Pooled Funds.

Scheme Name	Commissioner	Provider	Source of Funding	Expenditure (£)
Reablement Team	Local Authority	Local Authority	Minimum CCG Contribution	£2,349,289
Community Health Team (Social Care)	Local Authority	Local Authority	Minimum CCG Contribution	£1,300,378
7 Day Hospital Social Work Team	Local Authority	Local Authority	Minimum CCG Contribution	£1,665,152
Brokerage Service - Support for Hospital Discharge	Local Authority	Local Authority	Minimum CCG Contribution	£110,778
Community Equipment Services	Local Authority	Local Authority/Private Sector & Charity/VCS	Minimum CCG Contribution	£1,407,900
Community Equipment Services	Local Authority	Private Sector	Additional LA Contribution	£454,100
Community Equipment Services	Local Authority	Private Sector	Additional CCG Contribution	£322,000
Carers support	Local Authority	Charity/VCS	Minimum CCG Contribution	£662,000
Local Authority Support to Health and Social Care	Local Authority	Local Authority	Minimum CCG Contribution	£242,253

Integration				
Dementia Diagnosis and Community Support	Local Authority	Charity/VCS	Minimum CCG Contribution	£79,800
Social Worker input into the memory clinic	Local Authority	Local Authority	Minimum CCG Contribution	£57,028
LinkAge Plus (CCG contribution)	Local Authority	Charity/VCS	Minimum CCG Contribution	£325,000
LinkAge Plus (Council contribution)	Local Authority	Charity/VCS	Additional LA Contribution	£320,739
Adult Learning Disability Services	Local Authority	Local Authority & MH Provider	Minimum CCG Contribution	£253,521
Initial Assessment Service	Local Authority	Local Authority & MH Provider	Minimum CCG Contribution	£122,033
AMHP Service - Support for Hospital Discharge	Local Authority	NHS MH Provider	Minimum CCG Contribution	£66,327
Practice Development - OT Joint Practice Lead	Local Authority	Local Authority	Minimum CCG Contribution	£30,000
Disabled Facilities Grant	Local Authority	Local Authority	DFG	£2,320,693
iBCF	Local Authority	Local Authority	iBCF	£16,316,044
Locality Development Fund	Local Authority	Local Authority	Minimum CCG Contribution	£413,077
Local Authority pooled fund				**£28,818,112**

Out of Borough Social Worker	CCG	Local Authority	Additional CCG Contribution	£61,200
Age UK Last Years of Life	CCG	Charity / Voluntary Sector	Additional CCG Contribution	£93,641
Integrated Community Health Team (incorporating Extended Primary Care Team)	CCG	NHS Community Provider	Minimum CCG Contribution	£9,414,434
Integrated Community Health Team (incorporating Extended Primary Care Team)	CCG	NHS Community Provider	Additional CCG Contribution	£4,770,354
Integrated Clinical and Commissioning Quality NIS (Primary Care)	CCG	CCG	Minimum CCG Contribution	£1,382,624
Integrated Clinical and Commissioning Quality NIS (Primary Care)	CCG	CCG	Additional CCG Contribution	£3,216,625
RAID	CCG	NHS Mental Health Provider	Minimum CCG Contribution	£2,414,259
Adult Autism and Diagnostic Intervention Service	CCG	NHS Mental Health Provider	Additional CCG Contribution	£338,580
Mental Health Recovery College	CCG	NHS Mental Health Provider	Minimum CCG Contribution	£126,740
Community Geriatrician Team	CCG	NHS Community Provider	Minimum CCG Contribution	£132,501
Psycholgical Support for People with LTCs (MH PC)	CCG	NHS Mental Health Provider	Additional CCG Contribution	£150,000
St Joseph's Hospice	CCG	Charity / Voluntary Sector	Additional CCG Contribution	£2,425,271
Barts Acute Palliative Care Team	CCG	NHS Acute Provider	Additional CCG Contribution	£974,344
Admissions Avoidance Discharge Service (inclu D2A)	CCG	NHS Community Provider	Additional CCG Contribution	£850,955
Age UK Take Home and Settle Service	CCG	Charity / Voluntary Sector	Additional CCG Contribution	£114,000
Locality Development Fund	CCG	CCG	Minimum CCG Contribution	£555,410
Spot Purchase (overseen by CSU)	CCG	NHS Acute Provider	Additional CCG Contribution	£88,000
CCG pooled fund				**£27,108,938**
Total BCF				**£55,927,050**

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

7.3 Subject to Clause 7.4, it is agreed that the monies held in a Pooled Fund may only be expended on the following:[4]

7.3.1 the Contract Price*;*

7.3.2 the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Third Party Costs, where these are set out in the relevant Scheme Specification or as otherwise agreed in advance by the Partnership Board

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

7.3.6 any other explicit allowances stipulated in this Agreement; and

7.3.7 subject to Clause 7.4.

("Permitted Expenditure")[5]

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 or 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 in accordance with Clause 7.4.[6]

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.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, 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 for each Pooled Fund shall have the following duties and responsibilities:

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4 This dictates what can be funded out of the Pooled Fund and, therefore, what would constitute an overspend if it exceeded the amount in the Pool. Money spent on other things would be in breach of this agreement and, therefore not recoverable by the Host Partner.

5 Parties should discuss how to deal with management costs in relation to hosting arrangements. For example, should these be charged or will each Party provide the services without recharging. If management costs and costs for hosting a Pooled Fund such as audit costs are to be charged to the Pooled fund this should be included as an additional point at clause 7.3.

6 This links liabilities of the Host Partner for default to the indemnity provisions.

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

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

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

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

8.2.5 reporting to the Partnership Board as required by this Agreement and by the Partnership Board;

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

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

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:

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

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

8.4 The Partnership Board may agree to the viring of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

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 solely for the purposes agreed by the Partners. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

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

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

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 any Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

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

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the 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 shall be as set out in the relevant Scheme Specification.

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

10.3 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to a 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 Unless set out in a Scheme Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any Service that they are Lead Partner or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular Service. These contributions shall be provided at no charge to the other Partners or to the Pooled Fund.

11.2 Each Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services 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 risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

Locality Development Fund

12.2 A locality development fund will be developed by the CCG and the Council. This is to support the further development of the Tower Hamlets neighbourhoods and localities around the Primary Care Networks (PCNs) involving the wider communities and voluntary sector. The criteria for funding projects will involve working with multiple partners to achieve the aims of the integration agenda through the Tower Hamlets Together Partnership and the Better Care Fund. Both parties will contribute into the fund and will make joint decisions on the award and allocation through the Tower Hamlets Together partnership on behalf of the Health and Wellbeing Board.

Overspends in Pooled Fund

12.3 Subject to Clause 12.1, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

12.4 The Host Partner shall be in breach of its obligations under this Agreement if an Overspend occurs and it is the responsibility of the Host Partner to inform the Partnership Board in accordance with Clause 12.5.

12.5 Where the Pooled Fund Manager identifies an actual or projected Overspend and notifies the Partnership Board in accordance with Clause 8, the provisions of Clause 12.6, 12.7 and Schedule 3 shall apply.

12.6 Subject to Clause 12.7, 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.

12.7 The Partnership Board may agree, in circumstances where an Overspend arises, 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 Partners Financial Contribution to a Non-Pooled 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 Partner is responsible for the management of the Non-Pooled Fund. The Lead Partner 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 or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners and the provisions of Schedule 3 shall apply. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE[7]

13.1 Except as provided in 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 Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

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 each 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 appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

[7] Once the arrangements are confirmed, a reference to s. 256 grants can be included if relevant.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

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

16 LIABILITIES AND INSURANCE AND INDEMNITY[8]

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 (including a Loos arising under an Individual Scheme) 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 any 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.

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[8] This is a sample clause which will need to be discussed. What about any liabilities to third parties that a Partner incurs as a result of a breach by the Provider but in respect of which the Lead Commissioner/relevant Partner is unable to recover from the Provider. Should such loss be shared amongst the Partners? Perhaps apportioned by reference to the value of their respective Financial Contributions? This could be dealt with by way of indemnity or by permitting the Lead Commissioner to take this out of the Pooled Fund, thereby triggering the Overspend provisions.

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.

Conduct of Claims

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

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

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

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

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with the 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 Partner 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 it is 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[9]

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

[9] The Partners could include a procedure in this Agreement for the resolution of conflicts of interest.

19 GOVERNANCE[10]

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Tower Hamlets Together Executive Board (THTEB) which reports into the Health and Wellbeing Board. For these purposes the THTEB Board shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Tower Hamlets Together Executive Board (THTEB) to[11]:

19.2.1 Oversee joint strategic commissioning of services in Tower Hamlets for children and young people, adults and public health.

19.2.2 Coordinate the development of joint strategies for the relevant service areas and ensure necessary arrangements are in place to implement strategies and procure service changes.

19.2.3 Oversee strategic market development and management, and oversee plans to re-commission and de-commission services, aligning this work with joint strategic procurement plans.

19.2.4 Report key decisions to the Tower Hamlets Together Executive and related Delivery Boards as well as to relevant executive and governing bodies of the CCG and Council.

19.3 The THTEB 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 appendix 1.

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 Tower Hamlets Together (THTEB) Board shall be responsible for the overall approval of Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Tower Hamlets Together (THTEB) Board.

20 REVIEW

20.1 The Partners shall produce a BCF Quarterly Report which shall be provided to the Health and Wellbeing Board in such form and setting out such information as required by National Guidance and any additional information required by the Health and Wellbeing Board or National Commissioning Board

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.

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[10] We have set out a proposed approach to governance with an officer working group structure has been suggested. There are three separate functions here which need to be addressed: First Strategic overview of partnership working which is the responsibility of the Health and Wellbeing Board and outside this agreement save to the extent that the HWB signs off the Better care plan and variations to is. Secondly oversight and holding to account the management structures for delivery of the schemes; we have suggested a partnership board to avoid CCG accountability running through the HWB; finally there is the management of the individual schemes. Depending on complexity this could be the pooled fund manager or a commissioning officer, but may be a management group
The Partners will need to go through the detail of how the governance structure will work; the terms of reference for the Board; and wider discussions about whether it would be helpful to set out how the Board will deal with situations where a particular decision falls outside of the scope of delegated authority of the relevant officers.

[11] The Partners will need to determine the specific functions and objectives of the Partnership Board.

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 shall secure 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 Clinical Commissioning Group, as the NHS body, will act as the lead Partner in any such engagement with NHS England.

21 COMPLAINTS[12]

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[13]

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 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.

22.2.1 Each Individual Scheme may be amended or terminated by agreement of the Partnership Board provided that: such termination is possible in accordance with the National Guidance and Law; and

22.2.2 That the Partners ensure that the statutory Better Care Fund Requirements continue to be met.

For the avoidance of doubt, the operation of the Agreement shall continue in respect of the remaining Individual Schemes.

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

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:[14]

12 Consider whether the Partners will develop a joint complaints procedure. If not, we have suggested an approach for each Partner to use its own complaints procedure with cooperation from the other Party.

13 We have set out a suggested approach to termination and default here as a basis for discussion.

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 Partner 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 Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Partner 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 Partner 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 Partner 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[15]

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

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Council's Director of Adult 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 the Partnership Board.

23.5 If the dispute remains after the meeting detailed in Clause 23.3 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

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14 These provision sets out a suggested approach to what happens if the Agreement terminates particularly where there are contracts still in place. The Partners will need to address this in each service contract and also in the individual Scheme Specifications.

15 A sample dispute resolution procedure has been included. Consider for example whether a referral of the dispute will be made to the Board and it should. Would arbitration proceedings be a preferred method of resolution?

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[16]

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[17]

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 Discloser shall use all reasonable endeavours to ensure that the third party keeps the Confidential Information confidential and does not use the Confidential Information for any other purpose than the purpose for which disclosure was made; and

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

25.1.3 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 provided that, to the extent that it is legally permitted to do so, the Discloser advises the other Partner of its intention to do so.

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16 Consider whether the suggested procedure (including the definition of Force Majeure Event and timescales) is acceptable.

17 Confidential information and the sharing of information will need to be considered since the partners have different rules that apply.

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 INFORMATION REGULATIONS

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

26.2 The Partners acknowledge that the decision on whether any exemption to the general obligations of public access to information applies to any request for information received under the 2000 Act and the 2004 Regulations is a decision ultimately for the Receiving Partner.

26.3 The Partners accept and acknowledge that the final decision regarding the disclosure of information under the 2000 Act or 2004 Regulations rests with the Receiving Partner.

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

27 OMBUDSMEN

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

28.1 The Partners will follow the information governance protocol set out in schedule 7, and shall duly observe all their obligations under Data Protection Legislation, which arise in connection with this Agreement.

28.2 The Partners agree to only process Personal Data lawfully and in accordance with the Data Protection Legislation principles.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 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 sent by facsimile, at the time of transmission;

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

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

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 facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

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 Corporate Director of Health, Adults and Communities, Health, Adults and Community Services, London Borough of Tower Hamlets, 4th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG

Tel: 020 7364 2609

Email: Denise.Radley@towerhamlets.gov.uk

and

if to the CCG, addressed to if to the CCG, addressed to: Managing Director of NHS North East London Clinical Commissioning Group of 4th Floor Unex Tower, 5 Station Street, London, E15 1DA

Tel: 0203 688 2316

Email: Selina.Douglas@nhs.net

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 [18]

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

30.2 Where the Partners agree that there will be:

30.2.1 a new Pooled Fund;

30.2.2 a new Individual Scheme; or

30.2.3 an amendment to a current Individual Scheme,

the Partnership Board shall agree the new or amended Individual Scheme and this must be signed by the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or

other matters set out in the relevant Scheme Specification may be made by any Partner but will require agreement from all of the Partners in accordance with the process set out in Clause 30.3. The notice period for any variation unless otherwise agreed by the Partners shall be 3 Months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

30.3 The following approach shall, unless otherwise agreed, be followed by the Partnership Board:

30.3.1 on receipt of a request from one Partners to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partnership Board will first undertake an impact assessment and identify those Service Contracts likely to be affected;

30.3.2 the Partnership Board will agree whether those Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the Partners holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged;

[18] The Partners may find it helpful to set out a procedure for agreeing to add a new scheme to the framework arrangement and the alternative drafting in Clauses 30.1 to 30.3 sets out an example of a more detailed variation procedure.

30.3.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

30.3.4 should this not be possible and one Partner is left financially disadvantaged as a result of holding a Service Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed, be [shared equally between the Partners[19].]

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.

[19] Risk sharing arrangements will be for local agreement between the Partners.

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 by the Partners on the date of this Agreement[20]

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

Signed for on behalf of
NHS North East London CLINICAL COMMISSIONING GROUP

_____

Authorised Signatory

[20] Partners to confirm execution blocks

SCHEDULE 1 – PART 1 INTEGRATED COMMISSIONING AND BUDGET CONTRIBUTIONS

1 OVERVIEW OF SERVICES

1.1 Context and background information

Tower Hamlets has a rapidly growing resident population of 304,900 people – the GLA estimates that it will rise, to 364,500 in 2026 - with a number of distinctive features that impact directly on health and social care services. These include the following:

An unusually young age profile: the borough's population has the fourth youngest median age in the UK, at 30.6, and nearly half of our population is aged 20-39. Only 6% (18,000) of the population is over 65.
A diverse ethnic composition, with widely divergent age profiles between the White British and Bangladeshi populations, the two largest ethnic groups. Over one third of the Bangladeshi population is aged below 16, compared with only 9 per cent of White British residents. Conversely, only 5% of Bangladeshi residents are aged 60 or over, compared with 16 per cent of White British residents.

Both male and female life expectancy are shorter than the national averages (male life expectancy is 78.1 years and female life expectancy is 82.5). On average, a man living in the borough starts to develop health problems from the age of 54, compared to 64 in the rest of the country. For a woman, it is 56, compared to 64. The annual GP consultation rate for adults aged 50-64 in the most deprived parts of the borough is up to twice as high as in wealthier parts of the country.

While residents aged 90+ are by far the smallest group in number, this group is expected to nearly double over the next decade, growing faster than any other.
Compared to London, when adjusted for age, Tower Hamlets has amongst the highest premature death rates for circulatory disease (103.3 per 100,000), cancer (150.9 per 100,000), and respiratory disease (40.4 per 100,000). These conditions typically constitute 75% of all premature deaths.
Around 1,000 Tower Hamlets residents die per year, of whom around 780 will need some form of last years of life care.

19,356 people identified themselves as unpaid carers in the 2011 census. 43.5% of Carers provide more than 20 hours of care per week, compared to 36.9% in London and 36.4% across England. Nevertheless, the bi-annual carers' survey of 2017 found that carer satisfaction has increased significantly over the last three years, with 64% of respondents stating they are extremely, very or quite satisfied with support or services.

2 AIMS AND OUTCOMES

Included in the service specification.

3 THE ARRANGEMENTS

The Tower Hamlets integrated care programme was established in 2013 as one of the pilot sites of the national integrated care pioneer programme. Since 2013 we have been working with health and care providers in the borough to transform the way services are organised to better meet the needs of people who are frail and/or have multiple conditions and, as such, are at risk of an emergency hospital admission.

In 2015 these providers formed Tower Hamlets Together, a multi-speciality community provider, working in partnership to deliver a new model of care for adults with complex needs, a model of care for children and young people, and the development of a population health programme that focuses on prevention. These new models of care will ensure that people have their care coordinated around their needs and that resources are used effectively to match individual and population needs. The new models will also help more vulnerable patients receive care in their own homes, limiting time spend in hospital away from family and friends.

In 2021-22 we are using the Better Care Fund programme for developing closer joint working between our system partners and the emerging Integrated Care System at North East London level to strengthen this partnership approach across integrated care, reduce duplication in the way that services are delivered, and ensure that our joint approach to commissioning improves patients' experience, delivers improvements in health and wellbeing, and provides value for money.

4 FUNCTIONS

Included in the service specification.

5 SERVICES

This agreement is a framework partnership agreement, allowing for a range of different services to be commissioned under pooled fund arrangements or aligned fund arrangements, utilising flexibilities under section 75 of the National Health Service act 2006 where relevant.

This agreement references service specifications which are defined as:

"a specification setting out the detailed arrangements relating to a particular service within a commissioning plan agreed by the parties to be commissioned under this agreement."

6 COMMISSIONING, CONTRACTING, ACCESS

Not Used

7 FINANCIAL CONTRIBUTIONS

Financial year 2021/22. See detailed breakdown in Clause 7 at the commencement date there shall be two pooled funds.

2021/22	**£**
Minimum CCG Contribution	£23,110,504
Additional CCG Contribution	£13,404,970
CCG Total	£36,515,474
iBCF	£16,316,044
Disabled Facilities Grant (DFG)	£2,320,693
Additional LA Contribution	£774,839
LA total	£19,411,576
BCF Total	£55,927,050

Financial resources in subsequent years to be determined in accordance with the Agreement

8 FINANCIAL GOVERNANCE ARRANGEMENTS

As mentioned in Clause 10.

9 VAT

Details of the treatment of vat in respect of the individual scheme set out in Clause 14.

10 GOVERNANCE ARRANGEMENTS

Details in respect of the individual scheme set out in Clause 19.

11 NON FINANCIAL RESOURCES

Details in respect of the individual schemes set out in Clause 11.

12 STAFF

Not used

13 ASSURANCE AND MONITORING

Details in respect of the individual schemes set out in service specifications. Each Scheme has its own individual assurance and monitoring measures via their contract mechanisms as detailed in Schedule 5.

14 LEAD OFFICERS

As set out below:

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Denise Radley Corporate Director of Health, Adults and Communities	London Borough of Tower Hamlets 4th Floor, Mulberry Place, 5 Clove Crescent London E14 2BG	020 7364 2609	Denise.Radley@towerhamlets.gov.uk
CCG	Selina Douglas	NHS North East London Clinical Commissioning Group of 4th Floor Unex Tower, 5 Station Street, London, E15 1DA	0203 688 2316	Selina.Douglas@nhs.net

15 INTERNAL APPROVALS

The authority from the Council's Constitution has been delegated to the Director of Adult Social Care Services (DASS) by Cabinet for sign off for the next 5 years commencing 2021.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

Details in respect of this has been included in Clause 12.

17 REGULATORY REQUIREMENTS

Not Used.

18 INFORMATION SHARING AND COMMUNICATION

Details in respect of this has been included in Clause 28.

19 DURATION AND EXIT STRATEGY

Details in respect of this has been included in Clauses 29-33.

20 OTHER PROVISIONS

Not used.

Part 2 – Agreed Scheme Specifications

This part sets out agreed service specifications between the partners as had been agreed under previous section 75 agreements to which the partners are working.

LBTH Hosted Schemes	
Service/Scheme	**Reablement Team**
Commissioner Lead	LBTH
Annual Budget 21/22	£2,349,289
Objectives	To help people mitigate illness or disability, by learning or re-learning the skills necessary for daily living, following deterioration in health and/or an increase in support needs. To promote and optimise independent functioning, and help people to do as much for themselves as possible, and in particular: - Improving their quality of life - Keeping and regaining skills, especially those enabling people to live independently - Regaining or improving confidence (e.g. for someone who has had a fall) - Increasing people's choice, autonomy, and resilience - Enabling people to be able to continue living at home The service also seeks to ensure: - The safe transfer of support between acute care, community health and social care services and to support service users' return to independent living - The prevention of unnecessary hospital admissions and the facilitation of early supported discharge - To the provision of information and onward referral to other services, so that users/patients and their carers can make choices about support needs - The prevention of premature admissions to residential and nursing care. The service also has the following organisational objectives: - To reduce admissions and readmissions - Financial benefits, in the form of reduced support packages required post-reablement - A sustainable reduction in medium-term support packages, 6-12 months post-reablement.
Service/Scheme	**Community Health Team (Social Care)**
Commissioner Lead	LBTH
Annual Budget 21/22	£1,300,378
Objectives	The strategic objective of the scheme is to improve the experience and outcomes for people at medium or high risk of hospital admission, using co-ordinated, person-centred and Multi-Disciplinary Team (MDT) approaches. The scheme aims to: - Improve partnership working and joint decision making, with earlier referral to, and intervention from, social care. - Provide joint and coordinated multi-disciplinary assessments and person-centred planning, which involves service users and their families from the outset. - Provide early support and information provision to service users and their families to enable them to make informed decisions about care options in the community, with the aim of delaying/preventing the need for long term care provision. - Provide greater continuity and standardisation of community assessment and integrated interventions. - Provide earlier identification and support to carers, thereby preventing

	carer breakdown and the need for crisis response.
Service/Scheme	**7 Day Hospital Social Work Team**
Commissioner Lead	LBTH
Annual Budget 21/22	£1,665,152
Objectives	The 7 day Hospital Social Work Team expedites the discharge of patients for the Royal London Hospital. It has enabled the council to extend the work of the Hospital Discharge Team at the Royal London Hospital from a Monday to Friday to a 7-day service. Social work staff are available at weekends and on public holidays to assess and discharge patients on acute wards who are deemed medically fit for discharge. This has freed up acute beds within the hospital, and allowed for resources to be used more effectively. It has also provided greater capacity for new admissions from A&E requiring an acute bed. The scheme aims to: - Reduce hospital stays for patients, by facilitating speedier discharges, through appropriate interventions. - To improve performance in the area of Delayed Transfers of Care, by increasing, patient flow and reducing trolley rates. - Prevent admission for those without acute medical need and deal with inappropriate delayed discharges for people who require short term admission.(AAU) - Reduce pressure on acute beds by preventing unnecessary hospital admissions.
Service/Scheme	**Brokerage Service - Support for Hospital Discharge**
Commissioner Lead	LBTH
Annual Budget 21/22	£110,778
Objectives	This scheme funds two Brokerage Officers covering 7 day working and OOH working at weekends and evenings until 8pm – includes costings for cover and enhanced salary payments for OOH periods at weekends and bank holidays.
Service/Scheme	**Community Equipment Services**
Commissioner Lead	LBTH
Annual Budget 21/22	£2,184,000
Objectives	Community Equipment Services in Tower Hamlets include: • Community Equipment Service • Telecare Service • Independent Living Hub • Wheelchair service / Pharmacy prescriptions The Community Equipment Service procures stores, delivers, installs, maintains, collects, cleans and recycles daily living, paediatric, moving & handling and sensory impairment equipment, and carries out minor adaptations and alterations to property. The Telecare Service provides a range of front-line services that include: Referral processing, Alarm installation, Alarm call monitoring, Emergency Visiting Response and a Regular Visiting Service. The Service operates 24/7 365 days a year. The service is also the first point of contact for Social Care referrals received Out of Hours, and is responsible for taking referrals relating to Children and Adults Social Care; on behalf of the Out of Hours Emergency Duty Team, Assistive technology delivers and fits a range of innovative technology to residents which enables them to remain at home and independent with

	sustained life choices, the focus is on prevention and a reduction in hospital admission and readmission The strategy arm of the team raise awareness among health and social care professionals through training and reinforcing of good practice at team level The Sight and Hearing service helps anyone who is deaf, blind, suffers from hearing loss, visual loss or a dual sensory loss. The service provides social work support, general information and advice, rehabilitation training and equipment to encourage independent living skills. Work is undertaken with individuals apart from the self-assessment which would need to be re-evaluated in light of any changes and the low vision clinic which is external to the contractual arrangements. **7-Day Community Equipment Provision Team** This scheme will permit community equipment services to be provided to people able to leave hospital for longer hours on a 7 days a week basis. Community Equipment Service personnel will be available to receive requisitions for simple aids to living and complex pieces of equipment, such as hoists, special beds, pressure care, hand rails and so on via dedicated secure electronic faxes, telephone calls and secure emailing. The service will: • avoid unnecessary admissions and trips to A&E, by providing emergency deliveries, repair and replacement of hoisting, special beds and mattresses and other essential toileting and mobility equipment over extended hours. • support hospital teams to carry out safer discharges by providing an out of hours service • minimise and prevent readmissions and Delayed Transfer of Care (DTOC). • facilitate safe, integrated and seamless transfer of patients between hospital, community health and social care services.
Management of the Pooled Fund	This Pooled Fund will be managed as in the Agreement, with the following changes in the treatment of overspends and underspends. In continuation of previous arrangements governing the pooled Fund relating to Integrated Community Equipment Services, the treatment of overspends and underspends shall be as follows: 1. Overspends 1.1. It is expected that the Services shall be managed within the Pooled Fund. Arrangements to prevent and address predicted overspends will be the responsibility of the Host Partner, based on timely information from the Pool Manager and in consultation with the Health and Wellbeing Board and/or Tower Hamlets Together Board or nominated partners. 1.2. Whenever during a Financial Year an overspend in the Pooled Fund is projected the Pool Manager will notify the Partners within five working days, following which the Partners shall agree how to manage the overspend and the Partners shall act in good faith and in a reasonable manner in agreeing the management of the overspend. 1.3. Where an overspend is incurred because of maladministration of the Pooled Fund, the liability for this will rest with the Host Partner. For the purposes of this clause, maladministration shall be deemed to include (without limitation) expenditure outside the terms of this Agreement and without proper authorisation. 1.4. Where an overspend occurs and is not due to maladministration and liability will be shared between the Partners in proportion to their Contributions to the Pooled Fund (for this Service) in that Financial Year.

	1.5. In the event that agreement cannot be reached in respect of any of the matters referred to in this clause 1.1 then the partners shall follow the dispute procedure set out in Clause 23 of this agreement. 2. Underspends 2.1. Whenever an underspend is projected during a Financial Year in respect of the Pooled Fund the Pool Manager will notify the Partners within five working days of such projection being calculated following which the Partners shall agree to how to manage the underspend and the Partners shall keep the position under review. The Partners may agree that the underspend may be used to fund new initiatives for the benefit of the Client Group in accordance with agreed priorities and subject in either case to the Partners' respective financial governance rules, legislation or guidance. The Partners shall act in good faith and in reasonable manner in agreeing the management of the underspend. 2.2. If at the end of any Financial Year there is an underspend in the Pooled Fund the Pool Manager shall identify to the Partners the reasons for the underspend. The underspend shall be apportioned between the Partners in proportion to the Contributions to the Pooled Fund. 2.3. In the event that agreement cannot reached in respect of any matters referred to in paragraphs 2.1 and 2.2 above, the Partners will follow the dispute procedure as set out in Clause 15.
Service/Scheme	**Carers' Support**
Commissioner Lead	LBTH
Annual Budget 21/22	£662,000
Objectives	The joint Carers' Strategy has identified a number of priorities we should be delivering, either via current internal or commissioned services. Through co-designing, the council is committed to ensuring that as many of these priorities as possible will be addressed to minimise shortfalls that carers have said they are experiencing or have already experienced. This strategy aims to ensure that carers are respected; that they have access to good quality information, access the services and support they need to care for their relative or friend, and have a life of their own. The council commissions the Carers' Centre to provide information, advice and guidance services for carers and other providers to access as the first point of call. The council also provides carer-associated support, such as assessments, care packages, respite services, flexible breaks for the various carer groups and ensuring the necessary infrastructure is in place. The strategic objective of the scheme is to help carers to care effectively and safely – both for themselves and the person they are supporting. Since the transfer of safeguarding duties form health to the local authority, the demand for such Independent Mental Health Advocacy (IMHA) and Independent Mental Capacity Advocacy (IMCA) services has increased significantly. The funding will ensure the authority meets its statutory obligations.
Service/Scheme	**Local Authority Support for Health and Social Care Integration**
Commissioner Lead	LBTH
Annual Budget 21/22	£242,253
Objectives	The scheme aims to ensure: - The programme management of BCF-funded initiatives in the council - High level management support for strategic decision making on health and social care integration - Coordination of the council's input to partnership arrangements, such as the Health and Wellbeing Board, Tower Hamlets Together and the Integratd)

	- Manage health and social care partnership governance and planning arrangements within the council - The preparation of dashboards and monthly monitoring of performance measures for internal and external teams and partnerships - Provide advice and guidance to scheme managers to strengthen integration work with health.
Service/Scheme	**Dementia diagnosis and community support**
Commissioner Lead	LBTH
Annual Budget 21/22	£79,800
Objectives	The BME Inclusion service provides community-specific input to BME communities, in order to support people to understand dementia, break down stigma and access services. It does this by undertaking awareness raising at culturally-specific community networks; case finding and building relationships with people with dementia who may be hard to reach; case management through one to one support prioritised to those with the highest needs, and working with GP practices with high patient numbers from Bangladeshi and other BME communities where there is a lower than expected dementia diagnosis rate. The objective of this service is to address the particular issues preventing people with dementia from BME communities from accessing services. Getting a diagnosis of dementia enables people to access services and plan for the future, thereby avoiding admissions in crises to both health and social care services. However, there are significant barriers to people from BME communities getting a diagnosis, as there are strong stigmas associated with dementia, with it being perceived as 'madness', and often hidden by families until the point of breakdown. The scheme aims to: - Increase the proportion of people from Bangladeshi and other BME communities with dementia receiving a formal diagnosis. - Increase the proportion of people from Bangladeshi and other BME communities with dementia receiving a diagnosis while they are in the early stages of the condition. - Identify and support hard- to-reach individuals with dementia and their carers to access services - Provide access to information and guidance - Support people with dementia, their carers and/or family members to access help and services and to experience an integrated range of services that includes access to health and care professionals and other voluntary organisations - Reduce or prevent social isolation experienced - particularly by reducing the stigma associated with dementia. - Increase community awareness and acceptance of dementia - Contribute to shifting from crisis-driven engagement with services to a more preventative focus - Increase the engagement of local people with NHS and statutory services.
Service/Scheme	**Social Worker Input into the Memory Clinic**
Commissioner Lead	LBTH
Annual Budget 21/22	£57,028
Objectives	The scheme provides: - An early assessment of service users in need of social care support. - Early signposting to other non-statutory agencies for those not in need of social care input. - Efficiencies, by reducing the number of referrals made directly to Adult Social Care (Assessment and Intervention Team) - A more seamless service for service users, reducing the number of changes of key workers for the service user and family.

	It seeks to minimise the time a service user may be on the dementia diagnosis pathway if their needs are more likely caused by social care issues, depression or family dynamics and are mimicking deficits in day-to-day functioning. With the input of a Social Worker at an earlier stage in the pathway, the Memory Clinic can signpost or provide appropriate support in a more timely fashion. The social worker offers community assessments under the Care Act (2014), carer's assessments, organises provision of packages of care, signposting and offer advice, information and support. The presence of social work input into the team also enhances the MDT planning process.
Service/Scheme	**LinkAge Plus**
Commissioner Lead	LBTH
Annual Budget 21/22	£645,739
Objectives	This is a preventative service which will support this vision by providing Tower Hamlets residents aged 50 and over universal access to: - Community outreach; - A wide range of physical and social activities; - Information and low level Advice, including signposting and onward referrals as required; and - A range of health-related services.
Service/Scheme	**Adult Learning Disability Service**
Commissioner Lead	LBTH
Annual Budget 21/22	£253,521
Objectives	The Adult Learning Disability Services is comprised of three separate schemes, which are listed below. **1. Developing Capacity** This scheme funds a team within the Community Learning Disability Service who: • Provide training and advice to staff in positive behaviour support (PBS) approaches to support people who present with behaviour that challenges. • Support family carers of people who present with behaviour that challenges with training advice and consultation and promote peer support networks with the aim of increasing resilience and reducing the need for additional social care support and home placement breakdown. • Work with local community services, activities and groups to develop their awareness, capacity, outreach and inclusion of adults with learning disability. The aim of the scheme is to ensure that the support needs of individuals with the most complex needs are met within a person-centred Positive Behaviour Support framework to reduce the risk of placement breakdown and associated increase costs in care provision. **2. Shared Lives** The scheme funds a Shared Lives Manager post and associated business support and on-costs. The post sits within the Community Learning Disability Service. Shared Lives is a Registered service and is subject to ongoing CQC inspection, therefore adequate staffing is required to monitor regulated activity. **3. Hospital Admission and Discharge**

	A contribution is also made to support hospital discharge for people who have a learning disability. (0.5 FTE)
Service/Scheme	**Initial Assessment Service - Support for Safeguarding**
Commissioner Lead	LBTH
Annual Budget 21/22	£55,706
Objectives	This is a new scheme added in 2021-22. It will fund an ELFT post but sit within MASH as part of the safeguarding point of access in the IA team. The scheme will support better pathways for people with MH conditions who come to the attention of the police, potentially reducing the need for hospital admission or exacerbation of a MH condition.
Service/Scheme	**AMHP Service - Support for Hospital Discharge**
Commissioner Lead	LBTH
Annual Budget 21/22	£66,327
Objectives	This scheme funds an AMHP in the AMHP Centralised Team who supports the team to assess people promptly within the Royal London Hospital, including A&E, enabling people to be discharged in a timely manner.
Service/Scheme	**Practice Development - OT Joint Practice Lead**
Commissioner Lead	LBTH
Annual Budget 21/22	£30,000
Objectives	This scheme supports the development of integrated working in therapeutic practice and also provides support to the student placement programme. This is in line with our 'grow your own' approach to address OT recruitment issues. (.5 FTE)
Service/Scheme	**Disabled Facilities Grant**
Commissioner Lead	LBTH
Annual Budget 21/22	£2,320,693
Objectives	Expenditure of the DFG will centre on meeting the council's duties to provide adaptations and facilities in the homes of disabled people, as set out in the Housing Grants, Construction and Regeneration Act, 1996. The council provides services to clients requiring adaptations through its Occupational Therapist service and Home Improvement Agency. It works closely with Registered Providers which own the majority of social housing in the borough. The tenants of the borough's Registered Providers account for around 75% of DFG expenditure. This spend reflects the relatively low level of owner occupied housing in the borough. Types of work eligible for Grant funding are: - To make it easier to get into and out of a dwelling, for example, by widening doors and installing ramps; - Ensuring the safety of a disabled person, for example, by improving lighting to ensure better visibility; - Improving access within a dwelling - including making facilities such as toilets, washbasins and bath (and/or shower) facilities more accessible or by installing appropriate facilities; - The improvement or provision of a domestic heating system, which is suitable to the needs of the disabled person; - To improve access to and from the garden of the home. DFG will be used to: • decrease hospital admissions as a result of slips, trips and falls in the home. (The adaptations enable qualifying residents to remain safe in their homes.) • increase in general well-being – The adaptations provided allow

	people to be more independent in their homes. • ensure disabled residents have safe access in and around their homes and access to facilities. • Provision of AT equipment to ensure residents remain safe in their homes.
Service/Scheme	**Improved BCF**
Commissioner Lead	LBTH
Annual Budget 21/22	£16,316,044
Objectives	IBCF is being used by the council to address a number of high priority needs, including demographic pressures, safeguarding and ethical care and to meet inflationary pressures within the care system. To strengthen the stability and sustainability of the provider market, it is also proposed to increase nursing home provision in the borough. This will complement already agreed uplifts in care funding to improve the quality of residential/nursing provision and wider support in the community, such as enhancing home care linked to hospital discharge and improving reablement approaches in day support. Further investment of approximately £1.4m in a full year is being made that will benefit health services in the borough. This includes provision to enhance capacity and skills in the Community Health Social Work team to increase the number of people it is able to support on the integrated care pathway. It also includes the enlargement of the Hospital Social Work Team to get more people home quickly and safely and reduce the need for residential placements. In addition, the IBCF is being used to fund social work support to strengthen the continuing healthcare process. A number of initiatives are being funded that are designed to address unmet need in mental health services. These include projects targeted young people transitioning from children's services to adults' and working with people at risk of anti-social behaviour. For instance, a Community Multi-Agency Risk Assessment Case Conference, MARAC, is being established, along with an Independent Anti-Social Behaviour Victim Advocate post. A scheme for people at risk of self-neglect and self-harming behaviours is also being funded. A number of areas of unmet need and services experiencing demand pressures will also be supported via IBCF. Initiatives include a project to reduce isolation among vulnerable older people. Additional resources are also being directed to the reablement service to address rising demand, and a significant sum has been allocated to commission additional support to address assessment and review backlogs in adult social care. Finally, the IBCF is being used to support the implementation of a number of adult social services transformation initiatives.
CCG Hosted Schemes	
Service/Scheme	**Out of Borough Social Worker**
Commissioner Lead	CCG
Annual Budget 21/22	£61,200
Objectives	Provision of social worker, from Monday to Friday, to liaise with out-of-borough local authorities to facilitate discharge for patients who do not live in Tower Hamlets. To support wards in Royal London Hospital to support with discharge of all in-patients.
Service/Scheme	**Age UK Last years of Life**
Commissioner Lead	CCG
Annual Budget 21/22	£93,641
Objectives	- To work closely with hospitals and GP's in Tower Hamlets to identify people for service input; - To engage socially isolated people who may be reluctant to accept help and support - particularly from the statutory sector;

	- To signpost and refer people into support services provided by local NHS, local Government and voluntary sector at the earliest opportunity; and - Work with other service providers to provide seamless care. - Needs assessment o Understand people's requirements in their last years of life. - Support o Provide a befriending service; o Provide practical help in the home that is not covered by social services; o Provide carer's support enabling the carer to have short term 'care-free' time; (i.e. a few hours per week); and o Provide holistic support e.g. therapeutic services - Prevention o To protect the health and wellbeing of both cared for people and their carers through befriending, practical and emotional support - Patient / care experience o To improve the experience of service users and their carers; - To generate feedback from carers and cared for people on their needs and the degree to which local services are accessible, equitable and appropriate.
Service/Scheme	**Integrated Community Health Team (incorporating Extended Primary Care Team)**
Commissioner Lead	CCG
Annual Budget 21/22	£14,184,788
Objectives	The Integrated Community Health Team provides health and social care input to housebound patients over the age of 18. The service offers a comprehensive range of specialities within one multi-disciplinary team, including nursing, therapies, social care, mental health and case management. . Services include: • Extended Primary Care Teams • Frailty Assessment Clinic • Rapid Response Team • Community Rehabilitation Service • Continuing Healthcare Team • Foot Health • Continence Team • District Nursing Evening Service The scheme aims to: • 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.
Service/Scheme	**Integrated Clinical and Commissioning Quality NIS (Primary Care)**
Commissioner Lead	CCG
Annual Budget 21/22	£4,599,249
Objectives	The over-arching aim of this Network Incentive Scheme (NIS) is to support high quality primary care for patients with one or more long-term conditions. This scheme aims to provide holistic, person-centred, packages of care that support partnership work with patients, their families and carers. The scheme also supports the development of a 'learning health system' within primary care, under the following principles: - Every consenting patient's experience is available for learning - Best practice is immediately available to support decisions - This happens routinely, economically and accessibly. It also funds the GP element of engagement, both with specialist consultants (e.g. the 'diabetes MDT' and practice level meetings with practice-aligned psychiatrists and system-level involvement, such as locality commissioning and Locality Health and Wellbeing Boards).
Service/Scheme	**RAID (Rapid assessment, interface & discharge)**
Commissioner Lead	CCG
Annual Budget 21/22	£2,414,259
Objectives	- 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 admitted to wards at the Royal London Hospital - Reduce re-attendances at A&E by patients with a mental health or drug or alcohol problem who have been admitted to wards at the Royal London Hospital - Improve the experience of patients with a mental health or drug or alcohol problem who have been admitted to wards at the Royal London Hospital or attend A&E - Reduce direct admissions to care homes by people with a mental health or drug and alcohol problem - Improve Royal London Hospital staff awareness, skills and knowledge in mental health and drugs and alcohol - Improve in the identification of hidden harm among families related to drug or alcohol.
Service/Scheme	**Autism Diagnostic and Intervention Service**
Commissioner Lead	CCG
Annual Budget 21/22	£338,580
Objectives	The aims of this service are to: - Provide a high quality diagnostic and intervention service for high functioning adults in Tower Hamlets (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD). - Sub-contract a local Third Sector provider (JET) to provide a range of support options for people diagnosed with ASD, and facilitate appropriate referral and signposting to other services where needed. - Deliver a diagnostic service for adults (18+) who may have ASD

	(including Asperger's Syndrome) for whom no care pathway currently exists (those who have a co-existent learning disability are diagnosed by the community learning disability team) - Deliver a service for reviewing patients already diagnosed with ASD where an expert review and re-signposting is needed. - Deliver a timely diagnosis to those who may present with ASD behavioural conditions and symptoms - Deliver a virtual service that incorporates the best clinical practice with regard to adults with ASD - Provide post diagnosis support and brief interventions for adults with ASD - Provide clear pathways and signposting to other local services, and support for adults with ASD to access those services - Provide a community focused model that promotes greater opportunity for support within the community for people with ASD - Provide a model of care that actively supports principles of non-discriminatory practice and service delivery and avoids unnecessary and disruptive transitions across a range of providers - Ensure recognition of the role of those with caring and parental responsibilities and (with permission of the person with ASD) to ensure their participation in discussions and decisions whenever possible. - Provide clear pathways and signposting to other local services, and support for adults with an alternative diagnosis to ASD.
Service/Scheme	**Mental Health Recovery College**
Commissioner Lead	CCG
Annual Budget 21/22	£126,740
Objectives	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 to learn how to manage these better in pursuit of their aspirations. It will promote: - The delivery of a planned, co-produced and co-delivered learning programme covering a range of mental health and physical health-related topics that provides education as a route to recovery, and foster increased resilience and self-management. - Collaboration and co-production between people with personal and professional experience of mental health challenges; and provide an educational approach operating on college principles. It will use strengths-based and person-centred approaches that are inclusive, aimed at people with mental health and physical health challenges, their relatives and carers and staff; and focused on mental health recovery and helping people reach their own goals. - Increased use of scheduled care and decreased use of episodic care - Decreased or better managed symptoms of mental ill health - Improved mental health wellbeing.
Service/Scheme	**Community Geriatrician Team**
Commissioner Lead	CCG
Annual Budget 21/22	£132,501
Objectives	Funding will be maintained to increase the capacity of the existing Community Geriatrician Team (part of the Integrated Community Health Team) to enable additional caseload and more effective Multi-Disciplinary Team working. The purpose of the role is to provide specialist input to both practitioners and patients in the community. This includes work such as attending community MDT meetings, delivering training for General Practice staff (via PLT sessions) and undertaking ad-hoc visits for housebound patients.

Service/Scheme	**Psychological Support for People with LTCs**
Commissioner Lead	CCG
Annual Budget 21/22	£150,000
Objectives	The service will pilot enhanced psychological care for people with poorly controlled long term conditions in general practice in Tower Hamlets. The objectives of the service are: - To support all primary care staff to detect psychological distress and mental health problems in people with long term conditions and to support them to access mental health care at the right level - To improve the ability of all primary care staff to support people living with long term conditions to self-care for their conditions by promoting and supporting lifestyle behaviour change and treatment adherence as part of care planning processes. - To offer direct psychological work to decrease psychological distress in people with poorly controlled long term conditions to improve emotional wellbeing and health outcomes.
Service/Scheme	**Specialist Palliative Care (St Joseph's)**
Commissioner Lead	CCG
Annual Budget 21/22	£2,425,271
Objectives	- To provide high quality, efficient and effective Specialist Palliative Support for Last Years, Months and Days of Life Care through a trained and competent workforce - To use a multi-disciplinary approach to care with access to the full multi-disciplinary team as defined by NICE Supportive and Palliative Care Guidelines - To advise and support nurses, doctors, GP's and other members of the wider health and social care team providing care to the patient and their carer/family - To provide timely and appropriate care based to patients and their carers on best practice guidelines and using competent, trained staff - To be responsive to specific needs relating to patients" age, gender, disability, race, religious and cultural beliefs and sexual orientation - To provide a resource for generic staff in providing Specialist Palliative Support for Last Years, Months, Days of Life Care - To deliver care along appropriate pathways and against agreed productivity targets.
Service/Scheme	**Barts Acute Palliative Care Team**
Commissioner Lead	CCG
Annual Budget 21/22	£974,344
Objectives	-Specialist advice about symptom control as well as psychological and social support to patients, families, carers and staff. -In the early stages of illness, palliative care may be provided alongside other active treatments. -For patients at the end of their life the service aims to provide appropriate end of life care to ensure comfort and dignity in death. -Provides families, partners and carers expert support in bereavement. -Support end-of-life patients dying in their preferred place of care -Ensure actively dying inpatients referred to the specialist palliative care team for assessment and management -Ensure actively dying inpatients that are referred to specialist palliative care are seen within one working day unless in an emergency -Ensure actively dying patients nursed via the Compassionate Care plan (CCP)
Service/Scheme	**Admission Avoidance & Discharge Service (incorporating Discharge to Assess)**
Commissioner Lead	CCG
Annual Budget 21/22	£850,955

Objectives	A pilot for a discharge to assess model was funded in 2015/16. Further operational resilience funding has been provided from September 2016 to March 2018 for the Admission Avoidance & Discharge Service (AADS), which incorporates the Discharge to Assess model for patients at the Royal London Hospital. The community service operates 7 days per week from 8am-6pm, with up to 6 weeks' input. The team takes a proactive and responsive approach to discharge and aims to triage patients within 2 hours of referral. Since July 2017, patients who are expected to return to their usual place of residence, who have had a positive checklist, are awaiting a continuing health care assessment (DST) and are expected to return to their usual place of residence can have this assessment completed at home.
Service/Scheme	**Age UK Take Home and Settle**
Commissioner Lead	CCG
Annual Budget 21/22	£114,000
Objectives	The Take Home and Settle scheme provides a 7-day service, working closely with health and social care to support and deliver integrated and co-ordinated care to older people and their carers across Tower Hamlets. It is available to patients aged 50+ who are registered with a GP within the London Borough of Tower Hamlets. It prioritises those who live alone, are socially isolated, or are at risk of readmission. The scheme aims to achieve its objectives by: - Delivering practical support to those patients at risk of admission or re-admission to hospital (e.g. adults with at least one long term condition; those living with dementia). - Reducing delayed transfer of care across Royal London and Mile End Hospital. - Preventing unnecessary admissions through A&E, by providing practical and emotional support to patients. - Working closely with health and social care to improve patient experience, reduce costs and reduce the number of occupied bed days, by providing practical support to older people. - Reducing avoidable re-admissions within a 28-day period through the lack of practical support at home. - Proactively engaging with NHS re-enablement.
Service/Scheme	**Locality Development Fund**
Commissioner Lead	CCG
Annual Budget 21/22	£968,487 (£555,410+ £413,077)
Objectives	A locality development fund has been developed by the CCG and the Council. This is to support the further development of the Tower Hamlets neighbourhoods and localities around the Primary Care Networks (PCNs) involving the wider communities and voluntary sector. The criteria for funding projects will involve working with multiple partners to achieve the aims of the integration agenda through the Tower Hamlets Together Partnership and the Better Care Fund. Both parties will contribute into the fund and will make joint decisions on the award and allocation through the Tower Hamlets Together partnership on behalf of the Health and Wellbeing Board.
Service/Scheme	**Spot Purchase (overseen by CSU)**
Commissioner Lead	CCG
Annual Budget 21/22	£88,000
Objectives	To purchase beds predominantly for patients with complex needs to undertake assessments for eligibility. There is a 6-week limit. Patients must be TH residents and registered with a GP in the borough.

A. Introduction

The government has provided a national discharge fund via the NHS, for quarters 1 and 2 of 2021/22 (1 April 2021 to 30 September 2021), to help cover some of the cost of post-discharge recovery and support services/ rehabilitation and reablement care following discharge from hospital. These financial arrangements apply for patients discharged or using discharge services during that time period.

Systems must ensure they provide adequate health and social care discharge services, operating seven days a week during quarters 1 and 2 of 2021/22, to ensure people receive the most appropriate care at home where possible. The national discharge fund can be used to fund discharge services covered by the hospital discharge programme seven days a week inquarters 1 and 2. Systems should seek also to improve discharge performance and support hospital elective recovery plans.

The government has agreed to fund, via the NHS, new or extended packages of care on discharge from hospital starting on or before 30 September 2021.

B. Requirements of the Hospital Discharge Service

The requirements of the Hospital Discharge Service is included at Appendix 1 of Part Seven of Schedule 1

This Appendix is the 'Hospital Discharge and Community Support' guidance published by NHSE in May 2021.

In accordance with the 'Hospital Discharge and Community Support' guidance' the CCG and LBTH have agreed the following;

Duration of national discharge funded care are as follows for quarters 1 and 2 of 2021/22 (Scheme 3).

People discharged between 1 April 2021 and 30 June 2021 (inclusive) will have up to six weeks of funded care.

People discharged between 1 July and 30 September 2021 (inclusive) will have up to four weeks of funded care.

Scheme 3: funds patients discharged from 1 April 2021 to 30 September 2021.

C. Funding and Support

The Hospital Discharge Service Extension is included at Appendix 1 of Part Seven of Schedule 1 as follows;

From 1 April 2021 each integrated care system (ICS) is allocated a system budget. The budget will continue to be held centrally by NHS England and NHS Improvement, with clinical commissioning groups (CCGs) being reimbursed based on their actual spend.

Where a system uses its allocated discharge budget in full it will need to fund and maintain hospital discharge services from its core system budgets up to 30 September 2021. This is to ensure that there is no reduction in activity on discharge pathways, performance is maintained and delays in discharging people are minimised during all of these six months.

Budgets have been allocated to systems using a blended approach, which has regard to weighted population and actual spend on national discharge support Scheme 2 in 2020/21 (from September 2020 to March 2021).

The national discharge fund is available to fund the additional costs of:

1. Services that support the new or additional needs of an individual on discharge from hospital. This will include recovery and support services, such as rehabilitation and reablement to help people return to the quality of life they had prior to their most recent admission.

2. Designated care settings for those discharged from acute care who are COVID-positive and cannot return directly to their own care home until 14 days of isolation has been undertaken.

The additional funding available to support delivery of hospital discharge should only be used to fund activity arising from the programme that is over and above activity normally commissioned by NEL CCG and LBTH.

The Financial Principles for Hospital discharge programme for the duration of Scheme 3 has been agreed by NEL CCG's and partners and included at Appendix 3.

D. Assessments and Funding Flows

NEL CCG and LBTH should ensure they undertake joint planning at health and wellbeing board (HWB) level, in line with the wider funding allocation for the ICS footprint to ensure equitable distribution.

It is expected that, an assessment for ongoing health and care needs takes place within the six (or four) weeks of discharge and that a decision is made about how ongoing care will be funded by this point. NEL CCG will not be able to draw down on national discharge funding inrespect of care provided after the six (or four) week period.

The ongoing cost of the health and care needs will then be apportioned according to the outcome of the assessment and this assessment will have determined who funds care beyond the national discharge- funded period.

On the rare occasion that a decision on ongoing care requirements and funding route is not reached within the six week (or four week) timeframe, the responsibility falls on both parties to agree the costs until the relevant care assessments are complete. Costs from week seven (or five for packages starting from 1 July) cannot be charged to the national hospital discharge budget and must be met from existing budgets.

The funding arrangements described in this Part Three apply to care packages starting from 1 April 2021 and replace previous Hospital Discharge Service Scheme 2 funding arrangements introduced on 1 September 2020 as described in the Hospital Discharge Service: Policy and Operating Model dated 21 August 2020.

Where care packages started before 1 April 2021 and continue to be funded in 2021/22 this will be under Hospital Discharge Service Scheme 2 arrangements.

E. Monitoring of hospital discharge expenditure and activity

The CCG will submit a monthly non-ISFE return to NHS England, by the required deadline, that incorporates the actual spend on the Hospital Discharge Service in the preceding month. Following the monthly reconciliation carried out by the CCG and the Local Authority, any over/under claiming in a month will be adjusted in the following month's Non-ISFE submission. The "HDP non ISFE return" is included at Appendix 2 of Part 3 of Schedule 1. If deadlines are altered the CCG will notify the Council as soon as possible after the CCG becomes aware of the change.

The Council must complete the Local Authority section of the HDP Non-ISFR return template monthly; this template included at Appendix 2 of Part 3 of Schedule 1.

When	Party responsible	Action
During the preceding month	London Borough of Tower Hamlets	Accurately records expenditure under the Hospital Discharge Service on the Local Authority Spend reimbursement template
At the end of the preceding month	London Borough of Tower Hamlets	Close Local Authority Ledger for the preceding month
Working Day 7 of the month	CCG	Close CCG Ledger for the preceding month
Midday, Working Day 4 of the month[1, 2]	London Borough of Tower Hamlets	Submit final Local Authority HDP Non-ISFR return to the CCG with working papers and evidence to support claim
Working Day 5 of the month	London Borough of Tower Hamlets & CCG	Meeting held to discuss claim figures
COP, Working Day 8 of the month[2]	CCG	Complete and Submit final Non-ISFE return to NHS England
Working Day 9 of the month	London Borough of Tower Hamlets	Send Invoice to CCG for Hospital Discharge Service monthly amounts – the invoice should be marked for the attention of Sunil Thakker, Director of Finance

Working Day 16 of the month	CCG	Complete and Submit cash drawn down request to NHS England
Working Day 17 of the month	London Borough of Tower Hamlets and the CCG	Carry out a retrospective month-end reconciliation to ensure the actual costs submitted in the Non-ISFE reconcile back to the local authority and CCG actual, allowable Hospital Discharge Service costs.
Working Day 1 of the following month	NHS England	Release cash to the CCG Bank Account
Next available BACS run	CCG	Pay invoice / transfer money to LBTH

F. The Timetable for monthly activities relating to the Hospital Discharge Service

The Working Day 8 deadline

Year	Reporting Month	Deadline (WD8) COP
2021/22	April 21	12/05/2021
	May 21	10/06/2021
	June 21	12/07/2021
	July 21	11/08/2021
	August 21	10/09/2021
	September 21	12/10/2021
	October 21	10/11/2021
	November 21	10/12/2021
	December 21	13/01/2022
	January 22	10/02/2022
	February 22	10/03/2022
	March 22	12/04/2022

E. Financial Reporting

Expenditure will be recorded under the following Expenditure Categories:

Expenditure Categories	**Definition**
Pathway 1	Clients able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.
Pathway 2	Recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home
Pathway 3	People discharged to a care home for the first time plus existing care home residents returning to their care setting following discharge. Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.
Designated Care Setting	Clients that are likely to be infectious with Covid-19 are discharged to a designated care setting as step-down prior to discharge back into a registered care home setting in line with government guidance on infection control
Hospice	For people identified as being in the last days or weeks of their life following discharge, to facilitate this rapid discharge transfer may be to a hospice
Other Care Accommodation	Other forms of support may be available to aid rapid discharge including extra care, sheltered accommodation and supported living.
Other	Other costs may be incurred to aid the rapid discharge of clients into the above pathways.

APPENDIX 1 – Hospital Discharge and Community

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APPENDIX 2 - non ISFE return template for financial reporting

Section 75 non ISFE
- Hospital Discharge

APPENDIX 3 – Local Authority spend reimbursement template

Section 75 Local
Authority Template

APPENDIX 4 – Financial Principles - Hospital discharge programme (NEL CCG's) - Scheme 3

Draft - HDP
Financial Principles

SCHEDULE 2 – GOVERNANCE[21]

1 **Partnership Board**

1.1 The Tower Hamlets Together Executive Board (THTEB) is the Partnership Board, as set out in the remainder of this Schedule and elsewhere in this agreement.

2 **Role of Partnership Board**

2.1 The Partnership Board shall:

2.1.1 provide strategic direction on the individual Schemes and Projects. This includes ensuring there are appropriate links and engagement between all authorities involved in agreements in the Borough;

2.1.2 receive financial and activity information;

2.1.3 review the operation of this Agreement and performance manage the Services;

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

2.1.5 review and agree annually revised Schedules, as necessary;

2.1.6 review and agree all BCF and joint commissioning business cases;

2.1.7 oversee the Better Care Fund (BCF) and associated Section 75 agreement;

2.1.8 review and agree annually a risk assessment;

2.1.9 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.

2.1.10 request such protocols and guidance as it may consider necessary in order to enable staff employed by the Partners to manage the pooled budgets and approve expenditure from Pooled Funds.

3 Partnership Board Support

3.1 The THTEB will be supported by Officers from the Partners, as required.

4 Meetings

4.1 The THTEB will meet monthly at a time to be agreed, or more frequently at the request of any member.

4.2 The quorum for meetings of the THTEB shall be a minimum of three (3) [including one (1) representative from each of the Partner organisations.

4.3 Decisions of the THTEB 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 THTEB, which may be called especially to resolve the issue. 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 BCF Section 75 agreement.

[21] This is only an initial example. Other options include a formal Regulation 10 Committee (suitable only where pooled fund with Lead commissioning and no non S75 matters) or a parallel committee structure if the local Authority has opted back to committee governance.

4.4 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 Delegated Authority

5.1 The THTEB is authorised within the limitations of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:-

5.1.1 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

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

Appendix 1. THTEB Terms of Reference Document.

Tower Hamlets Together Board TOF

SCHEDULE 3 – FINANCIAL ARRANGEMENTS, RISK SHARE AND OVERSPENDS[22]

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

Pooled Fund Management

2. 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

3. Where potential or actual Overspends are reported in respect of any individual scheme the Partnership 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.

4. 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.

5. 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.

6. 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.

Underspend

7. Any underspends shall be reported to the partnership and any reallocation of resources agreed mutually.

[22] The Partners will need to carefully consider how to deal with Overspends and whether this will be an Agreement wide arrangement or different for each Individual Scheme.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD PARTNER OBLIGATIONS[23]

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.

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;

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

2.7 an Activity Management Meeting;

2.8 Contract Management Meeting;

2.9 Review Meeting;

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

3 The Lead Commissioner shall not:

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

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

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[23] These are illustrative only of the sorts of things that the Partners may want to have reported, agreed etc. It is based on the NHS Standard Contract so will need to be amended to reflect the fact that Councils are likely to commission some services on their own contracts. The Partners need to consider/amend these and consider whether there are other restrictions or requirements that need to be imposed. Also consider if consent would be needed from all Partners or just relevant Partners (e.g. dependant on the type of services affected)

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

3.4 give any approvals under the Service Contract;

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

3.6 suspend all or part of the Services;

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

3.8 serve any notice;

3.9 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.

4 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.

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

6 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[24]

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

[24] These are illustrative only of the sorts of things that the Partners may want to have reported, agreed etc. The Partners need to consider/amend these and consider whether there are other restrictions or requirements that need to be imposed. Also consider if consent would be needed from all Partners or just relevant Partners (e.g. dependant on the type of services affected)

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

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 methods:

   - A dashboard of key performance indicators to be reported regularly to the Partnership Board.
   - Exception reporting to the Partnership Board by Lead Commissioners of individual schemes within this Agreement.
   - Quarterly progress reporting of the Single Incentive Scheme.

2. The Partnership Board will use the exception reporting process, 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. A quarterly report prepared by the Lead Commissioner shall also include the income and expenditure report required by Clause 8.2.7 of this Agreement.

6. 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.

7. The Pooled Fund Manager(s) 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.

8. As and when directed by the Partnership Board as per Schedule 2, Clause 2.1.9, the Pooled Fund Manager(s) shall be responsible for preparing exception reports to the Health and Wellbeing Board.

SCHEDULE 6 – BETTER CARE FUND PLAN

Details in respect of this has been included in Schedule 1 Part 2 Service specifications.

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. The Partners agree to comply with appropriate Information Governance Protocols.

2. Information Governance - including assurance of compliance with the Data Protection Legislation, alongside the requirements of the Caldicott Guardians for each Partner - is a key component of the Tower Hamlets Together Partnership. Details of the Information Governance protocols in place to support the Programme can be obtained from NHS North East London CCG and London Borough of Tower Hamlets.

3. In particular, NHS numbers will be used by the Council as the common identifier for individual recipients of services, and the council reaffirms 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 18 and over whose services are being provided under the Children and Families Act 2014 and related legislation and regulations.

4. Each Partner needs to ensure that they achieve at least a Level 2 in their Information Governance Toolkit requirements.

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