TOWER HAMLETS

MAYOR'S EXECUTIVE DECISION MAKING

Monday, 21 March 2016

Mayor's Decision Log No. 126

1. BETTER CARE FUND (Pages 1 - 94)

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Matthew Mannion, Committee Manager, Democratic Services
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Individual Mayoral Decision Proforma Decision Log No: 126	TOWER HAMLETS
Report of: Luke Addams, Acting Director of Adult Services	**Classification:** Unrestricted
The Better Care Fund in Tower Hamlets: Review of Progress to Date and Proposed Programme for 2016-17	

Is this a Key Decision?	**No**
Decision Notice Publication Date:	16 February 2016
General Exception or Urgency Notice published?	**Not required**
Restrictions:	None
Reason for seeking an Individual Mayoral Decision:	There is a need to provide continuity of funding from 1 April 2016 for ongoing schemes. It was also necessary for the Health and Wellbeing Board, which oversees the BCF programme, to consider and agree its contents. The HWBB meets only quarterly, and met on 15 March 2016. It was not practicable for the BCF programme to be signed off on behalf of the council by the Cabinet until 5 April. Therefore, the Mayor agreed to consider the BCF programme by IMD.

EXECUTIVE SUMMARY

Following officer-level scrutiny and consultation with the Integrated Care Board and the Health and Well-Being Board, the Mayor is asked to agree the proposed BCF programme for 2016-17, as summarised in paragraph 3.11 of the attached report, and to agree to delegate to the Director of Adult Services any final amendments required in the light of feedback on the borough's proposals by NHS England. The Mayor is specifically recommended to agree that the council should enter into the required section 75 agreement with the Tower Hamlets Clinical Commissioning Group.

As there is a need to provide continuity of funding for ongoing schemes pending the final agreement of the BCF programme by NHS England, the Mayor is also asked to agree that, council-led schemes should be guaranteed funding until the end of June 2016, unless determined otherwise by the Director of Adult Services in consultation with the Mayor, as the Chair of the Health and Wellbeing Board.

DECISION

Recommendations:

The Mayor is recommended to:

1. note progress with the Better Care Fund (BCF) programme in 2015-16, as set out in the report to the Integrated Care Board attached as Appendix 1.
2. note that the final form of the BCF programme is subject to ratification by NHS England, and that this is not expected to occur until mid-May 2016.
3. note that much of the proposed programme for 2016-17 is a continuation of the 2015-16 programme.
4. agree the proposed BCF programme for 2016-17, as summarised in paragraph 3.11 and approve the proposed agreement under section 75 of the NHS Act 2006 (Appendix 2), subject to any final amendments required following the NHS assurance process.
5. agree that, pending the agreement of the BCF programme and plan by NHS England, council-led schemes should be guaranteed funding until the end of June 2016, unless determined otherwise by the Director of Adult Services in consultation with the Mayor, as the Chair of the Health and Wellbeing Board.
6. agree that any final amendments to the s75 agreement should be delegated to the acting Corporate Director of Adult Services, following consultation with the Mayor and Corporate Director of Law, Probity and Governance, to execute any necessary documents to give effect to this decision.
7. note that day-to-day governance of the BCF programme in 2016-17 will be delegated to the CCG's Complex Adults Programme Board, on which the council will be represented.
8. note that a comprehensive review of the BCF programme will take place in 2016-17, as part of wider reviews of joint working between the council and the CCG.

APPROVALS

1. (If applicable) Corporate Director proposing the decision or his/her deputy

I approve the attached report and proposed decision above for submission to the Mayor.

Signed ..... Date 16/3/16

2. Chief Finance Officer or his/her deputy

I have been consulted on the content of the attached report which includes my comments.

Signed ..... Date 2C 16/3/16

3. Monitoring Officer or his/her deputy

I have been consulted on the content of the attached report which includes my comments.

(For Key Decision only – delete as applicable)
I confirm that this decision:-
(a) has been published in advance on the Council's Forward Plan OR
(b) is urgent and subject to the 'General Exception' or 'Special Urgency' provision at paragraph 18 or 19 respectively of the Access to Information Procedure Rules.

Signed ..... Date 18/03/16

4. Mayor

I agree the decision proposed in paragraph above for the reasons set out in the attached report.

Signed ..... Date 18/3/16

Individual Mayoral Decision 17 March 2016	
Report of: Luke Addams, Acting Director of Adult Services	**Classification:** Unrestricted
The Better Care Fund in Tower Hamlets: Review of Progress to Date and Proposed Programme for 2016-17	

Lead Member	**Councillor Amy Whitelock Gibbs, Cabinet Member for Health & Adult Services**
Originating Officer(s)	Steve Tennison Senior Strategy, Policy and Performance Officer – Integration Lead
Wards affected	All wards
Key Decision?	No
Community Plan Theme	A healthy and supportive community

Executive Summary

This report outlines progress with the Better Care Fund (BCF) programme in 2015-16 and seeks the agreement of the Mayor to the proposed Better Care Fund programme for 2016-17. It covers a more detailed report presented to, and endorsed by, the Integrated Care Board on 18 February 2016 and the Health and Wellbeing Board on 15 March 2016. It also covers a provisional legal agreement under section 75 of the NHS Act 2006 (Appendix 2).

Recommendations:

The Mayor is recommended to:

1. note progress with the Better Care Fund (BCF) programme in 2015-16, as set out in the report to the Integrated Care Board attached as Appendix 1.
2. note that the final form of the BCF programme is subject to ratification by NHS England, and that this is not expected to occur until mid-May 2016.
3. note that much of the proposed programme for 2016-17 is a continuation of the 2015-16 programme.
4. agree the proposed BCF programme for 2016-17, as summarised in paragraph 3.11 and approve the proposed agreement under section 75 of the NHS Act 2006 (Appendix 2), subject to any final amendments required following the NHS assurance process.
5. agree that, pending the agreement of the BCF programme and plan by NHS England, council-led schemes should be guaranteed funding until the end of June 2016, unless determined otherwise by the Director of Adult Services in consultation with the Mayor, as the Chair of the Health and Wellbeing Board.
6. agree that any final amendments to the s75 agreement should be delegated to

the acting Corporate Director of Adult Services, following consultation with the Mayor and Corporate Director of Law, Probity and Governance, to execute any necessary documents to give effect to this decision.

7. note that day-to-day governance of the BCF programme in 2016-17 will be delegated to the CCG's Complex Adults Programme Board, on which the council will be represented.
8. note that a comprehensive review of the BCF programme will take place in 2016-17, as part of wider reviews of joint working between the council and the CCG.

1. REASONS FOR THE DECISIONS

1.1 There is a need to review and update the Better Care Fund programme and associated section 75 agreement that was adopted in 2015-16. There is also a need to report on progress with the programme during 2015-16.

1.2 The government's BCF policy framework makes BCF available to Health and Well-Being Boards to be spent in accordance with the local Better Care Fund plan. However, as the HWBB is not legally able to commit resources, its decisions need to be ratified by the council and the CCG. The recommendations in the present report reflect this situation.

2. ALTERNATIVE OPTIONS

2.1 The 2015-16 schemes were scrutinised when developing the present proposed programme. As many are new initiatives that only commenced in 2015, while others are ongoing activity experiencing a high level of demand, there is a large amount of continuity in the programme proposed for 2016-17.

2.2 To ensure the future effectiveness and value for money of the programme it is proposed that a comprehensive review of BCF should take place in 2016-17. This will dovetail with other service reviews and the joint review of commissioning by the council and the CCG.

3. DETAILS OF REPORT

3.1 The aim of the Better Care Fund (BCF) is to deliver better outcomes and secure greater efficiency in health and social care services through better integration of provision. The BCF programme needs to be agreed jointly by the council and Tower Hamlets CCG. The jointly agreed programme is then incorporated in a formal agreement under Section 75 of the NHS Act 2006

3.2 The BCF programme was overseen in 2015-16, on behalf of the Health and Well-being Board, by the Integrated Care Board (ICB), which is comprised of representatives from the CCG, the council and health provider organisations. The ICB endorsed the proposed programme for 2016-17 at its meeting on 18 February 2016.

3.3 The report to the ICB and a draft of the s75 agreement were also submitted to the Health and Wellbeing Board meeting on 15 March 2016.

3.4 On 23 February 2016, NHS England and the Local Government Association issued Technical Guidance on the Better Care Fund in 2016-17. In developing BCF plans for 2016-17, local partners are required to develop, and agree, through their relevant Health and Wellbeing Board (HWB):

- a short, jointly agreed narrative plan, including details of how they are addressing the national conditions for the Better Care Fund;
- confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

- a scheme level spending plan demonstrating how the fund will be spent;
- quarterly plan figures for the BCF national metrics.

3.5 The timetable associated with the Technical Guidance is as follows:

- **2 March:** Local areas to submit a BCF Planning Return template to NHS England detailing the technical elements of the Plan (This is a first 'checkpoint' to submit key information in draft format and an opportunity to flag any concerns or issues.).
- **21 March:** First submission of full narrative plans for Better Care, alongside a second submission of the BCF Planning Return template.
- **25 April:** Final submission, once formally signed off by the Health and Wellbeing Board.
- **13 May:** Local area confirmation of BCF plan by NHS England
- **30 June:** Deadline for signed Section 75 agreements to be in place in every area

3.6 The Technical Guidance was not available at the time the report to the Integrated Care Board was produced, and there is a need to take into account its implications more fully. It is not anticipated that the Technical Guidance will necessitate substantial changes to be made to the BCF programme proposed to the Integrated Care Board. However, there is always the potential for NHS England to require changes to the borough's proposals. On the other hand, there is a pressing need for continuation funding to be agreed for schemes being rolled forward into the new financial year from 2015-16.

3.7 In the light of the Health and Well-Being Board discussion, the Mayor and the CCG are now being asked formally to sign off the BCF programme for 2016-17 and the associated section 75 agreement (draft enclosed as Appendix 2). That is to say, it is proposed to continue to deliver the ongoing schemes within the proposed programme from 1 April 2016 and to make any necessary amendments subsequently, in the light of feedback from NHS England.

3.8 To minimise any disruption from the late NHS England timetable, it is proposed that any final amendments to the programme should be delegated to the relevant Chief Officers within the council - i.e. the Director of Adult Services - and the CCG, subject to consultation with the Mayor and Chair of the Health and Wellbeing Board.

3.9 When considering the proposed programme, the Mayor is asked to refer to Section 3 of the report to the 18 February meeting of the Integrated Care Board for a review of progress of approved schemes in 2015-16. Section 4 of the report to the ICB proposes a change to the governance arrangements for the BCF, whereby a Complex Adults Programme Board will replace the Integrated Care Board as the body with responsibility for oversight of the programme. Consideration will be given during 2016 to increasing the role of members in overseeing the programme and internal reporting arrangements.

3.10 The overall component structure of the BCF in 2016-17 is similar to that in 2015-16. There is one significant change, however. Prior to the 2016-17 BCF

funding announcement, there were two capital grants included in the BCF: Social Care Capital Grant and the Disabled Facilities Grant. These have now been integrated into one grant, the Disabled Facilities Grant. The full implications of this change need to be reviewed by the council, in particular whether there are types of scheme, previously funded by SCCG, which may require funding in 2016-17. The grant itself needs to be used in line with the criteria of the Better Care Fund, but the Department of Health is also encouraging local areas 'to think strategically about the use of home aids/adaptations, use of technologies to support people in their own homes and take a joined-up approach to improving outcomes across health, social care and housing.' In the present report and the draft Section 75 agreement, the full £1,572,542 is shown being used for housing grant purposes, but this needs to be confirmed.

3.11 There is one further proposed amendment to the overall programme set out in the paper to the Integrated Care Board, which arises from the technical guidance published on 23rd February. This allows for the performance pool from 2015-16 to be used as a local risk share. Given that the local incentive scheme within the BCF fulfils this function, there is no additional requirement for further CCG funds for community services to be included in the pooled budget. Consequently, the overall programme has been reduced by £1,100,800 leaving an overall programme of £21,462,617. The revised proposed programme is as set out in the table below:

	Scheme	15/16 BCF	Changes for 2016/17	16/17 Allocation
Integrated Teams	Integrated Community Health Team	£7,336,499	Possible changes following mobilisation of CHS contract but not for 1617	£7,336,499
	Primary Care Integrated Care Incentive Scheme	£1,020,746	No material changes, additional CCG contribution to reflect full budget for the NIS	£1,200,000
	Reablement and Rehabilitation Joint Working Pilot	£2,350,000	Potentially based on reablement review. Assume steady state	£2,413,871
	Integrated Health and Social Care CHC	£866,000	Increase due to NI changes	£895,500
	7 day working at the social work team RLH	£1,200,000	Increase due to NI changes	£1,230,800

Mental Health	RAID	£2,106,420	Not in 1617. Evaluation expected soon, maybe changes in 1718	£2,106,420
	Recovery College	£110,000		£110,000
Independence	Independent Living	£646,000	Reduction in line with underspend projection	£649,000
Other	Contribution to PMO	£50,000	No longer required due to TST programme	£0
	Peer researcher	£25,000	No longer required	£0
	Community Geriatrician	£150,000	Incorporated into Integrated Community Health Team	£0
Mandated	DFG and Capital	£1,629,000		£1,572,542
	Care Act	£733,000		£733,000
	Carers	£697,000		£697,000
	Performance Pool	£1,091,313	Preserve for local incentive scheme of £1m	£1,000,000
New schemes	Autism Service	£330,000	Following LBTH request in December 2015 and new guidance	£330,000
	BME Dementia	£55,000		£55,000
	Dementia Café	£25,000		£25,000
	Social Worker Input into the Memory Clinic	£50,000		£50,000
	LBTH Enablers	£176,000		£208,000
	Community Equipment Service	£0	7 Day CES Team	£154,985
Total		£20,596,978		£20,767,617

NON RECURRENT	Strategic Development	£852,000	Refreshed following CCG BC process: Personalisation Falls Prevention Mental Health in Primary Care Community Geriatrician	£695,000
Grand Total		£21,448,978		£21,462,617

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The Better Care Fund (BCF) is a combination of central government funding streams that used to flow to the Council and the NHS. The aim of the BCF is to facilitate an integrated approach to service procurement and delivery as well as ensure the social care budget is protected in terms of vital services to the community. The 2016-17 BCF guidance has placed a stronger emphasis on the protection of social care services which is being reflected in the proposed 2016-17 BCF allocation. The majority of the project funding is proposed to be spent on the services that interface with health and particularly on joint assessment and review teams

4.2 During 2015-16 the integration agenda has been pursued more on joint assessment and reviews. The rest of the funding was spent on covering the costs of social care services interfacing and impacting health services. The Council and the CCG are currently undertaking a joint commissioning review to assess the areas and level of integration, including the budgetary implications.

4.3 There is a need to address the partners' BCF risk sharing arrangements in detail and review it regularly. The current 2016-17 proposed allocation tries to address any potential shift in demand but going forward the risk share should be reviewed regularly and reflected in the allocation. Failure to review the risk regularly may lead to extra base budget pressures for the Council

5. LEGAL COMMENTS

Better Care Fund

5.1 The Care Act 2014 places a duty on the Council to exercise its functions by ensuring the integration of care and support provision with health provision, promote the well-being of adults in its area with needs for care and support and contribute to the prevention or delay of the development by adults in its area of needs for care and support. The 2014 Act also amended the National Health Service Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

5.2 The Government provides funding to local authorities under the Better Care Fund to integrate local services. The funding is through a pooled budget which is made available upon the Council entering into an agreement with a relevant NHS body under section 75 of the NHS Act 2006. Such agreements may be entered into where arrangements are proposed which are likely to lead to improvement in the way that prescribed NHS functions and prescribed health-related functions of the Council are exercised.

5.3 In order to receive the Better Care funding, the Government requires the Council to set out its plans for the application of those monies. The Government published a policy framework for the 2016/17 Better Care Fund

programme in January 2016 which indicated that plans should be agreed by the Council's Health and Wellbeing Board ("**HWB**"), then signed off by the Council and CCG. This is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment. The 2016/17 policy framework sets out the requirements for the plan to demonstrate how the area will meet certain national conditions, for example the delivery of 7-day services.

Contracting

5.4 Pursuant to section 75 of the National Health Service Act 2006, the NHS Bodies and Local Authorities Partnerships Arrangements Regulations 2000, the s75 Agreement provides for the establishment of funds made up of contributions from the Council and NHS CCG out of which payments may be made towards expenditure incurred in the exercise of their functions; for the exercise by NHS CCG of the Council's functions and for the exercise by the Council of the NHS CCG's functions in writing. In addition, the s75 Agreement covers specific objectives in relation (including but not limited) to:

5.4.1 agreed aims and outcomes of the partnership including the Council and NHS CCG's respective legal and regulatory responsibilities, and the client groups for whom the services will be delivered under the arrangement

5.4.2 agreed aims and outcomes of the partnership including the Council and NHS CCG's respective legal and regulatory responsibilities, and the client groups for whom the services will be delivered under the arrangement

5.4.3 operational arrangements for managing the partnership including performance and governance structures encompassing the resolution of disputes, conditions for renewal and termination of the partnership, provision and mechanisms for annual review, the treatment of VAT, legal issues, complaints and risk sharing

5.4.4 the respective financial contributions and other resources provided in support of the partnership including arrangements for financial monitoring, reporting and management of pooled, delegated and aligned budgets

5.4.5 linking in with existing governance arrangements including the role and function of the Integrated Care Board

5.4.6 achieving best value from Service Providers and principles in connection with the management of staff; and

5.4.7 flexibilities for the Council and NHS CCG in being permitted to add relevant service provisions and deciding future budgets for existing services within the remit of the s75 Agreement.

5.5 The s75 Agreement must be consistent with the 2016/17 Better Care Fund Plan approved by HWB and entering into it formalises the arrangements agreed by the Council and NHS CCG in accordance with the statutory, regulatory and guidance frameworks.

Wellbeing Principle and Equalities Duties

5.6 The Care Act 2014 places a general duty on the Council to promote an individual's wellbeing when exercising a function under that Act. Wellbeing is defined as including physical and mental health and emotional wellbeing and in exercising a function under the Act, the Council must have regard to the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist. The wellbeing principle should therefore inform the delivery of universal services which are provided to all people in the local population, including services provided through the Better Care Fund.

5.7 The Equality Act 2010 requires the council in the exercise of its functions to have due regard to the need to avoid discrimination and other unlawful conduct under the Act, the need to promote equality of opportunity and the need to foster good relations between people who share a protected characteristic (including age, disability, maternity and pregnancy) and those who do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The Better Care Fund is concerned with better integrating health and social care services to people with a diverse range of illnesses and conditions. These include people with mental health and drug and alcohol problems, and, in particular, elderly people at risk of being admitted to, or able to be discharged from, hospital with appropriate support. It also funds services concerned with Reablement - supporting 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.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The 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

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 The Better Care Fund has no direct implications for the environment.

9. RISK MANAGEMENT IMPLICATIONS

9.1 As in 2015-16, the section 75 agreement will specify pooled funds within the BCF, commissioning arrangements and the arrangements for risk share, including how overspends and underspends will be dealt with for each pooled fund.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 The Better Care Fund has no direct implications for crime and disorder reduction

11. SAFEGUARDING IMPLICATIONS

11.1 The Better Care Fund is particularly concerned with the improvement of services to vulnerable adults. BCF funded services are delivered in accordance with the council's safeguarding policies and procedures, which are fully compliant with the Care Act.

Linked Reports, Appendices and Background Documents

Linked Report

- Report to Integrated Care Board, 18 February 2016 - The Better Care Fund in Tower Hamlets: Review of Progress to Date and Summary of Changes for 2016-17 (see Appendix to present report)

Appendices

- Report to Integrated Care Board, 18 February 2016 - The Better Care Fund in Tower Hamlets: Review of Progress to Date and Summary of Changes for 2016-17
- Draft section 75 agreement between London Borough of Tower Hamlets and NHS Tower Hamlets Clinical Commissioning Group

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

- None

Officer contact details for documents:

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NHS
Tower Hamlets
Clinical Commissioning Group

Appendix 1

Integrated Care Board								Enclosure
Date of meeting	18 February 2016							
Agenda item								
Title of report:	**The Better Care Fund in Tower Hamlets: Review of Progress to Date, and Summary of Changes for 2016 – 17**							
Author(s):	Josh Potter, Deputy Director of Commissioning and Transformation, NHS Tower Hamlets CCG Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, Tower Hamlets Council							
Presented by: **Sponsor (if different):**	NA							
Executive summary	• Updates the Board on progress with agreed BCF initiatives in 2015-16 • Outlines the proposed BCF programme for 2016-17.							
Recommendation (place an ' X' in one only)								
Information	☐	**Approval**	☒	**To note**	☐	**Decision**	☐	
Key issues	There is a requirement to undertake an annual review of the BCF programme. There is also a need to agree a programme for 2016-17.							
Report history	The report is a standing item on the agenda.							
Patient and Public involvement	The Integrated Care Strategy has been developed and delivered with significant PPI activity. The BCF is a pooled budget to facilitate this ongoing delivery							
Risk implications	The CCG and LBTH require a Section 75 to be in place to govern pooled funds. An agreed BCF assists with compliance with the Operating Framework standards							
Impact on Equality and Diversity	N/A The Integrated Care Strategy was subject to an EQIA in 2014/15							
Resource requirements	N/A							
Next steps	A similar report will be presented to the Mayor's Advisory Board on 8 March 2016, the Health and Well-Being Board on 15 March, prior to sign off by the Executive Mayor and the CCG.							

APPENDIX 1

1. **Introduction**

1.1 This report is to seek the approval from the Integrated Care Board, CCG Governing Body, and Mayor's Advisory Board of the proposed 2016-17 Better Care Fund (BCF) programme, prior to its consideration at the Health and Well-Being Board on 15 March 2016 and its anticipated sign-off by the Mayor. The report also briefly summarises progress to date on the BCF programme in 2015-16 for information and comment.

1.2 The Board is asked to:

(i) note progress with the BCF programme in 2015-16;
(ii) approve the proposed BCF programme for 2016-17, and
(iii) note that the proposed 2016-17 programme will be considered at the 15 March 2016 meeting of the Health and Well-Being Board, prior to its anticipated formal sign-off by the CCG and by Individual Mayoral Decision in the council.

2. Background

2.1 The Better Care Fund was introduced in the 2013 Spending Round. The Government announced a national £3.8 billion pooled budget for health and social care services, building on the existing NHS transfer to social care services of £1 billion (usually referred to as S256 funding). The aim of the BCF is to deliver better outcomes and greater efficiencies in health and social care through more integrated health and social care services.

2.2 In 2014, the London Borough of Tower Hamlets, and Tower Hamlets Clinical Commissioning Group (CCG) submitted a jointly agreed Better Care Fund application to NHS England and Local Government Association. This was approved without conditions on 07 January 2015 by NHS England and came into effect on 1 April 2015. The total value of the fund in 2015-16 for Tower Hamlets was £21.577m.

2.3 The BCF programme is governed by a formal agreement between the council and the Tower Hamlets CCG under Section 75 of the NHS Act 2006. In recent weeks, the CCG and the council have been developing a proposed BCF programme for 2016-17. This will be reported to the Health and Well-Being Board (HWBB) on 15 March. The Health and Well-Being Board (HWBB) terms of reference state that it should be 'involved in the development of any CCG commissioning plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan'. However, it is not empowered formally to commit the resources of the CCG or the Council.

2.4 The Section 75 agreement governing the BCF, therefore, requires separate formal decisions to be made by both organisations. It is anticipated that the CCG and the Mayor will formally 'sign off' the programme shortly after the meeting of the HWBB.

3. Review of 2015/16 Better Care Fund Schemes

(i) Integrated Care Network Improved Service (ICNIS)

What is the purpose of the scheme?

3.1 The introduction of the IC NIS aims to incentivise an integrated care approach for patients in the top risk levels in Tower Hamlets.

3.2 Two levels of integrated care packages were introduced:

APPENDIX 1

- **"level 1"** package of integrated care will include many of the desirable features of the Avoidable Unplanned Admissions Direct Enhanced Service (AUA DES) (such as crisis plan and named clinician) – currently, given the undertaking by the CCG to make no changes to the disease specific NISs a person under for example, the diabetes care package, can also be in receipt of level 1
- **"level 2"** package of integrated care will deliver the remainder of the specification of the previous Co-ordinated Care NIS (including personalised care planning and where appropriate anticipatory care planning). Patients under the level 2 package will exit from disease specific care packages for the purpose of payment (i.e. their data will not contribute to payment outcome measures). However, practices will still be expected to provide the components of care as specified in these packages for as long as is clinically appropriate.

Have any changes been made to the scheme since the original proposal was made?

3.3 For 2016/17 the CCG has undergone a review of the Network Improved Services within Tower Hamlets. The review has resulted in a new structure to this incentive scheme, within the same overall cost:

- The scheme now focuses on clinical stratification (rather than using the risk of admission score). Therefore the population is divided into: complex (i.e. people with complex needs such as palliative), LTCs and a 'healthy' cohort (i.e. the remaining of our patients).
- Based on the above, the IC NIS will be divided into IC1 which will include the complex group and IC2 which will include people with LTCs who were previously under care packages (Diabetes, CVD, Hypertension, COPD and cancer).
- The AUA DES, if it is still funded by NHSE, will be replaced by the IC1 Admission Avoidance component of the NIS which will incentivise a comprehensive review within 3 weeks of the day of discharge of patients who are admitted due to MI/stroke/HF or patients over 65 years admitted with hypoglycaemia, falls and fractures or gastrointestinal bleeding/ COPD/vascular ulceration/gangrene.

What has the scheme achieved?

3.4 The ICNIS contributes towards the delivery of the Integrated Care Strategy as a whole. Please see "Integrated Community Health Team" for a description of achievements to date

3.5 In terms of process indicators, performance at January 2016 is:

	Entry Level Consent	Crisis Plan	Account GP	1st PAM	2nd PAM	Patient Centred Care Plan
Borough	1636	2435	1192	390	22	1847
The One Network	92	318	60	40	0	177
East End Health Network	236	449	263	0	0	312
Stepney and Whitechapel Network	283	166	83	35	0	131
The Highway Network	162	251	166	23	0	220
Bow Health Network	212	298	146	159	12	234
Mile End East and Bromley By Bow Network	326	329	155	131	10	274

Poplar and Limehouse Network	320	467	253	2	0	317
Healthy Island Network	5	157	66	0	0	182

(ii) Rapid Assessment Interface and Discharge (RAID)

What is the purpose of the scheme?

3..5 Rapid Assessment Interface and Discharge (RAID) is a service open to all patients with mental health and drug and alcohol problems over the age of 16 presenting at the Royal London Hospital and all associated Barts Health sites in Tower Hamlets.

3.6 The service offers a comprehensive range of mental health specialities within one multi-disciplinary team. The role of this team is to provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff.

3.7 The model emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on inpatient wards. This focus on prompt assessment and intervention is intended to improve patient experience and outcomes, support diversion and discharge from A&E and facilitate early discharge from inpatient wards. The RAID service is available 24 hours a day.

Have any changes been made to the scheme since the original proposal was made?

3.8 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

- Since its launch in April 2014, there has been a 40% increase in patients seen by RAID in A&E and a 62% increase in patients seen by RAID in inpatient wards.
- As of August 2015, the service reported seeing 93% of patients in A&E within 1 hour of referral and 94% of patients within inpatient wards within 24 hours of referral.
- Over 1,200 staff have been trained face to face by the RAID team.
- An interim evaluation of the four RAID services across East London (including Tower Hamlets) by UCLP partners indicated that, when outliers were excluded, the combined overall impact of RAID across all hospitals was as follows:
  - There is evidence of an overall decrease in length of stay for patients with mental health and drug and alcohol problems since the introduction of RAID. This is largely driven by a reduction in bed usage for non-elective patients, especially for those with dementia, substance misuse and severe mental illness. It is estimated that this reduction has in total saved approximately 2833 bed days in the 2014/15 financial year
  - According to the data available, the introduction of RAID does not appear to have had any impact on excess bed days for patients with mental health or drug and alcohol problems. It also appears that the percentage of readmissions for mental health and drug and alcohol patients has increased since the introduction of RAID.

(iii) Integrated Community Health Team

What is the purpose of the scheme?

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3.9 The integrated community health team provides health and social care input to all patients over the age of 18 graded as being at very high risk, high risk or medium risk of admission of a hospital admission. The service offers a comprehensive range of specialities within one multi-disciplinary team, including nursing, therapies, social care, mental health and case management. There is also specialist input from a community geriatrician and palliative care nurse. The teams are divided into 4 localities across the borough. The focus of the service is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and providing personalised, co-ordinated care in the community. The emphasis is upon improving patient experience and outcomes, supporting self-care, preventing A&E attendances and hospital admissions and facilitating timely discharge from inpatient wards. The service is available 24 hours a day (between 8pm-8am, this is comprised of nursing provision only).

Have any changes been made to the scheme since the original proposal was made?

3.10 No, and we would like to continue with the service in its current form. It should be noted that as a key part of a service subject to recommissioning, the mobilisation of any new Community Health Services contract may result in amendments being made to the day to day operations of the Community Health Teams

What has the scheme achieved?

- In March 2015, the integrated community health teams had over 1000 people from the integrated care pathway on their caseload.
- On average, across the four locality teams in March 2015, the service reported:
  - Responding to 98% of rapid response referrals within 2 hours
  - Providing input/putting in place packages of care for 97% of urgent referrals within 24 hours
  - Providing input/putting in place packages of care for 96% of routine referrals within 5 days
- Following a number of recruitment drives, the vacancy rate has significantly reduced and is expected to reach 95% posts filled over the next few months.
- The service, together with other key players across the integrated care pathway, has played a central part in reducing A&E attendances and emergency admissions:

Description	Annual Target Savings	Risk Band	YTD Actual Achieved £	FOT Savings Achieved £	FOT Variance (Savings Achieved) £
Inpatient	£1,183,031	**Very high**	£649,259	£3,105,369	**£1,922,338**
		High	£1,119,190		
		Moderate	£560,578		
Outpatient	£276,198	**Very high**	£64,816	£473,549	**£197,351**
		High	£185,052		
		Moderate	£105,294		

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A & E	£95,089	**Very high**	£43,744	£72,487	**-£22,602**
		High	£7,146		
		Moderate	£3,475		
	£1,554,318		**£2,738,554**	**£3,651,405**	**£2,097,087**

(iv) Community Health Team (Social Care) (CHT SC)

What is the purpose of the scheme?

3.11 This scheme seeks to improve the experience and outcomes for those with long term conditions, at the highest risk of hospital admission or readmission. The service works with those who are in the Integrated Care Pathway (ICP) target cohort; their families and Carers. The overall aim is to decrease the risk of hospital admission, reduce or postpone the need for long term care and prevent Carer breakdown.

Have any changes been made to the scheme since the original proposal was made?

3.12 It was evident that to deliver on the overall BCF CHT SC integrated operational and strategic aims, that a more robust management structure was needed. The staffing structure was reconfigured to address this issue and the team is now almost fully recruited to and operational.

What has the scheme achieved?

3.13 CHT SC Managers are working on specific operational and strategic areas in partnership with Health colleagues. These include planning and implementing procedures, WELC - Care Planning, Vanguard - Single Point of Access, THIPP and TST End of Life work. They are Continuing Health Care (CHC) Panel and Joint Funding meeting members and are proactive in improving CHC processes. They are responsible for the management of the team including operating a Duty/Safeguarding service for those in the target cohort.

3.14 Senior Practitioners each have a responsibility for 2 Localities and 4 Primary Networks; they attend Locality Board meetings in a liaison role. They act as a resource for CHT colleagues, around social care issues, legislation and safeguarding. A Senior Practitioner post is embedded in the Assessment and Intervention team leading on integrated working in the Adults service.There are now 10 Social Work posts in the team. Each has a responsibility for either a Primary Network or Central CHT Neuro rehabilitation work. They attend MDT meetings for their designated area. They carry out joint visits with health colleagues. This involves supporting the individual to self- assess; carrying out Carers' and joint assessments. They use a person-centred model in doing so, and also respond to crises to prevent a person being admitted to hospital or Carer breakdown. Each worker is allocated to approximately 24 people at any one time, plus others on a duty basis. Full co-location has not been possible due to ICT and telephone issues. However a successful bid to Vanguard was made for IT systems, equipment and mobile devices will be made available and this will support co-location becoming a reality. (There is a target of mid-2016.)

3.15 Outcomes include:

- Over the period June 2015 to January 2016, the number of clients at highest risk of hospital admission that are on the ICP list and receiving long term care service has risen from 891 to 1326.

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- The proportion of clients who are assessed as being at high risk has fallen from 28% to 24% in the same period.
- Joint intervention highlights where the client requires rehabilitation and/or an equipment solution, to reduce risk.

Measure	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Number ICP clients receiving long term social care services			891			1179	1254	1274	1307	1326
Number/% ICP cohort assigned to a social care team						747 (63.4 %)	871 (69.4 %)	881 (69.12%)	900 (68.85%)	949 (71.6 %)
Number/% ICP clients allocated to CHT			422			464	500	484	475	525
			47.40%			39.40%	39.90%	38.00%	36.40%	39.60%
Social Care Episodes Completed for ICP Cohort	*534*	*524*	*742*	*685*	*555*	*726*	753	*634*	*243*	*696*
ASCOF 1C - % of cohort receiving self-directed support			70.9			68.5	68.8	59.8	60.3	61.1
ASCOF 2A - permanent admissions of cohort to residential and nursing care 65+ (in last 12 months)			11			15	19	16	13	16
% clients in community care setting			779 (87.4 %)			%	1107 (88.3 %)	1132 (88.85%)	1164 (89.06%)	1178 (88.8 %)

(v) <u>Seven Day Hospital Discharge/ Avoidance</u>

What is the purpose of the scheme?

3.16 Unnecessary delays in discharging patients can lead to delays in admissions, transfers and cancellation of operations. An acute bed is estimated to cost the approximately NHS £500 per night. The goal is for timely, effective and appropriate discharges, which maximise the outcomes for individuals and support families and carers.

3.17 It is not in a patient's best interest to remain in an acute hospital bed longer than necessary; the risks include exposure to hospital-acquired infections, loss of functional independence and depression.

3.18 The BCF scheme supports the extension on the role of social workers to 7 days per week within Bart's Health NHS Trust, with particular attention to the Royal London Hospital, the Trust's trauma centre. The scheme expands the operating hours that social workers assess and discharge patients deemed medically fit for discharge. The area of the hospital covered initially was A&E and wards 11E and 11F.

Have any changes been made to the scheme since the original proposal was made?

3.19 The scheme has progressed due to its success in creating vacant beds at the Royal London Hospital. It now covers the entire hospital, apart from children's wards. We have introduced two designated social workers to be based in A&E and 11E/F the

area known as AAU – Acute Assessment Unit. A development for 2016-17 is to seek a move for social workers to be ward-based, as part of our integration program. This will lead to efficiencies in assessment turnaround times and improved multi-disciplinary working. We are continuing to develop our work with the Home from Hospital scheme in AAU regarding admission avoidance work. We also work closely with CHT – Community Health Team – in identifying people who are frequent visitors to hospital, via the ICP – Integrated Care Pathway list.

What has the scheme achieved?

3.20 There is a quick turnaround of cases, and good working relationships have been developed with health colleagues. Since the introduction of the Patient Flow Coordinators, there has been an increase in the number of referrals but also added pressure on social work staff. For the 7-day service, we are now able to both receive and assess patients on the acute wards who are deemed medically fit at weekends and bank holidays, and reduce the throughput of assessment time, thereby facilitating earlier discharges from acute beds.

Measure	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
Number of referrals to Out of hours	65	88	87	59	81	82	83	81	115	88	829
Number of referrals From Acute and Assessment Unit to Out of hours to prevent Hospital Admission	21	17	34	16	30	20	32	21	35	26	252
Total Number of discharges completed to reduce hospital length of stay	31	47	43	26	34	41	33	38	45	35	373
Total Number of discharges completed to prevent hospital Admission	9	10	17	9	17	12	16	15	26	19	150
Accelerated discharges completed to prevent hospital admission as a % of all referrals	42.9%	58.8%	51.5%	56.3%	56.7%	60.0%	50.0%	71.4%	74.3%	73.1%	
Accelerated discharges completed to reduce hospital length of stay as a % of all referrals	47.6%	53.4%	49.4%	44.1%	42.0%	50.0%	39.8%	46.9%	56.20%	56.40%	
Assessments undertaken and services needed identified	53	65	79	36	68	56	54	59	95	65	630

(vi) <u>Reablement Team</u>

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What is the purpose of the scheme?

3.21 Reablement services aim to help people with illness or disability cope better by learning or re-learning skills necessary for daily living. These skills may have been lost through deterioration in health and/or increased support needs. The focus is on helping people do as much for themselves as possible, rather than resolving health issues as such.

3.22 Reablement Services are generally provided for a period of up to six weeks. Some people meet their goals in a far shorter period of time, while others, such as stroke survivors, may need a much longer reablement and rehabilitation period. Typically, people receiving reablement services have suffered an acute illness/event (e.g. a fall), have a long-term condition, and/or are growing frail. The service is large, with approximately 60 employees, including its own dedicated Out of Hours Service.

3.23 *Joint working with Community Health Team Therapies***:** Reablement and CHT joint working agreements were set up by Lead Reablement OT and Lead CHT Physiotherapist to streamline service users journey through intermediate care services, promote integration and partnership working across health and social care, maximise functional outcomes for service users, target resources to services users likely to benefit most and prevent duplication. Initially, three target user groups were identified and pilot joint working agreements were set up for each target group.

Have any changes been made to the scheme since the original proposal was made?

3.24 Functional disorder joint working cases with CHT has been stopped due to the complex nature of the user group and negative functional responses by this user group to therapeutic input.

What has the scheme achieved?

3.25 The following relates to mainstream Reablement activity.

- Referrals for 2015-16 are on average 55 per month, with 54% of these referrals coming from the Hospital Social Work Team.
- The waiting list for an allocated worker in Reablement is at present 43 people, with the longest wait for an 'assessment' being 42 days. The average wait for an 'assessment' in Reablement is approximately 25 days.
- All urgent support packages within Reablement are started within 24-48 hours (for example, for hospital discharges or urgent request from Assessment and Intervention (A&I) Social Care Team).
- There have been 41 Community Physiotherapy cases to date since July 2015 and this joint working stream is going well, Physiotherapists are working with Reablement Officers to implement exercise programmes, practice outdoor mobility and progress independence in mobility aid (e.g. walking frame to stick).
- *Discharge to Assess/Home Assessment Pathway* – This is a new scheme running from November 2015 to March 2016. Its primary focus is safely to discharge medically stable patients, who are in the Royal London Hospital and aged over 65 years, either to an extra care sheltered flat, or home. The Reablement Service will be offering the option for this service to access Reablement Officer support to help support the therapy staff in the team to meet agreed treatment goals for this user group during the 28 day 'rehabilitation' period. There will be an option for these users to access the Reablement pathway following this period, where appropriate. As of the end of January 2016 the service has supported 26 users within this pathway, with 12 being referred in January 2016.

Reablement

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Measure	April	May	June	July	Aug	Sept	Oct	Nov
Number of referrals to reablement	41	47	49	45	57	39	64	56
Number of referrals from hospital team	23	28	22	30	32	25	37	20
Number of referrals from community teams	18	19	27	15	25	14	27	27
Number of independence plans completed	31	46	43	36	24	36	36	
Number completed reablement episodes	36	33	45	44	45	30	36	19
Average length of time in service (referral to conclusion) weeks	10	12.7	13.6					

(vii) Independent Living (Assistive Technology Project)

What is the purpose of the scheme?

3.26 The objective of the Assistive Technology (AT) Project is to integrate the use of assistive technology into mainstream health and social care provision, to enable residents to live independently in their own homes. It uses a range of training and communication methods to raise staff awareness, giving them the knowledge, confidence and support to prescribe appropriate assistive technology equipment for their service users.

3.27 The project also included the evaluation and development of an Independent Living Service (ILS) to look at the integration of a number of teams to rationalise processes and improve service provision.

Have any changes been made to the scheme since the original proposal was made?

3.28 The development of the ILS now forms part of a larger review of Adult Services, which is now underway.

What has the scheme achieved?

- Since April, operational staff across a wide range of health and social care teams have continued to receive training in the use of AT to support independent living. AT Implementation Officers have provided further support by having a presence in 18 operational teams across nine separate locations. They deliver awareness sessions, hold surgeries at area offices, and attend team meetings. The total number of training sessions delivered so far this year is 15 and has involved 104 staff, 37 from health and 67 from social care.
- Systems have been put in place to enable health and social care staff to prescribe appropriate items of assistive technology equipment and 1:1 support is provided to assist them, where appropriate. For April 2015 to January 2016, the number of requests for AT was 434, and installations was 472. Requests for AT were received from 14 different teams, 5 of which are hospital or community based teams. This illustrates that awareness has been raised across a range of social care and health professionals in various locations.
- Between April and December there were avoided costs of £235,230, in 21 cases, as a result of assistive technology. This does not include continuing avoided costs validated from previous periods. For the 21 cases, the projected annual avoided costs are £289,513. The avoided costs for cases identified in January cannot be validated yet and so no figures for this period have been included.

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Measure	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Total
Number of requests for AT equipment made per month	30	52	43	40	54	36	39	42	51	47	434
Number of installations of AT equipment	46	48	51	33	55	49	44	44	57	45	472
Number of health and social care staff trained	16	7	19	8	3	12	0	8	5	26	104

(viii) Better Care Fund Enablers

What is the purpose of the scheme?

3.29 This scheme involves four additional officers within the council's Children and Adult Services', Policy, Programmes and Community Insight service, to perform the following functions:

- Programme managing and monitoring BCF schemes
- Co-ordinating the council's involvement in a range of programmes and processes concerned with the integration of health and social care
- Improvement of joint information management systems to facilitate more effective service delivery involving health and social care providers.

Have any changes been made to the scheme since the original proposal was made?

3.30 The scheme was formally added to the BCF programme by the Integrated Care Board in December 2015.

What has the scheme achieved?

3.31 The Team:

- provides a programme management office for all of the council's work to integrate social care and NHS services.
- leads on the development of a strategic vision for the council's approach to integration, including the engagement of council members.
- has developed Service Level Agreements for all approved BCF schemes for which the council is the lead commissioner
- has established and maintains performance management and monitoring systems for BCF-funded initiatives within the council
- has strengthened the council's involvement in a range of partnership bodies concerned with the integration of health and social care, including the Tower Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Pioneer and Transforming Services Together (TST)
- has contributed to the development of data sharing arrangements between the council and Health sector organisations.

(ix) Capital Schemes - Disabled Facilities Grant/ Social Care Capital Grant

What is the purpose of the scheme?

3.32 The Council has a statutory duty to provide Disabled Facilities Grants (DFGs) to eligible disabled residents for the adaptation of their home environment, to enable

them to continue to live as independently and safely as possible. DFGs are mandatory for necessary adaptations to provide better movement in and around the home and access to essential facilities. Social Care Capital Grant is used for the same purposes as DFG. Types of work eligible for grant funding are:

- to make it easier to get into and out of the dwelling - for example, by widening doors and installing ramps;
- ensuring the safety of the disabled person and other occupants - for example, via improved lighting to ensure better visibility;
- to make access to the living room easier;
- improving access to the bedroom, and kitchen, toilet, washbasin and bath (and/or shower) facilities - for example, by installing a stair lift or providing showering facilities;
- to improve or provide a suitable heating system in the home;
- to adapt heating or lighting controls to make them easier to use;
- to improve mobility around the home to enable the disabled person to care for another person who lives in the property, such as a spouse, child or another person for whom the disabled person cares;
- to improve access to and from the garden of the home, where feasible.

Have any changes been made to the scheme since the original proposal was made?

3.33 No. The Grant will continue in 2016-17. The funding allocation is still awaited.

What has the scheme achieved?

3.34 The main outcomes are summarised in the table, below.

Adaptation	No of Approvals (1.4.15 – 31.1.16)	No of Completions (1.4.15 – 31.1.16)
Wet floor shower	100	123
Stairlifts	29	29
Ramps	8	18
Ceiling track hoists	12	17
Steplifts	5	5
Other (incl. Through-floor lifts, over-bath showers, door widening, door openers etc.)	8	9
Total	**162**	**201**

(x) <u>Care Act Duties</u>

What is the purpose of the scheme?

3.35 The 2014 Care Act placed a number of new duties on the local authority, including a requirement to assess and meet the needs of carers on a similar basis to people cared for.

3.36 This scheme covers funding of two main areas: 2014 Care Act Implementation and new duties in relation to Carers. The aim of the scheme is to set the needed infrastructure in place and deal with the extra demand arising from the new duties of the Care Act.

3.37 The council has created additional capacity within social care services to support and put carers on a par with users for assessment, review and provide carer services and packages (for carers and social care clients). In addition, the council is working on

improving services such as Safeguarding Adults Board, advocacy and legal literacy training as well as investing into much needed IT systems.

3.38 The Carers Hub provides a range of personalised services and support to carers, and in so doing seeks to prevent, reduce or delay the requirement of more intensive, publicly-funded care services. The Carers Centre also supports the wellbeing of the carer, enabling them to continue in their caring role. The services support the main adult carer, who is a Tower Hamlets resident or who is caring without payment for someone who lives in Tower Hamlets.

3.39 The service offers a range of person-centred information, advice and advocacy, including statutory independent advocacy, as defined by the Care Act 2014. It also provides supported carer's assessments and referrals for statutory assessments and supporting services, as appropriate.

3.40 The key services provided are:

- signposting to other available universal services in the borough
- specialist information, advice and independent advocacy, including statutory advocacy, as defined for carers by the Care Act 2014
- where appropriate, support a referral to the council for a full, statutory carer's assessment, which may lead to a Carer's One Off Direct Payment (CDP) or carers' breaks
- information and advice and access to other services, as appropriate, that support carers to prevent, delay or reduce social care needs
- support for carers on hospital admission/ discharge, and forming links with primary care and Public Health to support carers of those with long term conditions, including carers of people with mental ill health and of end of life care needs
- information and support for carers to manage their own health and wellbeing needs
- services and activities to alleviate and manage stress and provide a break from caring
- representing and supporting carers' views in local authority and CCG planning, and acting as the voice of carers and building partnerships with other organisations
- outreach and support for hidden carers
- the development and delivery of a range of carers' training and awareness programmes and production of a quarterly newsletter aimed at carers, with news and updates on available services, policy or legislative changes.

Have any changes been made to the scheme since the original proposal was made?

3.41 Yes, the Carers' Hub contract was varied to better fit with the Care Act 2014 and we would like to continue with the service in its current form.

What has the scheme achieved? *(Quarters 1 to 3, 2015-16)*

- Over 1,000 carers accessed specialist information and advice; 137 accessed non-statutory advocacy and 29 accessed statutory independent advocacy; as defined by the Care Act 2014.
- 260 carers (target 300) were supported through carers' assessments and/or referred to the council for a full statutory carer's assessment
- 206 carers were referred to other services to support them to prevent, delay or reduce social care needs.
- Services and activities to alleviate and manage stress and/or provide a break from caring: 315 carers attended a relaxation therapy (target 225), 303 attended

a Relaxation Day, 141 attended an Eid celebration, 93 attended a Carers' Christmas Party, 502 accessed emotional support, and 27 took part in a Carers' Week coach trip.

- The Carers Centre enabled 41 carers to participate in Local Authority and CCG planning/consultation events. The service works with a wide range of agencies, building partnerships facilitate the meeting carer's needs.
- Outreach and support for hidden carers: the service reached 437 new carers who have not received the service previously or in the last two years.
- The Carers Centre enabled 81 carers to access training on manual handling, managing stress and managing challenging behavior.

(xi) Dementia Cafes

What is the purpose of the scheme?

3.42 BCF funding enables the Dementia Café Service to support people with Dementia and their carers to stay well for longer in the community. The Alzheimer's Society delivers four cafes per month in two community venues. Two cafes are inclusive and two are aimed specifically at the Bangladeshi community. The service aims to reduce social isolation, increase knowledge of the dementia pathway and increase take-up of other services.

Have any changes been made to the scheme since the original proposal was made?

3.43 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

3.44 The success of the scheme can be seen from the performance data from the first three quarters of the year. The cafes were attended by 265 individual people with Dementia and 249 individual carers. The cafes are structured into information sharing and activities that are beneficial for the health of people with Dementia. For example, the past quarter saw the inclusive cafe deliver information sessions led by Safer Transport Team, Healthwatch, Talking Point, Stay Well this Winter campaign and the promotion of the Dementia-friendly swimming sessions. Activities at the inclusive café in quarter 3 included Singing for the Brain, the Connaught Opera, Strictly Come Dancing, Smell Reminiscence and an arts session led by the Geffrye Museum.

3.45 The following represents the number of individual people who attend any of the cafes during the quarter:

Unique users & carers	**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**	
	user	**carer**	**user**	**carer**	**user**	**carer**	**user**	**carer**
Target Inclusive Café 1	18	17	18	17	18	17	18	17
ACTUAL	25	22	25	21	36	32		
Target Inclusive Café 2	18	17	18	17	18	17	18	17
ACTUAL	23	17	25	19	30	27		
Target Bangladeshi Café 1	15	15	15	15	15	15	15	15
ACTUAL	14	14	17	21	18	22		
Target Bangladeshi Café 2	15	15	15	15	15	15	15	15
ACTUAL	17	16	18	20	17	18		

3.46 The impact of the service can be measured in part through its outcome monitoring. Quarter 3 of 2015/16 saw 96.8% of people from the inclusive café and 95.83% of people from the Bangladeshi Café indicate positive social engagement. Social isolation is especially damaging to the health of people with dementia. This service enables them to continue to access the community and activities targeted at making them feel included. A side effect of the cafes is that carers also feel supported and are able to network and share experiences with other carers. Keeping carers healthy is essential to keeping people well supported at home and not in hospital.

3.47 90.6% and 83.33% of people from the inclusive café and Bangladeshi cafe espectively reported a higher take up of local services. Often older people within the Bangladeshi community dislike accessing mainstream health services. The Alzheimer's Society manages this through bringing services into the café. A Quarter 3 case study details how the services work together. The Dementia Inclusion Service found an older Bangladeshi woman in the community with worries about her memory. Through their support she was able to get a formal diagnosis at the Memory Clinic and attend the café. At one of the café's health visiting sessions the optician was able to correctly attribute her deteriorating vision not to her vascular dementia but to her eye sight. Glasses thus restored her sight making the risk of falls much lower.

3.48 Finally, 90.6% and 87.5% of people from the inclusive café and Bangladeshi cafe respectively indicate better understanding of dementia and dementia care pathway. A better understanding of the services available to support someone with Dementia is necessary for diverting people away from emergency services to community based options.

3.49 Future plans for the scheme include ensuring that the services have maximum geographical reach. If the research suggests that there are people from areas of Tower Hamlets who do not access the service, there is an option of adding further venues if necessary. We are also exploring how to use assets in the community to instigate social support and networks between the formal café sessions and to use the current client base to facilitate this.

(xii) <u>BME Dementia Inclusion Service</u>

What is the purpose of the scheme?

3.50 The BCF funding enables the BME Dementia Inclusion Service to increase the proportion of people from Bangladeshi and other BME backgrounds with dementia who receive a formal diagnosis. The Alzheimer's Society delivers this service through case finding in the community, casework with individuals and their families, working with GPs, making referrals to diagnostic/support services and awareness-raising to communities which have little knowledge of Dementia.

3.51 Tower Hamlets has the fifth highest BME population in London and the largest Bangladeshi population in the UK. The proportion of older people from these groups is steadily increasing. The borough's population is set to grow by over 25% by 2026, with the 50-65 age groups increasing by 67% and 65+ by 38% (GLA). It is predicted that the number of people with dementia from BME groups will continue to rise. 6.1% of all people with dementia among BME groups being young onset, compared with only 2.2% for the UK population as a whole. Some BME groups may also have much higher incidences of vascular dementia which, has been linked to lifestyle and diet.

Have any changes been made to the scheme since the original proposal was made?

3.52 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

3.53 By increasing diagnosis, the scheme is achieving BCF objectives and reducing unplanned admissions as follows:

- By helping to explain problems people are experiencing crisis access of the health service is reduced
- There are other causes, such as depression, which exhibit similar symptoms that it is important to diagnose and treat, which prevents escalation of other health issues
- Advice on dementia prevention lifestyle changes helps keep people well and out of health services for longer.
- It allows access to medication which can maintain independence for longer.
- Post-diagnosis management of cardiovascular risk factors can help delay progression.
- After diagnosis people and their carers and families can access information and carer/ peer support through services such as Dementia Advisor, social care and Cafes making them more likely to understand pathways and less likely to access services in crisis.
- We can advise people on future planning which again prevents crisis accessing of costly services, such as accident and emergency.

3.54 The successes of the scheme can be seen in the performance monitoring data. Quarter 3 saw the BME Inclusion service meet the SLA targets. The Alzheimer's Society found 39 people from the BME community with possible dementia, who they are now supporting into diagnostic services; undertook casework with 40 people from the BME communities including the Bangladeshi community; and organised 8 awareness raising events.

SECTION A: Activity Description: Bangladeshi	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
(a) Case Finding *Definition: identifying and making contact with individuals/carers with memory problems*	28	27	25	29	
For commissioner's info only: (b) New clients referred for case work to BME Inclusion service DSW *Can be from case finding as part of this service, DA, etc.*	N/A For info only	4	**5**	4	
(c) Casework *Definition: one-to-one support – open cases. Carers can be reported as a separate number if dedicated individual support is being provided to them separate from the PWD to support them in their caring role*	25	27	29	29	
(d) Awareness Raising events held	4	4	4	5	

SECTION B: Activity Description: Other BME communities	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
(a) Case Finding *Definition: identifying and making contact with individuals/ carers with memory problems*	10	8	9	10	
For commissioner's info:	N/A For	2	**3**	2	

(b) New clients referred for case work to BME Inclusion service DSW *Can be from case finding as part of this service, DA, etc.*	info only				
(c) Casework *(one-to-one support – open cases)*	8	8	11	11	
(d) Awareness raising events held	3	0	3	3	

3.55 Services such as this which increase dementia diagnosis have had a huge impact on our national performance. The dementia diagnosis rate has increased in Tower Hamlets from below the national target of 2/3 to over 80% of people with dementia receiving a formal diagnosis. Tower Hamlets now has the 4th best diagnosis rate in London.

3.56 Future plans for the scheme include a targeted focus on ensuring other communities, in addition to the Bangladeshi community, are robustly supported by the service.

(xiii) <u>Adult Autism Diagnostic and Intervention Service</u>

What is the purpose of the scheme?

3.57 The Adult Autism Diagnostic and Intervention Scheme is designed to support the council and the NHS to meet specific statutory duties under the Autism Act and the Care Act. The Autism Act Statutory Guidance published those duties in March 2015:

> *Local Authorities and NHS bodies should jointly: Ensure the provision of an autism diagnostic pathway for adults including those who do not have a learning disability and ensuring the existence of a clear trigger from diagnostic to local authority adult services to notify individuals of their entitlement to an assessment of needs. NICE guidance and NICE Quality Standard on autism represent best practice when developing diagnostic services and related services.*

3.58 The Adult Autism Diagnostic and Intervention service (ASD service) provides a service for high functioning adults (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD) in Tower Hamlets. It also raises awareness within other agencies, including other parts of the Council and NHS. It sub-contracts a local Third Sector provider (JET) to provide employment support options for people diagnosed with ASD and facilitates appropriate referral and signposting to other services, where needed.

3.59 The service includes the following:

- A core diagnostic team to provide assessment of adults with potential ASD in Tower Hamlets, in line with NICE clinical guidelines for care of adults with autism
- Sign posting and referral to other services should a primary condition be other than ASD (e.g. mental health) or a risk be identified (e.g. self-harm or harm to others) that may require in-patient treatment
- Post-intervention support to adults with ASD (high functioning) including Cognitive Behavioural Therapies and assistance with developing social relationships
- Locally-based sub-contracted support service which enables user access to employment, training and advocacy.

3.60 The service is founded on the principles of a person-centred approach, with an emphasis on helping individuals to develop (or rediscover) their own unique skills through active engagement and participation. This includes a proactive approach in

utilising resources that are available within the service and the community to meet individuals' needs and aspirations.

Have any changes been made to the scheme since the original proposal was made?

3.61 No, we would like to continue with the service.

What has the scheme achieved?

3.62 The outcome of the 2014 Autism Self-Assessment Framework received in January 2016, confirmed that Tower Hamlets only received two Green ratings: one for the Autism JSNA produced by Public Health and one for the diagnostic pathway.

Service Outcome:	***Indicator:***	***Total***
Referrals	Total number of referrals (including self-referrals)	186
	Total number of people receiving a screening.	100%
	% of service users reporting they are satisfied/very satisfied with the diagnostic process. Bi- Annually Reporting	100%
Assessment and information on possible support options	Total number of people receiving a screening assessment assessed for coexisting physical health and mental health problems	69
	Total number of people approved for diagnostic assessment	51%
	Total number of people signposted to other services	25%
	Total number of basic health checks delivered	51%
	Total number of direct referrals to Mental Health Services	0.40%
	Total number of direct referrals to Community Learning Disability Services	0.10%
Case management	% of service users who are satisfied with the objectives set out in their care plan have been achieved	100%
Transitional support and planning	Total number of young people assessed as eligible to access the service. 18-25years	29
Employment, training and volunteering	Number of service users referred into Tower Project Employment Service to support into access employment and training	20
Awareness raising sessions	Number of ASD awareness raising sessions delivered to external agencies	32
Autism Carer Drop-in	Number of carers attending Autism Carers Drop in	29
	Number of Autism Carers Drop-in sessions delivered per annum	30
Service user surveys	Number of complaints	0
	Number of focus groups held	4

(xiv) <u>Social Worker input into Memory Clinic</u>

What is the purpose of the scheme?

3.63 A social worker working as an integral member of the Diagnostic Memory Clinic Team offers community assessments under the Care Act 2014, carers' assessments, organises packages of care, and provides signposting, advice and information and support. The inclusion of social care in the Diagnostic Memory Clinic (DMC) provides an integrated model of care throughout the dementia pathway in Tower Hamlets.

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Access to social care in the Diagnostic Memory clinic helps improve service users' journeys at a vulnerable and anxiety-provoking time in their lives.

3.64 The scheme aims to achieve:

- An earlier assessment of service users in need of social care support, and earlier signposting of those not in need of social care input, without referring service users onto another team/ service.
- A more seamless service, greater efficiencies and a reduction in 'hand-offs' and changes of key team/worker for service users.

Have any changes been made to the scheme since the original proposal was made?

3.65 There have been no significant changes to the scheme since it was first proposed. Some small changes were made following a Pilot scheme in 2014-15, but the scheme has run the same way for the past year, with the social worker being fully embedded in the team, and, therefore, able to give advice to team members and input into the Multi-disciplinary Team discussion at an earlier stage in the diagnostic process.

What has the scheme achieved?

3.66 The Pilot scheme had already shown greater service user satisfaction. The aim in 2015-16 has been to build on this and consolidate this improved level of service user satisfaction. The scheme is on track to meet the majority of its targets (see table, below).

Service Outcome:	***Activity:***	***Indicator:***	***Annual Target: Please insert figures and not % unless relevant***
Social Work Input into the Diagnostic Memory Clinic	Assessment of the social care needs of service users of the Diagnostic Memory Clinic	Number of referrals to the Memory Clinic	Target: 400 Actual : 290 to 15/01/16
		Number of those referred to Social Worker (SW) in the Memory Clinic	Target: 150 Actual : 133 to 15/01/16
		Number assessed for Social Care needs	Target: 120 Actual: 98 to 15/01/16
	Carers Assessments offered to carers of those seen by Diagnostic Memory Clinic	Carers advised of their entitlement to a Carers Assessment	Target: 95% of those referred to SW Of those with known carers: 100% offered
		Carers Assessments completed by Social Worker in the Memory Clinic	Target: 30 Actual: 12 to 15/01/2016
	Timely response (within 28 days) for social care assessment whilst under the Memory Clinic *difficulty in capturing this information from electronic system	Contact made with service user to arrange an assessment within 7 days of referral to Social Worker	80 % of those referred to the social worker Actual: 100% from small desktop audit
		Assessment contact completed within 28 days of referral to Social Worker	90% of those referred to the social worker who consent to assessment Actual: 60% from small desktop audit
	Gather Service	Satisfaction survey given	Target:25% response

	user and Carer satisfaction surveys	to all those service users and carers in contact with Memory Clinic Social Worker for an assessment.	rate; 80% positive response rate Actual: 20.4 % response rate to 15/01/16 (20 responses) Nearly 97.5% positive - satisfied or above.

(xv) <u>Strategic Development Schemes: 2015/16</u>

Personalisation

3.67 The Personalisation Programme supports greater person-centred care as part of Tower Hamlets' agenda on delivering Integrated Care. The Programme Board overseeing this work, reports to the CCG's Integrated Care Board. The work streams within the Personalisation Programme have been developed in response to the direction set within NHS Five Year Forward View and Forward View into action: Planning for 2015/16 and enables the delivery of the CCG's new strategic priority on person-centred care.

3.68 The work streams with the programme are as follows:

- Widening the offer of Personal Health Budgets (PHB) beyond Continuing Health Care (CHC)
- Delivering Integrated Personal Commissioning (IPC) in Tower Hamlets and contributing to the national evaluation of this. NHS England has Commissioned RAND Europe to undertake this evaluation.
- Piloting the use of Patient Activation Measure (PAM) in Tower Hamlets
- Self-management, including oversight of the self-management pilots, their evaluation and recommendations on future commissioning plans.

3.69 From October 2014, CCGs were required to offer personal health budgets (PHB) to people with continuing health care needs (CHC/CH). The Forward View into action: Planning for 2015/16 outlines the requirement for CCGs to expand this offer

> *"To give patients more direct control, we expect CCGs to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit. As part of this, by April 2016, we expect that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning difficulties, in line with the Sir Stephen Bubb's review."*

3.70 In addition, the NHS Mandate, 2015, sets the objective that:

- Everyone with long-term conditions, including people with mental health problems, should be offered a personalised care plan that reflects their preferences and agreed decisions;
- Patients who could benefit should have the option to hold their own personal health budget as a way to have even more control over their care.

3.71 As such, the expansion of Personal Health Budgets is a "must do" for CCGs with an ambition for 0.1% - 0.2% of CCG population to have a PHB in the next 3- 5 years. This is equivalent to 300 – 600 PHBs in Tower Hamlets the next 3- 5 years (based on GLA population projections). Tower Hamlets CCG has decided to provide this as part of an integrated personal budget for health and social care, required as part of the Integrated Personal Commissioning (IPC) programme.

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Tower Hamlets Integrated Personal Commissioning (IPC)

3.72 Tower Hamlets is a national demonstrator site for Integrated Personal Commissioning (IPC), which is a three-year programme from April 2015 – March 2018. In Tower Hamlets, it is intended that the expansion of PHB will be introduced as part of integrated personal budgets for people with existing social care packages and complex health needs.

3.73 The goals of IPC are as follows:

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care
- Better integration and quality of care.

3.74 These align closely with the objectives of Tower Hamlets Integrated Care, in particular in its focus on person-centred care planning and moving away from "what's the matter with you" to "what matters to you".

3.75 The IPC financial model also aligns with the capitation model being developed for integrated care. It attempts to shift incentives towards prevention and coordination of care, by testing an integrated capitated payment approach and incentivising providers to proactively understand who is at risk, and take early action to prevent deterioration and coordinate services, which, to be effective, involves working in partnership with people and their carers.

3.76 The four groups of people we will be focusing on are:

- Children with SEND
- Adults with severe and enduring mental health needs
- Adults with learning disabilities
- Adults with multiple LTCs including COPD and on level 2 of Integrated care NIS.

3.77 Early analysis shows approximately 900 adults fall into this cohort. Our original target for 16/17 were 1,275 care plans and 165 budgets. However, based on learning from year one of the programme we will be reviewing these targets. The costing in this business case is based on 100 care packages in 16/17.

3.78 In order to enable this to be delivered the following infrastructure needs to be developed including:

- processes and policies for agreeing and signing off and reviewing care plans and budgets
- determining the services which opened up as part of PHB and the contractual changes needed to enable the funding to be released from these budgets
- agreement around risk management
- set up of brokerage and finance services
- set up advise and support for people undergoing this process

APPENDIX 1

4. Proposed BCF Programme for 2016-17

4.1 The following table summarises the proposed funding allocations for 2016-17. It can be seen that, to a considerable extent, it is being recommended that the schemes funded in 2015-16 should continue to receive funding in the coming financial year. This is because a number of the schemes presently funded via BCF only commenced in 2015-16, while others are ongoing activity experiencing a high level of demand. In addition, the joint commissioning review between the CCG and LBTH may make recommendations that exceed the scope of current partnership arrangements, and so it is proposed that BCF changes in the interim be minimal, in order to reduce any duplication or additional administrative burden, following the joint commissioning review's report.

	Scheme	15/16 BCF	Changes for 2016/17?	16/17 Allocation
Integrated Teams	Integrated Community Health Team	£7,336,499	Possible changes following mobilisation of CHS contract but not for 1617	£7,336,499
	Primary Care Integrated Care Incentive Scheme	£1,020,746	No material changes, additional CCG contribution to reflect full budget for the NIS	£1,200,000
	Reablement and Rehabilitation Joint Working Pilot	£2,350,000	Potentially based on reablement review. Assume steady state	£2,413,871
	Integrated Health and Social Care CHC	£866,000	Increase due to NI changes	£895,500
	7 day working at the social work team RLH	£1,200,000	Increase due to NI changes	£1,230,800
Mental Health	RAID	£2,106,420	Not in 1617. Evaluation expected soon, maybe changes in 1718	£2,106,420
	Recovery College	£110,000		£110,000
Independence	Independent Living	£646,000	Reduction in line with underspend projection	£649,000
Other	Contribution to PMO	£50,000	No longer required due to TST programme	£0
	Peer researcher	£25,000	No longer required	£0
	Community Geriatrician	£150,000	Incorporated into Integrated Community Health Team	£0

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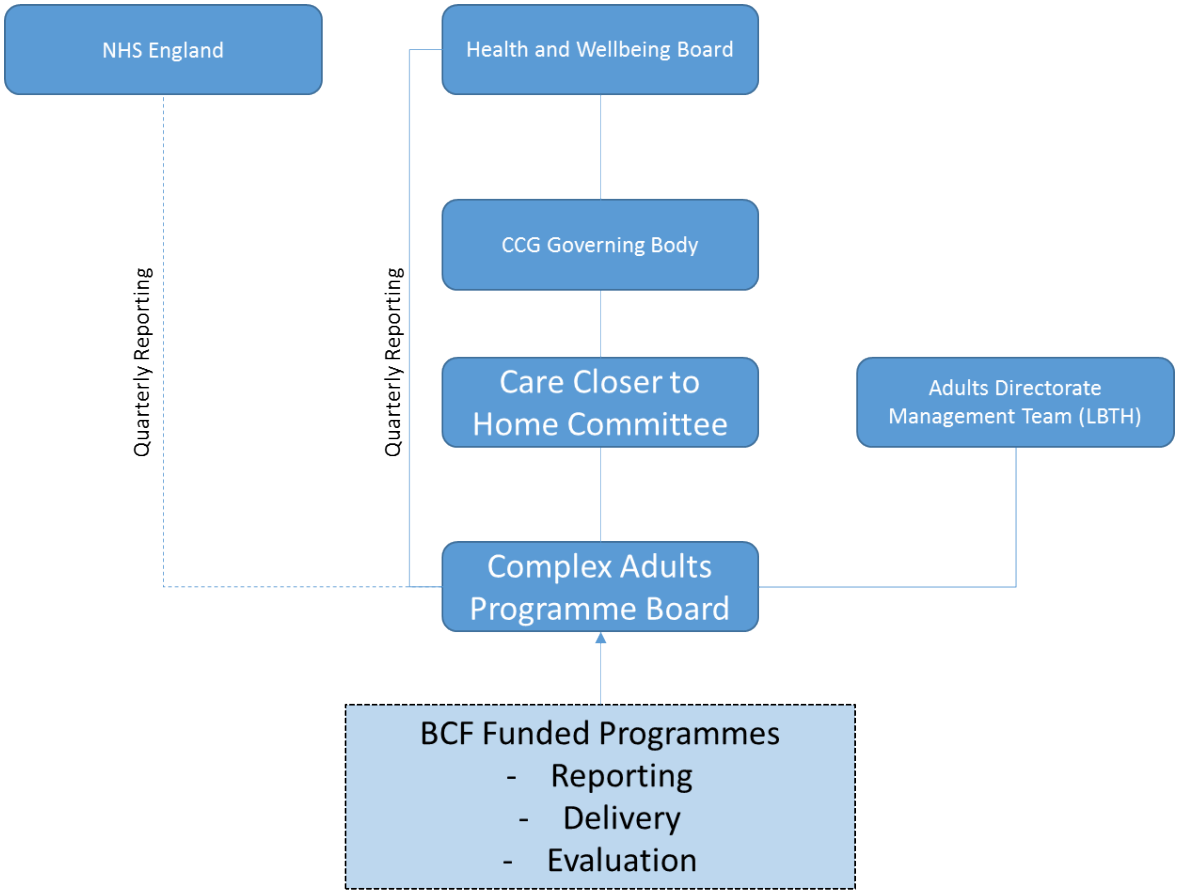
Mandated	DFG and Capital	£1,629,000		£1,572,542
	Care Act	£733,000		£733,000
	Carers	£697,000		£697,000
	Performance Pool	£1,091,313	Preserve for local incentive scheme of £1m	£1,000,000
New schemes	Autism Service	£330,000	Following LBTH request in December 2015 and new guidance	£330,000
	BME Dementia	£55,000		£55,000
	Dementia Café	£25,000		£25,000
	LBTH Enablers	£176,000		£208,000
	Additional NHS Community Services	£0	Following new guidance	£1,091,000
	Community Equipment Service	£0	7 Day CES Team	£154,985
Other			Additional Tower Hamlets BCF Allocation from DH	£67,000
Total		£20,596,978		£21,875,617

NON RECURRENT	Strategic Development	£852,000	Refreshed following CCG BC process: Personalisation Falls Prevention Mental Health in Primary Care Community Geriatrician	£695,000
Grand Total		£21,448,978		£22,570,617

Governance

4.2 The government makes Better Care Fund resources available to Health and Wellbeing Boards to be spent in accordance with a local Better Care Fund plan. It is proposed that the governance for the BCF remains with the CCG Committee that oversees the delivery of Integrated Care in Tower Hamlets. In 2015/16 this has been the Integrated Care Board. In 2016/17, in line with the refreshed programme structure of the CCG, this will transfer to the Complex Adults Programme Board. ToR and membership will be reviewed in order to accommodate this change

APPENDIX 1



Appendices:

Appendix 1: LBTH paper to the Integrated Care Board requesting re-profiling of schemes

Appendix 2: Proposal for 7 day ICES services

Bevan Brittan

Appendix 2

Dated **2016**

LONDON BOROUGH OF TOWER HAMLETS

and

NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP

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

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Contents

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THIS AGREEMENT is made on the day of 2016

PARTIES

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

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

BACKGROUND

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

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

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

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

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

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

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

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

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

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

ii. empowers patients, users and their carers;

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

iv. ensures consistency and efficiency of care.

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

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

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

1 DEFINED TERMS AND INTERPRETATION

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

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

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

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

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

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

CQUIN means the Commissioning for Quality and Innovation payments framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

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

Commencement Date means 00:01 hrs on 01 April 2016.

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

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

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

(c) which is a trade secret.

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

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

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

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

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

Force Majeure Event means one or more of the following:

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

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

(g) any form of contamination or virus outbreak; and
(h) any other event,

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

Functions means the NHS Functions and the Health Related Functions

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

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund [and for each Aligned Fund the Partner that will host the Aligned Fund]

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

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

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

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

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

Law means:

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

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

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

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

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

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

Local Incentive Scheme means the single incentive scheme payable to providers of Integrated Care services in Tower Hamlets which includes an element of CQUIN incentive monies (in the case of Acute, CHS and Mental Health), and a top slice incentive amount (in the case of Primary Care).

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

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

Month means a calendar month.

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

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

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.5.

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

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

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

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

Permitted Expenditure has the meaning given in Clause 7.3.

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

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

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

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

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

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

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

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

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

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

SOSH means the Secretary of State for Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

2 TERM

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

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

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements; and

4.1.2 the establishment of one or more Pooled Fund.

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

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

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

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

5 FUNCTIONS

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

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

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

5.3.1 Individual Schemes funded from the Better Care Fund:

Mandatory CCG contribution (recurrent schemes)

- Integrated Community Health Team
- Primary Care Integrated Care Incentive Scheme
- RAID
- Reablement Team
- Community Health Team (Social Care)
- 7 Day Hospital Social Work Team
- 7 Day Community Equipment Provision Team
- Assistive Technology Team
- Assistive Technology additional demand
- Dementia Café
- Community Outreach Service
- Adult Autism Diagnostic Intervention Service
- Carers
- Local Incentive Scheme
- Enablers
- Mental Health Recovery College

Additional CCG contribution (non-recurrent scheme)

- Falls Prevention
- Community Geriatrician Team
- Personalisation
- Mental Health Primary Care

LBTH contribution

- Disabled Facilities Grant

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

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

5.6 The introduction of any Individual Scheme will be subject to:

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

5.6.2 approval by the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

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

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

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

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

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

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

Appointment of a Lead Commissioner

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

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

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

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

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

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

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

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

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

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

Responsibilities of the other Partner

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

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

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

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

7.3.1 the Contract Price*;*

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

7.3.3 Performance Payments;

7.3.4 Third Party Costs;

7.3.5 Approved Expenditure;

7.3.6 any other explicit allowances stipulated in this Agreement; and

7.3.7 subject to Clause 7.4.

("**Permitted Expenditure**")

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

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

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

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

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

7.6.3 appointing the Pooled Fund Manager;

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

7.7 At the Commencement Date of this Agreement there shall be three (3) Pooled Funds:

Pooled Fund	BCF Scheme	Lead Commissioner	Provider	BCF Allocation (£)
Mandatory CCG contribution (recurrent schemes)	Integrated Community Health Team	CCG	CCG	7,336,499
	Primary Care Integrated Care Incentive Scheme	CCG	CCG	1,200,000
	RAID	CCG	CCG	2,106,420

	Mental Health Recovery College	CCG	CCG	110,000
	Reablement Team	CCG	Council	2,413,871
	Community Health Team (Social Care)	CCG	Council	895,500
	7 Day Hospital Social Work Team	CCG	Council	1,230,800
	7 Day Community Equipment Provision team	CCG	Council	154,985
	Assistive Technology team	CCG	Council	287,000
	Assistive Technology additional demand	CCG	Council	362,000
	Dementia café	CCG	Council	55,000
	Community outreach service	CCG	Council	25,000
	Social worker input into the memory clinic	CCG	Council	50,000
	Adult autism diagnostic intervention service	CCG	Council	330,000
	Carers	Council	Council	1,430,000
	Local incentive scheme	CCG	CCG	1,000,000
	Enablers	CCG	Council	208,000
Total				19,195,075
Additional CCG contribution (non-recurrent schemes)	Falls prevention	CCG	CCG	68,000
	Community Geriatrician Team	CCG	CCG	115,000
	Personalisation	CCG	CCG	212,000
	Mental Health Personal Commissioning	CCG	CCG	300,000
Total				695,000
Council contribution	Disabled Facilities Grant	Council	Council	1,572,542

Total	1,572,542
BCF total	**21,462,617**

8 POOLED FUND MANAGEMENT

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

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

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

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

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

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

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund and liaising with internal and external auditors as necessary;

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

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

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

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

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

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

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

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Regulations.

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

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

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

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

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

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

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

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

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

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

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

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

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

11 NON FINANCIAL CONTRIBUTIONS

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

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of Services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Local incentive scheme

12.2 An incentive scheme will be developed by the CCG and the council to encourage and reward joint working that achieves the aims of the Tower Hamlets Integrated Provider Partnership and the Better Care Fund.

Overspends in Pooled Fund

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

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

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

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

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

Overspends in Non Pooled Funds

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

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

Underspend

12.10 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

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

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

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

14 VAT

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

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Sections 20 and 21 (whichever is applicable to the relevant Host Partner of the relevant Pooled Fund) of the Local Audit and Accountability Act 2014.

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

16 LIABILITIES AND INSURANCE AND INDEMNITY

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

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

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

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

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

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its

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

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

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

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

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

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

16.6 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

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

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with 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 they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

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

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

18 CONFLICTS OF INTEREST

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

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Partnership Board to oversee:

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

19.2.2 Development of Integrated Care strategy, including the Better Care Fund.

19.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

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

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

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

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

19.8 Each Scheme Specification shall confirm the governance arrangements in respect of the Services and how the Services are reported to the Partnership Board and Health and Wellbeing Board.

20 REVIEW

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

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

20.3 The Partners shall within 20 Working Days of the Annual Review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Partnership Board, and subsequently to the Health and Wellbeing Board. Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

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

21 COMPLAINTS

21.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of

the Services and shall keep records of all complaints and provide the same for review by the Partnership Board every Quarter of this Agreement (or as otherwise agreed between the Partners).

22 TERMINATION & DEFAULT

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

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

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

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 15 (Audit and Right of Access) 16 (Liabilities and Insurance and Indemnity) 22 (Termination & Default) 25 (Confidentiality) 26 (Freedom of Information and Environmental Protection Regulations) and 28 (Information Sharing).

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

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

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

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

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

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

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

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

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

23 DISPUTE RESOLUTION

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

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

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Council's Director of Adult Services and the CCG's Chief Officer or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

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

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

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

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

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

24 FORCE MAJEURE

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

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

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

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

25 CONFIDENTIALITY

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

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

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

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

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

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

25.3 Each Partner:

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

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

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

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

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

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

27 OMBUDSMEN AND PROHIBITED ACTS

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

27.2 Neither Partner shall do any of the following:

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

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

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

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

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

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

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

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

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

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

28 INFORMATION SHARING

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

29 NOTICES AND PUBLICITY

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

29.1.1 personally delivered, at the time of delivery;

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

29.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) within one (1) Working Day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

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

29.3.1 if to the Council, addressed to the: Service Head: Commissioning and Health, Adults' Services, London Borough of Tower Hamlets, 4th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG;

Tel: 020 7364 0497
E.Mail: karen.sugars@towerhamlets.gov.uk

and

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

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

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

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

30 VARIATION

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

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all

reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

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

32 WAIVER

32.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

33.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

34.1 The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any 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

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

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

38.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

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

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

Signed for on behalf of **NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

SCHEDULE 1– SCHEME SPECIFICATION

Part 1– Template Services Schedule

TEMPLATE SERVICE SCHEDULE

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

40 OVERVIEW OF SERVICES

40.1 Context and background information

Local Context

Tower Hamlets has a resident population of 284,000 people with an unusually young age profile. Only 6% (17,000) of the population is over 65. The population is expected to rise to 353,000 by 2033, an increase of around 20%.

31% of the population is classified as White British and 32% Bangladeshi, though this distribution varies substantially across different age groups. The White British, White Irish and Black Caribbean populations in the borough have older age profiles compared to other groups, while residents from mixed ethnic groups, the Other Black group and the Bangladeshi group are all characterised by younger age profiles, with higher proportions of children. Over one third of the Bangladeshi population is children aged under 16, compared with only 9 per cent of White British residents. Conversely, only 5 per cent of Bangladeshi residents are aged 60 or over, compared with 16 per cent of White British residents. Given the contrasting age profiles of the two largest populations, the ethnic makeup of the population varies significantly by age. The proportion of residents that are White British rises with age: 15 per cent of the borough's children (aged under 16) are White British compared with almost two thirds (63 per cent) of the population aged 75 and over. More than half of the borough's children are Bangladeshi.

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is shorter than the national averages (male life expectancy is 76.7 years and female life expectancy is 81.9). Compared to London, Tower Hamlets has the second highest premature death rate from circulatory disease (87 per 100,000), the second highest premature death rate from cancer (128.5 per 1000) and the second highest premature death rate (36.9 per 100,000) from respiratory disease. (These conditions typically constitute 75% of all premature deaths.) Death rates vary across the borough and in general are higher in areas of higher deprivation.

Tower Hamlets has a higher rate for deaths that occur in a hospital (57.5%) (as opposed to other locations) compared to the national rate (48.3%). Our aim is that care should focus on reversing/ stabilising or effectively managing deterioration in functional or health status with palliative care as an integral component in line with our shift of focus on palliative care to a wider Last Years of Life perspective.

Integrated Care

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

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

40.2 **Pooled Funds:**

At the Commencement Date of this Agreement there shall be three (3) Pooled Funds:

Pooled Fund	BCF Scheme	Lead Commissioner	Provider	BCF Allocation (£)
Mandatory CCG contribution (recurrent schemes)	Integrated Community Health Team	CCG	CCG	7,336,499
	Primary Care Integrated Care Incentive Scheme	CCG	CCG	1,200,000
	RAID	CCG	CCG	2,106,420
	Mental Health Recovery College	CCG	CCG	110,000
	Reablement Team	CCG	Council	2,413,871
	Community Health Team (Social Care)	CCG	Council	895,500
	7 Day Hospital Social Work Team	CCG	Council	1,230,800
	7 Day Community Equipment Provision team	CCG	Council	154,985
	Assistive Technology team	CCG	Council	287,000
	Assistive Technology additional demand	CCG	Council	362,000
	Dementia café	CCG	Council	55,000
	Community outreach service	CCG	Council	25,000
	Social worker input into the memory clinic	CCG	Council	50,000
	Adult autism diagnostic intervention service	CCG	Council	330,000
	Carers	Council	Council	1,430,000
	Local incentive scheme	CCG	CCG	1,000,000
	Enablers	CCG	Council	208,000
Total				19,195,075
Additional	Falls prevention	CCG	CCG	68,000

CCG contribution (non-recurrent				
	Community Geriatrician Team	CCG	CCG	115,000
	Personalisation	CCG	CCG	212,000
	Mental Health Personal Commissioning	CCG	CCG	300,000
Total				695,000
Council contribution	Disabled Facilities Grant	Council	Council	1,572,542
Total				1,572,542
BCF total				**21,462,617**

40.3 **Strategic Objectives**

The strategic objectives for each individual scheme are as follows:

40.3.1 **Integrated Community Health Teams**

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

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

40.3.2 **Reablement Team**

Referral routes are generally via the two main social care access points: Assessment and Intervention Team (community-based users), and the Hospital Social Work Team (users in inpatient units/A&E). In addition, the Community Health Teams can refer direct, as can the social care Personalisation and Review services (both social work and Occupational Therapy teams). Once the user is within the Reablement pathway they will receive:

- Maximising independence assessment and development of individual support programmes
- Programme co-ordination
- Review of Independence plan
- Eligibility decision and resource allocation
- Other assessments

- *For the user/patient:*

- 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

- *For the service:*

- Safe transfer of patients between acute care, community health and social care services and support return to independent living
- Prevention of unnecessary hospital admissions and to facilitate supported discharge
- Provide information and onward referral for services so that users/patients and their carers can make choices about care needs
- Prevent premature admissions to residential and nursing homes by maximizing independence and choice

- *For the organisation:*

- Reduction in admissions and readmissions in 91 day measures
- Financial benefits
- Sustainable reduction in support packages in the longer term, 6-12 months post reablement

- *For the informal carer:*

- Provide information, training, and support to enable informal carers to maintain their roles with the user and within the community in which they live

40.3.3 **7 Day Hospital Social Work Team**

The 7-day service provides timely multidisciplinary assessments, which avoid unnecessary admissions to acute wards, and manages/facilitates speedier discharges in a seamless fashion, by commissioning community services that permit patients to return home.

The scheme operates 7 days per week (from 9am to 8pm, Monday to Friday, and 10am to 8pm on Saturdays and Sundays). The service aims to respond to referrals from the Royal London Hospital within 3 hours. If people present at A&E and are residents of Tower Hamlets, then the team addresses social care issues at that point. This can involve restarting social care services and preventing unnecessary admission. If people present at A&E and are from other council areas, they are signposted and the team notifies the responsible authorities to avoid social care admissions, following information from medical staff that there is no health reason for admission. The key strategic objective for the 7-day service is centred around prevention of unnecessary hospital admission, whereby community-based health and social care services can be quickly accessed by the referring social work team based at the hospital.

Those people requiring elective or emergency admission to the Royal London Hospital will have a planned discharge from the social work team based at the hospital by having a Care Act-required assessment of need carried out and services as necessary under the Act. Safeguarding adults investigations, as outlined in the Care Act 2014, are carried out following an alert from the community, hospital staff, residents or London Ambulance Service.

40.3.4 **Community Health Team (Social Care)**

The scheme seeks to improve the experience and outcomes for patients with complex health and social care needs, and the highest risk of hospital admission, by maximising independence, choice and control. Achieving this goal will result in improved overall health and wellbeing for the residents of Tower Hamlets.

The ongoing development and integration of the CHT (SC) will continue to strengthen links and partnership working between social care, health and other stakeholders. Activities being undertaken will build on the joint working already taking place across the 8 locality networks.

This includes:

- Working in partnership with health and other adults' teams systematically to identify adults who are most vulnerable and at risk of hospitalisation.
- Providing assessment and support using a coordinated, person centred and MDT approach.
- Promoting wellbeing and independence for those living with long term conditions.
- Assessing and supporting Carers if of people with long term conditions in alignment with the Care Act 2014

- Contributing to the reduction of unplanned admissions and readmissions to hospital.
- Maintaining patients in the community for longer and delaying admission to long term care.
- To develop and move towards integrated Continuing Healthcare assessments and joint planning for target cohort

40.3.5 **Mental Health Liaison (RAID)**

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

40.3.6 **Recovery College**

The Recovery College model complements health and social care specialist assessment and treatment, by helping people with mental health problems and/or other long term conditions to understand their problems and 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 provide 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.

40.3.7 **Independent Living**

Assistive Technology Team

The scheme enables vulnerable people who require support to remain living independently in their own homes, by utilising assistive technology, including Telecare and Telehealth solutions. The Assistive Technology (AT) Team provides training and support to social care and health professionals, as well as piloting and implementing new initiatives and projects. The specific objectives of the project are to:

- Expand the range of AT equipment.
- Raise awareness among social care and health professionals.
- Increase take-up.
- Demonstrate avoided costs.

The scheme also aims to embed the use of Assistive Technology into mainstream provision, to help vulnerable residents of Tower Hamlets to live independently in their own homes.

40.3.8 **Integrated Care Incentive Scheme**

For 2016-17 the CCG has reviewed the Network Improved Services (NIS) within Tower Hamlets. The review has resulted in a new structure to this incentive scheme, within the same overall cost:

- The scheme now focuses on clinical stratification (rather than using the risk of admission score). Therefore the population is divided into: complex (i.e. people with complex needs, such as palliative), LTCs and a 'healthy' cohort (i.e. the remaining of our patients).
- Based on the above, the IC NIS will be divided into IC1, which will include the complex group, and IC2, which will include people with LTCs who were previously under care packages (Diabetes, Cardio Vascular Disease, Hypertension, chronic obstructive pulmonary disease (COPD) and cancer).
    - The AUA DES, if it is still funded by NHS England, will be replaced by the IC1 Admission Avoidance component of the NIS which will incentivise a comprehensive review within 3 weeks

of the day of discharge of patients who are admitted due to myocardial infarction (MI)/stroke/HF or patients over 65 years admitted with hypoglycaemia, falls and fractures or gastrointestinal bleeding/ COPD/ vascular ulceration/gangrene.

40.3.9 **Adult Autism Diagnostic and Intervention Service**

The Adult Autism Diagnostic and Intervention service (ASD service) is intended to align autism services in Tower Hamlets with the aims of the National Autism Strategy, which include:

- Increasing awareness and understanding of autism;
- Developing a clear and consistent pathway for diagnosis;
- Improving access to the services and support people need to live independently within the community;
- Delivering on Employment Opportunities; and Enabling local partners to develop relevant services to meet identified needs and priorities

The service provides a high quality diagnostic and intervention service for high functioning adults (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD) in Tower Hamlets. It also sub contracts a local Third Sector provider (JET) to provide a range of support options for people diagnosed with Autism Spectrum Disorder, and facilitate appropriate referral and signposting to other services where needed.

The service includes the following:

- A core diagnostic team to provide assessment of adults with potential ASD in Tower Hamlets, which uses best clinical practice and in line with NICE clinical guidelines for care of adults with autism
- Sign posting and referral to other services should a primary condition be other than ASD (i.e. mental health) or a risk be identified (i.e. self-harm or harm to others) that may require in-patient treatment
- Post intervention support to adults with ASD (high functioning) including Cognitive Behavioural Therapies and assistance with developing social relationships
- locally based sub-contracted support service which enables user access to employment, training and advocacy

The service is founded on the principles of a person centred approach with an emphasis on helping individuals to develop (or rediscover) their own unique skills through active engagement and participation. This includes a proactive approach in utilising resources that are available within the service and the community to meet individual's needs and aspirations.

40.3.10 **Dementia Café**

The Alzheimer's Society provides a fortnightly, inclusive Dementia Café, run in English, for people with dementia and their carers in Tower Hamlets, including people from the black and ethnic communities and, a fortnightly Bangladeshi (Sylheti language) Dementia Café, for Bangladeshi carers and people with dementia.

The peer support group sessions within the café provide social and emotional support, encourage social engagement and shared experiences as well as information giving for both Sylheti speakers from the Bangladeshi community and the wider community.

The objective of the Dementia Café service is to help people with dementia to live well following diagnosis. The provision of dementia cafes in English and in Sylheti in Tower Hamlets are an important means by which the Council supports people with mild to moderate dementia and their carers. Intervention at an early stage helps to delay decline, by keeping people active, informed and connected to peers and linked to key services within the community and out of hospital. A survey undertaken for 2015-16 Q2 monitoring found that service users experienced positive social engagement, reported higher take up of other local services and said they had a better understanding of dementia.

40.3.11 **Community Outreach Service**

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 BAME 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.

40.3.12 **Carers & Care Act**

The strategic objective of the scheme is to help carers to care effectively and safely – both for themselves and the person they are supporting. It will include timely interventions or advice on matters such as moving and handling people safely, avoiding falls in the home and training for carers to feel confident performing basic care tasks.

The Carers Hub provides the following support to carers:

- specialist information, advice and independent advocacy including statutory advocacy for carers, as specified by the Care Act 2014.
- supported carers' assessments and referral to the council for a full statutory carers' assessment
- information, advice and access to other services, where appropriate, that support carers to prevent, delay or reduce social care needs
- support for carers on hospital admission/discharge
- services and activities to alleviate and manage stress and provide a break from caring
- representing carers' views in local authority and CCG planning; acting as the voice of carers and building partnerships with other organisations.
- outreach and support for hidden carers
- development and delivery of a range of training and awareness programmes for carers.

40.3.13 **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.

For the service user/patient, the service will:

- offer choice and flexibility for patients to be discharged from hospitals over a longer time span during weekdays and weekends.
- give patients, service users and carers confidence that equipment items have been delivered and installed prior to returning home.
- 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.

It will also:

- 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).
- support Community Health and Social Care Teams to provide more complex care and support in users' own homes through CES being more accessible and flexible with delivery and installation times.

- facilitate safe, integrated and seamless transfer of patients between hospital, community health and social care services.
- prevent unnecessary hospital admissions, by providing timely delivery of equipment over 7 days to make the home environment safer and accessible.

For organisations, the extended hours service will:

- reduce length of stay in acute beds.
- enable discharge co-ordinators and bed managers to plan for discharges of people needing essential pieces of equipment for a safe discharge over a 7 day period.
- generate cost savings by reducing in-patient episodes and prevent and delay need for care home placements and high cost support packages.

For families and informal carers it will:

- enable family members and informal carers to be better prepared for their relatives to return home at times that are flexible over 7 days, convenient and fit in with their other commitments, such as child care and employment.

40.3.14 **Enablers**

Four officers are employed within the council to ensure:

- high level management support for strategic decision making on health and social care integration.
- that the council is represented at partnership bodies and other groups concerned with integration.
- coordination of input to partnership arrangements, such as Health and Wellbeing Board, the Complex Adults Programme Board, THIPP, Tower Hamlets Vanguard, WELC/ Care Closer to Home and Transforming Services Together (TST).
- manage health and social care partnership governance and planning arrangements within the council.
- prepare 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.
- programme management and monitoring of BCF schemes managed by the council
- co-ordinating the council's involvement in a range of programmes and processes concerned with the integration of health and social care, including the Tower Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Integrated Care Pioneer and Transforming Services Together (TST)
- the development and implementation of new models of working within Adult Social Care
- the improvement of joint information management systems to facilitate more effective service delivery involving health and social care providers.
- the provision of operational and performance information to support the development of integrated services and internal/external monitoring.

40.3.15 **Disabled Facilities Grant**

The council has a statutory duty to provide Disabled Facilities Grants (DFGs) to eligible disabled residents for the adaptation of their home environment to enable them to continue to live as independently and safely as possible. DFGs are mandatory for necessary adaptations to provide better movement in and around the home and access to essential facilities. The Housing Grants, Construction and Regeneration Act 1996, requires that the Housing Authority must approve a DFG to meet the assessed needs of an eligible disabled resident.

40.3.16 **Falls Prevention**

The proposal is to implement an education programme which will provide skills and confidence to care home and domiciliary staff and provide:

- education sessions to care home and domiciliary staff.
- regular meetings with care home staff to discuss residents who have fallen and who are at risk of falls

- initial falls assessment of those at risk and take appropriate action (e.g. involvement of CHT multidisciplinary professionals, primary care and external agencies, such as care home staff.
- advice regarding equipment needed (e.g. cot sides, hoists, slings and chairs of appropriate height and support).
- falls prevention education sessions.

40.3.17 **Personalisation**

The Personalisation Programme supports greater person-centred care, as part of Tower Hamlets' agenda on delivering Integrated Care. The Programme Board overseeing this work reports to the CCG's Complex Adults Programme Board. The work streams within the Personalisation Programme have been developed in response to the direction set within the NHS Five Year Forward View and Forward View Into Action: Planning for 2015/16, and enables the delivery of the CCG's new strategic priority on person-centred care.

40.3.18 **Mental Health in Primary Care**

This initiative aims to increase the capacity of the Barts Health, Health Psychology Team, by employing 2 additional psychologists that will be based in primary care and focus on the management of patients with LTCs and depression and anxiety. The current Community Health Service Health Psychology Service uses a model that is similar to collaborative care, by having health psychologists embedded into physical health teams including diabetes, heart disease, respiratory, and stroke. This model enables patients to receive emotional support across the whole pathway, with particular benefit to patients who are not open to 1:1 counselling.

40.3.19 **Community Geriatrician Team**

Funding is planned 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.

40.3.19 **Local Incentive Scheme**

The incentive scheme is intended to encourage and reward joint working that achieves the aims of the Tower Hamlets Integrated Provider Partnership, namely to deliver an integrated model of care for patients with complex needs; an emerging system model for patients in the last years of life (LYOL); new models of delivery for long term conditions (LTC); new models of community health services (CHS); targeted health and social care initiatives and a public health prevention-orientated system that underpins the entire system. We have structured this single incentive scheme to be based on the achievement of outcomes, measured by:

- integrated care metrics (incl. mental health)
- Better Care Fund metrics
- Patient Experience metric development
- Population Health metrics

40.3.20 **Social workers input into the memory clinic**
The Diagnostic Memory Clinic is proposing a new pathway for 16/17 that puts more focus on the screening of referrals and early triage of service users, and a social work perspective on this is key to its success. We want to minimise the time a service user may be on the dementia diagnosis pathway if there 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 we can signpost or provide the more appropriate support in a more timely fashion. The social worker will offer community assessments under the Care Act (2014), carer's assessments, organise provision of packages of care, signposting and offer advice, information and support.

The presence of social work input into the team will have an additional benefit in that the MDT planning process will be enhanced and patients and carers will benefit from advice with a social care perspective included.

41 AIMS AND OUTCOMES

41.1 Integrated Community Health Teams

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

41.2 Reablement and Rehabilitation Joint Working Pilot

The service will work with 700-750 users during 2016-17; with approximately 70% of these users being over the age of 65. Of this cohort of users the aim is that:

  - 45% will result in no ongoing social care support needs
  - 20% will result in a reduction of their previous long term social care support needs
  - 10% will result in no change to their long term social care support needs
  - 90% of over 65s receiving Reablement will still be living at home 91 days post discharge from an acute hospital stay
- 90% of users will receive a Reablement assessment within 5 days of referral
- The average ‘length of stay’ in Reablement will be 4-5 weeks
- All Reablement users with urgent support needs will have this in place for discharge from hospital, or within 24 hours if already in the community
- Pre- and post-Reablement support package demonstrates a £1.5m saving per annum for 2016-17 cohort of users, as a result of Reablement intervention
- User satisfaction levels will be 80%, showing a general satisfaction with their experiences within Reablement.
- Increased information sharing, joint assessments, and joint working opportunities with Community Health Teams for users within Rehabilitative pathways
- Joint working protocols with health colleagues to improve access to Reablement for users in the community with both health and social care needs; enabling access to Reablement support for users with long term health needs
- Timely facilitation of discharge from hospital for Reablement users to reduce incidence of DTOC

41.3 Social work team 7 day working at Royal London Hospital

The key aim is to keep a positive bed flow, so that people do not wait in the Acute Admissions Unit (AAU) for acute beds or have to be taken to other hospital for admission.

The social work team works within Department of Health rules around 4-hour turnaround times when presenting to A&E. The social workers covering this area of the hospital are integrated sufficiently with medical colleagues to support the discharge from A&E within this time. Their aim is to commission new services or restart existing services by liaising directly with Tower Hamlets’ brokerage team or independent care agencies.

A further aim is for the social work team to help prevent further, unplanned attendances at hospital. The team commissions or restarts services and then transfers case management to our community colleagues who then review services or set up support plans to help maintain people in their own homes. The scheme will:

- demonstrate how a change in working practise in the hospital social work service can deliver better outcomes to patients being discharged from the Royal London hospital.
- identify potential efficiency savings
- facilitate and work with any additional Consultants in supporting patients in a timely fashion, who are medically fit for discharge.
- help reduce any bottlenecks occurring over weekends on acute wards, thereby improving patient flow through AAU and A&E.

41.4 **Community Health Team (Social Care)**

The aims of this council-based service are:

- improved partnership working and joint decision making, with earlier referral to and intervention by social services
- joint and coordinated multi-disciplinary assessments and person-centred planning, involving clients and their families from the outset.
- early support and information provision for clients and their families to enable them to make informed decisions about care options in the community with the intention of delaying/preventing long term care provision.
- greater continuity and standardisation of community assessment and integrated interventions.
- earlier identification and support to carers thereby preventing carer breakdown and need for crisis response.
- Improved communication and enhanced quality, choice and control for the person, their families, carers and advocates
- Better, faster decision making by setting a standard for CHT social care of ensuring completion of DSTs in less than 28 days

41.5 **Mental Health Liaison (RAID)**

This scheme aims to:

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

41.6 **Recovery College**

The aims of this scheme are to make a positive impact in the following areas:

- mental health
- social relationships
- volunteering
- learning and skills
- agency (self-esteem, autonomy, feeling valued, etc)

41.7 **Independent Living Service**

The aims of this scheme are to:

- help to facilitate timely discharge from hospital or reduce preventable hospital admissions.
- delay and avoid dependency on statutory and other long term services.
- support carers with their caring duties.
- train health and social care staff on the effective use of at.
- increase the number of at installations.
- demonstrate the benefits in terms of avoided costs.

41.8 **Integrated Care Incentive Scheme**

This scheme aims to achieve:

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

41.9 **Adult Autism Diagnostic and Intervention Service**

This scheme aims to:

- deliver a diagnostic service for adults (18+) who may have ASD (including Asperger's Syndrome) for whom no care pathway currently exists
- deliver a timely diagnosis to those who may present with ASD behavioural conditions and symptoms
- deliver a locally managed service that incorporates the best clinical practice with regard to adults with ASD
- provide clear pathways to post diagnosis support for adults with ASD
- provide a community focused model that promotes greater opportunity for support within the community for people with ASD
- provide effective transitional pathways to assist young people's (with ASD) transfer from children's to adult services
- 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.
- achieve the above we have increased the KPI's to include the number of users being referred for further education, training and employment opportunities, as well as strengthening the links with the Criminal Justice Service (CJS), including Probation, Courts, and the Police.

41.10 **Dementia Café**

The aim of the Dementia Cafes is to provide an inclusive peer support service for people at different stages of dementia and their carers, including people from the BAME communities in Tower Hamlets. The cafes aim to deliver a structured programme of activities and speakers to promote social engagement, understanding of dementia and help people to connect to other services and sources of support. They aim to complement formal care and information services as part of a wider range of psychosocial treatment, care and support for people with dementia. The identified outcomes of the service are:

- Reduction of social isolation
- Increasing access to services
- Access to information

41.11 **Community Outreach Service**

The Community Outreach Service aims to:

- Increase the numbers of people from Bangladeshi and other BAME communities receiving diagnosis and mainstream services available on the dementia pathway.
- Raise awareness of dementia, increase knowledge and reduce stigma within the Bangladeshi and other BAME communities.
- Identify unmet needs through case finding, and identify, connect and support individuals and carers to access appropriate services at the earliest opportunity.
- Reduce isolation and the number of people with dementia who are have not received a diagnosis and do not access services until crisis point has been reached.
- Provide one to one casework to people with dementia and their carers to ensure people can access the appropriate services at the right time.
- GP Practices – provide an expert resource/point of contact for practices wishing to refer patients for one to one community based support available through the proposed service

41.12 **Carers**

The aim is that Carers feel mentally and physically well, treated with dignity and that:

- they report feeling supported in their caring role
- there is accessible and relevant support for Carers
- they feel better informed about accessing support services
- both Carers and the cared for persons health and emotional wellbeing are maintained
- Carers from hard to reach groups know where to go for information.

Carers are recognised and supported as an expert partner

- More carers sustained in caring role
- Carers are supported to feel confident in their caring role through training to care
- Partner organisations help identify carers and know where to signpost carers for advice and support.

Carers are not financially disadvantaged:

- Carers know where to go for information and advice about benefits and the welfare reform changes
- Carers able to take part in educational, training or work opportunities

Carers enjoy a life outside caring:

- Carers are able to participate their local communities, including social and leisure activities
- Carers can balance their caring role and maintain a quality of life
- Carers have a voice in service development

41.13 **Disabled Facilities Grant**

Disabled Facilities Grant 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.

41.14 **Falls prevention**

This initiative aims to:

- reduce the number of avoidable falls and London Ambulance Service (LAS) callouts to care home settings and the risk of secondary falls
- provide care home and domiciliary agency staff with the skills and confidence to support people who are at risk of falls and prevent falls
- reduce the number of avoidable falls in all Tower Hamlets care homes and prevent injury to residents
- reduce the number of LAS call outs and subsequent transport, non-elective admission and follow-up outpatient appointment.
- facilitate appropriate referrals to the Community Health Teams.

41.14 **Personalisation**

This initiative has the following aims:

- widening the offer of Personal Health Budgets (PHB) beyond Continuing Health Care (CHC)
- delivering Integrated Personal Commissioning (IPC) in Tower Hamlets and contributing to the national evaluation of this. NHS England has Commissioned RAND Europe to undertake this evaluation.
- piloting the use of Patient Activation Measure (PAM) in Tower Hamlets
- self-management, including oversight of the self-management pilots, their evaluation and recommendations on future commissioning plans.

41.15 **Mental Health in Primary Care**

The aims of this scheme are to:

- Provide support to primary care clinicians to recognise, screen and manage for psychological distress, anxiety and depression
- deliver information/ provide support for those providing annual reviews, etc.
- provide training for motivational interviewing (management of MH + LTC for primary care clinicians)
- MDTs
- deliver reflective practice sessions
- provide group work for patients who are first diagnosed and training for primary care clinicians to deliver this training
- increase the number of patients attending existing self-management courses that are provided by CHS and CVS organisations.
- embed psychological interventions into all self-management programmes where this element missing.

41.16 **Community Geriatrician Team**

The team will provide enhanced care for over 65s as part of the Integrated Community Health Team with particular focus on care home population.

41.17 **Enablers**

The team will provide the following support to BCF projects managers, senior officers and members:

- develop Service Level Agreements for all approved BCF schemes for which the council is the lead commissioner
- implement performance management and monitoring systems for BCF-funded initiatives within the council, including the production of reports to the Complex Adults Programme Board and the council's Adult Services DMT
- coordinate the council's involvement in a range of joint bodies concerned with the integration of health and social care, including the Health and Well-Being Board, Complex Adults Programme Board, Tower

Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Pioneer and Transforming Services Together (TST)

- contribute to the development of data sharing arrangements between the council and Health sector organisations, in order to improve service outcomes through more effective joint working.
- provide management and guidance for strategic decision making within the council with an overview of policy, performance, finance and ICT relating to integration.

41.18 **Local Incentive Scheme**

An incentive scheme will be developed by the CCG and the council to encourage and reward joint working that achieves the aims of the Tower Hamlets Integrated Provider Partnership and the Better Care Fund.

41.19 **Social Workers into the memory clinic**

- An earlier assessment of service users in need of some support through social care, and earlier signposting of those not in need of social care input without referring service users onto another team/ service.
- The Pilot (in 2014-2015) showed greater service user satisfaction (this was an area of some anecdotal dissatisfaction and formal complaints before, and certainly an area of staff dissatisfaction for providing good care). The aim was to build on this & consolidate this improved level of service user satisfaction.
- Year on Year increase in service user and carer satisfaction in surveys given at end of contact with the social worker (have qualitative service user and carer feedback from previous MSNAP accreditation reviews as a baseline)
- Increased number of service users assessed by the Social Worker from pilot project last year. Target is 30% of all those referred to the Memory Clinic (approximately 50% of those referred are not expected to be seen for psycho-social assessments).
- Detailed map of interventions and subsequent onward referrals for those referred to Social Worker to assess the reduction of “hand-offs” to other social care services. Target for referrals onto Adult Social Care Teams is 30% of those assessed.

42 **SERVICES**

Scheme	*Services*	*Beneficiaries*	*Contracts in place*
Integrated Community Health Teams	Community virtual ward and case managers Community rehabilitation and support team (CReST) including the falls team Last years of life centre (facilitators and coordinators, service development and MCNS service) Adult community nursing (including Intranvenous therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hours nursing).	Community Health team caseload for all service lines. Enhanced services such as rapid response for the at risk integrated care population	Yes
Reablement Team	- Barts Community Health Team - Tower Hamlets Reablement	The beneficiaries of the service will be: • adults who are ordinarily resident in	Yes

	Service	Tower Hamlets • adults presenting with a health and/or social care need for support • adults who are experiencing difficulties managing activities of daily living due to illness or disability, whether temporary or permanent • in the case of carers, support will be provided if the cared-for person or people are ordinarily resident in Tower Hamlets • users who meet the criteria for input from a restorative (Reablement Service) service: • users who are discharged from hospital following a recent admission episode and are recovering from an acute illness or injury • users referred from the community who are experiencing increased difficulties in managing activities of daily living due to a chronic long term condition (LTC), or exacerbation of a LTC.	
7 Day Hospital Social Work Team	Social Work Team	Patients at the Royal London Hospital who are deemed medically fit at the weekend but require social services support before they can be discharged. The beneficiaries of this service are those who are ordinarily resident in the London Borough of Tower Hamlets and are deemed medically fit for	Yes

		discharge but require social services before they can be discharged.	
Community Health Team (Social Care)		The scheme will focus on the joint assessment and support planning of the top 20% hospital attendance 'frequent flyers' over the age of 18 years. This client group often represent one of the highest proportions of care costs. All beneficiaries of these services will be: • A Tower Hamlets resident • Over the age of 18 years old • Graded as being high/very high risk of hospital admission using the Q-admissions rating scale implemented by GPs • CHT (SC) plan to screen and potentially work with those scoring 60% or more on the ICP during 2016. This will involve approximately 170 more people. • Patient is likely to have at least one long term condition • Patients receiving active neuro-rehabilitation, including those Tower Hamlets residents who are in-patients in regional hospitals and may or may not be on ICP. • Patient has consented to inclusion on the ICP.	Yes
Mental Health Liaison (RAID)	- Royal London Hospital Liaison Psychiatry Service	People with a diagnosed mental health condition who present at/ are admitted to Barts Health sites. Barts Health Clinical	Yes

		Staff	
Recovery College		Stage 1: (Pilot) Mental health service users who have used ELFT (Tower Hamlets) services in the previous 12 months, including those who have been discharged. Stage 2: (Roll Out) Supporters (carers, family, friends) of people using mental health services in Tower Hamlets. ELFT, local authority and voluntary sector staff working within mental health services. Complex co-morbidity – mental health issue and other long term physical condition Groups at risk of emergency hospital admission where effective self-care within a professional/peer supported environment (i.e. recovery college) may reduce preventable admissions.	No
Assistive Technology Team	- Assistive Technology	• Social Care and Health professionals who require training, support and advice on the effective use of assistive technology. This constitutes 18 teams across 9 site locations. • Vulnerable service users will be indirect recipients of the service, which will contribute towards their being able to remain living independently in their own homes. This will include the provision of equipment and a	Yes

		service that facilitates discharge from hospital or a reduction of preventable hospital admissions. • Carers of vulnerable service users will be indirect recipients of the service, which will provide them with support and reassurance so that they can continue to care.	
Assistive Technology Additional Demand		To follow	
Social Worker input into the memory clinic		LBTH residents 18+ years-they may be referred in or refer themselves.	Yes

Integrated Care Incentive Scheme	- Integrated Care Incentive Scheme	All patients who are in the top 4% risk of admission (borough level risk) who are eligible for Level 1. All patients in the four mandatory groups: palliative, heart failure, dementia and nursing home-irrespective of Q Admissions risk. These patients will be eligible for both Level 1 and Level 2. All discretionary patients under the previous CC NIS who were identified in the CEG August 2013 baseline search and who were consented into the CC NIS by 31/3/14, Irrespective of Q Admissions risk. These patients will be eligible for both Level 1 and Level 2. [No further discretionary patients can enter the programme currently]	Yes
Adult Autism Diagnostic and Intervention Service		The service is primarily for people with suspected ASD in Tower Hamlets, who do not have a Learning Disability and who are not eligible for services through the Community Learning Disability Team. Families and carers are also provided with information about local support groups and services specifically for carers, and advised on how to access these. They are advised of their right to a formal Carer's Assessment for their own physical and mental health needs and their capacity to continue in their caring role in line with the council's Carers' Strategy	*Yes*
Dementia Café		The population covered is people with dementia	*Yes*

		and their carers in Tower Hamlets, including people from the black and ethnic communities and Bangladeshi communities	
Community Outreach Service		The population covered will be people with dementia and their Carers, both within the Bangladeshi population and within the wider BAME community.	*Yes*
Disabled Facilities Grant		Eligible disabled adults Disabled children Carers	Yes
Carers		The services are to support the main adult carers, aged 18 and over, who are Tower Hamlets residents or who are caring for someone who lives in Tower Hamlets. This includes unpaid carers who live in another borough but care for a resident of Tower Hamlets.	Yes
Falls prevention		Residents of domiciliary care homes	Yes
Community geriatrician team		Over 65s in the caseload of the Integrated Community Health Team	Yes
Mental health personal commissioning		with LTCs and depression or anxiety	Yes
Personalisation		People with enduring mental health needs; people with multiple LTCs (respiratory plus additional LTCs); children with special educational needs; people with learning disabilities	
Enablers		BCF programme management and coordination	Yes
Local incentive scheme		The incentive scheme will be open to all THIPP organisations and payment will be based on. achievement of outcomes, measured by: • Integrated Care	No

		Metrics (incl. Mental Health) • Better Care Fund Metrics • Patient Experience Metric development • Population Health Metrics	

43 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

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

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

44 FINANCIAL CONTRIBUTIONS

Contributor	2016/17 (£000s)
LBTH	1572.542
CCG Mandated	18805.193
CCG Additional (recurrent)	389.882
CCG additional (non recurrent)	695
Total	21462.617

Deployment of contributions:

Scheme	2015/16 (£000s)
Raid	2106.42
Mental health recovery college	110
Adult Autism and diagnostic intervention service	330
Social worker input into memory clinic	50
Dementia café and community outreach service	80
Integrated care incentive scheme	1200
Integrated community health team	7336.499
Community Health Team (Social Care)	895.5
Out of hours 7 day hospital team	1230.8
Reablement	2413.871
Independent living	649
ENABLERS (see section 7)	208
7 Day Community Equipment Team	154.985
DFG and CAPITAL	1572.542
Care act implementation	733
Support for carers	697
Local incentive scheme	1000
Strategic development	695

Total	21,462.617

45 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund	
Are any amendments required to the Agreement in relation to the management of Pooled Fund	**No**
Have the levels of contributions been agreed? How will changes to the levels of contributions be implemented?	**Yes. See S75 for rules on changes**
Have eligibility criteria been established?	**Yes, see scheme descriptors**
What are the rules about access to the pooled budget?	**See S75**
Does the pooled fund manager require training?	**No**
Have the pooled fund managers delegated powers been determined?	**Yes, in line with current SFIs**
Is there a protocol for disputes?	**Yes, see S75**
Audit Arrangements	
What Audit arrangements are needed?	**The current audit arrangements will apply**
Has an internal auditor been appointed?	
Who will liaise with/manage the auditors?	
Whose external audit regime will apply?	
Financial Management	
Which financial systems will be used?	**Existing financial systems in each partner org**
What monitoring arrangements are in place?	**Monthly budget reports** **Monthly provider performance reports**
Who will produce monitoring reports?	**Lead commissioner of that scheme**
Has the scale of contributions to the pool been agreed?	**Yes**
What is the frequency of monitoring reports?	**Monthly**
What are the rules for managing overspends?	**See S75**
Do budget managers have delegated powers to overspend?	**No, see S75**
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?	**See S75**

How will overspends and underspends be treated at year end?	**See S75**
Will there be a facility to carry forward funds?	**See S75**
How will pay and non pay inflation be financed?	**Annual review of budgets in accordance with S75 agreement**
Will a contingency reserve be maintained, and if so by whom?	**Performance pool. See S75**
How will efficiency savings be managed?	**See S75**
How will revenue and capital investment be managed?	**See S75**
Who is responsible for means testing?	**LBTH**
Who will own capital assets?	**NA**
How will capital investments be financed?	**NA**
What management costs can legitimately be charged to pool?	**Enablers scheme includes management costs**
What re the arrangement for overheads?	**None, the pool does not currently include commissioning overheads**
What will happen to the existing capital programme?	**NA**
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?	**See S75**

46 VAT

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

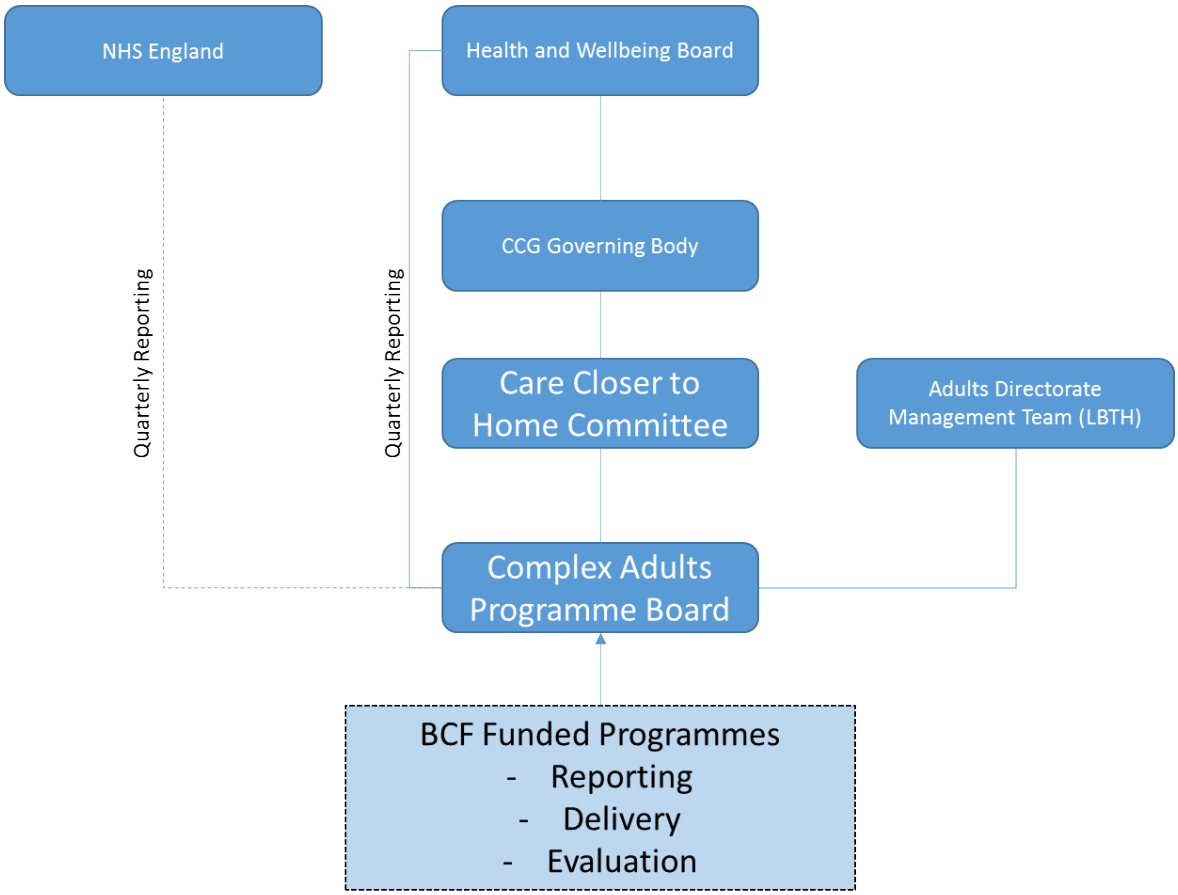
47 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

47.1 Integrated Care in Tower Hamlets is overseen and driven by a joint Complex Adults Programme Board (CAPB). The CAPB includes representatives from:
- CCG and LA commissioners
- Provider colleagues from social care, acute, community, mental health and primary care
- Voluntary sector
- Chaired by a provider Non-Executive Director

47.2 The CAPB is a formal sub-committee of the Health and Wellbeing Board, as well as being a Tower Hamlets CCG programme board. The Chair of the Complex Adults Programme Board sits on the Health and Wellbeing Board, and Integration is a key strategic priority under the Tower Hamlets Health and Wellbeing Strategy.

47.3 The Complex Adults Programme Board oversees:

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



48 NON FINANCIAL RESOURCES

Council contribution

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

CCG Contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA

	Details	Charging arrangements	Comments
Contracts	NA	NA	NA
Central support services	NA	NA	NA

49 STAFF

To be agreed following further discussion at the Partnership Board

50 ASSURANCE AND MONITORING

See Better Care Fund application excel submission

Outcome	Metric	Source	Timeliness
BCF Metrics	See Part 2	See Part 2	Monthly
Emergency admissions for target group	Emergency admissions for target group	Integrated Care Dashboard	Monthly
Readmissions for target group	Readmissions for target group	Integrated Care Dashboard	Monthly
Average length of stay	Average length of stay	Integrated Care Dashboard	Monthly
Total bed days	Total bed days	Integrated Care Dashboard	Monthly
Bed days per 1000 eligible population	Bed days per 1000 eligible population	Integrated Care Dashboard	Monthly
Non-elective admission rate per 1000 eligible population	Non-elective admission rate per 1000 eligible population	Integrated Care Dashboard	Monthly
Number of attendances at A&E	Number of attendances at A&E	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 30 days of discharge	Proportion of patients readmitted to acute hospital within 30 days of discharge	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 91 days of discharge	Proportion of patients readmitted to acute hospital within 91 days of discharge	Integrated Care Dashboard	Monthly
Average acute cost per patient	Average acute cost per patient	Integrated Care Dashboard	Monthly
Avoidable emergency admissions	Avoidable emergency admissions	Integrated Care Dashboard	Monthly

51 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Karen Sugars	London Borough of Tower	020 7364 0497	karen.sugars@towerhamlets.gov.uk

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
		Hamlets, 4th Floor, Mulberry Place, 5 Clove Crescent, London, E14 2BG		
CCG	Josh Potter	NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG	020 3688 2518	josh.potter@towerhamletsccg.nhs.uk

52 REGULATORY REQUIREMENTS

See individual service specifications

SCHEDULE 2 – GOVERNANCE

1 Partnership Board

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

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

Name	Role	CAPB Responsibility
Chair		
Victoria Tzortziou Brown	Tower Hamlets CCG Board member and Lead on Integrated Care and Research	Chair
Tower Hamlets CCG		
Isabel Hodkinson	Tower Hamlets CCG Board member and Lead on Informatics	Link to TST Informatics Work stream
CCG Clinical Leads TBC	Clinical Leads	As required depending on agenda item
Josh Potter	Deputy Director of Commissioning and Transformation	CCG BCF Lead and member of WELC Contracting and Reimbursement Steering Group
Julie Dublin	Transformation Manager	Crisis response
Angela Fernandez	Transformation Manager	Living with LTCs
Zakia Khatun	Programme Manager: Personalisation	Programme Manager for Personalisation
Folake Abayomi-Lee	Transformation Manager	Complex Care
Carrie Kilpatrick	Deputy Director of Mental Health and Joint Commissioning	CCG Mental Health Lead
Daniela Levarda	WELC PMO	
Dr Laura Eyre	Research Associate UCL-WELC Integrated Care Programme	
London Borough of Tower Hamlets		
Karen Sugars	Interim Service Head: Commission & Health Education, Social Care and Wellbeing	Pooled Fund Partner
Steve Tennison	Senior Strategy, Policy and Performance Officer – Integration Lead	
Abigail Knight	Acting Associate Director of Public Health	Public Health Input
Community and Voluntary Sector		
Myra Garrett	Health and Wellbeing Forum Lead: Tower Hamlets CVS	CVS Representative

2 Role of Partnership Board

The Partnership Board shall:

2.1.1 Provide strategic direction on the Individual Schemes

2.1.2 receive the 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 a risk assessment and a Performance Payment protocol;

2.1.6 review and agree annually revised Schedules as necessary;

2.1.7 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.

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

3 Partnership Board Support

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

4 Meetings

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

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

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

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.

4.5 Minutes of all decisions shall be kept and copied to the Pooled Fund Managers within seven (7) days of every meeting.

5 Delegated Authority

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

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

6 Information and Reports

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

7 Post-termination

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

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

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

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

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

Pooled Fund Management

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

Overspend

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

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

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

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

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

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

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

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

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

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

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 Joint Investigation Reports;

2.6 Service Quality Performance Report;

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

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

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

4 The Lead Commissioner shall not:

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

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

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

4.4 give any approvals under the Service Contract;

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

4.6 suspend all or part of the Services;

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

4.8 serve any notice;

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

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

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

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

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

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

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

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

1.1 resolve disputes pursuant to a Service Contract;

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

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

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

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

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

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

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SCHEDULE 6 – BETTER CARE FUND PLAN

1. The Tower Hamlets Better Care Fund plan 16/17 is working to the following timetable:

2 March: Local areas to submit only the completed BCF Planning Return template to your local DCO team (england.londonsubmissions@nhs.net) copied to the Better Care Support Team (england.bettercaresupport@nhs.net), detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.

21 March: First submission of full narrative plans for Better Care alongside a second submission of the BCF Planning Return template.

25 April: Final submission, once formally signed off by the Health and Wellbeing Board

Once approved the final Better Care Fund Plan will be appended to this agreement.

SCHEDULE 7– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

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

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

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

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

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

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

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

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

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

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

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

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