Dated 2019

LONDON BOROUGH OF HACKNEY

and

NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP

FRAMEWORK SECTION 75 AGREEMENT FOR THE DEVOLUTION OF HEALTH AND SOCIAL CARE SERVICES IN LONDON BOROUGH OF HACKNEY (INCLUDING THE BETTER CARE FUND)

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THIS AGREEMENT is made on day of 2019

PARTIES

(1) **LONDON BOROUGH OF HACKNEY** of Hackney Service Centre, 1 Hillman Street, London E8 1DY (the **"Council"**)

(2) **NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP** of 3rd Floor, Block A, St Leonard's Hospital, London, N1 5LZ (the "**CCG**")

each a "**Party**" and together the "**Parties**".

BACKGROUND

(A) The Council has responsibility for commissioning and may provide social care services on behalf of the population of the London Borough of Hackney.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the London Borough of Hackney.

(C) The Parties wish to establish a pooled and aligned fund, and delegate the exercise of certain commissioning functions to each other, in order to integrate the commissioning of health and social care services, as set out in this Agreement.

(D) This Agreement also sets out the arrangements for the Better Care Fund, which supports 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 Parties pool those funds in accordance with Section 75 of the 2006 Act. The pooled fund established for the purposes of this Agreement is broader than the Better Care Fund, and the requirements of the Better Care Fund plan (in terms of reporting, for example), shall only apply to the Better Care Fund element of the pooled fund.

(E) 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.

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

(G) The main **aims and objectives** of the Parties in entering in to this Agreement are to:

(i) meet the National Conditions and local objectives;

(ii) integrate the commissioning activities of the Parties in respect of the relevant populations (resident and GP registered) of London Borough of Hackney in line with the Health and Wellbeing Board's vision of integrated health and wellbeing, and through the pooling or aligning of financial resources and integrated governance create a sustainable health and wellbeing system with improved system performance;

(iii) agree strategies and ensure commissioning activity in order to make more effective use of resources to achieve improved health and wellbeing for the local population, improved outcomes and integrated service delivery and prioritise prevention and early intervention by ensuring people receive 'the right care in the right place at the right time';

(iv) help people take control of their lives and communities and ensure children, young people and adults are safe and confident in their lives and communities and that

people are treated with dignity and respect; and

(v) to deliver Integrated Commissioning that will focus on developing joined up, population based, public health, and preventative and early intervention strategies and services and adopt an asset based approach to providing a single system of health and wellbeing, focusing on increasing the capacity and assets of people and place.

(H) The Parties are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act, 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:

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.

2012 Act means the Health and Social Care Act 2012.

Affected Party means, in the context of Clause 28, the Party 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.

Aligned Commissioning means mechanisms by which the Parties commission services that are not included within a pooled arrangement, but which are closely related to those pooled commissioned services; and which are incorporated within the design of the overall integrated commissioned service. For the avoidance of doubt, aligned commissioning arrangements do not involve the formal delegation of any functions pursuant to Section 75 of the 2006 Act.

Aligned Fund means budgets for commissioning prescribed services (as set out in Part 3 of Schedule 1) which will be managed alongside the Pooled Fund.

Annual Review has the meaning set out in clause 24.1.

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

Best Value Duty means the duty on local authorities to provide best value and to provide services efficiently, effectively and economically and to strive for constant improvement of all services as set out in the Local Government Act of 1999 and the Local Government Act of 2000 and any similar duty.

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 Parties.

Better Care Fund Plan means the plan attached at Part 1 of Schedule 6 setting out the Parties plan for the use of the Better Care Fund.

Budget Contributions means the budget contributions made by each Party to the Integrated Commissioning Fund in any Financial Year.

CCG Contracts means any contract that the CCG holds but has agreed that the Council

should be the Lead Commissioner for, and therefore the CCG appoints the Council to act as agent to manage the contract in accordance with Clause 15.

CCG Contingency Funds means funds apportioned by the CCG (in accordance with the Financial Framework) that the CCG has designated to cover financial risks where such risks are not otherwise mitigated through Service Contracts.

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act and those duties that are set out in the 2012 Act.

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

Chief Financial Officer(s) means either the person appointed by the Council pursuant to section 151 of the Local Government Act 1972 or the person appointed to the role of chief finance officer by the CCG in accordance with [paragraph 11 of Schedule 1A] of the Health and Social Care Act 2012 or both of them as the context requires.

Commencement Date means 00:01 hrs on 1 August 2019.

Commissioning Plans means the plans setting out details of how the Integrated Commissioning Strategies (including but not limited to the Locality Plans) will be implemented and delivered.

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

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

(b) 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.

Council Contracts means any contract that the Council holds but has agreed that the CCG should be the Lead Commissioner for, and therefore the Council appoints the CCG to act as agent to manage the contract in accordance with Clause 15.

Data Controller, Data Processor, Data Subject, Personal Data, Processed, Processing and Special Categories of Personal Data will have the meaning ascribed to them by the DP Legislation.

Data Protection Officer means the individual detailed in Schedule 8 (Data Processing Schedule)

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

Dispute Resolution Procedure means the procedure set out at Clause 27.

DP Legislation means all applicable data protection and privacy legislation, regulations and guidance including: (i) Regulation (EU) 2016/679 (or, in the event that the UK leaves the European Union, all applicable legislation enacted in the UK in respect of the protection of

Personal Data) (the **"General Data Protection Regulation"** or **"GDPR"**) and the Privacy and Electronic Communications (EC Directive) Regulations 2003; and (ii) the Data Protection Act 2018;

Exit Plan means the exit plan described in Schedule 7 (Exit Planning Obligations).

Expiry Date means 23.59 hours on 31 March 2020.

Finance Economy Group means a group responsible for the financial management of the Integrated Commissioning Fund, as further set out in the Financial Framework.

Financial Framework means the financial framework agreed between the Parties in respect of this Agreement, as varied from time to time in accordance with Clause 34.2 and as set out in Schedule 3.

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 Party 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 from time to time as are relevant to the commissioning of the Services and which may be further described in the relevant Commissioning Plans, Service Specifications, Better Care Fund Plan and/or Scheme Specifications.

Host Partner means the Party that will host and provide the financial administrative systems for the Pooled Fund and undertake to perform the duties for which they will be responsible, as set out in paragraph 7(4) and 7(5) of the Regulations.

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.

Information Framework means the information framework agreed between the Parties in respect of this Agreement, as amended from time to time in accordance with Clause 34.2.

Integrated Commissioning means arrangements by which Parties commission Services in relation to an Integrated Commissioning Strategy on behalf of each other; and in the exercise of commissioning of both the NHS Functions and Health Related Functions.

Integrated Commissioning Board (or "**ICB**") means the committees responsible for review of performance and oversight of this Agreement with the terms of reference as set out in Schedule 2.

Integrated Commissioning Fund means the total of the Pooled Fund and Aligned Fund.

Integrated Commissioning Strategies means the commissioning strategies and priorities agreed between the Parties about what services to commission within the area, and amended from time to time in accordance with Clause 34, and the agreed Integrated Commissioning Strategies as of the date of this Agreement are set out in Part 1 of Schedule 1.

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 Party(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 Party(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 Party commissions Services in relation to an Integrated Commissioning Strategy or Commissioning Plan on behalf of the other Party in exercise of both the NHS Functions and the Health Related Functions.

Lead Commissioner means the Party responsible for commissioning an individual Service under a Commissioning Plan.

Locality Plan means a strategy designated as such by the Integrated Commissioning Board.

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 of the CCG listed in Regulation 5 of the Regulations from time to time as are relevant to the commissioning of the Services and which may be further described in the relevant Commissioning Plans, Service Specifications, Better Care Fund Plan and/or Scheme Specifications.

NHS Standard Contract means a contract based on terms published by NHS England for the commissioning of health services in accordance with their obligations under Regulation 17(1) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

Non-Recurrent Payments means funding provided by a Party to the Integrated Commissioning Fund in addition to the Budget Contributions pursuant to arrangements agreed in accordance with Clause 10.3.

Overspend means any expenditure from the Integrated Commissioning Fund in a Financial Year which exceeds the budget agreement for that Financial Year.

Performance Payment Arrangement means any arrangement agreed with a Provider and

one or more Parties in relation to the cost of providing Services on such terms as agreed in writing by all Parties.

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

Permitted Budget means in relation to a Service, the budget that the Parties have set in relation to the particular Service or Services (including the budgets for all the commissioning staff of each Party), such details being included at Schedule 1 (Integrated Commissioning Strategies and Budget Contributions).

Permitted Expenditure has the meaning given in Clause 7.2.

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

Pooled Fund Manager means such officer of the Host Partner, nominated by the Host Partner from time to time to manage the relevant Pooled Fund.

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

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

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

Regulator means the Information Commissioner's Office and the European Data Protection Board or any successor body to either regulator from time to time and any other supervisory authority with jurisdiction over either Party.

Scheme Specification means a specification setting out the detailed arrangements relating to a particular BCF Service within a Commissioning Plan agreed by the Parties to be commissioned under this Agreement as set out in Part 2 of Schedule 6.

Service Specification means a specification setting out the detailed arrangements relating to a particular Service within a Commissioning Plan agreed by the Parties to be commissioned under this Agreement and as may be specified in Part Four of Schedule 1.

Services mean such health and wellbeing services as agreed from time to time by the Parties as commissioned under the strategies set out in this Agreement, and "**Service**" shall be interpreted accordingly.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Parties in accordance with the relevant Commissioning Plan, or, in 2017/18, in accordance with plans previously made by one of the Parties

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

Task and Finish Group means a group responsible for the operational financial management and reporting for the Integrated Commissioning Fund, as further set out in the Financial Framework.

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

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 Parties shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict between the terms in the main body of this Agreement and the Schedules the terms in the main body of this Agreement shall take precedence.

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 Parties 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 and shall expire on the Expiry Date ("**Initial Term**"), subject to earlier termination in accordance with its terms or at law, unless the Parties agree in writing to extend the term of this Agreement, not later than 3 months before the end of the Initial Term or any Extended Term, as applicable. For the avoidance of doubt, this Agreement may be extended for two further one year periods (each an "**Extended Term**").

2.2 The duration of the arrangements for each Service shall be as set out in the relevant Services Contract, and the duration of the arrangements for each Scheme Specification (where different to the term of this Agreement) shall be set out within the relevant Scheme Specification.

3. GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Parties 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 Parties 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 The Parties acknowledge that it is a requirement of the Better Care Fund that the CCG and the Council establish a Pooled Fund for the purposes of supporting the integration of health and social care and to seek to achieve the National Conditions and local objectives. The Parties have agreed to establish such a Pooled Fund pursuant to this Agreement and in accordance with the Better Care Fund Plan and the Scheme Specifications. For the avoidance of doubt, the Better Care Fund Plan and the Scheme Specifications (and any requirements therein) shall only apply in respect of the Services commissioned pursuant to those Scheme Specifications. The Parties acknowledge and agree that the Better Care Fund will form part of the Pooled Fund for the purposes of this Agreement, however, only that part of the Pooled Fund will be subject to the requirements in the Better Care Fund Plan.

3.4 The Parties shall comply with their respective obligations as set out in with the Financial Framework and the Information Framework. Any reference to the Financial Framework or the Information Framework is a reference to the Financial Framework or the Information Framework as varied in accordance with Clause 34.2 from time to time.

4. PARTNERSHIP FLEXIBILITIES

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

4.1.1 Integrated Commissioning;

4.1.2 Lead Commissioning Arrangements;

4.1.3 Aligned Commissioning;

4.1.4 the establishment of one or more Pooled Fund;

in relation to the Services (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 Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to this Agreement and the Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party 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 Parties can secure the provision of health and wellbeing 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 Parties.

5.3 Where the Parties add a new Commissioning Plan to this Agreement it will need to be agreed by both Parties in accordance with the governance arrangements set out in this Agreement and include as a minimum details of who will act as the Lead Commissioner, the budget and other resource contributions of each Party.

5.4 The Parties shall not enter into a Commissioning Plan unless they are satisfied that the Commissioning Plan in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Commissioning Plans using Pooled Funds will be subject to business case approval by the Integrated Commissioning Board, unless otherwise agreed by the Parties.

5.6 The introduction of Commissioning Plans using Aligned Funds will be subject to business case approval by the Integrated Commissioning Board who will recommend them for approval by the relevant Party or Parties, unless otherwise agreed by the Parties.

5.7 The Parties agree to comply with the governance arrangements in Schedule 2.

6. COMMISSIONING ARRANGEMENTS

6.1 Where there are Integrated Commissioning arrangements in respect of individual Services, both Parties 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 Each Party shall be responsible for compliance with and making payments of all sums due from them to a Provider pursuant to the terms of a Service Contract.

6.3 Both Parties shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Commissioning Plan are commissioned within each Party's Budget Contribution in respect of that particular Service in each Financial Year.

6.4 The Parties shall comply with the arrangements in respect of the Integrated Commissioning or Aligned Commissioning (as relevant) as set out in the relevant Service Specification.

6.5 The Parties shall comply with the obligations set out in Schedule 7 (Exit Planning Obligations).

6.6 Each Party shall keep the other Party and other stakeholders regularly informed, through agreed governance arrangements, of the effectiveness of the arrangements including the Better Care Fund and any Overspend or underspend in a Pooled Fund or Aligned Fund through the agreed governance arrangements.

Appointment and Role of a Lead Commissioner

6.7 From time to time the Parties through the Integrated Commissioning Board shall appoint one of them to act as Lead Commissioner for an Integrated Commissioning Strategy, Commissioning Plan or an individual Service and unless agreed otherwise the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Budget Contributions of each Party 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 Service Specification;

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

6.7.5 comply with all relevant legal duties and guidance of both Parties in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard 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;

6.7.8 put in place appropriate systems, as agreed by the Parties, to make sure that payments of all sums due to a Provider take place pursuant to the terms of any Services Contract;

6.7.9 provide the other Party with information in accordance with the Information Framework; and

6.7.10 keep the other Party and the Integrated Commissioning Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or underspend in a Pooled Fund or Aligned Fund.

7. ESTABLISHMENT OF THE POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Parties have agreed to establish and maintain a Pooled Fund for revenue expenditure as set out in the Commissioning Plan.

7.2 The Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement and it is agreed that monies held in the Pooled Fund (except for the CCG Contingency Funds) may only be used for (i) the Permitted Budget, in order to commission prescribed services (either NHS Functions or Health Related Functions) that the Parties have agreed will contribute to the effective delivery of the prescribed services and (ii) Third Party Costs ("**Permitted Expenditure**").

7.3 The Parties may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Party. Failure to reach agreement on such issues may be resolved through the Dispute Resolution Procedure.

7.4 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by both Parties. The CCG Contingency Funds may only be used in accordance with the Financial Framework.

7.5 Pursuant to this Agreement, the Parties agree to appoint a Host Partner for the Pooled Fund who shall be responsible for:

7.5.1 administering the record of the funds contributed to the Pooled Fund on behalf of itself and the other Party;

7.5.2 administering the record of the funds expended by the Parties in relation to the Pooled Fund;

7.5.3 administering a record of the funds contributed and expended by the Parties in relation to Aligned Funds; and

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

7.6 For the avoidance of doubt each Party shall administer its own financial transactions initially within its own accounting ledger and seek reimbursement from the Host Partner out of the Pooled Fund.

8. POOLED FUND MANAGEMENT

8.1 The Parties hereby agree that the Host Partner shall appoint an officer to act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations, subject to the consent of the other Party (such consent not to be unreasonably withheld).

8.2 The Pooled Fund Manager shall have the following duties and responsibilities:

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

8.2.2 preparing and submitting to the Integrated Commissioning Board bi-monthly reports (or more frequent reports if required by the Integrated Commissioning 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 Parties and the Integrated Commissioning Board to monitor the effectiveness of the Pooled Fund and to enable the Parties to complete their own financial accounts and returns; and

8.2.3 compliance with the obligations set out in the Financial Framework.

8.3 Pursuant to this Agreement, the Parties agree to establishing a Finance Economy Group and a Task and Finish Group, with the composition and responsibilities of such groups further specified in the Financial Framework.

8.4 In carrying out the responsibilities under Clause 8.2 the Pooled Fund Manager shall be accountable to the Parties and have regard to the recommendations of the Finance Economy Group, the Task and Finish Group, and the Integrated Commissioning Board. Furthermore, the Pooled Fund Manager must comply with the Financial Framework and the Information Framework.

8.5 Both Parties acknowledge the importance of ensuring that there is sufficient financial management support for the Integrated Commissioning Fund, and the Chief Financial Officer (or equivalent) of each Party shall be responsible for ensuring this support.

9. ALIGNED FUNDS

9.1 Any Budget Contributions agreed to be held within an Aligned Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Commissioning Plan. For the avoidance of doubt, an Aligned Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Regulations, and all non-pooled funds referred to in this Agreement shall be Aligned Funds.

9.2 Where an individual Service is being supported by an Aligned Fund, the Parties agree that responsibility for expending monies from an Aligned Fund shall not be delegated to the Lead Commissioner.

9.3 The Parties shall work together to establish the financial and administrative support necessary to enable the effective and efficient management of an Aligned Fund, meeting all required accounting and auditing obligations.

9.4 Where there are shared Aligned Commissioning arrangements, both Parties shall work in cooperation and shall endeavour to ensure that:

9.4.1 the NHS Functions funded from an Aligned Fund are carried out within the CCG's Budget Contribution to an Aligned Fund for the relevant Service in each Financial Year; and

9.4.2 the Health Related Functions funded from an Aligned Fund are carried out within the Council's Budget Contribution to an Aligned Fund for the relevant Service in each Financial Year.

10. BUDGET CONTRIBUTIONS

10.1 The Budget Contribution of the CCG and the Council to the Pooled Fund and Aligned Funds for the first Financial Year of operation of each individual Service (including details of how such contributions shall be made) shall be as set out in Schedule 1 Part 2 to this Agreement and the Better Care Fund Plan (as relevant), and each Party hereby agrees to make such Budget Contribution.

10.2 Future Budget Contributions going forward will be determined by the Parties, who shall seek to agree such details prior to 31 December of the preceding year and set out in writing on or before the 31 March of the preceding financial year in accordance with the Financial Framework. Following determination of future Budget Contributions, the Parties will formally vary this Agreement in accordance with Clause 34, to reflect the required updates to Schedule 1 (Integrated Commissioning Strategies and Budget Contributions) and other parts of the Agreement as required.

10.3 With the exception of Clause 17, no provision of this Agreement shall preclude the Parties from making additional contributions of Non-Recurrent Payments to the Integrated Commissioning Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be recorded in Integrated Commissioning Board minutes and recorded in the budget statement.

10.4 Any grant contributions (or other ring-fenced funding) shall be subject to the relevant conditions that apply and both Parties hereby agree to comply with those conditions.

Non-financial contributions

10.5 Both Parties shall review non-financial contributions toward the Integrated Commissioning Fund including staff, 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) as part of the annual review.

11. CHARGING FOR SERVICES

11.1 The Services provided through this Agreement for which the Council normally charges will continue to attract a charge. There is no intention to increase or expand charging arrangements through this Agreement, although the Council reserves the right to do this at any time.

11.2 All charges will be collected by the Council.

11.3 Care plans will ensure that where a charge is made, it is carefully explained to Service Users at the outset, to avoid any misunderstanding that NHS services are being charged for.

11.4 Decisions about the charging policies to be adopted will rest with the Council. Changes of policy will be reported to the Integrated Commissioning Board. The Council will ensure that

written operational policies exist which provide staff with clear guidance on which services are charged for and which are non-chargeable.

11.5 The Council shall be liable for and release and indemnify and keep indemnified the CCG from and against all costs, claims, expenses, demands and liability arising from or as a result of the Council charging for any services.

12. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

12.1 The Parties have agreed that the arrangements and obligations as set out in the Financial Framework shall apply to this Agreement.

Overspends in Pooled Funds

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

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

12.4 In the event that the Finance Task and Finish Group identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Integrated Commissioning Board is informed as soon as reasonably possible.

Overspends in Aligned Funds

12.5 Where either Party forecasts an Overspend in relation to an Aligned Fund, that Party shall as soon as reasonably practicable inform the other Party and the Integrated Commissioning Board.

Risk share arrangements

12.6 The Parties have agreed risk share arrangements which provide for financial risks arising within the commissioning of services from the Pooled Fund and an Aligned Fund.

12.7 If the Integrated Commissioning Fund (or any part of the Integrated Commissioning Fund relevant to a Service Specification or Scheme Specification) records an Overspend or underspend in any year, the balance of Overspend is recorded in the Party that holds the statutory responsibility for the function or budget which incurred the Overspend or underspend, save for where a Service Specification, Scheme Specification or Better Care Fund Plan expressly states otherwise. The mechanisms for sharing risk and reward are set out in further detail in the Financial Framework.

12.8 Unless the Parties agree to the contrary, where:

12.8.1 any Overspend that is recorded at the end of any Financial Year; or

12.8.2 any Overspend is offset, during that Financial Year, by contributions from fund reserves accumulated in previous Financial Years;

12.8.3 any Overspend is met from the CCG Contingency Funds

the Parties shall be entitled to recover their share of those Overspends, through adjustment to their future Financial Years' contribution to the Integrated Commissioning Fund.

13. INFORMATION FRAMEWORK

13.1 The Parties agree to share information with each other relating to the Services commissioned under Commissioning Plans, in accordance with the Information Framework.

14. **PREMISES**

14.1 The Parties shall be responsible for providing any premises which are necessary for the commissioning of the Services and, where these requirements are not set out in the relevant Service Specification, they will be agreed by the Integrated Commissioning Board.

15. **PRE-EXISTING CONTRACTS**

15.1 Where from time to time the Parties have agreed to appoint a Lead Commissioner for a Service, the Party that is not the Lead Commissioner hereby appoints the other to act as agent to manage the CCG Contracts or the Council Contracts (as the case may be) from the Commencement Date. Each Party shall make available to the other copies of the CCG Contracts or the Council Contracts (as the case may be) to enable the other to carry out its role as agent.

15.2 The Parties may agree that, where necessary, and subject to the relevant contracting party's consent, the rights and obligations of the original contracting Party under the CCG Contracts or Council Contracts (as the case may be) may be transferred to the other Party by way of novation or assignment.

16. **GOVERNANCE AND PERFORMANCE MANAGEMENT**

16.1 The Parties shall comply with their respective obligations as set out in Schedule 2 (Governance) and Schedule 5 (Performance Arrangements).

17. **CAPITAL EXPENDITURE**

17.1 Neither Pooled Funds nor Aligned 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 Parties. If a need for capital expenditure is identified this must be agreed by the Parties and the capital expenditure must comply with any applicable grant conditions.

18. **VAT**

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

18.2 Further detail as to the agreement by the Parties with regard to VAT is set out in the Financial Framework.

19. **AUDIT AND RIGHT OF ACCESS**

19.1 Both Parties 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 Pooled Fund in accordance with the Regulations and section 7 of the Local Audit and Accountability Act 2014.

19.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access by them to any document, information or explanation they require from any employee or member of the Party 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.

20. **LIABILITIES AND INSURANCE AND INDEMNITY**

20.1 Subject to Clause 20.2 and 20.3, if a Party ("**First Party**") incurs a Loss arising out of or in connection with this Agreement or a Services Contract as a consequence of any act or omission of another Party ("**Other Party**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or a Services Contract then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Party acting in accordance with the instructions or requests of the First Party or the Integrated Commissioning Board.

20.3 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause 20 the Party that may claim against the other indemnifying Party will:

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

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

20.3.3 give the Other Party 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 Party 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.

20.4 Each Party 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.

20.5 Where a Party is the Lead Commissioner for any Service Contract, it shall ensure that any Provider that they appoint will have adequate insurance (or equivalent indemnity arrangements through schemes operated by the National Health Service Litigation Authority) including but not limited to employers liability, public liability, professional indemnity insurance and clinical negligence, as appropriate to the services being undertaken by the Provider.

20.6 Each Party 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.

21. STANDARDS OF CONDUCT AND SERVICE

21.1 The Parties will at all times comply with Law and ensure good corporate governance in respect of each Party (including the Parties' respective constitutions, standing orders, standing financial instructions and codes of conduct).

21.2 The Council is subject to the Best Value Duty. This Agreement and the operation of the Integrated Commissioning Fund is therefore subject to the Council's Best Value Duty and the CCG will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value Duty.

21.3 The CCG is subject to the CCG Statutory Duties and these include a duty of clinical governance, through which it is accountable for securing continuous improvements to the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund are subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

21.4 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

22. **CONFLICTS OF INTEREST**

22.1 The Parties shall comply with their respective policies for identifying and managing conflicts of interest. Without prejudice to the generality of this clause, this should include:

22.1.1 any existing conflicts of interest or potential conflicts of interest;

22.1.2 any conflict of interest or potential conflict of interest that may arise in the future;

22.1.3 ensuring that additional employment (paid or voluntary) may not be undertaken by any staff working within this Agreement which conflicts with or is detrimental to any of the Parties' interests, or which in any way weakens public confidence or affects the ability of the Parties to discharge their duties under this Agreement;

22.1.4 providing that each Party shall require that any employee employed as part of this Agreement considers that a conflict of interest exists in relation to their own role or position in connection with this Agreement, they shall notify and request guidance initially from their line manager (who shall inform the Integrated Commissioning Board where necessary);

22.1.5 the Parties shall ensure that their respective policies for managing and identifying conflicts of interest are maintained and where possible, consistent.

22.2 The Integrated Commissioning Board shall maintain a register of conflict of interests.

22.3 In the event of a conflict arising between the Parties' respective policies the matter shall be referred to the Authorised Officers for resolution acknowledging that NHS standards are strictly enforced by NHS England. Should the Authorised Officers be unable to reach a resolution the matter shall be determined as a dispute in accordance with Clause 27.

23. **GOVERNANCE**

23.1 Section 75 of the 2006 Act states that the partner organisations retain the statutory responsibilities and remain accountable for the prescribed services set out for each in the relevant legislation.

23.2 Overall strategic oversight of the development of Integrated Commissioning is vested in the Council's Cabinet and the CCG's Governing Body, which shall remain the statutory decision making bodies.

23.3 The Health and Well Being Board will provide strategic oversight of partnership working between the Parties and shall make recommendations to the Parties as to any actions it considers necessary.

23.4 The Parties have established the Integrated Commissioning Board to provide oversight and leadership for delivery of Integrated Commissioning.

23.5 The Integrated Commissioning Board is based on a committee in common committee structure. The Integrated Commissioning Board terms of reference are included at Part 2 of Schedule 2 (Governance).

23.6 The Parties will ensure membership is appropriate to carry out the required functions of the Integrated Commissioning Board.

23.7 The senior management and officers delivering Integrated Commissioning will be given sufficient relevant delegated authority to carry out their role.

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

23.9 The Integrated Commissioning Board shall be responsible for making decisions relating to the Pooled Fund where necessary, in accordance with the relevant standing financial

instructions and schemes of delegation. The Integrated Commissioning Board shall be responsible for making recommendations to the CCG's Governing Body or the Council's Cabinet or appropriate committee, where necessary, in relation to an Aligned Fund.

23.10 The Integrated Commissioning Board shall be responsible for the overall approval of Commissioning Plans and business cases, save for the approval of BCF Plans, which shall be approved in accordance with the terms set out in Schedule 6 (Better Care Fund Plan).

24. REVIEW

24.1 Save where the CCG's Governing Body and the Council's Cabinet or appropriate committee (as relevant) agrees alternative arrangements (including alternative frequencies) the Parties shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, the Integrated Commissioning Fund and the provision of the Services within three months of the end of each Financial Year. The Integrated Commissioning Board will agree the frequency and scale of any other reviews, monitoring and reporting of activity and the performance of the integrated commissioning function.

24.2 The Integrated Commissioning Board shall within twenty 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 24. A copy of this report shall be provided to the Parties.

24.3 In the event that the Parties fail to meet the requirements of the Better Care Fund Plan and NHS England the Parties shall provide full co-operation with NHS England to agree a recovery plan.

25. COMPLAINTS

25.1 In this Agreement, "complaints" shall include complaints, concerns and comments that come to the attention of the Parties through any source and in any medium; and shall include complaints about any aspect of the Services commissioned and about the function of commissioning.

25.2 The Parties agree that they and the Integrated Commissioning Board will adhere to the relevant policies of the Parties in responding to complaints. Complaints will be handled in accordance with the policies of the most appropriate Party. In the event of there being a dispute over which is the most appropriate Party, the role shall fall to the Lead Commissioner for the Service involved.

25.3 Analysis of the complaints handled by the Parties shall be reported to the Integrated Commissioning Board.

26. TERMINATION

26.1 Either Party may terminate this Agreement by giving not less than six (6) months' written notice to the other Party at any time.

26.2 Each of the individual Services may be terminated in accordance with the terms set out in the relevant Service Contract provided that the Parties ensure that the Better Care Fund requirements continue to be met, and the obligations under this Agreement are met.

26.3 If any Party (the "**Relevant Party**") fails to meet any of its obligations under this Agreement, the other Party may by notice require the Relevant Party to take such reasonable action within a reasonable timescale as the other Party may specify to rectify such failure. Should the Relevant Party fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 27.

26.4 Expiry or termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Parties' rights in respect of any antecedent breach and the provisions of Clauses 19, 20 and 29.

26.5 Upon expiry or termination of this Agreement for any reason whatsoever the following shall apply:

26.5.1 the Parties 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 Parties is carried out smoothly and with as little disruption as possible to service users, employees, the Parties and third parties, so as to minimise costs and liabilities of each Party in doing so, and shall each commit sufficient resource to implement the Exit Plan;

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

26.5.3 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 Party 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 Parties shall have agreed in advance who shall be responsible for any such payment;

26.5.4 where a Service Contract held by a Lead Commissioner relates all or partially to Services which relate to the other Party's Functions then, provided that the Service Contract allows it, the other Party may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original Service Contract;

26.5.5 the Integrated Commissioning 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

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

26.6 In the event of termination in relation to an individual Service the provisions of Clause 26.5 shall apply mutatis mutandis in relation to the individual Service (as though references as to this Agreement were to that individual Service).

27. DISPUTE RESOLUTION

27.1 The following principles are to be adhered to for any dispute resolution:

27.1.1 The resolution of a dispute under this Agreement must maintain the quality of health and social care provision now and in the future, deliver the best possible outcomes, support innovation where appropriate, make care more cost-effective, and allocate risk fairly.

27.1.2 The resolution of a dispute under this Agreement must promote transparency and accountability. It should hold the Parties to the Agreement accountable to each other and to Service Users and citizens, and facilitate the sharing of appropriate information to achieve the ambition of the Parties.

27.1.3 The Parties must engage constructively with each other within the dispute resolution process when working to reach agreement.

27.2 This dispute resolution process shall operate as follows:

27.2.1 The Parties may refer any disputes arising out of this Agreement to the members of the Integrated Commissioning Board for resolution. If any dispute referred to the Integrated Commissioning Board is not resolved within **14** days of such referral, either Party, by notice in writing to the other, may refer the dispute to the chief executives (or equivalent) of the Parties, who shall co-operate in good faith to resolve the dispute as amicably as possible within 14 days of service of the notice;

27.2.2 If the chief executives (or equivalent) fail to resolve the dispute within the allotted time, the Parties will attempt to settle it by mediation either: (a) with the Centre for Effective Dispute Resolution ("**CEDR**"); or (b) if agreed in writing by the Parties, with any other alternative mediation organisation, using the respective model procedures of CEDR or such other mediation organisation.

27.2.3 To initiate mediation a Party shall:

27.2.3.1 give notice in writing ("**Mediation Notice**") to the other Party requesting mediation of the dispute; and

27.2.3.2 send a copy of the Mediation Notice to CEDR or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator if the Parties are not able to agree such appointment by negotiation.

27.2.4 Neither Party may issue a Mediation Notice until the process set out in Clause 27.2.1 has been exhausted.

27.2.5 The mediation shall commence within twenty eight (28) days of the Mediation Notice being served. Neither Party will terminate such mediation until each Party has made its opening presentation and the mediator has met each Party separately for at least one hour or one Party has failed to participate in the mediation process. The Parties will cooperate with any person appointed as mediator, providing them with such information and other assistance as they shall require and will pay their costs, as they shall determine or in the absence of such determination such costs will be shared equally.

27.2.6 Should either Party dispute the outcome of the mediation process referred to in Clause 27.2.5, the Parties may refer the dispute for final resolution by arbitration. It is agreed that:

27.2.6.1 the tribunal shall consist of one arbitrator agreed by the Parties;

27.2.6.2 in default of the Parties' agreement as to the arbitrator within 14 days, the appointing authority shall be the Chartered Institute of Arbitrators in London;

27.2.6.3 the seat of the arbitration shall be London;

27.2.6.4 the law governing the arbitration agreement shall be English; and

27.2.6.5 the language of the arbitration shall be English.

27.3 Nothing in this Agreement shall prevent either Party seeking from any court any interim or provisional relief that may be necessary to protect the rights or property of that Party or that relates to the safety of Service Users or the security of Confidential Information, pending resolution of the relevant dispute in accordance with the CEDR or other mediation organisation procedure.

28. FORCE MAJEURE

28.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Party, or incur any liability to the other Party for any losses or damages incurred by that Party, to the extent that a Force Majeure Event occurs and the

Parties agree that such affected Party is / has been prevented from carrying out its obligations by that Force Majeure Event.

28.2 On the occurrence of a Force Majeure Event, the Affected Party shall notify the other Party 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 Party and any action proposed to mitigate its effect.

28.3 As soon as practicable, following notification as detailed in Clause 28.2, the Parties 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 28.4, facilitate the continued performance of the Agreement.

28.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Party shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Party. For the avoidance of doubt, no compensation shall be payable by either Party as a direct consequence of this Agreement being terminated in accordance with this Clause 28.4.

29. CONFIDENTIALITY

29.1 In respect of any Confidential Information a Party receives from another Party (the "**Discloser**") and subject always to the remainder of this Clause 29, each Party (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:

29.1.1 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

29.1.2 the provisions of this Clause 29 shall not apply to any Confidential Information which:

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

29.1.2.2 is obtained by a third party who is lawfully authorised to disclose such information.

29.2 Nothing in this Clause 29 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.

29.3 Each Party:

29.3.1 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

29.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 29.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 29;

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

30. FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

30.1 The Parties agree that they will each cooperate with each other to enable any Party receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall

include but not be limited to finding, retrieving and supplying information held, directing requests to the other Party as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

30.2 Each Party acknowledges that the other Party is subject to the requirements of the 2000 Act and each Party shall assist and co-operate with the other, at their own expense, to enable the other Party to comply with its information disclosure obligations.

30.3 Where a Party receives a request for information specifically in relation to a function of the other Party, it shall direct the request for information to the other Party as soon as practicable after receipt and in any event within two Working Days of receiving the request for information.

30.4 Where the request relates to functions of both Parties, the Party receiving the request will share the request with the other Party as soon as practicable after receipt and in any event, within two Working D ays and that Party will assist and co-operate with the other as is necessary for it to respond to the request within the time for compliance. If either Party determines that information must be disclosed it shall notify the other Party of that decision at least two Working Days before disclosure. Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

30.5 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Party shall be in breach of Clause 29 or any other confidentiality clauses or agreements if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

31. INFORMATION SHARING AND DATA PROTECTION

31.1 The Parties agree that each shall be an individual Data Controller in relation to Personal Data exchanged under this Agreement. Each Party shall comply with its obligations as a Data Controller under the DP Legislation.

31.2 For the avoidance of doubt, the Parties hereby acknowledge and accept that:

31.2.1 The Data Controller for the Council's Personal Data and Special Categories of Personal Data shall be the Council; and

31.2.2 The Data Controller for the CCG's Personal Data and Special Categories of Personal Data shall be the CCG.

31.3 Where the disclosing Party transfers Personal Data to the receiving Party, the disclosing Party shall ensure that any Personal Data that is transferred:

31.3.1 has been collected in accordance with the DP Legislation; and

31.3.2 the fair processing notice given to the relevant Service User and / or Data Subject entitles the receiving Party to Process such Personal Data for the purposes set out in this Agreement.

31.4 In the event that the receiving Party determines that it is required to provide its own fair processing notice to Service Users and / or Data Subjects, the disclosing Party will provide accurate and up to date contact details for the Service Users and / or Data Subjects whose Personal Data has been transferred under this Agreement.

31.5 Where the disclosing Party relies on the consent of the Service User and / or Data Subject to meet its obligations under Clause 31.3, the disclosing Party warrants that:

31.5.1 the consent entitles the receiving Party to Process the Personal Data for the purposes set out in this Agreement;

31.5.2 the consent has been collected in accordance with the DP Legislation; and

31.5.3 it will promptly notify the receiving Party in the event that the relevant Service User and / or Data Subject withdraws his or her consent.

31.6 Neither Party shall Process Personal Data transferred under this Agreement for any purposes other than those set out in this Agreement, unless otherwise permitted or required by Law.

31.7 Where Personal Data are disclosed by one Party to the other for the purposes of this Agreement, and the disclosing Party alone continues to determine the purposes for which, and the manner in which any such Personal Data and Special Categories of will be Processed by the receiving Party, the disclosing Party will remain the Data Controller of that Personal Data, and the receiving Party will be a Data Processor.

31.8 In the event that one Party is acting as Data Processor on behalf of the other Party, details of the Personal Data to be processed in that capacity shall be recorded in Schedule 8 (Data Processing Schedule). The Data Processor shall Process the data in accordance with Schedule 8 (Data Processing Schedule).

31.9 In the event that one Party is acting as Data Processor on behalf of the other Party, the Data Processor shall assist the other Party in complying with all applicable requirements of DP Legislation. In particular, the Data Processor shall:

31.9.1 keep confidential any Personal Data obtained in connection with this Agreement, subject to the DP Legislation;

31.9.2 implement and maintain appropriate technical and organisational measures to protect such Personal Data against unauthorised or unlawful Processing and against accidental loss or destruction of, or damage;

31.9.3 ensure that employees who have access to Personal Data have undergone training in respect of ensuring compliance with the DP Legislation and in the care and handling of Personal Data, and are also compliant with Clause 31.9.1;

31.9.4 not disclose Personal Data to any third party in any circumstances except as required or permitted by this Agreement;

31.9.5 notify the other Party within twenty four (24) hours of any known breach of technical and/or organisational security measures where the breach has affected or could have affected Personal Data transferred under this Agreement;

31.9.6 notify the other Party within twenty four (24) hours of any information security breaches or near misses or potential, actual, suspected or threatened unauthorised exposure, access, disclosure, Processing, use, communication, deletion, revision, encryption, reproduction or transmission of any component of the Personal Data, unauthorised access or attempted access or apparent attempted access (physical or otherwise) to the Personal Data or any loss of, damage to, corruption of or destruction of such Personal Data transferred under this Agreement;

31.9.7 allow the other Party to audit its compliance with the requirements of this Clause 31 on reasonable notice and/or to promptly provide the other Party with evidence of its compliance with the obligations set out in this Clause 31; and

31.9.8 not transfer any Personal Data received from the disclosing party outside the European Economic Area unless the transferor:

31.9.8.1 complies with the provisions of Articles 26 of the GDPR (in the event the third party is a joint controller);

31.9.8.2 ensures that the Data Subject has enforceable rights and effective legal remedies; and

31.9.8.3 ensures that (i) the transfer is to a country approved by the European Commission as providing adequate protection

pursuant to Article 45 GDPR; (ii) there are appropriate safeguards in place pursuant to Article 46 GDPR; or (iii) one of the derogations for specific situations in Article 49 GDPR applies to the transfer.

31.10 Where a breach notification is required under Clauses 31.9.5 and 31.9.6, the Data Processor shall confirm to the other Party, the nature of the breach, including the categories and approximate number of Data Subjects and records concerned, and the remediation measures being taken to mitigate and contain the breach.

31.11 In the event of a request relating to Personal Data transferred under this Agreement from a Service User and / or Data Subject for the rectification or erasure of Personal Data or restriction of Processing, the Party who has received the request shall determine whether such request is valid under the DP Legislation (unless the Party who has received the request is acting as a Data Processor on behalf of the other Party, in which case the Data Processor shall report the request to the other Party within 72 hours of receipt). In the event that the Party which has received the request determines that the relevant Personal Data should be rectified or erased or that any Processing shall be restricted, it shall notify the other Party promptly. The Party receiving the notification shall rectify or erasure the Personal Data or restrict Processing (as applicable) promptly.

31.12 On receipt of any request or enquiry from a Regulator that relates to Personal Data transferred under this Agreement, each Party will notify the other (unless prohibited by law) and shall provide the other with all reasonable assistance to allow the Party in receipt of the request to respond.

31.13 Each Party shall bear its own costs incurred in providing the assistance set out in Clauses 31.10 and 31.12.

32. OMBUDSMEN

32.1 The Parties 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.

33. PARTIES/NOTICES

33.1 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 Party shall be as set out in Clause 33.3 or such other address as each Party may previously have notified to the other Party in writing. A notice shall be deemed to have been served if:

33.1.1 personally delivered, at the time of delivery;

33.1.2 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

33.1.3 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 Party sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

33.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

33.3 The address for service of notices as referred to in Clause 33.1 shall be as follows unless otherwise notified to the other Party in writing:

33.3.1 if to the Council, addressed to:

Group Director for Children, Adults and Community Health, Hackney Council, Mare Street, E8 1EA; and

33.3.2 if to the CCG, addressed to:

Chief Officer, NHS City and Hackney CCG, 3rd Floor, Block A, St Leonard's Hospital, Nuttall Street, London N1 5LZ

34. **VARIATION**

34.1 Subject to Clause 34.2, no variations to this Agreement will be valid unless they are recorded in writing as a deed of variation and signed for and on behalf of each of the Parties.

34.2 The members of the Integrated Commissioning Board may choose to exercise their delegated powers on behalf of their employer organisation (which, for the avoidance of doubt, in each case must either be the CCG or the Council) to:

34.2.1 agree the addition of Commissioning Plans or Integrated Commissioning Strategies to this Agreement following the approval of a detailed business case by each of the Parties; and/or

34.2.2 consider the Annual Review of this Agreement pursuant to Clause 24 and implement agreed changes following the review; and/or

34.2.3 vary the Financial Framework, subject to the written approval of each of the Parties; and/or

34.2.4 vary the Information Framework, subject to the written approval of each of the Parties.

35. **CHANGE IN LAW**

35.1 The Parties 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.

35.2 On the occurrence of any Change in Law, the Parties shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Parties 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.

35.3 In the event of failure by the Parties to agree the relevant amendments to the Agreement (as appropriate), the Clause 27 (Dispute Resolution) shall apply.

36. **WAIVER**

36.1 No failure or delay by any Party 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.

37. **SEVERANCE**

37.1 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.

38. **ASSIGNMENT AND SUB CONTRACTING**

38.1 The Parties shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Parties, 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 Party's statutory functions.

39. **EXCLUSION OF PARTNERSHIP AND AGENCY**

39.1 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 Parties or render either Party directly liable to any third party for the debts, liabilities or obligations of the other.

39.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Party will have authority to, or hold itself out as having authority to:

39.2.1 act as an agent of the other;

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

39.2.3 bind the other in any way.

40. **THIRD PARTY RIGHTS**

40.1 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.

41. **ENTIRE AGREEMENT**

41.1 The terms herein contained together with the contents of the Schedules, including the Financial Framework and the Information Framework, constitute the complete agreement between the Parties 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 Party.

41.2 The Parties acknowledge that there was an unsigned agreement relating to section 75 arrangements for learning disability services that had been circulated between the Parties. For the avoidance of doubt, that unsigned agreement is not in force and the content of this Agreement with regard to learning disability services prevails.

42. **COUNTERPARTS**

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

43. **GOVERNING LAW AND JURISDICTION**

43.1 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.

43.2 Subject to Clause 27 (Dispute Resolution), the Parties 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 Parties on the date of this Agreement

Executed as a Deed by affixing the common seal of **LONDON BOROUGH OF HACKNEY**

in the presence of:

……
Authorised Signatory

……
Authorised Signatory

Executed as a Deed by the CCG acting by the Chief Officer of **NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP**

……

Paul Haigh
Chief Officer

in the presence of:

……..

Name:

Address:

Occupation:

SCHEDULE 1 – INTEGRATED COMMISSIONING STRATEGIES AND BUDGET CONTRIBUTIONS

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PART ONE – INTEGRATED COMMISSIONING STRATEGIES

The Integrated Commissioning Strategy is the joint commissioning between the CCG and the Local Authority. The Locality Plan is being developed and will form the detail and basis of the Integrated Commissioning Strategy. The four priority areas of the Locality Plan are:

- Children's, young people and maternity'
- Planned care
- Prevention
- Unplanned care

Four work streams are being established for these priority areas to review current plans and services, identify areas for improvement and test out their potential impact. Aligned Funds are connected to each of these priority areas (see Part 3).

Each work stream will report to the ICB. The ICB is made up of
the local system leaders and is responsible for developing and delivering improvement plans and making recommendations to the Integrated Commissioning Board for decision.

The following Service Specifications shall involve a Pooled Fund, with the relevant amounts for each Service Specification is specified in Table 1 of Part Two of this Schedule:

- Learning Disability Service (joint commissioning and integrated delivery team)
- Integrated Independence Team to support care in the community
- Better Care Fund (BCF) services

PART TWO – BUDGET CONTRIBUTIONS

Table 1: Integrated Commissioning Fund Contributions @ work stream level (LBH and CCG)

London Borough of Hackney + City and Hackney CCG ICB

Summary of contribution by organisation, Pooled vs Aligned, and by workstream

Fund type: Pooled Vs Aligned	CCG £'000	LBH £'000	TOTAL £'000
A. S75 'Pooled' Budgets			
1. Unplanned Care			
-BCF	15,263	-	15,263
-IIT	3,789	-	3,789
-IBCF		1,029	1,029
-Learning Disabilities			0
	19,053	1,029	20,082
2. Planned Care			
-BCF *(LA figs is funding from DGF Capital)*	748	1,525	2,273
-Learning Disabilities	6,063	14,546	20,609
-iBCF Local Authority allocation*		13,714	13,714
-Winter Pressures Local Authority allocation		1,405	1,405
3. Prevention			
-BCF		-	0
Total Contribution into **'Pooled'** budgets	25,864	32,219	58,083
B. 'Aligned' Budgets			
Aligned - Planned Care**	192,175	34,281	226,456
Aligned - Unplanned Care	115,324	4,270	119,594
Aligned - Children/Young people	49,570	9,049	58,619
Aligned - Prevention	3,415	23,554	26,969
Aligned - Corporate***	28,246		28,246
Total Contribution into **'Aligned'** budgets	388,731	71,154	459,885
Total Contrib into **'Integrated Comm Fund (ICF**	414,595	103,373	517,968
For Information Only			
In Collaboration - CCG Core Primary Care			48,021
			565,988

Note:

* £4.05m LD funding is from IBCF and is only capture in the IBCF allocation to avoid double counting

** Aligned - Planned care budgets for the CCG includes services not exercisable under S75 (surgery, endoscopy, termination of pregnancies and level 4 laser treatments). CCG exclusion on surgery was specifically non-elective surgery.

*** Aligned - Corporate for the Local Authorities relates to services not excercisable under S75 (income resulting from 'power to charge').

\+ Please note that the budgets may shift/change in year e.g. to reflect additional investment/efficiency savings, transfer of services from one workstream to another. Process for budget 'virements' (changes)is specified in the financial framework (schedule 3).

Table 2: Workstream service listing for LBH & CCG

Organisation	Updated workstream	Flag	Workstream	Scheme/Service	Budget Amount 19/20	LBH Split	CoI Split	Diretly Delivered?
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	CoL-Bryning Day Unit/Falls Prevention	14,396		14,396	N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	CoL-Homerton CHS -Adult Community Nursing	242,381		242,381	N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	CoL-Neighbourhood Care Model	41,528		41,528	N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	CoL-Paradoc	19,005		19,005	N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	CoL-Reablement Plus	66,164		66,164	N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Bryning Day unit/Falls Prevention	438,288	438,288		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Bryning Day unit/Falls Prevention (2)	927	927		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Community equipment and adaptations	1,098,039	1,098,039		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-End of Life - St Joseph's Hospice Hackney	2,466,230	2,466,230		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Homerton CHS -Adult Community Nursing	4,592,927	4,592,927		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Integrated Independence Team (IIT)	3,789,472	3,789,472		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-LA bed based interim beds	369,532	369,532		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Maintaining eligibility criteria	2,963,649	2,963,649		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Neighbourhood Care Model	1,296,531	1,296,531		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Paradoc	614,824	614,824		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Services to support carers	741,176	741,176		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Targeted preventative services	409,653	409,653		N/A
CCG	Pooled - Unplanned Care	BCF	Unplanned Care	LBH-Telecare	271,343	271,343		N/A
CCG	Pooled - Planned Care	BCF	Planned Care	CoL-Adult Cardiorespiratory Enhanced + Responsive Service (ACERS)	20,842		20,842	N/A
CCG	Pooled - Planned Care	BCF	Planned Care	CoL-Asthma	3,168		3,168	N/A
CCG	Pooled - Planned Care	BCF	Planned Care	CoL-Care Navigator Service	61,074		61,074	N/A
CCG	Pooled - Planned Care	BCF	Planned Care	CoL-Mental health reablement & floating support worker	81,432		81,432	N/A
CCG	Pooled - Planned Care	BCF	Planned Care	LBH-Adult Cardiorespiratory Enhanced + Responsive Service (ACERS)	598,881	598,881		N/A
CCG	Pooled - Planned Care	BCF	Planned Care	LBH-Adult Cardiorespiratory Enhanced + Responsive Service (ACERS) (2)	74,998	74,998		N/A
CCG	Pooled - Planned Care	BCF	Planned Care	LBH-Asthma	73,907	73,907		N/A
CCG	Pooled - Prevention	BCF	Prevention	CoL-Carers' support	50,895		50,895	N/A
CCG	Pooled - Planned Care	Learning Difficulties	Planned Care	Learning Difficulties & Autism (S75 with LB Hackney)	1,513,323	1,513,323		N/A
CCG	Pooled - Planned Care	Learning Difficulties	Planned Care	Learning Difficulties & Autism (S75 with LB Hackney) (2)	3,993,035	3,993,035		N/A
CCG	Pooled - Planned Care	Learning Difficulties	Planned Care	Learning Difficulties & Autism (S75 with LB Hackney) (3)	556,988	556,988		N/A

CCG	Aligned Children/Young people		**Children/Young people**	Barts Health Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	2,026,415	1,965,623	60,792	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Barts Health Hospital NHS FT Children & YP over / under performance	250,593	243,075	7,518	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CAMHS	4,352,555	4,221,978	130,577	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CAMHS Transformation Fund	386,569	374,972	11,597	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC – Children's PHB	789,095	765,422	23,673	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Childrens Equipment	44,193	42,868	1,326	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Complex Care Spot Purchase (Assesment, Reviews and Training services)	107,324	104,105	3,220	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Nurse Posts	140,620	136,401	4,219	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Spot Purchase Complex Care Packages	289,634	280,945	8,689	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Childhood Immunisation	115,148	111,694	3,454	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Childrens ASD	47,423	46,000	1,423	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHS - Barts (Paediatric Audiology Contract)	477,256	462,938	14,318	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Community Services Short Breaks Kids Sunday Club	41,342	40,101	1,240	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Early Years - Maternity service (Antenatal and Postnatal Care)	337,052	326,941	10,112	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Early Years Contract: Vulnerable Children - Non Recurrent	272,000	263,840	8,160	N/A
CCG	Aligned Children/Young people		**Children/Young people**	GP Confed - LTC Elements of Vulnerable Children's Contract	104,130	101,006	3,124	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Great Ormond Street Hospital (GOSH) Acute Contract	473,176	458,981	14,195	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Great Ormond Street Hospital (GOSH) Acute Contract over / under performance	(40,543)	- 39,327	- 1,216	N/A
CCG	Aligned Children/Young people		**Children/Young people**	GUYS & ST THMAS Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	514,605	499,166	15,438	N/A
CCG	Aligned Children/Young people		**Children/Young people**	GUYS & ST THMAS Hospital NHS FT Children & YP over / under performance	304,544	295,407	9,136	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Hearline	44,984	43,635	1,350	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - CAMHS	486,975	472,366	14,609	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Child Incontinence	149,381	144,900	4,481	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Children's Autism Spectrum Disorder (ASD)	49,578	48,091	1,487	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens Community Nursing Team (Incl HV)	747,882	725,445	22,436	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens Community Nursing Team (Incl HV) (2)	127,484	123,659	3,825	N/A
CCG	Aligned Children/Young		**Children/Young**	Homerton CHS - Childrens Specialist Nursing	279,239	270,862		N/A

	people		**people**				8,377	
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens transition service (Hackney Ark)	298,960	289,991	8,969	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Community Paediatrics	2,112,121	2,048,757	63,364	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - First Steps	1,150,018	1,115,517	34,501	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Hackney Ark Children's Service	657,108	637,394	19,713	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Key Working Childrens disabilities	302,734	293,652	9,082	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - MARAC Primary care liaison	58,392	56,640	1,752	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Occupational Therapy	677,870	657,534	20,336	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Physiotherapy	821,982	797,322	24,659	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Safeguarding	365,440	354,477	10,963	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Short Breaks	96,229	93,342	2,887	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Speech and Language Therapy	1,432,173	1,389,208	42,965	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton University Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	20,925,996	20,298,216	627,780	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton University Hospital NHS FT Children & YP over / under performance	305,113	295,960	9,153	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Huddleston Access Service (Short Breaks)	25,441	24,678	763	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Huddleston Centre - Children's Disability Forum [Carers Peer Support / Family Social Events]	30,052	29,150	902	N/A
CCG	Aligned Children/Young people		**Children/Young people**	IMP COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	147,899	143,462	4,437	N/A
CCG	Aligned Children/Young people		**Children/Young people**	IMP COLLEGE Hospital NHS FT Children & YP over / under performance	10,186	9,881	306	N/A
CCG	Aligned Children/Young people		**Children/Young people**	KINGS COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	63,053	61,162	1,892	N/A
CCG	Aligned Children/Young people		**Children/Young people**	KINGS COLLEGE Hospital NHS FT Children & YP over / under performance	45,811	44,437	1,374	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Looked after Children Nursing Service	291,439	282,696	8,743	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Maternity Targeted Antenatal Classes - Voluntary Sector Providers	9,863	9,567	296	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Maternity Targeted Antenatal Classes - Voluntary Sector Providers (2)	7,787	7,553	234	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Maternity Targeted Antenatal Classes - Voluntary Sector Providers (3)	7,787	7,553	234	N/A
CCG	Aligned Children/Young people		**Children/Young people**	NORTH MID Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	444,240	430,913	13,327	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Online Counselling Support (Eating Disorders)	15,405	14,943	462	N/A
CCG	Aligned Children/Young		**Children/Young**	Peri Natal Service	342,418	332,146		N/A

	people		**people**				10,273	
CCG	Aligned Children/Young people		**Children/Young people**	Perinatal MH Wave 2 Funding	217,512	210,987	6,525	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Richard House Children's Hospice	107,775	104,541	3,233	N/A
CCG	Aligned Children/Young people		**Children/Young people**	ROYAL FREE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	302,414	293,342	9,072	N/A
CCG	Aligned Children/Young people		**Children/Young people**	ROYAL FREE Hospital NHS FT Children & YP over / under performance	25,923	25,145	778	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Safeguarding - contribution to adult safegurading board	20,826	20,201	625	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Safeguarding - contribution to children's safeguarding board	24,728	23,986	742	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Targeted antenatal classes	5,500	5,335	165	N/A
CCG	Aligned Children/Young people		**Children/Young people**	UCLH Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	5,099,961	4,946,962	152,999	N/A
CCG	Aligned Children/Young people		**Children/Young people**	UCLH Hospital NHS FT Children & YP over / under performance	(68,427)	- 66,374	- 2,053	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Whittington Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	1,831,779	1,776,826	54,953	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Whittington Hospital NHS Children & YP over / under performance	(108,367)	- 105,116	- 3,251	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Bump Buddies	50,000	48,500	1,500	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHS - Older Peoples Reference Group (OPRG) - Age UK	28,844	27,979	865	N/A
CCG	Aligned Prevention		**Prevention**	Long Term Conditions - core contract	2,670,378	2,590,267	80,111	N/A
CCG	Aligned Prevention		**Prevention**	Social prescribing - Family Action	203,054	196,962	6,092	N/A
CCG	Aligned Prevention		**Prevention**	Time to talk - extended consultation for LTC pts	647,689	628,258	19,431	N/A
CCG	Aligned - Planned Care		**Planned Care**	CAMHS Eating Disorders - ELFT	63,476	61,572	1,904	N/A
CCG	Aligned - Planned Care		**Planned Care**	Core Arts (currently paid by innovation fund - NR)	60,000	58,200	1,800	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP Primary Care/ADHD Step Down - CAMHS Alliance (ELFT)	81,000	78,570	2,430	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP Primary Care/ADHD Step Down - GP Confed	11,000	10,670	330	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP ASD Pathway Improvement - CAMHS Alliance (HUHT)	67,000	64,990	2,010	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP ELC Crisis Pathway - ELFT	117,000	113,490	3,510	N/A
CCG	Aligned - Planned Care		**Planned Care**	Dementia Shared Care Plans - ELFT	56,000	54,320	1,680	N/A
CCG	Aligned - Planned Care		**Planned Care**	Depression Reviews	50,000	48,500	1,500	N/A
CCG	Aligned - Planned Care		**Planned Care**	HBPoS - ELFT	325,012	315,262	9,750	N/A
CCG	Aligned - Planned Care		**Planned Care**	IAPT (trainee placements) - HUHT	423,220	410,523	12,697	N/A
CCG	Aligned - Planned Care		**Planned Care**	IAPT 18 - 25 and extension to the LTC IAPT	420,234	407,627		N/A

				service (HUHT) - PTWA			12,607	
CCG	Aligned - Planned Care		**Planned Care**	Integrated Dementia Service (post QIPP of £60k) - ELFT/ Alzheimer's Society	274,319	266,089	8,230	N/A
CCG	Aligned - Planned Care		**Planned Care**	Namaste - St Joseph	60,000	58,200	1,800	N/A
CCG	Aligned - Planned Care		**Planned Care**	Recovery College - ELFT	40,000	38,800	1,200	N/A
CCG	Aligned - Planned Care		**Planned Care**	SOS therapy service	134,417	130,384	4,033	N/A
CCG	Aligned - Planned Care		**Planned Care**	24 hour cardiac - Homerton acute contract Cost Per Case (Additional Activity)	199,526	193,541	5,986	N/A
CCG	Aligned - Planned Care		**Planned Care**	Accessible gym - Ability Bow	38,078	36,936	1,142	N/A
CCG	Aligned - Planned Care		**Planned Care**	ACERS psychology (Primary care ACERS outreach) - Homerton Acute Contract	132,901	128,914	3,987	N/A
CCG	Aligned - Planned Care		**Planned Care**	ADHD	66,690	64,689	2,001	N/A
CCG	Aligned - Planned Care		**Planned Care**	Adult Cmht	3,326,201	3,226,415	99,786	N/A
CCG	Aligned - Planned Care		**Planned Care**	Afc Income Stream	(444,258)	- 430,930	- 13,328	N/A
CCG	Aligned - Planned Care		**Planned Care**	Anti-coagulation - service management (Jan Toms)	12,183	11,818	365	N/A
CCG	Aligned - Planned Care		**Planned Care**	Anticoagulation LES	369,648	358,559	11,089	N/A
CCG	Aligned - Planned Care		**Planned Care**	AQP - Any qualified provider for direct access diagnostics	241,902	234,645	7,257	N/A
CCG	Aligned - Planned Care		**Planned Care**	AQP - Homerton acute contract Cost Per Case (Additional Activity)	1,401,512	1,359,467	42,045	N/A
CCG	Aligned - Planned Care		**Planned Care**	AQP - Termination of Pregnancy	94,140	91,316	2,824	N/A
CCG	Aligned - Planned Care		**Planned Care**	Art Therapy (ADULT)	326,852	317,046	9,806	N/A
CCG	Aligned - Planned Care		**Planned Care**	Assessment and Support by CSU (2)	19,667	19,077	590	N/A
CCG	Aligned - Planned Care		**Planned Care**	Autism Service	274,721	266,479	8,242	N/A
CCG	Aligned - Planned Care		**Planned Care**	Bank Rate Uplift	286,203	277,617	8,586	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT BASELINE - Aligned	999,098	969,125	29,973	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT BASELINE over / under performance	24,851	24,106	746	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	14,869,911	14,423,813	446,097	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT Planned over / under performance	369,871	358,775	11,096	N/A
CCG	Aligned - Planned Care		**Planned Care**	Bereavement - St Joseph's Hospice	43,176	41,881	1,295	N/A
CCG	Aligned - Planned Care		**Planned Care**	BHR UNIV HOSP NHST BASELINE	317,995	308,455	9,540	N/A
CCG	Aligned - Planned Care		**Planned Care**	BHR UNIV HOSP NHST BASELINE over / under performance	62,193	60,327	1,866	N/A
CCG	Aligned - Planned Care		**Planned Care**	BMI Healthcare Ltd	571,972	554,813		N/A

							17,159	
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - 000000	71,671	69,520	2,150	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84003	19,301	18,722	579	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84008	20,687	20,066	621	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84021	29,721	28,830	892	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84033	29,325	28,445	880	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84036	3,287	3,189	99	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84038	7,690	7,459	231	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84041	12,430	12,057	373	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84060	7,570	7,343	227	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84063	10,108	9,805	303	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84069	18,364	17,813	551	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84072	12,974	12,585	389	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84080	2,098	2,035	63	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84096	30,126	29,222	904	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84115	14,073	13,651	422	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84117	16,525	16,029	496	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84119	10,129	9,825	304	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84619	2,752	2,669	83	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84620	12,577	12,200	377	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84624	2,641	2,562	79	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84635	9,649	9,360	289	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84636	5,517	5,351	166	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84640	14,150	13,725	424	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84685	5,324	5,165	160	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84686	10,792	10,468	324	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84694	4,405	4,273	132	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing -	5,014	4,864		N/A

				F84711			150	
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84013	(20,712)	- 20,091	- 621	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84015	10,799	10,475	324	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84018	17,912	17,374	537	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84035	6,729	6,527	202	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84043	6,606	6,408	198	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84105	20,170	19,565	605	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84601	11,916	11,559	357	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84621	6,885	6,678	207	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84632	830	805	25	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84692	11,615	11,267	348	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84716	8,682	8,422	260	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84719	17,516	16,991	525	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - Y00403	4,276	4,147	128	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - Y01177	13,314	12,915	399	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - Y03049	14,452	14,019	434	N/A
CCG	Aligned - Planned Care		**Planned Care**	Cancer (split out from LTC Core contract)	142,548	138,271	4,276	N/A
CCG	Aligned - Planned Care		**Planned Care**	Cardiac rehabilitation - Homerton Acute Contract	63,792	61,879	1,914	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84003	48,489	47,035	1,455	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84008	50,819	49,294	1,525	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84013	54,383	52,751	1,631	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84015	23,094	22,401	693	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84018	47,164	45,749	1,415	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84021	42,151	40,886	1,265	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84033	60,890	59,063	1,827	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84035	17,252	16,735	518	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84036	28,115	27,272	843	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84038	16,336	15,846		N/A

							490	
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84041	30,557	29,640	917	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84043	19,534	18,948	586	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84060	20,779	20,156	623	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84063	24,335	23,605	730	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84069	54,295	52,667	1,629	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84072	36,311	35,222	1,089	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84080	19,879	19,283	596	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84096	58,396	56,644	1,752	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84105	42,225	40,958	1,267	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84115	34,683	33,642	1,040	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84117	38,770	37,607	1,163	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84119	48,660	47,200	1,460	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84601	24,871	24,125	746	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84619	19,221	18,645	577	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84620	23,747	23,034	712	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84621	16,501	16,006	495	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84624	13,406	13,004	402	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84632	7,802	7,568	234	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84635	32,516	31,540	975	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84636	16,357	15,866	491	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84640	34,087	33,064	1,023	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84668	25,607	24,838	768	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84685	14,300	13,871	429	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84686	27,988	27,148	840	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84692	28,752	27,890	863	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84694	13,709	13,297	411	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84711	10,947	10,619		N/A

							328	
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84716	20,431	19,818	613	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84719	20,850	20,224	625	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84720	23,869	23,153	716	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - Y00403	23,517	22,811	706	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - Y01177	32,955	31,966	989	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - Y03049	34,551	33,515	1,037	N/A
CCG	Aligned - Planned Care		**Planned Care**	Central Dementia Ward (Columbia)	817,839	793,304	24,535	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP Arts Therapy	99,575	96,588	2,987	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP Liaison	145,797	141,423	4,374	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP Memory Clinic	324,064	314,342	9,722	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP O.T	323,263	313,565	9,698	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHAMRAS	320,153	310,548	9,605	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care- Palliative Care (FAST TRACK)	968,561	939,504	29,057	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Mental Health (<65)	571,804	554,650	17,154	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Mental Health (65+)	1,221,756	1,185,103	36,653	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Physical Disab (<65)	5,071,534	4,919,388	152,146	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Physical Disab (65+)	2,371,669	2,300,519	71,150	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Funded Nursing Care (FNC) allowance	1,455,254	1,411,597	43,658	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - PHB	475,152	460,897	14,255	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC Assessment and Support by CSU	367,719	356,688	11,032	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC- Cont Care-Learning Disab(<65)	48,896	47,429	1,467	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHEL WESTMS HOSP NHS FT BASELINE	528,678	512,818	15,860	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHEL WESTMS HOSP NHS FT BASELINE over / under performance	140,565	136,348	4,217	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Compression Garment (Hosiery) Pilot - Accelerate CIC	24,991	24,241	750	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Dressing Optimisation Scheme (DOS) - Accelerate CIC	49,982	48,483	1,499	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Garments Made Easy (GME) - Accelerate CIC	156,195	151,509	4,686	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Lymphodaema - Accelerate CIC	187,434	181,811		N/A

							5,623	
CCG	Aligned - Planned Care		**Planned Care**	CHS - Lymphoedema Nurse - Accelerate CIC	18,743	18,181	562	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Whittington Hospital (Community Health Contract)	838,369	813,218	25,151	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Wound Care NCA - Accelerate CIC	67,209	65,192	2,016	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Wound Dressing from NHS Business Services	418,165	405,620	12,545	N/A
CCG	Aligned - Planned Care		**Planned Care**	Clozapine Clinic	264,510	256,575	7,935	N/A
CCG	Aligned - Planned Care		**Planned Care**	Community ENT	169,402	164,320	5,082	N/A
CCG	Aligned - Planned Care		**Planned Care**	Community Rehab Team	1,279,858	1,241,462	38,396	N/A
CCG	Aligned - Planned Care		**Planned Care**	Complex Care	381,237	369,800	11,437	N/A
CCG	Aligned - Planned Care		**Planned Care**	Continence service - Homerton acute contract Cost Per Case (Additional Activity)	67,548	65,522	2,026	N/A
CCG	Aligned - Planned Care		**Planned Care**	Contract and Agency	350,738	340,216	10,522	N/A
CCG	Aligned - Planned Care		**Planned Care**	Crisis Cafe	52,600	51,022	1,578	N/A
CCG	Aligned - Planned Care		**Planned Care**	Depression Reviews	153,900	149,283	4,617	N/A
CCG	Aligned - Planned Care		**Planned Care**	Early Intervention	2,048,840	1,987,375	61,465	N/A
CCG	Aligned - Planned Care		**Planned Care**	Employment of MH practice liaison Worker	41,040	39,809	1,231	N/A
CCG	Aligned - Planned Care		**Planned Care**	Enhanced Primary Care	986,912	957,305	29,607	N/A
CCG	Aligned - Planned Care		**Planned Care**	EPC Mental Health Reviews	65,894	63,917	1,977	N/A
CCG	Aligned - Planned Care		**Planned Care**	Foot Health In patient Coordinator - Homerton Acute Contract	65,919	63,941	1,978	N/A
CCG	Aligned - Planned Care		**Planned Care**	GP Practice Manageable Prescribing Budget	26,318,225	25,528,678	789,547	N/A
CCG	Aligned - Planned Care		**Planned Care**	GP Practice Mental Health Training	82,706	80,225	2,481	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT BASELINE - Aligned	314,683	305,243	9,440	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT BASELINE over / under performance	73,484	71,279	2,205	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	1,640,551	1,591,334	49,217	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT Planned over / under performance	383,097	371,604	11,493	N/A
CCG	Aligned - Planned Care		**Planned Care**	Home Oxygen Service	251,868	244,312	7,556	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Psychosexual Health Service	94,787	91,943	2,844	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Bi Lingual Advocacy Services	1,209,167	1,172,892	36,275	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Chronic Fatigue	194,016	188,195		N/A

							5,820	
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Community Gynaecology	30,852	29,927	926	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Community Team (heart failure)	385,606	374,038	11,568	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Defoe / Other	7,498	7,273	225	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Dietetics	274,292	266,063	8,229	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Foot Health	1,682,155	1,631,691	50,465	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS -Locomotor Services	2,751,066	2,668,534	82,532	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Primary Care Psychology Therapy (Incl IAPT)	3,625,427	3,516,664	108,763	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - RIO	593,000	575,210	17,790	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Rotational Nurses	41,820	40,566	1,255	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Sickle Cell & Thalass(S75) Adult+Child A & E and Community	239,964	232,765	7,199	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Sickle cell psychology	124,495	120,761	3,735	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS -Dermatology	138,709	134,548	4,161	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS -Wheelchair Services	1,050,729	1,019,207	31,522	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton Psych Medicine	1,730,510	1,678,595	51,915	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT BASELINE - Aligned	7,577,228	7,349,911	227,317	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT BASELINE over / under performance	736,818	714,713	22,105	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	57,536,146	55,810,062	1,726,084	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT Planned over / under performance	2,175,963	2,110,684	65,279	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homes for Life	14,441	14,008	433	N/A
CCG	Aligned - Planned Care		**Planned Care**	IAPT Long Term Conditions (LTC)	422,286	409,618	12,669	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT BASELINE - Aligned	103,547	100,441	3,106	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT BASELINE over / under performance	(4,394)	- 4,262	- 132	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	539,822	523,627	16,195	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT Planned over / under performance	(22,908)	- 22,221	- 687	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT BASELINE - Aligned	58,289	56,540	1,749	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT BASELINE over / under performance	(5,858)	- 5,682	- 176	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT Planned	303,878	294,761		N/A

				(EL, OP, Crit Care, CHS, PTS,Other)			9,116	
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT Planned over / under performance	(30,540)	- 29,624	- 916	N/A
CCG	Aligned - Planned Care		**Planned Care**	Lawson Practise (CMS)	132,264	128,296	3,968	N/A
CCG	Aligned - Planned Care		**Planned Care**	LD	151,988	147,428	4,560	N/A
CCG	Aligned - Planned Care		**Planned Care**	LONDON NW HOSP NHST BASELINE	218,392	211,840	6,552	N/A
CCG	Aligned - Planned Care		**Planned Care**	LONDON NW HOSP NHST BASELINE Aligned over / under performance	126,406	122,614	3,792	N/A
CCG	Aligned - Planned Care		**Planned Care**	Maintenance & Building Register and Dashboard	25,650	24,881	770	N/A
CCG	Aligned - Planned Care		**Planned Care**	Management and oversight	30,780	29,857	923	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mental Health Depot	71,760	69,607	2,153	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mental Health NCA	347,985	337,546	10,440	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mental Health Reserves (2)	2,080,539	2,018,123	62,416	N/A
CCG	Aligned - Planned Care		**Planned Care**	Minor Eye Conditions Service (Primary Eyecare ELC)	150,000	145,500	4,500	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT BASELINE - Aligned	1,714,395	1,662,963	51,432	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT BASELINE over / under performance	(5,599)	- 5,431	- 168	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	4,821,913	4,677,255	144,657	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT Planned over / under performance	(15,937)	- 15,459	- 478	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mother & Baby - Specialist	15,194	14,738	456	N/A
CCG	Aligned - Planned Care		**Planned Care**	NELCSU SLA - Home Oxygen Service	15,264	14,806	458	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS BASELINE - Aligned	89,916	87,218	2,697	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS BASELINE over / under performance	(23,731)	- 23,019	- 712	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS Planned (EL, OP, Crit Care, CHS, PTS,Other)	600,035	582,034	18,001	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS Planned over / under performance	(158,365)	- 153,614	- 4,751	N/A
CCG	Aligned - Planned Care		**Planned Care**	Occupational Therapy	837,783	812,650	25,134	N/A
CCG	Aligned - Planned Care		**Planned Care**	Pathology Consumables	26,501	25,706	795	N/A
CCG	Aligned - Planned Care		**Planned Care**	Patient Transport	9,197	8,921	276	N/A
CCG	Aligned - Planned Care		**Planned Care**	PD Section 28a - Hackney Council CHC	125,686	121,915	3,771	N/A
CCG	Aligned - Planned Care		**Planned Care**	Personality Disorder	604,075	585,953	18,122	N/A
CCG	Aligned - Planned Care		**Planned Care**	Phlebotomy Local Enhanced Services (GP	312,390	303,018		N/A

				Confed from 1/1/16)			9,372	
CCG	Aligned - Planned Care		**Planned Care**	Physical Health checks for non-QOF patients on anti-psychotics non-QOF	30,780	29,857	923	N/A
CCG	Aligned - Planned Care		**Planned Care**	Post Operative Wound Care	114,543	111,107	3,436	N/A
CCG	Aligned - Planned Care		**Planned Care**	Practice Transformation support	485,279	470,721	14,558	N/A
CCG	Aligned - Planned Care		**Planned Care**	Prescribing Recharges to LBH	(70,400)	- 68,288	- 2,112	N/A
CCG	Aligned - Planned Care		**Planned Care**	Primary Care Liaison	585,185	567,630	17,556	N/A
CCG	Aligned - Planned Care		**Planned Care**	Primary Care Psychotherapy Service (PCPCS/Tavi)	1,102,493	1,069,419	33,075	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychological support - diabetes - Homerton Acute Contract	63,792	61,879	1,914	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychological Therapies Alliance	458,082	444,340	13,742	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychology	1,544,640	1,498,301	46,339	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychotherapy Services	1,785,277	1,731,719	53,558	N/A
CCG	Aligned - Planned Care		**Planned Care**	Pulmonary rehab for heart failure - Homerton Acute Contract	62,729	60,847	1,882	N/A
CCG	Aligned - Planned Care		**Planned Care**	Quality Improvement	(0)	- 0	- 0	N/A
CCG	Aligned - Planned Care		**Planned Care**	Recharge scans - Homerton acute contract Cost Per Case (Additional Activity)	618,324	599,774	18,550	N/A
CCG	Aligned - Planned Care		**Planned Care**	Recovery Pathways - Arts in Health	92,340	89,570	2,770	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROY BROMP HARE NHSFT BASELINE	225,044	218,293	6,751	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROY BROMP HARE NHSFT BASELINE over / under performance	(5,122)	- 4,969	- 154	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT BASELINE - Aligned	275,207	266,951	8,256	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT BASELINE over / under performance	30,644	29,725	919	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	1,434,747	1,391,704	43,042	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT Planned over / under performance	159,757	154,965	4,793	N/A
CCG	Aligned - Planned Care		**Planned Care**	Royal National Orthopaedic Hospital	732,473	710,499	21,974	N/A
CCG	Aligned - Planned Care		**Planned Care**	Royal National Orthopaedic Hospital over / under performance	93,645	90,836	2,809	N/A
CCG	Aligned - Planned Care		**Planned Care**	Secondary Care Physical Health Check	83,106	80,613	2,493	N/A
CCG	Aligned - Planned Care		**Planned Care**	SMI QOF Physical Health Checks	30,780	29,857	923	N/A
CCG	Aligned - Planned Care		**Planned Care**	Social Inclusion	328,132	318,288	9,844	N/A
CCG	Aligned - Planned Care		**Planned Care**	Software Licence (Scriptswitch)	117,590	114,062	3,528	N/A
CCG	Aligned - Planned Care		**Planned Care**	ST GEORGES HC NHST BASELINE	199,425	193,442		N/A

							5,983	
CCG	Aligned - Planned Care		**Planned Care**	ST GEORGES HC NHST BASELINE over / under performance	50,469	48,955	1,514	N/A
CCG	Aligned - Planned Care		**Planned Care**	Stroke Project	152,965	148,376	4,589	N/A
CCG	Aligned - Planned Care		**Planned Care**	Sun Project	151,396	146,854	4,542	N/A
CCG	Aligned - Planned Care		**Planned Care**	The Royal Marsden	232,824	225,840	6,985	N/A
CCG	Aligned - Planned Care		**Planned Care**	The Royal Marsden over / under performance	(73,567)	- 71,360	- 2,207	N/A
CCG	Aligned - Planned Care		**Planned Care**	Transitional Neurological Rehabilitation Unit	590,080	572,377	17,702	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT BASELINE - Aligned	1,236,342	1,199,252	37,090	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT BASELINE over / under performance	10,720	10,399	322	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	7,286,833	7,068,228	218,605	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT Planned over / under performance	63,874	61,958	1,916	N/A
CCG	Aligned - Planned Care		**Planned Care**	Well Family Plus	292,410	283,638	8,772	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS FT BASELINE - Aligned	167,400	162,378	5,022	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS FT BASELINE over / under performance	45,545	44,179	1,366	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS Planned (EL, OP, Crit Care, CHS, PTS,Other)	1,117,113	1,083,600	33,513	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS Planned over / under performance	303,934	294,816	9,118	N/A
CCG	Aligned - Planned Care		**Planned Care**	Contract and Agency & Training (Project work)	240,168	232,963	7,205	N/A
CCG	Aligned - Planned Care		**Planned Care**	Core24 Psychiatric Liaison (Dependent on QIPP target being met)	(14,689)	- 14,249	- 441	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Adult Acute	11,304,044	10,964,923	339,121	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Barts Health Hospital NHS FT Unplanned (Adult A&E +NEL activity)	11,572,083	11,224,921	347,162	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Barts Health Hospital NHS FT Unplanned over / under performance	1,225,244	1,188,487	36,757	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	C&H Commissioning	1,425,429	1,382,666	42,763	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CEOV weighted share adjustment	470,378	456,267	14,111	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CH MHCOP ACUTE (50% Leadenhall)	1,103,503	1,070,398	33,105	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CH MHCOP C-CARE (Thames - Ex Cedar)	1,037,645	1,006,516	31,129	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CH MHCOP CMHT	1,857,166	1,801,451	55,715	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Community Matron Service - Elsdale Street Surgery	144,741	140,398	4,342	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Community Matron Service - Shoreditch Park	134,328	130,298		N/A

				Surgery			4,030	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Duty Doctor	1,603,279	1,555,180	48,098	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	End of Life - St Joseph's Hospice Hackney	141,561	137,314	4,247	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	End of Life Care (GP contract)	200,883	194,856	6,026	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Enhanced PUCC - (Homerton PUCC) NR	643,000	623,710	19,290	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Frequent Attenders Team Lead	35,654	34,584	1,070	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	GUYS & ST THMAS Hospital NHS FT Unplanned (Adult A&E +NEL activity)	645,469	626,105	19,364	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	GUYS & ST THMAS Hospital NHS FT Unplanned over / under performance	8,668	8,408	260	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton CHS - Adult Community Nursing (incl Intermediate Care -Section 75)	3,755,281	3,642,622	112,658	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton CHS -Adult Community Rehabilitation Team	2,689,742	2,609,049	80,692	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton System resilience (part of Non Recurrent funding)	678,000	657,660	20,340	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton University Hospital NHS FT Unplanned (Adult A&E +NEL activity)	37,771,074	36,637,942	1,133,132	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton University Hospital NHS FT Unplannedover / under performance	2,320,526	2,250,911	69,616	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	HTT & Emergency Services	2,850,430	2,764,917	85,513	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	IMP COLLEGE Hospital NHS FT Unplanned (Adult A&E +NEL activity)	312,509	303,134	9,375	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	IMP COLLEGE Hospital NHS FT Unplanned over / under performance	86,319	83,729	2,590	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	KINGS COLLEGE Hospital NHS FT Unplanned (Adult A&E +NEL activity)	239,345	232,165	7,180	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	KINGS COLLEGE Hospital NHS FT Unplanned over / under performance	(13,015)	- 12,624	- 390	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	London Ambulance Service (LAS)	11,933,212	11,575,216	357,996	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	London Ambulance Service (LAS) over / under performance	416,444	403,950	12,493	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - BEH FT	509,405	494,123	15,282	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - Camden	807,373	783,152	24,221	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - Camden overperformance allowance	102,908	99,821	3,087	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - NELFT	90,419	87,707	2,713	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Mildmay Mission	431,893	418,936	12,957	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Moorfields Eye Hospital NHS FT Unplanned (Adult A&E +NEL activity)	1,102,479	1,069,405	33,074	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Moorfields Eye Hospital NHS FT Unplanned over / under performance	(84,228)	- 81,701	- 2,527	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NCA (Non Contracted Activity - Various)	3,251,904	3,154,347		

							97,557	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NHS 111 Service - CSU charges	46,645	45,246	1,399	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NHS 111 Service - LAS Contact	1,023,308	992,609	30,699	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NORTH MID Hospital NHS Unplanned (Adult A&E +NEL activity)	821,186	796,551	24,636	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NORTH MID Hospital NHS Unplanned over / under performance	(118,905)	- 115,338	- 3,567	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NORTH MID Hospital NHS Children & YP over / under performance	(91,639)	- 88,890	- 2,749	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Nursing Homes (LES) Acorn Lodge - Latimer	116,264	112,776	3,488	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Nursing Homes (LES) Barton House - St Anne's	25,386	24,624	762	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Other Social Care - Handyperson (Home from Hospital)	67,398	65,376	2,022	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Out of Hours and ParaDoc service	2,685,730	2,605,158	80,572	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Overseas visitor NonReciprocal agreement and 1/3 risk share	102,805	99,721	3,084	
CCG	Aligned - Unplanned Care		**Unplanned Care**	PICU	2,448,442	2,374,989	73,453	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Proactive Care: Home Visiting (Frail Home Visiting)	1,467,466	1,423,442	44,024	
CCG	Aligned - Unplanned Care		**Unplanned Care**	PUCC	958,857	930,092	28,766	
CCG	Aligned - Unplanned Care		**Unplanned Care**	ROYAL FREE Hospital NHS FT Unplanned (Adult A&E +NEL activity)	879,453	853,070	26,384	
CCG	Aligned - Unplanned Care		**Unplanned Care**	ROYAL FREE Hospital NHS FT Unplannedover / under performance	50,451	48,938	1,514	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Take Home and Settle	166,112	161,129	4,983	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Targeted Preventative Dementia Service (Alzheimer's)	263,946	256,027	7,918	
CCG	Aligned - Unplanned Care		**Unplanned Care**	UCLH Hospital NHS FT Unplanned (Adult A&E +NEL activity)	3,239,064	3,141,892	97,172	
CCG	Aligned - Unplanned Care		**Unplanned Care**	UCLH Hospital NHS FT Unplanned over / under performance	213,450	207,046	6,403	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Whittington Hospital NHS Unplanned (Adult A&E +NEL activity)	1,591,833	1,544,078	47,755	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Whittington Hospital NHS Unplannedover / under performance	128,836	124,971	3,865	
CCG	Aligned - Corporate		**Corporate**	1% NR (Uncommitted Funds 0.5%)	2,104,820	2,041,675	63,145	
CCG	Aligned - Corporate		**Corporate**	ACUTE GENERAL RESERVE	4,491,110	4,356,376	134,733	
CCG	Aligned - Corporate		**Corporate**	Additional Allocation Funding	662,063	642,201	19,862	
CCG	Aligned - Corporate		**Corporate**	BT Charges	74,974	72,724	2,249	
CCG	Aligned - Corporate		**Corporate**	Clinical Effectiveness Group (CEG)	183,269	177,771	5,498	
CCG	Aligned - Corporate		**Corporate**	Community Health Reserves	2,708,403	2,627,151		

							81,252	
CCG	Aligned - Corporate		**Corporate**	Contingency	2,383,620	2,312,111	71,509	
CCG	Aligned - Corporate		**Corporate**	Corporate	4,991,000	4,841,270	149,730	
CCG	Aligned - Corporate		**Corporate**	Corporate Reserve	1,263,000	1,225,110	37,890	
CCG	Aligned - Corporate		**Corporate**	General Programme Reserves	495,895	481,018	14,877	
CCG	Aligned - Corporate		**Corporate**	HLP Contribution	267,614	259,586	8,028	
CCG	Aligned - Corporate		**Corporate**	London Levies (programme)	134,328	130,298	4,030	
CCG	Aligned - Corporate		**Corporate**	Market rent - Homerton	901,583	874,535	27,047	
CCG	Aligned - Corporate		**Corporate**	Mental Health User Involvement Service	25,650	24,881	770	
CCG	Aligned - Corporate		**Corporate**	NHSE STP Primary Care Accomodation Recharge 2017-18	16,319	15,830	490	
CCG	Aligned - Corporate		**Corporate**	Pan-London CCG risk share for homeless TB patients	14,535	14,099	436	
CCG	Aligned - Corporate		**Corporate**	Patient User Experience Group Support	18,743	18,181	562	
CCG	Aligned - Corporate		**Corporate**	PEL Allocation	399,000	387,030	11,970	
CCG	Aligned - Corporate		**Corporate**	Primary Care IT - charges from CSU	764,314	741,385	22,929	
CCG	Aligned - Corporate		**Corporate**	Programme Projects	4,645,465	4,506,101	139,364	
CCG	Aligned - Corporate		**Corporate**	Programme Projects (STP)	636,520	617,424	19,096	
CCG	Aligned - Corporate		**Corporate**	Rent	1,200,371	1,164,360	36,011	
CCG	Aligned - Corporate		**Corporate**	Rent (2)	239,505	232,320	7,185	
CCG	Aligned - Corporate		**Corporate**	Rent (3)	497,347	482,427	14,920	
LBH	Planned Care		**Planned Care**	Hackney Adults Placement	174,274	174,274	N/A	
LBH	Planned Care		**Planned Care**	Learning Disability Team –ILDS	783,967	783,967	N/A	
LBH	Planned Care		**Planned Care**	Care Management and Review - South	1,412,863	1,412,863	N/A	
LBH	Planned Care		**Planned Care**	OT & Telecare Team	374,216	374,216	N/A	
LBH	Planned Care		**Planned Care**	Adult Social Care Management	1,540,616	1,540,616	N/A	
LBH	Unplanned Care		**Unplanned Care**	Rehabilitation Social Work	23,344	23,344	N/A	
LBH	Planned Care		**Planned Care**	Mental Health Services Management	168,940	168,940	N/A	
LBH	Planned Care		**Planned Care**	North Mental Health	1,174,559	1,174,559	N/A	
LBH	Planned Care		**Planned Care**	South Mental Health	624,163	624,163	N/A	
LBH	Prevention		**Prevention**	Lee House	274,654	274,654	N/A	
LBH	Planned Care		**Planned Care**	Forensic Social Work Team	49,396	49,396	N/A	
LBH	Unplanned Care		**Unplanned Care**	Emergency Duty Service	172,728	172,728	N/A	
LBH	Unplanned Care		**Unplanned Care**	Approved Social Workers Pool	158,030	158,030	N/A	
LBH	Unplanned Care		**Unplanned Care**	Home Treatment Team	42,940	42,940	N/A	
LBH	Planned Care		**Planned Care**	CM&R Team - Older People Mental Health	353,350	353,350	N/A	
LBH	Planned Care		**Planned Care**	Voluntary Sector Mental Health	388,054	388,054	N/A	

LBH	Planned Care		**Planned Care**	Mental Health Support (ELFT)	3,514,050	3,514,050	N/A	
LBH	Planned Care		**Planned Care**	Homeshare Daycare	137,852	137,852	N/A	
LBH	Planned Care		**Planned Care**	Meals on Wheels	71,555	71,555	N/A	
LBH	Planned Care		**Planned Care**	Management and Admin Support Team	149,428	149,428	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care Management	(146,116)	(146,116)	N/A	
LBH	Planned Care		**Planned Care**	Oswald St - Resource Centre	1,911,355	1,911,355	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Overbury Scheme	324,655	324,655	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Appleton & Morrell Scheme	410,144	410,144	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Peppie & Newton Scheme	495,035	495,035	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Penn & Albion Scheme	777,626	777,626	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Rose Court Scheme	907,997	907,997	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Liz McKeown & Catherine House Scheme	504,137	504,137	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Ashley Court & Benabo Scheme	762,856	762,856	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Century Court Scheme	665,280	665,280	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Southwold Scheme	665,515	665,515	N/A	
LBH	Planned Care		**Planned Care**	Housing with Care - Leander Court Scheme	579,191	579,191	N/A	
LBH	Planned Care		**Planned Care**	Physical Support	11,830,127	11,830,127	N/A	
LBH	Planned Care		**Planned Care**	Sensory Support	405,239	405,239	N/A	
LBH	Planned Care		**Planned Care**	Support with Memory & Cognitio	6,333,231	6,333,231	N/A	
LBH	Planned Care		**Planned Care**	Mental Health Support	1,169,283	1,169,283	N/A	
LBH	Planned Care		**Planned Care**	Asylum Seekers Support	169,615	169,615	N/A	
LBH	Planned Care		**Planned Care**	Assistive Equipment & T'nology	96,058	96,058	N/A	
LBH	Planned Care		**Planned Care**	Learning Disability Support	16,199,879	16,199,879	N/A	
LBH	Planned Care		**Planned Care**	Voluntary Sector Contracts -OP	293,392	293,392	N/A	
LBH	Unplanned Care		**Unplanned Care**	VULNERABLE PEOPLE Housing Related Support - Single homeless/Rough Sleepers	1,710,066	1,710,066	N/A	
LBH	Planned Care		**Planned Care**	Supporting People	6,025,782	6,025,782	N/A	
LBH	Planned Care		**Planned Care**	Workforce Development	359,704	359,704	N/A	
LBH	Planned Care		**Planned Care**	Performance & Innovation Team	840,139	840,139	N/A	
LBH	Planned Care		**Planned Care**	Commissioning	999,101	999,101	N/A	
LBH	Planned Care		**Planned Care**	Brokerage	232,696	232,696	N/A	
LBH	Planned Care		**Planned Care**	Direct Payments	216,347	216,347	N/A	
LBH	Prevention		**Prevention**	Carers	68,212	68,212	N/A	
LBH	Unplanned Care		**Unplanned Care**	Information & Assessment	985,729	985,729	N/A	
LBH	Unplanned Care		**Unplanned Care**	Hospital Social Work Team	919,988	919,988	N/A	
LBH	Unplanned Care		**Unplanned Care**	Unit Co-ordination (Front Office)	68,212	68,212	N/A	
LBH	Unplanned Care		**Unplanned Care**	Safeguarding	662,549	662,549	N/A	
LBH	Unplanned Care		**Unplanned Care**	City & Hackney SAB	76,540	76,540	N/A	
LBH	Unplanned Care		**Unplanned Care**	Substance Misuse rehabilitation	371,425	371,425	N/A	
LBH	Unplanned Care		**Unplanned Care**	Interim care accommodation	920,774	920,774	N/A	
LBH	Unplanned Care		**Unplanned Care**	Integrated Independence Team	126,760	126,760	N/A	
LBH	Unplanned Care		**Unplanned Care**	Integrated Independence Team	(1,000,000)	(1,000,000)	N/A	
LBH	Prevention		**Prevention**	Contraception	545,000	545,000	N/A	
LBH	Prevention		**Prevention**	STI Testing and Treatment	5,866,984	5,866,984	N/A	
LBH	Prevention		**Prevention**	Advice, Prevention & Promotion	236,965	236,965	N/A	
LBH	Prevention		**Prevention**	NHS Health Check Programme	215,000	215,000	N/A	
LBH	CYPM		**CYPM**	National Child Measurement Programme	40,000	40,000	N/A	

LBH	Prevention		**Prevention**	Public Health Advice	45,000	45,000	N/A	
LBH	Prevention		**Prevention**	Adult Obesity	577,326	577,326	N/A	
LBH	Prevention		**Prevention**	Child Obesity	549,000	549,000	N/A	
LBH	Prevention		**Prevention**	Physical Activity for Adults	115,410	115,410	N/A	
LBH	Prevention		**Prevention**	Physical Activity for Children	97,500	97,500	N/A	
LBH	Prevention		**Prevention**	Drug Misuse in Adults	4,783,850	4,783,850	N/A	
LBH	CYPM		**CYPM**	Youth Services (SM) Drug & Alcohol	386,000	386,000	N/A	
LBH	Prevention		**Prevention**	Stop Smoking Services & Interventions	842,726	842,726	N/A	
LBH	Prevention		**Prevention**	Wider Tobacco Control	80,000	80,000	N/A	
LBH	CYPM		**CYPM**	CHYPS + new service	516,760	516,760	N/A	
LBH	CYPM		**CYPM**	YH 5 - 19 Health and Wellbeing Service	275,000	275,000	N/A	
LBH	CYPM		**CYPM**	Safeguarding School Health Service	1,330,892	1,330,892	N/A	
LBH	CYPM		**CYPM**	School Entry HC, NCMP	0	0	N/A	
LBH	CYPM		**CYPM**	Disabled Children and Complex Additional Needs	0	0	N/A	
LBH	CYPM		**CYPM**	Welcome to the world hackney baby	5,000	5,000	N/A	
LBH	CYPM		**CYPM**	Nutrition Initiatives	30,000	30,000	N/A	
LBH	Unplanned Care		**Unplanned Care**	Accident Prevention	60,000	60,000	N/A	
LBH	Prevention		**Prevention**	Public Mental Health	1,625,000	1,625,000	N/A	
LBH	CYPM		**CYPM**	Health Visiting Services	5,999,790	5,999,790	N/A	
LBH	CYPM		**CYPM**	Family Nurse Partnership	410,556	410,556	N/A	
LBH	Prevention		**Prevention**	Support for Vulnerable Babies	10,000	10,000	N/A	
LBH	Prevention		**Prevention**	Consultant Public Health Midwife for Vulnerable Parents	36,000	36,000	N/A	
LBH	Prevention		**Prevention**	General Prevention	569,610	569,610	N/A	
LBH	Prevention		**Prevention**	Community Safety, Violence Prevention & Social Exclusion	400,187	400,187	N/A	
LBH	CYPM		**CYPM**	Dental Public Health	250,000	250,000	N/A	
LBH	Prevention		**Prevention**	Infectious Disease Surveillance & Control	0	0	N/A	
LBH	Prevention		**Prevention**	Seasonal Death Reduction Initiatives	65,000	65,000	N/A	
LBH	Prevention		**Prevention**	Other Public Health Services	87,904	87,904	N/A	
LBH	Prevention		**Prevention**	Health in the Workplace	20,000	20,000	N/A	
LBH	Prevention		**Prevention**	Public Health Staffing	2,318,929	2,318,929	N/A	
LBH	Prevention		**Prevention**	Public Health Overheads	1,000,000	1,000,000	N/A	
LBH	Prevention		**Prevention**	LBH Commissioned Services	3,621,000	3,621,000	N/A	
LBH	Prevention		**Prevention**	PH income	(497,083)	(497,083)	N/A	
LBH	CYPM		**CYPM**	PH income	(195,306)	(195,306)	N/A	
LBH	Planned Care/Unplanned/Prev		**Planned Care/Unplanned/Prev**	Removal Of BCF- To Avoid Double Count With CCG Figures(already removed within service lines)		0	N/A	
LBH	Planned Care		**Planned Care**	DFG (Capital)	1,525,299	1,525,299	N/A	
					530,590,822	**517,967,334**	12,623,487	

PART THREE – ALIGNED FUNDS

The Aligned Funds for both parties are per below:

- Aligned –Planned care
- Aligned –Unplanned care
- Aligned – Prevention
- Aligned – Children's & Young Peoples services
- Aligned – Other (for corporate budgets and support budgets)

1. **CCG Aligned Funds:**

   This is comprised of the services that fall within the five categories listed above, and commissioned services not exercisable under the Partnership Regulations as well as the CCG corporate management and support services commissioned services not exercisable under the Partnership Regulations:

   a. Surgery (the CCG has excluded Elective Surgery)
   b. Endoscopy
   c. Termination of Pregnancies
   d. Radiotherapy
   e. Laser treatments
   f. Emergency Ambulance Services

   Corporate management & support services: Include all management, administrative and support services such as contract management and finance, and, estates & facilities services.

2. **Local Authority Aligned Funds:**

This is comprised of the services that fall within the five categories listed above as well as income budgets arising out of local authority power to charge for

PART FOUR – SERVICE SPECIFICATIONS

This Agreement is a framework partnership agreement, allowing for a range of different Services to be commissioned under Pooled Fund arrangements or Aligned Fund arrangements, utilising flexibilities under section 75 of the National Health Service Act 2006 where relevant.

This Agreement references Service Specifications which are defined as:

"a specification setting out the detailed arrangements relating to a particular Service within a Commissioning Plan agreed by the Parties to be commissioned under this Agreement."

This Part four sets out agreed Service Specifications between the Partners as had been agreed under previous section 75 agreements to which the Partners are working.

A. INTEGRATED LEARNING DISABILITY SERVICES (ILDS)

Aims and Objectives of the partnership

The aim of the partnership is to support people with learning disabilities and their carers to tell their story once, receive the high quality services that they need and influence other partners to do the same. In short, we want people with learning disabilities and their carers to lead healthy lives that are part of the wider community in Hackney.

The objectives for the partnership are:

- To have informed discussions, and therefore decision-making that is based on data and community involvement
- To promote independence
- To improve health and reduce health inequalities
- Integrated services
- Choice and control for service users/patients

Services are jointly commissioned with the Council being the Lead Commissioner.

The Integrated Learning Disabilities Service Joint Commissioner (Christian Markandu as at June 2017) has overall responsibility for the budget for the Integrated Learning Disabilities Services.

Partnership Management Group

This Service Specification for Integrated LD Services is managed by the Partnership Management Group ("**PMG**"). The membership of the PMG will be as follows (together the 'PMG Members'):-

The CCG

- Programme Director for Primary Care (& Integrated Learning Disabilities Service)
- Clinical Lead for LD
- Finance Manager for the Integrated Learning Disabilities Service

The Council

- Head of Commissioning (Chair)
- Head of Integrated Learning Disabilities Service
- Head of Finance or nominated deputy

Joint

- Planned care workstream director
- ILDS Joint Commissioner - who will also provide the Secretariat function to the PMG.

The PMG is responsible on behalf of the Planned Care Workstream, for management of the Lead Commissioning partnership arrangements established under this Agreement, including monitoring the arrangements, overseeing performance and actions in respect of the operation and impact of the arrangements.

In terms of the overall integrated commissioning arrangements the PMG reports through the Planned Care Workstream core and the workstream is overseen by the ICB through the TB.

B. REHABILITATION, REABLEMENT & INTEGRATED INDEPENDENCE CARE TEAM (RR&IIC)

The RR&IIC budgets form part of the overall BCF. There are specific management arrangements for RR&IIC service through the RR&IIC Joint Working Group, as set out below.

In City & Hackney, the rehabilitation, reablement and intermediate care service delivered by the RR&IIC team will have the following features;

- An integrated range of services, including crisis response, intermediate care rehabilitation and home-care reablement, for which the Lead Provider is Homerton University Hospital**.** The Lead Provider will be responsible for all aspects of delivery and for the appointment and management of a Head of Service, who will be responsible for all day-to-day operations.

- The service is for all patients registered with City and Hackney GP Practices. It is also for all residents of Hackney and residents of the City of London. It should be noted that home-care reablement services will be provided to City of London residents by City of London reablement services.

- The crisis response is available for all residents of Hackney and residents of the City of London. It should be noted that home-care reablement services will be provided to City of London residents by City of London reablement services.

Services are commissioned under Integrated Commissioning arrangements, with the Council being the Lead Commissioner.

Membership of the Rehabilitation, Reablement and Integrated Independence Care Joint Working Group

The membership of the Joint Working Group will be composed of equal numbers of representatives of the Council and the CCG. There should be no more than 5 members from each organisation and they should include:

- The council's Head of Commissioning, who will chair the Joint Working Group.
- The council's Strategic Commissioner for Older People
- The council's Head of Performance - who leads on collating data on behalf of the partners that informs the performance framework
- CCG Clinical Lead for Older People
- CCG Commissioning Programme Manager for reablement and intermediate care - who supports the work of the lead clinician and who will also support the work of the Joint Working Group.
- Other CCG officer as nominated by the CCG authorised persons/management
- Finance representatives from the Council and CCG.
- Representatives of Health Watch.

Representatives of the Provider will be invited to meetings or part of meetings, as deemed appropriate by the Chair, but the Joint Working Group will work in constructive partnership with the Provider, whilst also holding the Provider to account, in order to deliver the best outcomes for patients and service users.
If there is a conflict of interest then this will be dealt with per the 'conflict of interest' clause (clause 22).

PART FOUR A – ILDS SERVICE SPECIFICATION

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Service Specification

Service Specification No.	XXX
Service	**Integrated Learning Disabilities Service**
Commissioner Lead	Joint Strategic Commissioner for Learning Disabilities
Provider Lead	London Borough of Hackney / East London Foundation Trust
Period	April 2019 – April 2024 Plus option to extend plus one, plus one.
Date of Review	Annual

Service Specification: Integrated Learning Disabilities Service

1. BACKGROUND

A learning disability is a reduced intellectual ability and difficulty with everyday tasks e.g. daily activities, socialising which affects someone from childhood. Someone with a learning disability takes longer to learn and may need support to develop new skills, understand complicated information and interact with other people. The Service detailed in this specification is for a specialist health and social care service, working together, for people with a learning disability.

There are approximately 1.5million people with a learning disability in the UK. In England (2011) 1,191,000 people were estimated to have a learning disability. This included 905,000 adults aged 18+ (530,000 men and 375,000 women) – *Source: People with Learning Disabilities in England (2011).*
People with learning disabilities are more likely to be deprived and experience inequalities in their health than the general population. For example, people with a learning disability are four times more likely to die of something which could have been prevented than the general population (Disability Rights Commission, 2006). They are often a very vulnerable group in society.

2. NATIONAL POLICY & FRAMEWORKS

2.1 Valuing People (2001) and Valuing People Now (2009)

Valuing People remains the key and most recent national policy framework for learning disabilities. Many of the key principles of Valuing People and Valuing People
Now (2009) are now enshrined in the Care Act 2014. Our commissioning intentions reflects these, and other key priorities described in Valuing People Now.

2.2 The Care Act (2014)

The Care Act sets out a vision for a reformed support system, ensuring health and social support is focused on people's wellbeing, prevention and supporting people to stay independent for as long as possible and lays out what local authorities must do. E.g.:

- carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care
- focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve
- involve the person in the assessment and, where appropriate, their carer or someone else they nominate
- provide access to an independent advocate to support the person's involvement in the assessment if required
- consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support) use the new national minimum threshold

It requires Local Authorities to identify the individual's strengths – personal, community and social networks – and maximise those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving or maintaining their wellbeing. The Act also gives people the legal right to a 'personal budget' and or a 'personal health budget'

It is expected that the Service will be Care Act compliant.

Source: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

2.3 Transforming Care & Building the Right Support (2015)

Building the Right Support is a national plan to develop community services and limit admissions for people with a learning disability and/or autism who display behaviour that challenges.
It identifies what good services and support looks like for people with a learning disability and/or autism who display behaviour that challenges, including behaviours which may result in contact with the criminal justice system. It is structured around nine core principles:

1. People should be supported to have a good and meaningful everyday life
2. Support should be person-centred, planned, proactive and coordinated
3. People should have choice and control over how their health and care needs are met
4. People with a learning disability should be supported to live in the community with support from and for their families/carers as well as paid support and care staff
5. People should have a choice about where and with whom they live
6. People should get good support from mainstream NHS services, using NICE guidelines and quality standards
7. People with a learning disability and/or autism should be able to access specialist health and social care support in the community
8. When necessary, people should be able to get support to stay out of trouble
9. When their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a hospital setting, staying no longer than they need to

There are 'golden threads' that run consistently through these principles:
• Improving quality of life
• Keeping people safe
• Promoting choice and control
• Support and interventions should always be provided in the least restrictive manner.
• Equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities.

(*Source:* Building the right support, LGA, ADASS, NHSE, October 2015)

The Service is expected to work within these policies, legislation and frameworks.

2.4 NHS long Term Plan

The NHS long term plan specifically mentions learning disabilities including Transforming Care and preventing premature deaths through addressing health inequalities e.g. through improving health checks and NHS services making reasonable adjustments for those with learning disabilities. It outlines intentions to improve health and care services better so that more learning disabled people can live in the community, with the right support, and close to home with a view to preventing hospital admissions where possible. It also identifies the need for timely diagnosis and access to specialist services. The Service is expected to support with implementation of this plan.

3. LOCAL CONTEXT

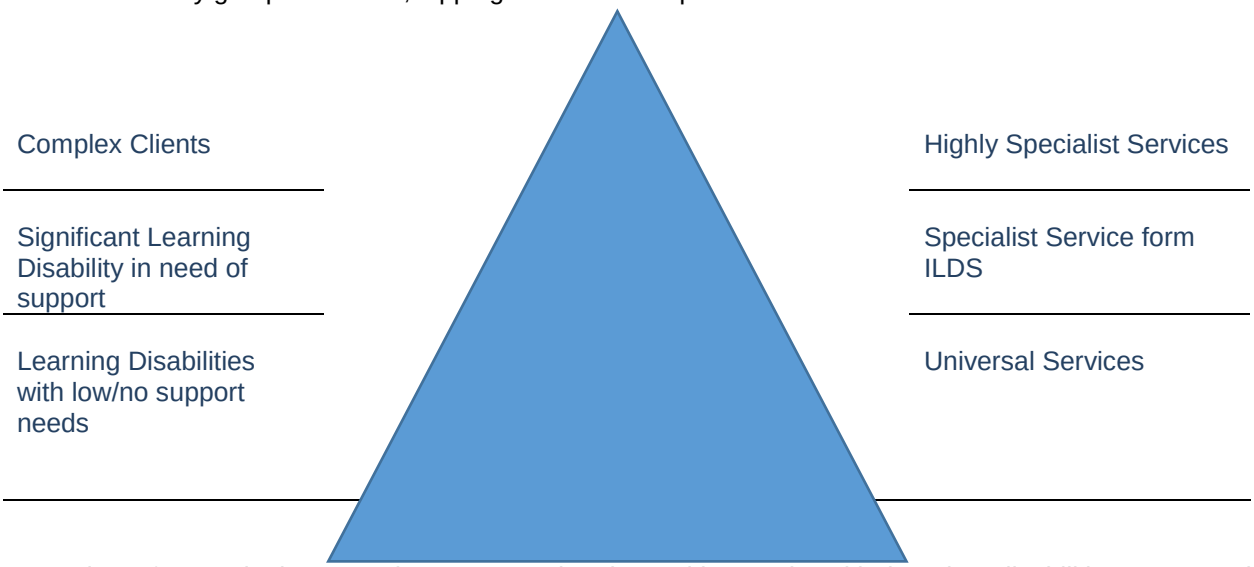
Health and social care organisations in Hackney and the City of London are increasingly working together more to try to improve residents' health and wellbeing.
Hackney is a diverse inner London borough, with significant 'Other White', Black and Turkish communities; e.g. the Charedi Jewish community is concentrated in the North East of the borough and is growing. It is a relatively young borough with a quarter of its population under 20. Services need to consider such diversity as part of their work.
Hackney's population is estimated at 263,150 people. Approximately 2.4% of adults in the City and Hackney population have a learning disability; this equates to 4,937 people in Hackney and 177 people in the City in 2015.

Information from City & Hackney's Joint Strategic Needs' Assessment JSNA (2017) identified the following:

- Approximately 2.4% of adults in the City and Hackney population have a learning disability; this equates to 4,937 people in Hackney and 177 people in the City in 2015.
- The size of the local adult learning disabled population is expected to grow by around 900 people (or 17%) to 2030. Around 200 people are expected to be living locally with a moderate/severe learning disability by 2030.
- The greatest proportion of adults with learning disability in contact with local services are classified as British/White British/Mixed British/English (around 30%). A relatively high proportion of adults receiving a care package in Hackney identify as Jewish.
- The largest number of people affected by learning disability are estimated to be in the 25-34-year age group. This is due to the relatively young population in Hackney as well as the higher prevalence of learning disability in younger people.
- Many have comorbid conditions. For example, there are significantly higher rates of serious mental illness (SMI) in adults with learning disability, around 14% of learning disabled patients affected locally (in comparison with around 1% of the total adult patient population). Provisional national data indicates that local rates are higher than might be expected (around 9% of learning disabled patients nationally coded with SMI).
- People with a learning disability are more likely to be living in the most deprived local neighbourhoods compared with the total population.
- Almost one quarter (22%) of adults with a learning disability are estimated to have a moderate or severe condition.
- Adults with learning disability who are in contact with social care services are unlikely to be in paid employment. In Hackney, the employment rate is significantly lower than comparable areas in London (Hackney rate 2.9%, CIPFA comparator group rate 6.2%).
- Around 40% of adults with learning disability are estimated to be living with their parents. This is much more common in younger age groups. The predicted ageing of the local adult learning disabled population is likely to create additional support and housing needs over the next 15 years and beyond.
- Overall, almost 40% of learning disabled adults with a care package in Hackney are in residential or nursing care; almost all of these adults are placed out of borough.
- Local learning disabled adults are at significant risk of social isolation.

City & Hackney JSNA (2017)

It is expected that most people with learning disabilities will be accessing universal services. For some their needs may go up and down, dipping in and out of specialist services.



A series of consultation exercises was undertaken with people with learning disabilities, carers, the Integrated Learning Disabilities Service and other stakeholders (2017-18). This service specification has been developed to include the feedback and findings from these exercises.
Some work has already been undertaken on shaping the Service Pathways of the Integrated Learning Disabilities Service (referred to as 'the Service'), and this work is expected to continue in order to meet the requirements of this schedule.

4. OUTCOMES

4.1 Outcomes Framework Domains & Indicators

The Service will work towards the following outcomes as laid out in the national Adult Social Care; NHS and Public Health outcomes framework:

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

Please see Appendix 1 for Outcomes based on the above domains and ASCOF etc. which are matched to the service delivery.
The service will work as part of the overall Learning Disabilities Strategy for City and Hackney, supporting it to achieve its outcomes.
As a specialist, adult, community learning disabilities service, the overall goal of the service will be:

> *To ensure people with learning disabilities achieve their potential, are as independent as they can be, have a good quality of life, and equal life opportunities to anyone else.*

4.2 Key Outcomes

The Service shall work to achieve the following local (coproduced) key outcomes:

- **People with a learning disability are an active part of their community**
- **People with a learning disability are enabled to achieve independence where possible**
- **People with a learning disability have a place they call home**
- **People with a learning disability are able to access the health care they need.**

A theme of safety shall run throughout these

4.1 Aims/ Principles of the Service

The key principles as laid out in Valuing People and Valuing People Now (2009) will be a constant theme across the Service. The Service will work to ensure

1. People with learning disabilities and their families have the same human rights as everyone else.
2. Choice and control are promoted in all aspects of the lives of people with learning disabilities, including their services and support.
3. People with learning disabilities are enabled to be as independent as they can be, whilst ensuring their personal safety, and freedom from discrimination.
4. People with learning disabilities lead fulfilling lives and participate in all aspects of community life – work, learning, be part of social networks and accessing goods and services.
5. People with learning disabilities will have good health and wellbeing.
6. People with learning disabilities and their carers are at the centre of everything the service does.

4.3 Objectives:

The Service will ensure that it is able to demonstrate positive outcomes for people with learning disabilities as a result of its work through achievement of the following objectives:

- An increase in the number in paid employment and an increase in volunteering activities.
- A reduction in residential placements and an increase in those living in their own home/ with a tenancy.
- An increase in the uptake of mainstream and universal services and activities.
- A high uptake of health checks and screening.
- An increase in the number of healthy behaviours/ or health promoting activities.
- A reduction in health inequalities.
- Avoidance of unnecessary admissions to hospital.
- Safe, planned and effective discharge from hospital.
- A reduction of social isolation.
- A feeling of safety among people with learning disabilities in their community.
- A reduction in the need for support.
- Good quality service provision for people with learning disabilities.
- An increase in Personalisation.

Key performance indicators are listed later in this Specification.

5. SERVICE MODEL

The Service will be an integrated service of health and social care partners working together to provide a holistic approach to meeting the needs of people with learning disabilities. It will be needs led but with enabling strengths-based approaches. The Service will use specialist knowledge and skills, evidenced

based and best practice to work in a multi-disciplinary way.
There will be a clear pathway/s including overall access into and out of the service.
The Service will support people with learning disabilities to achieve their goals, aspirations and full potential. It will work in collaboration with people with learning disabilities, their carers and others to enable the individual with learning disabilities and/or build the right support around them; ensuring good health and wellbeing.

The Service shall support people with learning disabilities to have the same rights and responsibilities as everyone else, supporting with reducing or removing the barriers faced by people with learning disabilities. This will include supporting positive risk taking.

The Service will work towards delivering the right support at the right time in a joined-up manner, so that people with a learning disability have positive experiences of support. This will include supporting smooth transitions, including at the time of preparation for adulthood and end of life.

The Service should use an outcomes-based model which provides greater choice, control and flexibility for those accessing services. This includes using a range of mechanisms such as Direct Payments, Personal Health Budgets and Individual Service Funds. The Service will support with ensuring good value for money services for people with learning disabilities.

6. KEY FUNCTIONS

The key functions required for delivery by the Service are to:

- Work in partnership with others, such as mainstream services, to ensure equal and fair access and advice on reasonable adjustments for people with learning disabilities.
- Assist people with learning disabilities and those supporting them to better understand the causes of ill-health, support to access to good primary care, community and specialist acute/mental health services, and wider mainstream opportunities in society.
- Respond positively and effectively to vulnerable people in need of support and ensure a smooth transition of eligible clients into the Service
- Offer a timely service which adheres to health and social care requirements.
- Provide effective integrated, person-centred support to people with learning disabilities
- Assess and meet the needs of people with a diagnosed learning disability, including young people transitioning into adulthood, using a coordinated and integrated approach.
- Provide direct specialist clinical, therapeutic and social care support for people with a learning disability
- Deliver individual outcomes as part of assessment and support planning processes.
- Ensure that individual service user Reviews are meaningful, timely, of high quality, and outcomes focused.
- Offer a holistic approach to care and support of the individual
- Involve people with learning disabilities and their carers in key decisions about service delivery and support.
- Deliver a specialist service in line with up to date best practice
- Work with Commissioners to identify gaps and develop service options appropriate for people with learning disabilities in the borough.
- Attend, inform and deliver the priorities of the Learning Disabilities Partnership Forum.
- Support and engage with key programmes that support people with learning disabilities to have better lives. This includes work on the Transforming Care Programme to avoid admissions.

Broadly these functions fall into three main roles for the service:

1. **Advice, Consultation, and Signposting**:

   This works on the principles that people with learning disabilities should be able to access the same opportunities and mainstream/universal services as anyone else in the population. The Service will work to ensure this through provision of advice, guidance in a consultative role. This will include providing accessible information and signposting to other services. The Service will work to address the inequalities experienced by people with learning disabilities more widely; developing positive relationships with other services is key to making this happen. Unlike the other roles, the service will

focus on the environmental factors.

2. Prevention, Enablement and Promotion of Independence:

Working in a person-centred, way the service will work to develop the strengths of individuals with a learning disability to support them to achieve their full potential and, where possible, prevent the need for further services. This will tend to be shorter term, discreet outcomes focussed pieces of work.

3. Complex and Longer-Term Specialist Cases:

Working in a person-centred way, the service will work to develop the strengths of individuals with a learning disability to support them to achieve their potential, maintain ability and ensure a good quality of life.

Some people with learning disabilities will use these discreet service roles, however, there may be those who need different aspects of these roles at different times and there may be some crossover. These roles will be undertaken in order to meet the service outcomes and via the pre-agreed integrated pathways.

Person Centred Practice

The Service will be person-centred and accessible in all aspects demonstrating a commitment to be flexible, sensitive and responsive to the individual's needs and preferences whilst ensuring client choice and informed risk taking. Adhering to the following principles:

- Put the person at the centre
- Give the person choice and control and support them to be a valued Citizen and part of their community
- Ensure the person is respected, listened to and their rights upheld
- Ensure the person's voice is heard, even if they can't say, or express themselves
- Use an outcome focused approach, enabling the person to achieve their goals
- Support planning tailored to each person's unique needs and wishes, is fully accessible and is ever evolving
- Include people who know the person best, to help plan support and recognise the contribution families can provide as experts
- Start with the resources already available within the person's life and wider community and then identify where 'just enough' support is needed to bridge any gaps
- Start planning for the future as early as possible
- Involve the person and their family in choosing who supports them, seek to match people with the right support staff

The Service will be committed to partnership working with service users and their families. Where possible and requested, the Service is expected to offer personalised approaches to meeting service user outcomes.

The Service needs to recognise that there are often complex and stressful demands upon carers and should ensure that the statutory requirements for the support of both service users and carers are met in line with the Care Act (2014).

7. SCOPE OF THE SERVICE

The Service is commissioned jointly through the London Borough of Hackney (LBH or the Council) and the NHS via City and Hackney Clinical Commissioning Group (CCG). It will be provided by LBH and East London Foundation Trust (the Trust).

This Integrated Learning Disabilities Service (The Service) will provide specialist health and social care services for adults with a learning disability and for young people Preparing for Adulthood to meet the health, social care and wellbeing needs of people with learning disabilities and their carers.

The Service will be accessible to any person with a learning disability and who meets any one of the below criteria:

- Is registered with a GP in City or Hackney.
- Is assessed as eligible for NHS Continuing Healthcare under City and Hackney CCG
- Is an ordinary resident of Hackney

(See also Section 10: Access to the Service for further information on diagnosis)

The Service will work to improve health and wellbeing, use preventative approaches wherever appropriate and enable people to live as independently as possible.

The Service must be a highly specialist service in order to provide direct specialist clinical, therapeutic and social care support for people with learning disabilities including those with complex needs.

In order to deliver high-quality person-centred care, continuity of care and coordinated support it is essential that care pathways are fully integrated to ensure good outcomes are achieved.

The Service will provide time limited, person-centred assessment, care management, care coordination, therapeutic intervention, monitoring and health professional training and support for people with learning disabilities and their carers in a range of settings.

Delivery of the Service will support social inclusion, access to mainstream and universal services; valuing equality and diversity.
The Service will support access to:

- Timely and meaningful diagnostic support and input.
- Individualised tailored care and support plans which are outcomes-focused.
- Personalised services including Personal Health Budgets
- A safe environment designed to meet the person's holistic needs
- Meaningful accessible information to navigate through services
- Well trained staff regardless of where people receive services
- Service user choice to design own services
- Personal Health/Care Plans based on service user need and wishes and not on how services are designed
- Accommodation that is right
- Support from the community (other teams & providers)
- Information, advice and support for carers
- Specialist support for behaviours that challenge, including Positive Behaviour Support
- Education
- Employment

The Service shall work in partnership with other organisations where appropriate to ensure suitable access to the above.
The assessment, treatment and care planning of interventions will be provided through a multi-disciplinary

team.

The multi-disciplinary Service will deliver a wide range of specialist support, including via the following disciplines:

- Social Work
- Speech and Language Therapy (SALT)
- Physiotherapy
- Occupational Therapy
- Nursing
- Psychology
- Behavioural Therapy
- Psychiatry
- Approved Mental Health Practitioners/ Social Supervisors

8. ENABLING ACCESS TO AND RESPONSES FROM MAINSTREAM SERVICES

Outcomes:
People with learning disabilities will be able to access the services they need.
Enhancing quality of life for people with long-term needs and improving the wider determinants of health.

The Service is required to engage in strategic development work that supports better universal access to community and mainstream services and positive outcomes reducing known health and other inequalities. The Service will be a key resource to enable mainstream health and care services to make reasonable adjustments for learning disabled people; it will have a consultancy role for mainstream services when required. This will include involvement in planned programmes of:

- multi-agency training
- education,
- mentoring
- informing
- consultancy to others about responding to the needs and concerns of people with learning disabilities.

The Service should also provide on-going support, supervision and advice to services (especially primary, community, specialist acute/mental health and criminal justice services) to support them in:

- Establishing joint registers and flagging systems for all known local patients with learning disabilities, thereby enabling the provision of 'reasonable adjustments' and positive support plans that mitigate known health inequality and service access outcomes
- Ensuring regular dialogue and joint training meetings with mainstream health and social care services to discuss any particular general concerns and support plans
- Developing increasing confidence, skills and experience in supporting patients with complex health support needs through training and other service development interventions.

Priority should be given in relation to supporting key target groups where awareness and understanding of learning disabilities will be critical to achieving high quality health and social care outcomes for service users and carers.

9. ADDRESSING HEALTH INEQUALITIES

Outcomes:
People with learning disabilities will have equal access to health services and experience good health and wellbeing.
Preventing people from dying prematurely

Health Facilitation and liaison is an important function of the Service to address the inequalities experienced by people with a learning disability and prevent premature death. It includes direct work,

supporting individuals to make informed choices about their health needs and supporting local health services to be more accessible to those with a learning disability. The Service will in future link in with the proposed Neighbourhoods Model in the borough.
Annual Health Checks can identify health conditions, ensure the appropriateness of on-going treatments, promote health (e.g. screening/ early immunisation) and establish trust and continuity of care. All patients with a learning disability should be on a learning disability register in their general practice and, once aged 14 and over, should have an annual health check and referred/supported to receive appropriate actions, such as lifestyle advice and sexual health. It is imperative that practices are helped to make reasonable adjustments and provide appropriate support materials; the Service is expected to support with this.

The Service needs to develop its health facilitation and liaison role to meet the following objectives:

- To support delivery of Annual Health Checks and Health Action Plans, in GP practices/primary care
- Be responsible for ensuring that everyone known to them and registered with a GP as having a learning disability is offered a Health Action Plan. This will require working closely with all other providers of care for people with a learning disability.
- Identify known gaps in the provision and delivery of Health Action Plans and 'Reasonable Adjustments' by generic providers to improve access to health care for people with Learning Disabilities and to inform Commissioners
- Implementation of the Health Equality Framework (HEF) or similar to demonstrate measurement and achievement of user outcomes.
- Support equal access to screening programmes and to ensure safe and clinically effective access to primary and secondary care.
- Support local NHS providers to communicate their services in accessible formats and make reasonable adjustments for people with learning disabilities to access their services.
- Ensure hospital passports are available and used
- Provide awareness raising, education, training and support to statutory generic NHS providers to make reasonable adjustments and develop accessible information.
- Provide proactive leadership in facilitating better coordination of care and improved patient experience involving specialist and mainstream healthcare.
- Enabling Others to Provide Effective Person-Centred Support to People with Learning Disabilities
- Provide specialist advice, limited support and client-specific training to people with learning disabilities, families, carers and service providers across the statutory, independent and voluntary sectors
- Establish a detailed understanding of all local resources relevant to support individuals with learning disabilities and their families/carers and promote effective integrated working maximising the health and well-being outcomes of individuals and the local community.
- To actively participate in the LeDer (prevention of premature deaths) Programme

9.2 LeDeR

The Learning Disability Mortality Review (LeDeR) Programme was established as a recommendation from the Confidential Inquiry into the premature deaths of people with learning disabilities. People with learning disabilities continue to die earlier than people without learning disabilities and in many cases the death may have been prevented with earlier diagnosis and prompt treatment.

Its aim is for local areas to review all deaths in someone with learning disabilities aged 4 and over to learn lessons from the case and implement change in practice.

The Service will be part of the local LeDer arrangements and contribute to these reviews. The service is expected to have a minimum of two LeDer trained Reviewers who can undertake allocated reviews and the service will undertake a minimum of three LeDer reviews a year (Appendix IV) and report on this as part of performance monitoring. Please see the guidance on the LeDeR process http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance for the conduct of reviews_FINALv2.2.pdf

Key Partnerships Include…
Primary Care, Acute Hospitals, Mental Health Services, Social Care agencies, Police,

Probation; Job Centre Plus; Community Services; Public Health

10. ACCESS TO THE SERVICE

Outcomes:
The Service is accessible to people with learning disabilities.
People with learning disabilities and their carers find it easy to find information about support

The starting point should be mainstream services (which should be available to all) to support people with a learning disability, making reasonable adjustments where needed and accessing specialist expertise as appropriate. However, there may be some who require more specialist support.
This Service is specialist to people who have a learning disability.

10.1 POPULATION COVERED

People who meet the criteria for a diagnosis of learning disability are an extremely varied group.

Access to the service will be by formal diagnosis. Evidence of all three of the following criteria must be met for a person to be considered to have a Learning Disability (British Psychological Society, 2000).

Diagnostic criteria for learning disability

1. Significant impairment of intellectual functioning (e.g. an intelligence quotient (IQ) of below 70, etc.)
2. Significant impairment of adaptive/social functioning (e.g. Score below the Process Cutoff on the Assessment of Motor and Process Skills)
3. Age of onset before the age of 18 (e.g. Statement of Special Educational Need; attendance at a special school; childhood medical reports).

The ILDS will provide a service to people who meet the learning disability diagnostic eligibility criteria as detailed above and who have an eligible health and/or social care need.

The Service shall ensure that the religious, cultural and spiritual needs and wishes of all Service Users are identified, respected and wherever possible met.

Referrals

The Service will operate a single point of access (SPA) for all referrals. All referrals will be screened for evidence of a learning disability. Screening will be done in a timely way along with responses to referrers.

If the evidence provided is inconclusive of a learning disability, the Service will offer a Learning Disability Diagnostic Assessment and will only proceed to complete a full Single Assessment once eligibility for the service has been determined.

Where there is no evidence of learning disability or it is concluded that a person's needs can be better met by mainstream services the person and/or referrer will be given information, advice and /or signposted to appropriate support to meet their needs in line with the Care Act, 2014.

If the person referred has urgent health or social care needs (e.g. safeguarding, imminent placement breakdown, immediate threat to person's physical health or safety or those around them) their referral will be discussed with seniors in the Service as soon as the referral is received and a plan will be agreed on the day and communicated to the referrer. Consequently, there may be instances of the Service working with people who it is later concluded do not have a global learning disability.

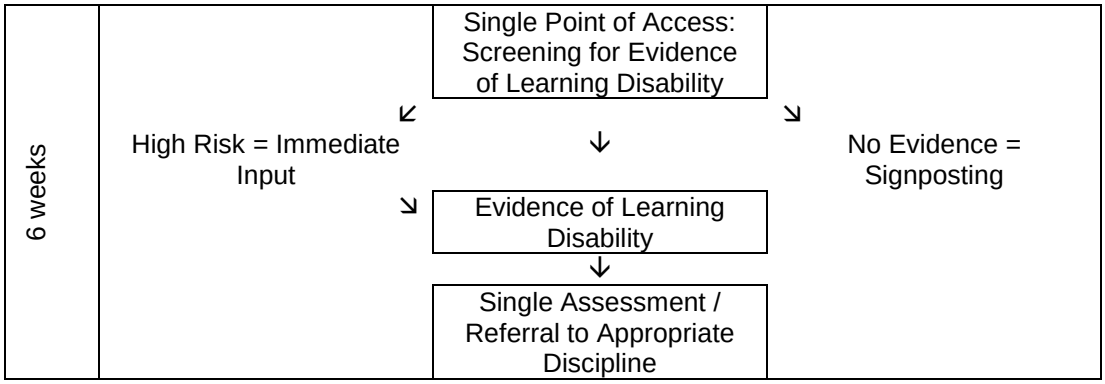
If there is evidence of learning disability the person referred will be offered a Single Assessment of his/her health and social care needs.

People who are already known to the Service will be offered a new Single Assessment if their living circumstances have changed or if they have not had a service from ILDS for at least three years.

If a new Single Assessment is not required, the referral will be passed straight to the most appropriate discipline(s) for the needs identified in the MDT referral discussion.

All referrals should be discussed at multidisciplinary team meeting to ensure a co-ordinated approach between disciplines and to avoid any duplication. All referrals should be prioritised according to levels of risk and urgency.

New adult referrals will receive initial joint multidisciplinary comprehensive single assessment' within 6 weeks of referral by the Service.



(Further information about the pathway through the Service can be found in 17. Processes & Procedures)

10.2 **Preparation for Adulthood**

Outcomes:

Young people with learning disabilities and their carers are involved in person-centred planning; they have a positive experience of care/support and transitioning between services.

The Service will support high quality person-centred transition planning as part of preparation for adulthood. Young people and their families should have a strong/the strongest voice at all meetings and planning concerning them. They should be expected and encouraged to say what

is positive in their lives and what is possible in their future and know that clear guidance has been given and actions set in key areas of their lives.

Young people should be supported to be aware of local opportunities and options regarding housing and community involvement, and such aspirations should be encouraged in the planning process. Transition should be based upon the idea that people with learning disabilities will live in inclusive communities and be supported in those communities.

Planning however should reflect individual circumstances and the Service will need to be aware of what the options are and how to help with accessing them e.g. Hackney's Local Offer.

The Service will need to ensure effective communication and mechanisms are in place to support a smooth transition into the Service. This includes the recommendations as laid out in NICE Quality standard (QS140) - Transition from children to adults' services which describes high-quality care in priority areas for improvement.
https://www.nice.org.uk/guidance/qs140

The Service will:

- Support effective Education, Health and Care Planning of people with learning disabilities.
- Ensure best practice is used when young people with learning disabilities are transitioning into adult services e.g. planning should start from age 14 or before.
- Work in line with the Transforming Care Local Protocol for service user aged 14+years.
- Ensure timely decision making about if and how the young person will be supported.
- Support young people into adulthood with paid employment where possible, good health, independent living options and friends, relationships and community inclusion.
- Ensure involvement in personalised annual reviews the school, family, representatives from the council and professionals will get together with the young person to identify the most appropriate pathway, enabling them to achieve their outcomes.
- Support with risk management especially those associated with young people e.g. online safety and gang culture.
- Agree short and long term outcomes to support the progress of the young person in meeting their educational and career aspirations including the areas of:
  - Higher Education, training and/or employment.
  - Independent living
  - Participating in society
  - Being as healthy as possible in adult life

Key Partnerships Include…
Children's Health and Social Care Services e.g. Children and Adolescent Mental Health Services, The Ark; The Learning Trust; Support Providers; Prospects; Colleges

11 PREVENTION, ENABLEMENT AND PROMOTION OF INDEPENDENCE

The Service will take a strengths-based approach and ensure that there is service provision for people with learning disabilities to develop their independent living skills and achieve their potential. This should prevent the need for longer term care and support.
The Service will enable people with learning disabilities to make healthier choices and improve their health and wellbeing adopting an approach of Making Every Contact Count (NHS Health Education) in interactions with service users and their support. It will strive to address the socioeconomic inequalities faced by people with learning disabilities, including through improved social integration, support to access employment, joined up working with other services/agencies, and planning ahead from an early age to

achieve positive outcomes.
The Service will be able to demonstrate individual outcomes for service users through appropriate measures, e.g. the Health Equalities Framework or similar.

Crisis Prevention

Crises are usually predictable; the Service should work proactively to prevent crisis situations for people with learning disabilities. One such mechanism is a risk register whereby risks are rated and stratified. The Transforming Care register should be used for this purpose and pro-active prevention of unnecessary hospital admissions by the Service. Senior members of the Service should be identified as responsible for leading on maintaining and updating such registers but using MDT approaches. If a crisis does happen, the Service should ensure the right sort of help/support is available to rapidly defuse and stabilise the situation/s. Suitable recording mechanisms also need to be in place.

The Service needs to ensure there are appropriate systems is in place, such as Duty or similar, to deal with urgent issues that arise in relation to service users, new enquiries or referrals. It should also deal with unallocated cases to prevent or manage crises in a timely and expert manner e.g. where the allocated/named worker is unavailable.

For service users known to experience crises, the Service should ensure a well thought out contingency plan is in place, which should assist the effective management of emergency and demanding situations.
The Service will deal effectively with crisis, responding on at least 3 levels:

- Proactive crisis prevention
- Reactive crisis management and immediate resource deployment
- Proactive Strategic planning and service development (informed by the first 2 levels)

The Service will retain accurate up-to date knowledge about all those locally with severe support reputations e.g. challenging behaviour, and their histories of crisis situations, and work proactively to prevent crises. The Service should ensure partnership working with others around the identified individuals to support this.
It should make sure the right support is available at the right time, including:

- Comprehensive summary assessments are already in place for all clients in transition, family homes and agency placements – critically defining the things that help and make things worse
- Positive health action and behaviour support plans (with potential crisis situations identified and clear relapse prevention plans) for the individuals with severe reputations at any point in time clearly described and understood by key stakeholders (i.e. what works and what to avoid)
- On-going monitoring and review systems in place for those with complex support needs, linking in with the service user's local CCG
- Having someone to talk to at short notice
- Problem solving learning to see where things go wrong and how they could be put right.
- Having sufficient capacity for responding with extra professional support around the person in situ
- Contingency options of going somewhere else for a period of time as a crisis respite or refuge breaks (such as social crisis and planned respite/breaks service)
- Access to crisis Mental Health and Learning Disability home treatment and admission to in-patient facility options through stepped care pathways

For any concerns outside of office hours, service users and carers will be encouraged to seek appropriate support elsewhere e.g. call the out of hours GP service or present to A&E; or contact the London Borough of Hackney Out of Hours Duty Team. The Service needs to ensure such information is available and shared appropriately in a clear and in an accessible format.

It is expected that there will be clarity around service pathways by the end of year one.

Key Partnerships Include…
Primary Health Services; Supported Employment Services; Client Affairs Team; Social Care Services; Community Volunteer Services; Support Providers; Public Health

12. COMPLEX AND LONGER-TERM SPECIALIST CASES

The Service will provide assessment and intervention for clients where the impact of their learning disability adversely affects their capacity to fulfil their potential in terms of independence, inclusion, making choices and living healthy lifestyles.

The Service is required to work with a range of caseloads and presentations such as clients with complex, severe and enduring problems, disorders related to learning disabilities, people with additional disabilities, severe challenging behaviours, mental health difficulties, dementia, dysphagia, long-term conditions, epilepsy, autism, personality disorder and those who are part of the criminal justice system, and/or who have been victims of abuse or are otherwise at risk.

The Service must be able to support those who, because of on-going complex support needs will remain in contact with the service for long term interventions e.g. many of the Transforming Care cohort. This will often include those with reduced mental capacity who meet the criteria under the Mental Capacity Act, requiring Best Interest Assessments and Deprivation of Liberties Safeguards (DoLS) input.

The Service will offer an individualised approach and will design support to meet individual needs. This will include determining if /what support and placements are appropriate to individual need.

This Service shall provide specialist care/support coordination, which may require monitoring for periods of several years or even life-long in some cases; with some individuals requiring options to step-up and step-down support. Service users receiving support will have and participate in regular, individual meaningful reviews of their support (as per Care Act or Continuing Health Care guidance). All reviews should include a review of health and social care needs.

The Service must deliver continuity of care for vulnerable people with complex needs requiring intensive intervention and/or long-term support, including an identified ‘named worker’ for these service users. It will work in partnership with the service user, their carers, networks and other services to ensure needs of such service users are effectively met.

It is expected that the Service will increase provision of communication and hospital passports (a description of how best to communicate with the individual service user) for all service users with a significant or complex communication difficulty.

The Service should provide consultation, advice, assessment and intervention in a person-centred way, including:

- relevant accessible information for service users and carers.
- specialist information, consultation, advice and support to relatives, carers and support workers.
- effective communication of confidential and specialist condition-related and personal information
- expert specialist advice, guidance, consultation and support to other professionals in a wide range of settings
- broader theoretical knowledge and specialist clinical skills to develop or support the ability of others

- Specialist and complex assessments of people with learning disabilities and summary formulations/ diagnosis including a good understanding of the person's history and narrative
- complex risk assessment and risk management programmes
- skilled evaluations and decisions about treatment options
- care/treatment plans for the treatment/management of a person's problems
- a range of complex highly specialist clinical interventions, employing methods based on proven efficacy and best practice
- physical health support and advice
- care coordination where appropriate, including initiating, planning and review of care plans e.g. CPA/CHC/Care Act
- outcome focused health and social care reviews that involve the appropriate people involved in that service users' life and the delivery of support e.g. family, Client Affairs representatives; advocacy
- access to bed-based services only where health input is highly intensive or unpredictable
- support with those admitted to hospital to ensure appropriate assessment and treatment
- an eclectic range of interventions beginning from an assumption that input locally is the first option to be explored.
- Commitment to using the 'least restrictive option'.
- Support with meaningful end of life care.

When working with people who have profound and multiple learning disabilities, the Service will adopt the Core and Essential Standards for Supporting People with Profound and Multiple Learning Disabilities (Doukas et al, 2017) as a tool to inform its service delivery and check the right measures are in place for the service user.

Where Continuing Health Care (CHC) funding responsibility has been agreed, or where joint funded complex care packages such as S117 aftercare arrangements apply, the Service is expected to:

- Facilitate specialist and community care assessment and care/treatment plans
- Support the completion of any specialist assessments
- Develop detailed individual client-level and service-level specifications
- Undertake a monitoring and service review/assurance function role, recording any key risks and issues.
- Follow protocol appropriately e.g. the CHC Protocol.

Key Partnerships Include…
Health Services; CSU/CCG; Advocacy; Client Affairs Team; Brokerage; Social Care Services; Community Volunteer Services; Support Providers

People with Learning Disabilities who Also have a Mental Health Diagnosis or Behaviour that Challenges

The Service will provide specialist service for adults who present with a learning disability with additional history of severe and enduring mental illness; emotional problems, long standing emotional distress, vulnerability and abuse. The role of specialist or Approved Mental Health Practitioners (AMHPs)/ social supervisors and Psychiatrists in the Service will be crucial in the support for these individuals and where possible, safely maintaining people in a community setting.

The Service will offer timely, specialist support and consultancy to learning disabled users and their carers for a range of complex and severe challenging behaviours, dementia and serious offending behaviour. In

addition to involvement in the promotion of good mental health, the Service will play a central role in hospital discharge planning and the Care Programme Approach and Transforming Care pathways. The provision of specialist education, consultation and advice are key aspects of such work.

The Service will ensure people with learning disabilities with behaviour that challenges are able to receive urgent mental health care when required, leading to a specialist mental health assessment where necessary within 24 hours or the next working day.

The Service will follow the guidance at laid out in *Positive and Proactive Care* guidance (DOH, April 2014), on reducing the use of restrictive physical interventions. This will ensure the Service uses day-to-day practices that:

- Are based upon Positive Behaviour Support
- Ensure that services provide strong leadership, assurance, accountability
- Are transparent about both the care they provide and when restrictive practices are used
- Provide effective monitoring and oversight through CQC and local professional/service inspections
- Support effective medication management (e.g. participation in the STOMP Project and advising on appropriate use of antipsychotic medications and dosage).

It is expected that most people's health needs will be able to be met in community settings and only a small number of people should need to access specialist in-patient beds appropriately. It is expected that the Service will work in partnership with Mental Health Trusts.

When a service user needs admission to in-patient services for more intensive help than can be provided in the community, the Service should offer time-limited active assessment, care and treatment, and links in with other services to enable a return to the community as soon as possible. For those with mental health or forensic presentations, support should be formalised with specialist mental health services and planning around rehabilitation in place.

While admitted to crisis centres, the Service should support people with learning disabilities and their carers/support staff to:

- be clear how long they will stay in an in-patient unit or emergency respite resource
- understand what their rights are
- feel supported and safe, ideally with those who are familiar to them.
- be offered assessment and treatment and effective care co-ordination
- know who is in charge to make sure things get done
- be helped to return home as soon as possible.

Where people are placed away from their own locality, it is important that the Service regularly reviews placements in order to ensure it is still safe, effective and appropriately meets the service user's needs.

The Service is expected to work proactively in a multidisciplinary way with a forensic cohort e.g. those who are released from secure settings but also those who are at risk of offending, to promote positive behaviours and reduce the risks of re-offending. Further work will be developed around this cohort and pathway within the first year of the contract.

13. TRANSFORMING CARE PROGRAMME

As part of the National Transforming Care Programme (TCP) each CCG is required to keep "a dynamic risk register" of those who are either in an Assessment and Treatment Unit or secure setting who have a diagnosis of LD and/or autism who present with deteriorating mental health or behaviour which is challenging. This register will be reviewed regularly and the Service is expected to collaborate with this.

A Care and Treatment Review (CTR) is triggered by any staff and is organised by the commissioner; if they have been admitted or are considered to be at risk of admission. The local policy will reflect the national criteria for consideration of deteriorating behaviour, but often clinical judgement is paramount in these cases.

The Service will work with the LD commissioner to identify service users aged 14+ years, with LD and autism/challenging behaviours which are at risk of admission to an Acute Treatment Unit or acute mental health ward. These details would be held on the admission avoidance/at risk register and risk rated as per local protocol. Staff in the Service will be aware of and follow the protocol to identify deterioration and advise accordingly.

The Service is required to support the Joint Commissioner for Learning Disabilities, the CCG and report to NHS England to meet standards, targets and areas for improvement relating to the TCP including:

- Care and Treatment Reviews (CTRs) for all patients who did not have a confirmed discharge date and discharge plan in place;
- The fixed-term recruitment of strategic case managers by NHS England, to liaise with and monitor CCG planning and progress; and
- The requirement for CCG Transforming Care leads to submit fortnightly reports detailing the current status and discharge planning for their patients.
- Medicines and prescribing for people with LD
- Support to maintain a local dynamic risk register.

It is expected that staff in the Service will be aware who is on the register and if there are changes or new additions they discuss with the responsible commissioner, document and participate in the CTR and subsequent action planning in a professional and timely manner.

Staff from the Service are required to attend the monthly admission avoidance meetings to discuss service users at the request of the LD commissioner and develop action plans.

Positive Behaviour Support

Positive Behaviour Support (PBS) is a multi-layered framework for improving the quality of life of people with learning disabilities and/or autism whose behaviour challenges services. The focus is upon the person and others with whom the person has a close and significant relationship.

The Service shall adhere to the following standards developed in relation to Positive Behavioural Support (PBS):

1. The service evidences how the PBS values base informs their practice
2. The service evidences that they know each person they support and can match that support with goals that are important to the person and their families
3. The service evidences that each person is supported to communicate effectively
4. The service evidences that each person is supported to make choices, and participate in meaningful activity
5. The service evidences that the physical, emotional and psychological health and wellbeing of each person is supported and promoted
6. The service evidences that they actively seek the involvement of family, friends and wider community for each person they support
7. The service evidences that people feel safe and secure, valued and respected, in predictable and stable environments

The Service will co-develop positive behaviour support plans with the individual, families and the support partners where appropriate. This will identify triggers and actions required to enable and manage risks and be followed by support staff working with the individual.

The Service will be compliant with the PBS Competency Framework - http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-

Framework-May-2015.pdf

Key Partnerships Include…
Mental Health Services (including acute and rehabilitation services), Court Liaison and Diversion schemes, Social Care providers; Specialist Forensic Services, Probation, Ministry of Justice representatives; support networks

14. SAFEGUARDING

Outcomes:

People feel safe

People are free from physical and emotional abuse, harassment, neglect and self-harm

Safeguarding is everybody's responsibility. All staff will undertake mandatory safeguarding training relevant to their role and duties. Any concern about a child or adult at risk must be escalated and discussed as soon as practicable with a senior member of the team.

The Service must reflect best practice and responsibility, protecting the individual with due regard to vulnerability and safety, ensuring that safeguarding practice is robust and that the safeguards e.g. afforded by advocacy and the Mental Capacity Act, are fully met.

All practitioners in the Service should take the lead in managing positive interventions that prevent deterioration in health and wellbeing; safeguard people at risk of abuse or neglect, or who are subject to discrimination, and to take necessary action where someone poses a risk to themselves, their children or other people.

The Service must take an outcomes-focused, person-centred approach to safeguarding practice, recognising that people are experts in their own lives and working alongside them to identify person centred solutions to reduce risk and harm. In situations where there is abuse or neglect or clear risk of those, social workers must work in a way that enhances involvement, choice and control as part of improving quality of life, wellbeing and safety.
The Service shall:

- Comply with and support the delivery of Pan London Adults Safeguarding Procedures, timeframes and operate under the Council's multi-agency protocol.
- Deliver the requirements of the Safeguarding Adults Board, including ensuring appropriate representation.
- Support the Local Authority in delivering the requirements of the annual Safeguarding Adults Return.
- Deliver the requirements of the Mental Capacity Act, Care Act and the associated code of practice, including DOLS.
- Maintain an effective interface between Adults and Children's services, by supporting the delivery of the SEN reforms which extend the responsibilities of transitions to the age of 25.
- Ensure the delivery of quality outcome measures.
- Enable the participation of service users, family members, carers and advocates in safeguarding processes.
- Work in partnership with other organisations (e.g. those providing care and support, and host boroughs) as part of safeguarding approaches.
- Ensure the effective budget management and note that local authority resources might not be fixed due to austerity.
- Inform the CCG of any issues relating to placements and support packages for health care funded clients

Key Partnerships Include…

The Police, Safeguarding Adults Services; Advocacy; Judicial representatives; Children & Families Services

15. CONTINUING HEALTH CARE (CHC)

The National Framework for NHS Continuing Healthcare and funded Nursing Care (DH 2007, revised 2009; 2012; 2018) sets out the principles and processes for the implementation of NHS Continuing Healthcare & NHS funded-nursing care and it provides national tools to be used in assessment applications and for Fast Track cases. The Service is expected to adhere to these processes and principles.

Principles

1) People will have fair and equitable access to NHS funded continuing healthcare and have a positive experience of the process.
2) Decisions about eligibility will be transparent for people, their carer/family and partner agencies.
3) Informed consent will be obtained and if the person lacks capacity a 'best interests' decision will be taken on their behalf. No third party can give or refuse consent on behalf of a person who lacks capacity, unless they have valid and applicable Lasting Power of Attorney for Welfare or have been appointed as a Deputy by the Court of Protection for Welfare only.
4) Health and social care professionals will work in partnership with person and their carer/family throughout the process and adopt a person-centred approach.
5) The person and their carer/family will be provided with information (including easy read) to enable them to participate fully in the process; reasonable adjustments will be made as appropriate.
6) Advocacy support will be offered when appropriate to help people through the process.
7) At least two professionals from different disciplines will complete the Decision Support Tool.
8) Assessments and eligibility decisions should be undertaken within 28 days of the completion of the CHC Checklist and every effort will be made to ensure that people receive the care they require in the appropriate setting without unreasonable delays.
9) Personal Health Budgets will be the default delivery model for all NHS Continuing Healthcare funded home care.
10) The outcome is clearly communicated in an accessible format and in writing for the individual.

The Case Coordination role can be held by an individual from differing professional backgrounds and a multi-disciplinary team used to ensure:

- A fully evidenced decision
- A holistic assessment which can then lead to a clearly defined package of care
- Joined up working which reduces disputes between statutory organisations.

All practitioners in the Service should have good knowledge and understanding of the CHC Framework, appropriate CHC Tools, local processes and the individual. The Service will ensure proportionate completion of the NHS Continuing Healthcare Checklist, ensuring that resources are directed towards people who are most likely to be eligible for CHC. The Service should ensure accurate scoring of CHC checklists.

If the checklist indicates a need to carry out a full assessment of eligibility for NHS continuing healthcare, the Service will ensure this assessment is followed up appropriately by completion of a Decision Support Tool and a decision made within 28 days of City and Hackney CCG receiving the Checklist.

Relevant documentation e.g. completed checklists or Fast Track Tools, should be forwarded to CHCCG by the Service for monitoring purposes and future reference.

Placement details including provider, support package and a breakdown of costs together with panel date must be forwarded to the CHC co-ordinator for the CCG.

A local CHC Protocol is currently being developed and, once agreed, the Service is expected to follow this.

NHS Funded Nursing Care (FNC) -
In some cases, the need for care from a registered nurse may need to be determined following a nursing needs assessment by the Service. This assessment will specify the day-to-day support needs of the person and the outcome will be used to assess whether they are eligible for FNC.
The Service is expected to follow The Department of Health's Guidance around FNC and liaise with Brokerage and the CCG as appropriate e.g. completion and submission of relevant form to the CCG to support eligibility, placement and payment arrangements.

16. SERVICE USER INVOLVEMENT

Outcomes:

People with learning disabilities and their carers are satisfied with the Service.
Carers report that they have been included or consulted in discussion about the person they care for.

The Service will ensure and demonstrate that service delivery is informed by service users and carers at every level e.g. at an individual planning level and service direction at a strategic level. The Service will engage service users to place their voice, aspirations, and interests at the heart of service management and delivery. Engagement should be flexible and could include, but is not limited to, user reported outcomes; service user led meetings; 1:1 interviews; service user feedback, participation in staff recruitment.

17. PROCESSES AND PROCEDURES

The Service will make sure there are effective and efficient processes and procedures in place to ensure it can deliver on the outcomes and objectives in a sustainable way, whilst ensuring there is a clear and smooth transition for the service user in their journey through the service.
Delivery shall be in line with health and social care legislative requirements and agreed Council and/or NHS protocols.
The Service must ensure information is in accessible formats for service users (e.g. Easy Read).

17.1 The Front Door:

The Service will be able to demonstrate clear means of access to the Service that is responsive in a timely manner. There will be clear lines of communication enable people with learning disabilities to get the right support at the right time.
In all instances consent should be sought from the service user and guided by the Mental Capacity Act, ideally at the time of the referral or soon after for their engagement with the Service

The Service will create an assessment process which can:
- Identify need and outcomes for individuals referred (including for those people deemed to have ineligible needs).
- Facilitate access to services where necessary
- Act as a single assessment so the individual does not have to keep repeating their story
- Be shared with the individual

Where all or some of a person's needs do not meet the eligibility criteria, or where an individual has no eligible needs, they will nevertheless be offered advice and information about:
(a) what can be done to meet or reduce the needs;
(b) signposting to other appropriate services where needed.

The Service is expected to work within the following response times:

Acknowledgement of referral	5 working days
Acknowledgement/Response to query	5 working days

New adult referrals receive initial 'joint multidisciplinary comprehensive single assessment'	6 weeks of referral
Allocation of a transition to adulthood social worker for transition to adulthood cases	By the individual's age of 16
Completed assessments and decisions regarding eligibility to adults' services for transition to adulthood cases referred to service	By the individual's age of 17
CHC Assessment and eligibility decision following completion of the CHC Checklist	28 days

Carers will be offered a Carer Assessment if needs are identified as part of the assessment process and as per local guidelines.

17.2 **Input and Support**

The Service will develop a process and tools to ensure that service users and their carers are at the heart of assessment, treatment and support planning and review. Practitioners must be able to develop personalised assessment and care plans that enable the individual to determine and achieve the outcomes they want for themselves.

Support and treatment plans need to demonstrate involvement of service users and where appropriate their carers and include clear, agreed outcomes and goals for that service user.
An accessible copy of such plans should be given to the service user in line with the Accessible Information Standard ('DCB1605 Accessible Information').

Individual support plans and reviews should be shared with the support provider in a timely manner to enable clarity around provision.

The roles and needs of informal or family carers should be recognised and holistic, systemic approaches used to support individuals and carers.

It is important that the Service develops knowledge and good partnerships with community resources to work effectively with individuals.

Input and support should be delivered by the Service in a coordinated, multidisciplinary and joined up way.

Support should be consistent with clear points of contact such as a named worker (SCIE, 2018 https://www.scie.org.uk/social-work/named-social-worker).

Effective processes should be in place with appropriate governance to ensure individual need and packages are monitored and clear decision making recorded. This should include reporting on financial implications.

17.3 **Leaving the Service**

The Service should ensure positive move-on for service users is at the heart of its work, supporting people with learning disabilities to achieve their goals, where possible their full potential and reduce the need for a specialist service.

It is important that service users and their carers have clarity around signposting if needed; methods and resources to sustain their independence from the Service and a means of contacting the Service should needs change; this could include an information pack that identifies what goals have been achieved and contacts where the service user can go for help if needed.

Criteria for closures to the ILDS:

1. Intervention not accepted by service user or carers*
2. Service user has moved independently out of borough
3. Death of a service user
4. Other reasons following discussion by the multidisciplinary team.

**Caution should be taken to ensure that carer is acting in best interests of the service user and service user mental capacity considered.*

A closure/discharge report will be written by the designated named worker or professional involved. This will include recommendations for further support if applicable and with signposting and advice for future intervention and details for making a re-referral. This will be sent to the client and a copy sent to the GP.

Clients Moving out of the Borough

When clients are moved out of Hackney with a service commissioned by LBH, Adult Social Care will remain responsible for care. Transfer of health care will be to another Community Learning Disabilities Service and primary care services within the client's new area within a month of the client's move.

There will be a transfer period of a maximum of six months following the move whereby health professionals from the Service will continue to offer advice and support. Once the transfer process is complete the client will be closed to the health professionals of the Service, though advice and support can be provided by health care professionals to social work colleagues.

For clients who move voluntarily out of borough, they will become an 'Ordinary Resident' of the area in which they move to. The Service will no longer commission services but will liaise and refer to local services where necessary including local Learning Disabilities Services and provide a handover.

An Out of Borough Protocol will be developed to support with procedures when service users move out of Borough and the Service is expected to adhere to this.

18. STAFFING

The Service is expected to ensure there is suitable staffing in place to ensure safe and effective delivery of the Service.
The Service will ensure appropriate guidance is followed with regards to the specialist nature of service provision by the professionals in the Service (e.g. as in Safe, Sustainable Protective Staffing – An improvement for learning disabilities services; National Quality Board, 2018).
The Service is responsible for ensuring staff are appropriately qualified, meet relevant professional requirements, undertaking relevant checks and that staff are suitably trained to deliver the service.

All new staff and students to the team, including agency and bank staff, will receive a local induction.

Staff shall demonstrate ability to:

- Provide person-centred bespoke support
- Ensure well-being and promote human rights
- Build community capacity by promoting independence
- Reduce unnecessary hospital admissions

- Ensure consistency of care
- Use of best and evidenced based practice
- Knowledge of innovative and emerging practice in the field of learning disabilities.
- Reflective practice and engagement in continuous professional development
- Fulfil their statutory responsibilities
- Provide a holistic approach to assessing need and providing support.
- A commitment to multidisciplinary, interagency and partnership working.
- Deliver an outcome focused and enabling approaches.
- Deliver an ethical and equitable service.
- Effective communication skills including those with special communication needs. This includes adherence to the five good communication standards:

> 1. There is a detailed description of how best to communicate with individuals.
> 2. Demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.
> 3. Staff value and use competently the best approaches to communication with each individual they support.
> 4. Create opportunities, relationships and environments that make individuals want to communicate.
> 5. Individuals are supported to understand and express their needs in relation to their health and wellbeing.
>
> (Royal College of Speech and Language Therapists, 2013)
> https://www.rcslt.org/news/docs/good_comm_standards

All staff must have supervision, every four to six weeks in line with professional and local standards; this must be documented. Informal supervision should be undertaken as and when required.

Staff who hold professional registration working within the Service must adhere to relevant Professional Standards & Codes of Ethics and Continuing Professional Development requirements.
Each discipline in the Service will be responsible for maintaining up to date practice within their specialism and in the context of learning disabilities specialist support.

Practitioners in the Service will have, or have a commitment to develop a core set of skills, such as:

- Assessment of learning disability need and delivery of specific interventions.
- Knowledge and understanding of the Mental Capacity Act (MCA) and Code of Practice and be able to apply these in practice e.g. mental capacity assessment.
- Communication Skills and Strategies including those who have significant communication difficulties.
- Dysphagia awareness
- Health improvement and enablement approaches
- Care Co-ordination
- Advocacy
- Clinical Leadership

- Person Centred Approaches
- Ability to plan, grade and deliver appropriate service user goals and outcomes.
- Ability to be reflective and a commitment to professional development.
- Proactively working and engaging with others
- Awareness of Mental Health Legislation and Basic Mental Health Screening
- Awareness of Clinical Governance and ability to undertake audit
- Autism Awareness
- Epilepsy awareness
- Risk assessment
- Ability to work autonomously within community and other settings (lone working).
- Manual Handling

Practitioners need to be able to work effectively with individuals and their families using professional approaches, good interpersonal skills and emotional intelligence, developing relationships based on openness, transparency and empathy.

Staff must work effectively and confidently in partnership with professionals in inter-agency, multi-disciplinary and inter-professional groups particularly at the interface between health, children and adult social care and the third sector.

Professionals in the Service should play an active role in strategic planning, care package oversight, supporting wider commissioning.
They should contribute to developing awareness of personalisation and outcome-based approaches to improving people's lives.

Leadership
There will be clear lines of responsibility and accountability with effective clinical, management and leadership structures in place.
All staff should demonstrate a degree of leadership throughout the Service.

19. QUALITY

The Service will ensure it delivers a high quality, seamless service and will be able to demonstrate this.
It will maintain appropriate performance information to enable the Local Authority, CCG and ELFT to meet statutory reporting requirements, including:

- The statutory annual return, financial return; returns for the Service.
- Any additional Local Authority requested performance measures as agreed on a periodic basis.
- The ASCOF requirements as listed in Appendix

Key Performance Indicators (KPIs)

The Service is expected to demonstrate how it is delivering the four local outcomes see Appendix 2.

A small number key performance indicators (KPIs) have been selected with a focus on outcomes that are detailed in the service specification. These are indicators only and the focus should remain on outcomes. Our contract management and monitoring approach will require that qualitative information is used to supplement and illustrate the quantitative returns against these

KPIs. Commissioners will agree the nature of qualitative information with the provider but it is likely to take the form of simple case studies.

Commissioners will work with the provider to identify priority areas each year where appropriate. For example, the selection of which mainstream services to work with for KPI2.

KPIs will be reported on as part of contract monitoring of ILDS, undertaken quarterly and shared with the Commissioning Section 75 Board. Any targets not achieved would be subject to Commissioner review and service improvement planning. Further details on these KPIs can be found in the Appendix.

KPI		**Target**
1	80% service users achieve their goals following intervention from ILDS.	80%
2	Advice, guidance and or training delivered by ILDS to mainstream services makes a demonstrable, positive difference to accessibility for people with learning disabilities.	4 per year
3	80% of ILDS service users live in settled accommodation within the first three years of the contract.	80%
4	Having input from ILDS has made a positive difference to service users' lives.	85%
5	Safety - Service users are identified in a timely way of being at risk and risk assessed appropriately. All service users who are identified as being at high risk have a risk management plan and the service can demonstrate proactive steps are taken to mitigate risks.	100% of those in High Risk

For activity data for the service please see Appendix 3

The Service will ensure there is a suitable framework and mechanisms in place to assure appropriate care governance. This will include assurances to external inspectors such as the Care Quality Commission.

Continuous Service Improvement

The Service needs to continually develop its capacity to respond to local needs and adapt the skills base to match changing demand. It should play a significant leadership role in coordinating and demonstrating action in line with the national and local joint Health and Social Care learning disabilities standards and frameworks.

The Service will proactively engage in quality improvement of the Service. This will include but is not limited to regular audit (such as clinical audits); seeking and responding to feedback from service users, carers, complaints and compliments; keeping up to date with relevant legislation.

Quality Assurance and Monitoring Requirements

The Provider must have a quality management system in place to ensure internal control of quality and consistency of practice and be committed to a process of continuous service improvement. To demonstrate continuous improvement, the Provider will be required to:

- Submit activity and performance data to the Authority as detailed in this specification;
- Develop and agree a service improvement plan with the commissioning authority to address any underperformance identified as part of the contract monitoring and review processes;
- Ensure that the views of Service Users and families/carers are actively sought and used to continuously improve the quality of support provided and demonstrate how service users who have received support are used to influence service improvements;
- Cooperate in the provider concerns process.

Key performance indicators, performance indicators, and outcomes will be reviewed on a quarterly basis throughout the life of the contract.

The activity and performance data should be submitted to the commissioning authority via a Service workbook within two weeks of the quarter end. The format of the workbook will be finalised during the first six months of the service starting and will link in with the commissioning quality assurance framework. The Council may spot check and audit Service documents and provision to ensure contract compliance and quality assure practice throughout the life of the contract.

Throughout the lifetime of the contract, the Service will hold quarterly quality assurance and monitoring meetings with key stakeholders including but not limited to the Council's Commissioning Team. On an annual basis, the Service will be subject to quality, function, and performance review.

20. INFORMATION GOVERNANCE AND CONFIDENTIALITY

The Service is expected to adhere to the Trust's and Hackney Council's policies and procedures in relation to record keeping, patient confidentiality, with due regard to the Mental Capacity Act 2005 and Pan London Safeguarding Adults procedures, the Care Act 2014. All contacts with service users will be recorded on the appropriate database. Correspondence with other health professionals will follow appropriate guidance e.g. ensuring GPs are kept informed with appropriate documentation.

Permission to Use and Share Information forms will be completed with all service users and their families/carers and copied to the relevant database/s. The Service will respect service users' wishes on confidentiality as far as is possible and adopt the approach of nothing about us without us, i.e. ensuring users have copies of relevant correspondence about them.

There are some exceptions to the Duty of Confidentiality where permission is not required:

- Where disclosure is required by law (legislation or court order).
- Where the disclosure is in the public interest e.g. to protect a member of the public from harm (including carers and family members), or to protect the patient.
- Where there is an 'overriding concern' about the patient's safety or the safety of others
- If the service user is deemed not to have capacity under the Mental Capacity Act, 2005 information may be passed to their carer if it is in the patient's best interest.
- Where possible this will be communicated to the patient and the decision recorded.

Service Users wishing to access their records will need to follow the steps set out in the Trust's Access to Records policy or the Council's Records Management Policy.

All staff are expected to complete mandatory training in Information Governance.

All staff must follow the Information Governance and IMT Security Policy where there has been a misuse of personal information in relation to the person's health records. Where a breach has occurred in relation to adult social care or health records, the relevant process should be followed. All Trust guidance regarding Duty of Candour must be followed.

CONFIDENTIALITY REVIEW

The Service must adhere to the Council's Confidentiality Policy. This sets out areas where information will be shared and under what circumstances and serves as a record of their consent within these areas. In other cases, the residents' consent must be obtained as the need arises. This includes passing information to other agencies.

The Confidentiality Policy must set out the Council's requirements concerning its access to the Provider's records relating to service users. The Provider must ensure that everyone engaged in the Service with access to personal information understands their responsibilities and can demonstrate evidence of compliance with their procedures. This includes employees, volunteers, self-employed workers, consultants or contractors.

The procedure must comply with the Data Protection Act 2018 and any contractual requirements. It should also cover accuracy and consistency of record keeping, security of data, information to service users, and consent for disclosure requirements and identify responsible persons. Contracts of employment, volunteering agreements, contracts with consultants and others should include a clause making explicit the person's responsibilities for confidentiality and data protection. The policy should also cover actions to be taken if a staff member breaches confidentiality.

The Provider Confidentiality Policy must be aligned to the principles laid out in the 2013 Caldicott review of information sharing in the health and social care system:

- Justify the purpose(s)
- Don't use personal confidential data unless it is absolutely necessary
- Use the minimum necessary personal confidential data
- Access to personal confidential data should be on a strict need-to-know basis
- Everyone with access to personal confidential data should be aware of their responsibilities
- Comply with the law
- The duty to share information can be as important as the duty to protect [Service User] confidentiality

21. MANAGEMENT OF CASE FILES

All client and carer information will be stored in line with the Trust's and Council's policies regarding Information Governance. Staff should have access to both the ELFT and LBH intranets to view the policies.

22. IT REQUIREMENTS

The service will ensure that all staff have and comply with the following:

- Providing and maintaining IT equipment so that is fit for purpose.
- Use all of the Council's and the Trust's management information systems and processes or any system that might be developed in the future.
- Compliance with LBH and Trust recording protocols and reporting requirements.

23. INCIDENT MANAGEMENT

All incidents are dealt with the Council's Incident Reporting procedure. All staff are expected to report incidents and near misses via LBH's reporting procedure. All health-related incidents will need to be reported via the Trust's Datix system an in line with Trust protocol.

All incidents or near misses should be discussed with a manager or senior member of the staff. The member of staff reporting the incident must ensure the information in the incident report is factual, accurate, comprehensive and timely.

The guidelines on timeframes for reporting incidents and near misses is as soon as practicable (immediate remedial action to deal with the incident is likely to take priority over completion of an incident report) and always within 24 hours of the incident. Serious incidents should be reported within two hours.

Learning from all incidents and near misses will be reviewed as part of lessons learnt discussions within clinical governance meetings and team meetings.

24. HEALTH AND SAFETY

The nominated Risk Officer will lead on all aspects of health and safety under the supervision of the appropriate manager. This includes the annual health and safety audit and following up any outstanding actions. The manager and Risk Officer will also lead on building issues and escalate any issues to Estates and Facilities.

The Service staff will adhere to Hackney's Lone Worker Policy and Lone Working Procedures can be found on the staff intranet.

25. RISK MANAGEMENT

The service will manage clinical risk in line with the Trust's Clinical Risk Assessment and Management policy including the completion of a risk assessment tool for all clients referred for interventions. Specialist risk assessment tools and risk screening tools should also be used where applicable.

Staff will update risk assessments when required i.e. any change in presentation, and as part of a scheduled review. Risks are to be discussed with the team manager and lead clinician where appropriate. Risk assessment and management will be discussed within the MDT meetings, peer reviews and during supervision.

Staff must update the risk status of patients on the note's system/s, this includes adherence to the TCP protocol.

26. EQUALITY AND DIVERSITY

Hackney is a culturally diverse borough and the Service must be culturally sensitive. It must have an Equality and Diversity Policy that can be provided on request. The policy must cover the ways in which the Service will promote equality of opportunity and prevent discrimination in relation to those protected characteristics outlined in the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership

- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Information on these must be gathered as a matter of course so they can be reported on.

The Service will ensure, at a minimum, the following good practice is followed:

- Recruitment, Selection, and Retention policies are appropriately developed to ensure that the workforce is diverse and the workplace is inclusive;
- All staff will be required to attend Equality and Diversity training to equip them with the skills and knowledge to carry out their tasks in a culturally sensitive, non-discriminatory manner;
- Anti-discriminatory, pro-equality, and confidentiality messages are prominently displayed with clear actions for Service Users, staff and others if they feel these have been breached;
- Complaints are monitored and corrective action is taken as necessary;
- All residents who receive support from the Service have access to the appropriate communication resources for their needs, including translation, interpreting services, sign language and braille;
- The Service User population will be monitored by protected characteristics to identify anomalies against the general population and gaps in provision.

The Service will make available to service users and/or families/carers who use the Service a copy of its Equality and Diversity Policy at commencement of the service. Likewise, a copy will be made available for staff at commencement of employment.

The Service must align to LB Hackney's Equal Opportunities and Cohesion Policy Statement and Equal Opportunities Policy. https://www.hackney.gov.uk/media/2859/Equality-and-cohesion-policy/pdf/Equality-and-Cohesion-Policy

27. LOCATION OF THE SERVICE

The service shall be based at:
Hackney Service Centre
1 Hillman Street
London
E8 1DY
However, the Service will have some clinical services at St Leonards, Nuttall St, N1 5LZ.
It will also ensure service delivery in a range of settings such as service users' homes and other community settings.

28. APPLICABLE SERVICE STANDARDS

The Service is expected to be compliant with the following legislation and work towards best practice as identified in the listed applicable service standards.

The Care Act (2014) Support delivery of the statutory requirements of the Care Act: - Meet the new statutory obligations around Carers, by ensuring their involvement in the development and delivery of services, and conducting Carers assessments;	● Health Equalities Framework (HEF) ● Building the Right Support Service Model 2015 (Transforming Care) ● DH (July 2013) Six Lives: Progress Report on Health for People with Learning Disabilities. London, DH ● DH (December 2012) Winterbourne View Review Concordat: Programme of Action ● Hoghton, M., Turner, S and Hall, I (October

- Delivery of a whole family approach to transitions; - Delivery of the Think Local Act Personal agenda - Delivery of the Personalisation agenda. Mental Capacity Act (MCA, 2005) and Code of Practice The Autism Act The Children and Families Act (2014) The NHS Long Term Plan (2019)	2012) Improving the Health and Wellbeing of People with Learning Disabilities. An Evidence Based Commissioning Guide for Clinical Commissioning Groups (CCGs) Learning Disabilities Observatory, RCGP, Royal College of Psychiatrists ● Learning Disability Services Inspection programme: National Overview (June, 2012). CQC ● Emerson, E et al (2012) Health Inequalities & People with Learning Disabilities in the UK: 2012 ● Turner, S and Robinson, C (2011) Health Inequalities and People with Learning Disabilities in the UK: 2011. Implications and actions for commissioners. Evidence into Practice Report No 1 (revised) Learning Disabilities Observatory ● Parliamentary and Health Service Ombudsman (March 2009) Six Lives ● DH (2009) Valuing People Now: a new three-year strategy for people with learning disabilities. London, DH ● DH (2009) Improving the health and wellbeing of people with learning disabilities. Best Practice Guidance. London, DH ● CQC (2009) Position statement and action plan for learning disability 2010-2015. CQC London ● Michael, J. (2008). Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. Healthcare for All ● Mencap (2007) Death by Indifference ● Mencap (2004) Treat me right! Best healthcare for people with a learning disability ● NPSA (2004) Understanding Patient Safety Issues for people with learning disabilities ● Department of Health (2001) Valuing People: A New Strategy for Learning Disability for the 21st Century. London, DH

The Service should ensure it maintains awareness of relevant future legislation, standards and plans that may affect people with learning disabilities so it can apply them appropriately.

APPENDIX I

Outcomes Framework for the Service

Domain 1. Preventing people from dying prematurely **NHS Outcomes Framework Domain 1 (Department of Health, 2013a), Public Health Outcomes Framework Domain 4 (Department of Health, 2014)**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Potential years of life lost from causes considered amenable to healthcare	Reduce premature mortality from the major causes of deaths in people with a learning disability	• Supporting primary, secondary and specialist health services with reasonable adjustments, accessible communication • Healthcare coordination for people with complex and multiple health needs • Facilitate access to mainstream healthcare services • Healthcare advocacy Reducing premature death in adults with a learning disability and serious mental illness/challenging behaviour • Facilitate access and joint working with generic, specialist and in-patient mental health services and out-of-hours/emergency mental health services so that skills, expertise and resources from these services could be utilised • Ensure and support monitoring of physical health of people with a learning disability and mental health/challenging behaviour • Where appropriate, joint working with community paediatric services
Domain 2. Enhancing quality of life for people with long-term needs and improving the wider determinants of health **NHS Outcomes Framework Domain 2 (Department of Health, 2013a), Public Health Outcomes Framework Domain 1(Department of Health, 2014)**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Quality of life related to health and social care for people with a	Ensuring people feel supported to manage their condition Improving functional ability in people	• Person-centred planning of care and support needs • Ensure self-determination by providing opportunities to make

learning disability and long-term conditions	with a learning disability and long-term conditions Reducing time spent in hospital Enhancing quality of life for carers Enhancing quality of life for people with a learning disability and mental illness/ challenging behaviour Enhancing quality of life for people with a learning disability and dementia	choices • Enhancing independent living skills and activities of daily living • Enhance access to appropriate day and leisure opportunities • Health promotion • Hospital in reach services • Healthcare coordination for people with complex physical healthcare needs • Ensuring access to information and advice about support available, including respite care • Ensuring access to appropriate day opportunities • Managing people in the community or appropriate setting • Skilled long-term support to enable people to live as independently as possible in the community • Improved access to healthcare services • Ensuring people with dementia receive a timely diagnosis and the best available treatment and care with a clear pathway
	Ensuring care and support is more personalised so that support more closely matches the needs and wishes of the individual, putting people in control of their care and support. Asking people with learning disabilities about the extent to which they feel in control of their daily lives.	• Enabling people with learning disabilities have as much control over daily life as they'd like • Enabling people manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. • Supporting adults aged over 18 / carers to receive self-directed support • Enabling adults and carers to receive direct payments
Proportion of adults with a primary support reason of learning disability support in paid employment	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation. NB: it refers to the proportion of adults with a learning disability who are "known to the council" (those adults of working age with a primary support	• Enabling and supporting people with a learning disability (of working age) into and sustaining paid employment through partnership working • Supporting workplace accessibility.

	reason of learning disability support who received long term support during the year in the settings of residential, nursing and community but excluding prison), who are recorded as being in paid employment.	
Proportion of adults with a primary support reason of learning disability support who live in their own home or with their family	'Living on their own or with their family' is intended to describe arrangements where the individual has security of tenure in their usual accommodation, for instance, because they own the residence or are part of a household whose head holds such security.	• Support people with a learning disability to live in stable and appropriate accommodation. Situations included within the scope of 'living on their own or with their family': - Owner occupier or shared ownership scheme; - Tenant (including local authority, arm's-length management organisation, registered social landlord, housing association); - Tenant – private landlord; - Settled mainstream housing with family/friends (including flat sharing); - Supported accommodation/ supported lodgings/supported group home (i.e. accommodation supported by staff or resident caretaker); - Shared Lives Scheme (formally known as Adult Placement Scheme); - Approved premises for offenders released from prison or under probation supervision (e.g. probation hostel); - Sheltered housing/extra care housing/other sheltered housing; and, - Mobile accommodation for Gypsy/Roma and Traveller communities.
Proportion of people who use services and carers, who reported that they had as much social contact as they would like.	Tackling loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family.	• Support with developing social networks and support. • Enabling people with a learning disability and their carers to participate in their community and community groups.
Domain 3. Helping people recover from episodes of ill health or injury, and delaying or reducing the need for care **Adult Social Care Outcomes Framework Domain 2 (Department of Health, 2013b), NHS Outcomes Framework Domain 3 (Department of Health, 2013a), Public Health Outcomes Framework Domain 2 (Department of Health, 2014).**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)

Delaying and reducing the need for care and support. Preventing admissions to hospital or permanent admissions to residential and nursing care homes because of placement breakdowns	Improving outcomes from planned and short term interventions	• Single care pathway, early diagnosis and intervention • Provision of effective short-term services that aim to enable people and promote their independence • Multidisciplinary team intervention • Use of care programme approach framework where appropriate • Facilitate discharge from the hospitals • Enhanced input to prevent placement breakdowns • Ensure access to primary care through health advocacy and liaison • Developing and delivering person centred outcomes.
	Helping people with a learning disability recover their independence after illness or injury	• Healthcare coordination for people with complex physical healthcare issues • Supporting primary healthcare, rehabilitation and enablement services in providing care to people with a learning disability • Supporting social care providers in making reasonable adjustment to ensure proper community integration
	Reduce the delayed transfer of care from hospitals and reduce delays that are attributable to adult social care	• Effective multi-agency working and coordination to prevent delayed discharges • Active involvement and coordination in the discharge planning process between community and in-patient services • Working jointly with commissioners to ensure clear care pathways between mainstream and specialist services
Domain 4. Ensuring that people have a positive experience of care **Adult Social Care Outcomes Framework Domain 3 (Department of Health, 2013b), NHS Outcomes Framework Domain 4 (Department of Health, 2013a)**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Patient experience of care and support services including	Patient experience of out-patient care	• Reasonable adjustments to improve access

healthcare services		• Accessible communication • Training to improve staff competency in dealing with people with intellectual disability • Person-centred care
	Patient experience of hospital care and accident and emergency services	• Reasonable adjustments to improve access • Accessible communication • Provide training • Liaison with acute hospital services
	Improving access to primary care	• Supporting primary care with health action planning • Supporting primary care with reasonable adjustment, accessible communication, etc.
	Improving the experience of care at the end of life	• End-of-life care pathways for people with intellectual disability based on national guidelines
Proportion of carers who report that they have been included or consulted in discussion about the person they care for	Improving experience of healthcare for people with a learning disability and mental illness/challenging behaviour Improving experience of transition services Improving carers' experience	• Accessible communication • Waiting times • Person-centred care and support planning • To ensure good interface between generic mental health services and early intervention and emergency services • Joint and multiagency working. • Ensure multi-agency transition care pathways • Carer involvement and engagement in service delivery and service development • Appropriate use of advocacy
Proportion of people who use services and carers who find it easy to find information about support	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.	• Supporting people with learning disabilities to find information and advice about support, services or benefits easily. • Supporting mainstream services to be accessible.
Domain 5. Safeguarding vulnerable adults and caring for people in a safe environment **Adult Social Care Outcomes Framework Domain 4 (Department of Health, 2013b), NHS Outcomes Framework Domain 5 (Department of Health, 2013a), Public Health Outcomes Framework Domain 3 (Department of Health, 2014).**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)

Patient safety incidents including those involving severe harm or death	Reducing the incidence of avoidable harm	• Ensure clinical and practice governance • Care programme approach processes where appropriate • Quality assurances through regular audits and quality improvement projects • Incident reporting and learning from incidents
	Delivering safe care to people with a learning disability in acute settings	• Health advocacy on behalf of people with a learning disability • Training of acute healthcare staff in understanding needs of people with a learning disability • Close working and liaison with acute health services
People feel safe	People are free from physical and emotional abuse, harassment, neglect and self-harm	• Ensure effective safeguarding processes in the service • Incident reporting • Active joint working between the in-patient and community services to reduce length of stay in hospital • Working with commissioners to ensure person centred care in the in-patient and community services • Liaison and joint working with other agencies (e.g. police, domestic violence unit) and other boroughs.

APPENDIX II

STATUTORY MEASURES

Statutory returns from the service reported by Performance & Innovation team:

- Safeguarding adults return
- Guardianship
- Short and Long Term Services Return
- Survey of adult social care users
- Adult Carer Experience Survey
- Deprivation of Liberty Safeguards
- Adult Social Care Finance Return

The measures include:

- 1A - Social care-related quality of life
- 1B - Proportion of people who use services who have control over their daily life
- 1I (1) - Proportion of people who use services who reported that they had as much social contact as they would like
- 1J - Adjusted Social care-related quality of life – impact of Adult Social Care services
- 3A - Overall satisfaction of people who use services with their care and support
- 3D (1) - Proportion of people who use services who find it easy to find information about services
- 4A - Proportion of people who use services who feel safe
- 4B - Proportion of people who use services who say that those services have made them feel safe and secure
- 1D - Carer-reported quality of life
- 1I (2) - Proportion of carers who reported that they had as much social contact as they would like
- 3B - Overall satisfaction of carers with social services
- 3C - Proportion of carers who report that they have been included or consulted in discussion about the person they care for
- 3D (2) - Proportion of carers who find it easy to find information about services
- 1C (1A) - Proportion of adults receiving self-directed support
- 1C (1B) - Proportion of carers receiving self-directed support
- 1C (2A) - Proportion of adults receiving direct payments
- 1C (2B) - Proportion of carers receiving direct payments for support direct to carer
- 1E - Proportion of adults with learning disabilities in paid employment
- 1G - Proportion of adults with learning disabilities who live in their own home or with their family
- 2A (1) - 1415 - Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population
- 2A (2) - 1415 - Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

KEY PERFORMANCE INDICATORS

KPI		Target	Definition	Means of Measurement
1	80% service users achieve their goals following intervention from ILDS.	80%	Anyone who has received an intervention (e.g. treatment, support package) from the service. This includes those receiving social care support only, and those preparing for adulthood.	Examples include • Outcomes/goals identified and achieved in support and treatment plans. • Patient reported outcomes measures. • Quarterly reporting. This will start from 6 months of contract commencement.
2	Advice, guidance and or training delivered by ILDS to mainstream services makes a demonstrable, positive difference to accessibility for people with learning disabilities.	4 per year	Mainstream services (i.e. non LD specific services). This will include health services to support with addressing any local health inequalities for people with a learning disability.	These services make reasonable adjustments for people with a learning disability. For example, a library, a stop smoking clinic. Updated quarterly and more detail provided in an annual report.
3	80% of ILDS service users live in settled accommodation within the first three years of the contract.	80%	Settled accommodation is as defined by ASCOF. It also includes those preparing for adulthood	Proportion living in Residential or Nursing care compared with other settled accommodation such as supported accommodation, living with family, etc. Updated quarterly and more detail provided in an annual report.
4	Having input from ILDS has made a positive difference to service users' lives.	85%	The difference should be indicated by before and after measurement indicating that something good has happened to the service user.	Standardised/ non-standardised outcome measures. E.g. Health Equalities Framework; professional specific outcome measures; quality of life measures before and after. User experience. Good news stories. Notes' audit. Quarterly reporting
5	Safety - Service users are identified in a timely way of being at risk and risk assessed appropriately. All service users who are identified as being at high risk have a risk management plan and the service can demonstrate proactive steps are taken to mitigate risks.	100% of those in High Risk	The Service will have a means of determining risk (e.g. type/ severity/ likelihood).	Examples of identification include the use of a risk register at point of assessment and review; CPA, following notification from others. Measurements for risk with appropriate procedures in place that are followed. Pan London Safeguarding procedures followed. Notes' audit. Incident reporting.

APPENDIX III

Suggested Reporting on Outcomes

INTEGRATED LEARNING DISABILITIES SERVICE CASE EXAMPLE TEMPLATE

This Case example should be completed and submitted to the Section 75 Board to demonstrate how the service has delivered on each of the key outcomes set in the service description. It should be no longer than two pages in length:

Case Identity Number:	
Client Cohort/Pathway:	
Outcome Achieved (Please Select): ▪ People with a learning disability are an active part of their community ▪ People with a learning disability are enabled to achieve independence where possible ▪ People with a learning disability have a place they call home ▪ People with a learning disability are able to access the health care they need.	
Brief Description of input:	
Evidence of multidisciplinary working:	
How you know the outcome was successfully achieved/ what difference did it make to the user?:	
Saving Made/Cost Avoidance (£):	
Practitioner/s completing the form:	
Date completed:	
Section 75 Board Submission (Select):	Q1 (April-June) Q2 (Jul-Sept) Q3 (Oct-Dec) Q4 (Jan-Mar)

APPENDIX IV

Activity Data

PI	Performance Description	Target by end of Yr. 1	Q1	Q2	Q3	Q4	Comment
1a	New adult referrals receive initial single assessment within 6 weeks of referral	95%					Quarterly
b	Number of discharges						Quarterly
c	Number of DNA						Quarterly
d	% of fully funded Continuing Health Care assessment in receipt of annual review and care plan	95%					Quarterly
e	% of new adult referrals have a completed assessment within- 12 weeks	95%					Reporting to start from Q3 in line with 12-week targets
2	% of people on Care Programme Approach (CPA) to have an up- to-date risk assessment (within 12 months)	95%					Reporting to start from Q3 in line with 12-week targets
3	% of clients have an up-to-date support plan (i.e. up-to-date within 12mths).	95%					Reporting to start for Q3 activity in line with care planning
4	% of people on the Transforming Care Risk Register and have the assessments in place (appropriate to the individual) as defined by Building the Right Support including Person Centred Care, Support and Risk Management Plan, Positive Behaviour Support Plan, Crisis/Contingency Plan and Communication Passport.	95%					Reporting in place from Q1
5	Annual quality audit measures the quality of health action plans and NICE compliance of Care Plans. BASELINE.	Audit					Annual Audit (baseline to be agreed in Q1 YR1; Audit Q1 YR2
6	% of client on medication recommended by ILDS have up to date medication review (NICE compliant) within 12mths	95%					Reporting to start from Q1 Y1
7	% of case open to ILDS have a Health Action Plan (HAP) which includes if necessary, a needs assessment/care plan in relation to bodily awareness, pain response and communication support.	95%					Reporting to start from xx
11a	Number of Clients at age 14 and above with ILDS involvement measured by: ILDS attendance at	number					Quarterly

	annual reviews/ EHCP meeting's/ transition surgeries/ LAC reviews						
b	% transition cases having an allocated ILDS transition social worker by age 16	%					
c	% all transition age cases referred to service at age 17 with completed ILDS assessments and decisions regarding eligibility to adults' services	%					
d	% complaints/ disputes/feedback from parents/ carers re: transition responded to within the Council's policy.	%					
12	% of those with antipsychotics medication review every 12 months.	95%					Year-end report (i.e. annually).
13	Number of clients in receipt of joint funding and associated costs	Number & Costs					Quarterly
14	Number of Patients on CTR	Number					Quarterly
15	Number of CTR patients with discharge plan in place	Number					Quarterly
16	Number of GP Registers validated	Number					Quarterly
17	Average time patient waited for first clinical contact	Less than 6 weeks					Quarterly
18	Number of People supported to have a health check.	Number					Quarterly
19	% of assessments for CHC that meet the 28-day decision from the CCG	80%					Quarterly
20	Number of Safeguardings – open, closed, substantiated	Number					Quarterly
21	Number of Leder, Premature Deaths, Reviews undertaken annually	4/year					Quarterly

SCHEDULE 2 – GOVERNANCE

PART ONE – OVERVIEW

1. The clinical and care principles by which the Pooled Fund will be operated will be overseen by the Integrated Commissioning Board. The Integrated Commissioning Board shall constitute committees in common of the Parties, and once the Partnership Regulations have been appropriately clarified and subject to further approval of the CCG and the Council, the Integrated Commissioning Board will constitute a Joint Committee of the CCG and the Council in compliance with the Local Government Act 1972 and the 2006 Act, which permit the creation of a joint committee.

2. The Integrated Commissioning Board represents the interests of both Parties in securing improved operation of the local health economy.

3. The Integrated Commissioning Board will set out the key priorities and principles for the Pooled Fund through which improvements to clinical and care outcomes and to financial sustainability will be secured.

4. Decisions to pool funding and management of Services or commissioning areas will be made by the Integrated Commissioning Board.

5. Decisions to deploy funds from the CCG Contingency Fund will require the written authorisation of the CCG's Chief Financial Officer.

6. The management of the Integrated Commissioning Fund is facilitated via the Pooled Fund Manager, the Finance Economy Group and the Task and Finish Group, as further set out in the Financial Framework.

7. As the Health and Wellbeing Board includes representatives of a number of organisations (including providers) who are not statutory commissioners of local health and care services, it is not appropriate to require the Health and Wellbeing Board to take decisions relating to the Pooled Fund. The Health and Wellbeing Board will however be kept informed of the performance of the Integrated Commissioning Fund.

PART TWO – TERMS OF REFERENCE OF INTEGRATED COMMISSIONING BOARD

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City of London Corporation Integrated Commissioning Sub-Committee, London Borough of Hackney Integrated Commissioning Committee, and NHS City & Hackney Clinical Commissioning Group Integrated Commissioning Committee
(known collectively as the "Integrated Commissioning Board")

Terms of Reference

Background and Authority

The City of London Corporation ("COLC") has established an Integrated Commissioning Sub-Committee ("the COLC Committee") under its Community and Children's Services Committee. The London Borough of Hackney ("LBH") has established an Integrated Commissioning Sub-Committee reporting to its Cabinet ("the LBH Committee") and NHS City & Hackney Clinical Commissioning Group ("the CCG") has also established an Integrated Commissioning Committee ("the CCG Committee"). These committees are the principal fora through which the CCG, LBH and COLC will integrate their commissioning of certain services.

This document is the terms of reference for the CCG Committee, the COLC Committee, and the LBH Committee.

The COLC Committee, the LBH Committee and the CCG Committee will meet in common and shall when doing so be known together as the Integrated Commissioning Board ("the ICB").

The COLC Committee has authority to make decisions on behalf of COLC, which shall be binding on COLC, in accordance with these terms of reference and the scheme of delegation and reservation for the integrated commissioning arrangements.

The LBH Committee has authority to make decisions on behalf of LBH, which shall be binding on LBH, in accordance with these terms of reference and the scheme of delegation and reservation for the integrated commissioning arrangements.

The CCG Committee has authority to make decisions on behalf of the CCG, which shall be binding on the CCG, in accordance with these terms of reference and the scheme of delegation and reservation for the integrated commissioning arrangements.

Except where stated otherwise (in which case the terms "the COLC Committee" and/or "the LBH Committee" and/or "the CCG Committee" or "the committees" are/is used), all references in this document to the "ICB" refer collectively to the three committees described above. The objectives of the ICB, as described below, are the objectives of the individual committees insofar as they relate to the individual committee's authority.

The members of the COLC Committee and the CCG Committee will manage the Pooled Funds for which they have been assigned authority in accordance with a section 75 agreement in place between COLC and the CCG ("City Pooled Funds").

The members of the LBH Committee and the CCG Committee will manage the Pooled Funds for which they have been assigned authority in accordance with a section 75 agreement in place between LBH and the CCG ("Hackney Pooled Funds").

The LBH Committee shall have no authority in respect of City Pooled Funds. The management of City Pooled Funds is assigned to the CCG Committee and the COLC Committee. The COLC Committee shall have no authority in respect of Hackney Pooled Funds. The management of Hackney Pooled Funds is assigned to the CCG Committee and the LBH Committee.

For Aligned Fund services the ICB acts as an advisory group making recommendations to the CCG Governing Body, or the COLC Community and Children's Services Committee, or the LBH Cabinet as appropriate, in accordance with the relevant s75 agreement.

Purpose

The ICB is the principal forum to ensure that commissioning improves local services and outcomes and achieves integration of service provision and of commissioning and delivers the North East London Sustainability and Transformation Plan (NEL STP). It is the forum for decision making and monitoring of activity to integrate the commissioning activities of the CCG, COLC and LBH (to the extent defined in the s75 agreement).

The ICB's remit is in respect of services that are commissioned using Pooled Funds (including the Better Care Fund budgets) within the Integrated Commissioning Fund (ICF). The ICB also has a remit with regard to Aligned Funds, whereby it is an advisory group making recommendations to the CCG Governing Body or the LBH Cabinet or the COLC Community and Children's Services Committee as appropriate.

The CCG and COLC, and the CCG and LBH, shall determine the funds, and therefore the services, that are to be the City Pooled Funds and the Hackney Pooled Funds respectively (to include requirements in respect of Better Care Fund budgets) subject to the s75 agreements between the CCG and COLC and the CCG and LBH. The CCG and the COLC, and the CCG and LBH, shall determine their respective Aligned Funds. Once defined, the remit will be stated in these Terms of Reference or in another appropriate document that is provided to the ICB.

In performing its role the ICB will exercise its functions in accordance with, and to support the delivery of, the City and Hackney Locality Plan and the City of London supplement and the North East London Sustainability and Transformation Plan (NEL STP).

The responsibilities for the ICB will cover the geographical area of the LBH and COLC. It is noted that there will need to be decisions made about how to address the issues of resident and registered populations across the CCG and COLC and LBH and workers who travel into the City of London.

In carrying out its role the ICB will be supported by the Accountable Officers Group.

The objectives of the ICB defined below are subject to the Scheme of Delegation, and subject to the financial framework (a schedule in each of the two s75 agreements). The s75 agreements define the budgets that are City Pooled Funds, Hackney Pooled Funds, and Aligned Funds.

Objectives

Specifically, the ICB will:

Commissioning strategies and plans

- Lead the commissioning agenda of the locality, including inputs from, and relationships with, all partners
- Ensure that co-production is embedded across all areas of commissioning in line with the city and Hackney co-production charter
- Ensure financial sustainability and drive local transformation programmes and initiatives
- Determine and advise on the local impacts of commissioning recommendations and decisions taken at a NEL level
- Ensure that the Locality plan is delivering the local contribution to the ambitions of the NEL STP
- Lead the development and scrutiny of annual commissioning intentions as set out in the Integrated Commissioning Strategy, including the monitoring, review, commissioning and decommissioning of activities
- Provide advice to the CCG about core primary care and make recommendation to the CCG's Local GP Provider Contracts Committee
- Ensure that the locality plan delivers constitutional requirements, financial balance, and supports the improvement in performance and outcomes established by the Health and Wellbeing Boards
- Promote health and wellbeing, reduce health inequalities, and address the public health and health improvement agendas in making commissioning recommendations
- Ensure commissioning decisions are made by the ICB in a timely manner that address financial challenges of both the in-year and longer term plans.

- Ensure that local plans can demonstrate their impact on City residents and City workers where appropriate.

Service re-design

- Approve all clinical and social care guidelines, pathways, service specifications, and new models of care
- Ensure all local guidelines and service specifications and pathways are developed in line with NICE and other national evidence, best practice and benchmarked performance
- Drive continuous improvement in all areas of commissioning, pathway and service redesign delivering increased quality performance and improved outcomes
- Ensure that services are. co-designed by residents and practitioners working together and adhere to the principles set out in the City and Hackney Co-production charter.

Contracting and performance

- Oversee the annual contracting and planning processes and ensure that contractual arrangements are supporting the ambitions of the CCG, LBH and COLC to transform services, ensure integrated delivery and improve outcomes
- Oversee local financial and operational performance and decisions in respect of investment and disinvestment plans

Stakeholder engagement

- Ensure adequate structures are in place to support patient, public, service user, and carer involvement at all levels and that the equalities agenda is delivered
- Ensure that arrangements are in place to support collaboration with other localities when it has been identified that such collaborative arrangements would be in the best interests of local patients, public, service users, and carers
- Ensure and monitor on-going discussion between the ICB and provider organisations about long-term strategy and plans

Programme management

- Oversee the work of the Accountable Officers Group including their work on the workstreams and enabler groups ensuring system wide implications are considered
- Ensure that risks associated with integrated commissioning are identified and managed, including to the extent necessary through risk management arrangements established by the CCG, LBH and COLC.

Safeguarding

- In discharging its duties, act such that it supports the CCG, LBH and COLC to comply with the statutory duties that apply to them in respect of safeguarding patients and service users.

Accountability and reporting

The ICB will report to the relevant forum as determined by the CCG, LBH and COLC. The matters on which, and the arrangements through which, the ICB is required to report shall be determined by the CCG, LBH and COLC (and shall include requirements in respect of Better Care Fund budgets). The ICB will present for approval by the CCG, LBH and COLC as appropriate proposals on matters in respect of which authority is reserved to the CCG and/or COLC and/or LBH (including in respect of aligned fund services). The ICB will also provide advice to the CCG about core primary care and make recommendation to the appropriate CCG Committee.

The ICB will receive reports from the CCG, LBH and COLC on decisions made by those bodies where authority for those decisions is retained by them but the matters are relevant to the work of the ICB.

The ICB will provide reports to the Health and Wellbeing Boards and other committees as required.

Membership and attendance

The membership of the COLC Committee shall be as follows:

- The Chairman of the Community and Children's Services Committee (Chair of the COLC Committee)
- The Deputy Chairman of the Community and Children's Services Committee
- 1 other Member from the Community and Children's Services Committee who is a Member of the Court of Common Council

The membership of the LBH Committee shall be as follows:

- LBH Lead Member for Health, Social Care, Leisure and Parks (Chair of the LBH Committee)
- LBH Lead Member for Children's Services
- LBH Lead Member of Finance and Corporate Services

The membership of the CCG Committee shall be as follows:

- Chair of the CCG (Chair of the CCG Committee)
- CCG Governing Body Lay Member
- CCG Accountable Officer

As the three committees shall meet in common, the members of each committee shall be in attendance at the meetings of the other two committees.

The membership will be kept under review and through approval from the CCG's Governing Body, COLC's Community and Children's Services Committee and LBH's elected Mayor as appropriate. Other parties may be invited to send representatives to attend the ICB's meetings in a non-decision making capacity.

The ICB may also call additional experts to attend meetings on an ad hoc basis to inform discussions.
The following shall be expected to attend the meetings of the ICB, contribute to all discussion and debate, but will not participate in decision-making:

- CCG Managing Director
- CCG Chief Financial Officer
- The Director of Community and Children's services (Authorised Officer for COLC)
- The City of London Corporation Chamberlain
- LBH Group Director – Finance and Corporate Services
- LBH Group Director – Children, Adults and Community Services

The following will have a standing invitation to attend the meetings of the ICB, contribute to all discussion and debate, but will not participate in decision-making:

- LBH and COLC Director of Public Health (which is a joint post)
- A person nominated by the Chief Financial Officers of the CCG and COLC
- Representative of City of London Healthwatch
- A person nominated by the Chief Financial Officers of the CCG and LBH
- Representative of London Borough of Hackney Healthwatch
- Representative from Hackney voluntary and community services.

Deputies

Any member of the CCG Committee who is unable to attend a meeting of the ICB may appoint a deputy, who shall be a member of the CCG's Governing Body, provided that the deputy has authority equivalent to the member that he/she represents.

Any member of the LBH Committee may appoint a deputy who is a Cabinet Member.

The COLC Community and Children's Services Committee may appoint up to three of its members who are members of the Court of Common Council to deputise for any member of the COLC Committee.

Any member appointing a deputy for a particular meeting of the ICB must give prior notification of this to the Chair.

Leading and facilitating the discussion

When the three committees are meeting in common as the ICB, the Chair of the LBH Committee shall lead and facilitate the discussions of the ICB for the first six months after its formation; the Chair of the CCG Committee shall perform the same role for the following six months; and the Chair of the COLC Committee shall perform the same role for the six months after that. Thereafter the role shall swap between three Chairs, with each performing it for six months at a time.

If the Chair nominated to lead and facilitate discussions in a particular meeting or on a particular matter is absent for any reason – for example, due to a conflict of interests – another of the committees' Chairs shall perform that role. If all three Chairs are absent for any reason, the members of the COLC Committee, the LBH Committee and the CCG Committee shall together select a person to lead and facilitate for the whole or part of the meeting concerned.

Quorum and voting

For the CCG committee the quorum will be two of the three members (or deputies duly authorised in accordance with these terms of reference).

For the COLC committee the quorum will be all three members (or deputies duly authorised in accordance with these terms of reference).

For the LBH committee the quorum will be two of the three Council members (or deputies duly authorised in accordance with these terms of reference).

Each of the COLC, LBH and CCG committees must reach its own decision on any matter under consideration, and will do so by consensus of its members where possible. If consensus within a committee is impossible, that committee may take its decision by simple majority, and the Chair's casting vote if necessary.

The COLC Committee, the LBH Committee and CCG Committee will each aim to reach compatible decisions.
Matters for consideration by the three committees meeting in common as the ICB may be identified in meeting papers as requiring positive approval from all three committees in order to proceed. Any matter identified as such may not proceed without positive approval from all of the COLC Committee, the LBH Committee and the CCG Committee.
These decision-making arrangements shall be included in the review of these terms of reference as set out below.

Meetings and administration

The ICB's members will be given no less than five clear working days' notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five clear days before the date of the meeting. In urgent circumstances the requirement for five clear days' notice may be truncated.

The ICB shall meet whenever COLC, LBH and the CCG consider it appropriate that it should do so but the 3 committees meeting as the ICB would usually meet every month. When the Chairs of the CCG, LBH and COLC Committees deem it necessary in light of urgent circumstances to call a meeting at short notice this notice period shall be such as they shall specify.

Meetings of the ICB shall be held in accordance with Access to Information procedures for COLC, LBH and the CCG, rules and other relevant constitutional requirements. The dates of the meetings will be published by the CCG, LBH and COLC. The meetings of the ICB will be held in public, subject to any exemption provided by law or any matters that are confidential or commercially sensitive. This should only occur in exceptional circumstances and is in accordance with the open and accountable local government guidance (June 2014).

Secretarial support will be provided to the ICB and minutes shall be taken of all of its meetings; the CCG, COLC and LBH shall agree between them the format of the joint minutes of the ICB which will separately record the membership and the decisions taken by the CCG Committee, the COLC Committee and the LBH Committee. Agenda, decisions and minutes shall be published in accordance with partners' Access to Information procedures rules.

Decisions made by the CoLC Committee may be subject to referral to the Court of Common Council in accordance with COLC's constitution. Executive decisions made by the LBH committee may be subject to call-in by members of the Council in accordance with LBH's constitution. Executive decisions made by the CCG committee may be subject to review by the CCG's Governing Body and/or Members Forum in accordance with CCG's constitution. However, the CCG, LBH and COLC will manage the business of the ICB, including consultation with relevant fora and/or officers within those organisations, such that the incidence of decisions being reviewed or referred is minimised.

Conflicts of interests

The partner organisations represented in the ICB are committed to conducting business and delivering services in a fair, transparent, accountable and impartial manner. ICB members will comply with the Conflicts of Interest policy statement developed for the ICB, as well as the arrangements established by the organisations that they represent.

A register of interests will be completed by all members and attendees of the ICB and will be kept up to date in line with the policy. Before each meeting each member or attendee will examine the agenda to identify any matters in which he/she has (or may be perceived to have) an interest. Such interests may be in addition to those declared previously. Any such conflicts should be raised with the Chair and the secretariat at the earliest possible time.

The Chair will acknowledge the register of interests at the start of the meeting as an item of business. There will be the opportunity for any potential conflicts of interest to be debated and the Chair (on the basis of advice where necessary) may give guidance on whether any conflicts of interest exist and, if so, the arrangements through which they may be addressed.

In respect of the CCG Committee, the members will have regard to any such guidance from the Chair and should adopt it upon request to do so. Where a member declines to adopt such guidance it is for the Chair to determine whether a conflict of interests exists and, if so, the arrangements through which it will be managed.

In respect of the COLC Committee and the LBH Committee, it is for the members to declare any conflicts of interests which exist (taking into account any guidance from the Chair) and, if so, to adopt any arrangements which they consider to be appropriate.

In some cases it may be possible for a person with a conflict of interest to participate in a discussion but not the decision that results from it. In other cases, it may be necessary for a person to withdraw from the meeting for the duration of the discussion and decision. Where the nominated Chair (or another person selected to lead and facilitate a meeting) has a conflict of interests, the arrangements set out above (under Leading and facilitating the discussion) shall apply.
When considering any proposals relating to actual or potential contractual arrangements with local GP providers the ICB will seek independent advice from the CCG Local GP Provider Contracts Committee who provide a scrutiny function for all such matters, particularly that the contract is in the best interests of local people, represents value for money and is being recommended without any conflict of interest from GPs.

All declarations and discussions relating to them will be minuted.

Additional requirements

The members of the ICB have a collective responsibility for the operation of it. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view. They will take advice from the Accountable Officers Group and from other advisors where relevant.

The ICB functions through the scheme of delegation and financial framework agreed by the CCG, COLC and LBH respectively, who remain responsible for their statutory functions and for ensuring that these are met and that the ICB is operating within all relevant requirements.

The ICB may assign tasks to such individuals or committees as it shall see fit, provided that any such assignments are consistent with each party's relevant governance arrangements, are recorded in a scheme of delegation for the relevant committee, are governed by terms of reference as appropriate, and reflect appropriate arrangements for the management of any actual or perceived conflicts of interest.

Review

The terms of reference will be reviewed not later than six months after the date of their approval and then at least annually thereafter, such annual reviews to coincide with reviews of the s75 agreements.

[Insert dates of approval of these TOR at each relevant forum within the CCG, LBH and COLC] – To be added

June 2019

NHS CITY & HACKNEY CLINICAL COMMISSIONING GROUP AND LONDON BOROUGH OF HACKNEY

INTEGRATED COMMISSIONING ARRANGEMENTS

SCHEME OF RESERVATION AND DELEGATION

Introduction

This document defines the authority reserved and delegated within the governance arrangements for the Integrated Commissioning Fund established by NHS City and Hackney Clinical Commissioning Group (the CCG) and London Borough of Hackney (LBH). The authority defined in this document is consistent with (and is referenced to) the Financial Framework (FF).

LBH has established an Integrated Commissioning Committee and the CCG has also established an Integrated Commissioning Committee. Those two committees shall meet in common and shall be known together as the Integrated Commissioning Board ("the Board").

LBH's Integrated Commissioning Committee has authority to make decisions on behalf of LBH, which shall be binding on the authority, in accordance with its terms of reference and this scheme of delegation and reservation. The CCG's Integrated Commissioning Committee has authority to make decisions on behalf of the CGG, which shall be binding on the authority, in accordance with its terms of reference and this scheme of delegation and reservation.

The authority of the LBH Integrated Commission Committee is subject to call-in arrangements (as set out in the terms of reference for the Board). The CCG's Integrated Commissioning Committee is subject to oversight from the CCG's Governing Body and Members such that they are assured that the Board does not breach any requirements.

This document distinguishes between "core primary care services", which are services commissioned by the CCG under authority delegated from NHS England, and "other primary care services" (such as enhanced services), have been and will continue to be commissioned directly by the CCG. Authority (for commissioning, procurement and other matters) in respect of core primary care services is reserved to the CCG's Primary Care Commissioning Committee; authority in respect of all other primary care services is delegated to the ICB.

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
	Pooled Budgets and Services							
1.	Determine the budgets (and therefore services) that are pooled (to include Better Care Fund) at any time	Authority to approve				Authority to approve		
2.	Determine the amount of the Integrated Commissioning Fund that is allocated to commissioning management and administration support.	Authority to approve				Authority to approve		
3.	Approve the Integrated Commissioning Strategy (ICS) for services within the pooled budget						Authority to approve	Authority to approve
4.	Approve a commissioning strategy or plan for each service or pathway identified in the ICS and included in the pooled budget						Authority to approve	Authority to approve
5.	Approve the design of services identified in the ICS and included in the pooled budget, including pathways, specifications and models of care.						Authority to approve (Refer to FF 34)	Authority to approve (Refer to FF 34)

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
6.	Approve expenditure from the pooled budget, including Better Care Fund budgets.						Authority to approve (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)
7.	Approve the procurement process to select providers to deliver services identified in the ICS and within the pooled budget						Authority to approve	Authority to approve
8.	Approve the appointment of providers to deliver services identified in the ICS and within the pooled budget						Authority to approve for	Authority to approve for
9.	Approve contracts with providers selected to deliver services identified in the ICS and within the pooled budget				Authority to approve. (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)		
10.	Approve action to address any variance from targets in respect of the performance of providers.						Authority to approve	Authority to approve

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
11.	Approve the arrangements for the CCG and LBH to work together, including the role of any supporting committees or work programmes.						Authority to approve	Authority to approve
12.	Approve strategies and plans to secure the engagement of patients, the public and other stakeholders.						Authority to approve	Authority to approve
	Aligned Budgets and Services							
13.	Approve the commissioning strategy for aligned budgets and services.	Authority to approve				Authority to approve		
14.	Approve a commissioning strategy or plan for each aligned service or pathway.	Authority to approve				Authority to approve		
15.	Approve the design of aligned budget services, including pathways, specifications and models of care.	Authority to approve				Authority to approve		
16.	Approve the procurement process to select providers to	Authority to approve				Authority to approve		

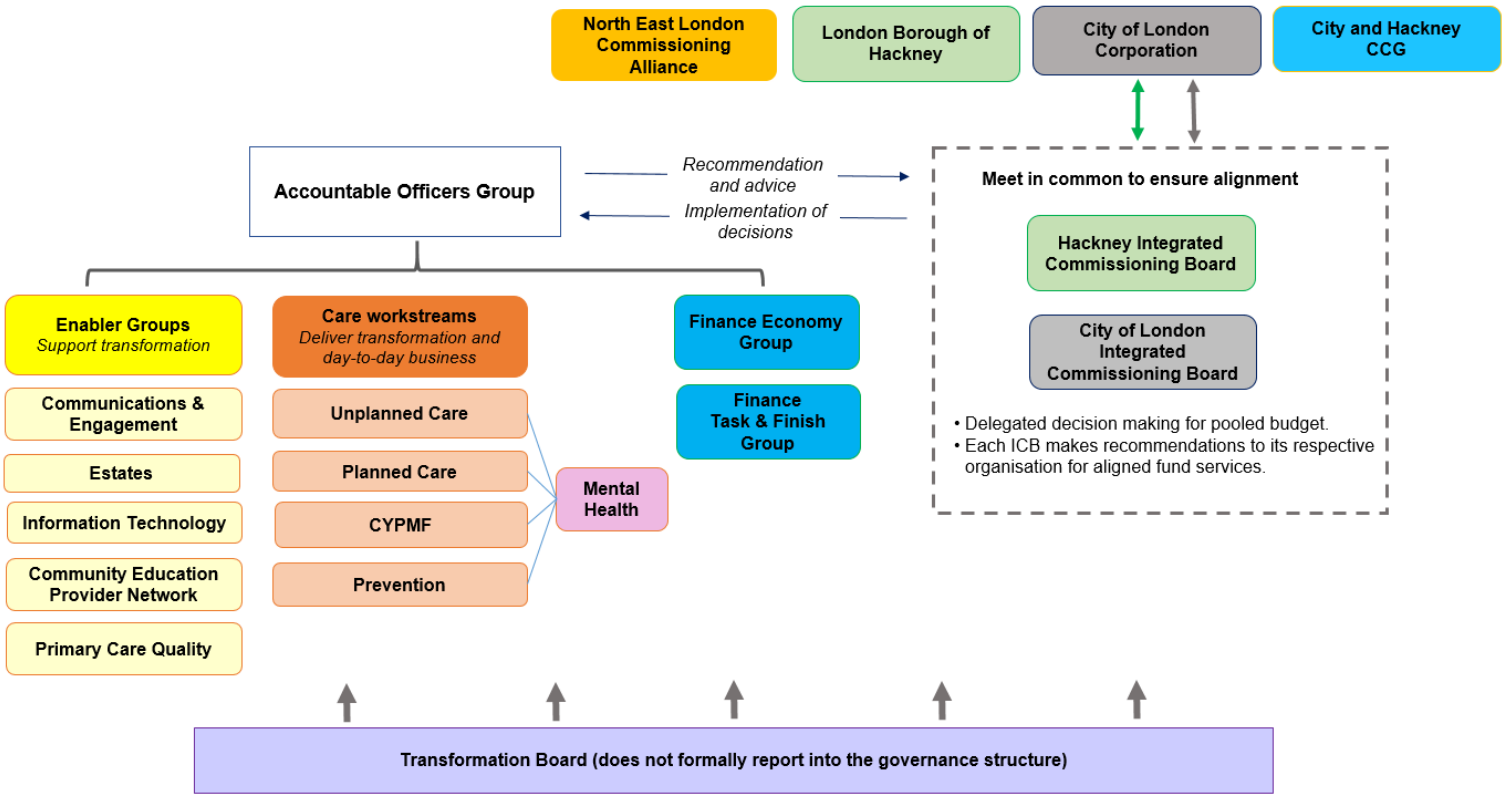
No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
	deliver aligned budget services.							
17.	Approve the appointment of providers to deliver aligned budget services.	Authority to approve				Authority to approve		
18.	Approve contracts with providers selected to deliver aligned budget services.				Authority to approve. (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)		
	CORE PRIMARY CARE SERVICES							
19.	Approve the commissioning strategy		Authority to approve					
20.	Approve a commissioning strategy or plan for each service		Authority to approve					
21.	Approve the design of services, including pathways, specifications and models of care		Authority to approve					
22.	Approve the procurement process to select providers to deliver services		Authority to approve					
23.	Approve the appointment of providers to deliver services		Authority to approve					

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
24.	Approve contracts with providers selected to deliver services		Authority to approve					
25.	Approve the establishment or merger of GP practices		Authority to approve					
26.	Approve discretionary payments		Authority to approve					
27.	Approve the design of local incentive schemes		Authority to approve					
	Other Primary Care Services							
28.	Approve the commissioning strategy						Authority to approve	Authority to approve
29.	Approve a commissioning strategy or plan for each service						Authority to approve	Authority to approve
30.	Approve the design of services, including pathways, specifications and models of care						Authority to approve	Authority to approve
31.	Approve the procurement process to select providers to deliver services						Authority to approve	Authority to approve
32.	Approve the appointment of providers to deliver services						Authority to approve	Authority to approve

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
33.	Approve contracts with providers selected to deliver services						Authority to approve	Authority to approve

[Insert dates of approval by the CCG's Governing Body and the relevant committee or officer in LBH]

PART THREE - STRUCTURE DIAGRAM OF THE GOVERNANCE ARRANGEMENTS



SCHEDULE 3 – FINANCIAL FRAMEWORK

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FINANCIAL FRAMEWORK

Between

City and Hackney Clinical Commissioning Group and

London Borough of Hackney

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Defined Terms

Defined terms in this Financial Framework shall have the same meaning as those give in the s75 Agreement. A selection of such defined terms (as well as other defined terms relevant for the Financial Framework) are included below for ease of reference:

Aligned Fund means budgets for commissioning prescribed services (as set out in Schedule 1 of the s75 Agreement) which will be managed alongside the Pooled Fund.

CCG – City and Hackney Commissioning Group, one of two partners to the Integrated Commissioning Fund and the s75 agreement

Council – London Borough of Hackney, one of two partners to the Integrated Commissioning Fund and the s75 agreement

DH – Department of Health

Financial Framework – (this document) describes the ground rules under which the financial decisions relating to the Integrated Commissioning Fund will be made.

Health and Wellbeing Board – established as a Council committee under s194 of the Health and Social Care Act 2012, the purpose of which is to promote more joined up delivery of services and involves oversight of achievement of the objectives of the integrated commissioning function; and oversight of proper governance of the integrated commissioning function

Integrated Commissioning Board – Committee in Common which has delegated decision making authority from CCG and Council to make decisions binding on both parties on use of the Integrated Commissioning Fund in accordance with its terms of reference and the s75 agreement.

Integrated Commissioning Fund means the total of the Pooled Fund and Aligned Fund.

Partners – means the CCG and the Council, and "Partner" shall be interpreted accordingly.

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

Pooled Fund Host means the Partner that will host and provide the financial administrative systems for the Pooled Fund and undertake to perform the duties for which they will be responsible, as set out in paragraph 7(4) and 7(5) of the Regulations

Section 75 (s75) – section 75 of the NHS Act 2006: the legislation that allows the establishment of pooled funds between NHS bodies and local authorities at a local level.

SoDA – scheme of delegation of authorities, or equivalent, of the CCG, the Council and the Integrated Commissioning Board.

Terms of the Financial Framework

1. **CONSULTATION AND APPROVAL**

1.1 The process for consulting on management and oversight of the Integrated Commissioning Fund and the Section 75 agreement (s75) agreement will include, as a minimum:

- Approval of the CCG (Governing Body)
- Approval of the Council

1.2 This Financial Framework is to be reviewed on an annual basis and may be varied in accordance with the provisions of the s75 agreement.

1.3 The process of consultation for the Financial Framework will be aligned with the development of the s75 agreement and the arrangements for the development of the Integrated

Commissioning Fund. It forms a Schedule to the s75 agreement.

1.4 Approval of the inaugural Financial Framework will be by:

- the CCG (Governing Body)
- the Council (Executive Cabinet)

2. FREQUENCY OF REVIEW AND RENEWAL

2.1 This Financial Framework will be reviewed and revised, as necessary on an annual basis. This review will involve the designated financial leads and governance leads of both Partners. The Integrated Commissioning Board will recommend approval of the reviewed Financial Framework to the:

- The CCG (Governing Body)
- The Council (Executive Cabinet).

2.2 The Partners may, at some point in the future, agree to extend the period between formal review and variation of the Financial Framework. Any changes will be subject to approval as above.

2.3 Detailed guidance about specific aspects of this Financial Framework may be issued from time to time. This guidance will be approved by the Integrated Commissioning Board, or by specific groups or individuals as delegated.

3. SCOPE OF THIS FINANCIAL FRAMEWORK

3.1 This Financial Framework lays out the general rules and sets the scope for the management and expenditure of public sector funds originating from NHS and Local Government sources.

3.2 It supports the relationship between the Partners via the Section 75 Agreement and the use of Aligned Funds. It:

- Provides detail of the framework of the formal relationship with regard to the management of the Integrated Commissioning Fund;
- Sets the expectation that the Partners will continue to work closely together; and with Providers, to ensure that the best quality care is provided and best value is achieved in the use of resources;
- Recognises the statute and regulations under which the Pooled Fund is established i.e. section 75 of the National Health Services Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000.

3.3 This Financial Framework sets out the requirements and makes provision for governance and accountability of:

- The Integrated Commissioning Fund;
- Authorities and responsibilities delegated from the Partners
- Financial planning and management responsibilities;
- Budgeting and budgetary control, including forecasting.

3.4 This Financial Framework identifies the responsibilities of each Partner to:

- Support and facilitate the achievement of the objectives of the Integrated Commissioning Fund;
- Ensure that the objectives and functions of the Partners and of the Integrated Commissioning Fund are complementary and mutually supportive;
- Ensure due diligence and appropriate oversight of financial decisions;
- Ensure the achievement of the Partners' objectives.

Responsibilities

4. PARTNER RESPONSIBILITIES

4.1 The Partners have stated their commitment to developing Integrated Commissioning whilst ensuring the financial health of both Partners; and of other organisations in the local health and wellbeing economy.

4.2 The Partners recognise their obligation to comply with statute and regulations.

4.3 The Partners recognise that each Partner's ultimate responsibility for service provision and delivery is not changed. However, they will delegate decision making and administration, where this improves the way that services are commissioned and where it is feasible.

4.4 The Partners recognise specific responsibilities regarding services included within Integrated Commissioning:

- Obligations and commitments to the residents of; and patients registered within London Borough of Hackney;
- Obligations to the Provider community; delivering pace of change whilst creating a sustainable provider market.

5. RESPONSIBILITIES OF THE PARTNER ORGANISATIONS' LEADERSHIP

5.1 The Partners will agree and approve the strategic objectives for Integrated Commissioning. They will:

- Set the strategic objectives for the Partner organisation;
- Seek assurance that these are incorporated within the strategic priorities for Integrated Commissioning;
- Ensure that strategic objectives for integrated commissioning will be progressed through 2017/18 and annually thereafter, in line with the business planning timetable.

5.2 The Partners will approve the policy and performance framework (business plan) for Integrated Commissioning and will:

- Ensure the adequacy of the Integrated Commissioning function's business plan and alignment with the partners' plans
- Approve the adequacy of organisation, staffing and management of Integrated Commissioning

- Aim to have a harmonised business planning and monthly reporting timetable by Q1 of 2017/18 and going forward, such a timetable shall be available by Q3 of the preceding financial year.

5.3 The Partners will approve the authority and governance framework for Integrated Commissioning, including:

- Approving the key governance documents (where these are different from the Partner organisations' documents);
- Approve the use of the relevant Partners Standing Orders, Standing Financial Instructions, Schedule of Decisions Reserved, Scheme of Delegated Authorities etc. The Partners will endeavour to unify these where appropriate;
- Ensuring the performance of the Pooled Fund is scrutinised regularly and appropriately;
- Delivering scrutiny and pre-approval of significant new programmes and projects.

Governance documents are to be reviewed in accordance with what is specified within the relevant terms of reference (at least).

6. RESPONSIBILITIES OF THE PARTNER ORGANISATIONS' AUTHORISED OFFICERS AND CHIEF FINANCIAL OFFICERS

6.1 Authorised Officer

6.1.1 Each Partner is required to appoint a member of the senior management team to be the Authorised Officer for their organisation.

- Signing approval of certain changes to the s75 Agreement (as identified in the s75 Agreement);
- Ensuring the record of minutes of meeting of the Integrated Commissioning Board is maintained.

6.1.2 The scope of these roles will be subject to the delegations approved by each Partner.

6.1.3 Authorised Officers are to be members of the Integrated Commissioning Board.

6.2 Chief Financial Officer

6.2.1 The overriding responsibility of the Chief Financial Officers will be to gain assurance as to the satisfactory standard of financial management, accounting and reporting of the Integrated Commissioning Fund. Each Chief Financial Officer will:

- Ensure that the Integrated Commissioning arrangements are appropriate and sufficiently secure to safeguard public funds;
- Ensure that financial governance and internal controls conform to the requirements of regularity, propriety and good financial management; sufficient to deliver successful operations;
- Ensure that reporting of Integrated Commissioning on strategic, operational and financial performance, budgetary control and risk management is adequate and reliable.

6.2.2 The Council Chief Financial Officer will ensure that the specific obligations of the s151 officer are delivered in respect of transactions involving the funds of the Council.

6.2.3 The Chief Financial Officer of each Partner will ensure the adequacy of arrangements to deliver new services, programmes and projects.

6.2.4 The Chief Financial Officer of each Partner will report assurance to their respective Audit Committees.

6.2.5 The Chief Financial Officers shall operate any risk sharing pooling arrangement and management of any contingency sums as specified in this Framework.

7. RESPONSIBILITIES OF THE HOST PARTNER

7.1 The decision on the appointment of the Host Partner is agreed by both Partners, after assessment of the relative merits of each holding the role. **For the Pooled Fund the Council has been appointed as the Host Partner.** This appointment will be reviewed periodically and may be re-assessed in the light of developments at each Partner or determined by external developments.

7.2 The scope of role of the Host Partner is determined, in the first instance, by the decision to seek to minimise organisational change resulting from the development of the Integrated Commissioning arrangement. As a minimum, the Host Partner will deliver the regulatory requirements:

- Appoint the Pooled Fund Manager;
- Deliver the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 7(4) and 7(5) requirements:
    - Accounts and audit
    - Managing the fund
    - Reporting to the partners and reporting frequency
    - Exercise NHS and health-related functions

8. RESPONSIBILITIES AND ROLE OF THE POOLED FUND MANAGER

8.1 The Pool Fund Manager is appointed by the Host Partner in accordance with requirements of the Section 75 Agreement and associated regulations.

Management of the Pooled Fund

8.2 Financial management of the Pooled Fund will be overseen by the Partners' Chief Financial Officers (CFOs) or equivalent.

8.3 The CFOs will lead a 'Finance Economy Group' comprising also of the Partners' CFOs. This group will be responsible for the strategic financial management of the Pooled Fund

8.4 A 'Task and Finish' group comprising of the Partners' deputy CFOs (or equivalent) will be responsible for the Pooled Fund operational financial management and reporting.

8.5 A summary of the responsibilities of the Finance Economy Group and Task and Finish Group

are set out in the table below:

Finance Economy Group	Task and Finish Group
Maintaining an overview of all joint financial issues affecting the Parties in relation to the Services and the Pooled Fund.	Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Commissioning Plans.
Ensure arrangements are in place in order that the Task and Finish Group provides all necessary information in time for the reporting requirements to be met.	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.
Ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with the s75 Agreement.	Reporting to the Parties as required by the Integrated Commissioning Board and the relevant Commissioning Plans.
	Preparing and submitting reports to the Health and Wellbeing Board as required by it

8.6 The CFOs have responsibility for ensuring the Pooled Fund is adequately resourced in terms of finance support.

9. TERMINATION OF THE SECTION 75 AGREEMENT

9.1 The options for terminating the Section 75 Agreement are set out within the Section 75 Agreement.

9.2 This Financial Framework identifies the scale of risks that both Partners will accept, before considering the need to reduce the scale of the Integrated Commissioning Fund and/or terminate the Section 75 Agreement.

9.3 The Partners will agree mechanisms for entering emergency arrangements to reverse adverse trends, including:

- protocol for suspending the Host Partner's management arrangements for the Pooled Fund;
- structure of governance and management of the Section 75 Agreement or this Financial Framework in emergency measures.

9.4 The Partners agree that in the event that the financial forecast expenditure for the Integrated Commissioning Fund will exceed available resources (after application of any contingencies), a remedial action plan must be agreed by the ICB within 4 weeks and signed off by the two CFOs as providing assurance it will bring the fund back in to balance.

10. CESSATION OF THE POOLED FUND

10.1 Where the Pooled Fund is to be ceased, due to the termination of the Section 75 Agreement, the Partners must (amongst other obligations) comply with any Exit Plan. This may include considering the ownership of assets, and where particular liabilities and commitments will be apportioned. If the relevant Partner is not clearly identified, ownership will fall to the Partner acting as the Lead Commissioner. This applies to:

- Ownership of invested assets;
- Ownership of consequential service obligations.

10.2 Where the Section 75 Agreement is to be terminated due to the financial failure of one or both of the Partners, the Partners will agree the stages for realising the losses accumulated by the Pooled Fund. The stages are:

- apportionment of financial risk;
- allocation and apportionment of financial risk as agreed between Partners;
- agreement of continuation of Services to Service Users.

The Partners acknowledge that they are public authorities, however "financial failure" in this context is interpreted to mean where the organisation is unable to provide viable recovery plans for both actual or forecast budgetary overspends or, where it cannot meet its financial obligations to its creditors. The Partners will need to both agree on whether a situation constitutes "financial failure" for the purpose of this section.

Scope and description of the Fund

11. SCOPE OF INTEGRATED COMMISSIONING

11.1 The Partners have agreed that the scope of the Integrated Commissioning Fund shall be as set out in the Agreement.

11.2 Commissioning funding will be pooled or aligned, at service and/or contract level. All services will be mapped to a relevant work stream of the four defined in the Devolution Business Case. Services not exercisable under Section 75 of the 2006 Act and, those services which are outside the current scope of the Pooled Fund but managed alongside the Pooled Funds will be mapped into Aligned Funds. Contracts will only be split where there is value in disaggregating the commissioning arrangement and where this can be managed effectively. The Partners' financial ledger record will be designed to allow for the pooled and aligned elements of the fund to be identified and disaggregated clearly.

11.3 Either Partner will be allocated the Lead Commissioner role for each service area, or contract, based on the most logical and effective design for the commissioning function.

11.4 The Partners agree in principle that further Services may be added to the Integrated Commissioning Fund; or specific Services may be removed from the Integrated Commissioning arrangements, in future. The decision and approval approach to this process will follow best practice in business case development, analysis and challenge.

11.5 The Partners recognise that the London Borough of Hackney community is included in the approach to planning for commissioning of care in London Borough of Hackney. The Partners will maintain a close relationship with London Borough of Hackney for the health related service needs of the London Borough of Hackney residents and registered patients.

11.6 The scope of the Integrated Commissioning Fund is illustrated in Schedule 1 of the Agreement and includes both the CCG and Council's commissioning resources and costs of administering these.

12. BETTER CARE FUND

12.1 The BCF is an element of the wider Pooled Fund.

12.2 For clarity, the Pooled Fund established under the s75 Agreement shall not be designated as the Better Care Fund, however, the Better Care Fund forms part of the overall Pooled Fund.

12.3 The Pooled Fund is combined with the Aligned Funds to make up the total value of the Integrated Commissioning Fund.

13. VALUE OF THE INTEGRATED COMMISSIONING FUND

13.1 The Integrated Commissioning Fund comprises the Pooled Fund and Aligned Fund.

13.2 The details of the Pooled Fund and Aligned Fund are set out in Schedule 1 of the s75 Agreement.

13.3 The stated intention is to maximise the resources and the scale of commissioning to be included in the Integrated Commissioning Fund, as either a Pooled Fund or Aligned Fund. The prescribed services that cannot be pooled, as summarised in SI(2000)617: NHS Bodies and Local Authorities Partnership Arrangements Regulations includes:

NHS

- Acute surgical (unlikely to be able to disaggregate from hotel services);
- Emergency ambulance;
- Radiotherapy;
- Termination of pregnancies;
- Endoscopy;
- Laser treatments (class 4);
- Other invasive treatments.

Local Government

- Adoption services (Adoption & Childcare Act, 2003);
- Appointment of mental health professional (MHA, 1983);
- MHP powers of entry (MHA, 1983);
- Safeguarding children in care homes (Children Act, 1989);
- Appointment of director of social services (LASSA, 1970).

13.4 Where possible, these services will be included in the Integrated Commissioning Fund as an Aligned Fund.

14. RANGE OF THE POOLED FUND (CROSS BOUNDARY FLOWS AND ISSUES)

14.1 The populations served by the Pooled Fund are not consistent between the Partners; and essential Integrated Commissioning extends beyond the boundaries of the Pooled Fund. The Partners agree to seek to avoid creating unnecessary barriers or inequalities of access for Service Users. They agree to seek to avoid creating perverse incentives in the design of commissioned and provided Services. The Partners recognise that the Council is funded for resident population, which is partially reflected in service cost recovery arrangements

between boroughs.

14.2 Funding inconsistencies are created by:

- Council residents registered with GPs outside of the London Borough of Hackney area;
- Non-Council residents registered with GPs within the London Borough of Hackney;
- Individuals not resident; and not registered with GPs in the area requiring services within the scope of the Integrated Commissioning arrangement;
- Service Users who receive Services who are not physically present in the borough.

14.3 Unwanted barriers and incentives to commissioning are created by:

- The 'footprint' of the main providers of NHS services extending into neighbouring areas,

14.4 Potential service level boundaries and inconsistencies may also occur as a result of the range of local government commissioned services that remain with the Council.

Statutory reporting requirements

15. ANNUAL FINANCIAL ACCOUNTS

15.1 The value of the budget for the Pooled Fund, as described in the Section 75 Agreement, will be material to both Partners; and as such will be subject to appropriate levels of external and internal audit scrutiny.

15.2 The annual financial accounts of both Partners will be required to include sufficiently detailed notes of the financial performance and records of the Integrated Commissioning arrangement:

- The structure of reporting to be followed for a "Joint Operation", such as this Integrated Commissioning arrangement, is prescribed by the International Financial Reporting Standards (IFRS) in IFRS11(Joint arrangements) and IFRS 12 (Disclosure of interests in other entities);
- 2017/18 is the first year of the Section 75 Agreement for the devolution of health and social care services in Hackney. Pooled Fund arrangements and fund flows in respect of services commissioned and delivered within this new Section 75 Agreement in year one are anticipated to remain as and where they are being reported in 2016/17. The reporting in Partners' respective financial statements for 2017/18 is therefore not expected to change materially. The overall Pooled Fund performance and explanatory comments will be reported in a note to the Council's financial statements and reflected appropriately in the CCG's accounts;
- The financial performance of Aligned Fund is to be reported within the body of the relevant Partner's accounts;

15.3 Planning for accounts preparation and required audit arrangements will take account of:

- Timetables for producing the annual accounts, their audit and reporting requirements; recognising the earlier reporting deadlines for NHS accounts. It is acknowledged that Council reporting deadlines are susceptible to change;
- The scope of required reporting, including the contribution to the CCG Annual Report; and to the Council Annual Report;

- The evidence required to support the annual statement on governance; and for reporting any financial concerns with the Integrated Commissioning Fund;

- The evidence required to support the Head of Internal Audit Opinion and the external audit Regularity Opinion.

15.4 The annual financial accounts will be delivered within the requirements of the financial regimes and rules of each Partner, specific to over and underspending:

- CCG – Resource Allocation Budgeting impact and treatment of over and underspends – impact carried forward into next year's allocation;

- Council – not allowed to carry forward overspend for the year. Overspending to be met from reserves, but more likely to be addressed through service reviews across the Council during the year.

16. ARRANGEMENTS FOR AUDIT AND COUNTER FRAUD

16.1 The Partners agree that they will seek a joint approach and joined up arrangements for the internal audit of the Integrated Commissioning function and associated budget resources:

- Access arrangements for both sets of (internal and external) auditors will be agreed as part of the annual audit planning and scoping exercise;

- Deliver combined assurance to the CCG and Council where possible;

- Deliver each Head of Internal Audit (HoIA) opinion and shared assurance for both Partner organisations.

16.2 In terms of the external audit legal and regulatory requirement:

- The Integrated Commissioning arrangements will represent a material and significant element of each Partner organisation's audit;

- The audit will address the Pooled Fund fully within the Council's 's accounts (Host Partner for the overall Pooled Fund), and partially within the accounts of the CCG;

- The audit will address the aligned elements of the fund within the accounts of the Partner with the originating budget, or the Partner to which the funds were transferred through s76 or s256 of the National Health Services Act 2006, if such transfers occur;

- A note will be included in the accounts of both Partners setting out the results; and the risk share impacts, for the entirety of the Integrated Commissioning Fund.

16.3 The assurances required for the sign off of the audit of both sets of financial accounts will be agreed between the external auditors.

17. LOCAL COUNTER FRAUD AND SECURITY MANAGEMENT SERVICES (LCFSMS)

17.1 NHS Protect has confirmed that its focus will continue to be on NHS resources. The Partners agree that coverage of counter fraud culture and issues within the Integrated Commissioning arrangement will be joined up, as far as is practicable:

- The CCG and Council will agree arrangements for sharing the approach to promoting the counter fraud culture; and for investigating and addressing instances of suspicion of illegal activity;

- The Council counter fraud functions will continue to be delivered by its internal audit provider and specific fraud team.

Budget Setting

18. **BUDGET SETTING GROUND RULES**

18.1 The Policy for commissioning through the Integrated Commissioning Fund is compatible with and delivers effectively the strategic priorities of both Partners.

18.2 Funds can only be used to commission prescribed services (as described in various legislation); and services that the Partners agree will contribute to the effective delivery of the commissioning priorities.

18.3 Delivery of a balanced outturn is a pre-requisite of commissioning decisions.

18.4 (Future Target) Budgets subject to specified limitations; and where agreed by the Partners, budget resource will be transferrable between the Partners, to enable optimum delivery of commissioned services and ensure best value in the use of resources. This will be recognised within each Partners medium term financial strategy.

18.5 The Partners agree that the Integrated Commissioning Fund will be reviewed during 2017/18 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

18.6 Commissioning decisions take account of the potential impact on services retained by the Partners.

18.7 Commissioning decisions are sensitive to the potential impact on the wider community of Providers.

19. **BUDGET SETTING METHODOLOGY**

19.1 Prior to the commencement of each financial year following the commencement of the s75 Agreement, both Partners need to be satisfied that the other Partner's methodology for setting the annual budget is robust and reliable. If they are not, the issue shall be escalated through the appropriate Dispute Resolution Procedure. The factors that will be considered include:

- Clarity of the Services to be included in the Integrated Commissioning arrangement and risk share (Pooled Fund and Aligned Fund);
- Verification of budget determined for each Service;
- Assumed and modelled trends in demand;
- Deliverability of the savings targets applied;
- Sufficiency of the budget applied (e.g. compared with previous year outturn).

19.2 The Partners will agree:

- A transparent approach to setting budgets shared between the Partners;
- Validation of the key assumptions and approaches used by each Partner to determine the budget;
- Plans for migration to a more consistent approach to budget setting and demand

forecasting that recognises the modelling challenges specific to each organisation.

19.3 Both Partners recognise the risk to resources from unmet need and rationed Services from previous years.

20. ACCURACY OF ACTIVITY PROJECTIONS, TRENDS AND INTERVENTIONS

20.1 The CCG approach differs depending on services but is a combination of totals agreed in contract negotiations with Providers and detailed demand modelling taking in to account of known activity, trends and forecast growth.

20.2 The Council approach is based on cost and volume analysis of likely trends in demand for Services. As part of this, the Council will:

- Determine the access eligibility thresholds for health related services, as defined by the Care Act 2014 and any flexibilities allowed;
- Determine the charges to be levied against Service Users, where this is an option.

21. ACCURACY OF COST PROJECTIONS

21.1 The Council commissioning budgets will be recognised in gross value, as well as in net value:

- Other budgets, where costs are partially offset by income from fees and charges and grants, will be included at their net value in the risk share calculations.

21.2 The Councils scope to assess the eligibility thresholds for access to services; and to set fees for services, will be taken into account when negotiating relevant contracts.

22. ADDRESSING CONFLICTS IN BUDGET SETTING PRIORITIES

22.1 It is expected that the Integrated Commissioning budget planning process will not adversely impact on the other commissioning obligations of the Partner:

- The Partners' oversight and scrutiny functions will have the opportunity to challenge any changes proposed. Any proposed changes to the budget planning process including harmonising the timetables will need to be signed off by the CFOs of each of the Partners. Any conflicting elements will be fed through to each Partner's governing body or equivalent.
- The scheme of delegations will provide a level of control over the approval of changes;
- Arrangements will be adopted for administering proposals for significant re-engineering; and compliance with business planning and investment proposal discipline, including comprehensive consultation.

22.2 It is expected that changes in the strategic direction of the Partners will not impact adversely on each other, or on the commissioning obligations of the Integrated Commissioning function.

23. USE OF INTEGRATED COMMISSIONING FUNDS

23.1 As set out in the s75 Agreement, the Integrated Commissioning Funds shall only be used for Permitted Expenditure.

24. FUTURE BUDGET SETTLEMENTS

Risk to be addressed: Financial settlements and budget uplifts for future years are

insufficient to meet rising demands and rising costs

Possible scenarios:

- Local Government grant funding from government (Revenue Support Grant) is projected to reduce significantly over the next 3 years. The main sources of funding will then be Council Tax and Business Rates;
- NHS funding earmarked for health related services (Better Care Fund) is expected to increase in the next years.
- The size and trend in the gap between the two funding streams over the next 5 years is not certain.
- Both Partners may be required to produce medium term efficiency plans in order to receive multi-year financial settlements.
- NHS England may impose the need for the CCG to provide financial support to other areas within the North East London health economy.

24.1 Principles of response to these risks and future pressures:

- As far as is possible, the value of the single budgets will be kept at their equivalent current value
- Treatment of remaining resource gaps is likely to be addressed as additional savings targets

24.2 Mitigations:

The Partners will agree a protocol for agreeing amendments to the budget setting model in subsequent years. This will include consideration of:

- Treatment of prior year overspends
- Treatment of efficiency savings delivered from previous years

25. BOUNDARIES TO THE FUND

25.1 Budget setting will take account of boundaries on a number of planes:

- Pooled Fund versus retained funds;
- Pooled Fund versus Aligned Funds;
- Non-resident patients registered with GPs in London Borough of Hackney;
- London Borough of Hackney residents registered with GPs outside of London Borough of Hackney;

25.2 Budget setting will also to take account of patients registered with GP Practices in the London Borough of Hackney area, whilst recognising that they are outside of the Integrated Commissioning Fund arrangement.

26. FINALISING THE PRIOR YEAR POSITION

26.1 Both Partners acknowledge that the financial performance of the relevant budgets in the current year should be regarded as a key indicator of future years' risks; and of the scale of

the savings targets agreed between the Partners. The following constraints will need to be accommodated:

- Current year out-turn position will not be known until very late in the process.

26.2 The value of the Integrated Commissioning Fund will be based on the budget allocations

- Indicative savings targets will be identified by the Partners from time to time.

27. TREATMENT OF HISTORICAL OVERSPENDS / UNDERSPENDS

27.1 CCG would account for prior year deficit as a negative balance on the RAB (Resource Account Budgeting) settlement and a prior year surplus as a positive balance.

27.2 The Council cannot record a year-end deficit; and must fund remaining overspends from reserves. Overspends identified during the year are addressed through service reviews and rationalisation of the scale of non-mandatory services provided, offsets from underspent directorates, or by allocation from reserves at the year-end.

28. PRIOR YEAR AND IN-YEAR OVERSPENDS / UNDERSPENDS

28.1 The Partners recognise that differences in funding regimes and freedoms result in a different response to recorded “overspends”:

- The CCG cannot carry “reserves” between years. Underspends and overspends are recognised within the annual resource allocation. Overspends in one year result in reduced allocation in the next. The CCG can set a budget that delivers a planned overspent position, but is expected to achieve balance over a 3 to 5 year period.

- The Council cannot record an overspend at the year-end; and has to account for overspent budgets through its reserves. But the reserves are limited and should be replaced through budget targets set in the subsequent year.

28.2 The Partners agree, in principle, that they will use these differing “flexibilities” in a combined approach to maximise protection to the Integrated Commissioning function. Any unused contingency sums in the Pooled Fund must remain in the Pooled Fund hosted by the Council and will form reserves available to the Integrated Commissioning Board in subsequent years.

28.3 Further detail in relation to the CCG Contingency Fund is set out in section 33 of this Financial Framework. Other contingencies available to the Partners may be provisions made from the balance sheet or accumulated reserves. Release of such contingencies shall be made following the approval of the relevant Partner that holds such contingency.

29. TREATMENT OF UNDERLYING AND EMERGING DEFICIT:

29.1 Underlying and emerging deficit will include:

- Unidentified deficit:
    - unmet need
    - unmet demand
- Identified deficit:
    - undelivered services

- service delivery backlogs
- waiting lists

29.2 The CCG and the Council agree to work together to identify responses to the threat of emerging unfunded demand pressures and growth in demand.

29.3 The first point of responsibility for addressing pressures through contracts will be the Lead Commissioner. A Lead Commissioner will be identified for each Service Contract.

29.4 Escalation arrangements will be agreed for Service Contracts and commissioning arrangements that appear to be overheating and indicate future losses. See section 9.3 of the Financial Framework.

30. SETTING SUBSEQUENT YEARS' BUDGETS

30.1 The Section 75 Agreement specifies that the Integrated Commissioning Fund will be subject to annual review. This will be alongside the medium term financial plans of each Partners.

30.2 The Partners shall seek to agree to a shared approach to:

- Identifying and agreeing future trends in demand and service design;
- Checking sufficiency of growth funding;
- Identifying and accounting for changes in cost pressures;
- Identifying and agreeing savings and efficiency approaches. Ensuring the robustness of planned savings programmes;
- Setting criteria for values for savings targets:
  - Minimum and maximum allowed;
  - Reality checked and deliverable.

30.3 The Partners agree to design a robust business case approach to service redesign; and to its financial impact. This will involve:

- Robust analysis of overall savings projections;
- Robust analysis of comparative impact on Partners; and recognition of the need to reflect (compensate) for these impacts in future budget setting;
- Agreement on the impact on the risk share.

30.4 Where the CCG is able to drawdown funds from prior year RAB surpluses, these funds shall only be committed by the Integrated Commissioning Board to support its programme of work. Such funds can only be applied non-recurrently.

30.5 Where CCG Contingency Funds have been applied to meet in year cost pressures, it is the responsibility of the Integrated Commissioning Board to ensure effective measures are put in place to restore the CCG Contingency Funds in the following year.

Risk Sharing Framework

31. SCENARIOS OF OPERATIONAL PRESSURES AND RISKS IN BUDGET SETTING

31.1 The following sections set out a range of scenarios of risk:

Pressures on Partners' budgets

(A) Risk: Pressures within either Partner which results in shortfall in growth funding and/or increased savings targets

Possible scenarios are:

- Shifting priorities in the Council from other directorates and services;
- Internal pressure on overall CCG position resulting in pressure on budget allocation for London Borough of Hackney patients;
- Changes in targets set (externally) for performance in specific service area(s) within the Integrated Commissioning Fund.
- Increased savings targets set (externally).

Principles of response to these risks and future pressures:

- Impacts due to shifts in internal policy and priority have to be discussed by both Partners
    - Partners have to agree on how and when to apply accumulated savings;
- Impacts due to external policy and target changes to be regarded as required changes; and partners to agree response
    - Accumulated savings can be applied to offset, but need to recognise limited resource

(B) Risk: Available resources and budgets do not address current demand

Possible scenarios are:

- Growth rates in demand for services exceed available funding increase;
- New commissioning arrangements and single approach to commissioning identifies previously un-met need;
- Providers are carrying backlogs in activity that need to be delivered and need to be funded.

Principles of response to these risks and future pressures:

- The Integrated Commissioning function must seek to achieve a balanced financial out-turn;
- Providers of services will be encouraged, including through contracting, to manage service delivery costs within the allotted amount;
- Where possible, Services will be prioritised and needs assessed. Non-statutory services may be withdrawn, if impact is less significant than effect of rationing funds to areas of demand growth. Service rationing will not be organisation specific;
- Funds will be made available to promote more effective and streamlined provision of Services.

Savings targets, reserves and contingencies

(A) Risk: Efficiency savings targets applied within budgets are undeliverable

Possible scenarios are:

- A Partner is unable to show persuasive plans for achieving the savings expectations;
- Savings target exceeds sensible levels;
- Savings proposals would have an adverse and costly effect on other elements of the overall service delivery.

Principles of response to these risks and future pressures:

- Agreed process for identifying efficiency savings targets:
    - From service delivery re-design;
    - From QIPP expectations;
    - From benefits expected of merged commissioning;
    - From share of organisation's overall target;
- Agreed approach to identifying benefit shares with Providers.
- Agreed process for verifying likelihood of delivery of the savings targets:
    - Arrangements for assessing schemes to deliver;
    - Risk assessment for schemes; and response to higher risk proposals.
- Agreed arrangements for sharing the risk of under-delivery of efficiency savings targets;
- Arrangements for allowing late amendments to budgets and savings target:
    - E.g. QIPP schemes determined late.

(B) Risk: Insufficient resources to allow for a contingency or reserve to be set

Principles of response to these risks and future pressures:

- Partners will agree rules specifying whether contingency (both recurrent and non-recurrent) is a required element of the annual budget; and what this level is:
    - Proportion of annual total allocation designated to contingency target to be agreed;
    - Arrangements for agreeing contingency that is lower than the agreed target;
- Partners agree proposed treatment of any reserves brought into the Integrated Commissioning Fund:
    - Budgeted from savings in previous year(s);
    - Agreement of priorities and triggers for calls upon reserves;
- Treatment of unspent contingency, or other underspend of the total budget to be determined by the Partners:
    - Proportion, or target value to retain within the Integrated Commissioning Fund;

- Treatment of any underspend to be returned to the Partners;

- Agreement on accounting for reserves. The CCG is unlikely to be able to report resource balances to carry forward:

  - But, the CCG would report the net position across the whole. The performance of City and Hackney and the rest of the CCG may, in total, allow for shadow reserves to be identified for the London Borough of Hackney element.

32. GOVERNANCE OF SERVICE REDESIGN

32.1 The Partners will agree a protocol for developing service re-design. Elements will be delivered within the Integrated Commissioning Strategy of the Integrated Commissioning Board. It will involve a formal project management procedure for planning significant changes in service delivery design, which:

- Identifies resource implications;

- Identifies staffing implications;

- Assesses the impact on commissioning intentions:

  - And status of agreements with providers;

- Assesses the impact on Service Contracts:

  - Potential differential share of savings between the CCG, the Council and the Provider;

  - Potential for budget shift impact in advance of risk share arrangement;

- Delivers alignment with wider service design agenda.

32.2 Formal approval arrangements will be implemented, involving both Partners and requiring formal sign-off of projects

32.3 The Partners will agree the approach to monitoring of the impact on budget allocations:

- Linked to potential recognition of impact in budget planning;

- Impact on financial risk share.

33. CCG ACUTE CONTINGENCY

33.1 The CCG will apportion some contingency budget which will be earmarked for CCG related pressures and risks. This is defined as the CCG Contingency Fund in the s75 Agreement. The CCG Contingency Fund will cover in-year cost pressures including acute contract over performance and managing any budgetary gaps that emerge.

33.2 The CCG Contingency Fund will not include the 0.5% unallocated strategic risk reserve required by NHS England as part of a system-wide NHS risk management approach.

33.3 Use of the CCG Contingency Fund will require approval by the CCG Chief Finance Officer. The CCG CFO will determine the apportionment of the CCG Contingency Funds between the Pooled Fund and the Aligned Fund at the start of each Financial Year, based on an analysis of risks.

The CFO may, at their discretion, extend the use of the CCG Contingency Funds sitting in the Aligned Fund to the Pooled Fund, especially if such action will minimise pressures on health, such as avoiding bed blockage. The CCG Contingency Funds will not be used outside of the

scope of the Pooled Fund and Aligned Fund.

33.4 Where CCG related budget pressures are unable to be contained within the totality of CCG's Pooled budgets, the CCG CFO must inform the Integrated Commissioning Board, and the Integrated Commissioning Board must take immediate mitigating action at its next meeting to ensure the Fund is in balance.

Note: For 2017/18, no Local Authority contingency budget is included in the Pooled Funds.

34. BUDGET VIREMENTS

34.1 Budget virement means moving budgets between different budget lines. This process is designed to cover virements involving movement of budgets within the Pooled Funds (e.g. from one work stream to another or within a work stream from one service to another), or from Aligned Funds to Pooled Funds subject to approval from the relevant statutory body CFO.

34.2 The budget setting process aims to ensure that all budget holders receive realistic budgets at the start of the year in order that the business plan can be achieved. Nevertheless, there will inevitably be in-year changes, and this is where virement may be used.

34.3 There are occasions where virement are generally appropriate. These include:

• Adjustments to reflect changes that could not have been foreseen at the start of the year.

• Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purpose and are used for another agreed purpose.

• Movement of Reserve to fund specific initiatives or mitigate budgetary risks where agreed by the Partner funding the reserve.

34.4 Virement Rules and Processes

- A virement is not permitted from non-recurrent to recurrent expenditure
- A Virement is not permitted where the CCG or Council would be committed to additional recurrent funding in excess of commitments agreed within the CCG or Council's operating plan
- Virements within the Pooled Funds must be approved by the CFO/Finance Director for the relevant Partner seeking to make the budget change
- Virements to / from BCF parts of the Pooled Fund must be agreed by the Partners and in accordance with BCF guidance and rules.
- A virement from or to a Service budget requires the approval of the Partner acting as Lead Commissioner for the Service

35. VALUE OF FINANCIAL RISK FROM THE OTHER PARTNER

35.1 The Partners recognise the high risk of overspending of the Integrated Commissioning Fund but there is a shared commitment for the maximum resources to be included within the Integrated Commissioning Fund.

35.2 The Partners will be responsible for the management of their own overspend arising within the level of resources which they contribute to the Integrated Commissioning Fund. The detail of how this works operationally is set out in Clauses 12.7 and 12.8 of the s75 Agreement.

Managing the transactions of the Pooled Fund

36. TRANSACTIONS WITHIN THE POOLED FUND

36.1 Funding management arrangements, at the transaction level, will be designed in line with the principle of limited change and aim for consistency with the administrative approach of the previous year: Where practicable funds will remain with the respective Partner; and relevant transactions will be handled by them. If required, to fulfil specific s75 Pool rules, recharges will be applied to ensure that the entirety of the Pooled Fund record is accounted for within the Pooled Fund.

36.2 The mechanism of "cash" flow and contribution to the Pooled Fund is:

- Partner organisations will continue to access financial resources in the same way as they currently do: CCG draw down of funds; the Council transfer of cash. A regular reconciliation of transactions made by the Partners on behalf of the Pooled Fund shall be overseen by the CFOs and any net balance of the cash due to the Host Partner shall be enacted by the CFOs.

36.3 Expenditure from the Integrated Commissioning Fund:

- Contractual arrangements will be unchanged from the Partners' existing arrangements, unless evolving integration necessitates redesign.

- A Lead Commissioner will be identified for each contractual arrangement.

36.4 Specific arrangements and rules will be determined for the "direct payments" processes for Service Users (use of a holding bank account and "debit cards").

36.5 Any potential impact of VAT regime differences will be reduced through the planned consistency of approach to:

- Identify the scale and scope of the issue;

- Ensure that the correct VAT regime is applied to each transaction;

- Identify NHS service elements versus health related service elements.

36.6 The Partners agree to assume a "fair proportions" contribution to the input of non-financial resources (staff, premises, equipment, support services etc.), in accordance with the existing arrangements. This assumption will be reviewed during the first year of the Integrated Commissioning approach.

Managing Financial Performance

37. BUDGET MANAGEMENT GENERAL ARRANGEMENTS

37.1 The starting principle is that the structure of the budget management and responsibility will evolve during 2017/18, rather than face a major re-structuring at the start of the year.

37.2 But the Partners expect to make clear and consistent progress, from the start of the financial year, towards a more joined up structure of budgetary control.

37.3 The financial regulations (SFIs, SoDA) of each Partner will be reviewed for consistency. Where required, the regulations will be amended to enable the proposed structures and responsibilities to be implemented.

Review of in-year budget allocation

37.4 The basic principle is that budget allocations to the Integrated Commissioning Fund will not change (in-year) once they have been agreed however agree that they will be reviewed during 2017/2018 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

37.5 Resources, identified during the year, and specific to the services in the agreement and to the population served, will be adjusted accordingly. Examples include:

- Specific grants;
- Funding from DH, NHS England, other government sources;

37.6 The Partners will agree a model whereby they retain the right to revisit allocations during the year provided that a minimum of three months' notice is given, unless both Partners agree otherwise (in writing)

- Risks arising from external sources (protocol for responding to pressures, faced by either partner, from external sources);
- Risks arising from internal sources.

38. IN-YEAR FINANCIAL PERFORMANCE

Local operating rules

38.1 The Partners will implement administrative arrangements that will be based on existing arrangements, but will be developed, where beneficial, for the Integrated Commissioning function as a whole.

38.2 For individual schemes, the arrangements will reflect:

- Any legislative / funding restrictions or requirements
- strategic priority restrictions

38.3 Reporting of performance (financial, contracts, quality etc.) will be delivered in terms of gross income and expenditure.

38.4 The forecasting approach for the Pooled Fund and the wider Integrated Commissioning Fund will be determined by the Partners.

Monitoring performance

38.5 The Partners will develop a model for monitoring monthly performance of the Integrated Commissioning Fund. This model will include:

- Actual and forecast expenditure and income;
- Arrangements for identified accruals for activity delivered;
- Monitoring of service backlogs.
- Cash transactions for receipts and payments.

Responding to overspend trends

Alerting Partners of the likely overspend

38.6 The Partners will develop an agreed approach to addressing trends towards overspending in the Integrated Commissioning Fund. Design of the tool for alerting partners of likely overspend will include:

- Triggers and thresholds;
- Agreed sensitivity measures;
- Trend analysis and alerts;
- Analysis of impact of/on related activities;
- Impact of progress along the annual timeframe – forecasting and sensitivity analysis over the medium term.

38.7 Escalation rules will address

- Scope for managing the situation including agreed delegations;
- Process for escalating to the other Partner.

The Partners' approach to responding to adverse trends will vary, depending on the value of the potential overspend and the progress along the annual timeline:

- differentiating response (scale, threshold etc.) according to progress through the financial year.

Managing potential overspends

38.8 Escalation arrangements for responding to overspends forecast through the year will include assessment of options for:

- Management of contracts (and contract adjustments);
- Management of demand;
- Service redesign.

38.9 The procedure includes arrangements for agreeing the response to; and flexibility allowed within the Integrated Commissioning Fund for changes in allocations, in-year:

- Both Partners options to curtail the Service at any point during the year.

38.10 Where elements of the trend to overspend are specific to one Partner, the Partners will agree:

- The priority of demand on available funds to offset overspends;
- The approach to allocating and apportioning risk (in year and forecast outturn) between the Partners.

38.11 Where elements of the trend to overspend exist within Integrated Commissioning elements i.e. where both Parties would otherwise separately contribute to the Service, the Partners will agree:

- The approach to allocating and apportioning risk between the Partners

38.12 The Partners will agree arrangements for emergency management of any recovery position, including:

- suspension of Host Partner's management of the Integrated Commissioning Fund;
- agreed amendments to the structure of governance and management of the Integrated Commissioning Fund in emergency measures.

39. **RESPONDING TO ANNUAL OVERSPENDS**

39.1 The Partners will develop arrangements for addressing Overspends not recovered at the year-end and/or projected in future years. These will include:

- Escalation thresholds for response, based on the value of the overspend;
- Mechanism of carry forward to next year's budget:
    - CCG accumulated loss;
    - The Council repayment to reserves (but more likely to have been addressed through reduction in service provision during the year);
    - Apportionment of any Overspend on a Service to the Partner acting as Lead Commissioner for the service

39.2 The Council's inability to carry-forward an Overspent position will be addressed through use of reserves, which will be recovered in the subsequent year(s).

40. **RESPONDING TO ANNUAL UNDERSPENDS**

40.1 The Partners will identify underspends as generated:

- By whole Pooled Fund;
- By specific Pooled Fund elements;
- By Partner responsibility.

40.2 Options for addressing underspends recorded at the year-end will include:

- Allocate to investment fund;
- Carry forward to next year's budget:
    - Legal restrictions (CCG RAB budgeting);
    - The Council scope to hold balance, but CCG to prove no draw-down in advance of need;
- Off-set against next year's budget;
- Underspend on a Service will otherwise return to the Partner acting as Lead Commissioner for the Service.

Other financial Considerations

41. **DESIGN OF THE FINANCIAL LEDGER**

41.1 Both Partners will design processes that deliver a clear audit trail of each element of the Integrated Commissioning Fund.

- Assurance on the accuracy and completeness of the records will be provided by the

Partners;

- Assurance of compliance with s75 may be through a self-assessment and self-certification. But the Partners agree that this will be subject to an IA review, as a minimum.

42. FINANCIAL REPORTING RESPONSIBILITIES OF THE HOST PARTNER AND THE POOLED FUND MANAGER

42.1 The Partners will agree the arrangements for administering and managing the financial records of the Pooled Fund. Elements specific to the set-up of financial record include:

- Ledger and consolidations (developing the arrangement for combining the Integrated Commissioning Fund records of the Partners);
- Transactions (delivering the audit trail to show the transactions making up the Integrated Commissioning Fund record);
- Reporting.

42.2 The Partners will agree the financial performance reporting needs of each, including providing analysis and summaries of the financial performance of the Integrated Commissioning function, in accordance with the Partner organisations' requirements

- In accordance with timetables agreed by both Partners;
- Providing the details required by both Partners;
- Designed to meet the needs of the differing audience(s).

42.3 The Pooled Fund Manager will ensure the proper treatment specific aspects of the Pooled Fund and its transactions:

- Ring-fenced budgets, specific schemes and funding restrictions:
- VAT;
- Year-end treatment of surpluses;
- Audit.

42.4 The Pooled Fund Manager will ensure the provision of the annual return to Partners, identifying separately and in total: BCF and Pooled Fund

- Contributions to the Pooled Fund:
- Expenditure from the Pooled Fund:
- Treatment of the difference / risk share;
- Detail for ring fenced schemes and restricted funds;
- Reporting deadlines.

Requirements of partner organisations

42.5 The Partners will agree their respective requirements for the monitoring and reporting of the

financial position:

- Financial contribution to the Integrated Commissioning Fund:
- Expenditure and commitments;
- Contract performance ;
- Overall performance of the Integrated Commissioning Fund.

42.6 Assurance framework requirements:

- Sources of assurance;
- Specific funding and ring fencing requirements in respect of appropriateness of spend.

42.7 Overview of management of the Integrated Commissioning Fund:

- Review arrangements;
- Access to records, including audit access;
- Ad hoc reviews.

42.8 And year-end requirements:

- Deadlines specific to NHS/LG and specific reporting requirements;
- Accountable Officer / s151 Officer assurance requirements;
- IFRS reporting requirement;
- Governance statement requirements.

43. MANAGING THE CASH POSITION

43.1 The Host Partner will:

- Hold monies contributed to the Pooled Fund that are required for transactions generated from the Host Partner:
    - The timing of contributions will align to payment obligations;
- Administer the payment processes for its own transactions;
- Administer the consolidation of the financial records of the Pooled Fund.

43.2 The Partners will adhere to the rules and restrictions applying to them:

- The CCG is required to limit cash draw-down to the monies required, when they are required:
    - Not allowed to draw excess cash;
    - Not allowed to earn interest, or investment income;
    - Not allowed to have a cash balance at the year-end;
- The Council is allowed to invest available cash to earn income on its own resource

allocation:

- The Council will determine how interest income is used; and is not obliged to include any part of that interest income in the Integrated Commissioning Fund.

43.3 Banking arrangements will reflect existing arrangements.

43.4 Transaction payments from the CCG and the Council will be unchanged from current arrangements. The Council should not suffer a reduced capacity to generate investment income from retained cash and investment balances. But, the Council will not be able to derive investment advantage through early draw-down of CCG funds.

44. PAYMENT MECHANISMS

44.1 The Partners acknowledge responsibility for paying all sums due to Providers, in compliance with contract terms.

44.2 The Partners will agree arrangements for making payments to Providers, such that Providers are not affected by any changes to the structure of commissioning from the Integrated Commissioning Fund.

44.3 The design of payment mechanism will ensure that the Integrated Commissioning Fund structure delivers the full process of receipt of invoice, confirmation of service delivery and standards compliance, confirming amount due to invoice amount, instructing payment.

44.4 Providers will not be affected adversely by any specific rules that apply to certain services managed through the Integrated Commissioning Fund.

44.5 Any specific arrangements for LG and NHS to comply with will be identified and addressed, as necessary.

45. DIRECT PAYMENTS

45.1 The Partners recognise the growing importance and impact of direct payments to Service Users for purchasing their own agreed packages of care.

45.2 The design of the resource allocation arrangements will deliver:

- Discipline over approval of proposed care plans and direct payments approach;
- Security of funding ahead of spend by Service Users (e.g. “debit card”, pre-approved spend)
- Approach to recovering unused funding from individual Service Users.

46. INCOME OPPORTUNITIES

46.1 Grants and sponsorship

46.1.1 The partners will seek to maximise uptake of opportunities of funding offered, including:

- Government Grant funding:
  - As an annual allocation;
  - Through one-off projects;

- Grants from other organisations;
- Sponsorship;
- Opportunities to charge for enhanced services commissioned.

46.2 **Chargeable health related services**

46.2.1 The Council will retain responsibility for assessing the contribution (to a provided social service) to be paid by Service Users.

46.2.2 The Council will retain responsibility for collecting the assessed contribution.

47. **VAT**

47.1 The Partners will set out the details of the treatment of VAT in respect of the Services commissioned through the Integrated Commissioning Fund:

- Identify range of services for which VAT is reclaimable;
- Identify charged services which have to be subject to VAT;
- Identify controls for ensuring that VAT is treated correctly.

47.2 The Partners shall agree that for the treatment of the Pooled Fund for VAT purposes:

- the Council will be the Host Partner and will hold and administer the Pooled Fund for VAT purposes.
- The Lead Commissioner for each Service Contract will be specified in each Service Specification or Scheme Specification (as relevant).
- The Council will commission services for which it is the Lead Commissioner and recover VAT according to the local authority VAT regime (full recovery).
- The CCG will commission services for which it is the Lead Commissioner and recover VAT according to the NHS VAT regime (limited VAT recovery).
- Any funds passing between the Partners under this agreement does not represent consideration for a supply of services and shall be outside the scope of VAT.

48. **CAPITAL INVESTMENT**

48.1 The financial arrangements for the Integrated Commissioning Fund will recognise and allow for the Council approach to delivering future service improvement through capital grants to achieve improved quality, lower cost accommodation for services:

- Disabled Facilities Grant

48.2 The Council will retain ownership of any assets that are to be retained.

48.3 The Council has the option to arrange on behalf of both Partners unsupported borrowing to support capital investment in the London Borough of Hackney economy.

49. **RESOURCES CONTRIBUTED BY PARTNERS**

49.1 Staffing, equipment, accommodation etc. resources provided by each Partner to the

management and administration of the Integrated Commissioning Fund will be based, initially, on existing structures.

49.2 The Partners will agree the approach to ensuring a fair share of the cost of administering the Pooled Fund.

49.3 The Partners will identify the savings to be generated through the medium term plan to deliver greater levels of integration of CCG and the Council staff, to identify operational and financial benefits from integration; and will agree the resulting benefit share between Partners.

SCHEDULE 4 – INFORMATION FRAMEWORK

1. Background

This Information Framework provides guidelines as to the level of information to be shared between the Parties, for the purposes of facilitating effective Integrated Commissioning.

The Parties shall share information relating to the commissioning of Services by way of Services Contracts with Providers when acting as Lead Commissioner.

The Parties will also share information in order to help better understand financial issues that may be arising with regard to a particular Service Contract.

Whilst complying with their respective obligations under this Information Framework the Parties acknowledge and agree that any information sharing contemplated by this Information Framework shall take place subject to the terms of the Agreement, and specifically:

i) Clause 6.7.9 of the Agreement, which sets out the obligation for the Lead Commissioner to provide the other Party with information as set out in this Information Framework; and

ii) Clause 31 (Information Sharing and Data Protection).

2. Interpretation

In this Information Framework:

i) the notification or provision of information to a receiving Party shall mean notification or provision of the information by the Lead Commissioner to that Party's Authorised Officer; and
ii) references to any definitions, information or circumstances shall include references to the equivalent definitions, information or circumstances where the Lead Commissioner is entered into a contract by way of Council Contract, CCG Contract or otherwise.

3. Variations

This Information Framework and the Parties' obligations contained herein may be varied in accordance with Clause 34.2.4 of the Agreement.

4. Obligations as Lead Commissioner

The capitalised terms used in this section are, except for where provided for in the Agreement, defined terms under the NHS Standard Contract, and shall be interpreted accordingly.

Notifications

Each Party acknowledges and agrees that where it is Lead Commissioner for any Service Contracts it shall notify the other Party:

If it receives or serves any of the following:

- a Change in Control Notification;
- a Notice of an Event of Force Majeure;
- a Contract Performance Notice;
- a Service Variation;
- a Variation;
- a notice in relation to a Suspension Event;
- an Exception Report;
- a Remedial Action Plan or Immediate Action Plan;

- notice of the appointment of an Auditor;
- a Material Sub-Contractor Change in Control;
- notice of a request for information under the FOIA, EIR or DPA (subject access request);
- notice in relation to the Health Service Ombudsman;

If it becomes aware of one of the following events occurring:

- a material breach of the Provider or Commissioners obligations under the Service Contract;
- a Suspension Event;
- a Provider Insolvency Event;
- a change in Consents;
- a Provider committing a Prohibited Act;
- a Data Breach or any Information Governance Breach;
- any circumstances that have a material and adverse effect on the ability of the Provider to provide the Services;
- any Provider default or Commissioner default (as contemplated by GC17.9 and GC 17.10 of the NHS Standard Contract);
- any breach of confidentiality obligations;
- any Information Breach;
- any publicity, coverage or publications which will both substantially and materially have a negative impact on either Party's or the Provider's reputation in relation to the Services or in the opinion of the Service Users

and provide information where requested by the other Party, in relation to the notification.

Disputes

The Lead Commissioner shall:

- advise the other Party of any matter which has been referred for Dispute and consult with the other Party where there is a material dispute, as part of that process; and
- notify the other Party of the outcome of any Dispute that is agreed by the Lead Commissioner or determined by Dispute Resolution.

Consultation

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

- an Activity Management Meeting;
- a Contract Management Meeting; and
- a Review Meeting; and
- a Joint Activity Review;

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

Reports and Record Provision

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).

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

- CQUIN Performance Reports;
- CQUIN Reconciliation Accounts;
- Essential Services Continuity Plans;
- Immediate Action Plans;
- Incident Response Plans;
- JI Reports;

- Joint Activity Reviews;
- Succession Plans;
- Transition Arrangements;
- Review Records;
- Remedial Action Plans;
- Quality Requirements;
- Service Quality Performance Report;
- Safeguarding Policies;
- Activity Management Plans;
- Data Quality Improvement Plan (DQIP);
- Service Development and Improvement Plan (SDIP);
- Auditor's draft report;
- Auditor's Final Report; and
- HCAI Reduction Plan

Restrictions

The Lead Commissioner shall not:

- permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;
- vary the Data Quality Improvement Plan (DQIP), Service Development and Improvement Plan (SDIP), Remedial Action Plan, Immediate Action Plan or any other Provider plans;
- agree (or vary) the terms of a Joint Investigation or associated Immediate Action Plan;
- suspend all or part of the Services;
- serve any notice to terminate the Service Contract (in whole or in part);
- agree (or vary) the terms of a Succession Plan or Transfer Arrangements,
- agree any substantive changes to the Service Contract in relation to an Auditor's final report;
- give any approvals under the Service Contract;
- agree to, or propose, any variation to the Service Contract (including any Schedule or Appendices);
- serve any notice.

without the prior approval of the other Party (acting through the Integrated Commissioning Board), such approval not to be unreasonably withheld or delayed.

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

1. INTRODUCTION

This Agreement between the Council and the CCG establishes a framework for joining together the commissioning, provision, finances, performance management, and governance for the Services covered by the Agreement.

This Schedule outlines the arrangements for the performance management framework for the Agreement.

2. PURPOSE

This Schedule aims to ensure that Parties adopt an integrated performance management framework to ensure they plan, deliver, review and act on relevant information to commission improved outcomes for the people of the London Borough of Hackney.

This approach will ensure that the actions and investment of Parties will lead towards the achievement of national, regional and local performance targets as well as improving outcomes for the people of the London Borough of Hackney.

3. DEFINITION

Performance management is the overall process that integrates planning, action, monitoring and review. Performance management means knowing:

- What you are aiming for (e.g. purpose, mission, corporate aims, strategic goals etc.);
- What you have to do to meet these aims (e.g. business plan, project plan, etc);
- What the priorities are, and ensuring that there are sufficient resources (inputs);
- What the current performance is through monitoring and reporting; and
- How to review progress, detect problems and take action in a timely manner to ensure the outcome/target is achieved.

4. BENEFITS

Effective performance management enables relevant staff throughout the partnership to:

- Be clear what the strategic objectives are for commissioning; and
- Be clear what outcomes are to be delivered in any one Financial Year,

thereby ensuring better quality Services are delivered to local people.

5. OUTLINE FRAMEWORK

Essentially, the performance management framework consists of three processes in relation to joint commissioning, as set out below.

5.1 BUSINESS PLANNING PROCESS

5.1.1 Commissioning Plans that state the strategic objectives and key performance measures for a period of three to five Financial Years, and commissioning intentions for those objectives with timescales for achievement.

5.1.2 Services Contracts that state how performance will be monitored, reported, reviewed and necessary action taken, including performance indicators.

5.2 **REPORTING AND REVIEW PROCESS**

5.2.1 Overall progress against delivery of the outcomes in the Commissioning Plans.

5.2.2 Overall progress against delivery on the Services Contracts and identification of reasons for under performance.

5.3 **PERFORMANCE IMPROVEMENT PROCESS**

5.3.1 Ensuring action is taken where the continuation of current performance would lead to an outcome/target not being met.

5.3.2 Application of a range of tools and techniques to improve overall performance.

6. FRAMEWORK DETAIL

6.1 **BUSINESS PLANNING PROCESS**

6.1.1 It is the responsibility of the Parties to develop, and annually review, a Commissioning Plan on a rolling three financial year basis for the particular Service to be commissioned. Each strategy will be developed by adherence to the 'commissioning cycle' and in consultation with Service Users and carers.

6.1.2 It is the responsibility of the Parties to develop an annual Commissioning Plan. This Commissioning Plan will state the outcomes to be achieved, by when and what the risks are if they are not achieved.

6.1.3 Each outcome in the Commissioning Plan should be aligned to one of the strategic objectives. Any outcome that is not so aligned should be reviewed as to why it is being considered.

6.1.4 The relevant Party (whichever Party is agreed to be the Lead Commissioner for the relevant Services Contract) should then go through a process of developing, negotiating and agreeing a Services Contract with each Provider regarding the outcomes they are to deliver. It will be clear which Services are to be discontinued e.g. in the advent of a budget reduction.

6.2 Services Contracts with Providers should:

6.2.1 Take account of the requirements of the Better Care Fund Plan (if applicable) and the agreed Commissioning Strategies and annual plans of the Council and the CCG;

6.2.2 Take account of legislative changes; and

6.2.3 Include a requirement on the Provider to develop a detailed service plan (e.g. stating what, by when, by who and the risk associated with not achieving the outcome) as to how the Provider intends achieving the said outcomes. It should also require the Provider to regularly measure progress against achieving the outcomes, to report this to the Lead Commissioner in a timely manner to an agreed frequency (e.g. monthly), and to provide a Performance Improvement Plan or Recovery Plan where financial under performance is significantly under target.

6.2.4 Include a process whereby outcomes may be added / removed as a result of changing needs.

6.3 REPORTING AND REVIEW PROCESS

6.3.1 Regular meetings should be held between the Host Partner and the Provider to review performance.

6.3.2 The Lead Commissioner will monitor Services, as part of a basket of measures that contribute to the delivery of key outcome, having regard to national, regional and local key performance indicators including:

6.3.2.1 National ASCOF Measures;

6.3.2.2 BCF Indicators (where relevant);

6.3.2.3 Audit and inspection recommendations;

6.3.2.4 Relevant Operational Plan indicators; and

6.3.2.5 NHS Operating Framework targets.

6.3.3 These key indicators form part of a basket of performance measures. Activity and Financial indicators will be another part of the complete basket.

6.3.4 The basket of performance indicators will be monitored and reported to the Integrated Commissioning Board using, wherever possible, existing performance reports generated within either the Council or the CCG, and making it clear where the areas of good performance and those of concern are, i.e. using a simple traffic light scheme with exception reporting on the key issues.

6.3.5 The performance of all Providers should be reported, on a regular basis by the relevant Partner to the Integrated Commissioning Board.

6.4 PERFORMANCE IMPROVEMENT PROCESS

Where necessary the Lead Commissioner should require the Provider to undertake specific performance improvement initiatives where performance is significantly under target.

SCHEDULE 6 – BETTER CARE FUND

BACKGROUND

The Better Care Fund will form part of the Pooled Fund, however the Parties acknowledge and agree that the Pooled Fund will not be subject to the BCF Reporting Requirements and Governance – only the Better Care Fund elements of the Pooled Fund will be subject to those terms. For the avoidance of doubt, the Pooled Fund shall not be considered to constitute the Better Care Fund, however the Better Care Fund will be an element of the Pooled Fund.

The Parties acknowledge that this Schedule 6 will be updated by way of a variation following the publication of the of the Better Care Fund Guidance in 2019.

INTERPRETATION

Unless the context requires otherwise, terms used in this Schedule 6 shall be interpreted in accordance with the defined terms set out in Clause 1 of this Agreement. It is acknowledged that the Better Care Fund Plan uses terminology similar but not consistent with the defined terms set out in Clause 1 of this Agreement. Where the word “overspend” is used, for example, and is not capitalised, this shall be interpreted as “Overspend” in accordance with Clause 1 of this Agreement.

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PART TWO – SCHEME SPECIFICATIONS

City and Hackney Clinical Commissioning Group Schemes

Scheme ref no.
2.1
Scheme name
Neighbourhood Model

A robust business case must be accepted by the workstreams and TB in order to progress this model.

The Neighbourhood Steering group signed off the principles of the model and configuration, which was then endorsed by the Unplanned Care Workstream.

A workshop was held by the Transformation Board on the 10 November 2017 to:

- Approve principles of neighbourhoods
- Agree working assumption of eight neighbourhoods
- Consider and recommend an approach to implementation
- Note governance arrangements

Proposed Neighbourhood Mode

A full business case will come back to December Transformation Board meeting.

Investment requirement

The following amounts have been nominally allocated to the Neighbourhood Model; however, as stated above this depends on approval of a business case. Additional business cases may be developed to support other pressures faced by the Unplanned Care Workstream.

£ 2017/18	**£ 2018/19**
1,249,981	1,273,731

Scheme ref no.

3.1.1, 3.1.2, 3.1.3, 3.1.4 - Overview

Scheme name

Long Term Conditions (LTCs)

What is the strategic objective of this scheme?

This scheme directly enhances the integrated care vision in Hackney of more independence and better quality of life. This scheme is expected to target patients with the most common LTCs and reduce their chances of hospital admission.

Overview of the scheme

City and Hackney CCG has an existing enhanced service for long term conditions (LTCs) which provides incentives to general practice to deliver quality enhancements. Improving the quality of care for patients with LTCs is essential for decreasing mortality especially cardiovascular and respiratory mortality, decreasing ambulatory care sensitive admissions, and improving support for patients and their experience. The LTC LES and its predecessors have been strikingly successful as the CCG is now in the top quintile of CCGs for achievements, whereas the PCT was for many years at the very bottom. The following schemes included in the BCF are part of wider LTCs LES in City and Hackney.

- Acute COPD Early Response Service (ACERS)
- Bryning Day Unit/Falls Prevention
- Asthma
- Palliative care - Out of hospital service

Please refer to individual Annex for details for each of the above services.
Annex 1 – Scheme ref no 3.1.1
Annex 1 – Scheme ref no 3.1.2
Annex 1 – Scheme ref no 3.1.3
Annex 1 – Scheme ref no 3.1.4

The delivery chain

Further to the existing LTC LES scheme, City and Hackney CCG is commissioning the above services to improve outcomes for people with these conditions.
Homerton University hospital is commissioned to provide:

- Acute Cardiorespiratory Enhanced & Responsive Service (ACERS)
- Bryning Day Hospital Urgent clinic
- Falls Post
- Asthma

St Joseph Hospice is commissioned to provide:

- Palliative care - Out of hospital service

The evidence base

15.4 million people in England (over a quarter of the population) have a long term condition, and an increasing number of these have multiple conditions (the number with three of more is expected to increase from 1.9m in 2008 to 2.9m in 2018). People with LTCs use a significant proportion of heath and care services (50% of all GP appointments and 70% of days spend in hospital beds), and their care absorbs 70% of hospitals and primary care budgets in England. Long term conditions are the leading causes of death and disability in the population of City and Hackney. Large numbers of patients in City and Hackney have been diagnosed with a long term condition – *Section 3: Case for Change – Table 3 and 4.*

Long term conditions such as coronary heart disease, stroke and cancer are among the leading causes of premature death locally and make a major contribution to the differences in life expectancy between

Hackney and average of England. Circulatory diseases contribute the highest numbers of years of life lost (YLL) of any causes to men Hackney and are the largest single cause of long-term ill health and disability.

City and Hackney has high levels of deprivation and population diversity, which is relevant considering strong links between long term conditions, deprivation (diabetes is more likely to occur in areas experiencing greater levels of deprivation: the rate of diabetes complications is 3.5 times higher among people in social class V compared with those in social class I), lifestyle factors and the wider determinants of health, and the higher prevalence of some long term conditions in particular ethnic groups:

- Type 2 diabetes is up to 6 times more likely in people of South Asian descent
- Type 2 diabetes is up to three times more likely in African and Afro-Caribbean people
- South Asians have a 50% greater risk of premature death from CHD and stroke (the highest prevalence of CHD in City and Hackney in is South Asians)
- Although African-Caribbean populations have a lower than national average risk of CHD, they have a 3 fold higher risk of stroke and a higher risk of hypertension (the highest prevalence of stroke and hypertension in City and Hackney is in people of African-Caribbean descent)

People with long-term conditions are intensive users of health and social care services. It is estimated that the treatment and care of those with long-term conditions accounts for 69% of the primary and acute health care spend in England

Mortality from LTCs in City and Hackney is higher than national rates. Mortality rates for cardiovascular disease have been steadily declining in the UK since the 1960"s and while City and Hackney's rates have shown a similar decline, the gap between local rates and the national rates are as wide as ever. Deprivation is strongly associated with high CVD mortality. The local under 75 mortality rates from CVD and stroke are 90.4 and 17.0 per 100,000 populations respectively, which are both significantly above London and England rates. The directly standardised mortality rate for CVD which is considered preventable is 55.3 per 100,000 populations, which is also significantly above the rate for England (40.6 per 100,000 populations). Around 180 people die each year in City and Hackney of CVD. Mortality rates from heart failure, diabetes and chronic renal failure are also significantly higher in City and Hackney than nationally.

City and Hackney historically have low rates of diagnosing long term conditions. Undiagnosed conditions are linked with increased morbidity and greater hospital admissions. Prevalence of diabetes across England is 4.6%, in City and Hackney it is only 4.1%; this is increasing over time but the gap with England remains. Prevalence of other diagnosed conditions is also low compared to the England or London averages: QOF data suggests City and Hackney are in the lowest 5 centiles in the country for identifying epilepsy, CHD, COPD, CKD, stroke, asthma and hypertension

City and Hackney has higher premature mortality from respiratory disease than nationally, and reducing this is one of the CCG's strategic priorities. Recorded prevalence of COPD is low (1.0% cf 1.7% nationally in 2012/13), against a higher smoking prevalence than the national average (32% compared to 21%). The DH 2012 strategy "An outcomes strategy for COPD and Asthma in England" recommends the commissioning of a community based detection programme focusing on patients at higher risk of COPD to improve diagnosis.

The risk stratification of City and Hackney population shows 13,045 high risk patients. Further analysis of these patients highlight 980 patients with COPD at high risk.

Investment requirement

Sch Ref	Scheme Name	£ 2017/18	£ 2018/19
3.1.1	Acute Cardiorespiratory Enhanced & Responsive Service (ACERS)	649,685	662,029
3.1.2	Bryning Day Unit/Falls Prevention	423,446	431,492
3.1.3	Asthma	71,253	72,607
3.1.4	Palliative Care – Out of Hospital Service	657,563	670,057
Total		**1,801,948**	**1,836,185**

Impact of scheme

See Annex 1 – Scheme ref no 3.1.1/2/3/4

Feedback loop

See Annex 1 – Scheme ref no 3.1.1/2/3/4

What are the key success factors for implementation of this scheme?

See Annex 1 – Scheme ref no 3.1.1/2/3/4

Scheme ref no.

3.1.1

Scheme name

Adult Cardio and Respiratory Emergency and Responsive Service (ACERS)

What is the strategic objective of this scheme?

This service comes under Scheme 3.1. Long Term Conditions, which is initiated as a direct result of City and Hackney Vision of more independence and better quality of life. COPD is among the top LTCs in City and Hackney *(Section 3: Case for Change – Table 4)*.

The objectives of the service are:

- the streamlining and standardisation of COPD care across City & Hackney in order to ensure equity of access, treatment and outcome
- the delivery of Consultant and Nurse clinical leadership for the City & Hackney COPD service in association with GP leadership
- the delivery of rapid and high quality community-based acute COPD care to patients who might otherwise need to access emergency or secondary care service
- the intensive management of inpatient COPD discharges so as to minimise lengths of stay and to ensure as much care as possible is delivered in patients' own homes
- the delivery of a responsive and effective admission avoidance service for COPD patients based on individualised short-term care packages
- the creation of appropriate End of Life care packages for COPD patients based upon acknowledged best practice
- the delivery of a service framework which integrates COPD care across City & Hackney thereby fully utilising existing services, building partnerships between providers and encouraging innovation and development
- the creation of a sustainable specialised service with highly qualified multi-disciplinary team working
- to ensure excellent continuity of care through full GP, Community Matron and Adult Community Services involvement and ongoing education, training and development
- the provision of ongoing education, training and development across the local health community

Overview of the scheme

Service model

1. Primary Care Support

b) To work with primary care to offer community support and advice in the management of COPD in primary care.

c) Refer patients to the ACERS where additional ongoing education and support is needed up and beyond that of the COPD LES or QOF annual review

d) Appropriate timely feedback and communication between ACERS and general practice

e) Offer ongoing education and support to practices as requested (as outreach visits to GP practices, education sessions for primary care staff in addition to a minimum of one centrally held training

session per year)

1. Community-based Rapid Response

f) Provide a 24-hour advice and referral line (accessible to Community Matrons, GPs, Emergency Care Practitioners, Paramedics and identified COPD patients)
g) A specialist COPD practitioner to visit patients in their homes (within 2-4hrs in between 09.00 and 18.00, the following morning if not) in order to assess their condition, ensure optimal therapy was instituted and arrange appropriate on-going care
h) Review and use care plans where appropriate, liaising with GP colleagues regarding updates

1. Community Clinics

i) Nurse Led Community clinics – review any patients discharged from the service with complications or specific ongoing care needs to ensure their care plans were functioning appropriately
j) Provide proactive case management to those at risk patients with moderate, severe and complex needs, ensure the coordination of care for these patients in liaison with clinical colleagues across the local health community (including but not restricted to GPs, Community Matrons, District Nurses, Psychology services, Smoking Cessation Services) and participate in multi-disciplinary review meetings
k) The clinics will offer a rapid access assessment service for COPD patients referred by GPs and Community Matrons.
l) Provide regular information and feedback to the multi-disciplinary team on patient management
m) Provide management of patients with exacerbations in the community
n) Provide and deliver the following services to the at risk patients:
    a. identifying warning signs with the patient/carer to support self-management and/or urgent GP review
    b. reviewing medication and adapting as required
    c. educating patients on the use of inhaler and oxygen techniques
    d. supporting use of rescue packs
    e. supporting medication compliance
    f. monitoring, review and follow-up arrangements
    g. educating and empowering patients and carers with self-management
    h. onward referral to pulmonary rehabilitation if appropriate (with home visits for support if needed)
o) Provide targeted education and support to patients, carers and clinical staff
p) Referrals to other internal ACERS services such as the Home Oxygen and/or Pulmonary Rehabilitation will occur as required
q) The clinics should utilise the input of all the practitioners with a special interest in COPD so as to create an integrated and multi-disciplinary clinic environment for patients at a practice or consortium level

1. Pulmonary rehabilitation

ii. Pulmonary rehabilitation service runs groups at the following sites Homerton Hospital and at 2 community sites: Clissold and Britannia Leisure centres. Inclusion criteria for the service is any patient with a chronic respiratory conditions limited by exertional dyspnoea.

iii. All patients are assessed pre and post attending a group, to determine exercise capacity, health related quality of life and anxiety and depression levels.

iv. The PR Service run rolling groups, and staffed by a Specialist Respiratory Physiotherapist and COPD specialist Nurse. The group combines an individually prescribed exercise program and an multidisciplinary education program as per National Guidelines (BTS PR guideline 2013 and NICE Management of COPD guideline 2010).

v. Total capacity of the service per year is 252 patients, per session this is broken down into Homerton 12, Britannia 18 and Clissold 12 (6 groups x 8 weeks each). However DNA, UTA and mobility level of patient effect these numbers.

vi. The PR service also provides a home pulmonary rehabilitation-based program for patients unable to exercise in a group environment with the goal of referring into a PR group or another community exercise based group on completion of this.

vii. The PR service also provides post exacerbation pulmonary rehabilitation as

appropriate, following National Guidelines.

1. Interventions with A&E

r) Provide support and education in the Homerton A&E department and to other City and Hackney urgent care providers to ensure a high quality evidence based response to managing acute COPD presentations and to support the development of standards and a pathway (a key aspect of this will be to ensure that communication between emergency services and primary care are built into the COPD care pathway both in hours and out of hours and this will also include 1:1 and group teaching sessions for ward and ACERS staff)

s) To ensure good communication between emergency and respiratory departments and primary care following acute presentation and adjustments to care plans.

t) Take immediate referrals for management of patients attending A&E with exacerbations (prior to admission) and provide initial case management and stabilisation

u) Develop protocols to ensure secondary care identifies/notifies the ACERS team of patients in hospital with COPD exacerbations presenting at A&E within 24 hours of their admission.

v) Patients are then assessed by a member of the ACERS team and an appropriate care plan agreed (with input from GP, where appropriate) and implemented (home visits from both nursing and therapy staff to provide intensive input during the acute phase of their exacerbation, follow up within the community and care plan to include self-management, management in the community, what to do to prevent future crises and prevent future attendances at A&E).

w) Each patient would have a named and contactable individual with direct responsibility for their care.

x) A full review of patients who have presented at A&E with COPD exacerbation by following up patients within a week of discharge (including supporting patients to register with a GP if unregistered) and supporting care plan reviews

1. Early Supported Discharge

y) As above, within 24 hours of admission (working with A&E, ACU and other Homerton wards), a ACERS nurse in conjunction with a Respiratory Consultant would assess the needs of each patient in order to develop a post-discharge care plan

z) The focus of this service would be on ensuring discharges within the first 48 hours post-admission (patients with longer lengths of stay would be also be included).

aa) The involvement of GPs and Community Matrons (and other allied health professionals with experience in managing patients with COPD including nurses, physiotherapists, occupational therapists and generic health workers) early in the increased level of community-based medical, nursing and social support for discharged patients should ensure that early discharges become sustainable.

bb) Arrangements would be put in place to ensure that any patients requiring urgent re-admission were fast-tracked.

cc) NICE data suggests that the benchmark population rate for eligibility of an assisted discharge scheme would be 0.06% per annum (60/100,000). This is based on a mean non-elective admission rate of 210 per 100,000 population for exacerbations of COPD and a 30% uptake rate for assisted discharge. For City and Hackney (with a population of 280,000) the average number is likely to be 150 per year (on average equating to 6 per year for an average sized practice [list size of 10,000], but dependent on demographic factors such as age and smoking and the high rate of under diagnosed COPD in the population).

dd) The length of care in the community may vary but studies indicate that on average each patient requires 7 days of care in the community as part of a single episode of assisted discharge. The total number of community based care is therefore 420 days per annum per 100,000 population. It is anticipated that the patients who have been through the assisted discharge scheme would then be referred onto the community pulmonary rehabilitation programme and Community Matrons as appropriate.

1. End of Life Care

ee) For those patients in whom death was deemed to be imminent, the team would work with the local hospice provider and / or the adult community nursing service

ff) For appropriate patients identified by the ACERS team, contact would be made with the relevant GP and St Joseph's Hospice Community Palliative Care team to agree a way forward on discussing developing an Advance Care Plan indicating preferred place of care and preferred place of death (including how to optimise continuity of care, symptom control and carer support) with patients. This may involve liaison with Community Matrons, social and voluntary sectors.

gg) Refer patients as appropriate to St Joseph's Hospice Community Palliative Care team
hh) Input to Breathing Space clinics at St Joseph's for patients with COPD in their last years of life

The delivery chain

Homerton Hospital is commissioned by City and Hackney CCG to provide the community COPD service for City and Hackney patients.

The evidence base

See Annex 1 – Scheme ref no 3.1

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£ 2017/18	**£ 2018/19**
649,685	662,029

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Medium
Admissions to residential and care homes	N/A
Effectiveness of reablement	N/A
Delayed transfers of care	Medium

Feedback loop

Process Measures		
Item	Target	Comments
Number of referral to ACERS team (source/for what service element)	1800 per annum	
Number of training sessions for GP practice staff	2 per annum	
Number of patients attending A&E reviewed and care plan developed	70	
Number of referrals to pulmonary rehabilitation	200 per annum	
Number of home visits	3,000	
Report number of patients referred to inpatient smoking cessation and community smoking cessation and receive feedback on patients who have attended	N/A	Data from inpatient and community teams
Record smoking status of patients known to the service	N/A	Record on RiO

Patient Measures		
Item	Target	Comments
Patient experience (annual survey)	50 per annum	
CAT/HAD scores (pre- and post-ACERS intervention)	50 per annum 75% of patients reducing their CAT score pre- to post-intervention	

Clinical Measures: Contribution to overarching outcomes, no specific targets

- Reduction in A&E attendances for COPD
- Reduction in emergency admissions for COPD
- Reduction in readmissions
- Reduction in LOS for COPD patients

KPIs for whole year presented quarterly to City and Hackney CCG Respiratory Board. Any issues raised to Long Term Conditions Programme Board. Annual report (including audits undertaken and performance improvement) presented alongside.

What are the key success factors for implementation of this scheme?

- Recruitment of skilled staff
- Agreement of evaluation framework
- Engagement of primary care staff – in diagnosis of patients, adherence to pathways/guidance, working with early discharge plans
- Engagement of A&E staff – establish links with ACERS staff for patients presenting to A&E with exacerbations of COPD
- Establishment and embedding of 24/7 advice and referral line for use by health professionals
- Engagement of St Joseph's hospice – for links around end of life care

Scheme ref no.

3.1.2

Scheme name

Bryning Day Unit/Falls prevention

What is the strategic objective of this scheme?

Bryning assessment and rehabilitation unit is a complementary service run by Homerton University Hospital. The unit targets elderly patients identified through risk stratification and aims to reduce the emergency admissions.

Overview of the scheme

The Bryning Unit has a multidisciplinary team consisting:

- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Social workers; and
- Nursing staff.

Their specialist skills in elderly care complement the highly experienced and knowledgeable consultants in Homerton Hospital to provide comprehensive multidisciplinary assessments.

A weekly programme of clinics and groups is run to provide assessment, rehabilitation and support for older people with complex problems.

Services available

- ***Medical clinics***

  Our specialist consultant geriatricians hold multi-disciplinary clinics to thoroughly assess and ensure any health problems the patient is experiencing are investigated and addressed.
- ***Leg ulcer clinic***

  This is a specialist, nurse-led clinic for people with complex leg ulcer or deterioration of an existing leg ulcer.
- ***Falls clinic***

  Specialist multi-disciplinary clinics for people who have had one or more falls, or are at risk of falling. The main aim is to identify the causes of falls, to prevent future falls.
- ***Falls group***

  Our physiotherapist and occupational therapist run a four–week group for people who have fallen. This includes specific advice and a twice-weekly exercise programme and relaxation session to improve confidence, muscle strength and ability to cope with falls in the future.
- ***TIA (Transient Ischaemic Attack) clinic***

  TIA is the medical term for a suspected minor or a short -lived stroke.
- ***Parkinson's disease and movement disorder clinic***

  Specialist multi-disciplinary clinic for people with suspected or known Parkinson's disease or other conditions that can affect movement and muscle control.
- ***Continence clinic***

  Specialist nurse-led clinic for people who have urinary problems. A full assessment is provided with various investigations. Nurses then recommend how they can best manage their incontinence.

The delivery chain

The service is provided by Homerton University Hospital and commissioned by City and Hackney CCG.

The evidence base

See Annex 1 – Scheme ref no 3.1

Investment requirements

£ 2017/18	£ 2018/19
423,446	431,492

Impact of scheme

The scheme is aimed to reduce emergency admission through complex needs and falls.

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Medium

	Admissions to residential and care homes	Low	
	Effectiveness of reablement	Medium	
	Delayed transfers of care	Low	
Feedback loop			
Monitored through Homerton UHFT's annual acute contract.			
What are the key success factors for implementation of this scheme?			
Already in place			

Scheme ref no.

3.1.3

Scheme name

Asthma

What is the strategic objective of this scheme?

The service objectives are:

1. **A long term aim** will be to reduce the number of people with asthma who die prematurely through a proactive approach to early identification, diagnosis and intervention, and proactive care and management at all stages of the disease, with a particular focus on disadvantaged groups and areas of prevalence and **this relates to our LTC board outcome of reducing under 75 years mortality from respiratory disease per 100,000 population.** Although it is expected that this service will contribute to this outcome, it is not anticipated that any changes in this measure will be observed during the lifetime of this contract. (KPIs 4,5,6,7,9)
2. To improve the respiratory health and well-being of all communities and minimise inequalities between communities.(KPIs 9,12,13)
3. To enhance quality of life for people with asthma, across all social groups, with a positive, enabling experience of care and support right through to the end of life.(KPIs 8,13,14)
4. To ensure that people with asthma, across all social groups, receive safe and effective care, which minimises progression, enhances recovery and promotes independence.(KPIs 7,8)
5. To ensure that people with asthma, across all social groups, are free of symptoms because of prompt and accurate diagnosis, shared decision making regarding treatment, and on-going support as they self-manage their own condition to reduce the need for unscheduled health care and risk of death.(KPIs 10,11,12)

Overview of the scheme

This service will support improvement in primary care management of asthma as well as a more structured approach to asthma care within the Homerton Hospital with a focus on self-management and effective communication. According to the INHALE benchmarking tool for asthma emergency department (ED) attendances and hospital admissions for asthma (per 100 patients on the asthma register) for residents in City and Hackney are significantly worse than the national average.

This service will also offer asthma expertise in the community in order to train health professionals, educate asthmatic patients in their own environment and integrate the provision of asthma care across the primary and secondary care sectors. The ACERS team at HUHFT work in a similar model on COPD and they have been shown to be very successful in reducing re-admissions and bed days from COPD.

The Service

The service will be available to patients over the age of 18 years registered with a City and Hackney GP.

This service will lead asthma management in primary care working closely with the lead asthma respiratory consultant at HUHFT and lead GP for asthma within City &Hackney. The service will address 9 key areas in excellent quality asthma care which are taken from best commissioning practice. The 9 areas include:

1. *Information for patients:* Working with Asthma UK to ensure that all information with regards to asthma is made available at the time of need.
2. *Accurate and timely diagnosis:* The service will ensure that primary care clinicians are adequately skilled to make an accurate diagnosis of asthma and have access to the required diagnostic facilities and expertise.
3. *Supporting self-management:* To ensure that written individualised self-management plans are a key element of asthma care for all patients through structured and tailored education programme for asthma. Ensure practices are using self-management plans.
4. ***Structured review by asthma-trained clinicians:*** To ensure that structured reviews are based on evidence based guidance and there is a regular programme of education for all

involved in the care of people with the condition.

5. *Optimising medication:* Develop ways in which clinicians and pharmacists need to consider how to achieve improved outcomes for people with asthma, while minimising wasteful use of medicines.
6. *Severe/brittle/difficult-to-control asthma:* Work with current services to ensure that the specialist services are available for all within this group, which may comprise only 5-10% of the asthma population, but use up to 80% of the costs of asthma care.
7. *Managing acute and life-threatening episodes:* Education in the emergency departments and with other healthcare settings who have access to specialist advice and expertise in managing acute asthma, and good communication between emergency and respiratory departments, to ensure continuity of care.
8. *Avoiding hospital admissions and emergency department attendances:* To work with HCP's to develop a pathway to ensure that all healthcare professionals should be working with patients to ensure that loss of asthma control is identified early and appropriate steps are taken to regain control to avoid a full attack developing. A key aspect of this will be to ensure that communication between emergency services and primary care are built into the asthma care pathway.
9. *Following up acute episodes:* A full review of the patients post exacerbation of ED visit should be followed up. And where patients do not have a registered GP to work with HUHFT to access primary care services and follow-up.

The service will include:

- Undertaking visits to the ED to review asthma patients and working with the ED to develop a clear pathway for asthma patients attending the ED to include primary care follow-up and review.
- Developing a tailor-made education package for asthma patients focusing on asthma annual reviews and self-management advice including the local incentive scheme for asthma as a benchmark.
- Undertaking visits to practices to identify and review complex asthma patients within primary care – and acting as an expert in treatment and education, including working alongside practice nurses to educate / supervise their practice.
- Undertaking a current audit of asthma practice using the NICE clinical standards as a benchmark.
- Providing regular updates and teaching sessions in group and 1:1 sessions for ward, primary care and ACERS staff.
- Acting as the clinical champion for asthma within primary care.
- Working with the respiratory consultant to develop and update the CHARM guidelines for Asthma Management.

All of which would contribute to improving outcomes for patients and reducing ED attendances/admissions.

The delivery chain

It is expected that the postholder will work within the framework of the existing COPD service arrangement in order to complement and share the expertise and expand the remit of the ACERS to cover both asthma and COPD. Therefore the post holder will be located in the ACERS team and have managerial support by the ACERS Nurse Consultant as well as from the Asthma respiratory Consultant and professional nursing leadership.

The evidence base

There are around 1,000 deaths from asthma a year in the UK, the majority of which are preventable. The UK has the highest prevalence of asthma in the world, at around 9-10% of adults. Asthma costs the NHS an estimated £1 billion a year. It is estimated that around 80% of spending on treating those with asthma is spent on the 20% with the severest symptoms. There is a 6 fold variation in admission rates across England for adults with asthma.

Many people with asthma are not achieving freedom from symptoms, with a recent large scale survey

reporting that around 35% of adults with asthma had had an asthma attack in the previous 12 months.
Asthma is a long-term common chronic inflammatory disease of the airways which affects more than 1 in 5 households in the UK and around 5% of the population in City and Hackney. Asthma responds well to appropriate management and is principally managed in primary care; however ineffective management can lead to poor health outcomes including emergency hospital visits and admissions. Asthma cannot be cured, but for most people it can be effectively managed with preventive therapy.
Clinicians should be supporting people to make the right choices to manage their asthma, by giving them information about their condition and providing clinical expertise. Asthma varies from day to day and from person to person, so managing it daily is not a straightforward process. People need help to recognise when their asthma is worsening and when they need access to the expertise of the NHS. When they do have contact with a healthcare professional, the aim must be to make the interaction as productive as possible and this means within a partnership of care based upon a process of shared decision making. Inputs of care must also be integrated across the traditional boundaries of hospital and community-based services. We know that Asthma costs to the NHS are an estimated £1 billion a year, with poorly controlled asthma more expensive for the NHS than well controlled asthma. A patient whose asthma exacerbates and requires hospital treatment is likely to cost 3.5 times that of a patient who does not.

An audit of the asthma admissions carried out at Homerton hospital has shown a gradual increase in the number of asthma patients attending the emergency department and subsequently admitted for an acute exacerbation of asthma. This service will support improvement in primary care management of asthma as well as a more structured approach to asthma care within the Homerton Hospital with a focus on self-management and effective communication. According to the INHALE benchmarking tool for asthma emergency department (ED) attendances and hospital admissions for asthma (per 100 patients on the asthma register) for residents in City and Hackney are significantly worse than the national average.

This data also shows that a number of asthmatics attend the ED for repeat inhaler prescriptions and a further 100 of them have attended twice or more in a year. There is also clear evidence that a significant number of asthmatics have not been on preventive therapy and many of them are complex patients who are difficult to reach using the existing follow up arrangements. There is a clear need to improve asthma care in the community to reduce ED visits and hospital admissions. A further recent study by Barts Health specialist community pharmacist undertaken in about 150 patients with airways disease has confirmed that expert review of the care and modification of medication has also resulted in a significant savings of around £32K on prescribing costs and reinforces the need for patient focussed expert asthma care and medicines management in the community.

There is wide variation in achievement of asthma QoF targets and asthma prevalence (table one).

This service will offer asthma expertise in the community in order to train health professionals, educate asthmatic patients in their own environment and integrate the provision of asthma care across the primary and secondary care sectors. The ACERS team at HUHFT work in a similar model on COPD and they have been shown to be very successful in reducing re-admissions and bed days from COPD.

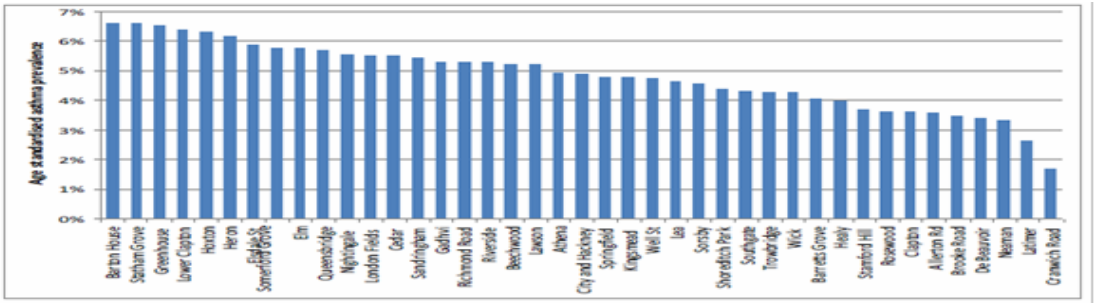


Figure One: Asthma Prevalence

1 Outcomes

- Link to NHS Outcomes Framework domains & Indicators

This proposal supports the combined CCG and HUHFT objectives of preventing unnecessary attendances at ED, reducing readmissions and reducing length of stay through building the number of asthma patients seen in the community rather than acute services.

Investment requirements

£ 2017/18	£ 2018/19
71,253	72,607

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Low
Admissions to residential and care homes	N/A
Effectiveness of reablement	N/A
Delayed transfers of care	N/A

Feedback loop

Performance indicator	Indicator/Quality Requirement	Format & Frequency	Consequences of breach
1. Total number of patients attending A&E with primary diagnosis of asthma	Record activity (C+H patients only)	Quarterly report	Formal report re: reason and action plan
2.Total number of patients admitted	Record activity (C+H patients only)	Quarterly report	
3.Total City & Hackney patient medication requests	Record activity (C+H patients only)	Quarterly report	
4.Number of GP practices visits	Minimum 1 per practice per year (pro rata if project runs for less than 1 year)	Quarterly report	
5.Number of training sessions for GP practice staff	Minimum 25 (pro rata if project runs for less than 1 year)	Quarterly report	
6.Number of Formal Study Days Organised	Minimum 3 per year (pro rata if project runs for less than 1 year)	Quarterly report	
7.Number of complex patients in primary care reviewed	Record activity (C+H patients only)	Quarterly report	
8.Number of patients with severe asthma with personal asthma	100%	Quarterly report	

	action plan			
	9.Record demographic details of clients using the service to enable equity audit	Ongoing data collection	Ongoing	
	10. Reduction in A&E attendances for asthma	5% on baseline (435)	Quarterly report	
	11. Reduction in emergency admissions for asthma (HUHFT reporting number of admissions with a primary diagnosis of asthma)	10% on baseline (110)	Quarterly report	
	12. Monitor number of patients who die of an asthma exacerbation	No target	Ongoing	
	13. Improvement in patients quality of life, measured via the asthma control test	75% of patients showing improvement	2 week sample audit	
	14. Patient satisfaction with service measured via service specific survey	80% of patients satisfied with service	Quarterly report	

What are the key success factors for implementation of this scheme?

Risk and brief explanation	Mitigating actions
Unable to recruit suitably trained staff	Wide recruitment campaign, target existing respiratory staff from a current London Network and aim to backfill post if on secondment perspective.
Long term funding post	Appropriate auditing and cost efficiency of savings needed from day one, along with appropriate evaluation to ensure appropriate data for long term investment.
Unable to fulfil KPI performance and make the recommended cost saving as suggested.	Part of risk share – pilot project to assess feasibility and learning from this. Ensuring appropriate audit, review and reporting mechanisms

Scheme ref no.

3.1.4

Scheme name

Palliative Care – Out of Hospital Service

What is the strategic objective of this scheme?

The aim of the service is to provide high quality Specialist Palliative Support to patients in the community in the last years, months and days of life, to enable patients to maintain their identify and independence during the changing phases of their illness, which includes:

- Expert assessment, advise, care and support for patients and carers
- Expert assessment, advise, support and education for health and social care staff caring for patients with Specialist Palliative Support for Last Years, Months, Days of Life Care needs
- Improvement to the quality of care to all patients which respects their wishes in regard to their preferred place of care and death

Overview of the scheme

The service commissioned will:

- Be comprised of the core members of the Specialist Palliative Support for Last Years, Months, Days of Life Care team as defined by NICE Supportive and Palliative Care Guidance with clear and timely processes for accessing the extended Specialist Palliative Support for Last Years, Months, Days of Life Care team
- Carry out ongoing assessment of needs using the four domains of care: physical, psychological, spiritual and social
- Use care planning, including advanced care planning, to meet identified needs
- Provide ongoing assessment and recording of patient and carer preferences for care including location for care and death.
- Have a minimum of weekly multidisciplinary team meetings for review of patients' needs and care planning
- Be involved in monthly GP based / lead multidisciplinary team meetings with wider health care team
- Communicate assessment and care planning to the referrer and wider health and social care team in a timely manner
- Coordinate care where specialist palliative care worker is identified as the key worker for a patient and liaise with local key worker when specialist palliative care team worker is not the key worker
- Provide care that is culturally and spiritually sensitive with access to translation and advocacy services when a patient's first language is not English
- Provide and promote care using the best practice tools Provide support and advice to staff in other services caring for patients with Specialist Palliative Support for Last Years, Months, Days of Life Care needs
- Deliver education regarding best practice in Specialist Palliative Support for Last Years, Months, Days of Life Care. This includes identification and assessment of patients' palliative care needs; communication skills, symptom management, Advance Care Planning and the diagnosis of dying
- Undertake assessment of carer needs and ongoing referral to support networks as required
- Provide comprehensive medical and nursing cover to deliver care twenty four hours a day seven days a week
- Undertake assessment of bereavement needs and onward referral and signposting to local bereavement support services

The following criteria are in addition to the criteria above and specific to services delivered in different care settings.

Specialist Palliative Support for Last Years, Months, Days of Life Care Unit

- Available to patients with complex problems in any of the four domains that cannot be managed adequately in other community settings and who would benefit from the continuous support of a multi-disciplinary Specialist Palliative Support for Last Years, Months, Days of Life Care team
- Timely and comprehensive communication with referrers and GPs following admission to the unit
- Timely and comprehensive discharge planning for patient returning home following an episode of

care in the unit
- Assessment of need in the last days of life and provision of care in line with the recently published guidance of the Leadership Alliance for Care of the Dying.
- Provision of medical interventions to manage complex symptoms using a variety of interventions.
- Clear processes for death certification preventing inappropriate referral to the coroner
- Provision of bereavement care to families and carers after a death in the in-patient unit
- Provide for medication and pharmacy needs for patients while on the ward and supply medication to take home on discharge

Community Specialist Palliative Support for Last Years, Months, Days of Life Care Service

- Provision of expert clinical advice to GPs and community health care staff including attending GP based MDT meetings at a practice and quadrant level
- Receive referrals from other staff (GP, community nursing, acute staff) of patients who have been identified as approaching the last years of life (who may have either generalist support needs and those with more specialist palliative care needs – subject to initial assessment) and to provide holistic assessment of patients' and carers' care, social and spiritual care needs
- Each CNS to hold a caseload of patients
- Effective individualised advance care planning, including support to other staff in creation of ACPs and CMC records, review of plans/records created by others and updating where necessary
- Signpost patients to other support from St Jo's
- Identify and support other professionals to identify when pts are deteriorating and reassess care needs as necessary
- Management of complex symptoms and signpost to sources of advice for increasing care needs/symptom worsening (to reduce unnecessary admissions to hospital)
- Assist in the prevention of any unnecessary hospital admissions
- Facilitating speedy discharge from hospital where appropriate, working with the Elderly Care Unit, and other wards, to improve the process of discharge and the care provided to patients once back in the community
- Identify and support other professionals to identify when pts are approaching last weeks/days of life and reassess care needs as necessary
- Coordination of services, in the last days of life, urgently as appropriate, including access to advice, non-medical prescribing, authorisation chart and access to medicines
- Support patients to be cared for and die in preferred place
- To advise and support nurses, doctors, GP's and other members of the wider health and social care team providing care to the patient and their carer/family, including joint patient visits where required
- Training and education to the non-specialist workforce (as above)
- Provide particular support to care/residential homes to ensure processes in place for accessing advice both in hours and out of hours, and staff feel confident on who to contact in case of deterioration (named CNS for each care home, support visits, raising awareness of urgent support/advice services, attendance at relevant care home/practice MDT, case management of patients including care home visits, support to staff in discussing future palliative care with patients/families, training for staff on advance care planning and identification/management of last years of life, deterioration and last weeks/days of life, encourage and support care staff in completing advance care plans for care home patients and in avoiding unnecessary hospital admissions/diagnostics at end of life
- Signpost families/carers to appropriate pre- and post-death bereavement support

Day care Specialist Palliative Support for Last Years, Months, Days of Life Care service

- Provision of day care to prevent hospital admission
- Provision of care across the four domains that enable the patient to avoid unnecessary hospital admissions and to focus on achieving the patient's choice of care and quality of life.
- Provide ongoing information and explanation patients and carers as the patients disease progresses to empower them to make informed choices and signpost to services
- Provide support to patient providing effective symptom control to enable them to remain at home and achieve quality in their life.
- Provide opportunity for cares to have a respite from their caring activities
- Provision of bereavement care to families and carers after a death of a patient using the day care facilities

Accessibility/acceptability
The service will have referral processes to ensure that patients in need of Specialist Palliative Support for Last Years, Months, Days of Life Care services are able to access and receive support from the service.

The service will be staffed by a work force that is competent in the delivery of Specialist Palliative Support for Last Years, Months, Days of Life Care including skills in communication, cultural awareness, promotion of dignity and with respect for patient wishes and preferences. The service will be responsive to age, culture, faith and ideology, disability and gender issues in relation to palliative care dealing with them in a sensitive and inclusive way. The service will have processes to ensure that specific cultural and religious beliefs relating to Specialist Palliative Support for Last Years, Months, Days of Life Care are respected at all stages of the care pathway and in the period after death.

The Service will provide interpreting services, inclusive of sign language interpreting, to ensure that all patients receive equal access to health and advice in accordance to their level of clinical need. Interpreting by family members or friends is not acceptable except in exceptional circumstances

Interdependencies
Continuity of care across care settings is essential to ensure that patients' identified needs continue to be met despite a change in care setting. Therefore assessments and care planning undertaken by the specialist palliative care service need to be communicated with other services involved with the patient. Key interdependencies are listed in the local Specialist Palliative Support for Last Years, Months, Days of Life Care pathways and include:

- Acute services including A&E, wards and out-patient departments
- Primary health care teams including district and community nursing and GPs, community matrons
- Long term conditions and specialist teams such as heart failure, COPD in acute and community settings
- Specialist Palliative Support for Last Years, Months, Days of Life Care (in other locations)
- Rapid response and urgent care teams, Out of Hours services including GPs, district and community nursing, specialist palliative care
- London Ambulance Service
- Social Services including case managers
- Coroners and funeral directors
- Voluntary and third sector organisations
- Service provided by the independent sector such as care homes

<u>Referrals</u>

Referrals will be received from – GPs, Community nursing teams, Integrated Independence Team, secondary care, and care homes, referrals are also accepted directly from patients and those significant to them

<u>Referral Process:</u>

- All referrals through First Contact team (telephone referrals are accepted). First contact teams working hours are 08.00-18.00 Monday to Friday. For urgent out of hours admission please call 0300 30 30 400.

- First contact team may contact referrer for further information. The patient will not be contacted until this information has been received. Minimum information is required before a referral can be actioned: a GP summary, last clinic letter where appropriate and confirmation of patient consent to referral.

- **Urgent referrals**: If the patient is considered to have urgent (RED) needs (significant and uncontrolled symptoms or thought to be in the last days of life) the patient will be contacted and where necessary have a face-to-face assessment within 24 hours, even outside of the first contact teams working hours. This may be before the MDM discussion has taken place. The patient will still be discussed at the next Multi-Disciplinary meeting (MDM) which are held at 09.00 Monday to

Friday.

- **All other community and inpatient referrals:** all non-urgent referrals are contacted by phone to ensure they are aware that St Joseph's have the referral and have an initial needs assessment within 24 hours to ensure there is no unreported urgent need. The patient will be given the 24/7 advice and support number at this time and the assessment process explained. If the patient has no unidentified urgent needs then they will be informed that they will be contacted by the First contact team who will conduct a full telephone assessment where the patient or their advocate will have an opportunity to express their concerns , issues and expectations of the support St Joseph's can offer them. The patient will then be discussed at the MDM the following day. If the referral is accepted, they are given a RAG rating for admission or contact with the community team, depending on their level of need. Soon (Amber) within 3 days or Routine (Green) within 7 days and passed to the relevant team.

Response times for urgent and non-urgent referrals:

- Patients with urgent (RED) need (significant and uncontrolled physical symptoms or in thought to be dying in next few days) will be contacted and admitted, subject to bed availability or seen in the community within 24 hours of referral

- For non-urgent referrals to supportive care the patient's needs will be assessed by the end of the next working day by the First contact team. The patient will be discussed at the MDM meeting and if the referral is accepted they are allocated to the appropriate service who will make the initial contact with the patient to arrange an assessment or admission within 3 days for Soon (AMBER) or 7 days for Routine (GREEN). If the patient is unable to participate in the assessment the information will be obtained from a relevant family member and/or health care professional, (the team does have access to interpretation services)

Communication with the GP

The GP will be contacted on the day the referral is received.

If the patient is referred to the community palliative care team the GP will receive a summary within 3 days of the face-to-face assessment.

Eligibility Criteria

- Any adult patient/s who have active and or progressive, life-limiting illness, and are experiencing difficulties related to that illness from within the catchment area.
- Young adults aged 16-18 for whom access to adult services is appropriate within the catchment area

- The patient requires Specialist Palliative Support for Last Years, Months, Days of Life Care needs that cannot be met by non-specialist staff
- The patient has distressing symptom(s) that are not responding to current treatment regimes
- The patient has multiple symptoms recognised as being difficult to control which are not responding to current treatment regimes
- The disease is perceived to be rapidly progressive by the multi-disciplinary team, the patient or his/her family
- The course of the illness is developing in an unexpected way that is not related to active treatment
- The patient or family are suffering due to psycho-social or spiritual distress due to the diagnosis, symptoms, treatment, prognosis of the disease, or the facing of death

The service should actively engage with other health and social care providers to ensure all patients with complex needs have access to expert advice and support.

Exclusion Criteria

Any referred patient that does not meet the referral criteria.

Discharge

Patient should be discharged by the Community Palliative Care team when:

- Specialist palliative support intervention is on longer required or need is being met by another service. Discharge should be discussed with the patient/carer and ensure they are aware that they can re-refer.
- Patient moves outside service area
- A patient dies

Prevention, Self-Care and Patient and Carer Information

Patients will be included in the development and implementation of care plans and in continuous re-evaluation of their needs and care requirements. These care plans will include review of needs, preferences for place of care and death and satisfaction with care provided. Patients and carers will be encouraged to take part in self-care, monitoring and active participation in their care plans and carers will be encouraged to utilise bereavement and psychology services as required.

The service will have available and offer to patients the following written information

- Description of the service including operation times, remit of service and contact telephone numbers
- Key contact information
- Emergency contact details
- Practical information about what to do when the patient dies
- Information in languages other than English, as required by the local population
- Information in format other than written for those unable to read the written word
- Letters regarding their care in line with the Patients Charter 2000

The delivery chain

St Josephs Hospice services will be delivered in all care settings including the community, care homes and extra sheltered care housing, the hospice, community hospitals, hostels for the homeless and mental health services

Inpatient care in will be provided 24 hours a day, 365 days a year.

The Community service will provide a visiting service during core hours (9am to 5pm) 7 days a week and access to Specialist Palliative Support for Last Years, Months, Days of Life Care advice 24 hours a day 365 days a year.

Support services (e.g. counselling, psychology, physiotherapy, occupational therapy) will be provided during core hours (9am to 5pm), 5 days a week as a minimum and as required by individual patient needs.

The evidence base

NICE Quality Standards for End of Life Care for Adults https://www.nice.org.uk/guidance/qs13

NICE guidelines on Care of the Dying Adults in the Last Days of Life https://www.nice.org.uk/guidance/ng31

Gold Standards Framework

Five Priorities for Care (Leadership Alliance for Care of Dying People): https://www.england.nhs.uk/ourwork/qual-clin-lead/lac/

National EOLC Ambitions (http://endoflifecareambitions.org.uk/):

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff prepared to care
6. Each community is prepared to help

Investment requirements

£ 2017/18	£ 2018/19
657,563	670,057

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	N/A
Effectiveness of reablement	N/A
Delayed transfers of care	N/A

Feedback loop

Performance Indicator	Indicator	Threshold	Method of measurement	Frequency of Monitoring
Service User Experience	Service user satisfaction Carer satisfaction Number of complaints and compliments received % of complaints acknowledged within 5 days % investigated within agreed timescale with complainant Experience improvement plan – number of complaints resulting in service change	80% satisfaction 100% 100%	Service user survey Review of complaints Review of complaints	Quarterly
Care closer to home	Average LOS	<16 days		
Reducing Inequalities	Number of patients with cancer and non-cancer diagnosis on caseload including ethnicity	To achieve 30-50% mix	Reporting of patient diagnosis	Quarterly
Reducing Barriers	Patient ethnicity	30-50% from BME groups	Report on patient ethnicity	Quarterly
Personalised Care Planning	% Patients with a document advanced care plan offered by third contact with the Hospice	100% 80%	Report on % offered discussion	Quarterly

	% Patients expressed preference of place of death		Report on & with documented ACP or PPOD	
Outcomes				
Integrated Coordinated Care	% Patients dying in place of choice	70%	Caseload data	Quarterly
Performance & Productivity				
Improving Productivity	Average length of stay	<16 days	Reporting ALOS	Quarterly
Patient safety and service quality	Provider information return on: · Serious Incidents; · Complaints by type · Healthcare associated infections; and, · 4 patients harms measures: Falls, pressure ulcers (grades 1-4), Urinary tract infections in patients with a catheter, and, Venous thrombo-embolism (VTE).		Report on numbers and type for complaints and pressure ulcers	Quarterly
Access	Provision of care against hospice care pathways - with specific detail on use of respite beds within STJH		Report on numbers following each pathway and respite day beds used	Quarterly
Additional Measures for Block Contracts				
Staff turnover rates	Number of staff leaving and starting work at hospice (clinical)		Reporting	Annual
Sickness levels	Number of working days lost to sickness in clinical and non-clinical staff		Staffing report	Annual
Agency and bank spend	Exception reporting		Reporting	Annual
Contacts per FTE	Not applicable			
Activity				

What are the key success factors for implementation of this scheme

This scheme is already in place.

Positive engagement between:

- Acute services including A&E, wards and out-patient departments
- Primary health care teams including district and community nursing and GPs, community matrons
- Long term conditions and specialist teams such as heart failure in acute and community settings
- Specialist Palliative Support for Last Years, Months, Days of Life Care (in other locations)
- Rapid response and urgent care teams, Out of Hours services including GPs, district and community nursing, specialist palliative care
- London Ambulance Service
- Social Services including case managers
- Coroners and funeral directors
- Voluntary and third sector organisations
- Service provided by the independent sector such as care homes

Scheme ref no.
3.2
Scheme name
Paradoc
What is the strategic objective of this scheme
To reduce avoidable emergency admissions
Overview of the scheme

The aim of this project is to extend the three month pilot of a joint response to defined groups of patients in the community with urgent and primary care needs. The response will be provided by an OOH GP with a LAS Paramedic in a response car. The target groups of patients are those who have a low threshold for seeking emergency care for urgent care conditions by calling 999:

- patients conveyed to ED by Ambulance who are subsequently discharged home or have a zero length of stay
- patients who call 999 with primary care/ urgent care needs that do not require an emergency ambulance/ paramedic response
- frequent callers/ attenders
- exacerbations of long term conditions

The key objective of this initiative is to ensure patients receive the most appropriate response in terms of seeing the right healthcare professional at the right time. It is also critical that they are aware of all local primary care provision allowing referral and interaction as appropriate.

London Ambulance Service respond to patients with complex, chronic and co-existing conditions that will often have acute episodes or exacerbations that require a level of assessment/ intervention beyond the normal scope of ambulance clinicians / paramedics. These cases are often conveyed to hospital but some could be managed more appropriately at home with rapid input by a GP.

Conversely the AMPDS call-handling tool results in an ambulance response to patients triaged as “life threatening” due to their telephone presentation, but where the face to face assessment will often find the patient in need of Primary/Urgent Care.
Currently ambulance clinicians in City and Hackney have limited options available to facilitate the successful referral of patients to other providers and services. As a consequence, this results in the easy and risk adverse option of an unnecessary conveyance to an Emergency Department. PARADOC offers a more appropriate solution to this cohort of patients. It will also provide support to ambulance clinicians for patients will clinical need but refuse A&E.

It is anticipated that the joint response service will run 7 days a week from mid-afternoon to the early hours of the morning, in line with trends in LAS call demand. Initially 2pm to 2am has been considered with GPs operating split shifts of 6 hours. Weekends may need to be different hours although further discussion is required to agree the optimum shift pattern. Further detailed analysis of LAS call demand and outcomes within the CCG footprint is required to verify the hours of operation by day of week. The service will not respond to calls in public places or workplaces, it will only respond to patients at home (including nursing and care homes).

Referral to PARADOC

To achieve outcomes that support admission avoidance and non- conveyance to an ED, it is essential that PARADOC is tasked to appropriate calls. PARADOC will respond to 999 calls that have either been:

1. Reviewed by a Clinical Team Leader in the Clinical Hub within the LAS control room, this will include an assessment using Manchester Triage, where the outcome suggests the patient is in need of a GP assessment but unlikely to need conveyance to hospital
2. Assessed on scene by an ambulance clinician (Paramedic or EMT), including use of Paramedic Pathfinder assessment tool and Pre Hospital Early Warning Score , where the outcome indicates the

patient is in need of a GP assessment/ urgent care but unlikely to need conveyance to hospital

3. Named patients who are frequent 999 callers or frequent ED attenders

Patient Conditions/ indications for referral to PARADOC

Using the referral approach described above, a wider range of patients can be seen by PARADOC, for example:

- exacerbations of COPD
- UTI
- elderly "scared and home alone". Patients with a low threshold for seeking urgent care
- Patients with pre-existing/ multiple health needs with urgent care needs, e.g. chest infection
- heart failure
- non traumatic back pain
- paediatric patients with minor ailments (LAS currently takes all patient under 2 years of age to hospital and has a very low threshold for taking any child under 16 to A and E, irrelevant of condition)
- chest pain where cardiac cause can be excluded
- abdominal pain
  - diarrhoea and Vomiting
  - flu symptoms
  - diabetics
  - medication issues
  - patients refusing consent to be conveyed to hospital but allowing on scene assessment/treatment
  - risk stratification for mental patients suffering from depression, to avoid A&E
  - advice, analgesics and possible antibiotics for patients post minor operations
  - allergic reactions
  - end of Life Care patients
  - post – hospital discharge patients, e.g.post op wound infections (avoidance of readmission)
  - patients in nursing homes and care homes without priority symptoms
  - patients with a CMC record

The delivery chain

London Ambulance Service will be the lead provider for the PARADOC service supported by CHUHSE who will provide the GP and other identified resources.

The evidence base

The case for change essentially relates to managing rising demand by providing a smarter and different response, thus ensuring there are appropriate resources available to meet the differing needs of patients.

The London Ambulance Service is commissioned to provide a pan-London emergency ambulance service, handling approximately 1.8 million 999 calls a year that result in over 1 million emergency responses. There is a year on year increase in Cat A workload, YTD this is trending at around 7% pan – London. Cat A calls are generally more resource intensive, thus providing a good level of service to less urgent patients is problematic during surges in demand. Typically there is a surge in demand over the winter period due to an increase in alcohol related calls over the festive period, seasonal flu and viral illness, exacerbations of chronic illness due to cold weather. The table below shows the increase in Cat A work load and total incidents from Winter 11/12 to Winter 12/13 in the Homerton Operational Area:

Month	Cat A Incidents 12/13	Cat A Incidents 11/12	% Difference Cat A	Incidents 12/13	Incidents11/12	% Difference
Oct	**1578**	**1385**	**13.94%**	**3906**	**3640**	**7.31%**
Nov	**1560**	**1429**	**9.17%**	**3790**	**3617**	**4.78%**
Dec	**1719**	**1597**	**7.64%**	**3725**	**3874**	**-3.85%**
Jan	**1544**	**1352**	**14.20%**	**3761**	**3499**	**7.49%**
Feb	**1474**	**1435**	**2.72%**	**3542**	**3481**	**1.75%**

Mar	**1595**	**1558**	**2.37%**	**3951**	**3854**	**2.52%**

NB: The number of incidents in Winter 12/13 will be reduced by use of DMP.
The total number of incidents by category in the City and Hackney CCG area from October 2012 to March 2013 is shown in the table below:

	Cat A	Cat C1	Cat C2	Cat C3	Cat C4	Total Incidents
City and Hackney CCG	**7683**	**1108**	**5036**	**1756**	**3127**	**18710**

In 32% of cases, patients are not conveyed to an ED however evidence from the Physician Response Unit (PRU) shows that a greater number of patients do not need to be taken to hospital. The Physician Response Unit is based at the Royal London and consists of a Doctor (HEMs rotation) and LAS Paramedic, operating Monday – Friday 8am – 4pm. PRU data collected over a 6 month period (Nov 12 – April 13) showed the following outcomes:

- 48% referred to GP
- 17% referred to specialist
- 4% no follow up required
- 24% conveyed by ambulance to ED
- 7% deceased (cardiac arrest and major trauma)

Unlike the PRU, this proposal uses a GP in place of an ED/HEMS clinician and therefore will be more efficient as the service will able to directly deal with the types of call the PRU refers to GPs. By ensuring the joint response service is tasked to the most appropriate urgent calls, the number of patients requiring conveyance to acute care will be minimal.
PARADOC can provide an alternative pathway that ambulance clinicians, both in the control room and on the road, will be able to refer to with ease and with confidence. PARADOC will offer a solution to those patients where the on scene ambulance clinician doesn't believe the patient is appropriate to be left at home without further assessment by a more appropriate clinician (i.e. a Doctor) but may not need A&E.

Investment requirements

£ 2017/18	**£ 2018/19**
592,750	604,012

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	Low
Effectiveness of reablement	N/A
Delayed transfers of care	N/A

Feedback loop

Key performance indicator	**Target**	**Comment**
Minimum activity level- number of calls attended by PARADOC	Trajectory Weeks 1 and 2 - Average of 46 patients per week Weeks 3 and 4 - Average of 55 patients per week Weeks 5 onwards: Average of 63 patients per week	

Non-conveyance/ referral to an Emergency Department	75% of all cases?	Difficult to ascertain the current conveyance levels for these patient groups and ultimately therefore the improvement delivered through the service

What are the key success factors for implementation of this scheme?

Risk and brief explanation	Mitigating actions
Availability of suitable Doctors	Current level of GP engagement with CHUHSE has been excellent and so it is expected recruitment should not be an issue
Technology solution for Adastra	Utilising the process CHUHSE have undertaken in preparation for go-live for ooh likely to be similar
Appropriate tasking to calls	Close collaboration and feedback to be delivered to LAS in the management of call distribution
Ability to develop a joint service governance framework	Utilise experience gained through similar initiatives currently running

Scheme ref no.

4.1

Scheme name

Adult Community Rehab Team (ACRT)

What is the strategic objective of this scheme?

The service aims to provide specialist inter-disciplinary rehabilitation to clients with community goals over the age of 18 with a physical or neurological impairment. Clients who are living with one or more long term condition(s) that would benefit from slow-stream, rehabilitation would benefit being seen by ACRT. The service encourages self- management and can offer therapy case management to enable clients to stay living in their chosen environment.

The team aim to prevent unnecessary hospital admissions and achieve reductions in length of stay by facilitating timely discharge for clients with long term conditions and/or slow stream rehabilitation needs when leaving hospital.
For clients with complex needs requiring medical intervention and/or review, joint working arrangements are in place with both Homerton Geriatric Consultants and a Neurology Consultant.

The service also offers advice and support to carers, family and friends of service users to maximise the function and wellbeing of ACRT clients.

Overview of the scheme

ACRT bases itself on The Social Model of Disability which puts the client at the forefront emphasising independence and choice whilst respecting clients' dignity. This is why intervention is not time limited and is based on clients' own goals and desired achievements. Therapists work with clients to help improve their ability to participate in normal day-to-day activities in order to minimise the impact of living with a disability.

The amount of rehabilitation provided is determined by the client's needs and goals. Clients with progressive conditions may require on-going reviews by their therapists and vulnerable clients will be placed on a review register to ensure appropriate reviews take place. Clients who require equipment as part of the rehabilitation process can be prescribed equipment by ACRT therapists.

The team operate as one but work according to 2 different pathways – neurological and physical conditions and although clinically the two groups of therapists work within different clinical specialties, operationally they work according to the same policies and procedures.

Robust screening protocols mean that all senior therapists are skilled in receiving referrals and prioritising accordingly, regardless of a neurological or physical background. All 1-2-1 clients are assessed using the same Single Assessment Process and the same goal setting procedures.

Clients are seen in the place that is most appropriate to them. This may be at home, work, college, local leisure centre or on site at St Leonard's. Rehabilitation can include Physiotherapy, Occupational Therapy, Speech and Language Therapy, Clinical Neuropsychology, Psychological Therapies and Consultant Allied health Professional (AHP) in Neurological Rehabilitation.

Neurological conditions

Any client with a progressive (e.g. Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease) or non-progressive (e.g. stroke, Traumatic Brain Injury) condition can be seen by any of the specialist neurological therapists. Other conditions that are shown to benefit a neurological approach to rehab are those such as those diagnosed with Medically Unexplained Symptoms (e.g. Conversion Disorder).

The AHP Consultant in Neurological Rehabilitation is responsible for co-ordinating the neurological rehabilitation pathway for clients requiring placement in tertiary centres. As part of this pathway the AHP Consultant works alongside the neurological conditions side of ACRT to facilitate discharge to the community and also to provide support to the clinicians in the management of clients with complex neurological rehabilitation needs. This aspect of the role includes support to integrate rehabilitation, nursing and social care. The AHP consultants involved in clinical research and evaluation of the rehabilitation pathway. The AHP Consultant holds a monthly community neurology clinic with a Consultant Neurologist

which provides a responsive service to clients living in the community with neurological conditions. Clients receive a neurology review as part of the multidisciplinary team and this allows clients equal access to neurology services and supports the team's principle of facilitating clients with complex disability to remain at home. The AHP Consultant holds a clinical caseload that involves a case management approach for clients with complex neurological rehabilitation needs. The AHP Consultant also supports the management of neurological clients who require are eligible for Continuing Health Care needs alongside the Continuing Health Care Team.

Physical conditions

Clients with any physical condition who require a community-based rehabilitative approach can be seen by the specialist physical conditions team. Services and Pathways include: Falls and Osteoporosis Care Pathway, Balance Group, Pulmonary Rehab, Lymphoedema, Physiotherapy for adults with mental health difficulties, Housebound service for clients with chronic pain, Hand Therapy and Obesity.

Population covered

The service is provided for City and Hackney GP registered population and people who are not registered with any GP but resident of City and Hackney. If the service does see anybody not covered by the above criteria they need to ensure that they charge the host commissioner and not count within City and Hackney activity targets.

Any acceptance and exclusion criteria and thresholds

Acceptance

- Adults aged 18 upwards
- Registered with a City and Hackney GP
- Clients who are unable to access out-patient therapy services requiring community assessment
- Clients with primarily a physical disability or neurological diagnosis (progressive or non-progressive)
- Clients who require management and/or rehabilitation of physical or neurological progressive or non-progressive long term conditions that will benefit function and mental well-being

Exclusion

- Clients under 18 years old
- Clients without a City and Hackney GP (except those neuro rehab clients under the AHP consultant who may reregister with a different GP)
- Hospital in-patients
- Is currently open to another therapy team for the same intervention
- Has needs that would be better met by an intensive approach to rehabilitation (signpost to IIT)
- Requires immediate assessment (within less than 5 days) due to high risk of hospital admission or to facilitate discharge (signpost to IIT)
- Has primarily medical needs and/or an acute medical condition that will prevent them from participating in rehabilitation
- Clients who do not require rehabilitation
- Refusal by client for assessment/intervention by team
- Requires OT equipment provision only - signpost to Social Services OT
- Has primarily social issues - sign post to Social Services
- Requires Psychological input only - Primary Care Psychology - referral via GP

Interdependence with other services/providers

The team liaises with GPs, Consultants and therapists (at Homerton, Barts and RLH, St Joseph's Hospice and the National Hospital for Neurology and Neurosurgery), carers, Community Nurses, other Homerton University Hospital NHS Foundation Trust providers (e.g. Locomotor and Wheelchair Service), Community Palliative Care Team, Healthwise, Greenwich Leisure Limited (GLL) and the Access Team at LBH. The team also works closely with the voluntary sector, including the Stroke Survivors Project, Ability Bow, Headway East London, Rehab UK and the Stop Falls Network. These services have full access to the professionals

within the team for support and advice and are a vital link in a number of different care pathways. Local leisure centres and third sector networks often provide the exit pathway for clients who have completed all clinical rehabilitation.

The delivery chain

See above

The evidence base

- Shepperd S, Illiffe S. 2006. Hospital at home versus inpatient hospital care. The Cochrane Database of Systematic Reviews.
- Kendall E, Buys N, Larner J. 2000. Community based service delivery in rehabilitation: the promise and the paradox. Disability and Rehabilitation. 22(10):435-45.
- Finkenflugel H, Wolffers I, Huijsman R. 2005. The evidence base for community-based rehabilitation: a literature review. International Journal of Rehabilitation Research 28(3):187-201.vHartley S, Finkenflugel H, Kuipers P, Thomas M. 2009. Community-based rehabilitation: opportunity and challenge. Lancet 374(9704):1803-1804.

Investment requirements

£ 2017/18	**£ 2018/19**
2,569,180	2,617,994

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	N/A
Admissions to residential and care homes	High
Effectiveness of reablement	High
Delayed transfers of care	Medium

Feedback loop

NHS Outcomes Framework Domains and Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	**X**
Domain 3	Helping people to recover from episodes of ill-health or following injury	**X**
Domain 4	Ensuring people have a positive experience of care	**X**
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	**X**

Local defined outcomes

- All urgent clients are contacted within 2 working days and seen within 5 working days
- All non-urgent clients seen within 5 weeks
- All GPs and clients are sent a letter confirming their referral and waiting time for assessment
- All clients given the opportunity to set goals within 4 weeks of initial assessment
- All clients requiring intervention for longer than 10 weeks will be reviewed
- On discharge, clients, GPs and referrers are sent a report outlining their goals, intervention to date and discharge plans
- Provide ACRT clients (1:1 and groups) the opportunity to provide feedback about service they have received by offering satisfaction questionnaires and inviting attendance to User Involvement Group

- All clients with complex rehabilitation needs referred to the AHP consultant seen within 1 week of referral
- All clients discharged from AHP Consultant rehabilitation programmes to suitable long term or community placements without unnecessary delays in rehabilitation placements
- The AHP Consultant/ neuro navigator will coordinate and support timely access to, provision of, and discharge from specialist rehabilitation settings without unnecessary delays.
- The AHP consultant/ neuro navigator will provide specialist advice, assessment and support to the continuing healthcare team for people with complex neurological conditions.

Reporting Requirements

Reporting Requirement	**Frequency of reporting**	**Method for the delivery of the report**	**Information Source**
90% of urgent clients seen within 1 week	Monthly	Electronically	RiO
90% of non-urgent clients seen within 5 weeks	Monthly	Electronically	RiO
90% ethnicity recording	Monthly	Electronically	RiO
Less than 10% DNAs	Monthly	Electronically	RiO
15256 client attendances per year	Monthly	Electronically	RiO
AHP consultant/ neuro navigation intervention commenced within 1 week of referral.	Monthly	Electronically	RiO
All clients discharged from level 1 specialist neuro rehab units to long term rehabilitation or community placements/home are reviewed within 3 months of discharge by AHP Consultant/ neuro navigator	Monthly	Electronically	AHP consultant submit quarterly returns (Spreadsheet)

What are the key success factors for implementation of this scheme?

Given the interdependence of various services providers, the key success factor of this scheme is the positive engagement between all relevant providers at any given time related to a given case.

Scheme ref no.
5.4
Scheme name
Adult Community Nursing
What is the strategic objective of this scheme?
The overall function of this service is to provide high quality closer to home aimed at improving or maintaining health, promoting independence and self-care and avoiding hospital admissions.
Overview of the scheme

NHS City & Hackney commission the Adult Community Nursing (ACN) service to provide nursing care, case management, advice and education, to residents over the age of 18 years.

The ACN Service is responsible for providing a service to all City and Hackney residents, primarily in their own homes, in clinics and residential care settings. This includes those residents registered with City & Hackney GPs, residents without a GP and residents who are registered with a GP outside of the borough.

The ACN service is made up of several component parts:

- Integrated community matrons and district nursing teams
- Specialist services
- Discharge planning and continuing care teams

District nurses

The district nursing team will focus on the provision of high quality clinical care for service users within their own home and associated leg ulcer clinics. The teams will enable service users to maximise their health and wellbeing to ensure hospital admissions are kept to a minimum and time spent in hospital is reduced. The teams will work very closely with social care and voluntary care organisations to ensure the needs of people living in Hackney and City are met.

The teams will provide a palliative care service and ensure that service users that wish to die in their own home are assisted to do this and that all care is provided in a timely and supportive manner. The End of Life pathway will be implemented and when appropriate the Liverpool care pathway instigated ensuring that the service user, GP and carers/relatives are fully involved in all decisions. All patients will be treated with dignity and respect at all times.

These teams operate Mon – Sunday 08.30hrs – 23.00hrs. There is no on call facility for outside of these hours.

Community Matrons

The community matrons will support patients with long term conditions in both preventive work and the effective management of these conditions to reduce hospital admissions and bed days in hospital. The community matrons will manage a case load to ensure the service users care is consistent and of a high quality.

These teams operate on a Mon – Fri basis 09.00 – 17.00hrs with no on call facility

Nurse Specialist Teams

Tissue Viability & Wound Management

The team will deliver a service to ensure wound care is evidence based and that all staff within the services are skilled in providing wound management. They will work alongside the district nursing teams to assess, advise and review wound care including pressure ulcers. They will work actively with the teams to ensure the most up to date and appropriate pressure relieving equipment is purchased for service users where appropriate.

Continence/Parkinson's/Multiple Sclerosis/Learning Disabilities

The team will work with service users to enable them to maintain an independent lifestyle. They will ensure that appropriate equipment is provided in a timely manner and that reviews are undertaken to ensure that it meets the service user's needs.

Service users will be assisted to manage their condition, they will be aware of where and when to seek help to prevent deterioration and hospital admission.

Specialist teams operate Mon – Friday 09.00 – 17.00hrs with no on call facility.

Discharge Planning & Continuing Care

The team will support the continuing care process including reviews of all patients in non NHS care homes and completion of documentation for CCP.

The team will work very closely with all neighbouring hospitals to ensure the timely discharge home of all end of life patients by ensuring a care package is in place and all equipment is in the home.

Telehealth

Telehealth has been described as 'the delivery of health related services enabled by the use of technology without the need for travel.'

The use of Telehealth by the community teams will continue to be utilised and reviewed re its effectiveness and for those services users who will benefit from the system, full use of it will be implemented within their home.

Referral criteria

The service is provided for clients 18 years old above who are primarily housebound. All referrals are via a generic email address or fax number.

All referrals will be accepted from all health care professionals. Self-referrals will also be accepted if appropriate. All patients referred to the service are visited and assessed in order to develop an individualised care plan. There are criteria for priority for admission to the service. The service recognises that different types of patients require different response times and this is determined by using a priority rating system (as below):

- High Priority - These patients are seen within 4 hours.
- Medium Priority - To respond within 24 hours and to visit within 48 hours
- Low Priority - To respond within 48 hours and arrange visit.

Specialist Teams:

These services receive referrals from all health care providers. Each referral will be assessed and triaged as appropriate.

Exclusion criteria

The following groups of patients will not be accepted for care provision by the Adult Community Nursing service:

- Patients below the age of 18 years
- Patients with no nursing need
- Patients resident outside City and Hackney area/boundaries, except in the case of Continuing Care patients, who will be assessed for their continuing care needs if they are within City & Hackney boundaries at the time the assessment was required, regardless of where they normally reside.
- Where a patient funded by NHS City and Hackney as NHS Continuing Healthcare receives a service above and beyond the maximum service provided by Adult Community Nursing the service will agree funding prior to provision of service.
- For patients that are in a Hackney Nursing Home, in a nursing bed and in receipt of RNCN contribution

and are recorded on the RNCN Database the service will be reimbursed for the costs of continence products.

For patients funded by NHS City and Hackney who meet the NHS Continuing Care criteria the provider will be reimbursed for specialist equipment costs incurred, Such as suction pumps and ventilators, this does not apply to small equipment such as gloves and dressings

Discharge

Once the nursing intervention is completed and the patient no longer requires the nursing service, the patient is discharged from Adult Community Nursing care.

- Care package achieved
- Patient/carer can self-manage condition safely and independently
- Care package declined by patient and following consultation and agreement from the GP that it is appropriate to withdraw ACN input
- Transfer to other Health Care setting
- Referral to more appropriate service
- Patient death

The service will send all discharge letters to referrers and GPs within 24 hours of discharge.

The delivery chain

Commissioner
City and Hackney CCG

Provider
Homerton University Hospital

The evidence base

National Priorities

- The Health Bill 2011
- Our Health Our Care Our Say (2006): - Our NHS, Our Future (DOH, 2008)
- The Black Report 2008
- **National Service Framework for Long Term Conditions (DOH, March 2005)**
- National Service Framework for Older People (DOH, March 2001)
- National Service Framework for Diabetes
- **Royal College of Physicians.** *National clinical guidelines for stroke,* **2nd edition.**
- Falls – The Prevention of Falls in Older People (NICE, November 2004)
- Standards for Better Health (2004)
- **NHS Plan (DOH, 2000)**
- Mental Capacity Act 2005 (DOH)
- **National Framework for NHS Continuing Healthcare and NHS funded care (DOH 2007)**
- Good Practice in Continence service (DOH 2000)
- Essence of Care—Benchmarking for Continence bladder and bowel care.
- Health Care Commission Standards for Better Health—National Programme of standards to be achieved, performance monitoring, overall PCT performance rating.
- Government Public Service Agreement (PSA) target to reduce emergency bed days through improved care in primary and community settings.
- The Government Seven Principles for Supporting Self Care 2/5/08
- Lord Ara Darzi's 10 year vision for "High quality Care for All" 30/6/08.
- Transforming Community health services - Enabling new patterns of provision (DH 2009)
- 2020 vision – A future for District Nursing (Queen's Nursing Institute 2009)

Local Policies

- Older People's Dignity Charter (adopted by THC Board)
- Partnership Boards: Older People, Physical Disabilities.
- Joint Strategic Needs Analysis (JSNA 2014)
- DOH & Policy in CHCCG, LBH, HUH & ELFT: Safeguarding Adults – Protection of Vulnerable Adults.
- Urgent Care Strategy CHCCG
- End of Life Care Strategy (Liverpool Care Pathway & Case Management
- City & Hackney Falls Pathway
- Wound Management
- PCT Annual Report 2008: Improving patient experience, staff satisfaction and public engagement.

Investment requirements

£ 2017/18	£ 2018/19
3,546,689	3,614,076

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	Medium
Effectiveness of reablement	Medium
Delayed transfers of care	Medium

Feedback loop

Refer to schedule 6

What are the key success factors for implementation of this scheme?

- Good partnership working between clinicians and health professionals across primary and secondary care
- Patient and user involvement and control in planning of their care

London Borough of Hackney Commissioned Schemes

Scheme ref no.
1.1
Scheme name
Support to carers
What is the strategic objective of this scheme?
The strategic objective is to support carers to continue caring by providing information and advice, early intervention and respite to carers across the City and Hackney, encouraging greater carer control.
Overview of the scheme
The model of care and support provides a pathway of support including: • Information and signposting to personalised services and support • Identification of carers under stress • Early intervention for new carers • Direct payments to carers for a short break, equipment or activities that support their wellbeing • Residential respite • Carers assessments, reviews and support plans. • Support that encourage carers' skills in coping strategies and retaining ' a life of their own' for example, coaching, well-being activities, stress reduction courses. The carers services have capacity to support 3,100 carers each year from 2015-16. This represents an increase of 1,800 in the number of carers currently being supported through Adult Social Care and Carers' Contracts. Providers will manage new demand by supporting a proportion of carers receiving support to access universal services and community res that promote their health and well-being and be supported into employment
The delivery chain
The service is commissioned by LBH on behalf of City and Hackney CCG. The providers include a range of independent sector and third sector providers of short breaks, residential respite and direct payments. Key third sector providers include City and Hackney Together, consortia of third sector providers locally, City and Hackney Carers' Centre, Bikur Cholim and the Alzheimer's Society.
The evidence base
Carers UK and University of Leeds (20ll) Valuing Carers estimated that the 2011 value of carer support in Hackney is worth £336 million based on a unit cost of replacement care of £18 per hour, hence support to carers is critical to patient outcomes. This is reflected in Hackney Council's Carers Strategy 2012- 14 (attached). Evaluation of the National Carers' Strategy Demonstrator Sites Programme (2009-2011) found the benefits of partnership working to be – improved carer support procedures, better monitoring systems, more effective communications and more carers registering for support. In the ND sites 80% of carers responding to their survey reported not previously taking a break of more than a few hours from their caring role. Accessing support allowed carers to 'have a life of their own' even if for a short time. Cost savings were felt to be achieved by: preventing hospital or residential care admissions, improved health and wellbeing of carers and assisting carers to return to, or remain in work.
Investment requirements
2016/17 £702k **2017/18 £715k** **2018/19 £728k**
Impact of scheme

Impact on National Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Medium
Admissions to residential and care homes	Medium
Effectiveness of reablement	Medium
Delayed transfers of care	Medium

- Increase the number of carers returning to paid employment, training or education
- Maximise income for carers
- Help carers to stay mentally well
- Help carers to stay physically well.
- Increase the number of carers accessing health and wellbeing support
- Improved quality of life for carers

Feedback loop

Biannual ASCOF carers survey results
Metrics 2016/17

No. of carers supported to have 'a life of their own' – CCG to supply
Respite or other forms of carer support delivered to the cared for person = 93
Carers assessed or reviewed = 1138
No. of carers supported to access Direct Payments = 150
No. of older carers supported = 304
No. of carers identified previously unknown to statutory or voluntary services - delete
No. of carers supporting someone with a long term condition – CCG to supply
No. of carers supported to remain healthy by timely and appropriate access to GP and other health and social care services - CCG to supply
No. of carers who supported who subsequently self-manage their caring role – CCG to supply
No. of carers supported to stay in full or part time work, or supported to return to work – CCG to supply
No. of carers supported to access volunteering or training opportunities – CCG to supply
No. of carers participating in the design, planning and implementation of carer services – What is the source?
No. of carers accessing service reviews – no such data

Percentage of carers for whom quality of life has improved and who report that they are satisfied with the service which they have received.

Last reported 2016/17
Carer-reported quality of life 6.9
Overall satisfaction of carers with social services 26.19%
Proportion of carers who report that they have been included or consulted in discussion about the person they care for 58.93%

Activity levels 2015/16

- 1160 carers supported per year
- 1138 carers assessed/reviewed
- 150 direct payments per year

What are the key success factors for implementation of this scheme?

Successful partnerships with key providers – Strong collaborative working in place

Carer support expertise – Significant experience and expertise in the third sector of providing carer support.

Outreach to unknown and new carers – Strategy in development.
Some this service is already in place.

Scheme ref no

1.2 / 1.5

Scheme names

- **Integrated Community Equipment Service (ICES)**
- **Telecare**
- **Occupational Therapy**

What is the strategic objective of this scheme?

The main objectives of Community Equipment and Telecare Services are to enable older and disabled people, including children with disabilities, to remain in their own homes, to live more independently and to maximize their potential.

These objectives are in line with Marmot priorities which stipulate a shared framework between City & Hackney CCG and LBH Adult Social Care:

- To give people the best start in life
- To provide people with a healthy standard of living
- To create healthy and sustainable places and communities

Overview of the schemes

ICES: In line with national guidance, LB Hackney offers it residents a variety of equipment, ranging from simple to complex, when assessment by a health and social care practitioners identifies the need.

Telecare: These devices are a category of community equipment that use telecommunications to alert others of service users' needs for assistance. Basic telecare tools range from pendants to wrist bands and pull cord alarms. These devices can be complemented by additional sensors for a variety of hazards within the home including falls, fire, flood, etc.

Occupational Therapy Service: During the assessment stage, Occupational Therapists take a whole-person approach to their client's mental and physical wellbeing to allow those individuals achieve their full potential. In particular, the OT Service aims to help those with physical and cognitive impairments to maintain optimum levels of functionality and mobility. This may necessitate referral of service users to other health and social care professionals with whom the Service works in partnership in order to provide them with tailor-made package of care.

Since the selection of a new Telecare provider in August 2017 who themselves are providers of equipment, it has been brought to light that a complete disaggregation of Community Equipment and Telecare Services may be advantageous in that it would ensure flexibility in the selection of providers, enable more rigorous monitoring and financial controls as well as result in smoother business process within Commissioning, Procurement and for health and social care teams who refer their clients to the Telecare service.

Integrated pathways across health and social care teams have been developed to improve joint working and service delivery, resulting in a better use of resources and an improved customer experience. One example is a new pathway aimed at facilitating hospital discharge.

Currently, Telecare, ICES and Occupational Therapy predominantly benefit the frail elderly as well as children and adults with physical disabilities. However Telecare initiatives have targeted those with learning disabilities for example by prescribing GPS sensors that can assist them to become more self-sufficient and travel independently; or by supplying their parents with proximity sensors that monitor children's movement and ensure that they remain safe in the home.

There is now increasing demand on services to use technology to cater for those with more complex needs for example people with dementia, learning disabilities and mental health issues plus those with acquired brain injuries.

The delivery chain

ICES: The Council has commissioned the supply of ICES including delivery, repair and refurbishment through a company called Medequip following a competitive tender in 2011. The contract term has expired, but Medequip continue to deliver the service through a mutual agreement with LBH pending the outcome of the Summer 2017 tender exercise. This is expected to be published in Dec 2017.

Telecare: In late August 2017 a single tender action appointed Millbrook Healthcare to deliver all aspects of Hackney's telecare including the equipment, the monitoring and the response service. This is for a two year period pending a review of the service.

The Occupational Therapy Team in Hackney, in particular the staff assigned to Telecare play a key role in supporting prescribers in their orders as well as the external Telecare and ICES providers.

The Council and City & Hackney CCG jointly resource telecare.

The evidence base

Provision of equipment including telecare for older and disabled people produces savings for health and social care through speedier hospital discharges and lessening the need for beds in care establishments. It will also help maintain people's independence since the majority of service users wish to live in their own homes for as long as possible.

Occupational Therapists support service users, facilitate their recovery and help them to overcome barriers that prevent them from doing the activities and occupations that matter to them. This support enhances people's freedom, autonomy and satisfaction of life.

Occupational Therapy also contribute to cost savings through effective hospital discharges and keeping individuals safe outside care institutions and by reducing dependence on double-handed care packages.
http://www.cot.co.uk/occupational-therapy-evidence-fact-sheets
http://www.cot.co.uk/sites/default/files/commissioning_ot/public/Cost-savings-commissioners.pdf

Investment requirements

Community Equipment and Adaptations

- Estimated at £6 – 7.5 Million

Telecare

- External provider August 2017 – July 2018: £541K plus equipment costs
- LBH Telecare Team £85,500 approximately
  - 1 x Project Manager @ 40% WTE
  - 1 x Occupational Therapist @ 50% WTE
  - 1 x Coordinator @75% of WTE
  - 1 x Service Manager @ 10% WTE

BETTER CARE FUND CONTRIBUTION

Scheme 1.2 Community equipment and adaptations:

2016/17 £1,040k
2017/18 £1,059k
2018/19 £1,079k

Scheme 1.5 Telecare

2016/17 £257k
2017/18 £262k
2018/19 £267k

Impact of scheme

Impact on National Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Medium
Admissions to residential and care homes	High

Effectiveness of reablement	Medium
Delayed transfers of care	High

Expected outcomes from ICES include:

- Relative independence for older people and those with disability through rehabilitation/ intermediate care
- Respect, dignity and a positive experience of care and treatment for service users
- Speedier release from hospital

For Telecare, the following additional outcomes are expected:

- Reduction in number of people requiring more intensive forms of intervention
- Increase in number of people completing their recovery and recuperation at home
- Contributing to providing holistic housing options
- Supporting carers

Activity levels

- In 2016/17 Hackney Telecare was responsible for approximately 3,500 connections
- In 2016/ 17 Hackney ICES delivered approximately 37,000 items of equipment

Feedback loop

Regular contract monitoring meetings between commissioning team, occupational therapy and the external ICES and Telecare providers offer a platform at which contractual and operational issues as well as activity are discussed.

In relation to occupational therapy, sharing of workforce development programmes enables joint training across adult social care and health teams which has in turn resulted in the sharing of good practice.

What are the key success factors for implementation of these schemes?

- Employing recent innovations and advances in technology
  Following good practice in the respective services and continuous monitoring of and improvement in service quality
- Robust service specifications
- Continues budget monitoring in order to maintain the expenditure within budget and Search for potential savings and efficiencies
- Robust implementation plans for the new contracts – including transition plans to ensure smooth transfer for service users
- Contributing to speedy hospital discharges
- Improving take up of services which contribute to prevention i.e. Telecare
- Increase in joint working among health and social care professionals including Occupational Therapy
- Service user and stakeholder participation

Scheme ref no.

1.3

Scheme name

Maintaining eligibility criteria and other services associated with the Care Act 2014

What is the strategic objective of this scheme?

The overarching strategic objective of this scheme is to provide the highest quality care and support services to vulnerable adults in Hackney and to respond to the requirements under the Care Act 2014 so that we make a vital and positive difference to people's lives.

The aim is supported by five core objectives

- **Meeting the person, not just the need** – ensuring that the needs of the whole person are recognised so that services are designed around them
- **Promoting Independence** – enabling people to live a fulfilled life, making the most of their capacity and potential
- **Providing wider choice** – having access to a choice of, and control of, good quality services
- **Improving access** – enabling people to access services which meet, and are responsive to, their individual and diverse needs
- **Joining up and innovating** – working in partnership to develop the capacity to achieve change and deliver our priorities

Overview of the scheme

The scheme offers services to people who are eligible within the National Fair Access to Care Services Framework ensuring that the principles of the In Control model are embedded in our practice. This ensures that the interventions, commissioning and support planning offered enables people to be in control and maximise or maintain their independence and choice while robustly addressing safeguarding issues for all vulnerable adults. The service works collaboratively with preventative services offered through the Information and Assessment Team, Hospital Social Work Team and Targeted Preventative Services. This close working enables the reablement pathway to operate seamlessly across the Adult Social Care pathway.

The Care Act introduced national eligibility criteria framework and early indications are that an increased number of adults will come forward with eligible care needs and there will be a need to increase the size of care packages for those receiving services as more of their care needs will be eligible under the new framework. The scheme ensure that funding is available to meet this new duty and will provide the following services for service users with eligible care needs

- **Housing with Care schemes** with partners with suitably adapted accommodation and to offer care and support in the community wherever that is feasible to meet someone's needs (as opposed to residential care).
- **Home care** to support people with long term care needs to stay at home we offer home carers to help with personal care needs.
- **Personal budgets** to ensure that the people requiring longer term care can take as much control over their lives as their needs allow; this will include direct payments.

The focus of the allocation from the BCF will be on people over 65 with long term conditions who are eligible for care under the national eligibility framework.

The delivery chain

Commissioners:
London Borough of Hackney Commissioning team set the overall commissioning strategies for the provision of adult social care services.

Providers:
Home Care:
We currently use the following providers (November 2017)

- Aquaflo Care
- Castlerock Group
- Supreme Care
- Care World London
- Hartwig Care
- London Care
- Care Outlook
- Goldsmith Personnel
- Bikur Cholim
- North London Bikur Cholim

Housing with Care: London Borough of Hackney Provider Services

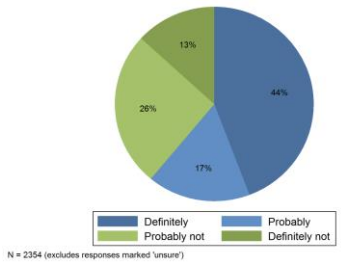
The evidence base

Department of Health The Care Act 2014 : Assessment and eligibility workshops

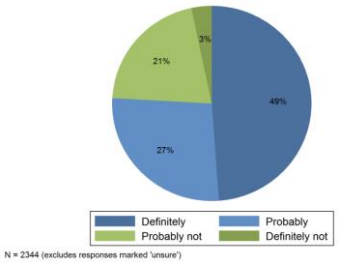
- Eligibility threshold set in regulations. Engagement on first version of the draft regulations:
- DH held engagement workshops;
  - Eight workshops held: three in London, Birmingham, Taunton, Derby, Preston, Gateshead. Around 250 people, representing over 100 local authorities
- The Care and Support Alliance engaged with people who use services and their carers; and
  - Nearly 400 users of care services and carers took part in the survey.
- Comments received through the eligibility mailbox
  - 68 submissions from 63 respondents (34 third sector organisations, 24 local authorities, 5 individuals)

Eligibility: Research

Estimated eligibility under FACS: older people



Estimated eligibility under national eligibility criteria: older people



6 The Care Bill: reforming care and support legislation

The results of the national workshops show an expected increase of 24% in the number of older people "definitely or probably" eligible for services under the national framework.

For Hackney the number of older people receiving long term care services is 2,369, an increase of 24% equates to an additional 568 older people potentially eligible for services.

Our Promoting Independence policy will aid the Council in managing the potential increase in demand however this policy will not manage out all of the demand for services and so this allocation will assist the

Council in meeting the cost of the expected increase in demand for services.

Based on the cost of delivering services to the current cohort of service users a 24% increase in care services to meet long term care needs would cost up to £8m.

Investment requirements

2016/17 £2,807k
2017/18 £2,857k
2018/19 £2,912k

Impact of scheme

Impact on National Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	High
Effectiveness of reablement	Medium
Delayed transfers of care	Low

In addition to the above outcomes the scheme will contribute to the following Adult Social Care Outcome Framework measures:

ASCOF measure		**2015-16**
ASCOF 1a	Service user quality of life	17.9
ASCOF 1b	Proportion of people who use services who have control over their daily life	67.8%
ASCOF 1I1	Proportion of people who use services who reported that they had as much social contact as they would like	36.4%
ASCOF 3a	Satisfaction of people who use service with their care and support	60.2%
ASCOF 3d	People who use services who find it easy to find information about services (service users and carers)	71.9%
ASCOF 4a	People who use services who feel safe	64.8%
ASCOF 4b	People who use services who say that those services have made them feel safe and secure	76.5%

Feedback loop

We will use the performance achieved on the outcome measures outlined above to monitor the achievements of this investment in services.

In addition to this monitoring we regularly involve and consult people who use our services, carers and other people who live in Hackney to get their views on what we do. We do this in a variety of ways including:

- routine meetings with local forums
- specific consultation events
- telephone surveys
- through our new user and carer involvement reference group

Surveys

We conduct statutory surveys that measure satisfaction rates and quality of life among our service users and carers. All surveys are anonymous. Some service providers also conduct their own surveys but we are aware people may feel uncomfortable giving honest feedback in these circumstances. Our annual surveys are carried out independently of our providers.

Day to Day feedback
Everyone can comment on the services they receive via our complaints procedure and our confidential home care complaints line.

Service user and carer reference group
We have a user and carer involvement reference group made up of representatives from Hackney's various service user forums. The group meets every two months to:

- Advise commissioners on who to consult when services are changed or commissioned
- Advise on how services should be monitored and delivered from the point of view of service users
- Make sure people who want to give their views get a chance to do so
- Consider reports from the Commissioning for Personalisation Reference Board
- Vote on topics the group should consider at future meetings

The local account
The local account is produced annually and consultation is part of its production. We have given service users and their carer's the opportunity to tell us what they think about our services and we us this feedback to develop and improve services.

What are the key success factors for implementation of this scheme?

Key success factors for implementing the scheme are as follows:

1. Changed eligibility criteria used in all new assessments; we will ensure that all procedures and processes are developed to meet the new requirements of the Care Act 2014 and that a care staff are fully trained to deliver assessments in line with the new criteria. The new ASC IT system will reflect the requirements of the Care Act.
2. Service users are informed of the changes; will deliver a communications plan to inform service users of the changes under the Care Act so that they have the advice and information they need to plan their care and support.
3. Workforce is adequately trained to deliver services in line with the requirements of the Care Act; our workforce development plan reflects the requirements of the Care Act and we will deliver this to ensure staff are able to deliver the new requirements.
4. All policy and procedures reflect the changed eligibility criteria and other changes associated with the Care Act.
5. Adult Social Care achieves its financial targets, i.e. keeps within its approved budget; the implementation of this scheme will reflect the Council's Promoting Independence strategy and will work with partners to maximise Service User independence. This demand management strategy is a key element of our financial strategy for ASC.

Scheme ref no.

1.4

Scheme name

Targeted preventative services

What is the strategic objective of this scheme?

The strategic objective for the scheme is to provide an effective targeted prevention service to support vulnerable people with health and social care needs to live independently in their communities for as long as possible, reducing or delaying the need for long-term care.

Overview of the scheme

Targeted Preventative Services comprise:

- Housing related floating support services delivered through four neighbourhood-based services
- A programme of health and wellbeing activities
- Volunteering and befriending services

The scheme works with Hackney residents above the age of 16 who have a range of needs, including older people, people with learning disabilities and people with mental health issues. There is a single referral point to all the schemes, managed by the volunteering and befriending service provider. Service users have an identified keyworker and work to an agreed outcomes-focused support plan.

Floating support works with 1,500 service users at any one time receiving support of up to a year in duration. Health and wellbeing and volunteering and befriending are activities which are available alongside, following or independent of floating support. Services enable people to step down from the more intensive form of support, offering an ongoing focus on health and wellbeing and social inclusion, and complementing the Council's universal service offer.

The delivery chain

Hackney Council commission the services and manages the contracts.

There are 5 providers involved in delivery of the model:

- Floating support: One Housing, SHP, Family Mosaic
- Volunteering and befriending: Outward

All services are individually specified. The Council meets monthly with all provider contract managers and key staff to ensure the model is joined up and works effectively, minimising duplication.

The evidence base

The services meet the Council's Promoting Independence vision and are core to Commissioning for Personalisation and Transforming Adult Social Care programmes.

The Council has responsibility for promoting the broader wellbeing of the whole population and for developing stronger communities. The scheme has been selected as it addresses challenges such as reducing budgets and demographic growth, including an ageing population. The model contributes to a sustainable model of social care that places a greater emphasis on developing /maintaining people's independence and preventing deterioration, developing individual and community resilience that reduces individual risk of developing higher needs.

The review of services undertaken in advance of the commission found that:

- Floating Support should be a core part of the Council's prevention offer
- The need for support is often diverse and complex - users highlighted the importance of crisis provision and responsiveness to need
- The impact of welfare reform means people require additional help
- Support produces positive outcomes and delivers financial benefits for the Council
- Some people had become dependent on floating support services whilst others could be supported for shorter periods of time
- Providers of services found it difficult to move people on to services providing lower levels of support due to limited options available

- Commissioning support for those with moderate needs such as health and wellbeing and volunteering and befriending would allow people to move on
- Feedback, particularly from older people, included request for more activities

Application of the Cap Gemini toolkit[1] by Hackney in 2012 showed that for every £1 invested in delivery of housing-related support including floating support, £1.73 net financial benefits are received, £1.47 of which goes to our directorate. The evaluation of the Older People Pilot Programme (POPP) shows that for every £1 invested in older people's wellbeing; this saves £1.20 in hospital costs[2]. A recent study undertaken by Northern Ireland Housing Executive specifically on the effectiveness of floating support found that 'the evidence from providers and users is clear: floating support does help people who use the service to live independently and that for many service groups, the service can be delivered in a cost-effective manner when compared to accommodation support'.[3]

Investment requirements

2016/17 £388k
2017/18 £395k
2018/19 £402k

Impact of scheme

Impact on National Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Low
Admissions to residential and care homes	Medium
Effectiveness of reablement	Medium
Delayed transfers of care	low

Services have been set targets as follows:

Floating support

- Focussed intervention – duration of support: 25% will exit the service within 3 months, 25% will exit the service within 3-6 months, 45% will exit the service within 6-12 months
- Maintenance of tenancy: 80%
- Use of specialist services (inc. DAAT, MH, Falls Clinic etc.): 90%
- Registration with primary health services: 100%
- Improved employability: targets to be set based on Year 1 figures
- Service user satisfaction: 80%
- Fair access to services: targets to reflect recent census demographic information

Outcome star methodology has been implemented which aims to measure the progress of the individual in the following areas:

- Motivation and taking responsibility
- Self-care and living skills
- Managing money
- Social networks
- Drug and alcohol use
- Physical health
- Emotional and mental health

[1] https://www.gov.uk/government/publications/supporting-people-financial-benefits-model

[2] http://www.pssru.ac.uk/pdf/rs053.pdf

[3] http://www.nihe.gov.uk/effectiveness_of_floating_support_-_final_report_december_2012.pdf

- Meaningful use of time
- Managing tenancy and accommodation
- Offending behaviour (including anti-social behaviour)

Volunteering and befriending/ health and wellbeing

The following outcomes have been set:
- No. self-reporting an improvement in their physical health
- No. self-reporting an improvement in their emotional wellbeing
- No. self-reporting an improvement in their level of independence
- No. self-reporting an improvement in their social inclusion
- No. self-reporting an improvement in their self confidence
- No. self-reporting an improvement in their skills and abilities

Targets will be set following the evaluation taking place at the end of Year 1.

Rather than the Outcome Star use of the Warwick-Edinburgh Mental Well-being Scale[4] is proposed – a survey developed to enable people to identify feelings of wellbeing which will be used before and after completion of programmes of activity.

Feedback loop

Key performance including outcome data is collated quarterly. Satisfaction data will be collated annually. In person meetings across providers/stakeholders are held monthly. Focus groups with service users are being held to test acceptance of the offer and how promotion of it can improve.

Public Health will undertake an independent review of the model towards the end of its first year which will look at the Year 1 data, compare with the previously commissioned models of support, and will include focus groups with staff and stakeholders, and further groups with service users.

What are the key success factors for implementation of this scheme?

- Effective partnership working, clear implementation plans, good communications, effective marketing of new offer.

- Key milestones are:

- Public health evaluation of overall impact - April 2015

- Further refinement of targets for Health and Well-Being and Volunteering and Befriending Schemes – April 2015

[4] http://www.nhs.uk/Tools/Documents/Wellbeing%20self-assessment.htm

Service Specification

Integrated Independence Team

Together Towards Independent Living

London Borough of Hackney and
City & Hackney Clinical Commissioning Group

Version 9
FINAL

Version Number	Date Approved	Approved By	Brief Description
0.1	14/1/13	TMc	Initial draft
1.0	14/1/13	AM-B	Review and initial draft issued to DW and PH
1.1	4/2/13 issued	AM-B	Updated with title change requested
2.0	16/4/13 issued	AM-B	Updated with feedback from providers, LBH and CCG Board
2.1	18/4/13 issued	AM-B	Updated with feedback from Hackney Healthwatch

3.1		DW	Updated with enhanced community-based model and transitional arrangements for the bed-based service
3.2		DW	Updated with feedback from Jarlath O'Brien and Mark Scott
4.0		DW	Updated following meeting between Jemima, Diane and Ed Wallace
5.0	30/07/15 issued	DW	Updated following HuH comments
6.0	01/09/15 issued	GL	Add Geriatrician service description as para 16 Update references to bed based care and review Tidy up formatting of paragraphs
7.0	28/09/15 issued	GL	Eligibility and funding of patients/service users Charging CCGs who have Hackney residents Access Geriatrician service Links with other services and One Hackney SU input in monitoring Removing/clarifying acronyms Outcome indicators and KPIs Where appropriate replace Crisis with Rapid Response Cover sheet Updated contract monitoring and service provider's response in the schedules
8.0	13/10/15 issued	GL	Finalising KPIs and minimum data sets Submission of KPIs as opposed to monitoring Benefit 5 – a more responsive service Contents page
8.1	18/11/15	DB	Added to S.75 Agreements as

			Schedule 1. Moved Staff, Budget and Payments sections to S.75 Schedule 4 (Resources). Amended paragraph 8.3. Some minor corrections. Completed Contents page.
8.2	29/03/15	CD	Revised KPIs schedule 2 & 3; pages 18 – 23.
9	7th April 2016	CD/JS	Agreed and revised KPI's - Final

Contents

1. Introduction

1.1 This service specification describes the outcomes that the new Integrated Independence Team will achieve in City & Hackney and the standards, principles and values that will underpin its delivery.

1.2 This version of the specification is a transitional document that reflects the phased implementation of Integrated Independence Team.

1.3 From August 2015, the Integrated Independence Team service will commence implementation and development of the service. The full community-based model will be available to the people of City and Hackney from October 2015. The community based model will support the care and rehabilitation of service users in community settings.

1.4 The bed-based model is being further reviewed and whilst the review is taking place, additional bed-based care will be spot purchased from other providers.

1.5 This specification has been developed jointly by the London Borough of Hackney and the City & Hackney Clinical Commissioning Group as part of a joint commissioning strategy for intermediate care. As an integrated strategy, it represents the commitment of the partners to joint commissioning and to use this strategy as a blue-print for the development of integrated strategies in other service areas.

1.6 A principle requirement of this strategy is that a Lead Provider will act on behalf of the provider arm of the London Borough of Hackney and of the Homerton University Hospital to ensure integrated delivery of intermediate care services so that a holistic approach to the health and social care needs of local people is achieved. The Lead Provider is the Homerton University Hospital.

1.7 The service is being developed in the context of significant local challenges to the local health and social care system with increasing demand for hospital beds and more intensive packages of support to enable people to continue to live in the community. Thus, the development of this strategy and specification is intended to help health and social care partners tackle these challenges, ensuring the maximum impact of the resources deployed through an integrated approach.

1.8 Intermediate care, whilst a service for all adults, is primarily a service for older people, with the majority of admissions being of people over 75 and more than half of people over 85. The National Service Framework (NSF) for older people,[5] which established the concept of intermediate care, recognised intermediate care as a key service for older people.

1.9 In City & Hackney, as with the rest of country, intermediate care has developed over several years, responding to emerging challenges and initiatives. This paper articulates:

a) What is intermediate care and reablement and the different service elements within it?
b) How does it interface with the wider system of health and social care?
c) What are the outcomes that we expect?
d) What is the future direction of intermediate care and reablement services?

1.10 The specification will also be characterised by:

a) A focus on outcomes. This is what commissioners expect to be achieved to improve the lives of service users and patients, through the investments in intermediate care and reablement services. This document will draw on the outcomes frameworks developed for the NHS, Adult Social Care and for Public Health. It will not focus on the detailed design of services, although it will set some broad requirements, necessary to achieve the outcomes described. Nor will it comment on management structures agreed by the

[5] National Service Framework for Older People, Standard 3, Intermediate Care, 2002.

providers as they are clearly the responsibility of the providers and the means that the provider considers will achieve the outcomes articulated for the service.

b) The achievement of person-centered, integrated care for the service user and patient that reflects their needs and wishes and which places them in control in order to achieve the best outcomes for them.[6]

1.11 Both of these key points reflect the Outcomes Frameworks for both the NHS and Adult Social Care[7], which place significant emphasis on the patient and service user and carer experience. A sharp focus on the needs of patients and service users and carers is essential to meet these severe local challenges by supporting them to maintain their independence and manage their care and support needs as best as possible.

2. National Policy

2.1 The development of the new intermediate care and reablement service will be in line with all recent policy initiatives and requirements and particularly will promote;

a) Person-centered and seamless care.
b) Choice for and empowerment of patients/service users.
c) Care closer to home.
d) Greater emphasis on prevention.
e) Greater integration of services, both through primary care and acute care working more closely together but also greater integration across health and social care.
f) Support for people to manage their conditions better and maximising independence.

2.2 In particular, it will reflect the emphasis and urgent need to reduce the demand for excessive and unnecessary use of hospital care and more intensive health and social care interventions.

3. What is intermediate care and reablement?

3.1 Intermediate care and reablement is a proactive multidisciplinary community based service that aims to meet the needs of individuals who are experiencing a health or care crisis; to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. [8]

3.2 The NSF standard is still relevant to the effective operation of intermediate care:

"Older people will have access to a range of new intermediate care services at home or in designated settings, to promote their independence by providing enhanced services from the NHS and Councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care."

3.3 It should focus on three key points in the pathway of care:

- Responding to or averting a crisis.
- Active reablement and/or rehabilitation following a multi-disciplinary assessment and/or crisis, either in the community or following a stay in hospital.
- Where long term care is being considered.

3.4 It is a collection of different service elements that bridge the gap between primary and community-based support and more intensive interventions, either in hospital or the

[6] Principles for integrated care, Public Voices, May 2012
[7] NHS Outcomes Framework, 2012/13, Transparency in Outcomes, a Framework for Quality in Adult Social Care, 2012/13
[8] Intermediate Care - Halfway Home, Updated Guidance for the NHS and Local Authorities, 2009

community. The aim in City & Hackney is to ensure that these different elements operate as a single system, providing seamless support to individuals.

3.5 Intermediate care and reablement is an essential and critical part of a wider health and social care system, with other services playing an important role in both enabling people to access intermediate care and reablement, and also ensuring effective discharge and follow-up from intermediate care and reablement. These other services also have key aims of prevention, maximising independence and enabling people to remain in the community. However, intermediate care has a specific role in the care pathway, as described above.

4 The evidence base for intermediate care

4.1 The Department of Health refreshed guidance Intermediate Care – Halfway Home [2009] describes emerging evidence from a number of major research programmes that intermediate care is effective, although there is acknowledgement that, in some instances, conclusions are mixed.

4.2 Rapid response services can have a significant impact upon the use of urgent and unscheduled care, intensive rehabilitation in the community and can assist people to regain independence. There is very strong evidence that the Comprehensive Geriatric Assessment (CGA) is particularly effective in helping to maintain the independence of older people and this will form a key element of intermediate care services in City & Hackney.

5 Description of current intermediate care and reablement services in City & Hackney

5.1 The services designated as intermediate care are the following:

5.2 Rapid Response, currently known as First Response Duty Team (FRDT). The Rapid Response element will undertake assessment and arrange support plans within 2 hours of receiving an urgent referral and within 4 hours of a non-urgent referral.

5.3 Individuals will be managed within the rapid response pathway and transitioned to an alternative Integrated Independence Team pathway, at the most appropriate time to ensure seamless Integrated Independence Team intervention or referrals onto the most appropriate team, such as Community District Nursing or another appropriate service.

5.4 The services elements designated as intermediate care and reablement are the following:

a) Rapid Response, currently known as First Response Duty Team (FRDT).
b) Intermediate care rehabilitation, currently known as Therapy at Home (T@H).
c) Home-care reablement, currently known as First Response Provider Team (FRPT).
d) Bed-based intermediate care purchased from St Pancras during the bed-based review and implementation of the recommendations from the review.

5.5 The resources related to the above services will be re-organised to create the Integrated Independence Team.

6 Outcomes

6.1 The outcomes to be achieved through intermediate care and reablement are derived from the joint commissioning strategy:

a) Independent living.
b) Faster recovery from illness.
c) Reduction in avoidable admissions to residential and nursing care, particularly directly from hospital.
d) Safe, sustainable and timely discharge from hospital
e) Timely transfer of nursing and rehabilitation care from acute hospital to community.
f) A skilled and capable intermediate care workforce. Success measured from the view point of patients/service users, carers and staff.

6.2 As has been stated, the health and social care system is complex with many inter-dependencies and other services will also play a key part in achieving these outcomes, as they will in achieving the key strategic aims of intermediate care that sit alongside these outcomes:

a) Reduction in hospital lengths of stay and excess bed days contributing to the system-wide outcome of reducing emergency bed days for the over 75s.
b) Reduction in avoidable emergency ambulance
c) Reduction in avoidable GP call-outs
d) Reduction in avoidable A&E attendances and emergency admissions contributing to the system-wide outcome of reducing emergency bed days for the over 75s.
e) Reduction in demand for long term high intensity care packages including nursing and residential care[9].
f) Safe and sustainable discharges from hospital contributing to the system-wide outcome of reducing emergency bed days for the over 75s.

6.3 Quantitative and qualitative measures which measure and inform a better understanding of the impact of services is in the Performance Framework section of this document.

7 Key features of the intermediate care service

7.1 Thus, in City & Hackney, the intermediate care and reablement service will have the following features:

a) An integrated range of services, including rapid response, intermediate care rehabilitation and home-care reablement, managed by the Lead Provider, from the Homerton University Hospital or London Borough of Hackney. The Lead Provider will be responsible for all aspects of delivery and for the appointment and management of a Head of Service, who will be responsible for all day-to-day operations.

b) The service is for all residents of Hackney and residents of the City of London who are over 18 years old. It should be noted that home-care reablement services will be provided to City of London residents by City of London reablement services.

c) Development of a Hub for intermediate care and reablement.
   i. The Lead Provider and a Head of Service will ensure that the intermediate care and reablement service functions is a coherent and single service and not as a collection of separate and disparate services.
   ii. The Integrated Independence Team will be co-located at a single site.

8 Access

8.1 There will be a single point of access to the service (SPA). The SPA will be staffed by senior physiotherapists or occupational therapists. A&E will continue to bleep Rapid Response to ensure a timely response.

8.2 The Single Point of Access will screen referrals and work with referrers to ensure that the patient is referred to the most appropriate service in a timely manner.

8.3 If the patient referred into the service is not a resident of Hackney or City and is registered with a GP practice that is in Hackney or City, then the provider shall charge the relevant Clinical Commissioning Group for the costs incurred related to any health interventions for that patient.

8.4 The provider will work proactively with stakeholders to increase referrals from appropriate sources such as Primary care, London Ambulance Service, A&E, Paradoc, 111, Care Homes and community teams.

[9] Compared to expected demand profile based on demographic and other known changes

8.4 The Single Point of Access (SPA) will:

a. Ensure that other professionals can easily access the service and that patients and service users access the right service as quickly as possible.
b. Be run by appropriately trained professionals who are able to make speedy decisions and direct team members to respond to the needs of the service user and patient within an appropriate time-frame.
c. Access to the SPA and the Rapid Response will be from 08.00 to 22.00 Monday to Friday and 10.00 to 18.00 at weekends and bank holidays.
d. Reablement will operate 07:30-22:00 seven days a week.
e. Home Treatment (Therapy input) will operate (09:00 – 17:00 Monday to Friday)
f. For those service users who do not need the intervention of the intermediate care and reablement service, there should be knowledge of other services within the SPA to which referrers can be sign-posted.
g. It is the intention of commissioners that through enabling easier access to intermediate care and reablement services, more people will benefit from them.

9 Effective assessment

9.1 Integrated Independence Team will be a multi-disciplinary service, able to respond to the range of needs of the local population, including capacity to respond to those patients and service users who also have mental health needs. Close links will be made to mental health services as there will only be psychotherapy input from this service.

9.2 The assessment process will be under-pinned by CGA, which will be applied particularly to those service users with needs to be addressed by multiple disciplines.

10 Rapid response to crises

10.1 The intermediate care and reablement service has a key role in responding to crises, which, in the case of many older people, can result in admissions to hospital or to residential care. The service needs to be able to treat people effectively in their own homes and also to divert people, as appropriate, when they present at A&E or are admitted to observation wards.

10.2 The maximum time for response should be no longer than 2 hours for urgent intervention.

11 Strong focus on rehabilitation and reablement

11.1 Older people, in particular, can lose functioning as a result of a crisis or admission to hospital and rehabilitation, led by skilled therapists, will be necessary to enable the person to regain their independence.

11.2 There should be a seamless transition for those patients who also require help to regain their skills of daily living, through goal-focused home-care reablement programmes, which are regularly reviewed.

11.3 Particularly for those patients with more complex needs, therapists should have a key role in ensuring that reablement plans are robust, achievable and regularly reviewed.

12 Bed-based intensive rehabilitation

12.1 This will be spot purchased from St Pancras whilst a review of bed based care takes place and the recommendations are implemented.

12.2 The three organisations that make up commissioners and providers will contribute to the further bed based review, which will be led by the Lead Commissioner. The bed based review will report in October 2015. All three parties will commit to looking within their respective estates to find a local site for the provision of the identified number of beds from the further review.

13 Managing transfers of care

13.1 The safe and speedy transfer of patients who need on-going rehabilitation, following an acute phase of treatment, is a key role of intermediate care and reablement services.

13.2 Intermediate Care and reablement provider to promote understanding and use of Integrated Independence Team by health and social care stakeholders. This will involve developing pathways to enable timely transfer of care into the community.

14 Focus on hospital avoidance

14.1 Currently the majority of referrals to intermediate care and reablement services in City & Hackney, is supporting hospital discharge. This will remain a critically important role for intermediate care and reablement. However, in order to deliver improved outcomes for patients and generate efficiencies, it is necessary that more admissions to hospital are avoided when clinically appropriate. This is reflected by many of the statements and actions described in this specification, for example, increasing the skill mix of nurses in intermediate care and reablement. It will be an aspect of the service that will be monitored keenly in the revised performance framework agreed with the service.

14.2 The intermediate care and reablement provider will proactively engage with stakeholders to increase referrals such as from Primary Care, London Ambulance Service, A&E, Paradoc, 111, care homes and other community teams.

15 Review and case management

15.1 An individual may require the intervention of different members of the intermediate care and reablement service and their recovery will depend upon seamless and coordinated multi-disciplinary working. The service must, therefore, ensure that there are clear, focused plans for every individual and that there are arrangements in place for their effective delivery through a case management approach, notwithstanding the involvement of several members of the intermediate care and reablement service.

15.2 This also includes robust arrangements for the transfer of service users to other services following the appropriate period of input from Integrated Independence Team.

16 Geriatrician service

16.1 The integrated Independence Team has 1.6 WTE (whole time or full time equivalent) input from intermediate care Geriatricians. The role of the intermediate care Geriatrician is:

1. Work with the Integrated Independence Team at the interface of Primary and Secondary Care, to both facilitate early supported transfer of care into the community and provide joined up assessment of patients either in the community or within a multi-disciplinary clinic.
2. Provide rapid access clinics to enable patients to be seen in a timely fashion as an alternative to having to attend Accident and Emergency and reduce non elective admissions.
3. Provide Geriatric intervention within the Integrated Independence Team in screening, assessment, multi-disciplinary team decision making and underpinning the Comprehensive Geriatrician Assessment within Integrated Independence Team.

17 Specialist skills and knowledge

17.1 The Comprehensive Geriatrician Assessment will be a manifestation of the application of specialist skills and knowledge to ensure the patients and service users receive the highest quality of care and that treatment and support can, wherever possible, take place in a person's own home.

17.2 In addition, links will be forged to mental health specialists who will be able to contribute their expertise across the different elements of the intermediate care and reablement service.

17.3 The intermediate care and reablement provider and commissioners will work together to ensure there are robust and efficient pathways with other specialist services such as Community Mental Health and Dementia Teams and Memory Assessment services.

17.4 In order to prevent hospitalisation when admission is not absolutely necessary, the service should also have capacity to offer treatments, requiring specialist nursing skills, for example, treatment of cellulitis or treatments that involve the administering of intravenous antibiotics, in order that more older people, in particular, can avoid an unnecessary hospital admission. A review of potential pathways such as cellulitis, UTI and DVT will include guidelines to be developed by December 2015.

18 Links with other key services

18.1 The Integrated Independence Team should develop appropriate agreements and protocols with a range of other key services in order to ensure that there are effective interfaces with these services along the care pathway. This would include the Acute COPD Early Response Service (ACERS), the Adult Community Rehabilitation Team (ACRT), Community Nursing GPs, Adult and Older People's Mental Health Services and Adult Social Care and the One Hackney and City services. Such agreements are intended to deliver seamless and timely interventions for service users and contribute to the overall effectiveness and efficiency of the health and social care system.

19 Working with One Hackney quadrants

19.1 Integrated Independence Team will develop effective working relationships with One Hackney and City services by attending the Quadrant meetings.

20 Central role of GPs as orchestrators of care.

20.1 Of all health professionals, GPs have the most intimate knowledge of patients. They are likely to be aware not only of the patient's medical history but also have knowledge of their extended family, their carer(s) and their social circumstances. They are the usual referrer of their patient to other services, will be aware of the different treatments offered to their patient and continue to provide their primary care when the patient is discharged from that service. GPs knowledge is likely to be greater of older patients, the main users of intermediate care and reablement. Thus, they should be involved in all stages of the patient's journey through intermediate care and reablement:

a) On receipt of a referral, the Integrated Independence Team should consult the patient's GP. All relevant information about the patient should be sought from the GP and shared with the service.
b) In urgent situations, this should normally be done by phone. As far as practicable, no decisions should be taken about admitting a patient to hospital without consulting the GP, unless it would be clinically unsafe not to act immediately.
c) Members of the Integrated Independence Team should ensure that the GP is involved in the assessment and consulted about the plans and interventions that are proposed for their patient.
d) On discharge, GPs will receive a discharge summary for their patient within 2 working days. This will be emailed to the practice.

20.2 Communications can take place with GPs securely using nhs.net email addresses but Integrated Independence Team should explore other means of communication that will integrate with methods of communication that other services use with GPs and which would enable the information about a patient to be located in one place. GP practice "Bypass" numbers will be provided to the Integrated Independence Team.

20.3 GPs are expected to make themselves available to discuss and facilitate the care of their

patients supported by Integrated Independence Team.

21 The patient and service user in control

21.1 Research with older people has shown that there are a number of straightforward steps that can make a significant difference to the quality of the service received and the outcomes that are achieved;[10] identification and summary of older people's desired outcomes during assessment; briefing other care staff on older people's desired outcomes; identification of outcomes for carers during assessments and reviews; using postal questionnaires to collect information on outcomes.

21.2 The service will use the National Audit for Intermediate Care as one of the basis for service user feedback and will participate in the national audit on a yearly basis.

21.3 The success of the service in adopting such approaches will be measured as part of the performance framework for Integrated Independence Team.

21.4 The Lead Provider should establish strong links with user and carer representative organisations such as the Hackney Older People's Reference Group and Hackney Healthwatch, and ensure they agree the design and administration of any user feedback processes.

21.5 Information leaflets will be produced for all users and carers clearly explaining the services being provided and how to offer feedback, raise concerns or complain/compliment. This will occur by October 2015 and will be reviewed annually and revised as required.

22 Wellbeing

22.1 In order for the health and social care system to meet the challenges of an ageing population, it is important that the whole system is focused on enabling people to stay healthy and independent. Intermediate care and reablement services, therefore, should ensure that there are effective links and referral processes with wellbeing services to enable people to be supported to develop and maintain social relationships which will promote both good physical and mental health and enable them to maintain their independence.

23 Clinical Governance

23.1 The Lead Provider will ensure that there is a robust clinical governance framework in place which will include the following policies:

a) Risk Management Policy
b) Clinical Audit Policy
c) Serious Incidents/Root Cause Analysis (RCA) Investigations Policy
d) Incident Reporting Policy
e) Implementing National Guidelines (including NICE and national audits)
f) Mandatory Training

This list is not exhaustive.

23.2 Staff induction days will include governance training and management will support staff and identify opportunities for professional growth and development.

23.3 The nursing lead, SPA & RR lead, HTR & Deputy Head of Service and Head of Service will lead clinical governance at service level. They are responsible for:

23.3.1 All protocols/procedures for the entire patient pathway, including:

a) Information governance/records management
b) Equality and diversity
c) User involvement, experience and complaints

[10] University of York, PRSSU, Choice and change: disabled adults' and older people's experiences of making choices about services and support, 2011

d) Failsafe procedures for screen-detected cases.

23.3.2 Programme decision making

23.3.3 Quality improvements and strengthening clinical governance

23.3.4 Complaint information sharing amongst key stakeholders

23.3.5 Incident and risk management and reporting, including training of all staff

23.3.6 Completion and timely submission of all nationally mandated reports/audits

23.3.7 Multidisciplinary representation at the Programme Board

24 Contract Monitoring

24.1 KPIs will be submitted monthly by the provider to the Lead Commissioner, ie KPIs for November will be submitted by the 10th of December.

24.2 The contract and performance will be monitored, as part of contract monitoring meetings and reports to the Commissioning Board on a monthly basis for the first six months from November 2015 and then at least quarterly from May 2016. Therefore, quarterly reporting will look like May, June and July submitted by the 10th August.

24.3 The Provider will ensure that the Head of Service will be available to meet with commissioners, performance officers and nominated SU representatives to discuss performance and contract compliance.

24.4 The Provider will collect a minimum data set to identify the baseline for the service and within the first year the KPIs will be developed in negotiation with the commissioners.

24.5 The Provider must make available any records and performance information requested by the commissioner as long as it is reasonable in terms of timescales.

Appendix 1

Performance framework

There are a number of dimensions to incorporate into the performance framework for intermediate care and reablement:

Outcome for the service user or patient.
The outcomes for intermediate care and reablement have been articulated in both the commissioning strategy and within this specification. It is appreciated that these outcomes are shared with other health and social care services and so it is important that the measures that are introduced identify the specific contribution of the Integrated Independence Team services to their achievement. It is also important that across the health and social care system, we develop a whole system approach to measuring performance against outcomes that recognise the interdependence between health and social care and describes the effectiveness of our joint approach across the health and social care system.

Experience and satisfaction of the service user or patient.
Our aim is that the patient and service user experience should be the organising principle of integrated care as this is the means to ensure that the outcomes that we have set will be achieved.

Service efficiency and cost effectiveness.
We must maximise the operational capacity of our resources, which will mean sharp focus on such things as access, length of stay and transfers and destinations on discharge from intermediate care and reablement.

Providers will support the commissioners in benchmarking the service to determine value for money. The business case for investment into intermediate care and reablement is based not only on the evidence that improved outcomes for service users and patients can be delivered through intermediate care and reablement but also that intermediate care and reablement can be more cost effective than other interventions, particularly treatments in an acute setting. Therefore, the performance framework must include data that allows comparison of costs of intermediate care and reablement to other forms of interventions. Commissioners will work with the Providers to develop these data sets to be used for comparison.

Although three categories of indicators have been identified, there is a recognition that some indicators will relate to more than one category.

The performance of the service will be regularly monitored through the Integrated Independence Team Commissioning Board which will meet at least quarterly and be comprised of members from both the council and CCG. It will be the responsibility of the Lead Provider to submit this information monthly to the named contact for the Lead Commissioner by the 10th of each month.

A baseline will be developed from the first 6 months of activity.

Appendix 2

Outcome indicators

Benefit one – Responding to health and care crisis in the patient's home without the need to attend A&E or to be admitted.

Currently majority of referrals are from A&E and inpatient facilities including the Observation ward. The Integrated Independence Team will provide a proactive and responsive service for the community so that health and social care crisis can be managed within a patient's home, improving both patients' outcomes and experience of care.

There will be a clear information framework that will set out what information needs to be collected across the service. For example:

- Monthly reporting of referrals with a breakdown of the source of referral and the outcome

Benefit two – working seamlessly with other community services

The new intermediate care and reablement service will be a key linking service with other community services. There has been recent considerable investment in new multi-disciplinary community provider team to co-ordinate care for frail patients out of hospital – in the overall service known as One Hackney. The new Integrated Independence Team will work closely together with all community services to manage patients out of hospital. The synergy of these two new services working together should greatly improve co-ordination and experience for patients as well as ensure that patients and service users have access to a wide range of services to support them at home. There will be close link ups with the variety of multidisciplinary staff working in the services and a common approach to processing and coordinating referrals.

Benefit three – a service open evenings and weekends

The Integrated Independence Team has extended working times:

- Access to the SPA and the Rapid Response (RR) referrals will be from 8.00am to 22.00pm Monday to Friday and 10.00am to 18.00 at weekends and bank holidays.
- Reablement will operate 7:30-22:00 seven days a week.

The extended opening hours will be beneficial to patients and should reduce unnecessary A&E attendances and admissions out of hours.

Reporting of the number of referrals outside of normal business hours, i.e. before 9am and after 5pm or at any time during the weekends or bank holidays. The reports should present the information in these three categories; a) before 9am, b) after 5pm and c) weekends and bank holidays.

Benefit four – better referral screening and overall coordination

In the new model all referrals will go through one access point and there will be screening of all referrals. This should support improved referral quality and will mean that referrals are passed onto the best service(s) for the patient/service user. The overall patient journey will try to be determined at the outset, defining the support provided over a given period. Once accepted into the service, service users will undergo one single assessment process. This will mean the service user will not have to keep repeating their story across multiple teams.

Benefit five – a more responsive service

The new service will have response times it will need to meet across all areas of the service. This will mean that service users will receive the care and support they need in an appropriate timescale. This should encourage more community referrals into the service and support the delivery of some system wide outcomes and targets.

Benefit six – improved outcomes

Service users/patients of the new IIT service will benefit from having and integrated support package, as per KPIs at Appendix 3

All baseline and resultant measurements will be established & refined at the end of year one for year 2 (17/18).

Benefit seven – improved experience for patients and service users

The service will support better patient experience. There is a yearly audit of the service with patient experience survey as part of this audit. The service user representatives on the Reablement and Intermediate Care Commissioning Board have identified three areas set out below, where they are seeking improvements in reaching the national average benchmarked results:

- ***Goal setting***: I was involved in setting these aims
- ***Staff response to questions:*** When I had important questions to ask the staff they were answered well enough
- ***Aftercare:*** Staff discussed with me whether I needed any further health or social care services after this service stopped (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)

Appendix 3

Key performance indicators and Minimum Data Sets

It is essential that Commissioners and providers have data to inform decisions on future service developments. The below table specifies the key data set for this service. There will be a 6 month period of data collection starting November 2015. The data will be sent to both the London Borough of Hackney and City and Hackney CCG. During this period the information collected will inform future targets and baselines.

Area	Item	KPI	MDS
Referral	Total number of referrals		√
	Time and day of week of referral		√
	Referral source - this may be required as snapshot detail. (GP by quadrant, LAS, 111, Paradoc, Community teams, Homerton hospital wards, Other hospital wards, A&E, Observation Ward/OMU, ACU)		√
Referrals – Geriatrician input	% of IIT cases receiving Geriatrician input: ▪ Clinic ▪ Home visit ▪ Advice (MDT) ▪ Combination of above ▪ Hospital Quarterly - snapshot data Monitoring in year one - target set for year 2.		√
	Number of referrals signposted		√
	Number of referrals accepted to Rapid Response		√
	Number of referrals accepted to Home Treatment and Reablement		√
GP measures	GP receives notification their patient is under the management of the IIT within 48 hours of assessment & acceptance by the IIT.		
	GP receives discharge summary with remaining issues within 48 hours of discharge.		
Single Point of Access:	Timely decision re appropriateness of referral to Integrated Independence Team dependent on level of risk; this would usually be within 24hrs. Response times will be; ▪ for A&E and the Observation Medical Unit – within 1hr, for urgent community referrals and non-urgent acute (ACU) - with 2 hrs, ▪ for community non urgent – within 4hrs. This will be closely monitored and a baseline set to define "timely", this would usually be determined		
Rapid Response:	95% of urgent rapid response referrals receiving an assessment and action plan within 2 hours of decision to accept. "Urgent" referrals from the community will be defined in order to distinguish from non-urgent Rapid Response referrals and next steps determined.		
Home Treatment and Reablement:	90% of referrals to have a reablement package in place within 24 hours following an Integrated Independence Team screening assessment, decision to *accept, and service user at home.*		

	90% of service users with a reablement support plan to have an assessment by a therapist within 72hrs of the start of the package.	90%	
	90% of non-reablement referrals to have a therapy assessment within 72hrs of service user being ready to allocate and at home.	90%	
Discharge	Length of stay in IIT (need to be able to analyse)		√
	Measure (No. and %) of Integrated Independence Team service users re-admitted to Homerton University Hospital within 30 days.	√	√
Outcomes	Achieving a reduction in the costs of a package of care for existing social care clients – this target is to be monitored in the first year in order to set the baseline and target for year 2 (17/18)		√
	92% of Older People (65 and over) discharged from hospital via Integrated Independence Team who remain at home after 91 Days.	92%	√
	82% of Integrated Independence Team service users, who require a care package are fully independent after discharge form Integrated Independence Team,	82%	
	Measure (No. and %) of IIT service users who need a i) new care package following a reablement intervention; ii) Existing service user who require an increased care package.		
Patient focused outcomes – via annual audit	Proportion of people who feel involved as much as they want in decisions about their health and social care	√	√
	Proportion of people who feel in control of their health and social care	√	√
	Proportion of people who know who to contact if they need help	√	√
	Proportion of people who think health and social care staff work well together		√
	Proportion of people who think that in the last 12 months health and social care staff have offered information about other available services	√	√

Key Processes

Providers will record when a care plan is completed, when an update to a care plan is completed, and when a discharge letter is sent to the patient's GP. This information will be provided to commissioners on a *monthly* basis.

Process	Standard	Met	Not Met
Completion of relevant information on Support Plan and Discharge letter	Within 48 hours of completion of IIT		

Service Discharge and Measure of Independence – do we need these.

- Delayed completion of IIT and reason for delay
- Independence/ POC at 91days, post IIT completion.
- Outcome for older people discharged from hospital via re-ablement/rehabilitation 91 days later
- Number of discharges above where person was still at home 91 days later

Reassessments

For existing clients reassessed (social workers will capture this)
Significant event
Hospital Episode (Planned)
Hospital Episode (Unplanned)
Emergency related to carer
Change of residence
Safeguarding Concern
Fall
Bereavement
Change in Client Condition
Other Accident / Incident

Appendix 4

Future developments

Intermediate care and reablement will remain a critical element in maximising independence and reducing unnecessary admissions to hospital and residential care and managing crisis episodes in the community.

The bed-based services are the subject of a further review, which must be able to provide for the nursing needs of patients that are fit for discharge or with the right medical support could avoid being admitted to hospital.

Comprehensive Geriatrician Assessment (CGA) is a critical element of the approach within intermediate care and reablement and commissioners and providers will need to work together to ensure the right balance and capacity within the multi-disciplinary team, particularly in respect of social care, to support the CGA approach.

It will be considered to incorporate mental health specialists into the multi-disciplinary team and monitoring of the demands made of intermediate care and reablement services for people who also have mental health needs will need to be undertaken as the impact of an ageing population falls upon services. As the numbers of older people grow who have both long term conditions and mental health needs, the challenge will be to ensure greater integration between mental health services as a whole and other health and social care services so that the full range of mental health supports are more easily accessible, including to patients and service users in intermediate care and reablement.

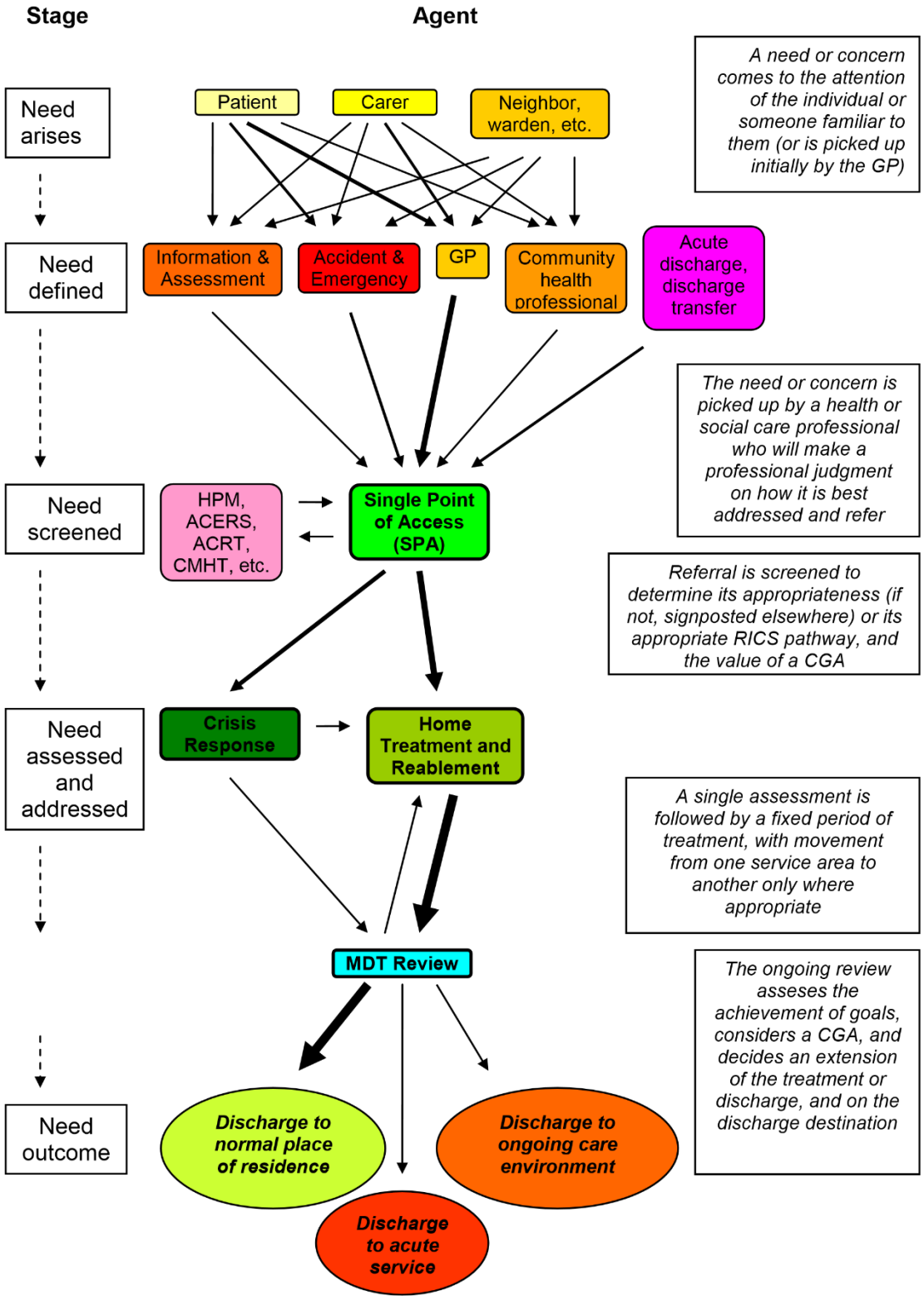
A central element of the work of intermediate care is to prevent unnecessary admissions to hospital and a robust programme of staff training and pathway development will need to be undertaken in order to minimise the number of unnecessary hospital admissions.

GPs engagement with intermediate care and reablement has not been consistent. In order to fulfil their desired role as orchestrators of care, GPs will need to become more familiar with intermediate care and reablement provision and Integrated Independence Team staff and GPs will need to work together to develop the role of orchestrators of care and to establish a genuine partnership between primary care and intermediate care and reablement service provision.

The intermediate care and reablement commissioning strategy and this specification have acknowledged the interdependence of intermediate care and reablement with other key health and social care services. Protocols and agreements with other key services, particularly those supporting people with long-term conditions in both health and social care organisations, will need to be made in order to ensure that case management responsibilities are clear and that there is an integrated approach across the whole system to the management of long term conditions.
A performance framework has been proposed within this specification. As new pathways and challenges emerge, agreements will need to be reached with providers to ensure that the performance framework changes to reflect those developments.

Appendix 5

Workflow Diagram



APPENDIX 6

KPIs – REMEDIATION/DEFAULT

The Council will be entitled to issue a Remediation Notice where the following KPI targets are not met, at the following frequency:

KPIs will be agreed between both parties during the first 6 months (see Appendix 3)

Where a Remediation Notice is issued, the provider will be required to produce a Performance Improvement Plan, specifying approaches to making required improvements. These processes should be read in conjunction with the general provisions on non-performance and service default (Clause 20).

Note: The references to remediation notice and default are to a related IIT Contract between the Council (lead commissioner) and Homerton Hospitals University Trust (lead provider).

APPENDIX 7 - Contract Management

1. AUTHORISED REPRESENTATIVES

The Commissioners' Authorised Representative:
Strategic Commissioner for Older People and Long Term Conditions

The Service Provider's initial Authorised Representative:
Head of Integrated Independence Team

KEY PERSONNEL

3.1 Members of the Integrated Independence Team Commissioning Board

MEETINGS

First six months: Monthly meetings to discuss submitted performance information and agree targets and baselines

Second six months: Monthly meetings to review performance against targets and baselines

Year two onwards: Quarterly meetings to review performance against targets and baselines

REPORTS

KPIs

The Provider will submit on a monthly basis, to the Commissioner's authorised representative, by the 10th of the month for the preceding month, eg 10th December for November's performance

Information provided should be as per the Key Performance Indicator and Minimum Data Sets, set out in this specification

In turn, the Lead Commissioner will submit a report to the Commissioning Board about performance based on the information provided and the contract monitoring meetings

Service delivery performance

The Provider will submit on a quarterly basis, to the Commissioner's authorised representative, by the 10th of the month for the preceding quarter, e.g. 10th February for November, December and January performance

Information provided should be as per the Outcome Indicators, Key Performance Indicator and Minimum Data Sets, set out in this specification

In turn, the Lead Commissioner will submit a report to the Commissioning Board about performance based on the information provided and the contract monitoring meetings

An annual report will be submitted to the Commissioning Board, which is co-produced with the nominated SU representatives

Scheme ref no.
5.1
Scheme name
Interim care beds
What is the strategic objective of this scheme?
The focus of this intervention is to provide bed based support to individuals on a short-term basis following acute treatment or a crisis or fluctuation in needs in the community; thus avoiding unnecessary admissions to hospital or long-term residential care in line with the Council's Promoting Independence strategy.
Overview of the scheme

This scheme is an essential component of our approach to an integrated way of working through the merging of the Hospital Social Work Team and Hospital Discharge Planning Team at Homerton University Hospital. Our pathway will ensure joined up and more effective discharge planning and service delivery that focuses on achieving better outcomes for service users. We expect to see significant decreases in unnecessary residential and nursing placement admissions. The model will assure a case management approach with input and interventions from different members of the multidisciplinary team to deliver a seamless and co-ordinated service. Through interim bed provision we will be able to transfer service users who are medically fit for discharge to a setting that would allow further assessment and planning for permanent service provision.

Interim beds provision also enable people who are in crisis in the community to receive a comprehensive assessment in an appropriate setting and suitable intervention rather than being considered for residential care when an option for someone to remain at home is not feasible.

The scheme will mainly be targeted at older, frail people, people with dementia and people with life limiting conditions.

The delivery chain

Commissioned by adult social care and provided by a range of accommodation providers in the independent sector.

The evidence base

Based on research, stakeholders feedback and benchmarking exercises our joint commissioning strategy clearly illustrates that interventions such us intermediate care and interim beds promote:

- Maximisation of independent living in the community.
- Faster recovery from illness.
- Reduction in avoidable admissions to residential and nursing care, particularly directly from hospital.
- Safe, sustainable and timely discharge from hospital
- Effective alternative care where acute hospital admission is not required
- A skilled and capable intermediate care workforce. Success measured from the view point of patients/service users, carers and staff.

In some circumstances provision of intermediate care may not be possible at the outset which is where an interim bed base provision is necessary to enable service users to access appropriate support and interventions before long term/permanent decisions are being made.

The option of interim bed provision stabilises clients and creates an opportunity for achieving better long term outcomes in a more supportive and suitably resourced environment while being less straining to health and social care system.

Investment requirements

2016/17 £350k
2017/18 £356k
2018/19 £363k

Impact of scheme

Impact on National Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	Medium
Effectiveness of reablement	High
Delayed transfers of care	High

Other key metrics:

- % of placements limited to 4, 6, 8 weeks or less

Feedback loop

- Outcome for the service user or patient.

- Experience and satisfaction of the service user or patient.
  - Our aim is that the patient and service user experience should be the organising principle of integrated care. Indicators collated by interview or survey, either on or following discharge from the service to include:

    1. The proportion of patients or service users who felt that the service responded to their personal needs and wishes.
    2. Proportion of people who were satisfied with the experience of the service
    3. Proportion of carers who felt that they had been involved in or consulted about the plans for the person for whom they cared.
    4. Number of significant events or complaints about the service.

- Service efficiency and cost effectiveness.
  - We must maximise the operational capacity of our resources, which will mean sharp focus on such things as access, transfers and destinations on discharge from interim bed provision.

  Indicators to include:
  - Referral data.
  - Movement through the system, use of step up/step down.
  - Delays and reasons in entering the interim bed service.
  - Occupancy and/or capacity utilisation across the service.
  - Length of stay within bed based services.
  - Destination on discharge.
  - Avoided admissions.

The business case for investment in interim beds is based not only on improved outcomes for service users and patients but also in terms of its relative cost effectiveness in relation to alternative interventions. Therefore, the performance framework will include data that allows comparison of costs of interim beds to other forms of interventions.

The performance of the service will be regularly monitored, including through the BCF Programme Board, and it will be the responsibility of the Lead Provider to ensure that information is collated and presented quarterly to the Partnership.

What are the key success factors for implementation of this scheme?

- Good partnership working across clinicians and other professional staff.

- Robust assessment process.

- Good relationship with Housing and Registered Landlords.

- Strong patient/user involvement and control in the planning of their care.

- Strong links to the Integrated Independence Team (ITT).

Scheme ref no.

7.3

Scheme name

Disabled Facilities Grant For Major Home Adaptations

What is the strategic objective of this scheme?

Reduce the need for care & support to older and disabled people
-Contribute to delaying dependence of older and disabled for care and support
-Provide adaptations in privately owned and Housing Association properties that are occupied by older and disabled residents so that they can remain there safely.
-Enabling people to live independently
-Helping carers to support older and disabled people more effectively

Overview of the scheme

Adaptations & Home Improvements are key prevention services that enable older and disabled individuals including children to live independently
Resourced through the DFG the Scheme will fund adaptations to individuals residing in their own properties and tenants living in the private sector.

The objectives of this Home Adaptation Scheme are:

- To empower older and disabled individuals to remain in their own homes with relative independence
- To place the needs and preferences of the disabled person and individuals in their household at the forefront of our decision making
- To maximise grants and other resources available for disabled adaptations
- To ensuring value for money in commissioning the adaptation works
- To ensure an inclusive approach in the planning and delivery of the disabled adaptation programme
- To promote good practice and partnership working among stakeholders involved in home adaptation provision so as to improve outcomes for disabled residents and members of their immediate household.
- To have in place suitable arrangements to recycle adaptations where this is possible.

Delivery chain partners

LBH Occupational Therapy, Private Sector Housing and Property Services, as well as an external home improvement agency and contractors constitute the internal and external providers who are involved in the delivery chain.

The contractors who undertake the actual works can be selected by the residents themselves or by the Home Improvement Agency appointed by the Council.

The legislative evidence base

The following articles of legislation relate to ensuring adaptations are considered for disabled people.

- Housing Act 1985 (Section 8)
- Housing Grants, Construction and Regeneration Act 1996
- Chronically Sick and Disabled Persons Act 1970
- NHS and Community Care Act 1990
- Disability Discrimination Act (DDA) 1995
- The Marmot Priorities which provide a framework for joint commissioning between Councils and CCGs

Investment requirements/

Disabled Facilities Grant

- 2016/17: £1,185k
- 2017/18: £1,299k
- 2018/19: £1,414k

Impact of the scheme on National Better Care Fund Metrics

Non-elective admissions (General and Acute)	Medium
Admissions to residential and care homes	Medium
Effectiveness of re-ablement	Medium
Delayed transfers of care	Medium

Time Scales/ Feedback Loop

The following maximum timescales are set out in the policy.

Occupational Therapy Service	
Assessment requested for service user and completed	Within 28 days
If the outcome of the assessment is positive, recommendation is made to Private Sector Housing (PSH) by entering the referral onto MillFlow (Millbrook's IT system). For complex cases in particular paediatrics where negotiations with families are required, the 28 day time frame may not be achievable.	Within 28 days

Home Improvement Agency	
Check the referral and pass it to Private Sector Housing electronically	5 days

Private Sector Housing	
Pick up the electronic referral from HIA and send a preliminary pack to service user and ask if they wish to be referred to the Home Improvement Agency (HIA)	Within 10 days
Allowed for the completed form to come back to PSH	Within 14 days
If the preliminary form is returned and HIA help is requested, referral is sent to HIA within 7 days	Within10 days
For clients who have not replied another 2 weeks is allowed during which telephone reminders or another letter is sent to service user. If no response, assume DFG not required and the case is closed.	14 days

Home Improvement Agency	
To arrange visit to service users home, prepare plans and specification and return to OT for agreement	Within 28 days

Occupational Therapy Service	
To return specifications with comments/amendments if required	Within 14 days

Home Improvement Agency	
Notify selected contractors, invite tenders, select contractor and fix the start date Liaise with service user regarding any financial contribution Start to prepare the application papers and submit application to PSH	Within 28 days

Private Sector Housing

Approve grant (this is an internal target the statutory time limit is 6 months)	Within 3 months

Home Improvement Agency	
Notify selected contractor and obtain start date, liaise with service user regarding financial contribution and preparation for start of works.	28 days
Start works within 3 months	3 months
Aim to complete works and submit claim to PSH for payment	3 months

Home Improvement Agency& Occupational Therapy (on rare occasions)	
HIA Technical Officer and on rare occasions the OT prescriber visit the property to ensure service user satisfaction. HIA Technical officer confirms that the work has been done to specification and professionally. The PSH Grant Officer will be informed The contractor will be asked to present their invoice If work has not been done satisfactorily, a snagging list will be given to contractor.	14 days

Private Sector Housing	
Grant Officer will arrange final inspection	30 days from invoice date

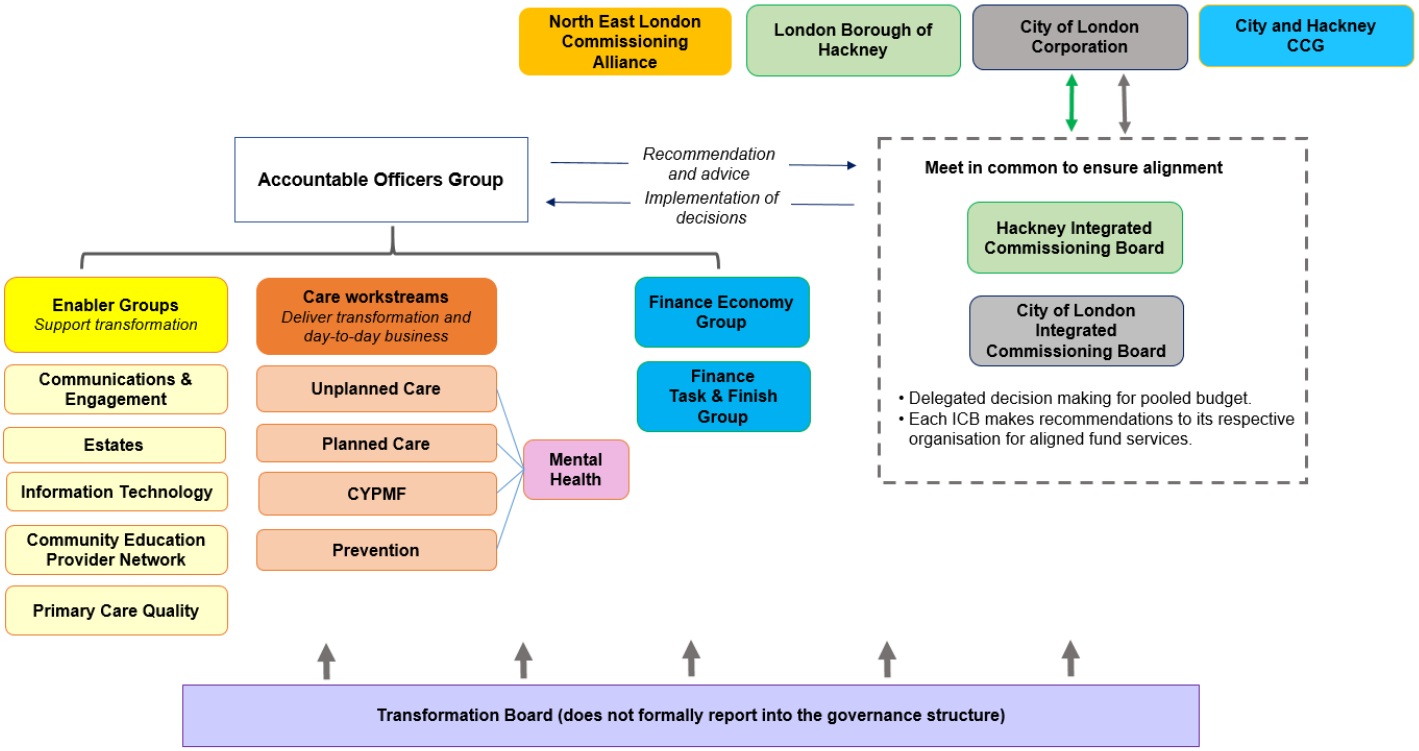
What are the key success factors for implementation of this scheme?

- Case management of each referral and application
- Clear communication with service users throughout the entire process
- Supporting service users throughout the process to prevent delays
- Effective partnership working among stakeholders in the delivery chain to ensure a seamless process

PART THREE – BCF REPORTING REQUIREMENTS AND GOVERNANCE

Reporting requirements

Reporting and monitoring of performance will be in line with NHS England reporting requirement and produced on a quarterly basis.



SCHEDULE 7 – EXIT PLANNING OBLIGATIONS

1. GENERAL ARRANGEMENTS

1.1 Upon termination of this Agreement (in whole or in part) the Parties agree to co-operate with each other in accordance with Clause 26.5.1 (Termination) of this Agreement, to ensure the orderly unwinding of the integrated and joint activities so as to minimise disruption to all Service Users and relevant staff, and to each commit sufficient resources to implement the Exit Plan.

1.2 For the avoidance of doubt:

1.2.1 this Agreement may only be terminated (in whole or in part) in accordance with Clause 26 (Termination) of this Agreement; and

1.2.2 the contents of this Exit Plan are without prejudice to the provisions of this Agreement.

2. GUIDING PRINCIPLES

In carrying out the winding down of the integrated and joint activities the following guiding principles shall apply to the extent that they are appropriate and in accordance with applicable Law and any NHS of local authority guidance at the time the unwinding takes place.

For the avoidance of doubt, these principles will not apply to the extent that any matter has been dealt with under Section 3 below.

2.1 Stage 1:

2.1.1 Exiting Party to notify both the other Party in accordance with Clause 26.1 (Termination) of this Agreement and the Integrated Commissioning Board of its intention to terminate this Agreement. Other Party to acknowledge exit notification; or

2.1.2 Parties mutually agree in writing that the unwinding of this Agreement is in the best interests of Service Users.

2.2 Stage 2: Parties to determine the scope and nature of the exit requirements and establish an exit team with representatives from both parties who are reasonably familiar with the day-to-day functioning of this Agreement.

2.3 Stage 3: Parties to obtain approval/authorisation in accordance with their internal governance arrangements to initiate the unwinding process.

2.4 Stage 4: Parties to allocate relevant resources to the exit team in order to establish a detailed exit plan covering the extent of the Services to be unwound.

2.5 Stage 5: Parties to re-establish commissioning arrangements in accordance with their statutory duties or put in place arrangements for transfers to a third party.

2.6 Stage 6: The Parties shall agree the contents of any public announcement regarding the dissolution of the integrated and joint activities.

2.7 Stage 7: Notice of confirmation that this Agreement has been wound down in relation to all or part of the integrated and joint activities.

3. CONSEQUENCES OF TERMINATION APPLICABLE TO EXIT

3.1 Upon termination of this Agreement (in whole or in part), the following will apply in all instances:

3.1.1 Premises and assets shall be returned to the contributing Party in

accordance with the terms of any leases, licences or other such applicable agreements;

3.1.2 Service Contracts: shall be dealt with in accordance with the provisions of Clauses 26.5.2, 26.5.3 and 26.5.4 of this Agreement;

3.1.3 ICB: shall continue to operate pursuant to Clause 26.5.5 of this Agreement, as applicable;

3.1.4 Overspends/Underspends: shall be dealt with in accordance with the provisions of Clauses 6.7.10, 12 and the Financial Framework.

3.1.5 Disputes: shall be dealt with in accordance with Clause 27 of this Agreement.

3.1.6 Data Protection: data shall be returned and / or destroyed in accordance with the plans set out in Schedule 8 (Data Processing Schedule) of this Agreement.

SCHEDULE 8 - DATA PROCESSING SCHEDULE

1. Data Protection Officer details

   1.1. The contact details of the Council's Data Protection Officer are: Sarah Palmer-Edwards.

   1.2. The contact details of the CCG's Data Protection Officer are: Keith James**.**

2. Processing, Personal Data and Data Subjects

Description	Details
Subject matter of the Processing *[This should be a high level, short description of what the processing is about i.e. its subject matter]*	
Duration of the Processing *[Clearly set out the duration of the processing including dates*	
Nature and purposes of the Processing *[Please be as specific as possible, but make sure that you cover all intended purposes.* *The nature of the processing means any operation such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction of data (whether or not by automated means) etc.* *The purpose might include: employment processing, statutory obligation, recruitment assessment etc.]*	
Type of Personal Data *[Examples here include: name, address, date of birth, NI number, telephone number, pay, images, biometric data etc.]*	

Categories of Data Subject *[Examples include: Staff (including volunteers, agents, and temporary workers), customers/ clients, suppliers, patients, students / pupils, members of the public, users of a particular website etc.]*	
Plan for return and destruction of the data once the Processing is complete UNLESS requirement under union or member state law to preserve that type of data data *[Describe how long the data will be retained for, how it be returned or destroyed]*	