Dated 2015

SOUTHEND-ON-SEA BOROUGH COUNCIL

and

NHS SOUTHEND CLINICAL COMMISSIONING GROUP

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

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Contents

Item		Page
PARTIES		4
BACKGROUND		4
1	DEFINED TERMS AND INTERPRETATION	4
2	TERM	9
3	GENERAL PRINCIPLES	9
4	PARTNERSHIP FLEXIBILITIES	10
5	FUNCTIONS	10
6	COMMISSIONING ARRANGEMENTS	10
7	ESTABLISHMENT OF A POOLED FUND	11
8	POOLED FUND MANAGEMENT	12
9	NON POOLED FUNDS	13
10	FINANCIAL CONTRIBUTIONS	13
11	NON FINANCIAL CONTRIBUTIONS AND STAFF	14
12	RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS	14
13	CAPITAL EXPENDITURE	15
14	VAT	15
15	AUDIT AND RIGHT OF ACCESS	15
16	LIABILITIES AND INSURANCE AND INDEMNITY	16
17	STANDARDS OF CONDUCT AND SERVICE	16
18	CONFLICTS OF INTEREST	17
19	GOVERNANCE	17
20	REVIEW	18
21	COMPLAINTS	18
22	TERMINATION & DEFAULT	18
23	DISPUTE RESOLUTION	19
24	FORCE MAJEURE	20
25	CONFIDENTIALITY	20
26	FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS	21
27	OMBUDSMEN	21
28	INFORMATION SHARING	21
29	NOTICES	21
30	VARIATION	22
31	CHANGE IN LAW	22
32	WAIVER	22
33	SEVERANCE	22
34	ASSIGNMENT AND SUB CONTRACTING	22
35	EXCLUSION OF PARTNERSHIP AND AGENCY	23
36	THIRD PARTY RIGHTS	23

37	ENTIRE AGREEMENT	23
38	COUNTERPARTS	23
39	GOVERNING LAW AND JURISDICTION	23
SCHEDULE 1 – SCHEME SPECIFICATION		25
AGREED SCHEME SPECIFICATIONS		25
1	FINANCE	25
2	SCHEME DESCRIPTIONS	25
3	REPORTING	25
1	OVERVIEW OF INDIVIDUAL SERVICE	26
1	OVERVIEW OF INDIVIDUAL SERVICE	29
1	OVERVIEW OF INDIVIDUAL SERVICE	31
5	SERVICES	31
6	COMMISSIONING, CONTRACTING, ACCESS	32
7	LEAD OFFICERS	32
1	OVERVIEW OF INDIVIDUAL SERVICE	33
5	SERVICES	33
6	COMMISSIONING, CONTRACTING, ACCESS	34
7	LEAD OFFICERS	34
1	OVERVIEW OF INDIVIDUAL SERVICE	35
1	OVERVIEW OF INDIVIDUAL SERVICE	37
SCHEDULE 2 – GOVERNANCE		40
1	BACKGROUND	40
2	GOVERNANCE AND ACCOUNTABILITY	40
3	MEMBERSHIP	40
4	SUBSTITUTIONS	40
5	FREQUENCY	40
6	RESPONSIBILITIES	41
7	REPORTING	41
8	RECORDING	42
SCHEDULE 3 – TEMPLATE SERVICE SPECIFICATION		43
9	OVERVIEW OF INDIVIDUAL SERVICE	43
10	AIMS AND OUTCOMES	43
11	THE ARRANGEMENTS	43
12	FUNCTIONS	43
13	SERVICES	43
14	COMMISSIONING, CONTRACTING, ACCESS	43
15	FINANCIAL CONTRIBUTIONS	44
16	FINANCIAL GOVERNANCE ARRANGEMENTS	44
17	VAT	45
18	GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP	45
19	NON FINANCIAL RESOURCES	46
20	STAFF	46

21 ASSURANCE AND MONITORING 47
22 LEAD OFFICERS 47
23 INTERNAL APPROVALS 47
24 RISK AND BENEFIT SHARE ARRANGEMENTS 47
25 REGULATORY REQUIREMENTS 47
26 INFORMATION SHARING AND COMMUNICATION 47
27 DURATION AND EXIT STRATEGY 47
28 OTHER PROVISIONS 48
SCHEDULE 4 – JOINT WORKING OBLIGATIONS 49
Part 1 – LEAD COMMISSIONER OBLIGATIONS 49
Part 2 – *OBLIGATIONS OF THE OTHER PARTNER* 50
SCHEDULE 5 – PERFORMANCE ARRANGMENTS 51
SCHEDULE 6 – BETTER CARE FUND PLAN 52
SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLCITS OF INTEREST *NOT USED* 14

THIS AGREEMENT is made on day of 2015

PARTIES

(1) **SOUTHEND-ON-SEA BOROUGH COUNCIL** of Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER (the **"Council"**)

(2) **NHS SOUTHEND CLINICAL COMMISSIONING GROUP** of Harcourt House, 5-15 Harcourt Avenue, Southend on Sea, SS2 6HE (the "**CCG**")

BACKGROUND

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

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Southend-on-Sea.

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

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

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

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

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

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

for the benefit of the population of Southend on Sea.

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

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

1 DEFINED TERMS AND INTERPRETATION

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

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

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments pursuant to clause 7.4

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

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

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

BCF Contribution means the Financial Contribution made by the CCG under the provision of Section 223GA(3) of the 2006 Act

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

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

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

Commencement Date means 00:01 hrs on 1 April 2015

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

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

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

(c) which is a trade secret.

Contract Price means any sum payable to a Provider of the delivery of an Individual Scheme 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

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

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

Force Majeure Event means one or more of the following:
(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

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

(h) any other event,

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

Functions means the NHS Functions and the Health Related Functions

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

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

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

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

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

Information Governance Protocol means the insert name of information governance protocol as agreed between the Partners from time to time.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75 of the 2006 Act.

Joint Executive Group means the Joint Executive Group responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Law means:

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

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

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

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

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

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

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, and Monthly shall be interpreted accordingly.

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

National Guidance means any and all guidance in place from time to time published by the NHS Commissioning Board in relation to the Better Care Fund.

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

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

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 8.4.

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

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

Payment for Performance Framework means the framework set out by the Department of Health which determines the Payment for Performance Fund

Payment for Performance Fund means the value of the Payment for Performance element of the Better Care Fund as calculated in accordance with National Guidance

Payment for Performance Shortfall means the value of the Payment for Performance Fund relating to the shortfall in the Performance Target in the relevant Quarter

Performance Target means the performance target in respect of non-elective admission as set out in the Better Care Fund Plan or such other relevant performance target that may be introduced from time to time under National Conditions or by agreement of the Partners

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

Permitted Expenditure has the meaning given in Clause 7.3.

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

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

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.1.2.

Programme Transformation Board means the Programme Transformation Board, established by the Joint Executive Group in February 2015, to support the management of all aspects of the Better Care Fund's (BCF) work, taking day to day decisions on the running of the BCF and being

responsible for ensuring the BCF delivers its objectives, manages risk and for ensuring that there is a comprehensive and effective approach for stakeholder participation and involvement.

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

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

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

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

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

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

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

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

SOSH means the Secretary of State for Health.

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

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

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

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

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

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

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

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

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

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

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

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

2 TERM

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

2.2 This Agreement shall continue until it is terminated in accordance with Clause 21.

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

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

3.2.4 Mange the system of accountability and performance management in such a way as to support then overall objectives and to support the partnership.

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

4 PARTNERSHIP FLEXIBILITIES

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

4.1.1 Lead Commissioning Arrangements;

4.1.2 Joint (Aligned) Commissioning

4.1.3 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

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

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

5 FUNCTIONS

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

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as set out in the Scheme Specifications.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners. The initial scheme specification is set out in schedule 1 part 2

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

5.5 The introduction of any Individual Scheme will be subject to business case approval by Joint Executive Group.

6 COMMISSIONING ARRANGEMENTS

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

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

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

6.4 Each Partner shall keep the other Partner and the Joint Executive Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund through the reporting mechanisms. .

Appointment of a Lead Commissioner

6.5 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall, in accordance with any further agreement set out in the Scheme particulars, :

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

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

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

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

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

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

6.5.7 undertake performance management and contract monitoring of all Service Contracts, including where appropriate enforcement action under the contract;

6.5.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract;

6.5.9 keep the other Partner and the Joint Executive Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund;

6.5.10 the day to day operation and management of the Scheme Specification including payment arrangements with the Provider;

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

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

6.5.13

7 ESTABLISHMENT OF A POOLED FUND

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

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

7.3 Subject to Clause 7.4 it is agreed that the monies held in a Pooled Fund may only be expended (by the partner to whom it is transferred or directly) on the following:

7.3.1 the Contract Price;

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

7.3.3 Performance Payments;

7.3.4 Grants payable out of capital contributions to the Fund

7.3.5 Approved Expenditure pursuant to clause 7.4

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

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities or compensating either Partner for Losses or Indirect Losses unless this is agreed by all Partners in accordance with Clause16 .

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

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

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

7.6.3 appointing the Pooled Fund Manager;

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

8 POOLED FUND MANAGEMENT

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

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

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

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

8.2.1 management of the Pooled Fund;

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

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

8.2.4 reporting to the Joint Executive Group as required by the Joint Executive Group and the relevant Scheme Specification;

8.2.5 preparing and submitting to the Joint Executive Group Quarterly reports (or more frequent reports if required by the Joint Executive Group) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Executive Group to monitor the

effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

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

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

8.4 The Joint Executive Group may agree to the varying of Individual Schemes provided that any variation is for the purpose of furthering the aims and outcomes of that particular Individual Scheme.

9 NON POOLED FUNDS

9.1 In the event that the partners introduce a scheme based on Non-Pooled Funds the following provisions of this clause shall apply.

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

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

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

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

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

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

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

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

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

10 FINANCIAL CONTRIBUTIONS

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

10.2 The Partners shall agree any proposed contributions no later than 31 December in any year for the Financial Year following, subject always to final approval by the relevant body at the Council and CCG. Such final approval shall be provided no later than 31st March unless agreed otherwise between the Partners.

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

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

11 NON FINANCIAL CONTRIBUTIONS AND STAFF

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

11.2 Save as provided in the Scheme Specifications, no staff are expected to transfer between the council and the CCG. The Council and the CCG may implement integrated commissioning arrangements, including the making available of staff under S113 of the Local Government act 1972

11.3 Where staff are made available under s113 the provisions of the Information Governance Protocol shall apply and the Partners shall decide who shall be responsible for any vicarious liability for the staff so made available.

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Better Care Fund scheme Risk share arrangements

12.1 In relation to the schemes set out in Schedule 1 part 2, and subject to this clause the commissioner responsible for the individual schemes as set out in that part of Schedule 1 shall carry the risk of any overspend in relation to that scheme. In the event that any underspend arises in relation to any scheme, they shall be applied

12.1.1 Where the scheme is led by the CCG, firstly in respect of meeting any shortfall in the pooled fund caused by the failure to meet the emergency admissions target, and consequent non release of the Performance payment or any part of it.

12.1.2 Secondly, to be used to meet any overspend in any other scheme managed by the same Partner.

12.1.3 And finally by being released to the Partner responsible for managing the scheme which has underspent, subject always to that Partner retaining the discretion to make payments for the purpose of health and social care either within or outside the Better care schemes to the other party.

12.2 Any savings generated in services which are not commissioned as part of the Better care fund shall accrue to the partner responsible for that service.

Overspends in Pooled Fund Non BCF

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

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

12.5 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Joint Executive Group is informed as soon as reasonably possible..

Schemes outside the Better care fund

12.6 Subject always to the terms agreed in any scheme specification, the following shall apply to any new schemes introduced after 1 April 2015.

12.7 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Joint Executive Group .

12.8 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Joint Executive Group.

Underspend

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

13 CAPITAL EXPENDITURE

13.1 Except as provided in Clause 13.2 Pooled Funds shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The Partners agree that capital expenditure is included in Pooled Funds as set out set out in the Scheme Specification 1 and 5 of the Better care fund.

13.3 Capital assets purchased from the capital in the Better Care pooled fund shall be owned by, and be the responsibility of the Council.

14 VAT

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

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 Both Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance

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

16 LIABILITIES AND INSURANCE AND INDEMNITY

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

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

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

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

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

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

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

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

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

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

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

18 CONFLICTS OF INTEREST

The Partners shall comply with their own policy for identifying and managing conflicts of interest.

19 GOVERNANCE

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

19.2 The Partners have established a Joint Executive Group to:

19.2.1 Approve commencement of new activity

19.2.2 Approve roles and responsibilities

19.2.3 Delegate assurance roles

19.2.4 Review definition documents

19.2.5 Agree scope extensions to existing activities

19.2.6 Agree addition of projects

19.2.7 Act as an escalation point for any issues that cannot be resolved at the project or work stream level

19.2.8 Monitoring and programme finances

19.2.9 Ensuring progress against significant milestones and strategic objectives

19.2.10 Approving any required changes

19.2.11 Monitoring any significant risks and issues

19.2.12 Agree communications

19.2.13 Agree project closures and benefit reports

19.2.14 Issue instructions to the Programme Transformation Board

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

19.4 Subject to clause 19.5, the terms of reference of the Joint Executive Group shall be as set out in Schedule 2.

19.5 The Partners shall review Schedule 2 and agree any amendments within 1 month of the Commencement Date.

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

19.7 The Joint Executive Group shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

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

19.9 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Joint Executive Group and Health and Wellbeing Board.

20 REVIEW

20.1 The Scheme Commissioning Lead in respect of each Scheme Specification shall provide a monitoring report to the Programme Transformation Board for onward transmission to Joint Executive Group on a monthly basis and the report shall be in such form as may be specified by the Transformation project board.

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

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

20.4 The Partners shall within 30 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Joint Executive Group.

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

21 COMPLAINTS

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

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination of the obligations on the parties to maintain a Better Care Fund.

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

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

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) and/or any Individual Scheme shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 12,15,16,21,22,25,26,27,28,32,33,37 and 39

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

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

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

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

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

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

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

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

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

23 DISPUTE RESOLUTION

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

23.2 The Council's Corporate Director for People and the CCG's Accountable Officer, or any person acting in these positions, shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

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

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting

mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

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

24 FORCE MAJEURE

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

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

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

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

25 CONFIDENTIALITY

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

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

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

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

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

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

25.3 Each Partner:

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

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

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

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

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

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

27 OMBUDSMEN

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

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol, and in so doing will ensure that the operation this Agreement complies comply with Law including (without limitation) the 1998 Act and the Better Care Fund Requirements.

29 NOTICES

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

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

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

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

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message

was received informing the sender that it had not been received by the recipient (as the case may be).

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

29.3.1 if to the Council, addressed to the Corporate Director for People, Simon Leftley;

Tel: 01702 215000
Fax: 01702 534618
E.Mail: simonleftley@southend.gov.uk

and

29.3.2 if to the CCG, addressed to the Acting Accountable Officer, Melanie Craig:

Tel: 01702 314299
Fax: 01702 313703
E.Mail: melaniecraig@nhs.net

30 VARIATION

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

31 CHANGE IN LAW

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

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

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

32 WAIVER

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

33 SEVERANCE

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

34 ASSIGNMENT AND SUB CONTRACTING

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

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

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

35.2.1 act as an agent of the other;

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

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

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

37 ENTIRE AGREEMENT

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

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

38 COUNTERPARTS

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

39 GOVERNING LAW AND JURISDICTION

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

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

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

THE CORPORATE SEAL of **THE COUNCIL OF THE BOROUGH OF SOUTHEND-ON-SEA** was hereunto affixed in the presence of:)
)
)

THE CORPORATE SEAL of **NHS SOUTHEND CLINICAL COMMISSIONING GROUP** was hereunto affixed in the presence of:)
)
)

SCHEDULE 1 – SCHEME SPECIFICATION

AGREED SCHEME SPECIFICATIONS

The schemes set out in appendices 1- 6 comprise the Better care fund schemes for the financial year 2015/16.these schemes shall be funded through a single pooled fund Hosted by the Council and managed as set out below

1 FINANCE

1.1 Pooled fund contributions for 2015/16:-

1.1.1 The Council :- £1,153,000 payable 1 April 2015

1.1.2 The CCG :- £10,641,560 payable 1 April 2015, together with £ 977,440, payable quarterly in arrears against the performance of the Schemes against the Payment for Performance target for Emergency admissions.

1.2 The pooled fund shall be divided into sub funds to reflect the Six schemes and paid out from the pool to the lead organisation identified next to it in the table below

	Scheme	Lead	Amount
BCF001	Independent Living	Council	£4,781,000
BCF002	End of Life	CCG	£3,000,000
BCF003a	Prevention including Intermediate Care	CCG	£3,051,000
BCF003b	Prevention including reablement	Council	£1,431,000
BCF004	GP Hub	CCG	£50,000
BCF005	Infrastructure to support integrated working	Council	£459,000
Total			£12,772,000

1.3 The Council shall host the pooled fund, and appoint the pooled fund manager.

1.4 The initial pooled Fund Manager shall be Ian Ambrose, Group Manager – Financial Management.

1.5 Payments from the pooled fund shall be to the lead authority for the purpose of payments due under contracts or by way of grant in accordance with the individual schemes only.

2 SCHEME DESCRIPTIONS

2.1 The scheme descriptions set out in the appendices to this schedule shall be supplemented by and read in the context of the relevant annexes tot eh Better care plan set out at Schedule 6

3 REPORTING

3.1 The Council and the CCG shall ensure that the individual scheme leads report back to the Programme Transformation Board and the Joint Executive Group as required under this agreement to provide accountability and transparency as to the use of the money, and the effectiveness of its use in accordance with the timetable and format to be agreed by between the Partners.

Appendix 1 - Protect Social Services through Independent Living including reducing the reliance on residential care

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

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The strategic objective of this scheme is to invest in services which support independent living and reduce reliance on all forms of institutional care.

1.2 The scheme is a significant contributor to increasing independence and includes key areas of social care delivery by the Council.

1.3 Southend has an ageing population; currently 18.3% of the population are aged over 65 and this is expected to double by 2020. This scheme focuses on supporting existing services to better promote independent living particularly among frail and older people.

2 AIMS AND OUTCOMES

2.1 The scheme aims to reduce permanent admissions to residential care and reduce or delay reliance on longer term social care support in line with Southend Borough Council's corporate requirements.

2.2 In particular the scheme aims to:

2.2.1 Increase in the numbers of people with dementia supported at home

2.2.2 Dementia pathway fully integrated into intermediate care pathway through Single Point of Referral (SPoR)

2.2.3 Reduction in the rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over (PHOF 2.24)

2.2.4 Reduction in the rate of emergency hospital admissions for fractured neck of femur in persons aged 65 and over (PHOF 4.14)

2.2.5 Reduction of 11.5% in the number of people aged over 65 admitted to permanent residential care.

2.2.6 To reduce the number of preventable re-admissions to hospital within 30 days of hospital readmissions (PHOF 4.11) and reduced social isolation (PHOF 1.18)

2.2.7 Reduction in non-medical admissions of people with dementia into acute hospital beds

2.2.8 Reduction in length of stay and delayed discharges from acute hospital settings

2.2.9 Increase in the health related quality of life and wellbeing for older people

3 THE ARRANGEMENTS

The Council shall be responsible for commissioning the services.

4 FUNCTIONS

4.1 The Council will be responsible for commissioning a range of local providers to provide reablement, home care, non-statutory advice and support and care home placements. The functions are all Health related functions.

5 SERVICES

5.1 The following services will be delivered within this scheme:

5.1.1 Maintaining hospital social work services to support early assessment and discharge. Although supporting all adults with eligible needs; this is particularly focused on the frail, elderly population and their carers. This service supports the provision of timely advice, information, guidance and assessment within the acute hospital. The service works closely with the Acute Trust

5.1.2 Maintain capacity within integrated teams and the reablement service to minimise waiting times for assessment and support. Our assessment and support teams work as part of multi-disciplinary teams centred around GP practices or clusters of practices.

5.1.3 Developing a discharge to assess model focusing on reducing admissions to residential care homes and hospital re-admission. Investment will focus on reviewing existing domiciliary care contracts to flex the provision of services.

5.1.4 Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.

5.1.5 Extending the Single Point of Referral, (SPoR) to provide a seven day assessment and therapies service. The SPOR is an integrated, multi-disciplinary assessment and reablement service and supports early hospital discharge and admission prevention. This service has been successful in ensuring that high numbers of people being discharged from hospital are offered and receive reablement. The admission prevention role is underdeveloped at weekends and our plan to extend assessment hours will help to change this. However, success in this area requires engagement with primary care which currently operates a skeleton locum service at weekends. This is being addressed through the Primary Care Strategy.

5.1.6 Dementia Extra care scheme. Extra Care Housing is an innovative alternative for older people to residential care which can help them live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle. Although we have extra care schemes in Southend none are specifically commissioned for people with dementia. This project will provide for extra care accommodation with communities of people with a range of needs of which those with dementia will be a part. The cohort of those initially targeted will predominately be those with dementia whose needs can be met in mixed level of need communities. Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve will achieve an efficiency of £200k per annum from 15/16; The project will span both health and social care and aims to demonstrate the potential for the development of extra care provision both in short term and medium to long term.

5.1.7 The investment in extra care supports a personalised, community based approach and will highlight the health and social care benefits of investing in quality housing for older people and those with a long term condition to prevent a move to institutional residential care and "reable" individuals to avoid frequent hospital readmissions

5.1.8 Telecare

It is our intention to invest in additional Telecare equipment and other technology within the scheme to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations.

Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person

5.1.9 Disabled Facilities Grant, (DFG). This funds adaptations to individuals homes to support independent living and ranges from a ramp to a complex adapted kitchen and beyond. Although we have had some success in reducing the cost of DFG work and the time taken to get the works done the Council will be exploring innovative ways to see whether there is some scope to achieve a more joined up service for both those disabled people living in the private sector and those living in Council accommodation. In addition the possibility of exploring whether there could be a new approach developed to help with hospital discharge cases where adaptations need to be done quickly

5.1.10 Southend has over 150 care homes. During 2014/15 we are extending our Single Point of Referral (SPoR) to care homes to ensure maximum benefit of community and social care services are delivered to care home residents including those with dementia. This will mean that care home residents have access to reablement services. During 2013/14 we piloted a new service with GP practices to improve quality of care for patients in care homes. We will evaluate and extend this service (with appropriate modifications) and link the service to MDTs, and the accountable GP model.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The Council will commission the services

Contracting Arrangements

6.2 The Council shall enter into any relevant Provider Contracts required or make arrangements to provide the service in house.

Access

6.3 The scheme is for the benefit of those individuals ordinarily resident in Southend On Sea Borough council area, who meet the eligibility criteria for care and support under the Care Act and the regulations made thereunder.

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Martin Wintle (Head of Adult Operations)	Same as Council	01702 215000	martinwintle@southend.gov.uk	01702 534618

Appendix 2 – End of Life and Palliative Care

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

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The strategic objective of this scheme is to redesign and remodel existing services to increase the number of people supported to remain in their home and community setting who achieve their preferred place of care during the final stages of their lives to reduce hospital admissions and to protect social services.

2 AIMS AND OUTCOMES

2.1 The overarching aim of the scheme is to redesign & decommission as appropriate existing end of life pathways to align with the new model for the delivery for integrated community services through the GP Primary Care Hub, the Community Recovery Pathway and the wider integrated approach to care set out in the BCF plan to ensure better coordinated case managed care for people in the end stages of their lives.

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the CCG.

4 FUNCTIONS

4.1 The CCG will using the Scheme to fulfil in part its NHS functions

5 SERVICES

5.1 Service delivery will be through an integrated pathway from a range of statutory and third sector providers. We will be working with the following stakeholders to redesign & remodel the end of life pathway:

5.1.1 South Essex Partnership Foundation Trust: EOL Register Community Services, Integrated Teams, Case Coordination, EOL Facilitators. Long Term Condition Matrons

5.1.2 Southend University Hospital Foundation Trust:

5.1.3 Havens Hospices: Community bed base and day centre services

5.1.4 St Luke's Hospices.

5.1.5 SPNDS: Hospice at Home Respite

5.1.6 Ashley Care: Emergency Respite

5.1.7 Primary Care: GPs Primary Care Hub, Enhanced Care Home Services, Care coordination MDT care.

5.1.8 Ambulance Services:

5.1.9 Care Home Providers

5.1.10 Domiciliary care providers

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The commissioning will be carried out by the CCG commissioning Team

Contracting Arrangements

6.2 The CCG shall enter into any relevant Provider Contracts required.

Access

6.3 Access will be in accordance with the referrals for patients for whom the CCG is the responsible Commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
CCG	Linda Dowse (Chief Nurse)	Same as CCG	01702 314299	linda.dowse@nhs.net	01702 313703

Appendix 3 - Prevention including intermediate care, primary and community care and transforming the emergency care pathway

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

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 This scheme seeks to transfer the care of patients with ambulatory conditions into the Primary and Community Care setting together with reablement with social services.

2 AIMS AND OUTCOMES

2.1 The strategic objective of this scheme is to reduce hospital admissions and protect social services by funding a change in approach to the treatment of patients with Ambulatory conditions.

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the CCG.

4 FUNCTIONS

4.1 The CCG will be commissioning the services as part of its fulfilment of the NHS Functions

5 SERVICES

5.1 The Community Recovery and Independence pathway includes a range of services traditionally referred to as intermediate care, reablement and rehabilitation. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a single pathway across health and social care and may include, but is not exclusive to:-

5.1.1 Crisis and rapid response

5.1.2 Hospital supported discharge

5.1.3 Community rehabilitation and reablement

5.1.4 Bed based rehabilitation

5.1.5 Domiciliary care

5.1.6 Falls service

5.1.7 Voluntary sector provision (including universal provision to sign posted services)

5.2 The pathway is being designed to meet the needs of individuals entering the health and social care economy irrespective of their eligibility for on-going social care, the pathway is also a key

component of the prevention agenda and the development of GP Hubs in the locality. It will also support the discharge to assess and the ambulatory care pathways.

5.3 The focus of the community recovery pathway will be on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for on-going packages of care and thereby reducing long-term dependencies on care and support.

5.4 This pathway will not only support efforts to keep people out of hospital and remain independent for as long as possible, but also achieve further progress with integrated care and improve the local preventative services offer.

5.5 The service will be for adults with a primary need for short-term rehabilitation, recovery from and/or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence. The service will include crisis and rapid response, early supported hospital discharge, community rehabilitation and reablement, bed based rehabilitation and a falls service.

5.6 At the centre of the model will be an integrated multi-disciplinary team providing a sevenday service. The team will include occupational therapists, physiotherapists, social workers, nurses (including psychiatric liaison) and therapy assistants and support workers. The team may also include a GP and a nurse prescriber.

5.7 The team will carry out person-centred care, holistic assessment, goal setting and review to enable people to achieve their desired outcomes and reach their maximum level of independence. Staff will have a common set of core skills including assessment, planning and case coordination, as well as retaining their specialist skills and knowledge. Risk stratification will be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management.

5.8 The re-modelling of the pathway will include a review of the processes and systems across partner organisations aligned to the pathway to ensure that recipients do not experience delays in the discharge and referral process, and that services are in place to avoid people going into crisis in the community. This will have a positive impact on the number of people presenting at A&E, the time taken to discharge patients from hospital, the number of people being admitted inappropriately into residential care contributing towards the 11.5% reduction in admissions to residential care, achieving the optimum level of throughput thereby avoiding blockages in the system; and a reduction in the number of people requiring long term care and support.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The commissioning will be carried out by the CCG commissioning Team

Contracting Arrangements

6.2 The CCG shall enter into any relevant Provider Contracts required.

Access

The service is commissioned for individuals for whom the CCG is the responsible commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
CCG	Linda Dowse (Chief Nurse)	Same as CCG	01702 314299	linda.dowse@nhs.net	01702 313703

Appendix 4 – Prevention including reablement service

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

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 Re-ablement complements the work of intermediate care services and aims to provide a short term, time limited service to support people to retain or regain their independence at times of change and transition. It is intended to promote the health, well being, independence, dignity and social inclusion of the people who use the service.

1.2 The funding will be used to facilitate seamless care for patients on discharge from hospital, to promote ongoing recovery and independence and to prevent avoidable hospital admissions.

2 AIMS AND OUTCOMES

2.1 The strategic objective this scheme is to protect social services and reduce hospital admissions through funding re-ablement services with the aim of improving Social Care discharge management and admission avoidance including developing existing re-ablement services.

2.2 In particular the scheme aims to:

2.2.1 reduce avoidable admissions to hospital

2.2.2 Facilitate timely hospital discharges

2.2.3 Prevent and maximise independence

2.2.4 Recovery and enablement services.

2.2.5 Community rehabilitation and re-ablement.

2.2.6 Processes to minimise delayed discharge

2.2.7 Contribute towards an integrated single pathway across health and social care.

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the Council.

4 FUNCTIONS

4.1 The functions are all Health related functions, and commissioned to fulfil in part the Council's obligations under those functions

5 SERVICES

- Maintain home Again Service to cover NHS and social care delays
- Social Work Post to work across intermediate care beds supporting the development of a discharge to assessment
- Social work capacity to maintain and improve speed of assessment

- Therapy capacity to maintain and improve speed of assessment for admission avoidance and supported discharge (2 x OT's for SPOR, 1 x MTA plus van))
- Project management to support the frailty pathway, developing a discharge to assess model of care
- Increase therapy capacity to support reablement of patients on the early supported discharge pathway
- External Re-ablement Capacity
- Implementation of the Care Act

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The commissioning will be carried out by the CCG commissioning Team

Contracting Arrangements

6.2 The CCG shall enter into any relevant Provider Contracts required.

Access

6.3 The service is commissioned for individuals for whom the CCG is the responsible commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Martin Wintle (Head of Adult Operations)	Same as Council	01702 215000	martinwintle@southend.gov.uk	01702 534618

Appendix 5 – Integrated care through the GP Hub

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

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The GP Hub will act as an ‘early adopter, and a catalyst for improvement that will deliver seven-day services across the whole system which will ensure better outcomes and improved patient experience. Services will be monitored and evaluated to understand impact and effectiveness which may lead to further project design, or full roll-out to other GP practices.

1.2 Advances in technology and changing demographics means that, with the right premises and correct skills mix, more integrated care can be delivered in a primary care setting. Citizens who have historically gone to hospitals to receive their care will no longer need to make hospitals their first port of call. Similarly, people who are supported by social care can be referred to the service via a variety of routes.

1.3 Exciting new initiatives are being developed which will deliver improved outcomes for citizens, the supply chain and the health and social care economy. The target operating model will ensure that functional integration of system partners is developed and tested.

1.4 The Community Recovery Pathway will be implemented initially around the GP Hub as this will enable on-going evaluation and monitoring of the model and the effectiveness.

2 AIMS AND OUTCOMES

2.1 The strategic objective of this scheme is to reduce hospital admissions and protect social services.

2.2 Southend’s vision for the GP Hub is that it will act as an ‘early adopter’ and catalyst for improvement that will deliver 7-day services across the whole system from which the following outcomes and benefits will be accelerated:

2.2.1 Reduction in none elective stays

2.2.2 Improved patient outcomes

2.2.3 Increased adherence to end of life plan

2.2.4 Improved performance on the national and local indicators

2.2.5 NHS constitutional standards

2.2.6 To make our current health and social care financially challenged system sustainable

2.2.7 Enhanced GP engagement in the local urgent care agenda and the development and implementation of evidence based services

2.2.8 Reduction in the number of people presenting at A & E

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the CCG.

4 FUNCTIONS

4.1 The CCG will be commissioning the services as part of its fulfilment of the NHS Functions

5 SERVICES

5.1 Premises and a pilot GP service are to be identified by the CCG so as to meet the criteria for the scheme of accessibility, and suitability of premises and size of practice list. .

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The CCG commissioning team to manage the commissioning arrangements .

Contracting Arrangements

6.2 To be awarded by the CCG

Access

6.3 Access will be in accordance with the referrals for patients for whom the CCG is the responsible Commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
CCG	Linda Dowse (Chief Nurse)	Same as CCG	01702 314299	linda.dowse@nhs.net	01702 313703

Appendix 6 - Infrastructure to support integrated working

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

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The Extra care housing scheme will give people the opportunity to live independently in a home of their own, but with other services on hand if they need them.

1 AIMS AND OUTCOMES

1.1 The scheme will assist in the following:

1.1.1 Reduction in residential placements

1.1.2 Reduction in avoidable hospital admissions

1.1.3 Reduction in individuals who are social isolated

1.1.4 Better on line information & advice services for individuals and carers

1.1.5 The required information of individuals and carers to meet the expectations of the care act is recorded electronically.

1.1.6 Technical changes are in place to support better data sharing

2 THE ARRANGEMENTS

2.1 The scheme will be commissioned by the Council.

3 FUNCTIONS

3.1 The functions are all Health related functions, and commissioned to fulfil in part the Council's obligations under those functions

4 SERVICES

4.1 Extra care - £233k

4.1.1 Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve an efficiency of £200k per annum from 15/16; The project will span both health and social care and aims to demonstrate the potential for the development of extra care provision both in short term and medium to long term. This is line with Southend on Sea’s vision for older people which is:-

4.1.2 “Older people will have opportunities to live independently and remain active for longer. They will have greater choice and control over their lives and will be valued and respected”

4.1.3 The investment in extra care supports a personalised, community based approach and will highlight the health and social care benefits of investing in quality housing for older people and those with a long term condition to prevent a move to institutional residential care and reable individuals to avoid frequent hospital readmissions

4.1.4 Extra Care Housing is an innovative alternative for older people to residential care which can help them live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle.

4.2 Telecare – £50k

4.2.1 It is the intention to invest in additional Telecare equipment and other technology within the scheme to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations.

4.2.2 Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person

4.3 Care Act capital monies £176k

4.3.1 Investment in IT

4.3.2 The strategic objective is the Investment of capital monies to improve the IT systems in preparation for the implementation of the Care Act.

4.3.3 The Care Act requirements and the priorities for data and technology include

(a) Transparency – drive better care through release of data about health care services

(b) Transactions – Modernise services to match expectations of today's online society

4.3.4 Interoperability – health and social care systems

4.3.5 Patient participation and control – Enable patient access to their own professional held records

4.3.6 Patient participation and control – Enable patients to control their own health/care (Citizen Driven Health)

4.3.7 Reduce admin burden – Provide front line with information required enter information only once.

5 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

5.1 The council shall be responsible for the purchasing of equipment and the provision of equipment to individuals in accordance with eligibility criteria.

Contracting Arrangements

5.2 At the discretion of the Council for the purchase of equipment.

Access

5.3 For support of housing and telecare, individuals who are ordinarily resident in in Southend on sea borough Council; the care act capital investment directly benefits the council and indirectly benefits the local eligible population

6 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Jacqui Lansley (Head of Procurement, Commissioning and Housing to become Joint Associate Director of Integrated Care Commissioning as of 1 April 2015)	same as Council	01702 215000	jacquilansley@southend.gov.uk	01702 534618

SCHEDULE 2 – GOVERNANCE

Joint Executive Group

Terms of Reference

1 BACKGROUND

The purpose of the Joint Executive Group is to set the strategic vision for South East Essex and to act as the programme board for key integration change initiatives currently:

- Health and Wellbeing strategy
- Integration Pioneer Programme
- Better Care Fund
- Seven day services

2 GOVERNANCE AND ACCOUNTABILITY

The Joint Executive Group will be chaired by Simon Leftley, Corporate Director Department for People and will report regularly to the Health & Wellbeing Board

3 MEMBERSHIP

1. Accountable Officer, Southend CCG, Melanie Craig (Acting)
2. Chair, Southend CCG, Dr Jose Garcia
3. Corporate Director Department for People, Southend Borough Council, Simon Leftley (SBC)
4. Head of Adult Operations, Southend Borough Council, Martin Wintle (interim)
5. Head of Children Services, Southend Borough Council, John O'Loughlin
6. Head of Procurement, Commissioning and Housing, Southend Borough Council (to become Joint Associate Director of Integrated Care Commissioning as of 1 April 2015), Jacqui Lansley
7. Chief Executive, SUHFT, Sue Hardy (Acting)
8. Chief Executive, SEPT, Sally Morris
9. Executive Director for Integrated Care, SEPT, Malcolm McCann
10. Accountable Officer, CP&R CCG, Ian Stidston (CP&R CCG)
11. Chief Executive, SAVs, Alison Semmence
12. Director, Public Health, Dr Andrea Atherton

Other colleagues will be invited to attend specific items as agreed in advance by the Chair.

4 SUBSTITUTIONS

Substitutions for annual leave or short term sickness absence are required and subject to the Chair's agreement.

5 FREQUENCY

The group will convene once each calendar month

6 RESPONSIBILITIES

The Joint Executive Group has ultimate responsibility for the definition and delivery of Health and Social Care Integration in Southend. It has ownership of, and authority for, the overall direction and management of the integration programme, projects and initiatives, and is accountable for delivery. As the 'voice' to the outside world, the JEG is responsible for any communication about the integration programme, projects and initiatives.

Specific responsibilities include:

- Approving commencement of new activity via acceptance of a mandate.
- Approving roles and responsibilities
- Delegation of any Assurance roles
- Reviewing definition documents including PID, business cases, benefits plans, project plans etc
- Agreeing scope extensions to existing activities
- Agreeing the addition of projects to the Programme
- Agreeing to bring projects under the purview of the Joint Executive Group as is necessary
- To act as escalation point for any issues that can not be resolved at the project or workstream level
- Monitoring and programme finances
- Ensuring progress against significant milestones & strategic objectives
- Approving any required changes
- Monitoring any significant risks and issues
- To agree communications
- Reviewing project closure and benefit reports
- to issue instructions to the Programme Transformation Board

For the purposes of integrated commissioning activity it may be necessary for a sub group of the JEG to meet and agree integrated commissioning related plans and proposals. If the need arises then a subgroup will meet with the following organisations represented;

- Southend CCG
- Southend on Sea Borough Council
- Public Health

Specific responsibilities include:

- Jointly commission activity as recommended by the Programme Transformation Board;
- Agreeing extensions to existing jointly commissioned services as recommended by the Programme Transformation Board; and
- Agreeing the de-commissioning of integrated services as recommended by the Programme Transformation Board
- Overseeing delivery of the BCF as defined by the Section 75 agreement, effective 1st April 2015
- Agreement to include or exclude revenue expenditure other than expenditure agreed within the section 75 agreement.

7 REPORTING

Reporting will be carried out using Joint Executive Group approved templates.

- Highlight reports will be presented monthly.

- Exception reports will be produced as required, and may necessitate the convening of an additional meeting, or for a “meeting” to be held virtually.

8 RECORDING

All JEG meetings will be minuted, with agreed actions and timescales

In normal circumstances, papers will be made available to all attendees at least 3 working days in advance. Papers will only be ‘tabled on the day’ with the agreement of the Chair.

SCHEDULE 3– TEMPLATE SERVICE SPECIFICATION

This Schedule is for illustrative purposes only.

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

1 OVERVIEW OF INDIVIDUAL SERVICE

Insert details including:

(a) Name of the Individual Scheme
(b) Relevant context and background information
(c) Whether there are Pooled Funds:

The Host Partner for Pooled Fund X is [ ] and the Pooled Fund Manager, being an officer of the Host Partner is [ ]

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

3 THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme:

(1) Lead Commissioning;
(2) Joint (Aligned) Commissioning;
(3) the establishment of one or more Pooled Funds and/or Non Pooled Funds as may be required.

4 FUNCTIONS

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

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

5 SERVICES

What Services are going to be provided within this Scheme. Are there contracts already in place?
Are there any plans or agreed actions to change the Services?
Who are the beneficiaries of the Services? [1]

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning/Joint (Aligned) commissioning. How will these arrangements work?

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[1] This may be limited by service line –i.e. individuals with a diagnosis of dementia. There is also a significant issue around individuals who are the responsibility of the local authority but not the CCG and Vice versa See note [ ] above

Contracting Arrangements
Insert the following information about the Individual Scheme:

(a) relevant contracts

(b) *arrangements for contracting. Will terms be agreed by both partners or will the Lead Commissioner have authority to agree terms*

what contract management arrangements have been agreed?
What happens if the Agreement terminates? Can the partner terminate the Contract in full/part?
Can the Contract be assigned in full/part to the other Partner?

Access
Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible.

7 FINANCIAL CONTRIBUTIONS

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

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

8 FINANCIAL GOVERNANCE ARRANGEMENTS

[(1) As in the Agreement with the following changes:

(2) Management of the Pooled Fund

Are any amendments required to the Agreement in relation to the management of Pooled Fund
Have the levels of contributions been agreed?
How will changes to the levels of contributions be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the pooled fund manager require training?
Have the pooled fund managers delegated powers been determined?
Is there a protocol for disputes?

(3) Audit Arrangements

What Audit arrangements are needed?
Has an internal auditor been appointed?
Who will liaise with/manage the auditors?
Whose external audit regime will apply?

(4) Financial Management

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
Has the scale of contributions to the pool been agreed?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?
Will there be a facility to carry forward funds?
How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?
What management costs can legitimately be charged to pool?
What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
What closure of accounts arrangement need to be applied?][2]

9 VAT

Set out details of the treatment of VAT in respect of the Individual Service consider the following:

- *Which partner's VAT regime will apply?*
- *Is one partner acting as 'agent' for another?*
- *Have partners confirmed the format of documentation, reporting and*
- *accounting to be used?*

10 [GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

[2] We note that some of the information overlaps with the information that is included in the main body of Agreement, however, we consider it is appropriate that this is considered for each Scheme in order to determine whether the overarching arrangements should apply.

Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?
Who does that group report to?
Who will report to that Group?

Pending arrangements agreed in the Partnership Agreement, including the role of the Health & Wellbeing Board, Partners to confirm any bespoke management arrangements for the Individual Scheme

11 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements[3]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

	Details	Charging arrangements[4]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

12 STAFF

Consider:

- *Who will employ the staff in the partnership?*
- *Is a TUPE transfer secondment required?*
- *How will staff increments be managed?*
- *Have pension arrangements been considered?*

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.

If the staff are being seconded to the CCG this should be made clear

CCG staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the Council.

If the staff are being seconded to the Council this should be made clear.

---

[3] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

[4] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

13 ASSURANCE AND MONITORING

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.
In relation to the Better Care Fund you will need to include the relevant performance outcomes. Consider the following:

- *What is the overarching assurance framework in relation to the Individual Scheme?*
- *Has a risk management strategy been drawn up?*
- *Have performance measures been set up?*
- *Who will monitor performance?*
- *Have the form and frequency of monitoring information been agreed?*
- *Who will provide the monitoring information? Who will receive it?*

14 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council					
CCG					

15 INTERNAL APPROVALS

- *Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;*
- *Consider the scope of authority of the Pool Manager and the Lead Officers*
- *Has an agreement been approved by cabinet bodies and signed?*

16 RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?
Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

17 REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

18 INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing arrangements?
How will charges be managed (which should be referred to in Part 2 above)
What data systems will be used?

Consultation- staff, people supported by the Partners, unions, providers, public, other gency
Printed stationary

19 DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all of the Individual Scheme be terminated on notice by a party? Can part/all of the Individual Scheme be terminated as a result of breach by either Partner?
What is the duration of these arrangements?

Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreement

(1) maintaining continuity of Services;

(2) allocation and/or disposal of any equipment relating to the Individual Scheme;

(3) responsibility for debts and on-going contracts;

(4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

(5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

Consider also arrangements for dealing with premises, records, information sharing (and the connection with staffing provisions set out in the Agreement.

20 OTHER PROVISIONS

Consider, for example:

- *Any variations to the provisions of the Agreement*
- *Bespoke arrangements for the treatment of records*
- *Safeguarding arrangements*

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

This Schedule is for illustrative purposes only.

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

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

1.1.1 a Change in Control Notice;

1.1.2 a Notice of a Event of Force Majeure;

1.1.3 a Contract Query;

1.1.4 Exception Reports

and provide copies of the same.

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

2.1.1 CQUIN Performance Reports;

2.1.2 Monthly Activity Reports;

2.1.3 Review Records; and

2.1.4 Remedial Action Plans;

2.1.5 JI Reports;

2.1.6 Service Quality Performance Report;

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

3.1.1 an Activity Management Meeting;

3.1.2 Contract Management Meeting;

3.1.3 Review Meeting;

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

4 The Lead Commissioner shall not:

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

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

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

4.1.4 give any approvals under the Service Contract;

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

4.1.6 suspend all or part of the Services;

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

4.1.8 serve any notice;

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

without the prior approval of the other Partners (acting through the [JCB]) such approval not to be unreasonably withheld or delayed.

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

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

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

Part 2– *OBLIGATIONS OF THE OTHER PARTNER*

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

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

1.1 resolve disputes pursuant to a Service Contract;

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

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

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

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

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

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

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

NOT USED

SCHEDULE 6 – BETTER CARE FUND PLAN

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Southend Borough Council
Clinical Commissioning Groups	NHS Southend Clinical Commissioning Group
Boundary Differences	Southend is largely coterminous. The most significant boundary considerations are with neighbouring Castle Point & Rochford CCG (CP&R) (who are partnered in the South Essex resilience process) and Essex CC. The CP&R Accountable Officer is a member of the Joint Executive Group, so fully involved in strategic discussions and the Southend BCF. Essex CC are involved on a less formal basis via existing local authority networks
Date agreed at Health and Well-Being Board:	**3rd September 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.687M**
2015/16	**£12.772M**
Total agreed value of pooled budget: 2014/15	**£0.687M**
2015/16	**£12.772M**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Southend Clinical Commissioning Group
By	Melanie Craig
Position	Chief Operating Officer
Date	19th September 2014
Signed	

Signed on behalf of the Council	Southend-on-Sea Borough Council
By	Simon Leftley
Position	Corporate Director for Adult Social Services
Date	19th September 2014
Signed	

Signed on behalf of the Health and Wellbeing Board	Southend-on-Sea Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Norman
Date	19th September 2014
Signed	

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Appendix 1 – Better Care Fund Plan on a Page Appendix 1_BCF on a page.pdf	An Executive Summary of our BCF submission.
Appendix 2 – Integration Agreement Appendix 2_Integration Concor	Southend system partners have a shared joint vision and have formed a strategic alliance with major stakeholders and a governance structure that reports directly to the Health and Wellbeing Board.
Appendix 3 – Data Sharing Appendix 3a_Data Sharing Report.pdf Appendix 3b_CAG 5-05 (a) 2014 SoS ICI	Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs. In February 2014 the DH Informatics Support Team spent two days working with Southend to seek a national solution relating to information governance that hampers the integration process, their final report is embedded A deferred decision letter following the Confidentiality Advisory Group (CAG) on 24th July 2014 is also attached. The CAG considered an amendment to s251. The CAG are due to reconsider on 2nd Oct 2014.
Appendix 4 – Protection of social care	A strategic alliance and governance framework has been developed that will form the strategic oversight that ensures sustainability of social care. **Please refer to Appendix 2**
Appendix 5 – Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable	A successful track record of developing joint health and social care assessments underpinned Southend's successful bid to become one of 14 national Integrated Pioneer Pilots for integrating services.

Appendix 5_Integration Pioneer	**Please also refer to Appendix 2**
Appendix 6 – Agreement on the consequential impacted changes in the acute sector	Southend system partners have commissioned a System wide capacity review which reported in February and has informed planning and future commissioning. System partners have also formed a strategic alliance that seeks to ensure the risk associated with radical service change to improve outcomes is managed collectively. **Please refer to Appendix 2**
Appendix 7 – Perfect Week report Appendix 7_Perfect week.pptx	The Perfect Week was initiated by Southend University Hospital NHS Foundation Trust, supported by Emergency Care Intensive Support Team (ECIST) to support the improvement plan regarding A&E performance. Appendix 7 is a summary of the activity and an early indication of the findings.
Appendix 8 – Length of Stay Review Appendix 8_LOS Rev Southend and Comm	Southend recognised the need to understand the perceived and actual patient flow issues during a review of the length of stay

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision is;

'To create a **health and social care economy** in which the population can access **optimal care** and enable **urgent care** to be delivered with maximum **efficiency and effectiveness'**

Health and Social Care economy; Southend will adopt a system wide view and understand impacts across all key constituents.

Optimal Care and Urgent Care; right care at the right time in the right setting to minimise need to use acute resources.

Efficiency and Effectiveness; Focus on both cost and quality of care, not one at the expense of the other. The current scope of focus and solutions should have positive impact on broader acute care setting and the overall health economy

Our vision is underpinned by the Southend System Leaders Integration Agreement which includes the following focus areas:

- Risk stratification
- Joint commissioning
- Improvement of the community MDTs
- Improvement of the Single Point Of Referral
- Pilot seven day access to services
- Reducing admissions to acute care
- Integrated care records
- Acute Hospital sector challenges
- Prevention/recovery in Mental Health

b) What difference will this make to patient and service user outcomes?

We will build upon our current successes in integrated care delivery to ensure that our prevention offer and self-management options are fully developed and optimised and where longer term care or support is needed it is provided around the service user/patient.

We will build self-reliant confident communities to enable people to be in control of their care and self-manage.

We will invest in preventative services to allow people to be in control and demand less on statutory services through new procurement models which incentivise providers to work collaboratively, which reward support for reablement and independence and which reflect social value principles

We will improve the service user/patient experience through shared use of IT to support individual care planning as well as the use of CARETRAK to support mapping of local need, service planning and identifying more efficient ways of providing support across the system.

We will pilot pooled care budgets which follow the patient as a means of providing more integrated care and offering individuals more choice and control over how their services are delivered integrating budget arrangements which include pooling of resources within clear systems of delegation which recognise the statutory responsibilities of each partner.

We will focus on promoting the use of personal health and social care budgets where appropriate and develop new joint contracting and commissioning models to support this.

Service users and patients will have more choice and control over how their health and social care is delivered through developing a collaborative approach to resource planning and efficiency savings which builds on an open dialogue about partners service and financial pressures

People will experience health and social care as responsive and personalised to their needs and situations through developing commissioning partnerships which drive innovation and take responsibility for evaluation of outcomes which improve people's lives

People will feel enabled to take responsibility for their own health and wellbeing with access to good quality and accessible advice and guidance.

The Patients and residents of Southend have been consulted with regarding what they want to see as an integrated Health and Social Care model towards 2018 / 19.

Patients want to feel confident and safe at home with support in the community. They want an involvement in the development and delivery of their care plan, they require an involvement from friends and family and they want to be at the centre of their own care planning and provision.

The staff of Southend's Health and Social Care economy have been consulted with regarding what they want to see as an integrated Health and Social Care model towards 2018 / 19.

Staff want to commission and provide a service that is measured by outcomes, that provides individuals with the ability to live independent lives and take responsibility for their own care. Staff want capacity to be built within the community and meet the needs of those residents that are harder to reach.

The JSNA is currently being reviewed and will be used to inform the process of developing a vision for Southend once available.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The changes that will be delivered to the pattern and configuration of services during the next 5 years will be driven by robust, integrated and consistent commissioning intentions …..

The vision described above will be delivered through six Better Care Fund Schemes:

- Protect Social Services through Independent living including reducing the reliance on residential care
- End Of life, palliative care and community services
- Prevention including intermediate care, primary and community care and transforming the emergency pathway
- Prevention including reablement
- Integrated Care through the GP Hub
- Infrastructure to support Integrated working

We are now in the implementation phase of our 14/15 schemes and we are currently reviewing the effectiveness of these schemes at the appropriate time and develop a plan to either change direction or increase the resource. This allows us to build on what is working well and if our close monitoring of metrics shows we are not getting the shift in activity we expect we can amend our plans or move resources as required.

We are currently implementing the following schemes;

- Pilot S/W in A&E 7 days a week
- SPOR 7 day working assessment availability

- Falls pathway alignment
- Pilot of integrated care record
- Care Track Risk stratification
- Hospital Discharge - step down offer
- Pilot "GP Hub"
- Extra Care dementia pilot

The detailed changes noted above will be delivered through the BCF programme. To complement our intentions through the BCF our Health and Wellbeing Board and status as Integrated Pioneer will have the following focus:

- Supporting people to live independently and take responsibility for personal health;
- Integrated care provision for adults requiring health and social care services;
- Investment in our workforce to develop an integrated and joint partnership approach;
- Reducing activity at our Hospital through the provision of integrated services within a community based setting; and
- Integrating Prevention and Engagement activity within commissioning and service provision.

Our integrated teams have already had an impact on the 6 conditions set at a national level and our ambitions for extending health and social care integration, the development of the 'GP Hub', the enhancement of the SPoR, falls strategy alignment and the placement of a social worker at A&E 24/7 will impact on avoidable unplanned hospital admissions, delayed transfers of care and effectiveness of reablement, while ensuring a greater increase in service user satisfaction, choice and personal responsibility.

Our ambitions for the Better Care Fund also extend into the wider prevention agenda. We recognise that in the medium to long term demand for acute and specialised health and social care services can only be reduced at a population level through more effective approaches to prevention. This will involve engaging service users, the third sector, Primary Care through a systematic approach to build a holistic team around the patient for individuals with complex health and social care needs including long term conditions.

Integrated service commissioning

The provision of health and social services will be grouped around the 'GP Hub'. The aim of the GP Hub is to become the patients' entry point for the prevention and treatment of illness, provide social services and support independence. The functions of the 'GP Hub' are;

- Risk stratification for people with long term conditions
- Introduction of a Care Coordinator within the practice to enhance whole system care planning and case management
- High intensity, pro-active care with own primary care physician
- Intermediate care, re-ablement and rehabilitation
- Information, advice and guidance to enable people to manage their own health conditions
- Discharge to assess
- Enhanced, pro-active working with care homes
- Integrated care records
- Seven-day services
- Rapid response and crisis prevention
- Falls prevention service
- Promotion of Telecare
- Single point of access / referral
- Risk stratification for people with long term conditions
- High intensity, pro-active care with own primary care physician
- Identification of Carers and referral pathway
- Integrated care records

- Whole system Care Planning
- Enhanced MDT's (children and adults)
- Enhanced working with care homes
- Intermediate Care, Re-ablement and Rehabilitation
- Rapid response - Crisis prevention
- Falls prevention
- Dementia support services
- Enhanced pharmacy services

And will focus on placing a team around the person. Each GP Hub will have a core team that will consist of GPs, clinical nurses, Mental Health professionals, social care, physio and occupational therapists.

The BCF is necessary but not sufficient to deliver the required transformation across Southend. Without BCF there will be a number of critical new activities that will not be delivered over the period to 2018 / 19. Additionally, without BCF the Southend plan will not enable change and transformation in services that have been identified as providing an opportunity to transform in support of the HWBs vision, specifically;

- Southend's social services are fully integrated into hospital health operations in support of admission avoidance and discharge from hospital. For example, Southend CCG and the council currently commission a Single Point of Referral (SPoR) with the aim of avoiding admission from GPs and supporting the hospital discharge team. Our BCF plan includes the aim of reviewing the SPoR and aligning the activity with the 7 day service plan currently in development.
  The review and subsequent change to operations will require investment in both infrastructure and staff structure.
- Southend's plan to develop a Primary Care Hub model in Southend is contingent on both partnership working and investment. Our plans to develop the proposed model are articulated in Annex 1, scheme 004.
- Southend's plan to invest funding into the 'End of Life' pathway is defined in Annex 1, Scheme 002. The evidence base and planned impact is well supported by data that has been made available through analysis of historic performance. The investment in redesigning the pathway is significant from both a resource and financial perspective. Without the BCF Southend would not have the opportunity to transform this partway and therefore support admission avoidance for patients in this cohort.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Data and information derived from the Director of Public Health for Southend's Annual Public Health Report, the latest Southend Health Profile (2014) and additional sources including the Health and Wellbeing Strategy and current Joint Strategic Needs Assessment, cardiovascular risk profile and other sources highlight the key health and social care challenges facing the Borough of Southend.

Key commissioners specifically Southend on Sea Borough Council (the council) and NHS Southend CCG (the CCG), previously used CareTrack, a computer based care and support tool. CareTrack enables the partnership to undertake risk stratification of local citizens in receipt of health or social care support. Through using this tool we have been able to identify whether needs could be better met through collaborative/ integrated service delivery. As a Year of Care pioneer and an integrated health pioneer local partners have also undertaken a number of complex mapping exercises including an epidemiological analysis of hospital attendances and admissions. This data has been used to complement the CareTrack information and identify issues and interventions where integrated service delivery would improve outcomes for local people and make service delivery more efficient and cost effective. (Care Track use is currently suspended pending resolution of data sharing issues).

Through joint partnership arrangements the CCG and the council have worked with NHS England to identify gaps and variation in primary care services. Locally there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years. These issues have been identified in the new Primary Care Strategy for Essex. Local partners have contributed to the development of this strategy. Current plans are that the strategy will enable the CCG and the council to co-commission primary care and community based services in new innovative ways to improve primary and secondary prevention interventions provided to vulnerable or hard to reach people who are currently accessing services in a way that is neither efficient nor cost effective. The impact of conditions affecting the population of Southend has been reviewed.

Currently the population of Southend is in the region of 175,000. By 2021, this is expected to rise by a further 7% to 186,399. Deprivation in Southend is higher than average and about 23.5% (7,700) children live in poverty. Life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend. This is worse than the average for England. The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity, alcohol (significantly higher admissions than the average for England for alcohol attributable conditions) have a negative impact on the health of the population. There are also high levels of mental ill-health within Southend. This means we need to take action to address the links between the social determinates such as worklessness and mental ill-health and demand for health or social care services in specific areas of disadvantage in Southend. We are currently undertaking a community development programme to address the impact of disadvantage and poor health outcomes in specific localities. We need to integrate local health and social care interventions better in these areas and we will use the resources of the Better Care Fund to support this through the schemes outlined. Southend has an ageing population. We know the incidence and prevalence of ill health and disease increases with age and have identified a number of conditions, population groups and specific interventions where we believe more effective collaboration and coordination between partners will improve outcomes for local people and reduce costs to the health and social care economy. The key issues identified are:

- older people (falling, social isolation)
- people living with long term conditions (Cardiovascular disease, diabetes, respiratory disease, asthma)
- people living with dementia

There are a number opportunities to improve the support provided to local people through more effective collaboration and integration. For example, strategic partners are currently working to develop more effective local approaches to support people living with dementia. By doing this we hope to reduce the significant gap and variation between the number of people currently diagnosed with dementia and those known to be living with the condition. Given people living with dementia are more likely to require health care and support they are a major priority for us. Currently it is estimated that circa 7.5% of the Southend population are living with dementia (2,503 aged 65+ source: POPPI / QOF register for Southend CCG 1,139 in 2012/13). Given the future significant impact that supporting people living with dementia will have on local health and social care services, improved pathways and integration between health, social care and voluntary sector organisations will support early identification, treatment and care for local people living with dementia and also reduce costs through provision of early support for carers and families

Living longer does not always mean a better life. Locally we have looked the impact of long term chronic conditions on the health of local people. currently the prevalence of LTC within Southend is (Number: 32,116 / 18,493 per 100,000 population - taken from ONS neighbourhood stats).

Tackling long term conditions through joining up pathways and commissioning services across health and social care that enable people to be supported to self-manage existing conditions is a key focus for local partners. Although the early mortality rate for persons <75 has reduced in recent years, it is still higher than the national average (Directly standardised mortality rate for mortality from all causes, aged <75 is 339 per 100,000 for Southend. England is 350 per 100,000 source: PHE).

Consequently linking programmes and interventions such as increasing access to stop, smoking services, weight management services tacking hypertension and mental ill-health are all key challenges that require better integration and targeted action. We are also working to tackle the issue of social isolation which we know can lead to people deteriorating and ending up requiring intensive health and/or social care support. 323 people per 100,000 were admitted to hospital as a result of a mental illness in 2011/12 which was significantly higher than the England average. The rate of injurious falls and subsequent admission to hospital is also of concern (1592 per 100,000 population persons age 80+). Given the increasing elderly population we know we have to better integrate services to promote bone health and manage and prevent the consequences of falling.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Engagement of the Southend System with Programme activity

The Better Care Fund is closely aligned with the activity currently underway and planned within the Southend Pioneer. For this reason the Southend System are adopting a programme approach to the delivery of the Better Care Fund to ensure stakeholders are both engaged and take ownership for the delivery. Further, the stakeholders will be required to take ownership of the outcomes and the required transformational change to ensure the vision outlined in section 1 is realised.

Schemes identified within our BCF plan are subject to robust governance arrangements and

project planning procedures. Prior to implementation a detailed Project Initiation Document (PID) is required and will be subject to appropriate governance procedure. The PID states the benefits and identify the return on investment. The PID will also provide detail regarding timeline, milestones, risks, mitigations and interdependencies.

An outline to each of the schemes can be found at Annex 1.

Interdependencies

Within each of the PIDs noted above there is a recognition of the local interdependencies that exist.

Across the Southend System and between stakeholder there are interdependencies for Southend's BCF plan to respond to, these are;

Seven day services. Development of seven day services across the Hospital and in the community. Southend CCG, Southend University Hospital Foundation Trust (SUHFT), South Essex Partnership NHS Foundation Trust (SEPT), the council and Castle Point & Rochford CCG. We are working together to enhance existing care pathways across seven days as well as developing new approaches. The hospital is a national pilot site for seven day services.

The Single Point of Referral, an integrated community team with a focus on hospital avoidance and discharge, will be piloting a seven day service during FY 14/15. This will be evaluated over six months to monitor the impact on hospital admissions and attendances at A&E. We will align our falls prevention pathways across the system to be in place by winter 2014.

From Autumn 2014 we are piloting A&E based social workers providing a seven day service with a focus on preventing unnecessary admission to hospital or residential care. The project will enhance the prevention offer through advice, guidance and routine and screening, redirection to appropriate care pathways e.g. falls, reablement and prevent carer breakdown through early identification and intervention.

Plans are forming to develop a GP Hub across Southend which will give greater resilience to practices and enable them to deliver a wider range of services and enable greater access outside core hours. Options and feasibility will be developed over 2014/15.

Pooled Budgets. The development of pooled budgets which follow the patient across health and social care delivery. This opportunity has emerged from the Year of Care work and we are planning virtual pooled budgets from Autumn 2014. We will to evaluate throughout the year with a target of initiating actual budgets from financial year 2015/16.

Emergency readmissions. Reduction in emergency readmissions within 30 days of discharge. The Home from Hospital service is being commissioned from April 2014 to help ensure that older people do not remain in hospital longer than they need once clinical requirements have been met. It has been identified, that due to social isolation, many older adults need some support and assistance in the home to regain their confidence, strength and reconnection with the community in the early days after discharge from hospital. The 'Home from Hospital' scheme will provide support and other practical assistance for a short term period of up to six weeks. The service will be coherent with current and future provision. This will assist us in achieving our aim for no person to enter permanent residential care directly from hospital.

Falls Prevention. Southend has recognised the need for alignment of Falls Prevention across the partners of Southend and is progressing discussion on the most appropriate process to achieve the required alignment. We are considering the adoption of an integrated approach to a falls pathway with additional investment which will enhance the delivery of community assessment and provide additional equipment e.g. tilt table etc.

The Falls Service will support provision of Falls Prevention training delivered to Health and Social Care Staff, and a Falls Prevention and Bone Health Strategy - with a focus on early screening.

Dementia Pathways. Development of dementia pathways.

We are in Year 2 of our Dementia Plan and developing options for the redesign of existing

sheltered housing into dementia specialist extra care housing.

To ensure early diagnosis assessment and support pathways for people with challenging behaviour. This work is being undertaken by SEPT, Southend CCG and the council.

Review of existing assessment pathways is complete and consultation on proposed changes is planned for Early 2015.

Mental health. Mental health is a key priority for Southend CCG and we are fully committed to delivering parity of esteem. Throughout 13/14 the CCG made significant progress in a number of areas and intend to build on this over the next 2 years. The joint mental health commissioning strategy has driven key changes within Southend, namely, the development of a GP crisis line, improving dementia intensive support services, piloting psychological therapies in long term conditions, developing shared care protocols and reducing mental health delayed discharges.

We have recently formed a joint commissioning arrangement that establishes a new model of care for primary mental health services in Southend.

b) Please articulate the overarching governance arrangements for integrated care locally

Southend's Integration Pioneer Programme is overseen by the Joint Executive Group (JEG) and schemes developed through the Better Care Fund will be included in these Governance arrangements. The JEG is directly responsible to Southend's Health and Wellbeing Board (HWB) for Pioneer implementation, Better Care Fund, 7 day services and Southend's integration strategy.

The JEG includes membership from the council, the CCG, Southend University Hospital NHS Foundation Trust, South Essex Partnership University NHS Foundation Trust, Southend Association of Voluntary Services, Essex County Council, Castle Point & Rochford CCG and Public Health. The JEG will monitor performance targets and milestones and include the partners required to take any corrective measures required to keep the schemes on track.

The governance structure is summarised in diagram 1 below:

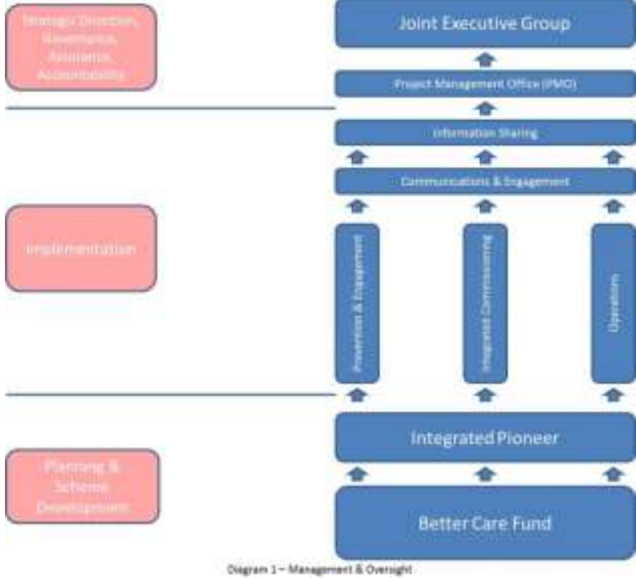

Diagram 1 – Management & Oversight

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Governance Structure

The Southend System will make use of an existing governance structure to oversee the delivery the 6 BCF schemes, as indicated in section 4b above with responsibility for strategic decision maki resting with the **Health and Wellbeing Board**.

Implementation

BCF leads from Southend will be represented at the JEG which will:

- drive the delivery of all projects
- engage with senior staff
- assess project performance through highlight and exception reports
- manage delivery by exception
- produce a report for Health and Wellbeing Board Programme on status, immediate challenges and accountable actions.

Schemes will be individually considered with regard to roles and assignment, for example;

- Executive Sponsor
- Programme and Project Manager
- Corporate Support (Finance and Information)
- Clinical Lead / Social Services Lead

Monthly Project Boards

Project delivery will be managed via the Integrated Pioneer Programme and governed through t JEG.

Each project team will report against project impact and elements that are off track via the monthly Highlight Report.

Project Tracking

A standardised monthly highlight report will be developed for each project team to track delivery:

Activity: key metrics to be reported on will include;

- Avoidable emergency admissions
- Permanent admissions of older people to residential and nursing care
- Effectiveness of reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience

Financial: outturns not achieving forecasted monthly targets (both savings and investments).

- Anticipated shifts in spending patterns. It is expected that the costs of community and social care will increase while the costs of acute hospital care will reduce. The extent of shifts in spending patterns indicates the degree of the success.
- Improved health outcomes should lead to reduction in costs of health and social care; healthier population requires less input from professional health and social care services.

Risks: exceeding agreed tolerances for:

- Quality in terms of impacts on the population and the proposed mitigating actions to remedy or reduce the risk.
- Delivery of Projects due to delays or dependencies and the proposed mitigations with impact analysis.

Please note that time did not allow for the CCG Governing body to sign off Southend’s BCF plan.

This plan is therefore submitted as an intent for Southend and is subject to CCG Governing Body sign off on 26th September 2014.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Please see embedded document for a summary of schemes

Southend Part 1 19.09.14_Summary (

Southend Part 1 19.09.14_Summary (

Ref no.	Scheme
001	Protect Social Services through Independent living including reducing the reliance on residential care
002	End Of life, palliative care and community services
003a	Prevention including intermediate care, Primary and community care and transforming the emergency pathway
003b	Prevention including reablement
004	Integrated Care through the GP Hub
005	Infrastructure to support Integrated working

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs Effect – the reputation of each partner is damaged.	3	4	12	• Appropriate governance structures Provision of regular, timely and accurate information to support monitoring of services • **Owner – Joint Executive**

				Group
Failure to reduce acute activity causing financial pressure Effect – continued financial pressures which will impact commissioning and provision of services.	3	4	12	• System planning is focused on a range of community interventions in a move away from hospital admission. • Regular joint monitoring of progress against identified deliverables and early identification of emerging risks will ensure that potential problems are spotted quickly and mitigation action taken. • Closely monitor demand for acute services and ensure that contingency plans are in place for diversion of funding if necessary • Development of the BCF plan across partnerships to explore sharing of risk and rewards • **Owner – Joint Executive Group**
The transition to new models of working lead to risks to quality and safety. Effect – patients experience low levels of quality and safety to patients is a risk of being compromised.	3	4	12	• Clear lines of accountability up to and including the HWBB. • Ensure a clear mobilisation transition plan is developed and overseen by JEG • A robust performance and quality outcomes framework needs to be developed to monitor quality and safety. • **Owner – Joint Executive Group**

The scale and pace of the change required with risk of increase in number of SUIs and safeguarding referrals across the partnership	3	4	12	• Review of quality and Safeguarding arrangements in place to respond to and learn from any issues that arise • Accountability to H&WB board as well as internal governance boards • Review of existing resource capacity to deal with SUIs and safeguarding referrals • **Owner – Southend BC**
Staff within partnership organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery Effect – detrimental impact on staff morale.	3	3	9	• Workforce strategies across partners need to take into account change requirements • **Owner – Joint Executive Group**
We are unable to engage care homes sufficiently Effect – admissions from Care Homes continue to increase which enhances the gap between commissioner and provider.	2	3	6	• Training and incentive programme in development for care homes • **Owner – Southend BC**
We are not able to share data across organisations Effect – the ability to risk stratify diminishes which leads to un-evidenced service redesign.	3	3	9	• Use of anonymous data until CAG approval to application to amend s251. • Liaison with national team to use CARETRAK as a model of best practice and pilot to remove barriers. • **Owner – Joint Executive Group**
Despite intentions and plans social care services are not protected. The council are subsequently not able to provide assurance to Cabinet that the BCF	3	5	15	• Closely monitor demand for social care arising from

submission protects social care due to minimal protection of social services which will have an impact on robustness of 15/16 budget. Effect – continued pressures on council social services which could potentially lead to effects on front line services.				demographic change and the new statutory duties under the Care Act • Robust governance process will ensure that risks are quickly identified. • **Owner – Southend BC**
Re investment and a changed commissioning focus may create viability problems for providers.	2	4	8	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of savings plans on providers • Impact of plans on quality of service delivery monitored • Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered • Resilient grant funding process. • Mapping the journey workshops to redefine pathways of care. • **Owner – Joint Executive Group**
There is a risk that the local authority and Southend CCG are unable to agree actions to re direct resources to meet the requirement soon Effect – delayed development of the implementation plan.	2	4	8	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan • Further development of integrated service delivery

				projects with robust evidence base to measure success • **Owner – Joint Executive Group**
There is a risk that demand for crisis services (residential/ hospital services) will not reduce because of insufficient quality of Community & primary services.	3	5	15	• Early and broad engagement with community and primary care providers on the CCG and the council quality agenda. • Resilient grant funding • **Owner – Joint Executive Group**
There is a risk that the acute services review in Essex will be out of sync with BCF implementation Effect – a continued provision of inefficient acute services.	2	3	6	• Close engagement with Monitor and the TDA as well as other local and national partners on emerging findings. • Use of CCG and the council plans to influence the outcome of the review. • Joint agreement on adaptions required to BCF planning for alignment with the wider strategic review • **Owner – Joint Executive Group**
Lack of engagement and support from Providers Effect – commissioner and provider plans are not aligned.	3	3	9	• CCG engaged with providers to remodel pathways and services. • Use the JEG to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for transformation and use these to inform on-going discussions

				• Use provider clinical forums to keep clinicians aware and engaged. • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business. Develop a communication strategy for both internal and external stakeholders. • **Owner – Joint Executive Group**
Staff are not fully aware of and engaged with the changes set out in the Better Care Fund plan Effect – reduced morale and staff buy-in to transformation.	2	2	4	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' comms channels to promote better understanding and flag examples of excellent performance and innovation • **Owner – Joint Executive Group**
GP practices do not take up and fully implement the DES	2	2	4	• GP clinical leaders are working with practices to encourage sign up • Integrated communication plan enabling GP practices to learn lessons from the GP Hub pilot and implementation. • **Owner – Southend CCG**
The significant gap that remains between	2	3	6	• The Southend System has an

Commissioners and Providers forecasted reduction in non-elective activity is not addressed substantially so that plans may be aligned.				established formal partnership. This partnership works within a robust governance structure that promotes and facilitates provider and voluntary sector engagement. The providers to the Southend market are represented at all levels of Southend System leadership, for example; the Health and Wellbeing Board (HWB), Joint Executive Group (JEG), operational working groups and resilience planning groups. • We continue to regularly review the robust governance structure in place to assure the system leaders with regards to issues concerning delivery and stakeholder engagement. As part of the BCF plan implementation process a 'data, analytics and communications work stream' has been incorporated with the remit of data, baseline and engagement assurance. This group will report directly to the JEG. Providers are represented on this working group. • A priority for this work stream is the agreement between all stakeholders with regards to the baseline position. • **Owner – Joint Executive Group**

The Southend Borough council may be exposed to a deficit of circa £4.7M even if the benefits of BCF are realised.	3	4	12	• It is recognised that the BCF, in its own right, will not deliver the required transformational change across the Southend system. Therefore, the BCF is aligned with other transformational programmes, e.g. QIPP, System Resilience. We continue to develop this alignment and programme approach within the governance process. • A well-established partnership approach that facilitates and enables the early identification of issues and a robust approach to addressing the issues proactively. • A robust structure to monitor performance and evaluate delivery. • We would expect for a fully developed contingency plan to have been completed as part of the implementation programme governance arrangements, noted above.
The partners do not work to meet the milestones defined in the 7 Day services plan	2	3	6	• It is recognised that the BCF, in its own right, will not deliver the required transformational change across the Southend system. Therefore, the BCF is aligned with other transformational programmes, e.g. QIPP, System Resilience.

				We continue to develop this alignment and programme approach within the governance process. • A well-established partnership approach that facilitates and enables the early identification of issues and a robust approach to addressing the issues proactively. • A robust structure to monitor performance and evaluate delivery.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Background

Our BCF plans are factored into the 2-year operational and 5-year strategic plans produced by the CCG and are in turn reflected in the 5-year strategy of the Southend University Hospital NHS Foundation Trust. These have been considered and signed off by the CCG Governing Body and the HWB.

Our Plans clearly show a record of shifting activity to the community from the acute sector. We anticipate this will be further delivered as part of the next iteration of Operational and Strategic Planning.

Within the Southend Better Care Fund, the financial value of the non-elective admission saving/performance fund is calculated as £977K pa, representing a 3.5% reduction in Southend CCG responsible activity.

Risk sharing arrangements between providers and commissioners

Financial risk falls mainly on the CCG as commissioner, in that if the reduction in emergency admissions is not achieved, this would mean that the CCG will bear the cost of these admissions, as well as the cost of the investment in BCF initiatives. This risk is managed primarily through the setting and achievement of the CCGs QIPP programme that includes the BCF pressures in the totality of the CCGs cost programme. We have established robust arrangements with our acute providers to monitor delivery of QIPP plans.

The CCG has established a range of internal mitigations (such as general and earmarked reserves) and also external risk sharing arrangements with other commissioners which it can draw upon.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

At Southend the BCF is viewed as part of a whole systems approach to health and social care integration, including our plans to implement the Care Act. The challenge for the Southend System is to ensure that Southend's activity re Pioneer, Year of Care and the pilot project for 7 day services are closely aligned with BCF plans.

Underpinning the work of the integrated teams in Southend is a whole systems approach to assessment, care coordination and choice and control that provides support to people to stay as independent as possible in the community and enjoy the best quality of life. For all people with social care needs, provision of a personal budget following assessment is key to ensuring that people have control over their circumstances and can make the best decisions about their own

support, which could include telecare, community equipment and adaptations; homecare or a personal assistant or if required, a move to extra-care accommodation.

Our pioneer integration project extends the reach of health and social care integration to include primary care networks at its heart and to work with all client groups with complex needs. This integrated service will become part of the Southend landscape and will make use of existing care pathways and services.

From a housing policy perspective the BCF plans closely align with SBC's Housing Strategy 2011-21. This Housing Strategy builds on the aspirations of SBC's Older Peoples Accommodation and Support Needs Strategy 2008-11 which set out the Council's support for older people to remain in their own homes for as long as they are able to possibly with support, assistive technology and a commitment to lifetime homes.

Also in line with the implementation of the Housing Strategy, SBC will be undertaking a review of sheltered housing stock within the borough to identify whether it is fit for meeting the needs of older people in the 21st century and if this can be enhanced to meet the needs of frailer older people. SBC are also seeking to create a Southend definition of extra care housing and look at whether increased provision would support people to remain living independently and reduce the need for residential accommodation.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our BCF plan is incorporated within Southend CCG's 2 year operational and 5 year strategic plans. The financial impact of the BCF has been included in the financial model, and is one of a number of factors driving the CCG's QIPP requirement of £34.1m over the 5 year period to 2018/19. The BCF is not viewed by the CCG as a standalone initiative, rather it is an integral part of our delivery plans including the Operational Resilience and Capacity plan, which taken in the round describe the changes necessary to deliver a modern model of integrated care, alongside other key system changes that are required to achieve high quality, sustainable services.

Our BCF seeks to address the challenges presented by a significant increase in prevalence of chronic diseases, which would lead to increased levels of admissions to hospital, but with the implementation of the Ambulatory Emergency Care scheme together with changes to primary care and Community Reablement will mitigate these admissions ;

- COPD – projected increase of 11% by 2015
- Diabetes - projected increase of 12.5% by 2015
- Stroke - projected increase of 9.5% by 2015
- Hypertension - projected increase of 4.5% by 2015

Delivering these requires the BCF vehicle in order to transform and align Community and Social Care for patients outside of the hospital setting. Our five year operating strategy then supports a process to make this a sustainable landscape through measuring and delivering seven outcome measures going forward to which the BCF schemes contribute significantly towards;

1 – Potential years of life lost from causes amenable to healthcare

2 – Health related quality of life for people with one or more long term conditions

3 – Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

4- Increasing the proportion of older people living independently at home following discharge from hospital

5 – Increase the amount of people who have a positive experience of hospital care

6 – Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

7 – Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NHS Southend CCG has bid to shadow the area team as part of its co-commissioning proposals. This is commencing in October 2014 and the CCG has already joined regular Essex area team meetings. A steering group has been established and is developing terms of reference and governance processes.

We believe that co-commissioning will better:

- support the integration of health and social care services locally;
- drive quality improvement within primary care, and reduce health inequalities;
- increase citizen involvement in the development of primary care services;
- support the development of sustainable local services.

Co-commissioning would provide the CCG with the ability to influence how local services are commissioned to ensure that these align with the unit of planning's 5-year strategy and with a focus on outcomes for our local population.

Our 5-year Strategic Plan identifies the need to improve the delivery of care, particularly for people with long term conditions and older people living with frailty. The opportunity to commission locally sensitive services, if deemed more suitable than nationally specified enhanced services would be particularly helpful in supporting delivery of more integrated services in partnership with the council through increased engagement with our member practices.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The current eligibility criteria for adult social care will remain at critical and substantial. It is not envisaged this will change over the next five years unless mandated by the Care Act, although this is dependent on the financial position. Our local definition of protecting social care services is, "ensuring eligibility criteria and investment remains at required levels with a focus on prevention and ensuring that health services are available earlier and in better co-ordinated ways to reduce demand on social care"

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Promoting independence and reablement, supporting carers and offering alternatives to longer term reliance on residential care are key elements of the Southend approach to protecting social care services. Our BCF schemes are focused on achieving these aims in tandem with a reduction in hospital admissions.

The CCG and the council will work together to agree levels of investment with a focus on achievement of agreed joint objectives. Investment in social care reablement and prevention services will reduce hospital admissions and admissions to residential care. This will support the achievement of a financially sustainable social care system.

There is recognition that in order to undertake radical change in services to achieve better outcomes requires support and commitment from all system partners. This ensures services are protected and risk is managed collectively. System leaders in Southend have formed a strategic alliance with a clear governance structure that reports directly to the Health and Wellbeing board.

We are currently scoping opportunities for joint commissioning across health and social care to achieve value for money and increased efficiencies and have identified the need for a wide ranging prevention strategy to support a shift in resources and manage demand. We will use the BCF to:

- Develop our prevention offer with a focus on increased utilisation of third sector opportunities
- Review our commissioning approaches with a view to developing joint commissioning where this can achieve better outcomes and value for money.
- Focus on integrated service delivery to improve efficiency and reduce duplication
- Support market development to broaden the range of alternatives to residential care.

The Care Act offers opportunities to review our approach to assessment and we will explore options for increased use of self-assessment and review options for the delivery of front end assessment with an increased focus on self-management and use of universal services. The Care Act is the catalyst for further developing our information, advice and guidance pathways and we will use the BCF to scope out opportunities for a joint IAG approach. Within our BCF schemes we have allocated £627k (of which £172K is capital) to support implementation of the Care Act.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total amount allocated from the BCF for the protection of adult social care services in 2015/16 is £5.930M.

Funding currently agreed for 2014/15 via the NHS transfers monies has enabled the local authority to maintain current eligibility criteria, keep delayed transfers of care to a minimum and offer timely assessment and longer term support to people with eligible needs. This will need to be increased, within the funding allocations for 15/16 and beyond to maintain and develop further the current offer. In particular the Care Act is likely to impact on the numbers of assessments required with larger numbers of people needing an assessment who would previously have not had contact with Social Care. This also raises the opportunity to engage in preventative approaches with a wider range of Southend residents and strengthens the importance of a joint

approach.

Due to the documented financial difficulties of Southend CCG it has not been possible, as yet, to find any additional allocation to protect Social Services within the BCF plan for 2015/16 beyond the minimum commitments and funding for the implementation for the Care Act.

If not successful, this will leave the council facing a deficit in the provision of Adult social services in the region of £4.7M (circa 11%) which is likely to impact on the provision of integrated front line services.

Both the CCG and the council have agreed a plan to work together on an open book basis to review the apportionment of BCF funding.

We can confirm that our local proportion of the £135M has been identified from the additional £1.9bn.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Our focus on prevention with an emphasis on promoting well-being and self-care will support the aims of the Care Act.

We recognise that underpinning all of the individual's care and support requirements is the need to ensure that what we are doing focuses on the needs and goals of the person concerned. We acknowledge that wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible

We are committed to ensuring that we consider how to meet each person's specific needs rather than simply considering what service they will fit into and we will adopt a co productive and flexible approach with service users and carers which concentrate on the aspects of wellbeing which matter most to them.

Our prevention work is well developed but is benefitting from a specific work stream focus led by Public Health and a third sector representative. A joint CCG and Local Authority prevention strategy is being developed focusing specifically on the frail elderly population which will bring together a joined up approach to commissioning prevention focused services.

A number of the BCF schemes have a clear connection to the new duties of the Care Act particularly around new duties to carers; prevention and wellbeing; assessment and eligibility; care planning and personalisation. These are schemes to:

- Increase in carers' assessments and provision of services and support to carers
- Increase in assessments in preparation for the reform of funding which takes effect from April 2016.
- Work collaboratively with voluntary organisation and advocates to identify people who might have support needs that are not being met and to make services available which will enable a person to stay independent.
- To ensure that there is accessible and proportionate information available which meets the needs of the person, ranging from information on a web site to a face to face discussion or advocacy
- Invest in staff training to ensure that all professionals are trained in early identification of behaviours that can lead to poor health and the advice and information they should provide to promote wellbeing..
- Work closely with Public Health to target the vulnerable areas of Southend.

A project plan is in place to assure implementation of the Care Act, which is overseen by the Head of Adult Services.

We will use the Care Act monies identified in the BCF (Annex 1, Schemes 003b and 005) to support funding for a wider range of carer's services which are currently being scoped. This will include developing our carer's assessment and support offer.

v) Please specify the level of resource that will be dedicated to carer-specific support

We are committed to extending our support to carers in recognition of the vital role they play in the cared for person's well-being and in line with the new duties in the Care Act. We have used the national models available to estimate the number of carers not currently known to the council and we are using this information to establish what the increase in carers' assessments is likely to be. We are committed to:

- Identifying the carers who are not currently known to the council
- Increasing and developing the workforce in response to the increased demand.
- Investing in staff training of both health and social care staff to ensure that the staff have the skills to recognise the impact of the caring role on the carer as well as ensuring the carer has a self-directed service.
- Ensuring that there is accessible advice and information available to carers to support them in their caring role

£437k is allocated to carer specific services, this is the council and CCG commissioning a range of services to support carers and the joint Carers Strategy.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no effect on the local authority's budget against what was originally forecast with the original BCF plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

In November 2013 Southend was accepted as an Early Adopter site to provide 7 Day services. Southend's aim for 7 Day services is ….

….. "We want to refashion our services to our patients, their carers and families, so that they always feel supported and cared for, no matter where they are in the system or what day of the week it is."….

During the course of 2014 we have been working to identify the improvement priorities and integrate these into existing programmes of work. New projects have been created where appropriate and progress is tracked through the governance of the Joint Executive Group (JEG).

Our review has focused on;

- access to health and social care outside of hospital;
- 7 day services in the hospital; and
- Leaving the hospital after treatment to the next place of care.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Our health and care systems will use the NHS Number. One of our BCF schemes is "Infrastructure to support integrated working" which aims to improve the service user/patient experience through initiatives which will include integrated care records, shared use of IT to support individual care planning, the use of CARETRAK to support mapping of local need, service planning and identifying more efficient ways of providing support across the system

Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We are fully committed and have a Health and Adult Social Care Services - Information Sharing Protocol (April 2013) with 4-5 more detailed sharing agreements that sit below this e.g. CARETRAK, Major Adaptations. We also annually submit the NHS IG Toolkit. An application has been made to the Confidentiality Advisory Group (CAG) to amend the s251 agreement and achieve a local short-term solution. The CAG will consider the application on 11th December 2014. Previous applications have been deferred by the CAG with the request that identified issues are resolved. We have worked through these issues which have led to the revised application on 11th December 2014.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Since September 2012 the CCG and the council has commissioned a Single Point of Referral Service (SPOR), which acts as the key contact point for health care professionals both in primary care and acute discharge services, to the integrated teams which provides a multi-disciplinary response to urgent issues or needs of patients within the community who would otherwise attended A&E and experienced a 0-1 length of stay. We anticipate this service will be available 7 days a week once it is fully up and running. At present the threshold has yet to be established with regard to the number of referrals that can be made into the service upon full implementation although the numbers of referrals have increased year on year since the commencement of the service.

The risk stratification used to identify high risk patients are as follows:

- Patients over 65 years of age
- 2 or more A&E attendances over the last 6 months
- Patient with 2 or more LTC
- Polypharmacy
  Evidence of cognitive problems (acute or chronic)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Our existing integrated teams bring together health and social care managers and front line staff into joint teams, delivering coordinated care with a clear focus on roles and responsibilities though practice level multidisciplinary team working for high risk patients though risk stratification. This style of patient management allows for the different professionals to shared information and knowledge to allow better care planning which results in better outcomes for patient and their families. This integrated care based model was developed and has been used as a model of best practice though the Year of Care National Programme.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

All patients moving through the Pioneer programme will have collaborative care plans in place.

There is a practice population of 186,000 in Southend and 2% of these are in receipt of an MDT which represents 3,720 people.

Southend was in the unique position of having a joint risk stratification system software system (CARETRAK) which can identify and risk assess people in the health and social care system via a patient identification number which is based on the NHS ID. Since the formation of the CCG on the 1st April 2012 it has not been possible to access this system as a consequence of the data protection and patient confidentiality issues that have been raised by the Department of Health. Southend BC and the CCG are currently awaiting a decision from the CAG (D of H Confidential Advisory Group) on the Section 251 Agreement which will enable the information sharing and risk stratification protocol to be utilised.

Please refer to **Appendix 3** for the evidence base re current position.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Patient, service user and public engagement

The application for Integrated Pioneer status was initiated by the council and has built upon a wide process for public, service user and patient engagement. This has been followed by a successful event, held by the CCG, in January 2014 which captured patient views on health and social care in Southend. This information has been used in developing our BCF and integrated pioneer plans and our five-year strategy. Essentially some of the main themes were as follows:

- Services available under one roof at the GP practice
- Better integration of care – a seamless service
- Better access to the GP practice
- Support for self-care

The CCG has a practice patient participation group (PPG) forum which is made up of representatives from many of our member practices. The PPG forum has a keen interest in the better care fund and how health and social care services work together to improve services to patients and has asked for regular update on our on-going projects.

The CCG has established a new patient and public engagement steering group to support the development of a new communications and engagement strategy. As well as including the CCG, Healthwatch and council Members, the group also includes representatives of our local population and the voluntary sector and will support and challenge the CCG in better engaging our citizens in commissioning. This group will also support the development of patient and public engagement in our better care fund plan and our integrated pioneer work.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

NHS foundation trusts and NHS trusts

Two workshops were held in May and June 2014 which included our key local health providers in order to develop our five-year strategy, with a key focus on integration of services across the borough.

ii) primary care providers

Southend GPs and member practices have been engaged at various levels. The GPs elected to the CCG's Governing Body and appointed to the clinical executive have been directly involved in the development of this plan, and key elements of the BCF schemes have been supported by GP colleagues working as clinical project leads (as part of our overall QIPP and Transformation Programme). In addition the CCG has appointed a GP as clinical lead for integration, who works with the CCG one day a week.

iii) social care and providers from the voluntary and community sector

Southend Association of Voluntary Services (SAVS) is a key member of the GP hub project board and also leads the prevention work stream under the Health and Wellbeing Board.

SAVS form part of our new patient and public engagement steering group which will be responsible for shaping the development of our communications and engagement strategy and for supporting its delivery.

Two workshops were held in May and June 2014 which included the council social care and SAVS in order to develop our five-year strategy, with a key focus on integration of services across the borough.

A whole system approach is being adopted for the modelling of a Community Recovery Pathway. The Community Recovery and Independence pathway includes a range of services traditionally referred to as intermediate care, reablement and rehabilitation. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a **single** pathway across health and social care.

This pathway would not only support efforts to keep people out of hospital and remain independent for as long as possible, but also mean further progress with integrated care and improve the local preventative services offer.

The model may include:

- Crisis and rapid response
- Early support hospital discharge
- Community rehabilitation and reablement
- Bed based rehabilitation
- Falls service

Key interdependencies:

- Hospital discharge team (social care)
- District nursing
- Community Matrons
- Locality social workers
- Primary Mental Health services
- Community geriatrician
- GPs
- Voluntary sector
- Private sector care providers

Who is the service for?

Adults with a primary need for short-term rehabilitation, recovery and/ or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence.

What does it look like?

At the centre of the model is an integrated multi-disciplinary team providing a 7-day service. The team may include:

- Occupational therapists
- Physiotherapists
- Social workers
- Nurses including psychiatric liaison
- Therapy assistants and support workers.

The team may also include a GP

The team will carry person-centred, **holistic** assessment, goal setting and review to enable people to achieve their outcomes and reach their maximum level of independence. Staff will have a common set of core skills, such as assessment, planning and case coordination, as well as retaining their specialist skills and knowledge.

Common principles:

- Person-centred and proportionate
- Prevention and maximising independence
- Recovery and enablement
- Focussed on goals and outcomes
- Effective case coordination
- Single referral route
- Single joint assessment
- Integrated care plan
- Positive risk taking

Throughout this pathway, a risk stratification tool may be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management. These cases may be identified through MDT meetings with clear outcomes agreed on a case-by-case basis.

What difference will it make?

The focus of the Community Recovery and Independence Pathway is on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for an on-going packages of care and thereby reducing long-term dependencies on care and support. Effective and coordinated services will achieve longer-term (financial) benefits for the health and social care economy.

What added value will this approach bring?

- Potential reduction in duplication of care planning and assessments leading to potential transactional efficiencies
- Proactive community offer and intervention to prevent hospital admission
- Better coordination and case management leading to better outcomes for the service user
- Bigger, more flexible resource may lead to efficiency savings
- Longer term savings from the care system as a result of effective interventions
- Focus on whole system working with all stakeholders, particularly Providers of services, working as partners to achieve the best outcomes.

Things to consider:

- Step up and step down (not necessarily bed based)
- Day resource centres and assessment flats
- Community ward and care navigator model may be included
- In-house versus commissioned personal care
- Role of the hospital discharge team

How will the model of delivery be achieved?

Four multi-disciplinary workshops have been held (one in July, two in August and one in September with a further workshop planned for early October) to map out the "as is" pathways and to understand what is working well and where there are weaknesses in the system which impact on outcomes for individuals using the services; particular emphasis will be placed upon ensuring that there is sufficient capacity in the market to meet changing demand and to incorporate flexibility so that surges in demand can be met.

The output from the workshops will influence the redesign of the pathway which will take a multi-disciplinary approach; Healthwatch and representative organisations will be invited to participate in the re-modelling.

Health and social care will review the services currently commissioned within the current pathways and engage with Providers to disseminate the vision for integrated working. This will enable Providers to adapt services and diversify, where necessary, to meet the requirements of the integrated pathways.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The overall impact of CCG allocations and BCF and QIPP requirements over a five year period is already modelled within the operational planning submissions made by the CCG for the 2014/15 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. The CCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Southend University Hospital NHS Foundation Trusts' financial sustainability.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

SCHEDULE 7– POLICY FOR THE MANAGEMENT OF CONFLCITS OF INTEREST

NOT USED

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

NOT USED

SCHEDULE 9 STAFF ARRANGEMENTS

NOT USED