Bevan Brittan

Dated 8th APRIL 2015

PORTSMOUTH CITY COUNCIL

and

NHS PORTSMOUTH CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES IN SUPPORT OF THE BETTER CARE PROGRAMME

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THIS AGREEMENT is made on 8th day of April 2015

PARTIES

(1) **PORTSMOUTH CITY COUNCIL** of Civic Offices, Guildhall Square, Portsmouth, PO1 2BG (the **"Council"**)

(2) **NHS PORTSMOUTH CLINICAL COMMISSIONING GROUP of St James Hospital,** Locksway Road, Southsea, Hampshire PO4 8LD (the **"CCG"**)

BACKGROUND

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

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the city of Portsmouth.

(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.

(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 provision of health and social care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

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

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives; and

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

(G) The Partners 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.

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

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

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

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

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

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

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

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

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

(c) which is a trade secret.

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

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

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 are relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

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

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

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

Individual Scheme or 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.

Individual Service means a service within one of the Individual Schemes.

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

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

Law means:

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

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

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

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

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

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

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

Month means a calendar month.

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

NHS Better Care Contribution means the minimum amount which each Partner must contribute to the Pooled Fund as identified by national guidance and/or through their Better Care allocations.

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

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

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

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

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

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

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 and as detailed in Schedule 3 Part 2 or as agreed by the Partnership Board.

Permitted Expenditure has the meaning given in Clause 7.3.

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

Performance Payment Arrangement *means any arrangement agreed with a Provider and one or 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.*

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 10. At the Commencement Date this will be the Council s151 officer.

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

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

Section 113 Officer means an officer of either of the Partners made available under the provisions of section 113 of the Local Government Act 1972

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, including agreements for the provision of equipment, entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individuals 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 22.

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

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

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

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning

4.1.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

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

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

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

5 FUNCTIONS

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

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

5.3 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 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 the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

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

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

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

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

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

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

Appointment of a Lead Commissioner

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

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

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

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

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

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

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

6.7.7 undertake performance management and contract monitoring of all Services Contracts and report to the Partnership Board;

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

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

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 and capital expenditure as set out in the Scheme Specifications.

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

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

7.3.1 the Contract Price;

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

7.3.3 Performance Payments where expressly agreed by the Partnership Board;

7.3.4 Approved Expenditure; and

7.3.5 any relevant employment contracts where this is identified and agreed through a Scheme Specification;

("Permitted Expenditure").

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

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

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for the Pooled Fund 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 their 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 Scheme where there is a Pooled Fund shall have the following duties and responsibilities:

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

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

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

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

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

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

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

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

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

8.4 The Partnership Board may agree to the virement of funds between Pooled Funds.

9 NON POOLED FUNDS

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

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

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

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

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

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

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

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

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

10 FINANCIAL CONTRIBUTIONS

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

10.2 Each Partner shall be required, as a minimum, to contribute to the overall Pooled Fund the NHS Better Care Contribution net of any amounts retained pending reductions in emergency admissions.

10.3 Subject to clause 10.2, the Partners shall agree additional contributions to the Pooled Fund on a recurrent or non-recurrent basis through the Partnership Board in accordance with the budget planning process set out in its terms of reference. For the avoidance of doubt there shall be no obligation on either Partner to make additional contributions to the Pooled Fund as part of the budget planning process. In determining such contributions the Partners shall take into account the objectives of the local Better Care Fund Plan, Schedule 6, the delivery of the local programme to date and any relevant local and national system pressures.

10.4 Financial Contributions will be paid monthly into the Pooled Fund on a one twelfth equal payment or as otherwise agreed through the Partnership Board or in accordance with the requirements of any national guidance. Payments out of the Pooled Fund shall be paid monthly on a one twelfth equal payment or as otherwise agreed through the Partnership Board or in accordance with the requirements of any national guidance.

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

11 NON FINANCIAL CONTRIBUTIONS

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

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

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

Overspends in Pooled Fund

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

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

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 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 Partnership Board.

12.6 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 Partnership Board of any Overspend.

Underspend

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

13 CAPITAL EXPENDITURE

13.1 Subject to Clause 13.2, neither Pooled Funds or Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 Capital expenditure within the Pooled Fund or Non Pooled Funds shall be permitted in relation to one-off expenditure on goods and/or services where this has been specifically identified in order to achieve the objectives of the Schemes laid out in Schedule 1, Part 2, and is in line with national guidance.

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. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

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

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a

consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

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

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

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

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

16.4 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.

16.6 In the event that the First Partner incurs a loss that they are not able to reclaim from the Provider as a direct result of a breach by a Provider which results in a successful claim by a third party against the First Partner the matter shall be referred to the Partnership Board to determine whether the loss should be shared between the Partners and if so in what proportions.

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 the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

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

19.2 The Partners have established a Partnership Board to

- provide strategic direction on the Individual Schemes;
- receive the financial and activity information;
- review the operation of this Agreement and performance manage the Individual Services;
- agree such variations to this Agreement from time to time as it thinks fit;
- review and agree annually a risk assessment and a Performance Payment protocol;
- review and agree annually revised Schedules as necessary;
- request such protocols and guidance as it may consider necessary in order to enable each Pooled Fund Manager to approve expenditure from a Pooled Fund.

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

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

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

19.6 The Partnership Board 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.

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

20 REVIEW

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

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

20.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Partnership Board.

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

21 COMPLAINTS

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

21.2 A summary of complaints raised in relation to the Individual Schemes shall be brought to the Partnership Board on a quarterly basis.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by either Partner giving not less than six (6) Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

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

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

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clause 23.

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 Services 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, as identified at Schedule 3, 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 Services Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Services 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 Services Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Services Contract allows the other Partner may request that the Lead Commissioner assigns the Services Contract in whole or part upon the same terms mutatis mutandis as the original contract;

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

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

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

23 DISPUTE RESOLUTION

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

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

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executive/chief officer or 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 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

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

27 OMBUDSMEN

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 set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act.

29 NOTICES

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 David Williams, Chief Executive;

Portsmouth City Council,
Civic Offices,
Guildhall Square,
Portsmouth,
PO1 2BG
Tel: 023 9283 4009
E.Mail: David.Williams@portsmouthcc.gov.uk

and

29.3.2 if to the CCG, addressed to Innes Richens, Chief Operating Officer;

Portsmouth CCG
St James Hospital,
Locksway Road,
Southsea,
Hampshire
PO4 8LD
Tel: 023 92684832
E.Mail: innes.richens@portsmouthccg.nhs.uk

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 as a deed by the Partners on the date of this Agreement

THE COMMON SEAL of **PORTSMOUTH**)

CITY COUNCIL was hereunto affixed in)

pursuance of a resolution of the Council)

passed at a meeting duly convened and held:-)

.....

Authorised Signatory

SEAL REGISTRY No. 74453

Sealed on behalf of **NHS PORTSMOUTH CLINICAL COMMISSIONING GROUP**

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

Part 1 – Template Services Schedule

In the event that the Partners wish to include additional schemes within the Better Care Plan programme the following template shall be used to develop a proposed specification for discussion through the Partnership Board and where appropriate the Health & Well Being Board.

TEMPLATE SERVICE SCHEDULE

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

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) Integrated Commissioning;
(3) Joint (Aligned) Commissioning;
(4) 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?

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?

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 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?]

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

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	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

	Details	Charging arrangements	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.

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 agency
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*

PART 2 – AGREED SCHEME SPECIFICATIONS

Scheme 1 Integrated localities

Scheme specification schedule - integrated

Scheme 2 Reablement

Scheme specification schedule reablement

Scheme 3 Bed based review

Scheme specification schedule - Bed Based

Scheme 4 Prevention

Scheme specification schedule prevention -

Scheme 5 Additional national requirements

Scheme specification schedule - scheme 5 f

SCHEDULE 1– SCHEME SPECIFICATION

Part 2 - Services Schedule - Integrated Localities

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

This is the Scheme Specification for the integrated health and social care localities teams

The Pooled Fund within the Scheme is outlined in Schedule 3, Part 2 of this Agreement - however certain elements of the Scheme are outside of the Pooled Fund at the Commencement Date.

The Partners may seek to add additional services within this Agreement through 15/16 by way of variation to be agreed in writing, via the governance procedures laid out in Schedule 2 of this Agreement.

2 AIMS AND OUTCOMES

The strategic objective of this Scheme is a fully integrated locality team based approach to ensure that individuals are empowered to self-manage to maximise their independence, health and wellbeing.

The Scheme aims to develop a model of integrated person-centred, co-ordinated care, through the development of three locality teams operating across the City; Central, North and South. The integrated teams will be comprised of a range of appropriate professional disciplines, including: social workers, occupational therapists, physiotherapists, geriatricians, community nurses, OPMH workers and others. The teams will operate around clusters of GP practices in the locality and support the ongoing development of primary care services within the City. The teams will work very closely with GP practices and key voluntary sector partners to improve patient outcomes and maximise independence.

Delivery of the Scheme will be through a number of key phases throughout 2015/16 and 2016/17.

In the first phase, an integrated leadership model will be developed the teams will be co-located and work to integrate operational process will follow. The integration will be an iterative process, based around co-designing the model of delivery around a shared purpose, involving service users. This will be expected to include: integrated triage and case allocation; single assessment process; shared performance framework. This integration is expected to generate savings over time and ensure a better experience for clients by avoiding fragmented approaches to care and support.

National Outcomes Frameworks

The review will support delivery of the following national outcomes which are shared or complimentary outcomes from the NHS, Public Health and Adult Social Care Outcomes Frameworks:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long term conditions
- Helping people recover form episodes of ill health of following injury.
- Ensuring that people have positive experience of care
- Treating and Caring for People in a Safe Environment and protecting them from avoidable harm.
- Health improvement
- Enhancing the quality of life for people with care and support needs
- Safeguarding adults who are vulnerable and protecting them from avoidable harm

Key outcomes of the resulting services are to ensure:

- More people will be able to die in their preferred place of death
- Reduction in emergency admissions to hospital, achieve through robust admission avoidance and early supported discharge mechanisms and pathways, which ensure that only acute interventions are undertaken within the acute setting.
- An increased proportion of older people who have remained at home 91 days after a discharge from hospital
- Further reductions in delays to transfers of care from the acute setting to the community, with increase quality of this discharge process
- People with complex needs who need to go into hospital who are known to community, locality teams who are safely and actively managed back into their home
- A further reduction in acute bed days for older people who need to go into hospital
- Delivery of a truly integrated and locally based teams that include the voluntary sector, social care, primary care, community and acute care
- A radically improved offer of early intervention and preventative health and social care services that allow individuals to have more choice and control over their own lives.
- Increased use of assistive technology through telecare and telehealth to help them stay well

For individuals this will mean:

- People receive effective services to meet their goals to manage their own health and stay well
- spend less time in hospital
- People receive responsive services which help them to maintain their independence
- People have access to the right information and support about services available
- People are empowered to participate in service development and delivery
- People feel confident that their care is co-ordinated and that they only have to tell their story once
- People are supported in their community, by their community to maintain their independence

The proposed model of care of the resulting services will be:

- The team will operate under a single line management structure with strong clinical and social care leadership. The multi-disciplinary team will be co-located to ensure seamless use of systems and enable short communication
- The team will consist of GP, social care staff, community nursing, community geriatrician, allied professionals and the voluntary sector working in a joined up way to deliver a single assessment and lead professional approach.
- Care co-ordination will range from intensive case management requiring a multi-disciplinary approach to welfare checks, light touch monitoring and support similar to that provided by dementia adviser model. Care co-ordination will be provided through a named worker
- A single personalised care plan approach will be required which is owned and understood by the individual and reflects their changing needs including supporting them through end of life decisions
- The team will recognise and value the specialist knowledge, skills and legal framework of each discipline whilst maximising opportunities to streamline delivery to avoid duplication of effort
- There should be an appropriate and rapid community response across 24/7 to avoid unnecessary admission to hospital or residential care

3 THE ARRANGEMENTS

The Scheme will be delivered through the established Better Care Programme management and governance arrangements on behalf of both Partners.

The Scheme will operate within a Pooled Fund as outlined in Schedule 3, Part 2 of this Agreement. There will be no Non Pooled Funds relating to this Scheme.

Commissioning and contracting arrangements are as outlined in paragraph 6 below.

It is envisaged that as a result of the current Scheme a future development may be for other services to be brought within the remit of this Agreement as a new scheme or variation.

4 FUNCTIONS

The Council acts on the basis of a range of duties including the Care Act 2014 to commission and deliver these services.

The power and duty of the CCG to commission these services is under the NHS Act 2006.

In delivering the scheme, the Partners shall take into account a range of relevant powers and duties such as the Equality Act 2010 and the Public Sector (Social Value) Act 2012.

5 SERVICES

The integrated teams will be comprised of a range of appropriate professional disciplines, including: social workers, occupational therapists, physiotherapists, geriatricians, community nurses, OPMH workers and others. The teams will operate around clusters of GP practices in the locality and support the ongoing development of primary care services within the City.

As a result of this scheme the Partners will seek to redesign services to deliver an integrated health & social care community locality team model of care that, prevents avoidable acute hospital and long term care admissions and enables people to maintain their independence..

Future changes to the services reviewed under the Scheme will be agreed between the Partners through the governance models of the Partners.

The beneficiaries of the Services may include any adult within the Portsmouth City boundaries as set out in Schedule 6 (BCF Plan).

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning and Contracting Arrangements

For 15/16 the following arrangements shall apply

Service team	Commissioning	Contracting	Pooled Fund	Performance Measures
Community Nursing	ICU	CCG	Yes	As detailed in Schedule 5
Social workers	Council	Council	Yes	As detailed in Schedule 5
Occupational Therapists	Council & ICU	Council & CCG	No	To be developed
Physiotherapists	CCG	CCG	No	To be developed
Geriatrician	CCG	CCG	No	To be developed
OPMH	ICU	CCG	No	To be developed

Other teams shall be included within the Scheme as appropriate and commissioning/contracting arrangements reported to the Delivery Board.

Additional performance measures shall be developed through the ICU across all elements of the Scheme.

Access

Portsmouth has a population of over 172,000 adults over the age of 18. The integrated locality teams provision is available to all adults who live within the geographic area covered by Portsmouth City Council and Portsmouth CCG.

The patient cohorts to be supported are:

Care co-ordination, appropriate to need, irrespective of Fair Access to Care eligibility will be available for;

- People with Long term conditions
- People with diagnosis of dementia
- People requiring end of life care
- People with health and social care circumstances adversely affecting their physical and mental wellbeing
- People over 75 year who will have a GP check and will receive care co-ordination and intervention as appropriate.
- People will be identified using risk stratification based on current and predicted use of health and care service

7 FINANCIAL CONTRIBUTIONS

There financial contributions for this Scheme are set out under the Pooled Fund arrangements within Schedule 3, Part 2 for the financial year 2015/16.

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

8 FINANCIAL GOVERNANCE ARRANGEMENTS

The Pooled Fund arrangements in relation to this Scheme for 1516 are outlined in schedule 3, part 2 of this agreement.

Each party shall separately contract/provide services which shall form the subject of the review process.

On the basis that there are separate commissioning arrangements outside the scope of this Agreement each organisation's audit processes shall apply to their respective services.

A summary of the financial position in relation to these service shall be provided to the Partnership Board on a quarterly basis, or as required, to inform future decisions about the potential introduction of these service within the remit of the Scheme in future.

9 VAT

For 1516 the development and delivery of the Scheme will operate on the basis of the Partners existing standard approach to VAT treatment.

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Governance arrangements for the overarching Scheme will be as laid out in Schedule 2, Governance, with an integrated locality team Project Group reporting into the identified structures.

11 NON FINANCIAL RESOURCES

Premises and other non-financial resources shall be determined through the Delivery Board.

12 STAFF

As at the Commencement Date staffing models shall be provided as follows:

Service team	Employer
Community Nursing	Solent NHS Trust
Social workers	Council
Occupational Therapists	Solent NHS Trust & Council
Physiotherapists	Solent NHS Trust
Geriatrician	Solent NHS Trust (subcontracted with PHT)
OPMH	Solent NHS Trust

It is intended that for 1516 staff shall not change employer as a result of this Scheme and that there will be no requirement for a TUPE transfer to take place.

Future developments of staffing models to support the delivery of this Scheme may require secondments and/or TUPE transfers which shall be developed jointly between the Partners and local provider organisations.

13 ASSURANCE AND MONITORING

Governance of the Scheme shall be in accordance with the provisions of Schedule 2 (Governance) and with the terms of reference set out for the project group.

Monitoring of the progress of this Scheme will be through the identified project management tool including as a minimum monthly updates on progress against a detailed project plan, risks, issues, etc.

Performance measures will be reported to the Partnership Board at an overarching level and will be reviewed in detail through the project group and/or delivery board as appropriate.

Outcomes will be identified that link to the local and national metrics with a range of additional qualitative data being collected and evaluated. This will include qualitative measures to understand what matters to people using services, using the patient voices narrative statements.

Contract Review meetings for services delivered by Solent NHS take place on a monthly basis and separate quality and SIRI meetings are pre-arranged to address issues should these arise.

Assurance in relation to provision of services through the Council is under review and will be developed through the project group.

Services are subject to monitoring and review by the Care Quality Commission.

Analysis of the scheme measures will be developed in collaboration with BCF Programme Lead and community partners and providers which will include, but is not limited to:

- Emergency admission activity
- ED attendances of known case managed patients
- Length of stay in acute hospital
- Acute occupied bed days rates
- Discharge to usual place of residence
- Permanent admissions to residential care
- Patient satisfaction feedback
- Service providers positive feedback
- Peer Review with comparator organisations
- Benchmarking.

Patient and service user impact

- Improved health & wellbeing
- Maintaining independence for longer
- Improved access to services
- Continuity of care
- Reduced duplication of assessment
- Improved patient experience
- Less time spent in hospital

Organisational impact

- Reduction in numbers of emergency admissions and readmissions to acute care
- Reduction in the length of stay in acute care, particularly for those of 14 days and over
- Reduction in the number of people transferred to into long term care - Nursing home or residential care
- Reduction in number of multi-disciplinary assessments
- Increase satisfaction in provision of service users care
- Potential efficiency savings to be achieved

Portsmouth BCF Metric Impact

- Reduction in non-elected admissions
- Reduction in delayed transfer of care
- Reduction in numbers in long term residential care
- Increase in reablement - (those still at home after discharge from hospital 91 days from hospital into reablement / rehabilitation services)
- Increased in patient users experience
- Increase in service users who have as much social contact as they like.

14 LEAD OFFICERS

The Head of Better Care has ultimate responsibility for the delivery of Schemes and reports through the governance procedures set out in Schedule 2 (Governance). The Lead Officers on the Scheme are Senior Operational Managers within NHS Solent and Portsmouth City Council Adult Social Care department who will carry out the delivery of the Scheme in association with staff from provider teams.

15 INTERNAL APPROVALS

The Scheme has received approvals for current contracts and commissioning models through the respective Partner's governance models.

To the extent that further approvals are required these may be sought through the Partnership Board or the Partners' governance processes as determined by the lead officer in conjunction with the programme lead for Better Care, and in accordance with all relevant schemes of delegations etc.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

As this Scheme relates to a phased approach to delivery, with the new model and ways of working being developed and tested in 2015/16; there are no current plans for risk sharing within 1516. It is envisaged that risk sharing may be appropriate at some stage in future between the Partners or between the Partners and service providers.

17 REGULATORY REQUIREMENTS

The regulatory obligations of providers delivering community health and adult social care services will be taken into account in the delivery of this Scheme.

18 INFORMATION SHARING AND COMMUNICATION

The Information Governance agreements in place as detailed in Schedule 2 shall apply to this Scheme

Data sharing arrangements between organisations which adhere to IG controls and Caldicott requirements are in place with high level information sharing protocol (ISP) agreed at NHS and ASC Director level. The NHS number is used and there are shared arrangements for a Patient Transfer List) which all health and social care professionals will be feeding into.

Information Management and Technology to support the integration of care services is at the core of Portsmouth and South East and PCC strategies. Both the LA and the CCGs recognise the complexity and technical challenge involved in integrating information across care services provided by different care providers but have already made significant steps toward sharing care information across health and social care through the joint support of the Hampshire Health Record and the extensive use of the NHS number as a key identifier across all care systems.

Both the CCG and LA are keen to move forward to the next stage of the strategy which will concentrate on the development of shared care plans across all provider care services supporting patients with long term conditions and complex care needs.

The development of shared care plans will in the first instance explore solutions based on existing and readily available technologies including the Hampshire Health Record, primary, community and social care systems and messaging solutions to bring information together into a virtual care record.

Looking forward our strategy sets out a vision for an inter-operable approach to integrating care information for the longer term. Unfortunately existing systems and information standards are not mature enough for us to achieve this at the moment. However much work has been and continues to be done through the combined efforts of the HSCIC and the health care system industry in the on-going development of the Interoperability Toolkit (ITK). It is our intention therefore to use as much as we can from the ITK to ensure that system developments supporting an integrated care environment can be used as a foundation for future longer term care system interoperability.

This work is overseen and directed by a whole systems IT Enabled Change Board, comprising healthcare providers, commissioners and Social Care representatives.

Consultation

As part of this Scheme consultation will be carried out with providers, third sector organisations, health and social care professionals, and service users. A communications and consultation plan will be developed setting out the approach to be taken for this Scheme and this will be reviewed regularly through the project group, and for all Schemes through the Delivery Board.

19 DURATION AND EXIT STRATEGY

This Scheme is to carry out a review of services currently available, develop and deliver future models of provision, in accordance with the project plan reported through the Partnership Board.

Variations to the Scheme will be agreed through the Partnership Board.

Services which form part of the Pooled Fund shall be governed in accordance with the provisions of this Agreement. Services forming part of the integrated locality model under this Scheme which do not

form part of the Pooled Fund shall remain the responsibility of the relevant commissioning Partner as set out in paragraph 6.

In the event that either Partner wishes to substantially vary or terminate these external service arrangements other than as identified through this Scheme they shall identify this at the Partnership Board and take into account the views of the other Partner prior to taking any action.

SCHEDULE 1– SCHEME SPECIFICATION

Part 1 – Template Services Schedule

TEMPLATE SERVICE SCHEDULE

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

1 OVERVIEW OF INDIVIDUAL SERVICE

a) Name of individual scheme

Increasing reablement provision

b) Relevant context and background information

The over-arching objective for this project as per the city's BCF submission is to 'increase reablement provision'. More accurately, the project aims to ensure that:

- Size and scope of reablement provision in the city is based on identifiable demand;
- Clients do not experience barriers to access;
- Reablement is used to effectively to support clients to maintain their independence;
- Provision is diversified wherever possible and desirable; and,
- Provision offers value for money.

The scheme will be based on a developing strategic plan for reshaping reablement provision in the city as part of BCF's wider redesign of the health and social care economy.

Portsmouth's existing reablement provision includes PRRT, an integrated multi-disciplinary team providing rehab, reablement, and rapid-response services, as well as fulfilling the requirement for intermediate care services. In addition, since 2013 the city has had a range of reablement pilots up and running provided by a wide range of voluntary and community sector (VCS) partners. These pilot schemes (five funded by contracts and 15 via grant) are scheduled to be complete by July 2015 with further provision from new contract and grant funding opportunities taking effect from that point.

In the sections that follow, the specification will be split to provide separate narrative on PRRT and the VCS provided services where this is appropriate.

(c) Funding arrangements

For 2015/16, PRRT will be funded partly by CCG from the overall BCF pooled fund and partly by contribution from PCC (see section 7 below) - and as laid out in Schedule 3 Part 2.

The Partners aim to have a true risk sharing arrangement for PRRT in place for 2016/17. This will be dependent on appropriate arrangements being put in place by January 1, 2016.

Funding for VCS provision is identified as "Reablement Pilots" under Schedule 3 Part 2 with commissioning and contracting taking place in accordance with paragraph 6 below. Funding is made available from the CCG to support this element of the Scheme.

2 AIMS AND OUTCOMES

The strategic objective is to increase the provision of reablement based services defined as services which provide a personalised and responsive approach to deliver a range of service and interventions which enable people to maximise their potential and quality of life and live as independently as possible for as long as possible'.

As the programme develops, the strategic aim of the Better Care Fund Plan in relation to this Scheme is for the people of Portsmouth to be able to access a comprehensive network of reablement services which is available on a 7 day basis and integrated with locality teams and PRRT.

More specifically, PRRT contributes to and is measured against two key national performance indicators, shown below.

Proportion of older people still at home 91 days post-discharge (NHSOF 3.6i)
Proportion of older people offered rehab following discharge from acute (NHSOF 3.6ii)

Over time, it is expected that increased reablement provision offered by both PRRT and the VCS will enable reductions in hospital admissions, reduction in cost from long-term care packages, and improvements in the ability of clients to manage independently. Specific outcome measures will be developed during 2015 and will be used to monitor both individual service performance and wider system impacts.

In addition, it is expected that quality measures will be introduced to the system (for both PRRT and VCS schemes) consistent with the model being developed via Wessex Strategic Clinical Networks.

3 THE ARRANGEMENTS;

For 2015/16, PRRT will operate on an aligned commissioning basis.

As detailed below the CCG shall contract with the local NHS provider trust and the Council shall second the in house provision to the same local NHS provider trust.

Aligned governance arrangements are in place to support this model.

The Portsmouth Rehabilitation and Reablement Team is an integrated health and social care team the purpose of which is to provide responsive support for people whose needs have intensified, often as the result of an acute illness.

VCS provision sits alongside the services provided through PRRT to deliver reablement support to a wider cohort of the population and without the same time limits on interventions.

There will be detailed service specifications both for PRRT and for contracted VCS schemes. For grant-funded VCS schemes there will be grant agreements with associated schedules setting out expected deliverables.

VCS services will be commissioned through the established Integrated Commissioning Unit.

The Scheme will not operate within a Pooled Fund or Non Pooled Fund arrangement in 2015/16.

It is envisaged that as a result of the current Scheme a future development may be for further services to be brought within the remit of this Agreement as a new scheme or variation. Further

changes may be required from 2016/17 to re-align the role of PRRT as integrated locality teams are developed (see Schedule 1 Part 2 Integrated Localities Scheme Specification).

4 FUNCTIONS

PRRT fulfils statutory health functions in respect of intermediate care. Other elements of its provision are delivered under discretionary powers of the local authority. Similarly, VCS reablement provision is funded via the ICU under discretionary powers.

The Council acts on the basis of a range of duties including the Care Act 2014 to commission and deliver these services.

The power and duty of the CCG to commission these services is under the NHS Act 2006.

5 SERVICES

5.1 - PRRT - Portsmouth Rehabilitation and Reablement Team (PRRT).
PRRT provides a joint approach across five disciplines (OT, Physiotherapy, Social Work, Geriatrician and Nursing) to assessment and care management with data sharing between clinical systems facilitated by the use of NHS numbers and common assessment tools. There is 7 day working across all disciplines with the ability to support acute hospital discharge, put in place packages of care and prevent admission over weekends. Reablement services support people to "do things for themselves, rather than having things done for them." improving wellbeing with an independent and confident recovery for people after hospitalisation avoiding readmission.

Reablement services must uphold this approach, working collaboratively with stakeholders and as part of the integrated care delivery model.

Service Users will be entitled to a period of up to six weeks of intermediate care, based on assessed need, in line with National Intermediate Care Guidance (DH 2010). This should be free at the point of delivery and not subject to social care financial assessment.

Reablement services must ensure consistency of response, effectively manage the workforce, recognising the need to respond to peaks and troughs in demand and seasonal pressures.

There should be an appropriate and rapid access to reablement services to avoid unnecessary admission to hospital or residential care.

Services will be provided in an integrated way with other elements of the integrated locality based model of care and seen as an integral part of the pathway and aligned with the wider rehabilitation pathways and bed based provision.

5.2 VCS Schemes - The city's VCS reablement provision currently comprises the following range of contracted and grant-funded services as of April 1st, 2015:

Contracted Schemes

Organisation	Beneficiaries	Service
Age UK Portsmouth	People over 50 living in Portsmouth	support post hospital discharge & range of community interactions e.g. Paulsgrove Pop In Shop

British Red Cross	adults following hospital discharge (focus on elderly)	support at home service - support settling back into a routine at home following a hospital admittance
Housing 21	People with dementia at end of life	providing support and training, reducing real or perceived carer isolation and breakdown
Solent Mind	those with a suspected or formal diagnosis of dementia in & leaving hospital	support at the Queen Alexandra Hospital & once discharged into the community
Rowans Hospice	people in the community who have been diagnosed with a life limiting illness	dedicated care management & person centred support, practical & emotional support, info & advice.
Telecare	people who are struggling to manage their medication	trialling the use of assistive technology telecare options

Grant-Funded Schemes

Organisation	Beneficiaries	Service
YOU Trust	people using adult and older person's mental health secondary services	general advice & specialist legal advice - housing, welfare benefits, employment and debt
Stroke Association	Stroke survivors	Life After Stroke service - supporting stroke survivors in the community
Action for Blind People	People newly diagnosed with sight loss	Delivering 3 sessions of Finding Your Feet Training
Headway	People following brain injury & their carers	access to social inclusion, cognitive rehabilitation and improved independence programmes
Paulsgrove Baptist Church	people of Wymering & Paulsgrove	Drop in centre and Choices courses to build confidence
Portsmouth Disability Forum	people with hearing impairments or dual sensory loss	to enhance two service user groups by dedicated staff to facilitate
University of the Third Age	Retired people	Publicity to maintain membership during move

SCA Group	those living with early stage dementia and their carers	pilot Cognitive Stimulation Therapy (CST) programme in the community
The Stacey Centre	over 50's living in Copnor	lunch club once a week
Personal Choice	over 50's living in Charles dickens ward	bridging funding for lunch club, activity group & drop in
Two Saints	Homeless people leaving hospital	Supported Intensive Recovery Service for homeless people
Brendoncare Club Hampshire	Socially isolated older people in Southsea	Club in a Pub
British Red Cross	adults following hospital discharge (focus on elderly)	Enhanced Support at Home
Age UK Portsmouth	people who are living the later part of their lives	Advanced Care Ambassadors
Action Portsmouth	Commissioners	mapping VCS provision

At the time of writing, grant award and tender processes are ongoing which may lead to changes in the range of services set out above from July 2015 - the new range of services shall be approved by the Head of the Integrated Commissioning Unit within the available budget without the need for further approval from the Partnership Board.

5.3 - Scope for Change

Due to the ongoing development of BCF as a vehicle for reshaping the health and social care system for Portsmouth, the future size, structure, and scope of both PRRT and the VCS schemes may be subject to change. Any such changes will be developed and agreed through the governance arrangements set out elsewhere in this document.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning and contracting Arrangements

In 2015/16

- The CCG will commission reablement services through the Integrated Commissioning Unit
- The health funded element of the PRRT service will be contracted for between the CCG and Solent NHS Trust
- The Council will commission in-house provision of its element of the PRRT service; this will be delivered through its staff being seconded using s113 LGA powers to Solent NHS Trust

As set out above in paragraph 3, these arrangements may develop over time in response to changes in the wider health and social care system, particularly via the Better Care Fund.

Access

Reablement services must be able to respond to and provide support for people with dementia and older people with functional mental health problems, where needs are stable and do not require secondary psychiatric support on an inpatient basis.

Reablement services will support the learning or relearning of the skills necessary for daily living which some people may have lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central with an emphasis on regaining independence and better functioning.

Support will be for people whose health and independence is in long term decline, but who are unlikely to get health or social care support until reaching a crisis

People with long term care needs also need to be able to access the 'reablement offer'

PRRT Access criteria:

Where the referral is the result of deterioration in physical health needs the person must be clinically stable. For community referrals the clients GP will be notified with a request for medical summary and medication list. In the case of all referrals, PRRT will work alongside primary care and the Community Geriatrician to ensure that the health needs of patients are met.

For transfers of care out of hospital assurance will be sought that the person is clinically stable and discharge ready.

The person must be agreeable to the support or intervention being provided, and in the case of rehabilitation and reablement programmes, be willing to participate in a goal based programme of reablement. Where capacity is impaired then intervention is provided in the 'best interests' of the individual in accordance with the Mental Capacity Act.

7 FINANCIAL CONTRIBUTIONS

The funding for this Scheme is within the Pooled Fund, no Non Pooled Funds apply.

The indicative financial contributions by the Partners towards PRRT for 2015/16 are:

Council - £1.870m
CCG - £900k

The indicative budget for 2015/16 for supporting the a range of additional reablement services including those from the VCS within the city is £1.2m

The commissioning resource for this Scheme is supplied through the existing staff within the Integrated Commissioning Unit.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

The Pooled Fund shall apply as set out in the Agreement in relation to the funding streams which support this Scheme.

Eligibility, access criteria, and funding levels are as detailed in this Schedule.

The lead finance officer and lead commissioner for this element of the Scheme, as identified in Schedule 3 Part 2, shall have the delegated authority to spend the relevant allocated money within the Pooled Fund.

Audit arrangements shall be the Council's standard approach, usually operated on a three year cycle in relation to Council commissioned elements of the services, and shall be in accordance with the CCG standard position in relation to CCG commissioned elements.

Each Partner's financial systems shall be applied to their respective element of the Scheme.

9 VAT

Each Partner's respective standard position on VAT treatment shall apply to the elements of this Scheme that it contracts for.

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Governance arrangements for the overarching scheme will be as laid out in Schedule 2, Governance, with a Reablement Project Group reporting into the identified structures.

Specific governance arrangements for PRRT are set out in a separate memorandum of understanding agreed between the Council and Solent NHS Trust as set out below.

PRRT MoU.doc

11 NON FINANCIAL RESOURCES

Non-financial resources in respect of PRRT are detailed in the memorandum of understanding set out above.

12 STAFF

12.1 **PRRT -** Council staff working for PRRT do so on secondment under a section 113 agreement. Such staff remain on Council terms and conditions in respect of salary, increments, pension arrangements, etc.

12.2 **VCS Schemes** - Staff and volunteers working on VCS schemes will be employed/engaged by the provider concerned.

13 ASSURANCE AND MONITORING

The management and monitoring of the programmes of work that underpin the Better Care Fund will happen via the CCG planning process and report back through the governance structure set out in section 10. The programmes and projects will be managed and monitored using the Covalent planning system with actions; milestones; key performance indicators and risks managed through this process. Progress against delivery; change management and project level reporting will be taken through the governance process.

Performance measures for the services will be reported to the Partnership Board at an overarching level and will be reviewed in detail through the project group and/or delivery board as appropriate.

Outcomes will be identified that link to the local and national metrics with a range of additional qualitative data being collected and evaluated. This will include qualitative measures to understand what matters to people using services, using the patient voices narrative statements.

Contract Review meetings for services delivered by Solent NHS Trust take place on a monthly basis and separate quality and SIRI meetings are pre-arranged to address issues should these arise.

Assurance in relation to provision of services through the Council is under review and will be developed through the project group.

Health and social care services such as PRRT are subject to monitoring and review by the Care Quality Commission.
The benefits realisation with regard to a number of the projects will result in a reduction in non-elective admissions. Each project will be monitored to establish the cause and effect in relation to project aims and the associated reduction in NEL admissions. This will demonstrate that the projects are delivering their required outcomes, and this will also be seen within acute contract reporting and review. Any over-performance the will require a rectification plan. This will be developed and monitored through Better Care and CCG governance structures. These key metrics will form part of the reporting mentioned above.

The memorandum of agreement between the two providers of the PRRT service also sets out governance at a provider level which reports back in to the Better Care Fund Plan governance models.

14 LEAD OFFICERS

The Head of Better Care has ultimate responsibility for the delivery of Schemes and reports through the governance procedures set out in Schedule 2 (Governance). The Lead Officer on the Scheme is a senior manager within the Integrated Commissioning Unit.

The Integrated Commissioning Unit, established under a separate section 75 NHSA 2006 agreement between the Partners will carry out the delivery of the Scheme in association with staff from provider teams.

15 INTERNAL APPROVALS

The Scheme has received approvals for current contracts and commissioning models through the respective Partner's governance models.

To the extent that further approvals are required these may be sought through the Partnership Board or the Partners' governance processes as determined by the lead officer in conjunction with the programme lead for Better Care, and in accordance with all relevant schemes of delegations etc.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

Portsmouth city has established formal integrated commissioning arrangements through Integrated Commissioning Unit (ICU), supported by a S75 agreement and the Integrated Commissioning Board. The ICU will manage the commissioning risk across health and social care on behalf of the partners through its lead delegated role for joint health and social care commissioning. There will be a pooled budget for delivering Better Care; this will include detailed risk sharing agreement between commissioners across health and social care.

For PRRT, as per the MoU between Solent NHS Trust and the Council, both parties bear their own costs in relation to the delivery of the service and remain separately liable for any losses or liabilities incurred due to their own or their employees actions. In future years, as and when a risk share agreement is developed and implemented, it will be necessary to revisit the risk and benefit sharing arrangements.

For strategic risk management, at the BCF programme level risks are identified and managed via the CCG planning process.

17 REGULATORY REQUIREMENTS

The regulatory obligations of providers delivering reablement services will be taken into account in the delivery of this Scheme.

18 INFORMATION SHARING AND COMMUNICATION

Data sharing arrangements between organisations which adhere to IG controls and Caldicott requirements are in place with high level information sharing protocol (ISP) agreed at NHS and ASC Director level. The NHS number is used and there are shared arrangements for a Patient Transfer List) which all health and social care professionals will be feeding into.

Information Management and Technology to support the integration of care services is at the core of Portsmouth and South East and PCC strategies. Both the LA and the CCGs recognise the complexity and technical challenge involved in integrating information across care services provided by different care providers but have already made significant steps toward sharing care information across health and social care through the joint support of the Hampshire Health Record and the extensive use of the NHS number as a key identifier across all care systems.

Both the CCG and LA are keen to move forward to the next stage of the strategy which will concentrate on the development of shared care plans across all provider care services supporting patients with long term conditions and complex care needs.

The development of shared care plans will in the first instance explore solutions based on existing and readily available technologies including the Hampshire Health Record, primary, community and social care systems and messaging solutions to bring information together into a virtual care record.

Looking forward our strategy sets out a vision for an inter-operable approach to integrating care information for the longer term. Unfortunately existing systems and information standards are not mature enough for us to achieve this at the moment. However much work has been and continues to be done through the combined efforts of the HSCIC and the health care system industry in the on-going development of the Interoperability Toolkit (ITK). It is our intention therefore to use as much as we can from the ITK to ensure that system developments supporting an integrated care environment can be used as a foundation for future longer term care system interoperability.

This work is overseen and directed by a whole systems IT Enabled Change Board, comprising healthcare providers, commissioners and Social Care representatives.

It is not envisaged that charges for reablement services under this Scheme will be payable and means testing will not be required.

19 DURATION AND EXIT STRATEGY

For 2015/16 each Partner retains responsibility for its own contracting and commissioning arrangements as laid out in paragraph 1 above. In the event that either Partner wishes to substantially vary or terminate these arrangements outside the scope of this Scheme and the review process they shall identify this at the Partnership Board and take into account the views of the other Partner prior to taking any action.

The CCG has contracted for the provision of PRRT through its contract with Solent NHS Trust and the exit/termination provisions of that agreement apply to any material changes.

The Council provision of PRRT is through in-house delivery however this is governed in part by the secondment agreements in relation to its staff and the memorandum of agreement it has entered into

with Solent NHS Trust. Any proposals to exit or terminate its role within PRRT would therefore be governed by this process.

Agreements with the VCS also include provisions governing exit and or termination and the Council as the contracting entity will apply these terms.

20 INTERDEPENDENCIES AND SCOPE EXCLUSIONS

Given the nature of reablement provision, this scheme has interdependencies with a range of other projects ongoing both within the BCF umbrella and within the work programmes of health and social care organisations locally. This includes ongoing work in relation to:

- Falls pathway
- Dementia pathway
- Integrated locality team work (see Schedule 1 Part 2 Scheme 1)
- Bed-based services (see Schedule 1 Part 2 Scheme 3)
- Agency work
- Personal independence co-ordinators

The CCG planning process used to support the monitoring of BCF, will enable the partners to retain a strategic overview of the relationship between this scheme and other ongoing projects within the system

SCHEDULE 1– SCHEME SPECIFICATION

Part 2 - Services Schedule

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

This is the Scheme Specification for the Bed Based Review.

There are no Pooled Funds or Non pooled Funds associated with this Scheme and no aligned funds within the remit of this Agreement.

The Partners may seek to include the provision of bed based services within this Agreement for 2016/17 by way of variation to be agreed in writing, via the governance procedures laid out in Schedule 2 of this Agreement.

As there are no Pooled Funds within this Scheme the following contracting arrangements are in place:

- CCG contract with Solent NHS Trust
  - Jubilee House services
  - Spinnaker Unit
  - Limes Unit
- CCG contract with Portsmouth Hospital Trust - Medicines for Older People Rehabilitation & Stroke
- Council in house provision at the Victory Unit including beds within Corben Lodge
- Council in house provision at long stay units within the city
- Council contracting for care home beds within the city including for continuing healthcare

2 AIMS AND OUTCOMES

Strategic Objective:
Bed based services should promote independence and empower self-management wherever possible. The strategic objective of this work is to ensure that people are supported in the right place, at the right time, and with the right services. Furthermore, this work stream will provide certainty that right capacity of beds is available to meet demand.

Delivery of the scheme will require a number of lines of enquiry which will be delegated to the lead commissioner through the established Integrated Commissioning Unit to include the following:

- Audit of occupancy of community beds and OPMH beds
- Review of the care provided in the different community bed settings and evaluation of its effectiveness - including the out of hours need.
- Development of referral pathways and mechanisms between primary care and community beds
- Development of early supported discharge pathways to reduce length of stay in community beds
- To review the discharge process between acute hospital and community beds
- Measure outcomes for individuals in terms of achieving their stated goals, returning to their usual place of residence, and avoiding readmissions.
- To consider the impact on other community services of any increase / decrease in the capacity of community beds.
- To review the residential / care home market capability to support discharge and demand of community beds.

- To identify gaps/ additional service requirements, such as PRRT, community nursing, and geriatrician resource that would impact on bed need.
- To promote and develop community / voluntary sector provider reablement and rehabilitation service to support discharge.
- To consider best practice examples from neighbouring areas and the NHS benchmarking studies.
- To work in partnership with other BCF work streams and align critical paths, interdependencies and relationships between work streams.
- Option paper on the future of community bed provision in Portsmouth
- Identify the numbers of patients that do not need to be in their current community setting and identify appropriate services.
- To recommend and implement community bed configuration and numbers
- To develop a revised accommodation strategy

National Outcomes Frameworks

The review will support delivery of the following national outcomes which are shared or complimentary outcomes from the NHS, Public Health and Adult Social Care Outcomes Frameworks:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long term conditions
- Helping people recover from episodes of ill health following injury.
- Ensuring that people have a positive experience of care
- Treating and Caring for People in a Safe Environment and protecting them from avoidable harm.
- Health improvement
- Enhancing the quality of life for people with care and support needs
- Safeguarding adults who are vulnerable and protecting them from avoidable harm

Key outcomes of the resulting services are to ensure:

- Robust admission avoidance and early supported discharge mechanisms and pathways are in place to ensure that only acute interventions are undertaken within the acute setting.
- Appropriate bed based service provision will enable the patient's health needs to be managed more effectively in a community environment, thus ensuring services are wrapped around patient need and choice with a focus on the national agenda of community based care.
- A managed admissions and discharge process, fully integrated into local specialist provision to facilitate a reduction in length of stay and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.
- Shift of current bed based services away from acute and community 'step-down' beds towards an increase of 'step up' beds in a community environment.
- Long term assessments / decisions about long term care needs are not undertaken within the acute environment. These assessments and therapeutic interventions should wherever possible be undertaken in the individual's own home or in a community based environment where this is not possible.

The proposed model of care of the resulting services will be:

- The bed service provision will work with the integrated health & social care community teams, as part of an integrated community delivery model, preventing avoidable acute hospital admissions and supporting appropriate early discharge. by providing assessment of patients, short term support and interventions
- Where admission to bed based services is required, every effort should be made to ensure the minimum possible length of stay. Where patients are receiving care co-ordination the

decision making should be in line with the personalised care plan. In all cases, discharge planning should begin at the point of admission and should be in partnership between the bed based provision and the integrated health & social care community team.

- There should be an appropriate and rapid response across 24/7 to access bed based provision in order to avoid unnecessary admission to hospital or residential care
- Bed based services need to be able to accommodate people with challenging behaviour
- Primary care, in partnership with community health and social care through the integrated locality based services will be required to provide increased medical cover and responsibility to support bed based provision, supported by secondary care colleagues.
- Independent bed based providers may be required to change existing service models to support shorter term placements, possibly for assessment. In addition care homes may also be required to cope with frailer, more complex patients and those requiring end of life care. Additional support from primary and community health services is likely to be required to support this.

3 THE ARRANGEMENTS

The Scheme will be delivered through the established Integrated Commissioning Unit on behalf of both Partners.

The Scheme will not operate within a Pooled Fund or Non Pooled Fund arrangement.

It is envisaged that as a result of the current Scheme a future development may be for the services to be brought within the remit of this Agreement as a new scheme or variation.

4 FUNCTIONS

The Council acts on the basis of a range of duties including the Care Act 2014 to commission and deliver these services.

The power and duty of the CCG to commission these services is under the NHS Act 2006.

In carrying out the review the Partners shall take into account a range of relevant powers and duties such as the Equality Act 2010 and the Public Sector (Social Value) Act 2012.

5 SERVICES

This Scheme is to review bed based provision at the following locations and to determine future delivery - it does not include the contractual arrangements for the following:

- CCG contract with Solent NHS Trust
  - Jubilee House services
  - Spinnaker Unit
  - Limes Unit
- CCG contract with Portsmouth Hospital Trust - Medicines for Older People Rehabilitation & Stroke
- Council in house provision at the Victory Unit including beds within Corben Lodge
- Council in house provision at long stay units within the city
- Council contracting for care home beds within the city including for continuing healthcare

As a result of this scheme the Partners will seek to redesign services to deliver bed based service provision that works with the integrated health & social care community teams, as part of an integrated community delivery model, preventing avoidable acute hospital admissions and supporting appropriate early discharge by providing assessment of patients, short term support and interventions.

Future changes to the services reviewed under the Scheme will be agreed between the Partners through the governance models of the Partners as delegated through the Partnership Board in accordance with Schedule 2 of this Agreement.

The beneficiaries of the Services may include any adult within the Portsmouth City boundaries as set out in Schedule 6 (BCF Plan).

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning and Contracting Arrangements

For 2015/16 contracting and commissioning responsibilities shall remain as set out in paragraph 1 of this Scheme and will be aligned in relation to bed based services with performance measurement through the Integrated Commissioning Unit.

Access

Portsmouth has a population of over 172,000 adults over the age of 18. The bed based provision is available to all adults who live within the geographic area covered by Portsmouth City Council and Portsmouth CCG.

Community bed based services support adults who are medically stable and require assessment, treatment and rehabilitation including, personal care, OT and physiotherapy, as an alternative to an acute hospital environment, where these cannot be provided for in the individual's own home.

7 FINANCIAL CONTRIBUTIONS

There will be no financial contributions for this Scheme under the Pooled Fund arrangements within the financial year 2015/16.

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

8 FINANCIAL GOVERNANCE ARRANGEMENTS

There will be no Pooled Fund or Non Pooled Fund arrangements in relation to this Scheme for 2015/16.

Each party shall separately contract/provide services which shall form the subject of the review process.

On the basis that there are separate commissioning arrangements outside the scope of this Agreement each organisation's audit processes shall apply to their respective services.

A summary of the financial position in relation to these services shall be provided to the Partnership Board on a quarterly basis, or as required, to inform future decisions about the potential introduction of these service within the remit of the Scheme in future.

9 VAT

For 2015/16 this Scheme is to deliver a review of provision and therefore the VAT treatment of the bed based services will be outside the scope of the s75 arrangements and will be dealt with under each organisation's standard approach.

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Governance arrangements for the overarching Scheme will be as laid out in Schedule 2, Governance, with a bed Based Review Project Group reporting into the identified structures.

The terms of reference for the project group are laid out below

Project Group ToR's -
Bed based review - Fi

11 NON FINANCIAL RESOURCES

N/A

12 STAFF

Staffing for the service provision is excluded from this Scheme.

The staff carrying out the review under this Scheme will be provided by the Partners and using existing resource within the Integrated Commissioning Unit. There will be no further secondments or TUPE transfers of staff in order to deliver the review function required under this Scheme.

13 ASSURANCE AND MONITORING

Governance of the Scheme shall be in accordance with the provisions of Schedule 2 (Governance) and with the terms of reference set out for the project group.

Monitoring of the progress of this Scheme will be through the identified project management tool including as a minimum monthly updates on progress against a detailed project plan, risks, issues, etc.

Performance measures to the services providing bed based care will be reported to the Partnership Board at an overarching level and will be reviewed in detail through the project group and/or delivery board as appropriate.

Outcomes will be identified that link to the local and national metrics with a range of additional qualitative data being collected and evaluated. This will include qualitative measures to understand what matters to people using services, using the patient voices narrative statements.

Contract Review meetings for services delivered by Solent NHS and Portsmouth Hospital Trust take place on a monthly basis and separate quality and SIRI meetings are pre-arranged to address issues should these arise.

Assurance in relation to provision of services through the Council is under review and will be developed through the project group.

Bed based services are subject to monitoring and review by the Care Quality Commission.

Analysis of the scheme measures will be developed in collaboration with BCF Programme Lead and community partners and providers which will include:

- Emergency admission activity
- ED attendances of known case managed patients
- Length of stay in acute hospital
- Acute occupied bed days rates
- Discharge to usual place of residence
- Appropriateness of access to bed based services

- Timeliness of access to bed based services
- Domiciliary and residential care package rate and cost
- Patient satisfaction feedback
- Service providers positive feedback
- Peer Review with comparator organisations
- Benchmarking.

Patient and service user impact

- Improved health & wellbeing
- Maintaining independence for longer
- Improved access to services
- Continuity of care
- Reduced duplication of assessment
- Improved patient experience
- Less time spent in hospital

Organisational impact

- Reduction in numbers of emergency admissions and readmissions to acute care
- Reduction in the length of stay in acute care, particularly for those of 14 days and over
- Reduction in the number of people transferred to into long term care - Nursing home or residential care
- Reduction in number of multi-disciplinary assessments?
- Increase satisfaction in provision of service users' care
- Potential efficiency savings to be achieved

Portsmouth BCF Metric Impact

- Reduction in non-elected admissions
- Reduction in delayed transfers of care
- Increase in reablement - (those still at home after discharge from hospital 91 days from hospital into reablement / rehabilitation services)
- Increase in patient users positive experience
- Increase in service users who have as much social contact as they like.

14 LEAD OFFICERS

The Head of Better Care has ultimate responsibility for the delivery of Schemes and reports through the governance procedures set out in Schedule 2 (Governance). The Lead Officer on the Scheme is a Senior Programme Manager within the Integrated Commissioning Unit.

The Integrated Commissioning Unit, established under a separate section 75 NHSA 2006 agreement between the Partners will carry out the delivery of the Scheme in association with staff from provider teams.

The key contacts for the team are as set out in the Scheme terms of reference

15 INTERNAL APPROVALS

The Scheme has received approvals for current contracts and commissioning models through the respective Partner's governance models.

To the extent that further approvals are required these may be sought through the Partnership Board or the Partners' governance processes as determined by the lead officer in conjunction with the programme lead for Better Care, and in accordance with all relevant schemes of delegations etc.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

As this Scheme relates to a review of services there will be no risk sharing within 2015/16. In light of the review findings it is envisaged that bed services may be brought within the scope of the Agreement, particularly with relation to community bed based services, and risk sharing may be appropriate at that stage between the Partners or between the Partners and service providers.

17 REGULATORY REQUIREMENTS

The regulatory obligations of providers delivering bed based services will be taken into account in the delivery of this Scheme.

18 INFORMATION SHARING AND COMMUNICATION

The Information Governance agreements in place as detailed in Schedule 2 shall apply to this Scheme.

Data sharing arrangements between organisations which adhere to IG controls and Caldicott requirements are in place with high level information sharing protocol (ISP) agreed at NHS and ASC Director level. The NHS number is used and there are shared arrangements for a Patient Transfer List) which all health and social care professionals will be feeding into.

Information Management and Technology to support the integration of care services is at the core of Portsmouth and South East and PCC strategies. Both the LA and the CCGs recognise the complexity and technical challenge involved in integrating information across care services provided by different care providers but have already made significant steps toward sharing care information across health and social care through the joint support of the Hampshire Health Record and the extensive use of the NHS number as a key identifier across all care systems.

Both the CCG and LA are keen to move forward to the next stage of the strategy which will concentrate on the development of shared care plans across all provider care services supporting patients with long term conditions and complex care needs.

The development of shared care plans will in the first instance explore solutions based on existing and readily available technologies including the Hampshire Health Record, primary, community and social care systems and messaging solutions to bring information together into a virtual care record.

Looking forward our strategy sets out a vision for an inter-operable approach to integrating care information for the longer term. Unfortunately existing systems and information standards are not mature enough for us to achieve this at the moment. However much work has been and continues to be done through the combined efforts of the HSCIC and the health care system industry in the on-going development of the Interoperability Toolkit (ITK). It is our intention therefore to use as much as we can from the ITK to ensure that system developments supporting an integrated care environment can be used as a foundation for future longer term care system interoperability.

This work is overseen and directed by a whole systems IT Enabled Change Board, comprising healthcare providers, commissioners and Social Care representatives.

Consultation

As part of this Scheme consultation will be carried out with providers, third sector organisations, health and social care professionals, and service users. A communications and consultation plan will

be developed setting out the approach to be taken for this Scheme and this will be reviewed regularly through the project group, and for all Schemes through the Delivery Board.

19 DURATION AND EXIT STRATEGY

This Scheme is to carry out a review of services currently available and future models of provision, in accordance with the project plan reported through the Partnership Board.

Following the review the next stage will be to identify adjustments to service provision, with an aspiration that this could result in services being brought within the remit of this Agreement.

Variations to the Scheme will be agreed through the Partnership Board.

For the duration of the Scheme each partner retains responsibility for its own contracting and commissioning arrangements as laid out in paragraph 1 above. In the event that either Partner wishes to substantially vary or terminate these arrangements outside the scope of this Scheme and the review process they shall identify this at the Partnership Board and take into account the views of the other Partner prior to taking any action.

SCHEDULE 1– PART 2

Services Schedule: Prevention

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

Prevention

Portsmouth City is a densely populated urban area, with areas of marked deprivation. There are correspondingly high levels of smoking, obesity and alcohol use by residents. As a result the City has high levels of respiratory (chronic lung disease and cancer), cardiovascular (heart attacks and strokes) and gastrointestinal diseases (alcoholic liver disease). The effects of this are made worse by late presentation to care services. This is demonstrated by the high level of premature mortality and low life expectancy for residents, which is statistically significant from the England average for men.

Men, in particular, have a shorter life expectancy caused by high levels of smoking, alcohol misuse and obesity. The causes of comparatively poor male health are complex and affected as much by culture and the broader determinants of health as by access to services. Alcohol misuse, domestic abuse, young people at risk, drug misuse and adult re-offending all impact on health and health services.

Almost half of all the deaths in Portsmouth are caused by heart disease, stroke, cancers and respiratory conditions. Heart disease is the most common cause of all early deaths. Many of these conditions could be prevented by adopting healthier lifestyles. For example smoking, diet, being overweight or obese and drinking alcohol to excess account for 34% of cancers. Early death from cancer for Portsmouth residents is significantly above the England rate.

In Portsmouth, the level of Chronic Obstructive Pulmonary Disease (COPD) is comparable to England (1.6%) but COPD early death is significantly worse than the England average. The highest COPD emergency admission rates are from our most deprived areas.

The Case for Change

30% of the population have a long term condition (LTC) and consequently use 50% of GP appointments and 70% of hospital beds. The 30% of people with one or more LTC account for £7 out of every £10 spent on healthcare.

Reducing the prevalence of heart failure, respiratory conditions, diabetes, cancer and dementia is therefore a key priority for the City; as is supporting people to better manage their existing conditions to prevent further deterioration and helping people to maintain their independence. The Better Care Plan, aligned with other key strategies and plans is focused on achieving these aims

Pooled Funds Arrangements

There are no Pooled Fund arrangements linked to this Scheme for 2015/16.
Although the intention of the Council is to continue spend in this area in accordance with its 1516 budget levels of spend have not been committed to under Non Pooled Fund arrangements.

2 AIMS AND OUTCOMES

To work with individuals, communities and organisations to tackle the underlying causes of ill health and reduced wellbeing (primary prevention) and improve the identification and treatment of individuals with early stages of disease (secondary prevention).

To commission effective integrated LTC pathways linked to prevention and self-management strategies.

3 THE ARRANGEMENTS

Commissioning and Contracting of prevention services within the meaning of this Scheme will continue to be carried out solely by the Council.
These services shall be reported through the governance arrangements of this agreement but shall not form part of any budget discussions in relation to the operation of the Pooled Fund.

4 FUNCTIONS

The Council's responsibility for public health functions is set out in the Health and Social Care Act 2012 and amendments to the NHS Act 2006. These are the relevant functions under which this Scheme will be delivered along with the Localism Act 2011.

5 SERVICES

This Scheme is focused on tackling the upstream causes of poor health and is underpinned by Portsmouth City's Health and Wellbeing Strategy. There are three key elements:

1. Working across organisations to tackle the underlying causes of ill health including poverty, education and crime. Portsmouth City's Health and Wellbeing Strategy identifies 5 themes with which to tackle this: best start, promoting prevention, supporting independence, intervening earlier and reducing inequalities. Each has three work streams and an action plan is now in the process of being developed by all stakeholders. These work streams are essential to improving the wider determinants of health and many of the actions are directly linked to the overall aims of the Better Care Fund.

2. Work with individuals, communities and the community and voluntary sector to prevent disease and improve quality of life by focusing preventative services on those most at risk of developing illness. A number of the current public health services, including health trainers, smoking cessation, and alcohol, are being integrated in to a single service and based in the community; this integrated wellbeing service will also provide advice around the wider determinants that affect health and wellbeing, including housing and income maximisation. A key role of the hubs will be to work with communities to identify needs and aspirations.

3. Public Health team working with the CCG commissioners to work with primary care services to increase the identification of individuals with early stages of disease and streamline their management. A systematic programme is also being developed to review the long term conditions pathways in primary care building on the success of the redesign of the local community diabetes service, musculoskeletal service and ongoing work with chronic respiratory disease pathway. Opportunities for streamlining services will be identified and there will be an emphasis on ensuring that opportunities for modification of lifestyle risk factors and self-care are embedded throughout pathways; this will also include the feasibility of using novel technology such as telehealth. This will be closely linked to the development of the integrated wellbeing service and the integrated care pilot scheme, focusing on the management of individuals with co-morbidity and multiple long term conditions LTC hubs and

The health of people in Portsmouth is generally worse than the England average and there is a real need to tackle health inequalities and life expectancy, therefore the beneficiaries are people registered with a GP in Portsmouth.

An indicative summary of current contracts held by the Council for 1516 is laid out below:

Provider	Service	Contract Value
Solutions 4 Health	Smoking Cessation	£240,000.00
Misc - Other NHS	PH Non-Commissioned Activity (out of area Sexual Health services)	£30,000.00
Portsmouth CCG	FP10 - Perscription Charges	£350,000.00
Passante	Condom Delivery & pharmacy distribution scheme	£2,000.00
BFN	Breastfeeding Peer Support Services	£27,656.09
Freshbox	Fresh fruit & veg	£21,350.00
Bodymorph	Staying Healthy Obesity (Adults)	97,118
MyTime Active	Staying Healthy Trainers	338,200
University of Portsmouth	PH Dental Commisioning	115,531
Solent NHS	PH Dental Commisioning	103,240
PHT	ICOS	77,257
North 51 Limited	Licence Quit Manager	7,300
Experian	Mosaic & Mini Marketeer	£11,601.98
Health Diagnostics	Call Off for Health Checks	12,120
Solent NHS	Community Contract	£3,809,832.00
(GPs & CPs)	Local Commissioned Services	£881,231.00
		£6,124,436.60

These contracts are held solely at the risk of the Council and are outside of the scope of the Pooled Fund and Non Pooled Fund arrangements.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning & Contracting Arrangements

There are no changes to existing commissioning and contract arrangements proposed within this Scheme in 15/16. All responsibility for contracting and commissioning shall remain with the Council at its sole discretion subject to taking into account the views of those attending the Partnership Board .

The CCG will continue to be the lead commissioner / contractor for long term conditions services provided by NHS service providers - this area is outside of the scope of this Scheme however the work carried out within this Service will develop and drive the commissioning and contracting agenda for LTC.

7 FINANCIAL CONTRIBUTIONS

Not relevant for this Scheme for 15/16 as no Pooled Fund or Non Pooled Fund arrangements are in place.

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

8 FINANCIAL GOVERNANCE ARRANGEMENTS

Not relevant to this Scheme as no Pooled Fund element for 15/16

Management of all prevention schemes and associated budgets shall be the responsibility of the Council and all commissioning/contracting risks shall remain with them

9 VAT

Not relevant to this Scheme as no Pooled Fund element for 15/16 - the VAT position will remain the standard Council approach.

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Governance arrangements for the overarching Scheme will be as laid out in Schedule 2, Governance, with a Prevention Project Group reporting into the identified structures.

11 NON FINANCIAL RESOURCES

N/A for this Scheme

12 STAFF

All staff involved in designing this Scheme shall be within the Council structure or as contracted for by the Council.

13 ASSURANCE AND MONITORING

The management and monitoring of the programmes of work that underpin the Better Care Fund will happen via the CCG planning process and report back through the governance structure set out in

section 10. The programmes and projects will be managed and monitored using the Covalent planning system with actions; milestones; key performance indicators and risks managed through this process. Progress against delivery; change management and project level reporting will be taken through the governance process.

The benefits realisation with regard to a number of the projects will result in a reduction in non-elective admissions. Each project will be monitored to establish the cause and effect in relation to project aims and the associated reduction in NEL admissions. This will demonstrate that the projects are delivering their required outcomes, and this will also be seen within acute contract reporting and review. Any over-performance the during the will require a rectification plan. This will be developed and monitored through Better Care and CCG governance structures. These key metrics will form part of the reporting mentioned above.

14 LEAD OFFICERS

The Head of Better Care has ultimate responsibility for the delivery of Schemes and reports through the governance procedures set out in Schedule 2 (Governance).

The lead officer from the Council for the Scheme will be the Public Health Consultant reporting to the Director of Public Health.

15 INTERNAL APPROVALS

The Scheme has received approvals for current contracts and commissioning models through the Council governance model. To the extent that further approvals are required these may be sought through the Partnership Board or the Council's governance process as determined by the lead officer in conjunction with the programme lead for Better Care, and in accordance with all relevant schemes of delegations etc.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

There are no planned risk or benefit sharing arrangements in place for this Scheme.

17 REGULATORY REQUIREMENTS

N/A

18 INFORMATION SHARING AND COMMUNICATION

The Information Governance agreements in place as detailed in Schedule 2 shall apply to this Scheme

Data sharing arrangements between organisations which adhere to IG controls and Caldicott requirements are in place with high level information sharing protocol (ISP) agreed at NHS and ASC Director level. The NHS number is used and there are shared arrangements for a Patient Transfer List) which all health and social care professionals will be feeding into.

Information Management and Technology to support the integration of care services is at the core of Portsmouth and South East and PCC strategies. Both the LA and the CCGs recognise the complexity and technical challenge involved in integrating information across care services provided by different care providers but have already made significant steps toward sharing care information across health and social care through the joint support of the Hampshire Health Record and the extensive use of the NHS number as a key identifier across all care systems.

Both the CCG and LA are keen to move forward to the next stage of the strategy which will concentrate on the development of shared care plans across all provider care services supporting patients with long term conditions and complex care needs.

The development of shared care plans will in the first instance explore solutions based on existing and readily available technologies including the Hampshire Health Record, primary, community and social care systems and messaging solutions to bring information together into a virtual care record.

Looking forward our strategy sets out a vision for an inter-operable approach to integrating care information for the longer term. Unfortunately existing systems and information standards are not mature enough for us to achieve this at the moment. However much work has been and continues to be done through the combined efforts of the HSCIC and the health care system industry in the on-going development of the Interoperability Toolkit (ITK). It is our intention therefore to use as much as we can from the ITK to ensure that system developments supporting an integrated care environment can be used as a foundation for future longer term care system interoperability.

This work is overseen and directed by a whole systems IT Enabled Change Board, comprising healthcare providers, commissioners and Social Care representatives.

19 DURATION AND EXIT STRATEGY

The prevention agenda remains the responsibility of the Council however this Scheme is included within the local Better Care plan to facilitate reporting and information sharing through the Partnership Board.
In the event that Services or commissioning models are to be materially changed this shall be reported through to the Partnership Board to determine any mobilisation or exit arrangements required.

SCHEDULE 1– SCHEME SPECIFICATION

Part 2 - Scheme 5

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

This Scheme 5 covers the following aspects of the Portsmouth Better Care Plan

(a) Disabled Facilities Grant (DFG)

(b) Carers

(c) Adult Social Care Capital Grant

These elements are not identified as a specific project or scheme within the Better Care Fund Plan, Schedule 6, but as mandatory elements within the funding streams of the Pooled Fund they are captured here for completeness.

The Pooled Fund will be held by the Council.

Disabled Facilities Grants are available to help with the cost of adapting an individual's home (including tenanted properties) for use by a person who is registered disabled and living in the property. This process for delivering this service is hosted by the Council who have a statutory responsibility to deliver this function.

Funding for Carers services has been transferred from the CCG to the Council in recent years using s256 NHS Act flexibilities. Under this Agreement while the method of transferring funding has changed the services and monitoring/reporting of outcomes will remain largely unchanged in 1516.

The Adult Social Care Capital Grant: in previous years this capital funding from the Department of Health has been used by local authorities to support investment in adult social care services. It is anticipated that relevant national conditions will be published from the Department of Health and the Department of Communities and Local Government clarifying the manner in which this grant may be used to help deliver the purposes of the Better Care Fund Plan.

2 AIMS AND OUTCOMES

The goal of the DFG process is to ensure that an individual can remain living within their property as independently as possible to help reduce or avoid the levels of care needed by that individual.

Carers agenda: there are four local priorities

1. Identification and recognition
2. Realising and releasing potential
3. A life alongside caring
4. Supporting carers to stay healthy

The aim of the Adult Social Care Capital Grant is to facilitate projects which will have a positive long term impact on facilities available for service users within Portsmouth and their wellbeing/health.

3 THE ARRANGEMENTS

Disabled Facilities Grant: existing processes and procedures in place within the Council shall continue to apply as laid out for indicative purposes in the attached flowchart:

DFG Process flow chart May 2014.doc

Carers services are operated through Adult Social Care within the Council and include the following:

- Short breaks
- Breaks service
- Contribution towards assessment team

The arrangements for the application of the Adult Social Care Capital Grant will be confirmed through the Partnership Board taking into account any published national guidance.

There are no Non Pooled Funds associated with any part of this Scheme.

4 FUNCTIONS

The holder of the Pooled Fund must by law pass the Disabled Facilities Grant allocation to housing authorities, which in Portsmouth is part of the Council. Grant conditions are set by the Department for Communities and Local Government. The functions and responsibilities in relation to the application of the DFG are laid out in the Housing Grant, Construction and Regeneration Act 1996, as amended.

The functions in relation to supporting carers are laid out in the Care Act 2014 and in the Children & Families Act 2014.

In relation to the Adult Social Care Capital Grant conditions are set by the Department of Health and the Department for Communities and Local Government. Nationally £50 million has been earmarked for the capital costs (including IT) associated with Care Act transition. The fund does not ring-fence the Care Act money, but local plans should show how they meet new duties - this will be developed through reports to the Partnership Board.

5 SERVICES

DFG; the range of services that can be provided and the limitations or exclusions for the application of the DFG process are laid out in the Housing Grant, Construction and Regeneration Act 1996, as amended.
An initial occupational therapy assessment is carried out by a health and social care professional within the system. The Housing Renewals team work with the individual and professional to ensure that works are carried out that are proportionate, value for money, meet the persons needs and are carried out effectively by a third party.

Carers: the main purpose of the carers strategy is to provide a coordinated approach to carers services and support in Portsmouth to ensure that all health and social care agencies are working with carers are able to provide a consistent approach to identification, signposting to support and including and respecting carers in their role as an expert. Carers who live in or support an individual who lives in Portsmouth are eligible for support.

The carers strategy will identify the distinct ways in which health and social care services can and do support carers. It also needs to recognise that health and social care services operate in a fast and ever changing environment and therefore it is not the intention that this strategy is "set in stone" but that it will provide a frame work for future developments and direction.

Adult Social Care Capital Grant: allocation of this funding will be determined through the Partnership Board.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning & Contracting Arrangements

DFG - Commissioning and contracting shall be carried out through the Council as agent on behalf of individuals receiving DFG funding.

Carers - Commissioning shall be carried out through the Integrated Commissioning Unit on behalf of the CCG. There shall be an aligned process with any additional commissioning or contracting carried out by the Council which may utilise resource within the Integrated Commissioning Unit as required.

The commissioning and contracting arrangements for the application of the Adult Social Care Capital Grant will be determined through the Partnership Board in the light of relevant guidance.

Access

DFG: the individual must be resident (or shortly will be resident) within the building which must be within Portsmouth city boundaries or, on a discretionary basis, currently resident with the city boundaries and seeking adaptations on a new premises where it is not possible to adapt their current accommodation.

A carer is anyone who cares (unpaid) for a family member or friend, who due to illness, disability, a mental health condition or an addiction, cannot cope without their support. The carer may live within the city boundaries or care for someone who lives within the city boundaries.

7 FINANCIAL CONTRIBUTIONS

At the Commencement Date it is understood that the funding levels are as set out in Schedule 3 Part 2 with an indicative funding amount as follows:

Disabled Facilities Grant - £645,000
Carers - £400,000
Adult Social Care Capital Grant - £496,000

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

8 FINANCIAL GOVERNANCE ARRANGEMENTS

The Pooled Fund shall apply as set out in the Agreement in relation to the funding streams which support this Scheme.

Eligibility, access criteria, and funding levels are as detailed in this Schedule.

Disabled Facilities Grant:

- The lead finance officer and lead commissioner for this element of the Scheme, as identified in Schedule 3 Part 2, shall have the delegated authority to spend the relevant allocated money within the Pooled Fund.
- Audit arrangements shall be Council's standard approach, usually operated on a three year cycle.

- The Council's financial systems shall be applied to this element of the Scheme.
- In the event that the funding within the Pooled Fund for this element of the Scheme is insufficient to meet demand the Council may at its discretion provide additional funding to support the aims and objectives of the service. Any potential overspend shall be dealt with in accordance with the provisions of Schedule 3 Part 1.
- In the event that additional funding cannot be identified the lead commissioner shall operate a waiting list and prioritisation matrix for works which shall be notified to the Partnership Board.

Carers
- The lead finance officer and lead commissioner for this element of the Scheme, as identified in Schedule 3 Part 2, shall have the delegated authority to spend the relevant allocated money within the Pooled Fund.
- Audit arrangements shall be Council's standard approach, usually operated on a three year cycle.
- The Council's financial systems shall be applied to this element of the Scheme.

Adult Social Care Capital Grant
- This element of the Scheme shall be held within the Pooled Fund by the Council and shall be subject to the Council's financial and audit rules.
- All other details in relation to the delegated spend of this element of the Scheme shall be agreed through the Partnership Board.

9 VAT

Funds within this Scheme sit within a Pooled Fund held by the Council who shall be the contracting party also - therefore the VAT treatment applicable to these sums for all three elements shall be the standard Council position.
No VAT is payable on Disabled Facilities Grants works or services.

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Governance arrangements for the overarching Scheme will be as laid out in Schedule 2, Governance,

11 NON FINANCIAL RESOURCES

Disabled Facilities Grant: in accordance with national rules and guidance the Council shall make a 10% charge of the total cost of works carried out to the DFG element of the Pooled Fund.

The contracting and commissioning resource to facilitate the application of the carers funding is provided through the Integrated Commissioning Unit with no charge to the Pooled Fund.

The position in relation to the Adult Social Care Capital Grant shall be determined through the Partnership Board.

12 STAFF

Staffing for the service provision is excluded from this Scheme.

The staff carrying out the review under this Scheme will be provided by the Partners and using existing resource. There will be no further secondments or TUPE transfers of staff in order to deliver the review function required under this Scheme.

13 ASSURANCE AND MONITORING

Governance of the Scheme shall be in accordance with the provisions of Schedule 2 (Governance) and with the terms of reference set out for the project group.

Monitoring of the progress of this Scheme will be through the identified project management tool including as a minimum monthly updates on progress against a detailed project plan, risks, issues, etc.

Carers: it is intended that monitoring information is provided to the Carers Executive who share with Carers Council as appropriate

Performance measures will be reported to the Partnership Board at an overarching level and will be reviewed in detail through the BCF Delivery Board as appropriate.

Outcomes will be identified that link to the local and national metrics with a range of additional qualitative data being collected and evaluated. This will include qualitative measures to understand what matters to people using services, using the patient voices narrative statements.

Assurance in relation to provision of services through the Council is under review and will be developed through the BCF Delivery Board.

Analysis of the scheme measures will be developed in collaboration with Head of Better Care Programme and community partners and providers.

14 LEAD OFFICERS

The Head of Better Care has ultimate responsibility for the delivery of Schemes and reports through the governance procedures set out in Schedule 2 (Governance).

The Lead Officer in relation to the DFG is a senior manager within the Council's Housing services team.

The Lead Officer on the Carers element of the Scheme is a senior manager within the Integrated Commissioning Unit. The Integrated Commissioning Unit, established under a separate section 75 NHSA 2006 agreement between the Partners will carry out the delivery of the Scheme in association with staff from provider teams.

The lead arrangements for the application of the Adult Social Care Capital Grant will be determined through the Partnership Board.

15 INTERNAL APPROVALS

The Scheme has received approvals for current contracts and commissioning models through the respective Partner's governance models.

The necessary approvals for the application of the Adult Social Care Capital Grant will be determined through the Partnership Board once guidance on this area has been published.

To the extent that further approvals are required these may be sought through the Partnership Board or the Partners' governance processes as determined by the lead officer in conjunction with the programme lead for Better Care, and in accordance with all relevant schemes of delegations etc.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

There are no risk or benefit sharing provisions in place for this Scheme at the Commencement Date.

Historically DFG has overspent the national allocation consistently within the city. Overspends have been met through the capital programme within the Council. The Housing Renewals team submit an annual capital programme bid to reduce the risk of having to operate a waiting list. In the event that additional funding could not be obtained prioritisation in conjunction with health and social care professionals would take place. The Council does not make any commitment to provide funding over and above the national identified DFG funding level as set out in Schedule 3 and will operate a waiting list rather than incur an overspend where alternative funding is not available.

17 REGULATORY REQUIREMENTS

N/A

18 INFORMATION SHARING AND COMMUNICATION

The Information Governance agreements in place as detailed in Schedule 2 shall apply to this Scheme.

19 DURATION AND EXIT STRATEGY

It is anticipated that all three aspects of this Scheme will operate on an ongoing basis.

In the event that the DFG obligations on the Council were to cease the referral process would cease and the Partners would need to consider alternative approaches to supporting people to remain independent in their own homes.

Carers are fundamental to the health and social care system with new rights laid out in the Care Act 2014 - therefore any removal of these obligations would take some time to take effect and again the Partners would need to consider alternative approaches to supporting this group.

The intention of the Adult Social Care Capital Grant is to apply it on an annual basis - long term spending plans are not in place and therefore an exit strategy has not been developed.

SCHEDULE 2 – GOVERNANCE

Partnership Board terms of reference:

1 Partnership Board

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

- CCG Chief Operating Officer (voting - alternate Chair)
- CCG Director of Finance (non voting)
- Council Chief Executive (voting - alternate Chair)
- Council s151 Officer (non voting)
- Head of Integrated Commissioning Unit for the Council and CCG (non voting)
- Head of Better Care Programme for the Council and CCG (non voting)

or a deputy to be notified in writing to Chair in advance of any meeting.

1.2 Other individuals may be invited to attend for specific items with the prior agreement of the Chair.

2 Role of Partnership Board

2.1 The Partnership Board shall:

2.1.1 provide strategic direction on the Individual Schemes;

2.1.2 receive the financial and activity information;

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

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

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

2.1.6 review and agree annually revised Schedules as necessary;

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

2.2 The Partnership Board will ensure that in commissioning and delivering health and social care in the city they:

2.2.1 Maximise patients' and service users' choice and control.

2.2.2 Encourage and support people to be as independent as possible.

2.2.3 Commission services which are safe, effective and can demonstrate value for money whilst ensuring that respect for individuals' dignity is central to their practice.

2.3 In exercising its duties the Partnership Board will:

2.3.1 Adopt a policy of mutual openness;

2.3.2 Address common problems and objectives in a co-ordinated way;

2.3.3 Have regard to the policies and guidance which applies in both partner organisations; and

2.3.4 Have regard to the principles set out in Appendix 1 to these terms of reference.

2.4 The Partnership Board will carry out its functions in accordance with the regulatory scope of authority framework of Portsmouth City Council and the Constitution, Standing Orders and Prime Financial Policies of NHS Portsmouth CCG.

3 Partnership Board Support

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

4 Meetings

4.1 The Partnership Board will meet monthly at a time to be agreed following receipt of each monthly report of the Pooled Fund Manager.

4.2 The quorum for meetings of the Partnership Board shall be a minimum of one voting representative from each of the Partner organisations, to include a notified deputy.

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

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

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

4.6 An extraordinary meeting may be called at any time by a voting member of the Partnership Board upon not less than three (3) clear days' notice being given to the other members of the Partnership Board of the matters to be discussed.

5 Delegated Authority

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

5.1.1 authorise a redistribution of the contributions of the Partners to Individual Schemes under the Better Care Fund Plan within the aggregate contributions of the Partners to any Pooled Fund;

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

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

5.1.4 take decisions on how best to give effect to the overall ambitions of the Better Care Fund Plan within the remit endorsed by the Health and Well Being Board; and

5.1.5 approve revisions to timescales set out for Individual Schemes.

5.2 Where a member does not have appropriate delegated authority to agree to a matter under discussion the item shall be deferred to the next meeting and appropriate approvals sought.

6 Decision Making

6.1 All matters shall be determined by unanimous voting only - where unanimity cannot be reached the matter may be escalated between the Partner organisations.

7 Information and Reports

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

8 Budget setting

8.1 The Partners budget cycles operate on the following indicative basis:

8.1.1 Council: initial budget setting at end of Q1, budget plan circulated Q3, budget sign off February

8.1.2 CCG: Initial budget setting commences Q3 on release of national guidance

9 Post-termination

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

10 Overarching Governance Structure

10.1 The Partnership Board shall receive reports and give direction to the BCF Delivery Board, locally known as HaSP (Health and Social Care Partnership), and relevant BCF Project Groups in relation to each Scheme.

10.2 The terms of reference for the BCF Delivery Board at the Commencement Date are laid out below - amendments to these terms may be proposed by that group and subject to ratification through the Partnership Board.

HaSP TOR v7.docx

10.3 The terms of reference for any elements of the BCF Project Groups shall be included within the Scheme Specifications, Schedule 1, where available and/or agreed through the BCF Delivery Board.

10.4 The Partnership Board shall utilise resources from the Partners including the Head of Better Care Programme for the Council and CCG to support the strategic delivery and lead on reporting to the Partnership Board.

11 Variation

11.1 The Partners acknowledge that at the Commencement Date further development is required on the structure and application of the Pooled Fund and that this should be completed by no later than the end of June 2015.

11.2 It is therefore agreed that the Partners shall work together to revise the Agreement as soon as is practicable, bearing in mind internal governance processes and timeframes, to ensure that the Agreement:

a) retains monitoring and reporting on all aspects of the Better Care Fund Plan

b) only includes within the Pooled Fund those funding streams where the Partners intend to make use of s75 NHS Act flexibilities, and excludes funding streams that may still report under paragraph 11.2 (a)

c) establishes multiple Pooled Funds with different Hosts where appropriate to give effect to the objectives of the Better Care Fund Plan.

Appendix 1

1.1 The Partners agree that these arrangements are the most efficient and effective way to deliver the Partners strategic commissioning intentions and enable them to:

1.1.1 Jointly commission integrated services
1.1.2 Improve the quality of services
1.1.3 Improve outcomes for the people of Portsmouth
1.1.4 Consolidate and strengthen collaborative and lead commissioning arrangements to more effectively manage the local market
1.1.5 Make the best use of resources against local and national priorities to provide value for money
1.1.6 Meet the requirements of the NHS, Public Health and Social Care Outcomes Frameworks

1.2 The Partners will work to the following ten principles that express commitments and behaviours which describe their approach to commissioning

OUTCOMES - Improving outcomes for Portsmouth residents will be at the heart of the commissioning process

- We will use public money effectively to improve outcomes for people in the city
- Commissioning staff will work together and share responsibility for outcomes across the city.

EQUALITY – Commissioning will seek to shape service delivery to reduce inequalities in the city

- We will target resources to reduce inequalities in the city
- We will monitor the impact of all commissioning decisions on all parts of the community

EVIDENCE - Commissioning decisions will be informed by evidence of what works

- We will use our resources effectively based on the identified need of our residents
- Where possible and appropriate, we will commission evidenced-based services and practice. We will balance this with risk-managed innovation
- We will evaluate impact rigorously to further enhance our understanding of what works

INTEGRATION - Commissioning will seek to integrate service delivery around the needs of individuals and families

- We will commission services which are joined up and easy to access
- We will commission personalised services which offer choice so that people are empowered to take personal
- We will work with service providers and support them to develop services which meet the needs of our diverse population

PREVENTION - Commissioning prevention and early intervention services will reduce dependency on public service delivery

- We will design services and support that tackle the causes of poor outcomes
- We will seek to build resilience in people and communities

PARTICIPATION - Residents will be active participants in the commissioning (and decommissioning) process

- We will involve residents in the planning, design, monitoring and evaluation
- We will increase our use of co-production, developing and managing services with residents

ACCOUNTABILITY - Resource allocation and commissioning decisions will be transparent, contestable and locally accountable

- We will publish our priorities and commissioning intentions in good time
- We will ensure clear accountability for our commissioning decisions
- We will ensure there is clear accountability for service performance

FAIRNESS - The commissioning process will ensure that no provider is given or gains an unfair advantage

- We will adopt the same approach (e.g. to service specification and performance monitoring) to any provider – local authority, NHS, voluntary, community or private
- We will ensure there is a clear distinction between commissioner and provider functions regardless of whether they co-exist within an single organisation

VALUE FOR MONEY - Commissioning decisions will be driven by the goal to achieve optimum quality, value for money and outcomes.

- We will monitor value for money and use it to inform commissioning decisions
- We will decommission ineffective services

PARTNERSHIPS - Strong and effective partnerships are key to good commissioning

- We will continue to build on the effective partnership work in Portsmouth including strategic partnerships, partnerships with service users and commissioner-provider partnerships

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

Part 1

1 Disinvestment

1.1 To the extent that the pay for performance element of the Better Care Fund, as detailed in Schedule 5 part 1, is not available to the Pooled Fund the Partners have agreed :-

a) The investment programme for Portsmouth will operate on the basis of the full performance element of the Better Care Fund being made available for use on the objectives.

b) The CCG shall seek to continue to fund the performance element as planned, however the CCG retains the right to recoup this element from the financial plans subject to the process set out below

c) The Partners will review the source of the increased pressures which have led to the performance targets within acute services not being achieved.

d) Where the financial pressure has arisen as a result of elements that are outside the scope of the Better Care Fund (e.g. paediatrics) there shall be a presumption that the CCG shall not disinvest in the planned programme under this Agreement.

e) Where the financial pressure has arisen as a result of schemes within the Better Care Plan not fully realising their targets the CCG shall inform the Partnership Board if it intends to disinvest in any part of the planned programme under this Agreement.

f) Any disinvestment should in the first instance be funded from schemes where investment plans have slipped or those which have been assessed by the Partnership Board as being less successful at achieving the objectives of the Better Care Fund Plan.

g) In the event that there is no slippage in the programme and no schemes can be identified for disinvestment without impacting on the objectives of the Better Care Fund Plan the Partnership Board would discuss pulling any resource from committed spending and the required notice period.

h) Where it is not possible to disinvest funding due to notice periods on Service Contracts or binding commitments between parties that cannot be varied the CCG shall not disinvest the performance element other than in exceptional circumstances.

1.2 In parallel with considering the approach laid out in paragraph 1.1 above the Partners may also consider:

- virement from other funds established under this agreement to the extent that their budget can be reduced;
- an additional contribution from either Partner of an amount required to meet the shortfall in the expected outcome;
- or any other measure recommended by the Partnership Board

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

<u>Pooled Fund Management</u>

3 For the 2015/2016 financial year the presumption is that any Overspend should be met by the Partner responsible for commissioning services within that area, or where there is no responsible commissioner the Partner with statutory responsibility for the function, unless otherwise agreed by the Partnership Board. The Partners anticipate working towards risk sharing in relation to Individual Schemes as laid out in Schedule 1, Part 2 in particular concerning elements of the "Reablement" Scheme.

4 In the event that a potential overspend or underspend is identified on any part of the Better Care Fund plan this shall be raised at the earliest possible opportunity with the Partnership Board by the Head of Better Care Programme.

5 Where a potential underspend has been identified the Head of Better Care Programme shall ensure that a proposed action plan is brought to the Partnership Board detailing:

- The rationale for the underspend and any programme slippage which may have contributed towards this
- Identifying the need to vire funds to any other Scheme within the Pooled Fund, or outside of the scope of this Agreement, to make best use of the available resources

6 Where a potential overspend has been identified the Head of Better Care Programme shall ensure that a proposed action plan is brought to the Partnership Board detailing

- steps to be taken to reduce or mitigate the overspend
- identifying underspends that can be vired from any other fund maintained under this agreement or outside of this agreement
- asking for more money from the respective Partners; and
- if no more money is available agreeing a plan of action, which may include decommissioning all or any part of the Individual Scheme to which the Fund relates

7 In the event that the Partnership Board identifies poor management by a Lead Commissioner as a contributing factor to an Overspend this will result in the other Partner having the right to take on responsibility for lead commissioning of the relevant functions.

8 The Partnership Board shall consider what action to take in respect of any actual or potential Overspend.

9 The Partnership Board shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

9.1 whether there is any action that can be taken in order to contain expenditure;

9.2 whether there are any underspends that can be vired from any other fund maintained under this Agreement;

9.3 how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

10 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

11 Where is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates.

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

Funding element	Budget £000's	Lead commissioner - organisation and contact	Lead finance - organisation and contact	Contracting arrangements	Notes	Position on termination
						PCC responsibility
Capacity building funding for VCS	300	CCG P Sheth	CCG M Spandley	To be confirmed	Funding confirmed, investment plan & project plan tbc by Partnership Board	CCG responsibility
Scheme 2: Review of Bed Based Provision - no Pooled Fund or Non Pooled Funds						
Scheme 3: Reablement						
PRRT ASC funded element (existing)	1,870	PCC R Watt	PCC G Whiteman	In-house provision	Funding to PCC for in house delivery of service with aim to move to pooled budget in year	PCC responsibility
PRRT CCG funded element (existing)	900	CCG P Sheth	CCG M Spandley	CCG contract with Solent NHS Trust	Agreed Services Contract 1516	CCG responsibility
Additional investment in PRRT	100	CCG P Sheth	CCG M Spandley	CCG contract with Solent NHS Trust	Agreed Services Contract 1516	CCG responsibility
Reablement pilots and Corben	1,200	PCC P Sheth	PCC G Whiteman	PCC & range of third sector providers	Agreed Services Contracts 1516 (Schedule 1)	PCC and CCG responsibility
Scheme 4: Prevention - no Pooled Fund or Non Pooled Funds						
Scheme 5: Miscellaneous						
Carers grant (existing CCG)	400	CCG P Sheth	PCC G Whiteman	In-house provision	Funding to PCC for in house delivery of service	PCC and CCG responsibility
DFG	645	PCC B Lomax	PCC N Haverly	PCC acting as agent on behalf of DFG	Agreed Services Contract 1516 through PCC Housing	PCC

Funding element	Budget £000's	Lead commissioner - organisation and contact	Lead finance - organisation and contact	Contracting arrangements	Notes	Position on termination
				applicants	Services	responsibility
Social care capital	496	PCC R Watt	PCC G Whiteman	tbc	Funding confirmed, investment plan & project plan tbc by Partnership Board	PCC responsibility

For the purposes of this table PCC shall be read as referring to the Council

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

A. where either party is to act as Lead Commissioner

1 It is intended that each Partner shall contract for the Services in accordance with all applicable law, including but not limited to the EU procurement rules, the Public Contracts Regulations 2015 and where applicable the National Health Service (Procurement, Patient Choice and Competition) No. 2 Regulations 2013 or any subsequent regulations, communications or guidance.

2 Where appropriate and in order to commission the Services, the Council shall utilise other NHS procurement services commissioned by the CCG, such as the commissioning support unit to contract on their behalf. In these cases the Council shall ensure that the procurement service provided by the third party complies with this Agreement and all applicable law more fully described in paragraph 1 above.

3 Subject to applicable law, each Partner shall procure the Services in accordance with its own standing orders (as may be revised from time to time) ensuring through competitive tendering, wherever possible, that best value for money is obtained.

4 It is accepted that, in appropriate circumstances (such as where there is only one specialist provider and no alternative or a short term pilot project, or any other grounds that fit within the EU procurement rules or the Public Contracts Regulations 2015), it may be appropriate to negotiate contracts with the providers on a single tender basis, provided any decision to negotiate contracts is made in accordance with the current public procurement rules and the Partner's current standing orders.

B. Where the CCG is to act as Lead Commissioner:

Terminology used in this Schedule 4 Part 1 section B 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 Partner if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

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

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report;

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

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Services Contract permits, raise issues reasonably requested by a Partner at those meetings. Such consultation may be at an operational level rather than through the Partnership Board.

4 The Lead Commissioner shall not materially:

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

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

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

4.4 give any approvals under the Services Contract;

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

4.6 suspend all or part of the Services;

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

4.8 serve any notice;

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

without the prior approval of the other Partner (acting through the Partnership Board) such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partner 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 Partner as part of that process.

6 The Lead Commissioner shall notify the other Partner 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 Services Contract (including audit reports)

C. Where the Council is to act as Lead Commissioner:

Terminology used in this Schedule 4 Part 1 section C shall have the meaning attributed to it in the Council's standard contractual terms of business as in place from time to time, save where this Agreement or the context requires otherwise.

8 The Lead Commissioner shall notify the other Partner if it receives or serves:

8.1 a change in control notice;

8.2 a Notice of a Force Majeure Event;

8.3 a Default Notice;

and provide copies of the same.

9 The Lead Commissioner shall provide the other Partner with copies of any and all:

9.1 monthly activity/contractual reports;

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10 The Lead Commissioner shall consult with the other Partner before attending:

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and, to the extent the Contract permits, raise issues reasonably requested by a Partner at those meetings. Such consultation may be at an operational level rather than through the Partnership Board.

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11.3 agree (or vary) the terms of an investigation or an action/remediation/rectification plan;

11.4 give any approvals under the Services Contract;

11.5 agree to or propose any variation to the Services Contract (including any Schedule or Appendices);

11.6 suspend all or part of the Services;

11.7 serve any notice to terminate the Services Contract (in whole or in part);

11.8 serve any notice;

11.9 agree (or vary) the terms of a succession plan;

without the prior approval of the other Partner (acting through the Partnership Board) such approval not to be unreasonably withheld or delayed.

12 The Lead Commissioner shall advise the other Partner 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 Partner as part of that process.

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

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

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

Part 1
Indicative 2015/16 financial impact of NEL deflected activity:

Baseline non-elective admissions	**18,912**	*(January 2014 to December 2014)*
National average cost of non-elective admission	**£1,490**	*(2012/13 Reference Costs www.gov.uk)*
Target deflected non-elective admissions	**548**	
Target savings (£)	**£816,520**	

NEL deflected level	Non-elective admissions deflected	Value of non-elective admissions deflected	Variance from target - Activity	Variance from target - Cost (£)
0.00%	0	£0	-548	-£816,520
0.50%	95	£140,894	-453	-£675,626
1.00%	189	£281,789	-359	-£534,731
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Part 2
Local performance metrics
The Partnership Board shall receive reports on the progress of the following matters and progress towards the respective outcomes and/or performance measures detailed in Tables 1 & 2.

For 2015/16 should either Partner fail to meet the levels identified in Tables 1 & 2 there shall be no adjustment to the funds which may be transferred from the Pooled Fund.

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(a) Council

Scheme	Service	Target
Scheme 1 - Integrated localities	Adult Social Care fieldwork (existing)	ASCOF measures aim of equal to or improvement against previous year, in particular: - Social care related quality of life - People receiving self directed support - People receiving direct payments - Older people receiving reablement services after leaving hospital Measure in relation to application of Care Act to be confirmed
Scheme 1 - Integrated localities	Early intervention social care services(new investment)	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Implementation of care act (new CCG investment)	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Additional investment in domiciliary care	See ASCOF measures above
Scheme 2 - Bed Based Review	Linked reporting: Bed provision at Longdean	Length of stay, occupancy levels, readmission rates, discharge destination, service user satisfaction
Scheme 3 - Reablement	PRRT ASC funded element (existing)	
Scheme 3 - Reablement	Additional investment in PRRT	To be confirmed through Partnership Board
Scheme 3 - Reablement	Reablement pilots and Corben	Reablement pilots: individual outcomes measures per scheme mapped to ASCOF and NHSOF. Including in particular - Support following admission/avoiding admissions - Independence and wellbeing - Support at end of life - Managing a long term

		condition Corben: Length of stay, occupancy levels, readmission rates, discharge destination, service user satisfaction
Scheme 4 - Prevention	Ongoing PH work	To be confirmed through Partnership Board
Scheme 5 - Other	Carers grant	See attached Carers Measures.xlsx
Scheme 5 - Other	DFG	See attached DFG measures.doc DFG measures 2.xls
Scheme 5 - Other	Social care capital	To be confirmed through Partnership Board

(b) CCG

Scheme	Service	Target
Scheme 1 - Integrated localities	Community Nursing	See attached Community Nursing KPIs.docx
Scheme 1 - Integrated localities	Expanding care co-ordination	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Access to Primary Care	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Capacity building fund for the VCS	To be confirmed through Partnership Board
Scheme 2 - Bed Based Review	Linked reporting: Bed provision at Jubilee, Spinnaker, Limes	Length of stay, occupancy levels, readmission rates, discharge destination, service user satisfaction
Scheme 3 - Reablement	PRRT Solent funded element (existing)	See attached PRRT measures.docx
Scheme 3 - Reablement	Additional investment in PRRT	To be confirmed through Partnership Board

SCHEDULE 6 – BETTER CARE FUND PLAN


Ports BCF submission - Final 1909.docx


Portsmouth City BCF submission template 1

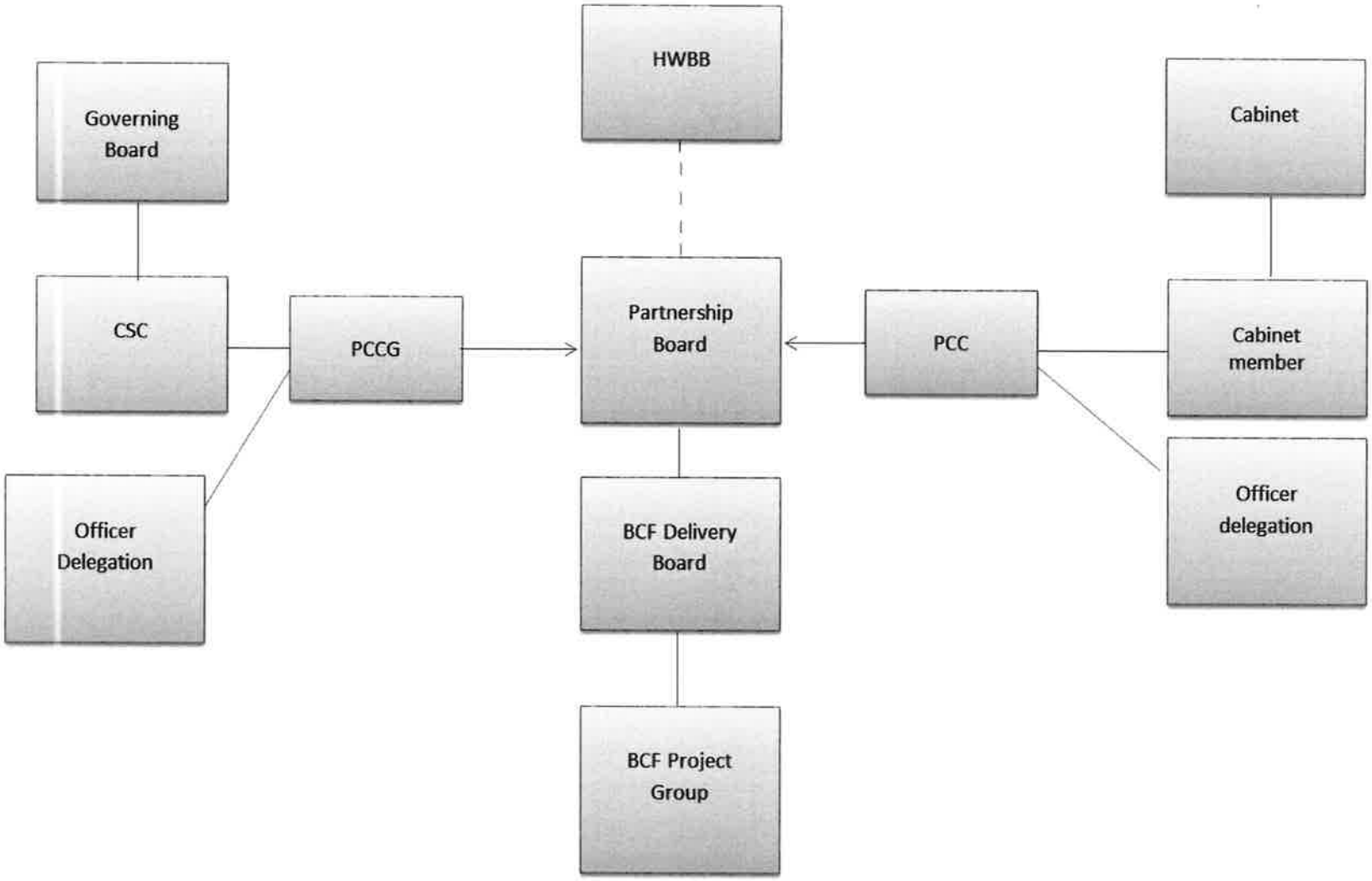

Portsmouth City BCF submission template 2

11.2 It is therefore agreed that the Partners shall work together to revise the Agreement as soon as is practicable, bearing in mind internal governance processes and timeframes, to ensure that the Agreement:

a) retains monitoring and reporting on all aspects of the Better Care Fund Plan

b) only includes within the Pooled Fund those funding streams where the Partners intend to make use of s75 NHS Act flexibilities, and excludes funding streams that may still report under paragraph 11.2 (a)

c) establishes multiple Pooled Funds with different Hosts where appropriate to give effect to the objectives of the Better Care Fund Plan.


HWBB
Governing Board
Cabinet
CSC
PCCG
Partnership Board
PCC
Cabinet member
Officer Delegation
BCF Delivery Board
Officer delegation
BCF Project Group

Appendix 1

1.1 The Partners agree that these arrangements are the most efficient and effective way to deliver the Partners strategic commissioning intentions and enable them to:

1.1.1 Jointly commission integrated services
1.1.2 Improve the quality of services
1.1.3 Improve outcomes for the people of Portsmouth
1.1.4 Consolidate and strengthen collaborative and lead commissioning arrangements to more effectively manage the local market
1.1.5 Make the best use of resources against local and national priorities to provide value for money
1.1.6 Meet the requirements of the NHS, Public Health and Social Care Outcomes Frameworks

1.2 The Partners will work to the following ten principles that express commitments and behaviours which describe their approach to commissioning

OUTCOMES - Improving outcomes for Portsmouth residents will be at the heart of the commissioning process

- We will use public money effectively to improve outcomes for people in the city
- Commissioning staff will work together and share responsibility for outcomes across the city.

EQUALITY – Commissioning will seek to shape service delivery to reduce inequalities in the city

- We will target resources to reduce inequalities in the city
- We will monitor the impact of all commissioning decisions on all parts of the community

EVIDENCE - Commissioning decisions will be informed by evidence of what works

- We will use our resources effectively based on the identified need of our residents
- Where possible and appropriate, we will commission evidenced-based services and practice. We will balance this with risk-managed innovation
- We will evaluate impact rigorously to further enhance our understanding of what works

INTEGRATION - Commissioning will seek to integrate service delivery around the needs of individuals and families

- We will commission services which are joined up and easy to access
- We will commission personalised services which offer choice so that people are empowered to take personal
- We will work with service providers and support them to develop services which meet the needs of our diverse population

PREVENTION - Commissioning prevention and early intervention services will reduce dependency on public service delivery

- We will design services and support that tackle the causes of poor outcomes
- We will seek to build resilience in people and communities

PARTICIPATION - Residents will be active participants in the commissioning (and decommissioning) process

- We will involve residents in the planning, design, monitoring and evaluation
- We will increase our use of co-production, developing and managing services with residents

ACCOUNTABILITY - Resource allocation and commissioning decisions will be transparent, contestable and locally accountable

- We will publish our priorities and commissioning intentions in good time
- We will ensure clear accountability for our commissioning decisions
- We will ensure there is clear accountability for service performance

FAIRNESS - The commissioning process will ensure that no provider is given or gains an unfair advantage

- We will adopt the same approach (e.g. to service specification and performance monitoring) to any provider – local authority, NHS, voluntary, community or private
- We will ensure there is a clear distinction between commissioner and provider functions regardless of whether they co-exist within an single organisation

VALUE FOR MONEY - Commissioning decisions will be driven by the goal to achieve optimum quality, value for money and outcomes.

- We will monitor value for money and use it to inform commissioning decisions
- We will decommission ineffective services

PARTNERSHIPS - Strong and effective partnerships are key to good commissioning

- We will continue to build on the effective partnership work in Portsmouth including strategic partnerships, partnerships with service users and commissioner-provider partnerships

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

Part 1

1 Disinvestment

1.1 To the extent that the pay for performance element of the Better Care Fund, as detailed in Schedule 5 part 1, is not available to the Pooled Fund the Partners have agreed :-

a) The investment programme for Portsmouth will operate on the basis of the full performance element of the Better Care Fund being made available for use on the objectives.

b) The CCG shall seek to continue to fund the performance element as planned, however the CCG retains the right to recoup this element from the financial plans subject to the process set out below

c) The Partners will review the source of the increased pressures which have led to the performance targets within acute services not being achieved.

d) Where the financial pressure has arisen as a result of elements that are outside the scope of the Better Care Fund (e.g. paediatrics) there shall be a presumption that the CCG shall not disinvest in the planned programme under this Agreement.

e) Where the financial pressure has arisen as a result of schemes within the Better Care Plan not fully realising their targets the CCG shall inform the Partnership Board if it intends to disinvest in any part of the planned programme under this Agreement.

f) Any disinvestment should in the first instance be funded from schemes where investment plans have slipped or those which have been assessed by the Partnership Board as being less successful at achieving the objectives of the Better Care Fund Plan.

g) In the event that there is no slippage in the programme and no schemes can be identified for disinvestment without impacting on the objectives of the Better Care Fund Plan the Partnership Board would discuss pulling any resource from committed spending and the required notice period.

h) Where it is not possible to disinvest funding due to notice periods on Service Contracts or binding commitments between parties that cannot be varied the CCG shall not disinvest the performance element other than in exceptional circumstances.

1.2 In parallel with considering the approach laid out in paragraph 1.1 above the Partners may also consider:

- virement from other funds established under this agreement to the extent that their budget can be reduced;

- an additional contribution from either Partner of an amount required to meet the shortfall in the expected outcome;

- or any other measure recommended by the Partnership Board

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

<u>Pooled Fund Management</u>

3 For the 2015/2016 financial year the presumption is that any Overspend should be met by the Partner responsible for commissioning services within that area, or where there is no responsible commissioner the Partner with statutory responsibility for the function, unless otherwise agreed by the Partnership Board. The Partners anticipate working towards risk sharing in relation to Individual Schemes as laid out in Schedule 1, Part 2 in particular concerning elements of the "Reablement" Scheme.

4 In the event that a potential overspend or underspend is identified on any part of the Better Care Fund plan this shall be raised at the earliest possible opportunity with the Partnership Board by the Head of Better Care Programme.

5 Where a potential underspend has been identified the Head of Better Care Programme shall ensure that a proposed action plan is brought to the Partnership Board detailing:

- The rationale for the underspend and any programme slippage which may have contributed towards this
- Identifying the need to vire funds to any other Scheme within the Pooled Fund, or outside of the scope of this Agreement, to make best use of the available resources

6 Where a potential overspend has been identified the Head of Better Care Programme shall ensure that a proposed action plan is brought to the Partnership Board detailing

- steps to be taken to reduce or mitigate the overspend
- identifying underspends that can be vired from any other fund maintained under this agreement or outside of this agreement
- asking for more money from the respective Partners; and
- if no more money is available agreeing a plan of action, which may include decommissioning all or any part of the Individual Scheme to which the Fund relates

7 In the event that the Partnership Board identifies poor management by a Lead Commissioner as a contributing factor to an Overspend this will result in the other Partner having the right to take on responsibility for lead commissioning of the relevant functions.

8 The Partnership Board shall consider what action to take in respect of any actual or potential Overspend.

9 The Partnership Board shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

9.1 whether there is any action that can be taken in order to contain expenditure;

9.2 whether there are any underspends that can be vired from any other fund maintained under this Agreement;

9.3 how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

10 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

11 Where is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates.

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

Schedule 3 Part 2

Funding element	Budget £000's	Lead commissioner - organisation and contact	Lead finance - organisation and contact	Contracting arrangements	Notes	Position on termination
Scheme 1: Integrated localities						
Community nursing commissioning budget (existing)	4,100	CCG P Sheth (ICU)	CCG M Spandley	CCG contract with Solent NHS Trust	Agreed Services Contract 1516	CCG responsibility
Expanding care co-ordination (new investment into community nursing)	400	CCG P Sheth (ICU)	CCG M Spandley	CCG contract with Solent NHS Trust	Agreed Services Contract 1516	CCG responsibility
Access to primary care (new CCG investment)	1,000	CCG K Hovenden	CCG M Spandley	CCG contracting arrangements tbc	Funding confirmed, investment plan & project plan tbc by Partnership Board	CCG responsibility
Adult social care fieldwork (existing)	3,198	PCC R Watt	PCC G Whiteman	In-house provision	Funding to PCC for in house delivery of service	PCC responsibility
Early intervention social care services(new investment)	600	PCC R Watt	PCC G Whiteman	In-house provision & possible use of contracting by PCC	Funding confirmed, investment plan & project plan tbc by Partnership Board	During notice period: CCG & PCC joint responsibility. Post notice period PCC responsibility
Implementation of care act(new CCG investment)	500	PCC R Watt	PCC G Whiteman	In-house provision & possible use of contracting by PCC	Funding confirmed, investment plan & project plan tbc by Partnership Board	During notice period: CCG & PCC joint responsibility. Post notice period PCC responsibility
Additional investment in domiciliary care	700	PCC R Watt	PCC G Whiteman	PCC contracting with private sector providers	Funding transferred into S75 pooled fund for CHC	During notice period: CCG & PCC joint responsibility. Post notice period

Funding element	Budget £000's	Lead commissioner - organisation and contact	Lead finance - organisation and contact	Contracting arrangements	Notes	Position on termination
						PCC responsibility
Capacity building funding for VCS	300	CCG P Sheth	CCG M Spandley	To be confirmed	Funding confirmed, investment plan & project plan tbc by Partnership Board	CCG responsibility
Scheme 2: Review of Bed Based Provision - no Pooled Fund or Non Pooled Funds						
Scheme 3: Reablement						
PRRT ASC funded element (existing)	1,870	PCC R Watt	PCC G Whiteman	In-house provision	Funding to PCC for in house delivery of service with aim to move to pooled budget in year	PCC responsibility
PRRT CCG funded element (existing)	900	CCG P Sheth	CCG M Spandley	CCG contract with Solent NHS Trust	Agreed Services Contract 1516	CCG responsibility
Additional investment in PRRT	100	CCG P Sheth	CCG M Spandley	CCG contract with Solent NHS Trust	Agreed Services Contract 1516	CCG responsibility
Reablement pilots and Corben	1,200	PCC P Sheth	PCC G Whiteman	PCC & range of third sector providers	Agreed Services Contracts 1516 (Schedule 1)	PCC and CCG responsibility
Scheme 4: Prevention - no Pooled Fund or Non Pooled Funds						
Scheme 5: Miscellaneous						
Carers grant (existing CCG)	400	CCG P Sheth	PCC G Whiteman	In-house provision	Funding to PCC for in house delivery of service	PCC and CCG responsibility
DFG	645	PCC B Lomax	PCC N Haverly	PCC acting as agent on behalf of DFG	Agreed Services Contract 1516 through PCC Housing	PCC

Funding element	Budget £000's	Lead commissioner - organisation and contact	Lead finance - organisation and contact	Contracting arrangements	Notes	Position on termination
				applicants	Services	responsibility
Social care capital	496	PCC R Watt	PCC G Whiteman	tbc	Funding confirmed, investment plan & project plan tbc by Partnership Board	PCC responsibility

For the purposes of this table PCC shall be read as referring to the Council

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

A. where either party is to act as Lead Commissioner

1 It is intended that each Partner shall contract for the Services in accordance with all applicable law, including but not limited to the EU procurement rules, the Public Contracts Regulations 2015 and where applicable the National Health Service (Procurement, Patient Choice and Competition) No. 2 Regulations 2013 or any subsequent regulations, communications or guidance.

2 Where appropriate and in order to commission the Services, the Council shall utilise other NHS procurement services commissioned by the CCG, such as the commissioning support unit to contract on their behalf. In these cases the Council shall ensure that the procurement service provided by the third party complies with this Agreement and all applicable law more fully described in paragraph 1 above.

3 Subject to applicable law, each Partner shall procure the Services in accordance with its own standing orders (as may be revised from time to time) ensuring through competitive tendering, wherever possible, that best value for money is obtained.

4 It is accepted that, in appropriate circumstances (such as where there is only one specialist provider and no alternative or a short term pilot project, or any other grounds that fit within the EU procurement rules or the Public Contracts Regulations 2015), it may be appropriate to negotiate contracts with the providers on a single tender basis, provided any decision to negotiate contracts is made in accordance with the current public procurement rules and the Partner's current standing orders.

B. Where the CCG is to act as Lead Commissioner:

Terminology used in this Schedule 4 Part 1 section B 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 Partner if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

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

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report;

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

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Services Contract permits, raise issues reasonably requested by a Partner at those meetings. Such consultation may be at an operational level rather than through the Partnership Board.

4 The Lead Commissioner shall not materially:

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

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

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

4.4 give any approvals under the Services Contract;

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

4.6 suspend all or part of the Services;

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

4.8 serve any notice;

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

without the prior approval of the other Partner (acting through the Partnership Board) such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partner 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 Partner as part of that process.

6 The Lead Commissioner shall notify the other Partner 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 Services Contract (including audit reports)

C. Where the Council is to act as Lead Commissioner:

Terminology used in this Schedule 4 Part 1 section C shall have the meaning attributed to it in the Council's standard contractual terms of business as in place from time to time, save where this Agreement or the context requires otherwise.

8 The Lead Commissioner shall notify the other Partner if it receives or serves:

8.1 a change in control notice;

8.2 a Notice of a Force Majeure Event;

8.3 a Default Notice;

and provide copies of the same.

9 The Lead Commissioner shall provide the other Partner with copies of any and all:

9.1 monthly activity/contractual reports;

9.2 remedial action/rectification plans;

10 The Lead Commissioner shall consult with the other Partner before attending:

10.1 Contract Management Meeting;

10.2 Review Meeting;

and, to the extent the Contract permits, raise issues reasonably requested by a Partner at those meetings. Such consultation may be at an operational level rather than through the Partnership Board.

11 The Lead Commissioner shall not materially:

11.1 permanently or temporarily withhold or retain monies pursuant to the payment provisions;

11.2 vary any Provider delivery plan;

11.3 agree (or vary) the terms of an investigation or an action/remediation/rectification plan;

11.4 give any approvals under the Services Contract;

11.5 agree to or propose any variation to the Services Contract (including any Schedule or Appendices);

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11.9 agree (or vary) the terms of a succession plan;

without the prior approval of the other Partner (acting through the Partnership Board) such approval not to be unreasonably withheld or delayed.

12 The Lead Commissioner shall advise the other Partner 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 Partner as part of that process.

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14 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Services 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 or Council's standard contractual terms 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 Services Contract;

1.2 comply with its obligations pursuant to a Services 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 Services 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 Services 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 ARRANGEMENTS

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Indicative 2015/16 financial impact of NEL deflected activity:

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(a) Council

Scheme	Service	Target
Scheme 1 - Integrated localities	Adult Social Care fieldwork (existing)	ASCOF measures aim of equal to or improvement against previous year, in particular: - Social care related quality of life - People receiving self directed support - People receiving direct payments - Older people receiving reablement services after leaving hospital Measure in relation to application of Care Act to be confirmed
Scheme 1 - Integrated localities	Early intervention social care services(new investment)	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Implementation of care act (new CCG investment)	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Additional investment in domiciliary care	See ASCOF measures above
Scheme 2 - Bed Based Review	Linked reporting: Bed provision at Longdean	Length of stay, occupancy levels, readmission rates, discharge destination, service user satisfaction
Scheme 3 - Reablement	PRRT ASC funded element (existing)	
Scheme 3 - Reablement	Additional investment in PRRT	To be confirmed through Partnership Board
Scheme 3 - Reablement	Reablement pilots and Corben	Reablement pilots: individual outcomes measures per scheme mapped to ASCOF and NHSOF. Including in particular - Support following admission/avoiding admissions - Independence and wellbeing - Support at end of life - Managing a long term

		condition Corben: Length of stay, occupancy levels, readmission rates, discharge destination, service user satisfaction
Scheme 4 - Prevention	Ongoing PH work	To be confirmed through Partnership Board
Scheme 5 - Other	Carers grant	See attached Carers Measures.xlsx
Scheme 5 - Other	DFG	See attached DFG measures.doc DFG measures 2.xls
Scheme 5 - Other	Social care capital	To be confirmed through Partnership Board

(b) CCG

Scheme	Service	Target
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Scheme 1 - Integrated localities	Expanding care co-ordination	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Access to Primary Care	To be confirmed through Partnership Board
Scheme 1 - Integrated localities	Capacity building fund for the VCS	To be confirmed through Partnership Board
Scheme 2 - Bed Based Review	Linked reporting: Bed provision at Jubilee, Spinnaker, Limes	Length of stay, occupancy levels, readmission rates, discharge destination, service user satisfaction
Scheme 3 - Reablement	PRRT Solent funded element (existing)	See attached PRRT measures.docx
Scheme 3 - Reablement	Additional investment in PRRT	To be confirmed through Partnership Board

SCHEDULE 6 – BETTER CARE FUND PLAN


Ports BCF submission - Final 1909.docx


Portsmouth City BCF submission template 1


Portsmouth City BCF submission template 2

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLCITS OF INTEREST

Each of the Parties has their own internal policy for the management of conflicts of interest within their organisation as set out in the respective constitutions and standing orders.

Conflicts of interest in relation to the development of partnership models will be dealt with in accordance with the terms of reference of each of the respective governance bodies and the terms of reference of the Partnership Board and Health and Well Being Board.

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

A protocol is in place in relation to information sharing across the Hampshire region - a copy of which is embedded below and which shall be applied to this Agreement and the delivery of the Better care Fund Plan.

Information Sharing
Protocol 26-03-2012