Dated 2019

THE MAYOR AND COMMONALTY AND CITIZENS OF THE CITY OF LONDON

and

NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP

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

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THIS AGREEMENT is made on day of 2019

PARTIES

(1) **THE MAYOR AND COMMONALTY AND CITIZENS OF THE CITY OF LONDON** a corporation by prescription of Guildhall, PO Box 270, London EC2P 2EJ (the **"City"**)

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

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

BACKGROUND

(A) The City, exercising its relevant local authority functions, has responsibility for commissioning and may provide social care services on behalf of the population of the City of London.

(B) The CCG has the responsibility for commissioning health services pursuant to the National Health Service Act 2006 in the City of London.

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

(D) This Agreement also sets out the arrangements for the Better Care Fund, which supports the integration of health and social care and to seek to achieve the National Conditions and local objectives. It is a requirement of the Better Care Fund that the Parties pool those funds in accordance with Section 75 of the 2006 Act. The pooled fund established for the purposes of this Agreement is broader than the Better Care Fund, and the requirements of the Better Care Fund plan (in terms of reporting, for example), shall only apply to the Better Care Fund element of the pooled fund.

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

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

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

(i) meet the National Conditions and local objectives;

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

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

(iv) help people take control of their lives and communities and ensure children, young

people and adults are safe and confident in their lives and communities and that people are treated with dignity and respect; and

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

(H) The Parties are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act, to the extent that exercise of these powers is required for this Agreement, and all other enabling powers.

1. DEFINED TERMS AND INTERPRETATION

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

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2012 Act means the Health and Social Care Act 2012.

Affected Party means, in the context of Clause 28, the Party whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

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

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

Annual Review has the meaning set out in clause 24.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) which is a trade secret.

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

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

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

Data Protection Officer means the individual named in Clause 31 (Information Sharing and Data Protection) of this Agreement.

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

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

DP Legislation means all applicable data protection and privacy legislation, regulations and guidance including: (i) Regulation (EU) 2016/679 (or, in the event that the UK leaves the European Union, all applicable legislation enacted in the UK in respect of the protection of Personal Data) (the **"General Data Protection Regulation"** or **"GDPR"**) and the Privacy and Electronic Communications (EC Directive) Regulations 2003; and (ii) the Data Protection Act 2018;

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

Expiry Date means 23.59 hours on 31 March 2020.

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

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

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

Force Majeure Event means one or more of the following:

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

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

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

(h) any other event,

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

Functions means the NHS Functions and the Health Related Functions.

Health Related Functions means those of the health related functions of the City specified in Regulation 6 of the Regulations from time to time as are relevant to the commissioning of the Services and which may be further described in the relevant Commissioning Plans, Service Specifications, Better Care Fund Plan and/or Scheme Specifications.

Host Partner means the Party that will host and provide the financial administrative systems for the Pooled Fund and undertake to perform the duties for which they will be responsible, as set out in paragraph 7(4) and 7(5) of the Regulations**.** The Parties have agreed that the Host Partner for the purposes of this Agreement shall be the City.

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

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

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

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

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

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

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

Law means:

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

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

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

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

Lead Commissioning Arrangements means the arrangements by which one Party commissions Services in relation to an Integrated Commissioning Strategy or Commissioning Plan on behalf of the other Party in exercise of both the NHS Functions and the Health Related Functions.

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

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

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

Month means a calendar month.

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

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

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

Non-Recurrent Payments means funding provided by a Party to the Integrated Commissioning Fund in addition to the Budget Contributions pursuant to arrangements agreed in accordance with Clause 10.2.

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

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

Performance Payments means any sum over and above the relevant Contract Price

which is payable to the Provider in accordance with a Performance Payment Arrangement.

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

Permitted Expenditure has the meaning given in Clause 7.2.

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

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

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

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

1 April to 30 June;

1 July to 30 September;

1 October to 31 December;

1 January to 31 March,

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

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

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

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

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

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

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

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

SVP means the City's Social Value Panel set up and established by the City to use to maximise social value outputs from the City's Services Contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. TERM

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

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

3. GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 For the avoidance of doubt, in the performance of this Agreement, the Parties agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

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

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

4. PARTNERSHIP FLEXIBILITIES

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

4.1.1 Integrated Commissioning;

4.1.2 Lead Commissioning Arrangements;

4.1.3 Aligned Commissioning;

4.1.4 the establishment of one or more Pooled Fund;

in relation to the Services (the "**Flexibilities**").

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

4.4 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to this Agreement and the Parties

shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5. FUNCTIONS

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

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

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

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

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

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

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

6. COMMISSIONING ARRANGEMENTS

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

6.2 Each Party shall be responsible for compliance with and making payments of all sums due from them to a Provider pursuant to the terms of a Services Contract.

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

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

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

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

Appointment and Role of a Lead Commissioner

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

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

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

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

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

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

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

6.7.7 undertake performance management and contract monitoring of all Services Contracts;

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

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

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

7. ESTABLISHMENT OF THE POOLED FUND

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

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

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

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

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

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

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

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

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

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

8. POOLED FUND MANAGEMENT

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

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

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

8.2.2 preparing and submitting to the Integrated Commissioning Board bi-monthly reports (or more frequent reports if required by the Integrated Commissioning Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Parties and the Integrated Commissioning Board to monitor the effectiveness of the Pooled Fund and to enable the Parties to complete their own financial accounts and returns; and

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

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

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

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

8.6 The Integrated Commissioning Board may agree to the viring of funds within the Pooled Fund (subject to any specific requirements of the Financial Framework).

9. ALIGNED FUNDS

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

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

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

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

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

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

10. BUDGET CONTRIBUTIONS

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

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

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

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

Non-financial contributions

10.5 Both Parties shall review non-financial contributions toward the Integrated Commissioning Fund including staff, premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services Contracts and the Pooled Fund) as part of the annual review.

11. CHARGING FOR SERVICES

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

11.2 All charges will be collected by the City.

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

11.4 Decisions about the charging policies to be adopted will rest with the City. Changes of policy will be reported to the Integrated Commissioning Board. The City will ensure that written operational policies exist which provide staff with clear guidance on which services are charged for and which are non-chargeable.

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

12. RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

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

Overspends in Pooled Funds

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

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

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

Overspends in Aligned Funds

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

Risk share arrangements

12.6 The Parties have agreed risk share arrangements which provide for financial risks arising within the commissioning of services from the Pooled Fund and an Aligned Fund; and the financial risk to the pool arising from any payment for performance element of the Better Care Fund.

12.7 If the Integrated Commissioning Fund records an Overspend or underspend in any year, the balance of Overspend is recorded in the Party that holds the statutory responsibility for the function or budget which incurred the Overspend or underspend. The mechanisms for sharing risk and reward are set out in further detail in the Financial Framework.

12.8 Unless the Parties agree to the contrary, where:

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

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

12.8.3 any Overspend is met from the CCG Contingency Funds

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

13. INFORMATION FRAMEWORK

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

14. PREMISES

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

15. PRE-EXISTING CONTRACTS

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

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

16. GOVERNANCE AND PERFORMANCE MANAGEMENT

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

17. CAPITAL EXPENDITURE

17.1 Neither Pooled Funds nor Aligned Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Parties. If a need for capital expenditure is identified this must be agreed by the Parties and the capital expenditure must comply with any applicable grant conditions.

18. VAT

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

18.2 The Parties shall agree that for the treatment of the Pooled Fund for VAT purposes:

18.2.1 The City will be the Host Partner and will hold and administer the Pooled Funds;

18.2.2 The City will be the Lead Commissioner for the Services set out in Schedule 1, Table 1;

18.2.3 The CCG will be the Lead Commissioner for the Services set out in Schedule 1, Table 2;

18.2.4 The City will commission services for which it is the Lead Commissioner and recover VAT according to the local authority VAT regime (full recovery);

18.2.5 The CCG will commission services for which it is the Lead Commissioner and recover VAT according to the NHS VAT regime (limited VAT recovery);

18.3 Any funds passing between the Parties under this Agreement do not represent consideration for a supply of services and shall be outside the scope of VAT.

18.4 The City shall reserve the right to review its VAT position at the Annual Review referred to in clause 24 of this Agreement, or earlier if so determined by the City (acting reasonably).

19. AUDIT AND RIGHT OF ACCESS

19.1 Both Parties shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the Pooled Fund in accordance with the Regulations and section 7 of the Local Audit and Accountability Act 2014.

19.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access by them to any document, information or explanation they require from any employee or member of the Party in order to carry out their duties. This right is not limited to

financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

20. LIABILITIES AND INSURANCE AND INDEMNITY

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

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

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

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

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

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

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

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

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

21. STANDARDS OF CONDUCT AND SERVICE

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

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

21.3 The City reserves the right to consult the City's SVP in the pre-procurement phase of any Services Contracts over the OJEU threshold, which the City may commission as Lead

Commissioner under this Agreement, regardless of whether the Service includes both NHS Functions and Health Related Functions;

21.4 The Parties acknowledge and accept that:

21.4.1 The City's SVP, where used, will make recommendations only to consider in respect of social value considerations for Services Contracts;

21.4.2 The City's SVP is not a decision making body;

21.4.3 The City is not bound to accept any of the recommendations made by the City's SVP in respect of the Services Contracts being procured by the City. Any recommendations made by the SVP which are not implemented will be reported back to the SVP by the City; and

21.4.4 Where the CCG act as Lead Commissioner for any Services Contracts over the OJEU threshold which are commissioned by the CCG under this Agreement, then the CCG may, subject to the City's agreement, use the City's SVP to consider social value issues relevant to the Services Contracts.

21.5 All members of the SVP and any other attendees who are not employed directly by the City are required to sign a Non -Disclosure Agreement ensuring that they do not disclose confidential information to third parties or for any other purpose other than that for which they are specifically engaged by the City.

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

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

22. CONFLICTS OF INTEREST

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

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

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

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

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

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

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

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

23. GOVERNANCE

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

23.2 Overall strategic oversight of the development of Integrated Commissioning is vested in the City and may be delegated to its appropriate Committees and the CCG's Governing Body, which shall remain the statutory decision making bodies.

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

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

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

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

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

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

23.9 The Integrated Commissioning Board shall be responsible for making decisions relating to the Pooled Fund where necessary, in accordance with the relevant standing financial instructions and schemes of delegation. The Integrated Commissioning Board shall be responsible for making recommendations to the CCG's Governing Body or the City's appropriate committee, where necessary, in relation to an Aligned Fund.

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

24. REVIEW

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

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

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

25. COMPLAINTS

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

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

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

26. TERMINATION

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

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

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

26.4 Expiry or termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Parties' rights in respect of any antecedent breach and the provisions of Clauses 18.4, 20 and 29.

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

26.5.1 the Parties agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Parties is carried out smoothly and with as little disruption as possible to service users, employees, the Parties and third parties, so as to minimise costs and liabilities of each Party in doing so, and shall each commit sufficient resource to implement the Exit Plan;

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

26.5.3 the Lead Commissioner shall make reasonable endeavors 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 Party requests the same in writing, provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Parties shall have agreed in advance who shall be responsible for any such payment;

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

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

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

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

27. DISPUTE RESOLUTION

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

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

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

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

27.2 This dispute resolution process shall operate as follows:

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

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

27.2.3 To initiate mediation a Party shall:

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

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

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

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

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

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

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

27.2.6.3 the seat of the arbitration shall be London;

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

27.2.6.5 the language of the arbitration shall be English.

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

28. FORCE MAJEURE

28.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Party, or incur any liability to the other Party for any losses or damages incurred by that Party, to the extent that a Force Majeure Event occurs and the Parties agree that such affected Party is / has been prevented from carrying out its obligations by that Force Majeure Event.

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

28.3 As soon as practicable, following notification as detailed in Clause 28.2, the Parties shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 28.4, facilitate the continued performance of the Agreement.

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

29. CONFIDENTIALITY

29.1 In respect of any Confidential Information a Party receives from another Party (the "**Discloser**") and subject always to the remainder of this Clause 29, each Party (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

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

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

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

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

29.2 Nothing in this Clause 29 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

29.3 Each Party:

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

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

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

30. FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

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

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

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

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

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

31. INFORMATION SHARING AND DATA PROTECTION

31.1 Subject to the following provisions of this Clause 31, Clause 29 (Confidentiality) and Cause 30 (Freedom of Information and Environmental Information Regulations), the Parties shall work together to establish effective arrangements to permit and control the exchange of information to support the Integrated Commissioning arrangements.

31.2 In all instances where the Parties share information with each other under this Agreement, and in the functioning of the ICB, the Parties will adhere to the relevant policies and information governance protocols of each Party. In doing so, the Parties will ensure that the operation of this Agreement complies with Law, in particular the DP Legislation and the provisions set out in this Clause 31.

31.3 Where Personal Data and Special Categories of Personal Data are disclosed by one Party to the other for the purposes of this Agreement, and it is necessary that the receiving Party will process that Personal Data and Special Categories of Personal Data to comply with its own statutory duties, and in doing so shall determine the purposes for which and the manner in which any such Personal Data and Special Categories of Personal Data will be Processed the receiving Party shall become a Data Controller (acting separately to the disclosing Party rather than jointly) of the Personal Data and Special Categories of Personal Data disclosed to them.

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

31.4.1 The Data Controller for the City's Personal Data and Special Categories of Personal Data shall be the City; and

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

31.4.3 The Data Protection Officer for the City is Michael Cogher, the City's Comptroller and City Solicitor.

31.4.4 The Data Protection Officer for the CCG is Keith James,

and each Party shall comply with its obligations as a Data Controller under the DP Legislation.

31.5 Where Personal Data is disclosed by one Party (the "**Disclosing Party**") to the other Party (the "**Receiving Party**") for the purposes of this Agreement, and the Disclosing Party alone continues to determine the purposes for which, and the manner in which any such Personal Data will be Processed by the Receiving Party, the Disclosing Party will remain the Data Controller of that Personal Data, and the Receiving Party will be a Data Processor.

31.6 Where a Party acts as Data Processor and processes Personal Data under or in connection with this Agreement and on behalf of the Data Controller, that Party warrants and undertakes that it will, in particular, but without limitation:

31.6.1 only Process Personal Data in accordance with the instructions of the Disclosing Party as set out in Schedule 8 (Data Processing Activities) of this Agreement;

31.6.2 only engage a third party to Process Personal Data on its behalf with the prior written consent of the Disclosing Party, and upon securing that third party will be subject to obligations no less onerous than those set out in this Clause 31;

31.6.3 not cause or allow Personal Data to be transferred outside of the European Economic Area;

31.6.4 assist and fully co-operate with the Disclosing Party as requested by the Disclosing Party from time to time to ensure the Parties are compliant with their respective obligations under the DP Legislation which shall include, but not be limited to:

31.6.4.1 completing and reviewing data protection impact assessments;

31.6.4.2 implementing any measures to mitigate any data protection risks;

31.6.4.3 implementing such technical and organisational measures to enable the Disclosing Party to respond to requests from Data Subjects exercising their rights under the DP Legislation;

31.6.4.4 allowing the Disclosing Party and its advisors to inspect and make copies of the records required under this Clause 31, and otherwise making available such information as the Disclosing Party requires to demonstrate compliance with this Clause 31 and the DP Legislation;

31.6.4.5 allowing access to the Receiving Party's premises on reasonable notice and providing all reasonable assistance to the Disclosing Party to enable the Disclosing Party to audit the Receiving Party's compliance with security measures,

31.6.5 take all necessary technical and organisational precautions and measures to preserve the confidentiality and integrity of Personal Data and prevent any unlawful processing or disclosure, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects. These shall include; but not be limited to:-

31.6.5.1 encrypting any Personal Data stored on any mobile media or transmitted over public or wireless networks;

31.6.5.2 only transferring Personal Data if essential, having regard to the purpose of which the transfer is conducted;

31.6.5.3 processing Personal Data relating to criminal allegations, proceedings or convictions strictly in accordance with the DP Legislation;

31.6.5.4 implementing and maintaining business continuity, disaster recovery and other relevant policies and procedures to ensure:

31.6.5.4.1 the confidentiality, integrity, availability and resilience of processing systems and services; and

31.6.5.4.2 the availability and access to Personal Data in a timely manner in the event of a physical or technical incident,

31.6.6 ensure the reliability of staff who will have access to Personal Data, and ensure that all employees and contractors who are involved in the Processing of Personal Data are trained in the policies and procedures set out in this Clause 31 are under contractual or statutory obligations of confidentiality concerning Personal Data;

31.6.7 maintain accurate written records of the Processing it undertakes in connection with this Agreement, including details regarding the categories of Processing carried out on behalf of the Disclosing Party and an accurate record of the security measures it has in place; and

31.6.8 pseudonymise Personal Data if requested to do so by the Disclosing Party.

31.7 The measures referred to in Clause 31.6 shall be regularly tested by the Receiving Party to assess the effectiveness of the measures in ensuring the security, confidentiality, integrity, availability and resilience of Personal Data and the Receiving Party shall maintain records of such testing.

31.8 Each Party shall assist the other in complying with all applicable requirements of the DP Legislation. In particular the Receiving Party shall:

31.8.1 promptly (but in any event within 24 hours) notify the Disclosing Party

31.8.1.1 should it be under a legal obligation to process the Personal Data, other than under the instructions of the Disclosing Party, in which case it shall inform the Disclosing Party of the legal obligation, unless the Law prohibits such information being shared on important grounds of public interest;

31.8.1.2 become aware that in following the instructions of the Disclosing Party, it shall be breaching the DP Legislation;

31.8.1.3 receive notice of any complaint made to a Regulatory Authority or any finding by a Regulatory Authority in relation to its Processing of Personal Data; and/or

31.8.1.4 receives any request on behalf of a Data Subject exercising their rights Personal Data breach under the DP Legislation.

31.9 The Receiving Party shall notify the Disclosing Party promptly (and in any event no later than 24 hours of discovery) if it becomes aware of any information security breaches or near misses, or potential, actual, suspected or threatened unauthorised exposure, access, disclosure, Processing, use, communication, deletion, revision, encryption, reproduction or transmission of any component of the Personal Data, unauthorised access or attempted access or apparent attempted access (physical or otherwise) to the Personal Data or any loss of, damage to, corruption of or destruction of such Personal Data.

31.10 Where a notification is required under Clause 31.9, the Receiving Party shall confirm the nature of the breach, including the categories and approximate number of Data Subjects and records concerned and the remediation measures being taken to mitigate and contain the breach.

31.11 In the event of a Personal Data breach, the Disclosing Party shall at its sole discretion determine whether to provide notification to the Data Subject, any third party or Regulatory Authority and the Receiving Party shall not notify the Data Subject, any third party or Regulatory Authority unless such disclosure by the Receiving Party is required by Law or is otherwise approved by the Disclosing Party. The Disclosing Party shall approve all notifications to Data Subjects, third parties or any Regulatory Authority which it determines are required or appropriate.

31.12 Unless required by Law, the Receiving Party shall, upon termination or earlier expiry of the Agreement for whatever reason, at the option of the Disclosing Party, either securely delete or return all Personal Data to the Disclosing Party. If the Receiving Party is required by Law or any Regulatory Authority to retain a copy of the Personal Data Processed, the Receiving Party shall inform the Disclosing Party what it is retaining and the legal reason as why it needs to be retained.

32. OMBUDSMEN

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

33. PARTIES/NOTICES

33.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Party shall be as set out in Clause 33.3 or such other address as each Party may previously have notified to the other Party in writing. A notice shall be deemed to have been served if:

33.1.1 personally delivered, at the time of delivery;

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

33.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has

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

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

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

33.3.1 if to the City, addressed to:

City Comptroller, Guildhall, PO Box 270, London EC2P 2EJ; and

33.3.2 if to the CCG, addressed to:

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

34. VARIATION

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

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

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

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

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

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

35. CHANGE IN LAW

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

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

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

36. WAIVER

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

37. SEVERANCE

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

38. ASSIGNMENT AND SUB CONTRACTING

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

39. EXCLUSION OF PARTNERSHIP AND AGENCY

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

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

39.2.1 act as an agent of the other;

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

39.2.3 bind the other in any way.

40. THIRD PARTY RIGHTS

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

41. ENTIRE AGREEMENT

41.1 The terms herein contained together with the contents of the Schedules, including the Financial Framework and the Information Framework, constitute the complete agreement between the Parties with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Party.

42. COUNTERPARTS

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

43. GOVERNING LAW AND JURISDICTION

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

43.2 Subject to Clause 27 (Dispute Resolution), the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed as a Deed by the Parties on the date of this Agreement

Executed as a Deed by affixing the common seal of **THE MAYOR AND COMMONALTY AND CITIZENS OF THE CITY OF LONDON**

in the presence of:

……
Authorised Signatory

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

……

Paul Haigh
Chief Officer

in the presence of:

……..

Name:

Address:

Occupation:

SCHEDULE 1 – INTEGRATED COMMISSIONING STRATEGIES & BUDGET CONTRIBUTIONS

PART ONE – INTEGRATED COMMISSIONING STRATEGIES

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

- Children, Young people & Maternity
- Planned care
- Prevention
- Unplanned care

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

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

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

- Better Care Fund (BCF) services

PART TWO – BUDGET CONTRIBUTIONS

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

City of London Corporation + City and Hackney CCG ICB

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

Fund type: Pooled Vs Aligned	CCG £'000	CoL £'000	TOTAL £'000
A. S75 'Pooled' Budgets			
1. Unplanned Care			
-BCF	383	-	383
-IIT		-	0
-IBCF		65	65
-Learning Disabilities			0
	383	65	448
2. Planned Care			
-BCF *(LA figs is funding from DGF Capital)*	167	85	252
-Learning Disabilities			0
-iBCF Local Authority allocation*			0
-Winter Pressures Local Authority allocation			0
3. Prevention			
-BCF	51	-	51
4. iBCF (Unplanned Care)			
-iBCF Local Authority allocation		265	
Total Contribution into **'Pooled'** budgets	601	415	1,016
B. 'Aligned' Budgets			
Aligned - Planned Care**	5,944	4,368	10,312
Aligned - Unplanned Care	3,567	29	3,596
Aligned - Children/Young people	1,533	1,532	3,065
Aligned - Prevention	106	1,507	1,613
Aligned - Corporate***	874		874
Total Contribution into **'Aligned'** budgets	12,023	7,436	19,459
Total Contrib into **'Integrated Comm Fund (ICF**	12,623	7,851	20,474
For Information Only			
In Collaboration - CCG Core Primary Care			1,485
			21,960

Note:

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

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

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

Table 2: Workstream service listing for CoL & CCG

Organisation	Updated workstream	Flag	Workstream	Scheme/Service	Provider	Proge Board/ Service Type	Budget Amount 19/20	LBH Split	CoI Split	Directly Delivered?
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	CoL-Bryning Day Unit/Falls Prevention	Homerton Acute	Integrated Care	14,396		14,396	N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	CoL-Homerton CHS -Adult Community Nursing	Homerton University Hospital NHS Foundation Trust	Integrated Care	242,381		242,381	N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	CoL-Neighbourhood Care Model	CoL	Integrated Care	41,528		41,528	N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	CoL-Paradoc	CHUHSE	Urgent Care / Integrated Care	19,005		19,005	N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	CoL-Reablement Plus	CoL	Integrated Care	66,164		66,164	N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Bryning Day unit/Falls Prevention	Homerton Acute	Integrated Care	438,288	438,288		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Bryning Day unit/Falls Prevention (2)	Homerton Acute	Integrated Care	927	927		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Community equipment and adaptations	LBH	Integrated Care	1,098,039	1,098,039		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-End of Life - St Joseph's Hospice Hackney	St. Joseph's Hospice	Integrated Care	2,466,230	2,466,230		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Homerton CHS -Adult Community Nursing	Homerton University Hospital NHS Foundation Trust	Integrated Care	4,592,927	4,592,927		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Integrated Independence Team (IIT)	LBH	Integrated Care	3,789,472	3,789,472		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-LA bed based interim beds	LBH	Integrated Care	369,532	369,532		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Maintaining eligibility criteria	LBH	Integrated Care	2,963,649	2,963,649		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Neighbourhood Care Model	LBH	Integrated Care	1,296,531	1,296,531		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Paradoc	CHUHSE	Urgent Care / Integrated Care	614,824	614,824		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Services to support carers	LBH	Integrated Care	741,176	741,176		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Targeted preventative services	LBH	Integrated Care	409,653	409,653		N/A
CCG	Pooled - Unplanned Care	BCF	**Unplanned Care**	LBH-Telecare	LBH	Integrated Care	271,343	271,343		N/A
CCG	Pooled - Planned Care	BCF	**Planned Care**	CoL-Adult Cardiorespiratory Enhanced + Responsive Service (ACERS)	Homerton Acute	Long Term Conditions / Integrated Care	20,842		20,842	N/A
CCG	Pooled - Planned Care	BCF	**Planned Care**	CoL-Asthma	Homerton Acute	Long Term Conditions / Integrated Care	3,168		3,168	N/A
CCG	Pooled - Planned Care	BCF	**Planned Care**	CoL-Care Navigator Service	CoL	Integrated Care	61,074		61,074	N/A
CCG	Pooled - Planned Care	BCF	**Planned Care**	CoL-Mental health reablement & floating support worker	CoL	Mental Health / Integrated Care	81,432		81,432	N/A
CCG	Pooled - Planned Care	BCF	**Planned Care**	LBH-Adult Cardiorespiratory Enhanced + Responsive Service (ACERS)	Homerton Acute	Long Term Conditions / Integrated Care	598,881	598,881		N/A
CCG	Pooled - Planned Care	BCF	**Planned Care**	LBH-Adult Cardiorespiratory Enhanced + Responsive Service (ACERS) (2)	Homerton Acute	Long Term Conditions / Integrated Care	74,998	74,998		N/A

CCG	Pooled - Planned Care	BCF	**Planned Care**	LBH-Asthma	Homerton Acute	Long Term Conditions / Integrated Care	73,907	73,907		N/A
CCG	Pooled - Prevention	BCF	**Prevention**	CoL-Carers' support	CoL	Integrated Care	50,895		50,895	N/A
CCG	Pooled - Planned Care	Learning Difficulties	**Planned Care**	Learning Difficulties & Autism (S75 with LB Hackney)	London Borough of Hackney	Long Term Conditions	1,513,323	1,513,323		N/A
CCG	Pooled - Planned Care	Learning Difficulties	**Planned Care**	Learning Difficulties & Autism (S75 with LB Hackney) (2)	London Borough of Hackney	Long Term Conditions	3,993,035	3,993,035		N/A
CCG	Pooled - Planned Care	Learning Difficulties	**Planned Care**	Learning Difficulties & Autism (S75 with LB Hackney) (3)	London Borough of Hackney	Long Term Conditions	556,988	556,988		N/A
CCG	Aligned Children/Young people		**Children/Young people**	Barts Health Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	Barts and the London NHS Trust	Planned Care	2,026,415	1,965,623	60,792	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Barts Health Hospital NHS FT Children & YP over / under performance	Barts and the London NHS Trust	Planned Care	250,593	243,075	7,518	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CAMHS	East London NHS Foundation Trust	Mental Health	4,352,555	4,221,978	130,577	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CAMHS Transformation Fund	East London NHS Foundation Trust (Fund holder) - CAMHS Transformation Fund	Mental Health	386,569	374,972	11,597	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC – Children's PHB	Various	Childrens	789,095	765,422	23,673	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Childrens Equipment	TBC	Childrens	44,193	42,868	1,326	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Complex Care Spot Purchase (Assesment, Reviews and Training services)	Homerton	Childrens	107,324	104,105	3,220	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Nurse Posts	Homerton	Childrens	140,620	136,401	4,219	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHC - Spot Purchase Complex Care Packages	Various	Childrens	289,634	280,945	8,689	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Childhood Immunisation	GP Confederation	Childrens	115,148	111,694	3,454	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Childrens ASD	Homerton University Hospital NHS Foundation Trust - Childrens ASD	Mental Health	47,423	46,000	1,423	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHS - Barts (Paediatric Audiology Contract)	Barts and the London NHS Trust	Childrens	477,256	462,938	14,318	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Community Services Short Breaks Kids Sunday Club	KIDS	Childrens	41,342	40,101	1,240	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Early Years - Maternity service (Antenatal and Postnatal Care)	GP Confederation	Maternity	337,052	326,941	10,112	N/A

CCG	Aligned Children/Young people		**Children/Young people**	Early Years Contract: Vulnerable Children - Non Recurrent	GP Confederation	Maternity	272,000	263,840	8,160	N/A
CCG	Aligned Children/Young people		**Children/Young people**	GP Confed - LTC Elements of Vulnerable Children's Contract	GP Confederation	Childrens	104,130	101,006	3,124	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Great Ormond Street Hospital (GOSH) Acute Contract	Great Ormond Street Hospital	Childrens	473,176	458,981	14,195	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Great Ormond Street Hospital (GOSH) Acute Contract over / under performance	Great Ormond Street Hospital	Planned Care	(40,543)	(39,327)	-1,216	N/A
CCG	Aligned Children/Young people		**Children/Young people**	GUYS & ST THMAS Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	514,605	499,166	15,438	N/A
CCG	Aligned Children/Young people		**Children/Young people**	GUYS & ST THMAS Hospital NHS FT Children & YP over / under performance	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	304,544	295,407	9,136	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Hearline	Hearline Ltd	Childrens	44,984	43,635	1,350	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - CAMHS	Homerton University Hospital NHS Foundation Trust	Childrens / Mental Health	486,975	472,366	14,609	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Child Incontinence	Homerton University Hospital NHS Foundation Trust	Childrens	149,381	144,900	4,481	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Children's Autism Spectrum Disorder (ASD)	Homerton University Hospital NHS Foundation Trust	Mental Health	49,578	48,091	1,487	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens Community Nursing Team (Incl HV)	Homerton University Hospital NHS Foundation Trust	Childrens	747,882	725,445	22,436	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens Community Nursing Team (Incl HV) (2)	Homerton University Hospital NHS Foundation Trust	Childrens	127,484	123,659	3,825	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens Specialist Nursing	Homerton University Hospital NHS Foundation Trust	Childrens	279,239	270,862	8,377	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Childrens transition service (Hackney Ark)	Homerton University Hospital NHS Foundation Trust	Childrens	298,960	289,991	8,969	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Community Paediatrics	Homerton University Hospital NHS Foundation Trust	Childrens	2,112,121	2,048,757	63,364	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - First Steps	Homerton University Hospital NHS Foundation Trust	Mental Health	1,150,018	1,115,517	34,501	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Hackney Ark Children's Service	Homerton University Hospital NHS Foundation Trust	Childrens	657,108	637,394	19,713	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Key Working Childrens disabilities	Homerton University Hospital NHS Foundation Trust	Childrens	302,734	293,652	9,082	N/A

CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - MARAC Primary care liaison	Homerton University Hospital NHS Foundation Trust	Childrens	58,392	56,640	1,752	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Occupational Therapy	Homerton University Hospital NHS Foundation Trust	Childrens	677,870	657,534	20,336	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Physiotherapy	Homerton University Hospital NHS Foundation Trust	Childrens	821,982	797,322	24,659	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Safeguarding	Homerton University Hospital NHS Foundation Trust	Childrens	365,440	354,477	10,963	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Short Breaks	Homerton University Hospital NHS Foundation Trust	Childrens	96,229	93,342	2,887	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton CHS - Speech and Language Therapy	Homerton University Hospital NHS Foundation Trust	Childrens	1,432,173	1,389,208	42,965	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton University Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	Homerton University Hospital NHS Foundation Trust	Planned Care	20,925,996	20,298,216	627,780	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Homerton University Hospital NHS FT Children & YP over / under performance	Homerton University Hospital NHS Foundation Trust	Planned Care	305,113	295,960	9,153	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Huddleston Access Service (Short Breaks)	Huddlestone	Childrens	25,441	24,678	763	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Huddleston Centre - Children's Disability Forum [Carers Peer Support / Family Social Events]	Huddlestone	Childrens	30,052	29,150	902	N/A
CCG	Aligned Children/Young people		**Children/Young people**	IMP COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	Imperial College Healthcare NHS Trust	Planned Care	147,899	143,462	4,437	N/A
CCG	Aligned Children/Young people		**Children/Young people**	IMP COLLEGE Hospital NHS FT Children & YP over / under performance	Imperial College Healthcare NHS Trust	Planned Care	10,186	9,881	306	N/A
CCG	Aligned Children/Young people		**Children/Young people**	KINGS COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	Kings College Hospital NHS Foundation Trust	Planned Care	63,053	61,162	1,892	N/A
CCG	Aligned Children/Young people		**Children/Young people**	KINGS COLLEGE Hospital NHS FT Children & YP over / under performance	Kings College Hospital NHS Foundation Trust	Planned Care	45,811	44,437	1,374	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Looked after Children Nursing Service	London Borough of Hackney	Childrens	291,439	282,696	8,743	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Maternity Targeted Antenatal Classes - Voluntary Sector Providers	Birth Companions	Maternity	9,863	9,567	296	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Maternity Targeted Antenatal Classes - Voluntary Sector Providers (2)	Comet Children's Centre	Maternity	7,787	7,553	234	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Maternity Targeted Antenatal Classes - Voluntary Sector Providers (3)	Minik Kardes	Maternity	7,787	7,553	234	N/A

CCG	Aligned Children/Young people		**Children/Young people**	NORTH MID Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	North Middlesex University Hospital NHS Trust	Planned Care	444,240	430,913	13,327	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Online Counselling Support (Eating Disorders)	Youthnet (The Mix) - Eating Disorder	Mental Health	15,405	14,943	462	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Peri Natal Service	East London NHS Foundation Trust	Mental Health	342,418	332,146	10,273	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Perinatal MH Wave 2 Funding	East London NHS Foundation Trust	Mental Health	217,512	210,987	6,525	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Richard House Children's Hospice	Richard House	Childrens	107,775	104,541	3,233	N/A
CCG	Aligned Children/Young people		**Children/Young people**	ROYAL FREE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	Royal Free London NHS Foundation Trust	Planned Care	302,414	293,342	9,072	N/A
CCG	Aligned Children/Young people		**Children/Young people**	ROYAL FREE Hospital NHS FT Children & YP over / under performance	Royal Free London NHS Foundation Trust	Planned Care	25,923	25,145	778	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Safeguarding - contribution to adult safegurading board	London Borough of Hackney	Corporate	20,826	20,201	625	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Safeguarding - contribution to children's safeguarding board	London Borough of Hackney	Childrens	24,728	23,986	742	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Targeted antenatal classes	Homerton University Hospital NHS Foundation Trust	Maternity	5,500	5,335	165	N/A
CCG	Aligned Children/Young people		**Children/Young people**	UCLH Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	University College London NHS Foundation Trust	Planned Care	5,099,961	4,946,962	152,999	N/A
CCG	Aligned Children/Young people		**Children/Young people**	UCLH Hospital NHS FT Children & YP over / under performance	University College London NHS Foundation Trust	Planned Care	(68,427)	(66,374)	-2,053	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Whittington Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	Whittington Hospital NHS Trust	Planned Care	1,831,779	1,776,826	54,953	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Whittington Hospital NHS Children & YP over / under performance	Whittington Hospital NHS Trust	Planned Care	(108,367)	(105,116)	-3,251	N/A
CCG	Aligned Children/Young people		**Children/Young people**	Bump Buddies	Shoreditch Trust	Maternity	50,000	48,500	1,500	N/A
CCG	Aligned Children/Young people		**Children/Young people**	CHS - Older Peoples Reference Group (OPRG) - Age UK	Age UK	PPI	28,844	27,979	865	N/A
CCG	Aligned Prevention		**Prevention**	Long Term Conditions - core contract	GP Confederation	Long Term Conditions	2,670,378	2,590,267	80,111	N/A
CCG	Aligned Prevention		**Prevention**	Social prescribing - Family Action	Family Action	Long Term Conditions	203,054	196,962	6,092	N/A
CCG	Aligned Prevention		**Prevention**	Time to talk - extended consultation for LTC pts	GP Confederation	Long Term Conditions	647,689	628,258	19,431	N/A

CCG	Aligned - Planned Care		**Planned Care**	CAMHS Eating Disorders - ELFT	East London NHS Foundation Trust	Mental Health	63,476	61,572	1,904	N/A
CCG	Aligned - Planned Care		**Planned Care**	Core Arts (currently paid by innovation fund - NR)	East London NHS Foundation Trust	Mental Health	60,000	58,200	1,800	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP Primary Care/ADHD Step Down - CAMHS Alliance (ELFT)	East London NHS Foundation Trust	Mental Health	81,000	78,570	2,430	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP Primary Care/ADHD Step Down - GP Confed	GP Confederation	Mental Health	11,000	10,670	330	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP ASD Pathway Improvement - CAMHS Alliance (HUHT)	Homerton University Hospital NHS Foundation Trust	Mental Health	67,000	64,990	2,010	N/A
CCG	Aligned - Planned Care		**Planned Care**	CYP ELC Crisis Pathway - ELFT	East London NHS Foundation Trust	Mental Health	117,000	113,490	3,510	N/A
CCG	Aligned - Planned Care		**Planned Care**	Dementia Shared Care Plans - ELFT	East London NHS Foundation Trust	Mental Health	56,000	54,320	1,680	N/A
CCG	Aligned - Planned Care		**Planned Care**	Depression Reviews	GP Confederation	Mental Health	50,000	48,500	1,500	N/A
CCG	Aligned - Planned Care		**Planned Care**	HBPoS - ELFT	East London NHS Foundation Trust	Mental Health	325,012	315,262	9,750	N/A
CCG	Aligned - Planned Care		**Planned Care**	IAPT (trainee placements) - HUHT	Health Education England	Mental Health	423,220	410,523	12,697	N/A
CCG	Aligned - Planned Care		**Planned Care**	IAPT 18 - 25 and extension to the LTC IAPT service (HUHT) - PTWA	Mind (Fund Holder)	Mental Health	420,234	407,627	12,607	N/A
CCG	Aligned - Planned Care		**Planned Care**	Integrated Dementia Service (post QIPP of £60k) - ELFT/ Alzheimer's Society	East London NHS Foundation Trust	Mental Health	274,319	266,089	8,230	N/A
CCG	Aligned - Planned Care		**Planned Care**	Namaste - St Joseph	East London NHS Foundation Trust	Mental Health	60,000	58,200	1,800	N/A
CCG	Aligned - Planned Care		**Planned Care**	Recovery College - ELFT	East London NHS Foundation Trust	Mental Health	40,000	38,800	1,200	N/A
CCG	Aligned - Planned Care		**Planned Care**	SOS therapy service	East London NHS Foundation Trust	Mental Health	134,417	130,384	4,033	N/A
CCG	Aligned - Planned Care		**Planned Care**	24 hour cardiac - Homerton acute contract Cost Per Case (Additional Activity)	Homerton University Hospital NHS Foundation Trust	Planned Care	199,526	193,541	5,986	N/A
CCG	Aligned - Planned Care		**Planned Care**	Accessible gym - Ability Bow	Ability Bow	Long Term Conditions	38,078	36,936	1,142	N/A
CCG	Aligned - Planned Care		**Planned Care**	ACERS psychology (Primary care ACERS outreach) - Homerton Acute Contract	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	132,901	128,914	3,987	N/A
CCG	Aligned - Planned Care		**Planned Care**	ADHD	East London NHS Foundation Trust	Mental Health	66,690	64,689	2,001	N/A
CCG	Aligned - Planned Care		**Planned Care**	Adult Cmht	East London NHS Foundation Trust	Mental Health	3,326,201	3,226,415	99,786	N/A
CCG	Aligned - Planned Care		**Planned Care**	Afc Income Stream	East London NHS Foundation Trust	Mental Health	(444,258)	(430,930)	-13,328	N/A
CCG	Aligned - Planned Care		**Planned Care**	Anti-coagulation - service management (Jan Toms)	Jan Tomes	Prescribing	12,183	11,818	365	N/A
CCG	Aligned - Planned Care		**Planned Care**	Anticoagulation LES	GP Confederation	Prescribing	369,648	358,559	11,089	N/A
CCG	Aligned - Planned Care		**Planned Care**	AQP - Any qualified provider for direct access diagnostics	InHealth and BMI	Planned Care	241,902	234,645	7,257	N/A
CCG	Aligned - Planned Care		**Planned Care**	AQP - Homerton acute contract Cost Per Case (Additional Activity)	Homerton University Hospital NHS Foundation Trust	Planned Care	1,401,512	1,359,467	42,045	N/A
CCG	Aligned - Planned Care		**Planned Care**	AQP - Termination of Pregnancy	(blank)	Planned Care	94,140	91,316	2,824	N/A

CCG	Aligned - Planned Care		**Planned Care**	Art Therapy (ADULT)	East London NHS Foundation Trust	Mental Health	326,852	317,046	9,806	N/A
CCG	Aligned - Planned Care		**Planned Care**	Assessment and Support by CSU (2)	NHS North and East London CSU	Integrated Care	19,667	19,077	590	N/A
CCG	Aligned - Planned Care		**Planned Care**	Autism Service	East London NHS Foundation Trust	Mental Health	274,721	266,479	8,242	N/A
CCG	Aligned - Planned Care		**Planned Care**	Bank Rate Uplift	East London NHS Foundation Trust	Mental Health	286,203	277,617	8,586	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT BASELINE - Aligned	Barts and the London NHS Trust	Planned Care	999,098	969,125	29,973	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT BASELINE over / under performance	Barts and the London NHS Trust	Planned Care	24,851	24,106	746	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Barts and the London NHS Trust	Planned Care	14,869,911	14,423,813	446,097	N/A
CCG	Aligned - Planned Care		**Planned Care**	Barts Health Hospital NHS FT Planned over / under performance	Barts and the London NHS Trust	Planned Care	369,871	358,775	11,096	N/A
CCG	Aligned - Planned Care		**Planned Care**	Bereavement - St Joseph's Hospice	St. Joseph's Hospice	Integrated Care	43,176	41,881	1,295	N/A
CCG	Aligned - Planned Care		**Planned Care**	BHR UNIV HOSP NHST BASELINE	Barking, Havering and Redbridge NHS Trust	Planned Care	317,995	308,455	9,540	N/A
CCG	Aligned - Planned Care		**Planned Care**	BHR UNIV HOSP NHST BASELINE over / under performance	Barking, Havering and Redbridge NHS Trust	Planned Care	62,193	60,327	1,866	N/A
CCG	Aligned - Planned Care		**Planned Care**	BMI Healthcare Ltd	BMI Healthcare	Planned Care	571,972	554,813	17,159	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - 000000	GP Practices	Prescribing	71,671	69,520	2,150	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84003	Lower Clapton Group Practice	Prescribing	19,301	18,722	579	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84008	BARTON HOUSE HEALTH CENTRE	Prescribing	20,687	20,066	621	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84021	LONDON FIELDS MEDICAL CENTRE	Prescribing	29,721	28,830	892	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84033	SOMERFORD GROVE PRACTICE	Prescribing	29,325	28,445	880	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84036	THE CEDAR PRACTICE	Prescribing	3,287	3,189	99	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84038	BEECHWOOD MEDICAL CENTRE E8 3AH	Prescribing	7,690	7,459	231	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84041	Southgate Road Medical Centre	Prescribing	12,430	12,057	373	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84060	ATHENA MEDICAL CENTRE	Prescribing	7,570	7,343	227	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84063	THE DALSTON PRACTICE	Prescribing	10,108	9,805	303	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84069	Well Street Surgery	Prescribing	18,364	17,813	551	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84072	DE BEAUVOIR SURGERY	Prescribing	12,974	12,585	389	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84080	FOUNTAYNE ROAD HEALTH CENTRE	Prescribing	2,098	2,035	63	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84096	THE LAWSON PRACTICE	Prescribing	30,126	29,222	904	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84115	THE STATHAM GROVE SURGERY	Prescribing	14,073	13,651	422	N/A

CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84117	Queensbridge Group Practice	Prescribing	16,525	16,029	496	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84119	THE HERON PRACTICE	Prescribing	10,129	9,825	304	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84619	THE RIVERSIDE PRACTICE	Prescribing	2,752	2,669	83	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84620	THE WICK HEALTH CENTRE	Prescribing	12,577	12,200	377	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84624	ABNEY HOUSE MEDICAL CENTRE	Prescribing	2,641	2,562	79	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84635	Shoreditch Park Surgery	Prescribing	9,649	9,360	289	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84636	THE SURGERY (BARRETTS GROVE)	Prescribing	5,517	5,351	166	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84640	THE NEAMAN PRACTICE	Prescribing	14,150	13,725	424	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84685	THE ELM PRACTICE	Prescribing	5,324	5,165	160	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84686	THE SURGERY (CRANWICH ROAD)	Prescribing	10,792	10,468	324	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84694	THE SURGERY (BROOKE ROAD)	Prescribing	4,405	4,273	132	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-GMS Cost of Drugs -Prescribing - F84711	ROSEWOOD PRACTICE	Prescribing	5,014	4,864	150	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84013	Stamford Hill Group Practice	Prescribing	(20,712)	(20,091)	-621	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84015	Kingsmead Healthcare	Prescribing	10,799	10,475	324	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84018	THE NIGHTINGALE PRACTICE	Prescribing	17,912	17,374	537	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84035	RICHMOND ROAD MEDICAL CENTRE E8 3HN	Prescribing	6,729	6,527	202	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84043	THE SORSBY HEALTH CENTRE	Prescribing	6,606	6,408	198	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84105	THE LEA SURGERY	Prescribing	20,170	19,565	605	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84601	Elsdale Street Surgery	Prescribing	11,916	11,559	357	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84621	SANDRINGHAM PRACTICE	Prescribing	6,885	6,678	207	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84632	THE GREENHOUSE WALK IN	Prescribing	830	805	25	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84692	tHE HOXTON SURGERY	Prescribing	11,615	11,267	348	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84716	THE ALLERTON ROAD SURGERY	Prescribing	8,682	8,422	260	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - F84719	Latimer Health Centre	Prescribing	17,516	16,991	525	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - Y00403	TROWBRIDGE PRACTICE	Prescribing	4,276	4,147	128	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - Y01177	TOLLGATE LODGE PRACTICE	Prescribing	13,314	12,915	399	N/A
CCG	Aligned - Planned Care		**Planned Care**	C&M-PMS Cost of Drugs -Prescribing - Y03049	THE SPRINGFIELD HEALTH CENTRE	Prescribing	14,452	14,019	434	N/A

CCG	Aligned - Planned Care		**Planned Care**	Cancer (split out from LTC Core contract)	GP Confederation	Planned Care	142,548	138,271	4,276	N/A
CCG	Aligned - Planned Care		**Planned Care**	Cardiac rehabilitation - Homerton Acute Contract	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	63,792	61,879	1,914	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84003	Lower Clapton Health Centre	Primary Care Quality	48,489	47,035	1,455	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84008	BARTON HOUSE HEALTH CENTRE	Primary Care Quality	50,819	49,294	1,525	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84013	Stamford Hill Group Practice	Primary Care Quality	54,383	52,751	1,631	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84015	Kingsmead Healthcare	Primary Care Quality	23,094	22,401	693	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84018	Nightingale Practice	Primary Care Quality	47,164	45,749	1,415	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84021	LONDON FIELDS MEDICAL CENTRE	Primary Care Quality	42,151	40,886	1,265	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84033	Somerford Grove Health Centre	Primary Care Quality	60,890	59,063	1,827	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84035	Richmond Road Medical Centre	Primary Care Quality	17,252	16,735	518	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84036	Cedar Practice	Primary Care Quality	28,115	27,272	843	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84038	Beechwood Medical Centre	Primary Care Quality	16,336	15,846	490	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84041	Southgate Rd & Whiston Rd	Primary Care Quality	30,557	29,640	917	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84043	Sorsby Health Centre	Primary Care Quality	19,534	18,948	586	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84060	ATHENA MEDICAL CENTRE	Primary Care Quality	20,779	20,156	623	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84063	THE DALSTON PRACTICE	Primary Care Quality	24,335	23,605	730	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84069	Well Street Surgery	Primary Care Quality	54,295	52,667	1,629	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84072	De Beauvoir	Primary Care Quality	36,311	35,222	1,089	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84080	Drs Gadhvi & Pathan	Primary Care Quality	19,879	19,283	596	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84096	THE LAWSON PRACTICE	Primary Care Quality	58,396	56,644	1,752	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84105	Lea Surgery	Primary Care Quality	42,225	40,958	1,267	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84115	Statham Grove Surgery	Primary Care Quality	34,683	33,642	1,040	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84117	Queensbridge Group Practice	Primary Care Quality	38,770	37,607	1,163	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84119	THE HERON PRACTICE	Primary Care Quality	48,660	47,200	1,460	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84601	Elsdale Street	Primary Care Quality	24,871	24,125	746	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84619	Riverside Practice	Primary Care Quality	19,221	18,645	577	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84620	Wick Health Centre	Primary Care Quality	23,747	23,034	712	N/A

CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84621	Sandringham Road	Primary Care Quality	16,501	16,006	495	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84624	Abney House	Primary Care Quality	13,406	13,004	402	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84632	Greenhouse Health Centre	Primary Care Quality	7,802	7,568	234	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84635	Shoreditch Park Surgery	Primary Care Quality	32,516	31,540	975	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84636	Barretts Grove	Primary Care Quality	16,357	15,866	491	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84640	Neaman Practice	Primary Care Quality	34,087	33,064	1,023	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84668	Clapton Surgery	Primary Care Quality	25,607	24,838	768	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84685	Elm Practice	Primary Care Quality	14,300	13,871	429	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84686	Cranwich Road	Primary Care Quality	27,988	27,148	840	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84692	Hoxton Surgery	Primary Care Quality	28,752	27,890	863	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84694	Brooke Road	Primary Care Quality	13,709	13,297	411	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84711	ROSEWOOD PRACTICE	Primary Care Quality	10,947	10,619	328	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84716	Allerton Road Surgery	Primary Care Quality	20,431	19,818	613	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84719	Latimer Health Centre	Primary Care Quality	20,850	20,224	625	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - F84720	Healy Medical Centre	Primary Care Quality	23,869	23,153	716	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - Y00403	TROWBRIDGE PRACTICE	Primary Care Quality	23,517	22,811	706	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - Y01177	Tollgate Lodge	Primary Care Quality	32,955	31,966	989	N/A
CCG	Aligned - Planned Care		**Planned Care**	CCE - LES GP Incentive - Y03049	Springfield Medical Centre	Primary Care Quality	34,551	33,515	1,037	N/A
CCG	Aligned - Planned Care		**Planned Care**	Central Dementia Ward (Columbia)	East London NHS Foundation Trust	Mental Health	817,839	793,304	24,535	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP Arts Therapy	East London NHS Foundation Trust	Mental Health	99,575	96,588	2,987	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP Liaison	East London NHS Foundation Trust	Mental Health	145,797	141,423	4,374	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP Memory Clinic	East London NHS Foundation Trust	Mental Health	324,064	314,342	9,722	N/A
CCG	Aligned - Planned Care		**Planned Care**	CH MHCOP O.T	East London NHS Foundation Trust	Mental Health	323,263	313,565	9,698	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHAMRAS	East London NHS Foundation Trust	Mental Health	320,153	310,548	9,605	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care- Palliative Care (FAST TRACK)	Various	Integrated Care	968,561	939,504	29,057	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Mental Health (<65)	Various	Integrated Care / Mental Health	571,804	554,650	17,154	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Mental Health (65+)	Various	Integrated Care / Mental Health	1,221,756	1,185,103	36,653	N/A

CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Physical Disab (<65)	Various	Integrated Care	5,071,534	4,919,388	152,146	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Cont Care-Physical Disab (65+)	Various	Integrated Care	2,371,669	2,300,519	71,150	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - Funded Nursing Care (FNC) allowance	Various	Integrated Care	1,455,254	1,411,597	43,658	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC - PHB	Various	Integrated Care	475,152	460,897	14,255	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC Assessment and Support by CSU	NHS North and East London CSU	Childrens	367,719	356,688	11,032	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHC- Cont Care-Learning Disab(<65)	Various	Integrated Care	48,896	47,429	1,467	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHEL WESTMS HOSP NHS FT BASELINE	Chelsea and Westminster NHS Foundation Trust	Planned Care	528,678	512,818	15,860	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHEL WESTMS HOSP NHS FT BASELINE over / under performance	Chelsea and Westminster NHS Foundation Trust	Planned Care	140,565	136,348	4,217	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Compression Garment (Hosiery) Pilot - Accelerate CIC	Accelerate Community Interest Company	Planned Care	24,991	24,241	750	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Dressing Optimisation Scheme (DOS) - Accelerate CIC	Accelerate Community Interest Company	Planned Care	49,982	48,483	1,499	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Garments Made Easy (GME) - Accelerate CIC	Accelerate Community Interest Company	Planned Care	156,195	151,509	4,686	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Lymphodaema - Accelerate CIC	Accelerate Community Interest Company	Planned Care	187,434	181,811	5,623	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Lymphoedema Nurse - Accelerate CIC	Accelerate Community Interest Company	Planned Care	18,743	18,181	562	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Whittington Hospital (Community Health Contract)	Whittington Hospital NHS Trust	Planned Care	838,369	813,218	25,151	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Wound Care NCA - Accelerate CIC	Accelerate Community Interest Company	Planned Care	67,209	65,192	2,016	N/A
CCG	Aligned - Planned Care		**Planned Care**	CHS - Wound Dressing from NHS Business Services	NHS Business Services	Planned Care	418,165	405,620	12,545	N/A
CCG	Aligned - Planned Care		**Planned Care**	Clozapine Clinic	East London NHS Foundation Trust	Mental Health	264,510	256,575	7,935	N/A
CCG	Aligned - Planned Care		**Planned Care**	Community ENT	Concordia Community Outpatients Ltd	Planned Care	169,402	164,320	5,082	N/A
CCG	Aligned - Planned Care		**Planned Care**	Community Rehab Team	East London NHS Foundation Trust	Mental Health	1,279,858	1,241,462	38,396	N/A
CCG	Aligned - Planned Care		**Planned Care**	Complex Care	East London NHS Foundation Trust	Mental Health	381,237	369,800	11,437	N/A
CCG	Aligned - Planned Care		**Planned Care**	Continence service - Homerton acute contract Cost Per Case (Additional Activity)	Homerton University Hospital NHS Foundation Trust	Planned Care	67,548	65,522	2,026	N/A
CCG	Aligned - Planned Care		**Planned Care**	Contract and Agency	Various	Prescribing	350,738	340,216	10,522	N/A
CCG	Aligned - Planned Care		**Planned Care**	Crisis Cafe	East London NHS Foundation Trust	Mental Health	52,600	51,022	1,578	N/A
CCG	Aligned - Planned Care		**Planned Care**	Depression Reviews	GP Confederation	Mental Health	153,900	149,283	4,617	N/A
CCG	Aligned - Planned Care		**Planned Care**	Early Intervention	East London NHS Foundation Trust	Mental Health	2,048,840	1,987,375	61,465	N/A
CCG	Aligned - Planned Care		**Planned Care**	Employment of MH practice liaison Worker	GP Confederation	Mental Health	41,040	39,809	1,231	N/A

CCG	Aligned - Planned Care		**Planned Care**	Enhanced Primary Care	East London NHS Foundation Trust	Mental Health	986,912	957,305	29,607	N/A
CCG	Aligned - Planned Care		**Planned Care**	EPC Mental Health Reviews	GP Confederation	Mental Health	65,894	63,917	1,977	N/A
CCG	Aligned - Planned Care		**Planned Care**	Foot Health In patient Coordinator - Homerton Acute Contract	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	65,919	63,941	1,978	N/A
CCG	Aligned - Planned Care		**Planned Care**	GP Practice Manageable Prescribing Budget	GP Practices	Prescribing	26,318,225	25,528,678	789,547	N/A
CCG	Aligned - Planned Care		**Planned Care**	GP Practice Mental Health Training	GP Confederation	Mental Health	82,706	80,225	2,481	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT BASELINE - Aligned	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	314,683	305,243	9,440	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT BASELINE over / under performance	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	73,484	71,279	2,205	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	1,640,551	1,591,334	49,217	N/A
CCG	Aligned - Planned Care		**Planned Care**	GUYS & ST THMAS Hospital NHS FT Planned over / under performance	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	383,097	371,604	11,493	N/A
CCG	Aligned - Planned Care		**Planned Care**	Home Oxygen Service	-	Prescribing	251,868	244,312	7,556	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Psychosexual Health Service	Homerton University Hospital NHS Foundation Trust	Planned Care / Mental Health	94,787	91,943	2,844	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Bi Lingual Advocacy Services	Homerton University Hospital NHS Foundation Trust	Planned Care	1,209,167	1,172,892	36,275	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Chronic Fatigue	Homerton University Hospital NHS Foundation Trust	Planned Care / Mental Health	194,016	188,195	5,820	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Community Gynaecology	Homerton University Hospital NHS Foundation Trust	Planned Care	30,852	29,927	926	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Community Team (heart failure)	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	385,606	374,038	11,568	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Defoe / Other	Homerton University Hospital NHS Foundation Trust	Planned Care	7,498	7,273	225	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Dietetics	Homerton University Hospital NHS Foundation Trust	Planned Care	274,292	266,063	8,229	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Foot Health	Homerton University Hospital NHS Foundation Trust	Planned Care	1,682,155	1,631,691	50,465	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS -Locomotor Services	Homerton University Hospital NHS Foundation Trust	Planned Care	2,751,066	2,668,534	82,532	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Primary Care Psychology Therapy (Incl IAPT)	Homerton University Hospital NHS Foundation Trust	Mental Health	3,625,427	3,516,664	108,763	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - RIO	Homerton University Hospital NHS Foundation Trust	Planned Care	593,000	575,210	17,790	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Rotational Nurses	Homerton University Hospital NHS Foundation Trust	Planned Care	41,820	40,566	1,255	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Sickle Cell & Thalass(S75) Adult+Child A & E and Community	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	239,964	232,765	7,199	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS - Sickle cell psychology	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	124,495	120,761	3,735	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS -Dermatology	Homerton University Hospital NHS Foundation Trust	Planned Care	138,709	134,548	4,161	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton CHS -Wheelchair Services	Homerton University Hospital NHS Foundation Trust	Planned Care	1,050,729	1,019,207	31,522	N/A

CCG	Aligned - Planned Care		**Planned Care**	Homerton Psych Medicine	East London NHS Foundation Trust	Mental Health	1,730,510	1,678,595	51,915	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT BASELINE - Aligned	Homerton University Hospital NHS Foundation Trust	Planned Care	7,577,228	7,349,911	227,317	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT BASELINE over / under performance	Homerton University Hospital NHS Foundation Trust	Planned Care	736,818	714,713	22,105	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Homerton University Hospital NHS Foundation Trust	Planned Care	57,536,146	55,810,062	1,726,084	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homerton University Hospital NHS FT Planned over / under performance	Homerton University Hospital NHS Foundation Trust	Planned Care	2,175,963	2,110,684	65,279	N/A
CCG	Aligned - Planned Care		**Planned Care**	Homes for Life	East London NHS Foundation Trust	Mental Health	14,441	14,008	433	N/A
CCG	Aligned - Planned Care		**Planned Care**	IAPT Long Term Conditions (LTC)	Homerton University Hospital NHS Foundation Trust (CHS) - IAPT Long Term Conditions (LTC)	Mental Health	422,286	409,618	12,669	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT BASELINE - Aligned	Imperial College Healthcare NHS Trust	Planned Care	103,547	100,441	3,106	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT BASELINE over / under performance	Imperial College Healthcare NHS Trust	Planned Care	(4,394)	(4,262)	(132)	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Imperial College Healthcare NHS Trust	Planned Care	539,822	523,627	16,195	N/A
CCG	Aligned - Planned Care		**Planned Care**	IMP COLLEGE Hospital NHS FT Planned over / under performance	Imperial College Healthcare NHS Trust	Planned Care	(22,908)	(22,221)	(687)	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT BASELINE - Aligned	Kings College Hospital NHS Foundation Trust	Planned Care	58,289	56,540	1,749	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT BASELINE over / under performance	Kings College Hospital NHS Foundation Trust	Planned Care	(5,858)	(5,682)	(176)	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Kings College Hospital NHS Foundation Trust	Planned Care	303,878	294,761	9,116	N/A
CCG	Aligned - Planned Care		**Planned Care**	KINGS COLLEGE Hospital NHS FT Planned over / under performance	Kings College Hospital NHS Foundation Trust	Planned Care	(30,540)	(29,624)	(916)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Lawson Practise (CMS)	Lawson Practice	Planned Care	132,264	128,296	3,968	N/A
CCG	Aligned - Planned Care		**Planned Care**	LD	East London NHS Foundation Trust	Mental Health	151,988	147,428	4,560	N/A
CCG	Aligned - Planned Care		**Planned Care**	LONDON NW HOSP NHST BASELINE	London North West Healthcare NHS Trust	Planned Care	218,392	211,840	6,552	N/A
CCG	Aligned - Planned Care		**Planned Care**	LONDON NW HOSP NHST BASELINE Aligned over / under performance	London North West Healthcare NHS Trust	Planned Care	126,406	122,614	3,792	N/A
CCG	Aligned - Planned Care		**Planned Care**	Maintenance & Building Register and Dashboard	GP Confederation	Mental Health	25,650	24,881	770	N/A
CCG	Aligned - Planned Care		**Planned Care**	Management and oversight	GP Confederation	Mental Health	30,780	29,857	923	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mental Health Depot	GP Confederation	Mental Health	71,760	69,607	2,153	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mental Health NCA	NCA (Acute and non acute)	Mental Health	347,985	337,546	10,440	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mental Health Reserves (2)	Mental Health Reserves	Mental Health	2,080,539	2,018,123	62,416	N/A

CCG	Aligned - Planned Care		**Planned Care**	Minor Eye Conditions Service (Primary Eyecare ELC)	Primary Eye Care Limited	Planned Care	150,000	145,500	4,500	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT BASELINE - Aligned	Moorfields Eye Hospital NHS Foundation Trust	Planned Care	1,714,395	1,662,963	51,432	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT BASELINE over / under performance	Moorfields Eye Hospital NHS Foundation Trust	Planned Care	(5,599)	(5,431)	(168)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Moorfields Eye Hospital NHS Foundation Trust	Planned Care	4,821,913	4,677,255	144,657	N/A
CCG	Aligned - Planned Care		**Planned Care**	Moorfields Eye Hospital NHS FT Planned over / under performance	Moorfields Eye Hospital NHS Foundation Trust	Planned Care	(15,937)	(15,459)	(478)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Mother & Baby - Specialist	East London NHS Foundation Trust	Mental Health	15,194	14,738	456	N/A
CCG	Aligned - Planned Care		**Planned Care**	NELCSU SLA - Home Oxygen Service	NHS North and East London CSU	Prescribing	15,264	14,806	458	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS BASELINE - Aligned	North Middlesex University Hospital NHS Trust	Planned Care	89,916	87,218	2,697	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS BASELINE over / under performance	North Middlesex University Hospital NHS Trust	Planned Care	(23,731)	(23,019)	(712)	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS Planned (EL, OP, Crit Care, CHS, PTS,Other)	North Middlesex University Hospital NHS Trust	Planned Care	600,035	582,034	18,001	N/A
CCG	Aligned - Planned Care		**Planned Care**	NORTH MID Hospital NHS Planned over / under performance	North Middlesex University Hospital NHS Trust	Planned Care	(158,365)	(153,614)	(4,751)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Occupational Therapy	East London NHS Foundation Trust	Mental Health	837,783	812,650	25,134	N/A
CCG	Aligned - Planned Care		**Planned Care**	Pathology Consumables	GP Practices	Planned Care	26,501	25,706	795	N/A
CCG	Aligned - Planned Care		**Planned Care**	Patient Transport	(blank)	Corporate	9,197	8,921	276	N/A
CCG	Aligned - Planned Care		**Planned Care**	PD Section 28a - Hackney Council CHC	London Borough of Hackney	Long Term Conditions / Integrated Care	125,686	121,915	3,771	N/A
CCG	Aligned - Planned Care		**Planned Care**	Personality Disorder	East London NHS Foundation Trust	Mental Health	604,075	585,953	18,122	N/A
CCG	Aligned - Planned Care		**Planned Care**	Phlebotomy Local Enhanced Services (GP Confed from 1/1/16)	GP Confederation	Planned Care	312,390	303,018	9,372	N/A
CCG	Aligned - Planned Care		**Planned Care**	Physical Health checks for non-QOF patients on anti-psychotics non-QOF	GP Confederation	Mental Health	30,780	29,857	923	N/A
CCG	Aligned - Planned Care		**Planned Care**	Post Operative Wound Care	GP Confederation	Planned Care	114,543	111,107	3,436	N/A
CCG	Aligned - Planned Care		**Planned Care**	Practice Transformation support	Practice Transformation Support	Primary Care Quality	485,279	470,721	14,558	N/A
CCG	Aligned - Planned Care		**Planned Care**	Prescribing Recharges to LBH	London Borough of Hackney	Prescribing	(70,400)	(68,288)	(2,112)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Primary Care Liaison	East London NHS Foundation Trust	Mental Health	585,185	567,630	17,556	N/A
CCG	Aligned - Planned Care		**Planned Care**	Primary Care Psychotherapy Service (PCPCS/Tavi)	Tavistock and Portman Foundation Trust	Mental Health	1,102,493	1,069,419	33,075	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychological support - diabetes - Homerton Acute Contract	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	63,792	61,879	1,914	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychological Therapies Alliance	Mind (Fund Holder)	Mental Health	458,082	444,340	13,742	N/A
CCG	Aligned - Planned Care		**Planned Care**	Psychology	East London NHS Foundation Trust	Mental Health	1,544,640	1,498,301	46,339	N/A

CCG	Aligned - Planned Care		**Planned Care**	Psychotherapy Services	East London NHS Foundation Trust	Mental Health	1,785,277	1,731,719	53,558	N/A
CCG	Aligned - Planned Care		**Planned Care**	Pulmonary rehab for heart failure - Homerton Acute Contract	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	62,729	60,847	1,882	N/A
CCG	Aligned - Planned Care		**Planned Care**	Quality Improvement	GP Confederation	Primary Care Quality	(0)	(0)	(0)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Recharge scans - Homerton acute contract Cost Per Case (Additional Activity)	Homerton University Hospital NHS Foundation Trust	Planned Care	618,324	599,774	18,550	N/A
CCG	Aligned - Planned Care		**Planned Care**	Recovery Pathways - Arts in Health	East London NHS Foundation Trust	Mental Health	92,340	89,570	2,770	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROY BROMP HARE NHSFT BASELINE	Royal Brompton and Harefield NHS Foundation Trust	Planned Care	225,044	218,293	6,751	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROY BROMP HARE NHSFT BASELINE over / under performance	Royal Brompton and Harefield NHS Foundation Trust	Planned Care	(5,122)	(4,969)	(154)	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT BASELINE - Aligned	Royal Free London NHS Foundation Trust	Planned Care	275,207	266,951	8,256	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT BASELINE over / under performance	Royal Free London NHS Foundation Trust	Planned Care	30,644	29,725	919	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	Royal Free London NHS Foundation Trust	Planned Care	1,434,747	1,391,704	43,042	N/A
CCG	Aligned - Planned Care		**Planned Care**	ROYAL FREE Hospital NHS FT Planned over / under performance	Royal Free London NHS Foundation Trust	Planned Care	159,757	154,965	4,793	N/A
CCG	Aligned - Planned Care		**Planned Care**	Royal National Orthopaedic Hospital	Royal National Orthopaedic Hospital NHS Trust	Planned Care	732,473	710,499	21,974	N/A
CCG	Aligned - Planned Care		**Planned Care**	Royal National Orthopaedic Hospital over / under performance	Royal National Orthopaedic Hospital NHS Trust	Planned Care	93,645	90,836	2,809	N/A
CCG	Aligned - Planned Care		**Planned Care**	Secondary Care Physical Health Check	GP Confederation	Mental Health	83,106	80,613	2,493	N/A
CCG	Aligned - Planned Care		**Planned Care**	SMI QOF Physical Health Checks	GP Confederation	Mental Health	30,780	29,857	923	N/A
CCG	Aligned - Planned Care		**Planned Care**	Social Inclusion	East London NHS Foundation Trust	Mental Health	328,132	318,288	9,844	N/A
CCG	Aligned - Planned Care		**Planned Care**	Software Licence (Scriptswitch)	(blank)	Prescribing	117,590	114,062	3,528	N/A
CCG	Aligned - Planned Care		**Planned Care**	ST GEORGES HC NHST BASELINE	St George's Healthcare NHS Trust	Planned Care	199,425	193,442	5,983	N/A
CCG	Aligned - Planned Care		**Planned Care**	ST GEORGES HC NHST BASELINE over / under performance	St George's Healthcare NHS Trust	Planned Care	50,469	48,955	1,514	N/A
CCG	Aligned - Planned Care		**Planned Care**	Stroke Project	Triangle Community Services	Long Term Conditions	152,965	148,376	4,589	N/A
CCG	Aligned - Planned Care		**Planned Care**	Sun Project	East London NHS Foundation Trust	Mental Health	151,396	146,854	4,542	N/A
CCG	Aligned - Planned Care		**Planned Care**	The Royal Marsden	Royal Marsden NHS Foundation Trust	Planned Care	232,824	225,840	6,985	N/A
CCG	Aligned - Planned Care		**Planned Care**	The Royal Marsden over / under performance	Royal Marsden NHS Foundation Trust	Planned Care	(73,567)	(71,360)	(2,207)	N/A
CCG	Aligned - Planned Care		**Planned Care**	Transitional Neurological Rehabilitation Unit	Homerton University Hospital NHS Foundation Trust	Long Term Conditions	590,080	572,377	17,702	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT BASELINE - Aligned	University College London NHS Foundation Trust	Planned Care	1,236,342	1,199,252	37,090	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT BASELINE over / under performance	University College London NHS Foundation Trust	Planned Care	10,720	10,399	322	N/A

CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT Planned (EL, OP, Crit Care, CHS, PTS,Other)	University College London NHS Foundation Trust	Planned Care	7,286,833	7,068,228	218,605	N/A
CCG	Aligned - Planned Care		**Planned Care**	UCLH Hospital NHS FT Planned over / under performance	University College London NHS Foundation Trust	Planned Care	63,874	61,958	1,916	N/A
CCG	Aligned - Planned Care		**Planned Care**	Well Family Plus	Family Action (GP Confederation)	Mental Health	292,410	283,638	8,772	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS FT BASELINE - Aligned	Whittington Hospital NHS Trust	Planned Care	167,400	162,378	5,022	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS FT BASELINE over / under performance	Whittington Hospital NHS Trust	Planned Care	45,545	44,179	1,366	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS Planned (EL, OP, Crit Care, CHS, PTS,Other)	Whittington Hospital NHS Trust	Planned Care	1,117,113	1,083,600	33,513	N/A
CCG	Aligned - Planned Care		**Planned Care**	Whittington Hospital NHS Planned over / under performance	Whittington Hospital NHS Trust	Planned Care	303,934	294,816	9,118	N/A
CCG	Aligned - Planned Care		**Planned Care**	Contract and Agency & Training (Project work)	Various	Prescribing	240,168	232,963	7,205	N/A
CCG	Aligned - Planned Care		**Planned Care**	Core24 Psychiatric Liaison (Dependent on QIPP target being met)	East London NHS Foundation Trust	Mental Health	(14,689)	(14,249)	(441)	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Adult Acute	East London NHS Foundation Trust	Mental Health	11,304,044	10,964,923	339,121	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Barts Health Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Barts and the London NHS Trust	Planned Care	11,572,083	11,224,921	347,162	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Barts Health Hospital NHS FT Unplanned over / under performance	Barts and the London NHS Trust	Planned Care	1,225,244	1,188,487	36,757	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	C&H Commissioning	East London NHS Foundation Trust	Mental Health	1,425,429	1,382,666	42,763	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CEOV weighted share adjustment	East London NHS Foundation Trust (overseas)	Mental Health	470,378	456,267	14,111	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CH MHCOP ACUTE (50% Leadenhall)	East London NHS Foundation Trust	Mental Health	1,103,503	1,070,398	33,105	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CH MHCOP C-CARE (Thames - Ex Cedar)	East London NHS Foundation Trust	Mental Health	1,037,645	1,006,516	31,129	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	CH MHCOP CMHT	East London NHS Foundation Trust	Mental Health	1,857,166	1,801,451	55,715	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Community Matron Service - Elsdale Street Surgery	Elsdale Street Surgery	Integrated Care	144,741	140,398	4,342	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Community Matron Service - Shoreditch Park Surgery	Shoreditch Park Surgery	Integrated Care	134,328	130,298	4,030	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Duty Doctor	GP Confederation	Urgent Care	1,603,279	1,555,180	48,098	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	End of Life - St Joseph's Hospice Hackney	St. Joseph's Hospice	Integrated Care	141,561	137,314	4,247	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	End of Life Care (GP contract)	GP Confederation	Integrated Care	200,883	194,856	6,026	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Enhanced PUCC - (Homerton PUCC) NR	Homerton University Hospital NHS Foundation Trust	Urgent Care	643,000	623,710	19,290	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Frequent Attenders Team Lead	Homerton University Hospital NHS Foundation Trust	Urgent Care	35,654	34,584	1,070	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	GUYS & ST THMAS Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	645,469	626,105	19,364	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	GUYS & ST THMAS Hospital NHS FT Unplanned over / under performance	Guys and St. Thomas' Hospital NHS Foundation Trust	Planned Care	8,668	8,408	260	N/A

CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton CHS - Adult Community Nursing (incl Intermediate Care - Section 75)	Homerton University Hospital NHS Foundation Trust	Integrated Care	3,755,281	3,642,622	112,658	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton CHS -Adult Community Rehabilitation Team	Homerton University Hospital NHS Foundation Trust	Integrated Care	2,689,742	2,609,049	80,692	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton System resilience (part of Non Recurrent funding)	Homerton University Hospital NHS Foundation Trust	Urgent Care	678,000	657,660	20,340	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton University Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Homerton University Hospital NHS Foundation Trust	Planned Care	37,771,074	36,637,942	1,133,132	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	Homerton University Hospital NHS FT Unplannedover / under performance	Homerton University Hospital NHS Foundation Trust	Planned Care	2,320,526	2,250,911	69,616	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	HTT & Emergency Services	East London NHS Foundation Trust	Mental Health	2,850,430	2,764,917	85,513	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	IMP COLLEGE Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Imperial College Healthcare NHS Trust	Planned Care	312,509	303,134	9,375	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	IMP COLLEGE Hospital NHS FT Unplanned over / under performance	Imperial College Healthcare NHS Trust	Planned Care	86,319	83,729	2,590	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	KINGS COLLEGE Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Kings College Hospital NHS Foundation Trust	Planned Care	239,345	232,165	7,180	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	KINGS COLLEGE Hospital NHS FT Unplanned over / under performance	Kings College Hospital NHS Foundation Trust	Planned Care	(13,015)	(12,624)	(390)	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	London Ambulance Service (LAS)	London Ambulance Services	Urgent Care	11,933,212	11,575,216	357,996	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	London Ambulance Service (LAS) over / under performance	London Ambulance Services	Urgent Care	416,444	403,950	12,493	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - BEH FT	Borough Border Contracts (CANDI,BEH & NELFT)	Mental Health	509,405	494,123	15,282	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - Camden	Borough Border Contracts (CANDI,BEH & NELFT)	Mental Health	807,373	783,152	24,221	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - Camden overperformance allowance	CANDI Cap	Mental Health	102,908	99,821	3,087	N/A
CCG	Aligned - Unplanned Care		**Unplanned Care**	MH Services (Out of Area) - NELFT	Borough Border Contracts (CANDI,BEH & NELFT)	Mental Health	90,419	87,707	2,713	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Mildmay Mission	Mildmay Mission Hospital	Integrated Care	431,893	418,936	12,957	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Moorfields Eye Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Moorfields Eye Hospital NHS Foundation Trust	Planned Care	1,102,479	1,069,405	33,074	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Moorfields Eye Hospital NHS FT Unplanned over / under performance	Moorfields Eye Hospital NHS Foundation Trust	Planned Care	(84,228)	(81,701)	(2,527)	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NCA (Non Contracted Activity - Various)	Various	Planned Care	3,251,904	3,154,347	97,557	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NHS 111 Service - CSU charges	CSU	Urgent Care	46,645	45,246	1,399	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NHS 111 Service - LAS Contact	London Ambulance Services	Urgent Care	1,023,308	992,609	30,699	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NORTH MID Hospital NHS Unplanned (Adult A&E +NEL activity)	North Middlesex University Hospital NHS Trust	Planned Care	821,186	796,551	24,636	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NORTH MID Hospital NHS Unplanned over / under performance	North Middlesex University Hospital NHS Trust	Planned Care	(118,905)	(115,338)	(3,567)	
CCG	Aligned - Unplanned Care		**Unplanned Care**	NORTH MID Hospital NHS Children & YP over / under performance	North Middlesex University Hospital NHS Trust	Planned Care	(91,639)	(88,890)	(2,749)	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Nursing Homes (LES) Acorn Lodge - Latimer	Latimer Health Centre	Integrated Care	116,264	112,776	3,488	

CCG	Aligned - Unplanned Care		**Unplanned Care**	Nursing Homes (LES) Barton House - St Anne's	St Anne's	Integrated Care	25,386	24,624	762	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Other Social Care - Handyperson (Home from Hospital)	London Borough of Hackney	Integrated Care	67,398	65,376	2,022	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Out of Hours and ParaDoc service	Homerton University Hospital NHS Foundation Trust	Urgent Care	2,685,730	2,605,158	80,572	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Overseas visitor NonReciprocal agreement and 1/3 risk share	East London NHS Foundation Trust (overseas)	Mental Health	102,805	99,721	3,084	
CCG	Aligned - Unplanned Care		**Unplanned Care**	PICU	East London NHS Foundation Trust	Mental Health	2,448,442	2,374,989	73,453	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Proactive Care: Home Visiting (Frail Home Visiting)	GP Confederation	Integrated Care	1,467,466	1,423,442	44,024	
CCG	Aligned - Unplanned Care		**Unplanned Care**	PUCC	Homerton University Hospital NHS Foundation Trust	Urgent Care	958,857	930,092	28,766	
CCG	Aligned - Unplanned Care		**Unplanned Care**	ROYAL FREE Hospital NHS FT Unplanned (Adult A&E +NEL activity)	Royal Free London NHS Foundation Trust	Planned Care	879,453	853,070	26,384	
CCG	Aligned - Unplanned Care		**Unplanned Care**	ROYAL FREE Hospital NHS FT Unplannedover / under performance	Royal Free London NHS Foundation Trust	Planned Care	50,451	48,938	1,514	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Take Home and Settle	Age UK	Integrated Care	166,112	161,129	4,983	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Targeted Preventative Dementia Service (Alzheimer's)	Alzheimers' Society	Mental Health	263,946	256,027	7,918	
CCG	Aligned - Unplanned Care		**Unplanned Care**	UCLH Hospital NHS FT Unplanned (Adult A&E +NEL activity)	University College London NHS Foundation Trust	Planned Care	3,239,064	3,141,892	97,172	
CCG	Aligned - Unplanned Care		**Unplanned Care**	UCLH Hospital NHS FT Unplanned over / under performance	University College London NHS Foundation Trust	Planned Care	213,450	207,046	6,403	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Whittington Hospital NHS Unplanned (Adult A&E +NEL activity)	Whittington Hospital NHS Trust	Planned Care	1,591,833	1,544,078	47,755	
CCG	Aligned - Unplanned Care		**Unplanned Care**	Whittington Hospital NHS Unplannedover / under performance	Whittington Hospital NHS Trust	Planned Care	128,836	124,971	3,865	
CCG	Aligned - Corporate		**Corporate**	1% NR (Uncommitted Funds 0.5%)	-	Reserves	2,104,820	2,041,675	63,145	
CCG	Aligned - Corporate		**Corporate**	ACUTE GENERAL RESERVE	TBC	Reserves	4,491,110	4,356,376	134,733	
CCG	Aligned - Corporate		**Corporate**	Additional Allocation Funding	-	Reserves	662,063	642,201	19,862	
CCG	Aligned - Corporate		**Corporate**	BT Charges	BT	Primary Care Quality	74,974	72,724	2,249	
CCG	Aligned - Corporate		**Corporate**	Clinical Effectiveness Group (CEG)	Queen Mary University	Primary Care Quality	183,269	177,771	5,498	
CCG	Aligned - Corporate		**Corporate**	Community Health Reserves	-	Reserves	2,708,403	2,627,151	81,252	
CCG	Aligned - Corporate		**Corporate**	Contingency	-	Reserves	2,383,620	2,312,111	71,509	
CCG	Aligned - Corporate		**Corporate**	Corporate	Various	Corporate	4,991,000	4,841,270	149,730	
CCG	Aligned - Corporate		**Corporate**	Corporate Reserve	-	Reserves	1,263,000	1,225,110	37,890	
CCG	Aligned - Corporate		**Corporate**	General Programme Reserves	-	Reserves	495,895	481,018	14,877	
CCG	Aligned - Corporate		**Corporate**	HLP Contribution	HLP	Other Programme Services	267,614	259,586	8,028	
CCG	Aligned - Corporate		**Corporate**	London Levies (programme)	Lambeth CCG	Other Programme Services	134,328	130,298	4,030	
CCG	Aligned - Corporate		**Corporate**	Market rent - Homerton	NHS Property services	Corporate	901,583	874,535	27,047	
CCG	Aligned - Corporate		**Corporate**	Mental Health User Involvement Service	London Borough of Hackney	Mental Health	25,650	24,881	770	
CCG	Aligned - Corporate		**Corporate**	NHSE STP Primary Care Accomodation Recharge 2017-18	Newham CCG	Corporate	16,319	15,830	490	
CCG	Aligned - Corporate		**Corporate**	Pan-London CCG risk share for homeless TB patients	(blank)	Planned Care	14,535	14,099	436	
CCG	Aligned - Corporate		**Corporate**	Patient User Experience Group Support	Healthwatch Hackney	Integrated Care	18,743	18,181	562	
CCG	Aligned - Corporate		**Corporate**	PEL Allocation	-	Reserves	399,000	387,030	11,970	

CCG	Aligned - Corporate		**Corporate**	Primary Care IT - charges from CSU	North and East London CSU	Primary Care Quality	764,314	741,385	22,929	
CCG	Aligned - Corporate		**Corporate**	Programme Projects	Other Programme Services	Corporate	4,645,465	4,506,101	139,364	
CCG	Aligned - Corporate		**Corporate**	Programme Projects (STP)	Other Programme Services	Corporate	636,520	617,424	19,096	
CCG	Aligned - Corporate		**Corporate**	Rent	NHS Property services	Corporate	1,200,371	1,164,360	36,011	
CCG	Aligned - Corporate		**Corporate**	Rent (2)	NHS Property services	Corporate	239,505	232,320	7,185	
CCG	Aligned - Corporate		**Corporate**	Rent (3)	NHS Property services	Corporate	497,347	482,427	14,920	
CoL	Aligned -Unplanned Care		**Unplanned Care**	provision of out of hours emergency care for ASC & Mental health services.	Authority	Adult Social Care	29,000		29,000	
CoL	Aligned -Prevention		**Prevention**	Care Navigator Service (BCF) (now part of the early intervention & prevention project)	voluntary sector	Adult Social Care	60,000		60,000	
col	Unplanned Care		**Unplanned Care**	Reablement Plus (BCF)	private sector	Adult Social Care	65,000		65,000	
CoL	Planned Care		**Planned Care**	Mental Health reablement & floating support worker (BCF)	mixed	adult social care / older people	85,000		85,000	
CoL	Aligned -Planned Care		**Planned Care**	Reablement equipment for clients-ASC assistive equipment & technoogy	private sector - Millbrook	Occupational Therapy	20,000		20,000	
CoL	Aligned -Planned Care		**Planned Care**	Reablement service various external agenices-Physical support - 18-64	private sector	Occupational Therapy	35,000		35,000	
CoL	Aligned -Planned Care		**Planned Care**	social work activities (employees, travel,subsistance-ASC Social Work Service	City of London	Adult Social Care	548,000		548,000	
CoL	Aligned -Planned Care		**Planned Care**	Advocacy & Advice to clients regarding Direct Payments &Telecare -ASC advocacy	Third sector	Adult Social Care	62,000		62,000	
CoL	Aligned -Planned Care		**Planned Care**	Residential care -Residential Care Adults 18-64	private sector	Adult Social Care	391,000		391,000	
CoL	Aligned -Planned Care		**Planned Care**	Winter Pressures - Hiring of additional temp OT/Reablement staff	private sector	Occupational Therapy	86,000		86,000	
CoL	Aligned -Planned Care		**Planned Care**	Home Help budgets-Physical support - 18-64	private sector	Adult Social Care	299,000		299,000	
CoL	Aligned -Planned Care		**Planned Care**	Supported Living -Supported Living - 18-64	private sector	Adult Social Care	1,086,000		1,086,000	
CoL	Aligned -Planned Care		**Planned Care**	social work activities (employees, travel,-Scoail work - Older People 65+	private sector	Older People	137,000		137,000	
CoL	Aligned -Planned Care		**Planned Care**	Independent DOLs Assessors-Mental Health Support 65+	private sector	Older People	20,000		20,000	
CoL	Aligned -Planned Care		**Planned Care**	Residential care -residential care - Older People 65+ -	private sector	Older People	782,000		782,000	
CoL	Aligned -Planned Care		**Planned Care**	Supported Living - various homes-Supported Living - Older People 65+	private sector	Older People	40,000		40,000	
CoL	Aligned -Planned Care		**Planned Care**	Home Help - Various agencies-Home Help - Older People 65+	private sector	Older People	666,000		666,000	
CoL	Aligned -Planned Care		**Planned Care**	software maintenance & support for ASC system-	private sector	Adult Social Care	32,000		32,000	
CoL	Aligned -Planned Care		**Planned Care**	social work activities (employees)ASC occupational therapy services	City of London	Occupational Therapy	180,000		180,000	
CoL	Aligned -Planned Care		**Planned Care**	Assistive technology - Care LineASC assistive equipment & technoogy	other local authority	Older People	44,000		44,000	
CoL	Aligned -Prevention		**Planned Care**	OT equipment for clientASC assistive equipment & technoogy	private sector - Millbrook	Occupational Therapy	20,000		20,000	
CoL	Aligned -Planned Care		**Planned Care**	social work activities (employees, consultants) -ASC reablement service	City of London	Occupational Therapy	51,000		51,000	

CoL	Aligned -Planned Care		**Planned Care**	Safeguarding - contribution to safeguarding Board	other local authority	Adult Social Care	29,000		29,000	
CoL	Aligned -Prevention		**Prevention**	Early Intervention & Prevention Service	Third sector	Adult Social Care	140,000		140,000	
CoL	Aligned -Prevention		**Planned Care**	Carers Payments - ASC - Social support. Support to carer	mixed	Older People	20,000		20,000	
CoL	Aligned -Prevention		**Prevention**	Public Mental Health	private sector	Public Health	30,000		30,000	
CoL	Aligned -Prevention		**Prevention**	City Health SignpostingPublic Health	voluntary sector	Public Health	14,000		14,000	
CoL	Aligned -Prevention		**Prevention**	Fusion Sports developmentPublic Health	private sector	Public Health	19,000		19,000	
CoL	Aligned -Prevention		**Prevention**	Square Mile Health (smoking, alcohol and substance misuse)Public Health	mixed	Public Health	737,000		737,000	
CoL	Aligned -Prevention		**Prevention**	Physical Activity - City LivingWise service 2018/19 HWMPA	private sector	Public Health	178,000		178,000	
CoL	Aligned -Prevention		**Prevention**	Health At Work	private sector	Public Health	4,000		4,000	
CoL	Aligned -Prevention		**Prevention**	Sexual Health Services	private sector	Public Health	316,000		316,000	
CoL	Aligned -Prevention		**Prevention**	LEAP & New children's obesity service	private sector	Public Health	9,000		9,000	
CoL	Aligned -Planned Care		**Planned Care**	Power to charge income	City of London	Adult Social Care			(180,000)	
CoI	Aligned - Unplanned Care		**Unplanned Care**	IBCF funding			265,000		265,000	
CoL	Aligned -CYPMS		**CYPMS**	School Nursing	voluntary sector	Public Health	14,000		14,000	
CoL	Aligned -CYPMS		**CYPMS**	Children 5-19 public health programmes	private sector	Public Health	24,000		24,000	
CoL	Aligned -CYPMS		**CYPMS**	Children 0-5 public health program	private sector	Public Health	138,000		138,000	
CoL	Aligned -CYPMS		**CYPMS**	CSC -General - Coram Capital Adoption	private sector	Child Social Care	15,000		15,000	
CoL	Aligned -CYPMS		**CYPMS**	Looked After Children and Leaving Care Services - Independent Visitors - Action for Children	private sector	Child Social Care	13,000		13,000	
CoL	Aligned -CYPMS		**CYPMS**	Looked After Children and Leaving Care Services - LAC/CL Engagement	private sector	Child Social Care	77,000		77,000	
CoL	Aligned -CYPMS		**CYPMS**	Placements	private sector	Child Social Care	149,000		149,000	
CoL	Aligned -CYPMS		**CYPMS**	Disabled Children Service - Clent Shortbreaks Direct Payments (£12k) Shortbreaks (£28k)	private sector	Child Social Care	64,000		64,000	
CoL	Aligned -CYPMS		**CYPMS**	City and Hackney Children's Safeguarding Board	private sector	Child Social Care	30,000		30,000	
CoL	Aligned -CYPMS		**CYPMS**	Safeguarding and Learning Service - Staff (£136k)	private sector	Child Social Care	135,000		135,000	
CoL	Aligned -CYPMS		**CYPMS**	Safeguarding and Learning Service - Aidhour (£35k)	private sector	Child Social Care	73,000		73,000	
CoL	Aligned -CYPMS		**CYPMS**	Clinical Services - LAC Health (£5k) CAMHS(£10k)	private sector	Child Social Care	15,000		15,000	
CoL	Aligned -CYPMS		**CYPMS**	Youth Offending Service - LB Hackney	private sector	Child Social Care	10,000		10,000	
CoL	Aligned -CYPMS		**CYPMS**	Out of Hours Service - LB Hackney	private sector	Child Social Care	3,000		3,000	
CoL	Aligned -CYPMS		**CYPMS**	Software Maintenance	private sector	Child Social Care	38,000		38,000	
CoL	Aligned -CYPMS		**CYPMS**	Client support/Interpreters Fees	private sector	Child Social Care	57,000		57,000	
CoL	Aligned -CYPMS		**CYPMS**	Subscriptions (Various)	private sector	Child Social Care	8,000		8,000	
CoL	Aligned -CYPMS		**CYPMS**	CSC -General	private sector	Child Social Care	669,000		669,000	
							435,069,020	414,594,533	20,474,487	

PART THREE – ALIGNED FUNDS

The Aligned Funds for both parties are per below:

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

1. CCG Aligned Funds:

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

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

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

2. Local Authority Aligned Funds:

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

SCHEDULE 2 – GOVERNANCE

PART ONE – OVERVIEW

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

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

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

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

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

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

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

8. The Partners will comply with the agreed Conflicts of Interest Policy Statement as may be amended from time to time by the agreement of the Integrated Commissioning Board.

PART TWO – TERMS OF REFERENCE OF INTEGRATED COMMISSIONING BOARD

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

Terms of Reference

Background and Authority

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

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

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

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

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

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

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

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

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

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

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

Purpose

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

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

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

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

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

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

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

Objectives

Specifically, the ICB will:

Commissioning strategies and plans

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

Service re-design

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

Contracting and performance

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

Stakeholder engagement

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

Programme management

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

Safeguarding

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

Accountability and reporting

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

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

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

Membership and attendance

The membership of the COLC Committee shall be as follows:

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

The membership of the LBH Committee shall be as follows:

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

The membership of the CCG Committee shall be as follows:

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

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

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

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

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

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

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

Deputies

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

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

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

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

Leading and facilitating the discussion

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

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

Quorum and voting

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

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

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

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

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

Meetings and administration

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

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

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

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

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

Conflicts of interests

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

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

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

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

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

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

All declarations and discussions relating to them will be minuted.

Additional requirements

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

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

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

Review

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

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

June 2019

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

INTEGRATED COMMISSIONING ARRANGEMENTS

SCHEME OF RESERVATION AND DELEGATION

Introduction

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

CoLC has established an Integrated Commissioning Sub-Committee of its Community and Children's Services Committee and the CCG has also established an Integrated Commissioning Committee. The CoLC Sub-Committee and the CCG Committee shall meet in common and shall be known together as the Integrated Commissioning Board ("the Board").

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

The authority of the CoLC Integrated Commissioning Sub-Committee is subject to referral to the Court of Common Council in accordance with the CoLCs constitution. The CCG's Integrated Commissioning Committee is subject to oversight from the CCG's Governing Body and Members such that they are assured that the Board does not breach any requirements.

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

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee	CCG officers	CoLC Community and Children's Services Committee	CoLC Category Board	CoLC Officers	CoLC Social Value Panel	CoLC Integrated Commissioning Sub-Committee	CCG Integrated Commissioning Committee
	Pooled Budgets and Services									
1.	Determine the budgets (and therefore services) that are pooled (to include Better Care Fund) at any time	Authority to approve			Authority to approve					
2.	Determine the amount of the Integrated Commissioning Fund that is allocated to commissioning management and administration support.	Authority to approve			Authority to approve					
3.	Approve the Integrated Commissioning Strategy (ICS) for services within the pooled budget								Authority to approve	Authority to approve
4.	Approve a commissioning strategy or plan for each service or pathway identified in the ICS and included in the pooled budget								Authority to approve	Authority to approve
5.	Approve the design of services								Authority to approve	Authority to approve

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee	CCG officers	CoLC Community and Children's Services Committee	CoLC Category Board	CoLC Officers	CoLC Social Value Panel	CoLC Integrated Commissioning Sub-Committee	CCG Integrated Commissioning Committee
	identified in the ICS and included in the pooled budget, including pathways, specifications and models of care.								(Refer to FF 34)	(Refer to FF 34)
6.	Approve expenditure from the pooled budget, including Better Care Fund budgets.								Authority to approve (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)
7.	Approve the procurement process to select providers to deliver services identified in the ICS and within the pooled budget							To be consulted prior to proposals to Integrated Commissioning Sub-Committee	Authority to approve	Authority to approve
8.	Approve the appointment of providers to deliver services identified in the ICS and within the pooled budget							To be consulted prior to proposals to Integrated Commissioning Sub-Committee	Authority to approve for	Authority to approve for
9.	Approve contracts with providers selected to deliver services identified in the ICS and within the pooled budget			Authority to approve. (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)					

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee	CCG officers	CoLC Community and Children's Services Committee	CoLC Category Board	CoLC Officers	CoLC Social Value Panel	CoLC Integrated Commissioning Sub-Committee	CCG Integrated Commissioning Committee
10.	Approve action to address any variance from targets in respect of the performance of providers.								Authority to approve	Authority to approve
11.	Approve the arrangements for the CCG and LBH to work together, including the role of any supporting committees or work programmes.								Authority to approve	Authority to approve
12.	Approve strategies and plans to secure the engagement of patients, the public and other stakeholders.								Authority to approve	Authority to approve
	Aligned Budgets and Services									
13.	Approve the commissioning strategy for aligned budgets and services.	Authority to approve			Authority to approve					
14.	Approve a commissioning strategy or plan for each aligned service or pathway.	Authority to approve			Authority to approve					

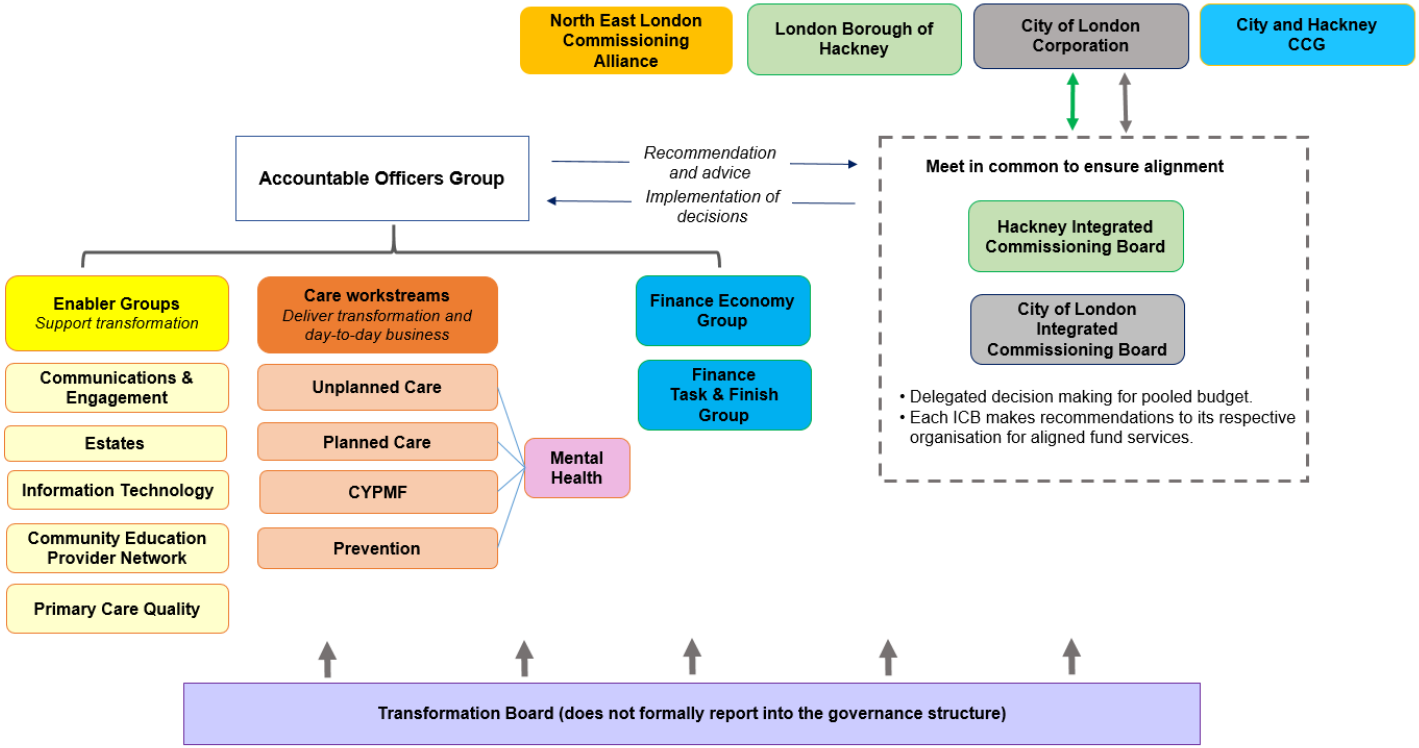
No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee	CCG officers	CoLC Community and Children's Services Committee	CoLC Category Board	CoLC Officers	CoLC Social Value Panel	CoLC Integrated Commissioning Sub-Committee	CCG Integrated Commissioning Committee
15.	Approve the design of aligned budget services, including pathways, specifications and models of care.	Authority to approve			Authority to approve					
16.	Approve the procurement process to select providers to deliver aligned budget services.	Authority to approve			Authority to approve	Authority to approve for budget in excess of £100,000		To be consulted prior to proposals to Community and Children's Services Committee on all tenders above OJEU level		
17.	Approve the appointment of providers to deliver aligned budget services.	Authority to approve			Authority to approve for budgets over £2,000,000	Authority to approve for budgets between OJEU threshold and £2,000,000	Authority to approve for budgets below OJEU threshold			
18.	Approve contracts with providers selected to deliver aligned budget services.			Authority to approve. (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3) BELOW £250k is Director sign off Above £250k is under sealed by Comptrollers and City Solicitors					

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee	CCG officers	CoLC Community and Children's Services Committee	CoLC Category Board	CoLC Officers	CoLC Social Value Panel	CoLC Integrated Commissioning Sub-Committee	CCG Integrated Commissioning Committee
	CORE PRIMARY CARE SERVICES									
19.	Approve the commissioning strategy		Authority to approve							
20.	Approve a commissioning strategy or plan for each service		Authority to approve							
21.	Approve the design of services, including pathways, specifications and models of care		Authority to approve							
22.	Approve the procurement process to select providers to deliver services		Authority to approve							
23.	Approve the appointment of providers to deliver services		Authority to approve							
24.	Approve contracts with providers selected to deliver services		Authority to approve							
25.	Approve the establishment or merger of GP practices		Authority to approve							

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee	CCG officers	CoLC Community and Children's Services Committee	CoLC Category Board	CoLC Officers	CoLC Social Value Panel	CoLC Integrated Commissioning Sub-Committee	CCG Integrated Commissioning Committee
26.	Approve discretionary payments		Authority to approve							
27.	Approve the design of local incentive schemes		Authority to approve							
	Other Primary Care Services									
28.	Approve the commissioning strategy								Authority to approve	Authority to approve
29.	Approve a commissioning strategy or plan for each service								Authority to approve	Authority to approve
30.	Approve the design of services, including pathways, specifications and models of care								Authority to approve	Authority to approve
31.	Approve the procurement process to select providers to deliver services								Authority to approve	Authority to approve
32.	Approve the appointment of providers to deliver services								Authority to approve	Authority to approve
33.	Approve contracts with providers selected to deliver services								Authority to approve	Authority to approve

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

PART THREE - STRUCTURE DIAGRAM OF THE GOVERNANCE ARRANGEMENTS



SCHEDULE 3 – FINANCIAL FRAMEWORK

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FINANCIAL FRAMEWORK

Between

City and Hackney Clinical Commissioning Group and

The Mayor and Commonalty and Citizens of the City of London

Table of Contents

Defined Terms

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

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

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

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

DH – Department of Health

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

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

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

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

Partners – the CCG and the Council are partners to the s75 agreement and the Integrated Commissioning Fund.

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

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

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

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

Terms of the Financial Framework

1. CONSULTATION AND APPROVAL

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

- Approval of the CCG (Governing Body)
- Approval of the Council, specifically the CSS Committee and P&R Committee, and (for the Better Care Fund) the Health and Wellbeing Board.

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

1.3 The process of consultation for the Financial Framework will be aligned with the development of the s75 agreement and the arrangements for the development of the Integrated Commissioning Fund. It forms a Schedule to the s75 agreement.

1.4 Approval of the inaugural Financial Framework will be by:

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

2. FREQUENCY OF REVIEW AND RENEWAL

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

- The CCG (Governing Body)
- The Council

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

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

3. SCOPE OF THIS FINANCIAL FRAMEWORK

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

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

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

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

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

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

- Support and facilitate the achievement of the objectives of the Integrated Commissioning Fund;
- Ensure that the objectives and functions of the Partners and of the Integrated Commissioning Fund are complementary and mutually supportive;

- Ensure due diligence and appropriate oversight of financial decisions;
- Ensure the achievement of the Partners' objectives.

Responsibilities

4. PARTNER RESPONSIBILITIES

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

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

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

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

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

5. RESPONSIBILITIES OF THE PARTNER ORGANISATIONS' LEADERSHIP

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

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

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

- Ensure the adequacy of the Integrated Commissioning function's business plan and alignment with the partners' plans
- Approve the adequacy of organisation, staffing and management of Integrated Commissioning
- Aim to have a harmonised business planning and monthly reporting timetable by Q1 of 2017/18 and going forward, such a timetable shall be available by Q3 of the preceding financial year.

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

- Approving the key governance documents (where these are different from the Partner organisations' documents);
- Approve the use of the relevant Partners Standing Orders, Standing Financial Instructions, Schedule of Decisions Reserved, Scheme of Delegated Authorities etc. The Partners will endeavour to unify these where appropriate;

- Ensuring the performance of the Pooled Fund is scrutinised regularly and appropriately;
- Delivering scrutiny and pre-approval of significant new programmes and projects.

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

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

6.1 Authorised Officer

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

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

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

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

6.2 Chief Financial Officer

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

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

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

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

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

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

7. RESPONSIBILITIES OF THE HOST PARTNER

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

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

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

8. RESPONSIBILITIES AND ROLE OF THE POOLED FUND MANAGER

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

Management of the Pooled Fund

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

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

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

8.5 A summary of the responsibilities of the Finance Economy Group and Task and Finish Group are set out in the table below:

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

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

9. TERMINATION OF THE SECTION 75 AGREEMENT

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

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

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

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

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

10. CESSATION OF THE POOLED FUND

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

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

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

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

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

Scope and description of the Fund

11. SCOPE OF INTEGRATED COMMISSIONING

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

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

financial ledger record will be designed to allow for the pooled and aligned elements of the fund to be identified and disaggregated clearly.

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

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

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

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

12. BETTER CARE FUND

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

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

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

13. VALUE OF THE INTEGRATED COMMISSIONING FUND

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

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

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

NHS

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

Local Government

- Adoption services (Adoption & Childcare Act, 2003);
- Appointment of mental health professional (MHA, 1983);

- MHP powers of entry (MHA, 1983);
- Safeguarding children in care homes (Children Act, 1989);
- Appointment of director of social services (LASSA, 1970).

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

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

14.1 The populations served by the Pooled Fund are not consistent between the Partners; and essential Integrated Commissioning extends beyond the boundaries of the Pooled Fund. The Partners agree to seek to avoid creating unnecessary barriers or inequalities of access for Service Users. They agree to seek to avoid creating perverse incentives in the design of commissioned and provided Services.

14.2 Funding inconsistencies are created by:

- Council residents registered with GPs outside of the City of London area;
- Non-Council residents registered with GPs within the City of London;
- Individuals not resident; and not registered with GPs in the area requiring services within the scope of the Integrated Commissioning arrangement;
- Service Users who receive Services who are not physically present in the borough.

14.3 Unwanted barriers and incentives to commissioning are created by:

- The 'footprint' of the main providers of NHS services extending into neighbouring areas,

14.4 Potential service level boundaries and inconsistencies may also occur as a result of the range of local government commissioned services that remain with the Council.

Statutory reporting requirements

15. ANNUAL FINANCIAL ACCOUNTS

15.1 The value of the budget for the Pooled Fund, as described in the Section 75 Agreement, will be material to both Partners; and as such will be subject to appropriate levels of external and internal audit scrutiny.

15.2 The annual financial accounts of both Partners will be required to include sufficiently detailed notes of the financial performance and records of the Integrated Commissioning arrangement:

- The structure of reporting to be followed for a "Joint Operation", such as this Integrated Commissioning arrangement, is prescribed by the International Financial Reporting Standards (IFRS) in IFRS11(Joint arrangements) and IFRS 12 (Disclosure of interests in other entities);
- The Statement of Financial Performance of the formal Pooled Fund is to be reported in the Host Partner's accounts and reflected in the other Partner's accounts;
- The financial performance of Aligned Fund is to be reported within the body of the relevant Partner's accounts;
- The financial performance of the entirety of the Integrated Commissioning Fund; and the associated risk share arrangement, is to be reported as an explanatory note in both Partners' accounts.

15.3 Planning for accounts preparation and required audit arrangements will take account of:

- Timetables for producing the annual accounts, their audit and reporting requirements; recognising the earlier reporting deadlines for NHS accounts. It is acknowledged that Council reporting deadlines are susceptible to change;

- The scope of required reporting, including the contribution to the CCG Annual Report; and to the Council Annual Report;

- The evidence required to support the annual statement on governance; and for reporting any financial concerns with the Integrated Commissioning Fund;

- The evidence required to support the Head of Internal Audit Opinion and the external audit Regularity Opinion.

15.4 The annual financial accounts will be delivered within the requirements of the financial regimes and rules of each Partner, specific to over and underspending:

- CCG – Resource Allocation Budgeting impact and treatment of over and underspends – impact carried forward into next year's allocation;

- Council – not allowed to carry forward overspend for the year. Overspending to be met from reserves, but more likely to be addressed through service reviews across the Council during the year.

16. ARRANGEMENTS FOR AUDIT AND COUNTER FRAUD

16.1 The Partners agree that they will seek a joint approach and joined up arrangements for the internal audit of the Integrated Commissioning function and associated budget resources:

- Access arrangements for both sets of (internal and external) auditors will be agreed as part of the annual audit planning and scoping exercise;

- Deliver combined assurance to the CCG and Council where possible;

- Deliver each Head of Internal Audit (HoIA) opinion and shared assurance for both Partner organisations.

16.2 In terms of the external audit legal and regulatory requirement:

- The Integrated Commissioning arrangements will represent a material and significant element of each Partner organisation's audit;

- The audit will address the Pooled Fund fully within the Host Partner's accounts, with the required narrative note in the accounts of other Partner;

- The audit will address the aligned elements of the fund within the accounts of the Partner with the originating budget, or the Partner to which the funds were transferred through s76 or s256 of the National Health Services Act 2006, if such transfers occur;

- A note will be included in the accounts of both Partners setting out the results; and the risk share impacts, for the entirety of the Integrated Commissioning Fund.

16.3 The assurances required for the sign off of the audit of both sets of financial accounts will be agreed between the external auditors.

17. LOCAL COUNTER FRAUD AND SECURITY MANAGEMENT SERVICES (LCFSMS)

17.1 NHS Protect has confirmed that its focus will continue to be on NHS resources. The Partners agree that coverage of counter fraud culture and issues within the Integrated Commissioning arrangement will be joined up, as far as is practicable:

- The CCG and Council will agree arrangements for sharing the approach to promoting the

counter fraud culture; and for investigating and addressing instances of suspicion of illegal activity;

- The Council counter fraud functions will continue to be delivered by its internal audit provider and specific fraud team.

Budget Setting

18. BUDGET SETTING GROUND RULES

18.1 The Policy for commissioning through the Integrated Commissioning Fund is compatible with and delivers effectively the strategic priorities of both Partners.

18.2 Funds can only be used to commission prescribed services (as described in various legislation); and services that the Partners agree will contribute to the effective delivery of the commissioning priorities.

18.3 Delivery of a balanced outturn is a pre-requisite of commissioning decisions.

18.4 (Future Target) Budgets subject to specified limitations; and budget resource will be transferrable between the Partners, to enable optimum delivery of commissioned services and ensure best value in the use of resources. This will be recognised within each Partners medium term financial strategy.

18.5 The Partners agree that the Integrated Commissioning Fund will be reviewed during 2017/18 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

18.6 Commissioning decisions take account of the potential impact on services retained by the Partners.

18.7 Commissioning decisions are sensitive to the potential impact on the wider community of Providers.

19. BUDGET SETTING METHODOLOGY

19.1 Prior to the commencement of each financial year following the commencement of the s75 Agreement, both Partners need to be satisfied that the other Partner's methodology for setting the annual budget is robust and reliable. If they are not, the issue shall be escalated through the appropriate Dispute Resolution Procedure. Each Partner will agree the other's methodology for setting the inaugural budget contribution; and future years' budgets. The factors that will be considered include:

- Clarity of the Services to be included in the Integrated Commissioning arrangement and risk share (Pooled Fund and Aligned Fund);
- Verification of budget determined for each Service;
- Assumed and modelled trends in demand;
- Deliverability of the savings targets applied;
- Sufficiency of the budget applied (e.g. compared with previous year outturn).

19.2 The Partners will agree:

- A transparent approach to setting budgets shared between the Partners;
- Validation of the key assumptions and approaches used by each Partner to determine the budget;
- Plans for migration to a more consistent approach to budget setting and demand

forecasting that recognises the modelling challenges specific to each organisation.

19.3 Both Partners recognise the risk to resources from unmet need and rationed Services from previous years.

20. ACCURACY OF ACTIVITY PROJECTIONS, TRENDS AND INTERVENTIONS

20.1 The CCG approach differs depending on services but is a combination of totals agreed in contract negotiations with Providers and detailed demand modelling taking in to account of known activity, trends and forecast growth.

20.2 The Council approach is based on cost and volume analysis of likely trends in demand for Services. As part of this, the Council will:

- Determine the access eligibility thresholds for health related services, as defined by the Care Act 2014 and any flexibilities allowed;
- Determine the charges to be levied against Service Users, where this is an option.

21. ACCURACY OF COST PROJECTIONS

21.1 The Council commissioning budgets will be recognised in gross value, as well as in net value:

- Other budgets, where costs are partially offset by income from fees and charges and grants, will be included at their net value in the risk share calculations.

21.2 The Councils scope to assess the eligibility thresholds for access to services; and to set fees for services, will be taken into account when negotiating relevant contracts.

22. ADDRESSING CONFLICTS IN BUDGET SETTING PRIORITIES

22.1 It is expected that the Integrated Commissioning budget planning process will not adversely impact on the other commissioning obligations of the Partner:

- The Partners' oversight and scrutiny functions will have the opportunity to challenge any changes proposed. Any proposed changes to the budget planning process including harmonising the timetables will need to be signed off by the CFOs of each of the Partners. Any conflicting elements will be fed through to each Partner's governing body or equivalent.
- The scheme of delegations will provide a level of control over the approval of changes;
- Arrangements will be adopted for administering proposals for significant re-engineering; and compliance with business planning and investment proposal discipline, including comprehensive consultation.

22.2 It is expected that changes in the strategic direction of the Partners will not impact adversely on each other, or on the commissioning obligations of the Integrated Commissioning function.

23. USE OF INTEGRATED COMMISSIONING FUNDS

23.1 As set out in the s75 Agreement, the Integrated Commissioning Funds shall only be used for Permitted Expenditure.

24. FUTURE BUDGET SETTLEMENTS

Risk to be addressed: Financial settlements and budget uplifts for future years are insufficient to meet rising demands and rising costs

Possible scenarios:

- Local Government grant funding from government (Revenue Support Grant) is projected to reduce significantly over the next 3 years. The main sources of funding will then be Council Tax and Business Rates;

- NHS funding earmarked for health related services (Better Care Fund) is expected to increase in the next years.

- The size and trend in the gap between the two funding streams over the next 5 years is not certain.

- Both Partners may be required to produce medium term efficiency plans in order to receive multi-year financial settlements.

- NHS England may impose the need for the CCG to provide financial support to other areas within the North East London health economy.

24.1 Principles of response to these risks and future pressures:

- As far as is possible, the value of the single budgets will be kept at their equivalent current value

- Treatment of remaining resource gaps is likely to be addressed as additional savings targets

24.2 Mitigations:

The Partners will agree a protocol for agreeing amendments to the budget setting model in subsequent years. This will include consideration of:

- Treatment of prior year overspends

- Treatment of efficiency savings delivered from previous years

25. BOUNDARIES TO THE FUND

25.1 Budget setting will take account of boundaries on a number of planes:

- Pooled Fund versus retained funds;

- Pooled Fund versus Aligned Funds;

- Non-resident patients registered with GPs in City of London;

- City of London residents registered with GPs outside of City of London;

25.2 Budget setting will also to take account of patients registered with GP Practices in the City of London area, whilst recognising that they are outside of the Integrated Commissioning Fund arrangement.

26. FINALISING THE PRIOR YEAR POSITION

26.1 Both Partners acknowledge that the financial performance of the relevant budgets in the current year should be regarded as a key indicator of future years' risks; and of the scale of the savings targets agreed between the Partners. The following constraints will need to be accommodated:

- Current year out-turn position will not be known until very late in the process.

26.2 The value of the Integrated Commissioning Fund will be based on the budget allocations

- Indicative savings targets will be identified by the Partners from time to time.

27. TREATMENT OF HISTORICAL OVERSPENDS / UNDERSPENDS

27.1 CCG would account for prior year deficit as a negative balance on the RAB (Resource Account Budgeting) settlement and a prior year surplus as a positive balance.

27.2 The Council cannot record a year-end deficit; and must fund remaining overspends from

reserves. Overspends identified during the year are addressed through service reviews and rationalisation of the scale of non-mandatory services provided, offsets from underspent directorates, or by allocation from reserves at the year-end.

28. PRIOR YEAR AND IN-YEAR OVERSPENDS / UNDERSPENDS

28.1 The Partners recognise that differences in funding regimes and freedoms result in a different response to recorded "overspends":

- The CCG cannot carry "reserves" between years. Underspends and overspends are recognised within the annual resource allocation. Overspends in one year result in reduced allocation in the next. The CCG can set a budget that delivers a planned overspent position, but is expected to achieve balance over a 3 to 5 year period.

- The Council cannot record an overspend at the year-end; and has to account for overspent budgets through its reserves. But the reserves are limited and should be replaced through budget targets set in the subsequent year.

28.2 The Partners agree, in principle, that they will use these differing "flexibilities" in a combined approach to maximise protection to the Integrated Commissioning function. Any unused contingency sums in the Pooled Fund must remain in the Pooled Fund hosted by the Council and will form reserves available to the Integrated Commissioning Board in subsequent years.

28.3 Further detail in relation to the CCG Contingency Fund is set out in section 33 of this Financial Framework. Other contingencies available to the Partners may be provisions made from the balance sheet or accumulated reserves. Release of such contingencies shall be made following the approval of the relevant Partner that holds such contingency.

29. TREATMENT OF UNDERLYING AND EMERGING DEFICIT:

29.1 Underlying and emerging deficit will include:

- Unidentified deficit:
    - unmet need
    - unmet demand
- Identified deficit:
    - undelivered services
    - service delivery backlogs
    - waiting lists

29.2 The CCG and the Council agree to work together to identify responses to the threat of emerging unfunded demand pressures and growth in demand.

29.3 The first point of responsibility for addressing pressures through contracts will be the Lead Commissioner. A Lead Commissioner will be identified for each Service Contract.

29.4 Escalation arrangements will be agreed for Service Contracts and commissioning arrangements that appear to be overheating and indicate future losses. See section 9.3 of the Financial Framework.

30. SETTING SUBSEQUENT YEARS' BUDGETS

30.1 The Section 75 Agreement specifies that the Integrated Commissioning Fund will be subject to annual review. This will be alongside the medium term financial plans of each Partners.

30.2 The Partners agree to a shared approach to:

- Identifying and agreeing future trends in demand and service design;
- Checking sufficiency of growth funding;
- Identifying and accounting for changes in cost pressures;
- Identifying and agreeing savings and efficiency approaches. Ensuring the robustness of planned savings programmes;
- Setting criteria for values for savings targets:
    - Minimum and maximum allowed;
    - Reality checked and deliverable.

30.3 The Partners agree to design a robust business case approach to service redesign; and to its financial impact. This will involve:

- Robust analysis of overall savings projections;
- Robust analysis of comparative impact on Partners; and recognition of the need to reflect (compensate) for these impacts in future budget setting;
- Agreement on the impact on the risk share.

30.4 Where the CCG is able to drawdown funds from prior year RAB surpluses, these funds shall only be committed by the Integrated Commissioning Board to support its programme of work. Such funds can only be applied non-recurrently.

30.5 Where CCG Contingency Funds have been applied to meet in year cost pressures, it is the responsibility of the Integrated Commissioning Board to ensure effective measures are put in place to restore the CCG Contingency Funds in the following year.

Risk Sharing Framework

31. SCENARIOS OF OPERATIONAL PRESSURES AND RISKS IN BUDGET SETTING

31.1 The following sections set out a range of scenarios of risk:

Pressures on Partners' budgets

(A) Risk: Pressures within either Partner which results in shortfall in growth funding and/or increased savings targets

Possible scenarios are:

- Shifting priorities in the Council from other directorates and services;
- Internal pressure on overall CCG position resulting in pressure on budget allocation for City of London patients;
- Changes in targets set (externally) for performance in specific service area(s) within the Integrated Commissioning Fund.
- Increased savings targets set (externally).

Principles of response to these risks and future pressures:

- Impacts due to shifts in internal policy and priority have to be discussed by both Partners
    - Partners have to agree on how and when to apply accumulated savings;
- Impacts due to external policy and target changes to be regarded as required changes;

and partners to agree response

  - Accumulated savings can be applied to offset, but need to recognise limited resource

(B) Risk: Available resources and budgets do not address current demand

Possible scenarios are:

- Growth rates in demand for services exceed available funding increase;
- New commissioning arrangements and single approach to commissioning identifies previously un-met need;
- Providers are carrying backlogs in activity that need to be delivered and need to be funded.

Principles of response to these risks and future pressures:

- The Integrated Commissioning function must seek to achieve a balanced financial out-turn;
- Providers of services will be encouraged, including through contracting, to manage service delivery costs within the allotted amount;
- Where possible, Services will be prioritised and needs assessed. Non-statutory services may be withdrawn, if impact is less significant than effect of rationing funds to areas of demand growth. Service rationing will not be organisation specific;
- Funds will be made available to promote more effective and streamlined provision of Services.

Savings targets, reserves and contingencies

(A) Risk: Efficiency savings targets applied within budgets are undeliverable

Possible scenarios are:

- A Partner is unable to show persuasive plans for achieving the savings expectations;
- Savings target exceeds sensible levels;
- Savings proposals would have an adverse and costly effect on other elements of the overall service delivery.

Principles of response to these risks and future pressures:

- Agreed process for identifying efficiency savings targets:
  - From service delivery re-design;
  - From QIPP expectations;
  - From benefits expected of merged commissioning;
  - From share of organisation's overall target;
- Agreed approach to identifying benefit shares with Providers.
- Agreed process for verifying likelihood of delivery of the savings targets:
  - Arrangements for assessing schemes to deliver;
  - Risk assessment for schemes; and response to higher risk proposals.
- Agreed arrangements for sharing the risk of under-delivery of efficiency savings targets;

- Arrangements for allowing late amendments to budgets and savings target:
    - E.g. QIPP schemes determined late.

(B) Risk: Insufficient resources to allow for a contingency or reserve to be set

Principles of response to these risks and future pressures:

- Partners will agree rules specifying whether contingency (both recurrent and non-recurrent) is a required element of the annual budget; and what this level is:
    - Proportion of annual total allocation designated to contingency target to be agreed;
    - Arrangements for agreeing contingency that is lower than the agreed target;
- Partners agree proposed treatment of any reserves brought into the Integrated Commissioning Fund:
    - Budgeted from savings in previous year(s);
    - Agreement of priorities and triggers for calls upon reserves;
- Treatment of unspent contingency, or other underspend of the total budget to be determined by the Partners:
    - Proportion, or target value to retain within the Integrated Commissioning Fund;
    - Treatment of any underspend to be returned to the Partners;
- Agreement on accounting for reserves. The CCG is unlikely to be able to report resource balances to carry forward:
    - But, the CCG would report the net position across the whole. The performance of City and Hackney and the rest of the CCG may, in total, allow for shadow reserves to be identified for the City of London element.

32. GOVERNANCE OF SERVICE REDESIGN

32.1 The Partners will agree a protocol for developing service re-design. Elements will be delivered within the Integrated Commissioning Strategy of the Integrated Commissioning Board. It will involve a formal project management procedure for planning significant changes in service delivery design, which:

- Identifies resource implications;
- Identifies staffing implications;
- Assesses the impact on commissioning intentions:
    - And status of agreements with providers;
- Assesses the impact on Service Contracts:
    - Potential differential share of savings between the CCG, the Council and the Provider;
    - Potential for budget shift impact in advance of risk share arrangement;
- Delivers alignment with wider service design agenda.

32.2 Formal approval arrangements will be implemented, involving both Partners and requiring formal sign-off of projects

32.3 The Partners will agree the approach to monitoring of the impact on budget allocations:

- Linked to potential recognition of impact in budget planning;
- Impact on financial risk share.

33. CCG ACUTE CONTINGENCY

33.1 The CCG will apportion some contingency budget which will be earmarked for CCG related pressures and risks. This is defined as the CCG Contingency Fund in the s75 Agreement. The CCG Contingency Fund will cover in-year cost pressures including acute contract over performance and managing any budgetary gaps that emerge.

33.2 The CCG Contingency Fund will not include the 0.5% unallocated strategic risk reserve required by NHS England as part of a system-wide NHS risk management approach.

33.3 Use of the CCG Contingency Fund will require approval by the CCG Chief Finance Officer. The CCG CFO will determine the apportionment of the CCG Contingency Funds between the Pooled Fund and the Aligned Fund at the start of each Financial Year, based on an analysis of risks.

The CFO may, at their discretion, extend the use of the CCG Contingency Funds sitting in the Aligned Fund to the Pooled Fund, especially if such action will minimise pressures on health, such as avoiding bed blockage. The CCG Contingency Funds will not be used outside of the scope of the Pooled Fund and Aligned Fund.

33.4 Where CCG related budget pressures are unable to be contained within the totality of CCG's Pooled budgets, the CCG CFO must inform the Integrated Commissioning Board, and the Integrated Commissioning Board must take immediate mitigating action at its next meeting to ensure the Fund is in balance.

Note: For 2017/18, no Local Authority contingency budget is included in the Pooled Funds.

34. BUDGET VIREMENTS

34.1 Budget virement means moving budgets between different budget lines. This process is designed to cover virements involving movement of budgets within the Pooled Funds (e.g. from one work stream to another or within a work stream from one service to another), or from Aligned Funds to Pooled Funds subject to approval from the relevant statutory body CFO.

34.2 The budget setting process aims to ensure that all budget holders receive realistic budgets at the start of the year in order that the business plan can be achieved. Nevertheless, there will inevitably be in-year changes, and this is where virement may be used.

34.3 There are occasions where virement are generally appropriate. These include:

- Adjustments to reflect changes that could not have been foreseen at the start of the year.
- Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purpose and are used for another agreed purpose.
- Movement of Reserve budget to fund specific initiatives or mitigate budgetary risks where agreed by the Party funding the reserve.

34.4 Virement Rules and Processes

- A virement is not permitted from non-recurrent to recurrent expenditure
- A Virement is not permitted where the CCG or Council would be committed to additional recurrent funding in excess of commitments agreed within the CCG or Council's operating plan
- Virements within the Pooled Funds must be approved by the CFO/Finance Director for the relevant Partner seeking to make the budget change
- Virements to / from BCF parts of the Pooled Fund must be agreed by the Partners and in accordance with BCF guidance and rules.

35. VALUE OF FINANCIAL RISK FROM THE OTHER PARTNER

35.1 The Partners recognise the high risk of overspending of the Integrated Commissioning Fund but there is a shared commitment for the maximum resources to be included within the Integrated Commissioning Fund.

35.2 The Partners will be responsible for the management of their own deficit arising within the level of resources which they contribute to the Integrated Commissioning Fund. The detail of how this works operationally is set out in Clauses 12.7 and 12.8 of the s75 Agreement.

Managing the transactions of the Pooled Fund

36. TRANSACTIONS WITHIN THE POOLED FUND

36.1 Funding management arrangements, at the transaction level, will be designed in line with the principle of limited change and aim for consistency with the administrative approach of the previous year: Where practicable funds will remain with the respective Partner; and relevant transactions will be handled by them. If required, to fulfil specific s75 Pool rules, recharges will be applied to ensure that the entirety of the Pooled Fund record is accounted for within the Pooled Fund.

36.2 The mechanism of "cash" flow and contribution to the Pooled Fund is:

- Partner organisations will continue to access financial resources in the same way as they currently do: CCG draw down of funds; the Council transfer of cash. A regular reconciliation of transactions made by the Partners on behalf of the Pooled Fund shall be overseen by the CFOs and any net balance of the cash due to the Host Partner shall be enacted by the CFOs.

36.3 Expenditure from the Integrated Commissioning Fund:

- Contractual arrangements will be unchanged from the Partners' existing arrangements, unless evolving integration necessitates redesign.

- A Lead Commissioner will be identified for each contractual arrangement.

36.4 Specific arrangements and rules will be determined for the "direct payments" processes for Service Users (use of a holding bank account and "debit cards").

36.5 Any potential impact of VAT regime differences will be reduced through the planned consistency of approach to:

- Identify the scale and scope of the issue;

- Ensure that the correct VAT regime is applied to each transaction;

- Identify NHS service elements versus health related service elements.

36.6 The Partners agree to assume a "fair proportions" contribution to the input of non-financial resources (staff, premises, equipment, support services etc.), in accordance with the existing arrangements. This assumption will be reviewed during the first year of the Integrated Commissioning approach.

Managing Financial Performance

37. BUDGET MANAGEMENT GENERAL ARRANGEMENTS

37.1 The starting principle is that the structure of the budget management and responsibility will evolve during 2017/18, rather than face a major re-structuring at the start of the year.

37.2 But the Partners expect to make clear and consistent progress, from the start of the financial year, towards a more joined up structure of budgetary control.

37.3 The financial regulations (SFIs, SoDA) of each Partner will be reviewed for consistency. Where

required, the regulations will be amended to enable the proposed structures and responsibilities to be implemented.

Review of in-year budget allocation

37.4 The basic principle is that budget allocations to the Integrated Commissioning Fund will not change (in-year) once they have been agreed however agree that they will be reviewed during 2017/2018 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

37.5 Resources, identified during the year, and specific to the services in the agreement and to the population served, will be adjusted accordingly. Examples include:

- Specific grants;
- Funding from DH, NHS England, other government sources;

37.6 The Partners will agree a model whereby they retain the right to revisit allocations during the year provided that a minimum of three months' notice is given, unless both Partners agree otherwise (in writing)

- Risks arising from external sources (protocol for responding to pressures, faced by either partner, from external sources);
- Risks arising from internal sources.

38. IN-YEAR FINANCIAL PERFORMANCE

Local operating rules

38.1 The Partners will implement administrative arrangements that will be based on existing arrangements, but will be developed, where beneficial, for the Integrated Commissioning function as a whole.

38.2 For individual schemes, the arrangements will reflect:

- Any legislative / funding restrictions or requirements
- strategic priority restrictions

38.3 Reporting of performance (financial, contracts, quality etc.) will be delivered in terms of gross income and expenditure.

38.4 The forecasting approach for the Pooled Fund and the wider Integrated Commissioning Fund will be determined by the Partners.

Monitoring performance

38.5 The Partners will develop a model for monitoring monthly performance of the Integrated Commissioning Fund. This model will include:

- Actual and forecast expenditure and income;
- Arrangements for identified accruals for activity delivered;
- Monitoring of service backlogs.
- Cash transactions for receipts and payments.

Responding to overspend trends

Alerting Partners of the likely overspend

38.6 The Partners will develop an agreed approach to addressing trends towards overspending in the Integrated Commissioning Fund. Design of the tool for alerting partners of likely overspend will include:

- Triggers and thresholds;
- Agreed sensitivity measures;
- Trend analysis and alerts;
- Analysis of impact of/on related activities;
- Impact of progress along the annual timeframe – forecasting and sensitivity analysis over the medium term.

38.7 Escalation rules will address

- Scope for managing the situation including agreed delegations;
- Process for escalating to the other Partner.
- The Partners' approach to responding to adverse trends will vary, depending on the value of the potential overspend and the progress along the annual timeline:
    - differentiating response (scale, threshold etc.) according to progress through the financial year.

Managing potential overspends

38.8 Escalation arrangements for responding to overspends forecast through the year will include assessment of options for:

- Management of contracts (and contract adjustments);
- Management of demand;
- Service redesign.

38.9 The procedure includes arrangements for agreeing the response to; and flexibility allowed within the Integrated Commissioning Fund for changes in allocations, in-year:

- Both Partners options to curtail the Service at any point during the year.

38.10 Where elements of the trend to overspend are specific to one Partner, the Partners will agree:

- The priority of demand on available funds to offset overspends;
- The approach to allocating and apportioning risk (in year and forecast outturn) between the Partners.

38.11 Where elements of the trend to overspend exist within Integrated Commissioning elements i.e. where both Parties would otherwise separately contribute to the Service, the Partners will agree:

- The approach to allocating and apportioning risk between the Partners

38.12 The Partners will agree arrangements for emergency management of any recovery position, including:

- suspension of Host Partner's management of the Integrated Commissioning Fund;
- agreed amendments to the structure of governance and management of the Integrated

Commissioning Fund in emergency measures.

39. RESPONDING TO ANNUAL OVERSPENDS

39.1 The Partners will develop arrangements for addressing Overspends not recovered at the year-end and/or projected in future years. These will include:

- Escalation thresholds for response, based on the value of the overspend;
- Mechanism of carry forward to next year's budget:
    - CCG accumulated loss;
    - The Council repayment to reserves (but more likely to have been addressed through reduction in service provision during the year);
- Apportion according to agreed risk share model for first element of overspend:
    - Split by % contribution to Pooled Fund;
    - Risk sharing limits set to identify maximum contribution to be made by either Partner;
- Allocate remainder according to overspend pattern, to responsible Partner:
    - In accordance with risk sharing agreement.

39.2 The Council's inability to carry-forward an Overspent position will be addressed through use of reserves, which will be recovered in the subsequent year(s).

40. RESPONDING TO ANNUAL UNDERSPENDS

40.1 The Partners will identify underspends as generated:

- By whole Pooled Fund;
- By specific Pooled Fund elements;
- By Partner responsibility.

40.2 Options for addressing underspends recorded at the year-end will include:

- Allocate to investment fund;
- Carry forward to next year's budget:
    - Legal restrictions (CCG RAB budgeting);
    - The Council scope to hold balance, but CCG to prove no draw-down in advance of need;
- Off-set against next year's budget;
- Return to Partners:
    - Mechanism for agreeing share of returns.

Other financial Considerations

41. DESIGN OF THE FINANCIAL LEDGER

41.1 Both Partners will design processes that deliver a clear audit trail of each element of the Integrated Commissioning Fund.

- Assurance on the accuracy and completeness of the records will be provided by the

Partners;

- Assurance of compliance with s75 may be through a self-assessment and self-certification. But the Partners agree that this will be subject to an IA review, as a minimum.

42. FINANCIAL REPORTING RESPONSIBILITIES OF THE HOST PARTNER AND THE POOLED FUND MANAGER

42.1 The Partners will agree the arrangements for administering and managing the financial records of the Pooled Fund. Elements specific to the set-up of financial record include:

- Ledger and consolidations (developing the arrangement for combining the Integrated Commissioning Fund records of the Partners);
- Transactions (delivering the audit trail to show the transactions making up the Integrated Commissioning Fund record);
- Reporting.

42.2 The Partners will agree the financial performance reporting needs of each, including providing analysis and summaries of the financial performance of the Integrated Commissioning function, in accordance with the Partner organisations' requirements

- In accordance with timetables agreed by both Partners;
- Providing the details required by both Partners;
- Designed to meet the needs of the differing audience(s).

42.3 The Pooled Fund Manager will ensure the proper treatment specific aspects of the Pooled Fund and its transactions:

- Ring-fenced budgets, specific schemes and funding restrictions:
- VAT;
- Year-end treatment of surpluses;
- Audit.

42.4 The Pooled Fund Manager will ensure the provision of the annual return to Partners, identifying separately and in total: BCF and Pooled Fund

- Contributions to the Pooled Fund:
- Expenditure from the Pooled Fund:
- Treatment of the difference / risk share;
- Detail for ring fenced schemes and restricted funds;
- Reporting deadlines.

Requirements of partner organisations

42.5 The Partners will agree their respective requirements for the monitoring and reporting of the financial position:

- Financial contribution to the Integrated Commissioning Fund:
- Expenditure and commitments;

- Contract performance ;
- Overall performance of the Integrated Commissioning Fund.

42.6 Assurance framework requirements:

- Sources of assurance;
- Specific funding and ring fencing requirements in respect of appropriateness of spend.

42.7 Overview of management of the Integrated Commissioning Fund:

- Review arrangements;
- Access to records, including audit access;
- Ad hoc reviews.

42.8 And year-end requirements:

- Deadlines specific to NHS/LG and specific reporting requirements;
- Accountable Officer / s151 Officer assurance requirements;
- IFRS reporting requirement;
- Governance statement requirements.

43. MANAGING THE CASH POSITION

43.1 The Host Partner will:

- Hold monies contributed to the Pooled Fund that are required for transactions generated from the Host Partner:
    - The timing of contributions will align to payment obligations;
- Administer the payment processes for its own transactions;
- Administer the consolidation of the financial records of the Pooled Fund.

43.2 The Partners will adhere to the rules and restrictions applying to them:

- The CCG is required to limit cash draw-down to the monies required, when they are required:
    - Not allowed to draw excess cash;
    - Not allowed to earn interest, or investment income;
    - Not allowed to have a cash balance at the year-end;
- The Council is allowed to invest available cash to earn income on its own resource allocation:
    - The Council will determine how interest income is used; and is not obliged to include any part of that interest income in the Integrated Commissioning Fund.

43.3 Banking arrangements will reflect existing arrangements.

43.4 Transaction payments from the CCG and the Council will be unchanged from current arrangements. The Council should not suffer a reduced capacity to generate investment income from retained cash and investment balances. But, the Council will not be able to derive

investment advantage through early draw-down of CCG funds.

44. PAYMENT MECHANISMS

44.1 The Partners acknowledge responsibility for paying all sums due to Providers, in compliance with contract terms.

44.2 The Partners will agree arrangements for making payments to Providers, such that Providers are not affected by any changes to the structure of commissioning from the Integrated Commissioning Fund.

44.3 The design of payment mechanism will ensure that the Integrated Commissioning Fund structure delivers the full process of receipt of invoice, confirmation of service delivery and standards compliance, confirming amount due to invoice amount, instructing payment.

44.4 Providers will not be affected adversely by any specific rules that apply to certain services managed through the Integrated Commissioning Fund.

44.5 Any specific arrangements for LG and NHS to comply with will be identified and addressed, as necessary.

45. DIRECT PAYMENTS

45.1 The Partners recognise the growing importance and impact of direct payments to Service Users for purchasing their own agreed packages of care.

45.2 The design of the resource allocation arrangements will deliver:

- Discipline over approval of proposed care plans and direct payments approach;
- Security of funding ahead of spend by Service Users (e.g. “debit card”, pre-approved spend)
- Approach to recovering unused funding from individual Service Users.

46. Income opportunities

46.1 **Grants and sponsorship**

46.1.1 The partners will seek to maximise uptake of opportunities of funding offered, including:

- Government Grant funding:
    - As an annual allocation;
    - Through one-off projects;
- Grants from other organisations;
- Sponsorship;
- Opportunities to charge for enhanced services commissioned.

46.2 **Chargeable health related services**

46.2.1 The Council will retain responsibility for assessing the contribution (to a provided social service) to be paid by Service Users.

46.2.2 The Council will retain responsibility for collecting the assessed contribution.

47. VAT

47.1 The Partners have set out terms relating to VAT in the main body of the s75 Agreement.

48. CAPITAL INVESTMENT

48.1 The financial arrangements for the Integrated Commissioning Fund will recognise and allow for the Council approach to delivering future service improvement through capital grants to achieve improved quality, lower cost accommodation for services:

- Disabled Facilities Grant

48.2 The Council will retain ownership of any assets that are to be retained.

48.3 The Council has the option to arrange on behalf of both Partners unsupported borrowing to support capital investment in the City of London economy.

49. RESOURCES CONTRIBUTED BY PARTNERS

49.1 Staffing, equipment, accommodation etc. resources provided by each Partner to the management and administration of the Integrated Commissioning Fund will be based, initially, on existing structures.

49.2 The Partners will agree the approach to ensuring a fair share of the cost of administering the Pooled Fund.

49.3 The Partners will identify the savings to be generated through the medium term plan to deliver greater levels of integration of CCG and the Council staff, to identify operational and financial benefits from integration; and will agree the resulting benefit share between Partners.

SCHEDULE 4 – INFORMATION FRAMEWORK

1. Background

This Information Framework provides guidelines as to the level of information to be shared between the Parties, for the purposes of facilitating effective Integrated Commissioning.

The Parties shall share information relating to the commissioning of Services by way of Services Contracts with Providers when acting as Lead Commissioner.

The Parties will also share information in order to help better understand financial issues that may be arising with regard to a particular Services Contract.

Whilst complying with their respective obligations under this Information Framework the Parties acknowledge and agree that any information sharing contemplated by this Information Framework shall take place subject to the terms of the Agreement, and specifically:

i) Clause 6.7.9 of the Agreement, which sets out the obligation for the Lead Commissioner to provide the other Party with information as set out in this Information Framework; and

ii) Clause 31 (Information Sharing and Data Protection).

2. Interpretation

In this Information Framework:

i) the notification or provision of information to a receiving Party shall mean notification or provision of the information by the Lead Commissioner to that Party's Authorised Officer; and
ii) references to any definitions, information or circumstances shall include references to the equivalent definitions, information or circumstances where the Lead Commissioner is entered into a contract by way of City Contract, CCG Contract or otherwise.

3. Variations

This Information Framework and the Parties' obligations contained herein may be varied in accordance with Clause 34.2.4 of the Agreement.

4. Obligations as Lead Commissioner

The capitalised terms used in this section are, except for where provided for in the Agreement, defined terms under the NHS Standard Contract, and shall be interpreted accordingly.

Notifications

Each Party acknowledges and agrees that where it is Lead Commissioner for any Services Contracts it shall notify the other Party:

If it receives or serves any of the following:

- a Change in Control Notification;
- a Notice of an Event of Force Majeure;
- a Contract Performance Notice;
- a Service Variation;
- a Variation;
- a notice in relation to a Suspension Event;
- an Exception Report;
- a Remedial Action Plan or Immediate Action Plan;
- notice of the appointment of an Auditor;
- a Material Sub-Contractor Change in Control;
- notice of a request for information under the FOIA, EIR or DPA (subject access request);

- notice in relation to the Health Service Ombudsman;

If it becomes aware of one of the following events occurring:

- a material breach of the Provider or Commissioners obligations under the Services Contract;
- a Suspension Event;
- a Provider Insolvency Event;
- a change in Consents;
- a Provider committing a Prohibited Act;
- a Data Breach or any Information Governance Breach;
- any circumstances that have a material and adverse effect on the ability of the Provider to provide the Services;
- any Provider default or Commissioner default (as contemplated by GC17.9 and GC 17.10 of the NHS Standard Contract);
- any breach of confidentiality obligations;
- any Information Breach;
- any publicity, coverage or publications which will both substantially and materially have a negative impact on either Party's or the Provider's reputation in relation to the Services or in the opinion of the Service Users

and provide information where requested by the other Party, in relation to the notification.

Disputes

The Lead Commissioner shall:

- advise the other Party of any matter which has been referred for Dispute and consult with the other Party where there is a material dispute, as part of that process; and
- notify the other Party of the outcome of any Dispute that is agreed by the Lead Commissioner or determined by Dispute Resolution.

Consultation

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

- an Activity Management Meeting;
- a Contract Management Meeting; and
- a Review Meeting; and
- a Joint Activity Review;

and to the extent the Services Contract permits, raise issues reasonably requested by the other Party at those meetings.

Reports and Record Provision

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

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

- CQUIN Performance Reports;
- CQUIN Reconciliation Accounts;
- Essential Services Continuity Plans;
- Immediate Action Plans;
- Incident Response Plans;
- JI Reports;
- Joint Activity Reviews;
- Succession Plans;
- Transition Arrangements;
- Review Records;
- Remedial Action Plans;
- Quality Requirements;
- Service Quality Performance Report;

- Safeguarding Policies;
- Activity Management Plans;
- Data Quality Improvement Plan (DQIP);
- Service Development and Improvement Plan (SDIP);
- Auditor's draft report;
- Auditor's Final Report; and
- HCAI Reduction Plan

Restrictions

The Lead Commissioner shall not:

- permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;
- vary the Data Quality Improvement Plan (DQIP), Service Development and Improvement Plan (SDIP), Remedial Action Plan, Immediate Action Plan or any other Provider plans;
- agree (or vary) the terms of a Joint Investigation or associated Immediate Action Plan;
- suspend all or part of the Services;
- serve any notice to terminate the Services Contract (in whole or in part);
- agree (or vary) the terms of a Succession Plan or Transfer Arrangements,
- agree any substantive changes to the Services Contract in relation to an Auditor's final report;
- give any approvals under the Services Contract;
- agree to, or propose, any variation to the Services Contract (including any Schedule or Appendices);
- serve any notice.

without the prior approval of the other Party (acting through the Integrated Commissioning Board), such approval not to be unreasonably withheld or delayed.

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

1. INTRODUCTION

This Agreement between the City and the CCG establishes a framework for joining together the commissioning, provision, finances, performance management, and governance for the Services covered by the Agreement.

This Schedule outlines the arrangements for the performance management framework for the Agreement.

2. PURPOSE

This Schedule aims to ensure that Parties adopt an integrated performance management framework to ensure they plan, deliver, review and act on relevant information to commission improved outcomes for the people of the City of London.

This approach will ensure that the actions and investment of Parties will lead towards the achievement of national, regional and local performance targets as well as improving outcomes for the people of the City of London.

3. DEFINITION

Performance management is the overall process that integrates planning, action, monitoring and review. Performance management means knowing:

- What you are aiming for (e.g. purpose, mission, corporate aims, strategic goals etc.);
- What you have to do to meet these aims (e.g. business plan, project plan, etc);
- What the priorities are, and ensuring that there are sufficient resources (inputs);
- What the current performance is through monitoring and reporting; and
- How to review progress, detect problems and take action in a timely manner to ensure the outcome/target is achieved.

4. BENEFITS

Effective performance management enables relevant staff throughout the partnership to:

- Be clear what the strategic objectives are for commissioning; and
- Be clear what outcomes are to be delivered in any one Financial Year,

thereby ensuring better quality Services are delivered to local people.

5. OUTLINE FRAMEWORK

Essentially, the performance management framework consists of three processes in relation to joint commissioning, as set out below.

5.1 BUSINESS PLANNING PROCESS

5.1.1 Commissioning Plans that state the strategic objectives and key performance measures for a period of three to five Financial Years, and commissioning intentions for those objectives with timescales for achievement.

5.1.2 Services Contracts that state how performance will be monitored, reported, reviewed and necessary action taken, including performance indicators.

5.2 REPORTING AND REVIEW PROCESS

5.2.1 Overall progress against delivery of the outcomes in the Commissioning Plans.

5.2.2 Overall progress against delivery on the Services Contracts and identification of reasons for under performance.

5.3 **PERFORMANCE IMPROVEMENT PROCESS**

5.3.1 Ensuring action is taken where the continuation of current performance would lead to an outcome/target not being met.

5.3.2 Application of a range of tools and techniques to improve overall performance.

6. FRAMEWORK DETAIL

6.1 **BUSINESS PLANNING PROCESS**

6.1.1 It is the responsibility of the Parties to develop, and annually review, a Commissioning Plan on a rolling three financial year basis for the particular Service to be commissioned. Each strategy will be developed by adherence to the 'commissioning cycle' and in consultation with Service Users and carers.

6.1.2 It is the responsibility of the Parties to develop an annual Commissioning Plan. This Commissioning Plan will state the outcomes to be achieved, by when and what the risks are if they are not achieved.

6.1.3 Each outcome in the Commissioning Plan should be aligned to one of the strategic objectives. Any outcome that is not so aligned should be reviewed as to why it is being considered.

6.1.4 The relevant Party (whichever Party is agreed to be the Lead Commissioner for the relevant Services Contract) should then go through a process of developing, negotiating and agreeing a Services Contract with each Provider regarding the outcomes they are to deliver. It will be clear which Services are to be discontinued e.g. in the advent of a budget reduction.

6.2 Services Contracts with Providers should:

6.2.1 Take account of the requirements of the Better Care Fund Plan (if applicable) and the agreed Commissioning Strategies and annual plans of the City and the CCG;

6.2.2 Take account of legislative changes; and

6.2.3 Include a requirement on the Provider to develop a detailed service plan (e.g. stating what, by when, by who and the risk associated with not achieving the outcome) as to how the Provider intends achieving the said outcomes. It should also require the Provider to regularly measure progress against achieving the outcomes, to report this to the Lead Commissioner in a timely manner to an agreed frequency (e.g. monthly), and to provide a Performance Improvement Plan or Recovery Plan where financial under performance is significantly under target.

6.2.4 Include a process whereby outcomes may be added / removed as a result of changing needs.

6.3 **REPORTING AND REVIEW PROCESS**

6.3.1 Regular meetings should be held between the Host Partner and the Provider to review performance.

6.3.2 The Lead Commissioner will monitor Services, as part of a basket of measures that contribute to the delivery of key outcome, having regard to national, regional and local key performance indicators including:

6.3.2.1 National ASCOF Measures;

6.3.2.2 BCF Indicators (where relevant);

6.3.2.3 Audit and inspection recommendations;

6.3.2.4 Relevant Operational Plan indicators; and

6.3.2.5 NHS Operating Framework targets.

6.3.3 These key indicators form part of a basket of performance measures. Activity and Financial indicators will be another part of the complete basket.

6.3.4 The basket of performance indicators will be monitored and reported to the Integrated Commissioning Board using, wherever possible, existing performance reports generated within either the City or the CCG, and making it clear where the areas of good performance and those of concern are, i.e. using a simple traffic light scheme with exception reporting on the key issues. Any other contractual key indicators will be added to the list of indicators. These will be for where the City has set specific key indicators for Services Contracts where the City is the Lead Commissioner.

6.3.5 The performance of all Providers should be reported, on a regular basis by the relevant Partner to the Integrated Commissioning Board.

6.4 PERFORMANCE IMPROVEMENT PROCESS

Where necessary the Lead Commissioner should require the Provider to undertake specific performance improvement initiatives where performance is significantly under target.

SCHEDULE 6 – BETTER CARE FUND

BACKGROUND

The Better Care Fund will form part of the Pooled Fund, however the Parties acknowledge and agree that the Pooled Fund will not be subject to the BCF Reporting Requirements and Governance – only the Better Care Fund elements of the Pooled Fund will be subject to those terms. For the avoidance of doubt, the Pooled Fund shall not be considered to constitute the Better Care Fund, however the Better Care Fund will be an element of the Pooled Fund.

The Parties acknowledge that this Schedule 6 will be updated by way of a variation following the publication of the Better Care Fund Guidance in 2019. For the avoidance of doubt, until such time as the revised Better Care Fund Guidance is published, the Parties will roll over the existing Better Care Fund Plan for continuity.

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City and Hackney CCG and The City of London Corporation

BCF Narrative Plan 2017-19

11 September 2017

City and Hackney
Clinical Commissioning Group

Contents Page

Introduction

This document provides assurance information and details of plans for the Better Care Fund (BCF) and the Improved Better Care Fund (iBCF) for the City of London Corporation for 2017–19.

It builds on previous BCF plans developed since 2015/16 and includes additional information required to demonstrate how it meets the national guidelines and requirements as set out by the BCF Policy Framework for 2017 - 19. It also contains details of the plans for the additional iBCF money allocated.

This BCF plan continues with a number of successful schemes and the iBCF supports the provision of additional care packages, work around Continuing Healthcare and intermediate care.

The plan covers two financial years (2017 – 19) which aligns with NHS planning timetables, giving the opportunity to plan strategically and to have stability for some on-going schemes.

Local Vision and Approach for Health and Social Care Integration

The City of London Corporation vision for health and social care is that:

- City of London residents live long and healthy lives, supported in their local community wherever possible by integrated health and social care services
- Health and social care services are person-centred, co-ordinated, high quality, responsive and fit around the needs and preferences of the individual, their carers' and family and that
- They deliver across the complexity and unique challenges of City of London boundaries, care pathways and partner interactions

As the Five Year Forward View stated, the traditional divide between primary care, community services and hospitals is increasingly a barrier to the personalised and co-ordinated health services patients need. The plan set a new shared vision for the future of the NHS, emphasising the need to move to place based systems of care where organisations collaborate and use their resources effectively to meet the needs of their local population in the most appropriate and effective way. It also explores the challenges to be addressed in the NHS around finance and efficiency, improving the health of the population and providing quality of care.

Local partners endorsed this approach but with the addition of social care as an integral part of the services needing to integrate around each patient and that we need ever closer working between the NHS and local government to achieve our aims for our communities.

In April 2017, the City of London Corporation entered into integrated commissioning arrangements with City and Hackney CCG to join up

commissioning across health, social care and public health. The London Borough of Hackney has also entered into similar arrangements with City and Hackney CCG. See diagram on page 36 for further details of the governance structure.

The integrated commissioning arrangements aim to remove organisational barriers, develop more joined up plans and commission integrated services that benefit patients and service users. It supports an approach of moving to contracting for outcomes and commissioning providers to work across organisational boundaries.

The integrated commissioning arrangements are currently based on aligned budgets with some pooled budgets that are already in place such as the BCF. The longer term ambition is to have one larger pooled budget for integrated commissioning.

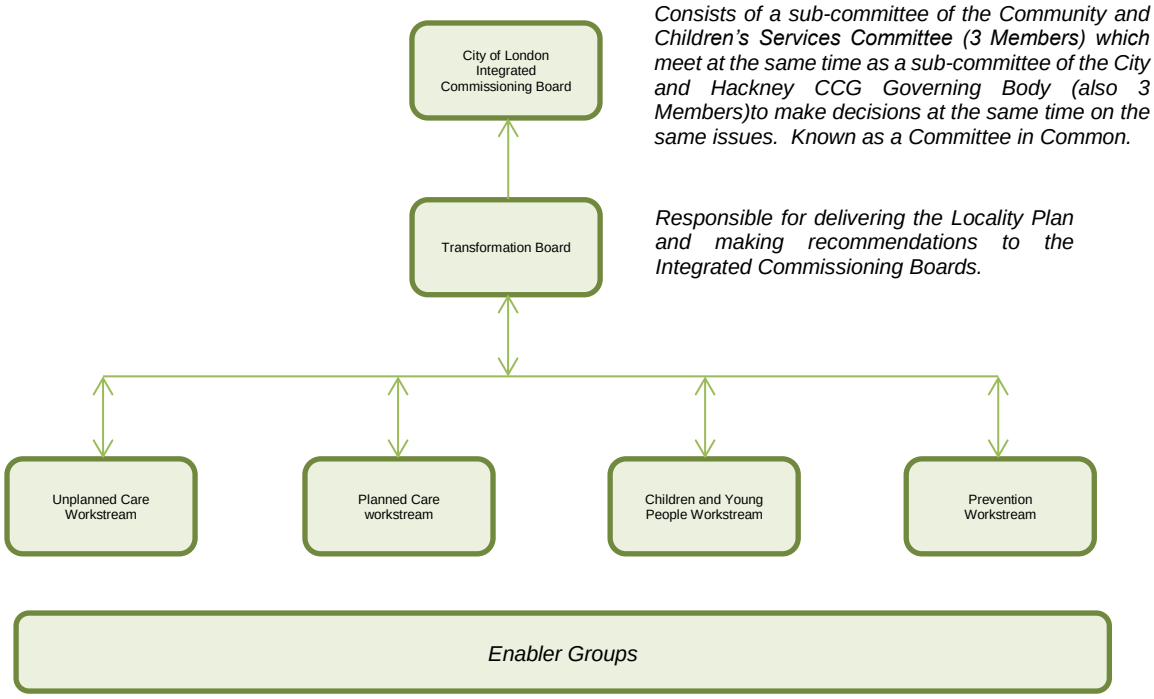
The aims of integrated commissioning include:

- Improving the health and wellbeing of local people with a focus on prevention and public health, providing care closer to home, outside institutional settings where appropriate, and meeting the aspirations and priorities of the 2 Health and Wellbeing strategies;
- Ensuring we maintain financial balance as a system and can achieve our financial plans;
- Delivering a shift in focus and resource to prevention and proactive community based care;
- Addressing health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value;
- Ensuring we deliver parity of esteem between physical and mental health;
- Ensuring we have tailored offers to meet the different needs of our diverse communities;
- Promoting the integration of health and social care through our local delivery system as a key component of public sector reform;
- Building partnerships between health and social care for the benefit of the population;
- Contributing to growth, in particular through early years services;
- Achieving the ambitions of the NEL Sustainability and Transformation Plan

The City of London's BCF plan supports the wider vision for integrated commissioning.

The following sets out how integrated commissioning arrangements are structured

Diagram 1: integrated commissioning arrangements



These groups work across the workstreams and include it, back office and workforce

East London Health and Care Partnership (North East London Sustainability and Transformation Plan)

The City of London is part of the North East London STP, known as the East London Health and Care Partnership (ELHCP). It also includes 7 other local authorities, 7 CCGs, 3 acute hospital providers and 2 mental health trusts.
The focus of the STP includes promoting independence and enabling access to care closer to home with less dependency on the hospital system and beds. Key enablers include new models of care, workforce, technology and infrastructure.

Whilst each of the local areas has a different starting point, common challenges include a growing population, a rapid increase in demand for services, and scarce resources. Based on these NEL-wide challenges, ELHCP have identified six key priorities:

1. The right services in the right place: Matching demand with appropriate capacity in NEL
2. Encourage self-care, offer care close to home and make sure secondary care is high quality
3. Secure the future of our health and social care providers. Many face challenging financial circumstances
4. Improve specialised care by working together
5. Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies
6. Using our infrastructure better

The plan also articulates some potential opportunities, which the BCF plan helps to support. These include reducing avoidable hospital admissions through prevention and out of hospital schemes that support self-care management and patient activation; support for better patient flow and early discharge; and greater capability and capacity in the community to help people recover and return home.

Across NEL the ambition is to go further in integrating health and social care services in order to implement person centred care models. A key part of doing this will be developing Accountable Care Systems that bring together providers of health and social care services around a single service model and a set of outcomes. There is also commitment to the integration of commissioning functions to support new population based contracting models.

The latest version of the plan can be found here - http://eastlondonhcp.nhs.uk/wp-content/uploads/2017/06/NEL-STP-draft-policy-in-development-21-October-2016.pdf

The City and Hackney integrated commissioning arrangements have been acknowledged as a new model of care within the ELHCP and with the move towards Accountable Care Systems (ACS), the partners within the integrated commissioning arrangements are considering how this could develop into a more formal ACS.

Table 1: Links with other plans

Government policy and local strategic context	**Overview**
Care Act 2014	Sets the legal framework for the adult social care

	system and is designed to focus on people's strengths and capabilities, supporting them to live independently for as long as possible.
Carers Strategy (2015-18) http://www.cityoflondon.gov.uk/services/adult-social-care/Pages/carers.aspx	Sets out the City Corporation's priorities for supporting adult carers in the Square Mile. The strategy has been developed based on analysis of evidence and consultation with carers and stakeholders, and in the context of recent legislative change. A key aim of the strategy is to identify and support more carers across the City, at an earlier stage, with a focus on improving their health and wellbeing. Delivery against the strategy will be monitored by the Adult Wellbeing Partnership. The Strategy identifies six priorities: **Priority 1:** carers are identified at the earliest opportunity and offered support to prevent , reduce or delay their needs and the needs of their cared for **Priority 2:** carers are provided with personalised, integrated support that is tailored to their assessed needs and aspirations, gives them choice and control and allows them to take a break **Priority 3:** carers are involved and consulted in the care and support provided to their loved ones, treated with respect and dignity, and have their skills and knowledge recognised **Priority 4:** carers are supported to improve and maintain good physical and mental health and wellbeing **Priority 5:** carers are supported to improve their individual social economic wellbeing, reduce isolation and fulfil their potential in life **Priority 6:** carers are supported to cope with changes and emergencies and to plan for the future, including when the caring role is coming to an end and to have a life after caring.
Community and Children's Services, Business Plan 2017 - 22	The Community and Children's Services Business Plan has 5 priorities: • Safe - People of all ages live in safe communities, our homes are safe and well maintained and our estates are protected from harm

	• Potential - People of all ages can achieve their ambitions through education, training and lifelong-learning • Independence, involvement and choice - People of all ages can live independently, be active in their communities and exercise choice over their services • Health and wellbeing - People of all ages enjoy good health and wellbeing • Community - People of all ages feel part of, engaged with and able to shape their community.
Health and Wellbeing Strategy https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/joint-health-and-wellbeing-strategy.pdf	The Health and Wellbeing Strategy has 5 priorities: • Good mental health for all • A healthy urban environment • Effective health and social care integration • All children have best start in life • Promoting healthy behaviours
City of London Health Profile https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/city-of-london-health-profile.pdf	Summary of some of the key health issues facing the City of London
Joint Strategic Needs Assessment (JSNA) https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/JSNA-City-Supplement.pdf	Assessment of the physical and mental health and wellbeing needs of individuals and communities in the City and Hackney. A City supplement has been produced to focus on the specific needs of the City.
The Adult Wellbeing Plan 2014-17  20150106 Adult Wellbeing Pla...	Set's out the City's vision for the right services at the right time, at the right place has determined the five key priorities of this Adult Wellbeing Plan. • **Early Intervention and prevention** - we are committed to a long term shift in service provision

	away from crisis intervention towards services that prevent or delay needs and reduce dependency. • **Stronger safeguarding** – we will lead locally in protecting peoples' health and wellbeing, and enabling them to live free from harm, abuse and neglect. • **Personalisation** – we will recognise people as individuals who have strengths and preferences. We will put them at the centre of their own care and support and provide good quality information, advice and advocacy so that people can make informed decisions. Support will be tailored to people's needs. • **Services working together** – we will work closely with other services and promote greater integration of health and social care to ensure that residents receive seamless, efficient and effective services to meet their needs. • **Co-production –** we are committed to finding innovative, collaborative ways of working to involve and support people to design, deliver and evaluate services.
Integration and Better Care Fund Policy Framework 2017-19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf	Published in March 2017, the framework has guided the development of the BCF plans and this document.
Housing Strategy http://www.cityoflondon.gov.uk/services/housing-and-council-tax/council-housing/Documents/housing-strategy-draft-march-2014.pdf	The Housing Strategy sets out the City of London Corporation's ambitions to deliver homes and housing services fit for the future in the Square Mile and central London including improving joint working with health and social care to support vulnerable and older people.
Mental Health Strategy	The overarching aims of the strategy are to improve the mental health of people in the City and keep people well and to provide effective support for

https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/city-of-london-mental-health-strategy.pdf	people with mental health problems. The priorities of the mental health strategy are: • Prevention • Personalisation • Recovery • Delivery
Corporate Plan 2015-19 https://www.cityoflondon.gov.uk/about-the-city/how-we-make-decisions/Pages/corporate-plans.aspx?page=all	The Corporate Plan's vision and strategic aims include providing and maintaining modern, efficient, accessible, responsive and high quality services to local residents within the Square Mile. These are supported by six key policy priorities including improving the value for money of services and maximising the opportunities and benefits afforded by the role of supporting London's communities.
City and Hackney CCG five year plan http://www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Equality%20and%20diversity/5%20YEAR%20PLAN%20UPDATE%20final.pdf	Plan sets out the CCG's intentions until 2019. It sets out the intention to use the BCF to ensure services and providers are working in unison to deliver patients' care plans and system wide metrics.

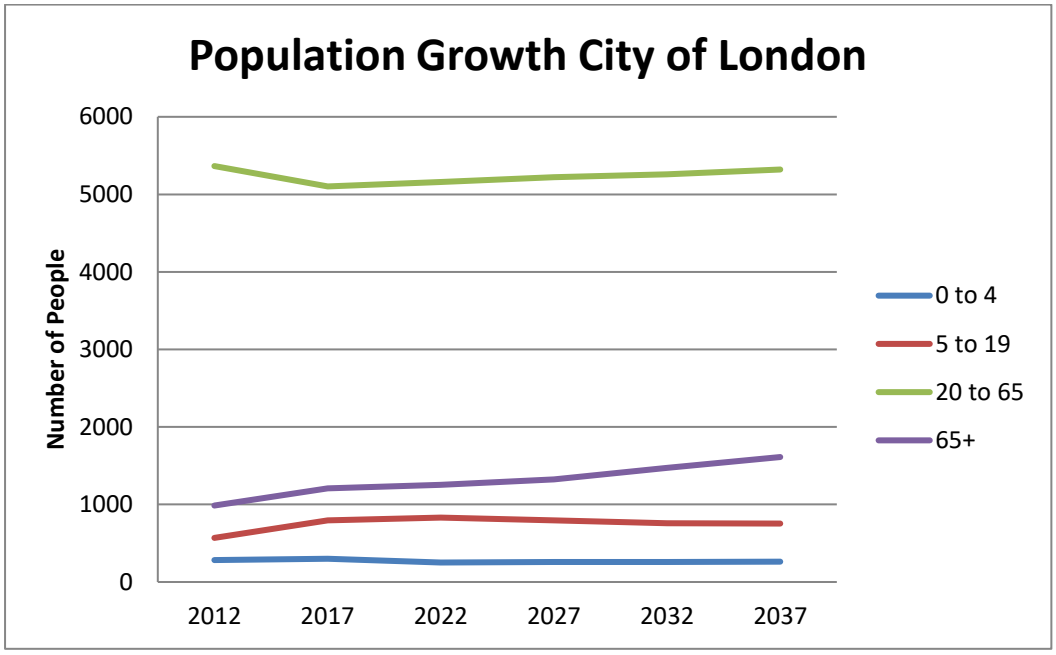
Background and context to the plan

The latest population estimates from the Office for National Statistics (ONS) places the City of London resident population at 9,400 which is projected to increase in coming years. Those aged 65 and over are projected to contribute the most to this growth, with their numbers increasing rapidly in the next decade. Life expectancy in the City of London is also better than the rest of London and England at 86.1 for males and 89 years for females. These two factors create potential for increased demand for health and social care

services in the future.

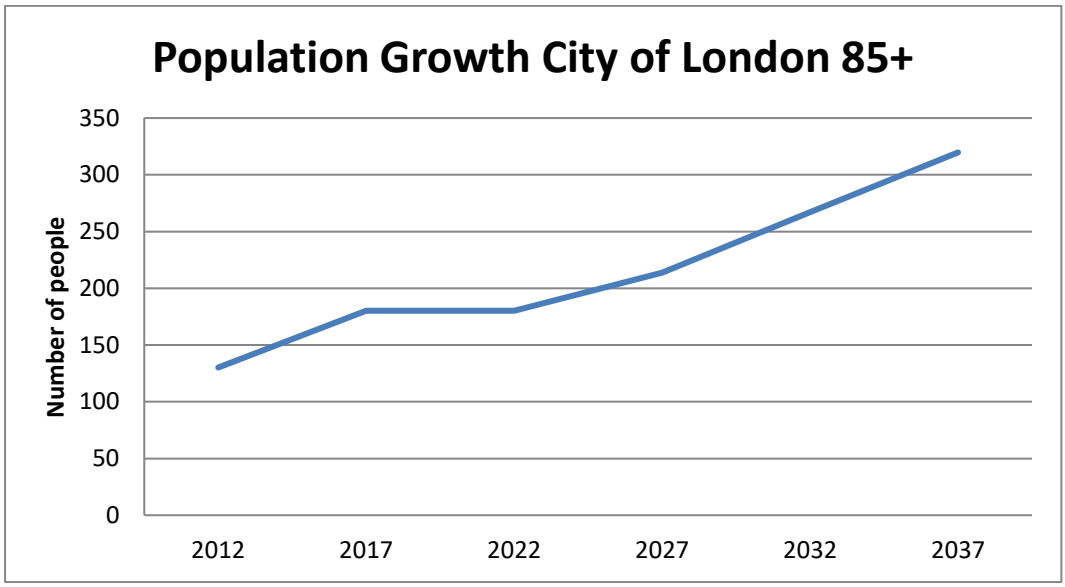
The charts below demonstrate the population growth in the City of London in the coming years. These are based on a different data source to the ONS.

Chart 1: Population Growth City of London 2012 – 2037



Source: GLA Population Projections July 2017

Chart 2: Growth in City of London population aged 85+ 2012 – 2037



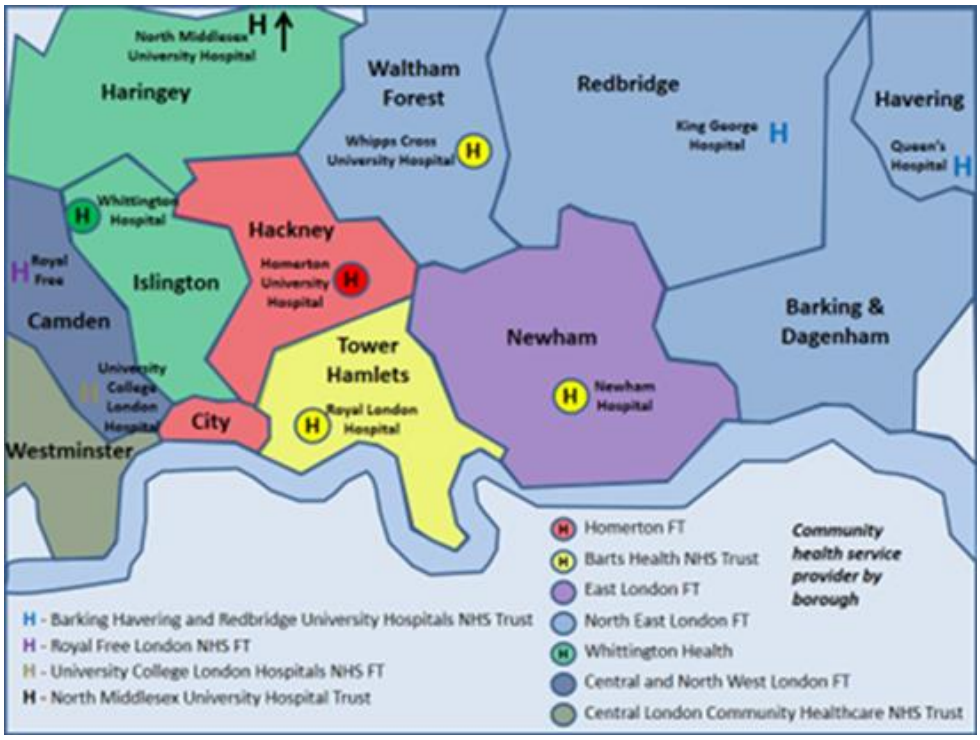
Source: GLA Population Projections July 2017

There has been improvement in the City's deprivation ranking in recent years but significant gaps remain between the areas of Portsoken in the east of the City (40% most deprived nationally) and Barbican (10% least deprived nationally).

The City of London has the highest daytime population of any UK local authority in the UK, with nearly half a million workers working in the Square Mile each day.

The City of London borders seven London boroughs and residents often have to access services that are delivered outside the square mile. As detailed in previous BCF plans, the City of London has complex care pathways. 75 per cent of City of London residents are registered with the one GP practice in the City, which is part of City and Hackney CCG. 16 per cent of residents, on the east side of the City of London, are registered with GPs which are part of Tower Hamlets CCG.

Diagram 2: Boroughs and Health Providers



For acute admissions, most City of London residents are taken to the Royal London Hospital (RLH) or University College Hospital (UCH). The main commissioned acute hospital for City and Hackney CCG is Homerton University Hospital Foundation Trust (HUHFT). Community Health Services are also provided by HUHFT and available to all City of London residents regardless of GP registration.

There is no residential care or supported living provision within the City boundaries and given the levels of demand for these services, they are spot purchased rather than block purchased. There is a single home care provider commissioned by the City of London Corporation in 2017. A number of service users use their direct payments to purchase other home care providers of their choice.

The City of London also commissions a number of preventative and support services from the voluntary sector. These include a Memory café, a carers' network, a wellbeing service and a universal advice service.

Given its size and location, the City of London does not have a huge range of providers within its boundaries but engages with a wider market through a number of market engagement events and tools. The integrated commissioning arrangements provide opportunities to look at existing contracts and identify if they can be provided in different, more efficient ways. This also provides the City of London Corporation to potentially have access to a wider range of providers. One example is the planned Care workstream of the integrated commissioning arrangements which is developing a working group to address issues related to continuing care and social care placements. System partners will develop a proposal for integration of the continuing healthcare pathway with the wider social care and residential care provision. These proposals will also consider arrangements for brokerage and

market management with the local authorities taking the lead.

Progress to Date

As noted above, the move to an integrated system has progressed significantly since the last BCF plan with the development of integrated commissioning arrangements. The BCF and iBCF are integral parts of this.

Table 2: Progress on the key BCF metrics 2016/17

Metric	Baseline	Target	Final Outturn	RAG	Comments
Non-elective admissions	549	549	600		Across City & Hackney, there has been an increase of 3.3% in admissions in all age groups which is greater than the increase in previous years. There was a 2.4% increase in admissions 2015/16 to 2016/17 in 60-74 year olds and a 7.8% increase in 75+
Permanent admissions to residential care	13	11	3		The City of London Corporation has continued to focus on supporting people maintain their independence at home as far as possible
Effectiveness of reablement and rehabilitation – still at home 91 days after discharge from hospital	88%	85%	89%		This target was met and those cases that were not at home 91 days after discharge were due to deaths rather than readmissions. The small cohort that this relates to means that any deaths or readmissions have a significant impact on the final percentage. The actual figures for 2016/17 were 16 out of 18 who were still at home 91 days after discharge. The other

					two individuals passed away.
Delayed Transfers of Care	216	200	795		These are actual days rather than rate. The bulk of these days were recorded as NHS attributable delays and were due to awaiting public funding or friend and family choice. There were a small number of longer term delays where people were awaiting discharge from non-acute care to further health services. Going forward, DTOCs will be seen as a system wide issue rather than the responsibility of one organisation and HICM will be a key mechanism for managing this.
Carer Reported Quality of Life	8.8	8.8	8.8		This survey is only carried out every two years and therefore the existing figure of 8.8 stands. A new survey has been completed and results will be published nationally shortly.
Service user experience	63%	63%	63%		This survey is only carried out every two years and therefore the existing figure of 63% still stands. A new survey has been completed and results will be published nationally shortly.

Evidence Base and Local Priorities to Support Plan for Integration

There is no acute hospital within the City boundaries, and as mentioned above, most patients attend the RLH or UCLH. The following information illustrates our

emergency activity and flow through our acute hospitals which relate to the BCF metric for non-elective admissions and indicates some areas for system improvement.

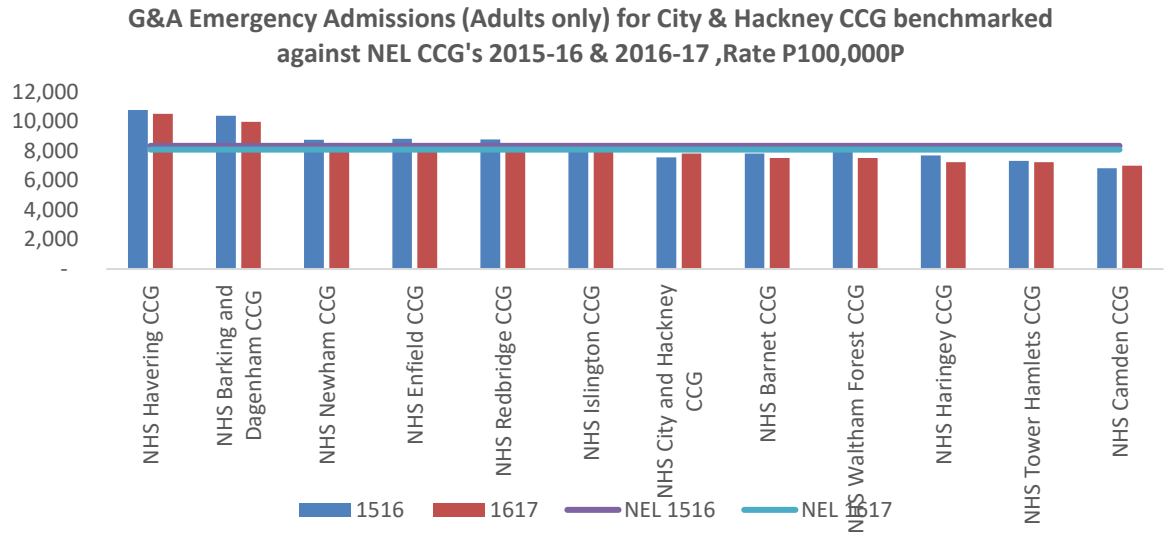
Table 3: Adult A&E Activity

Provider by City and Hackney Patients	14/15 - 15/16 % Change	15/16 - 16/17 % Change	A&E 16/17 Activity
All Providers	4.80%	0.70%	95189
Homerton (ED & PUCC)	5.00%	0.00%	61376
Barts	-1.40%	7.90%	9622
UCLH	10.20%	-0.40%	4399

- Despite the rate per 100,000 reducing by 2%, because of a growth in registered population there has been a small increase in C&H A&E attendances across all providers.
- Barts has the greatest percentage increase in attendances, which is far higher than other providers. UCLH has seen a reduction.
- The slight growth in A&E attendances is being driven by older adults. There has actually been a reduction in attendances from the 19-59 age group
- A greater percentage of patients arriving at the HUHFT A&E are being seen in the Emergency Department rather than the Primary Urgent Care Centre resulting in an increase in ED attendance of 3.5%
- There has been a rise in lower acuity activity seen in the Emergency Department
- The City and Hackney conversion rate from Emergency Department to admission has risen slightly from 2015/16 to 2016/7
- A rise in Emergency Department attendances potentially impacts on the ability to meet the 4 hour performance target

Admission Activity

Chart 3: General and Acute Emergency Admissions



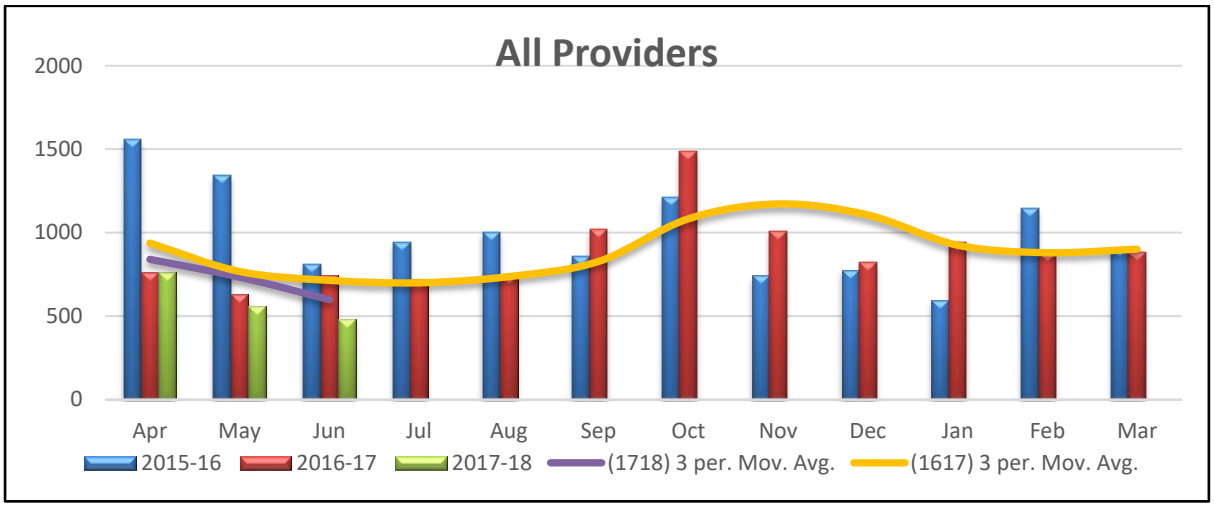
- City and Hackney admission rates have increased by 3.3% per 100,000 population from 2015/16 to 2016/17.
- City and Hackney remains just below the North East London average however, have seen the largest percentage increase in admission rate across North East London CCGs.
- There has been an increase in rate of same day and short stay admissions
- Short stay admissions are driving the increased admissions (short stay contribute 77% of the total increase in North East London admissions)

Table 4: City and Hackney Emergency Admissions by Provider – adults only

Provider by City and Hackney Patients	Admissions 14/15 - 15/16 % Change	Admissions 15/16 – 1617 % Change	Actual Increase in admissions 1516 -1617	2016/17 Admissions
All Providers	4.0%	6.1%	1047	18137
Homerton	0.6%	6.8%	766	11998
Barts	10.7%	9.3%	282	3304
UCLH	41.4%	9.3%	76	889

- The rise at HUHFT for C&H patients is slightly above the 6% rise in admissions which the trust has seen across all patients
- Barts Trust has seen a reduction of 6% in admissions overall; however, admissions for C&H patients has risen by 9.3%
- UCLH has seen only a 3% rise in admissions overall; however, C&H patients have seen a 9.3% increase.

Chart 4: City and Hackney Excess Bed Days by all Providers



- City and Hackney had an overall reduction of -26.4% in excess bed days from 2015/16 to 2016/17 across all providers with the downward trend continuing for this year. This may be seen as a proxy measure for better flow through the hospital and may link to reductions in delayed transfers of care.
- Overall reduction of 3.4% in emergency bed days 2015/16 to 2016/17 across all providers.

Plans to address performance

Work is currently being undertaken to review the HUHFT Primary Urgent Care Centre, including how patients are streamed between PUCC and the emergency department, and what the expected diversion rate should be. The specification will also be reviewed ensuring value for money, and it is our intention for 2018 to develop a plan for PUCC to become a Urgent Treatment Centre, meeting the national UTC Standards. Our commissioning intentions for 2018/19 also include local implementation of the pan-London Redirection and Streaming Guidance, which will maximise the use of primary care and PUCC to reduce any unnecessary ED attendances. This will involve working with the RLH and UCLH to ensure that City and Hackney patients can be redirected back to local community services.

We are also currently engaged in a procurement for the North East London Integrated Urgent Care service (111 + Clinical Assessment Service) which will be implemented in 2018 as will a new local model for 24/7 access to urgent primary care.

A retrospective case review of emergency admissions was done by the HUHFT in July 2017 to understand the drivers behind the increases in admissions. The review aimed to develop a greater understanding of why emergency admissions occur and to understand what interventions and/or service developments could reduce emergency admissions in the future. The final report is pending. A similar audit is being proposed to the RLH and UCLH as they have seen an increase in City & Hackney NEA compared to a decrease in all other patients registered to other local CCGs. The audit results will be reviewed by the Unplanned Care Board and recommendations for system change made. Further work will also occur with the RLH in the coming year to

support discharge.

Significant change and developments

One Hackney and City was an integrated care and support model funded through the BCF which ran for 2 years until the end of March 2017. It was a model built around care co-ordination and multi-disciplinary working.

Although the City of London Corporation did not need to use the whole model, it did use the Voluntary Sector Framework which provided access to a wider range of voluntary sector services than would normally be available to City residents.

The model was evaluated from a number of perspectives including the service user perspective, the experience of the voluntary sector and, the main evaluation, which looked at whether the model had met its objectives. The outcome of the main evaluation was that it was too early to conclude about meeting objectives when the service had only been delivered for 12 months.

These evaluations provided some valuable information and lessons to be learned going forward but also to unpick some of the areas for improvement, in particular, to develop a new model (the Neighbourhood Model) more clearly aligned to the objectives of the BCF and integrated commissioning.

In order to progress implementation of the Neighbourhood model, agreement of business cases will be via the Unplanned and Planned Care workstreams and then presented to the Transformation Board. There is the potential that we may consider other business cases if the Neighbourhood model does not look like it will spend the full £1.2m this year. Any uncommitted monies may also be used to address any cost pressures from non-elective admissions.

The Neighbourhood Care Model

Locally, there have been a number of pressures on the health and social care system including increases in emergency admissions, increased costs and an increasingly challenging financial environment which mean that there is a move towards transforming the way these services are delivered. This is coupled with a continuing focus on delivering the best quality care possible and delivering improved patient outcomes. These are underlying principles of the integrated commissioning arrangements.

There are significant opportunities to improve the way that primary care works and communicates with other providers (health, social care and the voluntary sector) and vice versa to improve quality and reduce costs. Co-production is an underlying principle of the integrated commissioning arrangements and patients and service users will be involved in shaping the neighbourhood model.

The proposed new model will mirror the principles of the Primary Care Home model in Hackney and City, creating small neighbourhood areas that will become provider networks for integrated care. All community / out of hospital services will be asked to arrange care within these neighbourhoods working closely with the practices within the neighbourhood. Community Health Services are provided by Homerton Hospital for all City of London residents.

Detailed mapping of populations and population would need to confirm the make-up of the neighbourhoods but it is expected that they will be:

- Mostly contained with existing quadrant boundaries
- No smaller than 30,000 patients and no larger than 50,000 patients
- Geographically co-located
- As far as possible not dividing existing community groups

Underpinning improvement work

In addition to the work required to develop neighbourhoods and organise services to create strong integrated working in these neighbourhoods, there are a number of underpinning improvement work streams which are currently underway. These include:

- Co-ordination/case management model for complex/high risk individuals

As part of this work, a project lead will work with teams to develop a proposal for the neighbourhoods for the coordination/support of complex/high risk individuals. This will also set out some guidelines for the type of patients who will benefit from this additional support and therefore attempt to clarify likely demand (and therefore resources required).

- Clinical pathway work

Once the detailed data analysis has been completed and shared with clinicians, the need for specific clinical pathway improvement work will be agreed. This will be based on a shared agreement that there is scope within a clinical pathway to improve the care provided to patients, the outcomes for patients and therefore an assumption that there will be efficiency savings.

It is expected that any clinical pathway improvement work will build on the principles of the redesign process carried out in New Zealand. Any clinical pathway work will also link into existing work within the CCG and system to avoid duplication of existing work.

- Formal (Paid) Carers

It was agreed in the initial scoping of this work stream that a project would be included on formal (paid) carers. This would look at:

- Could the formal carer role be enhanced to release time of other community teams
- This is based on an assumption that there are tasks which some community team members do which might be carried out by formal carers with appropriate training (and appropriate remuneration)
- Could the role of formal carers be developed to enhance their ability to more proactively identify deteriorating health/mental health needs based on time with their client to the appropriate person
- Could the role of formal carers be enhanced to improve signposting in times of crisis to the appropriate service
- Could formal carers be organised into neighbourhoods and develop stronger relationships with GPs/GP practices?

There are on-going discussions about how the neighbourhood model can be made to work in the most effective way for the context of the City of London.

Equality impacts

A Test of Relevance was carried out on City of London commissioned schemes in the 2016/17 BCF plan which did not identify any negative impacts on any of the protected characteristics set out in the Equality Act 2010 and therefore a full Equality Impact Assessment was not required.

As the schemes in the BCF 2017 – 19 remain the same and there have been no significant changes in the profile of the population since last year, the Test of Relevance remains valid.

Going forward, as new schemes come on stream such as the Neighbourhood Care Model or existing schemes are changed within the integrated commissioning arrangements, specific Equality Impact Assessments will be carried out as necessary.

CHCCG adopted the following equality objectives for 2016/17 to help deliver the CCG's commitment to deliver local priorities and to continuous improvement:

- Reduce mental health inequalities amongst communities in east London;
- Reduce mortality from cardiovascular disease and respiratory disease;
- Ensure equitable access to services for residents in the City of London;
- Implement the Equality Delivery System 2 (EDS2) toolkit that helps NHS organisations improve services and consider health inequalities.

In August 2016 a CCG wide working group was established to review progress against these objectives, to ensure that Equality and Diversity are embedded in all our plans and decisions and to formalise the processes around this. The work of this group is continuing across 2017/18 and includes focus on some areas within the BCF.

Better Care Fund Plan

Table 5: Schemes for 2017-19 City of London BCF

Metrics

Metric 1	Non-elective admissions (General and Acute)
Metric 2	Admissions to residential and care homes
Metric 3	Effectiveness of reablement
Metric 4	Delayed transfers of care

The table below shows the level of impact (none, low, medium or High) each project will have on each of the 4 Metrics.

Scheme	Lead commissioner	£,000 16/17	£,000 17/18	£,000 18/19	Brief Description of the scheme	Planned impact on Metric
Care Navigator	City of London Corporation	60	60	60	Supporting safe hospital discharge for City of London residents to minimise DTOCs, prevent readmission and maintain independence	<u>Metric</u> / <u>Impact</u> 1 / High (readmissions) 2 / High 3 / High 4 / High
Reablement Plus	City of London Corporation	30	65	65	Provision of up to 72 hours of 24 hour care to prevent hospital admission and to facilitate safe hospital discharge at weekends and bank holidays. City of London Discharge to Assess model	<u>Metric</u> / <u>Impact</u> 1 / High 2 / N/A 3 / N/A 4 / High

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<td>Mental Health Reablement and Floating Support</td>
<td>City of London Corporation</td>
<td>60</td>
<td>120</td>
<td>80</td>
<td>ELFT working with people with chronic mental health conditions living in supported living to support reaching of full potential with move to more independent living where appropriate. Ongoing floating support to ensure links are made with local health and community services and independence sustained.

Can also receive direct referrals to assist in the discharge process</td>
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<tr><th>Metric</th><th>Impact</th></tr>
<tr><td>1</td><td>Medium</td></tr>
<tr><td>2</td><td>Medium</td></tr>
<tr><td>3</td><td>N/A</td></tr>
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<td>Carers' support</td>
<td></td>
<td>10</td>
<td>10</td>
<td>50</td>
<td>To provide specialist independent support, information and advice to informal adult carers to support them in their caring role and promote their health and wellbeing</td>
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<table>
<tr><th>Metric</th><th>Impact</th></tr>
<tr><td>1</td><td>High</td></tr>
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Disabilities Facilities Grant	City of London Corporation	26	28	30	Mandatory scheme to support disabled people live more independently in their own home (private rented or owner occupied)	Metric	Impact
						1	High
						2	High
						3	High
						4	High
IBCF meeting adult social care need	City of London Corporation	-	90	114	To help sustain the adult social care system, by offsetting additional savings which would have been required, funding increased demand, and reducing pressures within services	Metric	Impact
						1	Low
						2	Medium
						3	Medium
						4	High
iBCF reducing pressures on the NHS	City of London Corporation		90	114	To help support intermediate care and CHC processes to facilitate discharge.	Metric	Impact
						1	Medium
						2	Medium
						3	High
						4	High

iBCF stabilising the care market	City of London Corporation		0	0	-	<u>Metric</u> / <u>Impact</u> 1 / -N/A 2 / N/A 3 / N/A 4 / N/A
One Hackney	CCG	54	-	-		
One Hackney	CCG	38	-	-		
Neighbourhood Care Model	CCG	-	40	40	Creation of smaller neighbourhood areas which will become the provider networks for integrated care. All community/out of hospital services will be asked to arrange care within these neighbourhoods working closely with the groups of practices within the neighbourhood. A robust business case must be accepted by the workstreams and	<u>Metric</u> / <u>Impact</u> 1 / TBC 2 / TBC 3 / TBC 4 / TBC The impact on metrics will be considered as the model is further developed.

					TB in order to progress this model.	
Adult Cardio respiratory Enhanced + Responsive Service (ACERS)	CCG	20	20	20	To provide an early intervention service for those with COPD, with the objective of more people having their condition managed at home, reducing A&E and emergency admissions	Metric / Impact 1 Medium 2 Low 3 Low 4 Medium
Bryning Day unit/Falls Prevention	CCG	13	14	14	The service manages patient at risk of falling, through interactive support and medicines management	Metric / Impact 1 Medium 2 Low 3 Medium 4 Low
Asthma	CCG	3	3	3	Support and develop a robust integrated care pathway to include education and training for general practice in the management of patients with Asthma	Metric / Impact 1 High 2 Low 3 Low 4 low

Palliative care - Out of hospital service	CCG	20	20	21	To provide high quality specialist palliative care to individuals wishing to remain in their own homes/the community at the end-of-life.	<u>Metric</u> / <u>Impact</u> 1 / High 2 / Med 3 / n/a 4 / High
Paradoc	CCG	18	18	19	The service provides an urgent GP and paramedic response service to patients in their own home/care home, reducing unnecessary conveyance to A&E via ambulance.	<u>Metric</u> / <u>Impact</u> 1 / High 2 / n/a 3 / Med 4 / n/a
Adult Community Rehab Team	CCG	78	79	81	To provide specialist inter-disciplinary and uni-disciplinary rehabilitation to those with a physical or neurological impairment.	<u>Metric</u> / <u>Impact</u> 1 / n/a 2 / High 3 / High 4 / High

Adult Community Nursing	CCG	147	161	164	To provide an integrated, case management service to patients living within the community To improve patient pathway and health and social care outcomes	Metric	Impact
						1	High
						2	Medium
						3	Medium
						4	Medium

National Conditions

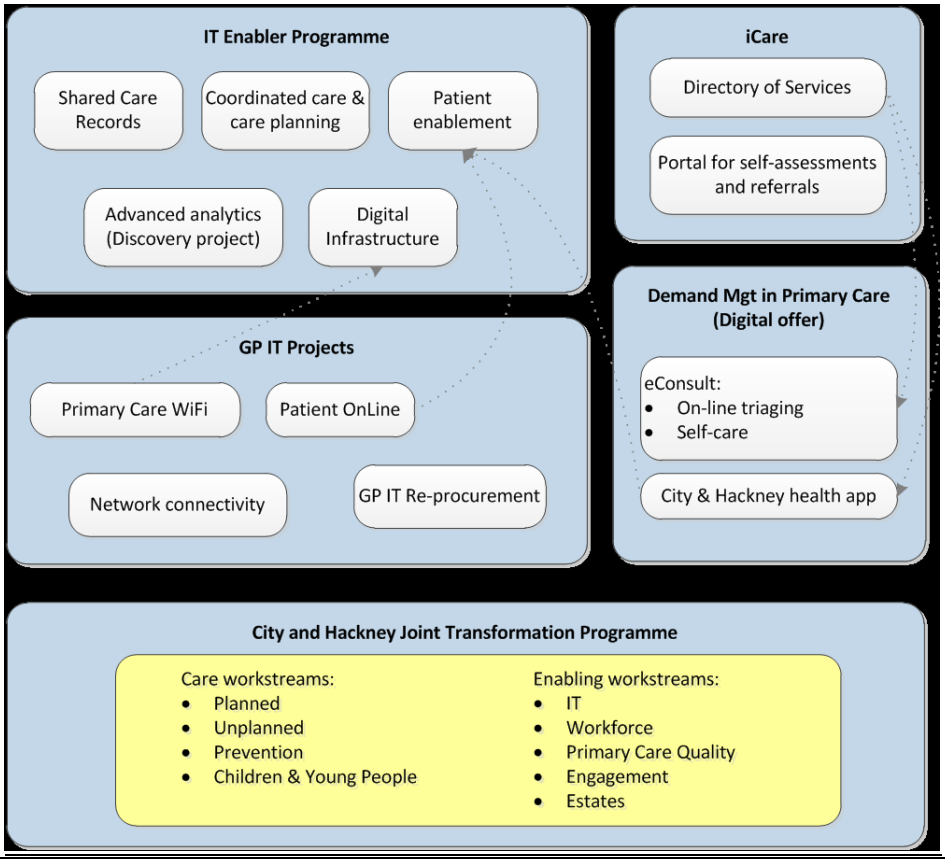
Table 6: National Conditions 2017/18

Condition	Detail
Jointly agreed plan	This plan has been agreed through the integrated commissioning arrangements which include statutory organisations, providers and the voluntary sector. Each of the schemes also sit within one of the four workstreams where their overall impact is monitored.
Social care maintenance	We confirm that the NHS contribution to adult social care is maintained in line with inflation and this is reflected in the BCF Planning Template.
NHS commissioned out of hospital services	Details on how the local area has agreed the use of BCF funding is evidenced in the BCF Planning Template. Out of hospital services under the BCF include: - ACERS - Asthma - Palliative care - Paradoc - ACRT - Adult Community Nursing - Neighbourhood Care Model
Managing transfers of care	The City of London has completed the High Impact Change Model (HICM) and the action plan is included in Appendix 1. There has been good performance around DTOCs in the City of London in relation to social care but some complex cases causing higher levels of NHS delays. Moving forward, managing transfers of care will be seen as a system wide issue rather than the issue of one or the other organisation. This is reflected in the HICM action plan. In 2016/17 there were 794 days of delayed days for City of London residents. The majority of these (718) were NHS attributable delays which were mainly due to friends and family choice, awaiting public funding and awaiting transfer top further secondary care. The 76 days of social care delays are disputed as these do not match local data. There is work underway to strengthen the process for signing off provider information on DTOCs before being submitted for SITREPs.

Additional Conditions

Table 7: National Conditions No Longer Required 2017-19

Condition	Detail
Seven-day services	Provision of a 7 day service for City of London residents includes out of hours social care, out of hours GP services, provision of a weekend reablement service, and an integrated independence team. There will be continued focus in 2017/18 on how to co-ordinate the full suite of integrated and urgent care services across 7 days and will be reflected in the High Impact Change Model action plan.
Better data sharing	The City of London and London Borough of Hackney are both part of the Health and Social Care IT Enabler Programme. Data sharing is being addressed by a joint IG group in WELC (Waltham Forest, east London and the City). A specific data sharing agreement has been signed off by C&H health providers, and will be extended to include social care in 17/18 which is to be signed off by all partners. The IT Enabler programme is now considered one of the enabler workstreams supporting the care workstreams within our integrated commissioning arrangements. The Local Digital Roadmap has an aim to achieve paperless working by 2020. Shared care records are largely being achieved through the east London Patient Record, or eLPR, previously known as Health Information Exchange. Homerton Acute, Community, City and Hackney GP practices and ELFT mental health are all linked to HIE at varying levels of maturity. St. Joseph's Hospice can also access health data using HIE. Homerton Acute can also view Barts Health data. All suppliers are working towards delivering an "any-to-any" connection model across east London by end Mar 2018. Other projects include building links with community pharmacies; extending electronic orders for diagnostic tests for GPs and St. Joseph's Hospice; and safeguarding. There are also opportunities to build on the work already underway for e-referrals, namely around "advice and guidance". This has the potential to change the way patients interact with health care services and reduce the number of physical attendances by the patient at hospital. Similarly the re-procurement of the 111 and out of hours service will require digital solutions to support the new models and streamlining the patient journey from the initial point of contact through to onward referrals to local services.

	Going forward, IT Enabler programme members and workstream directors will attend each other's meetings/workshops with a view to working up proposals for digital initiatives for the balance remaining within the financial envelope of £2.5m (this is outside the BCF envelop). Digital initiatives in City and Hackney are illustrated below: 
Joint approach to assessment	Coordinated care and care planning – City and Hackney remains a top performer in the adoption of Coordinate My Care. 93% of patients on the End of Life registers (5% declined) and 93% of patients on the frail home visiting registers (4% declined) now have a CMC plan. Latest analysis shows that overall 65% of C&H CMC patients have died in their preferred place. Where C&H patients have a CMC record, 27% die in hospital; nationally, 47% died in hospital. Planning to improve CMC adoption across care settings and build IT links with provider IT systems to streamline workflow is continuing. Further joint approach to integrated assessments are part of the Trusted Assessor section of the High Impact Change Model action plan.

Overview of Funding Contributions

Table 8: Funding Contributions

Running Balances	**2017/18**	**2018/19**
Local Authority Contribution (Disabled Facilities Grant)	£28,304	£30,294
CCG Minimum Contribution balance	£611,588	£623,208
Additional CCG Contribution balance	£0	£0
iBCF	£178,726	£228,418
Total	**£818,618**	**£881,920**

The funding contributions for the BCF have been agreed including identification of funds for Care Act duties, reablement and carers' breaks from the CCG minimum. These are detailed in the excel planning template that accompanies this narrative plan.

The CCG and the City of London Corporation have agreed to apportion the iBCF funds as follows:

Table 9: iBCF spend profile

Scheme	**Funding Source**	**£,000**	**%**	**£,000**	**%**
		17/18	**17/18**	**18/19**	**18/19**
iBCF meeting adult social care need	CoL	89,363	50%	114,209	50%
iBCF reducing pressures on the NHS	CoL	89,363	50%	114,209	50%
iBCF stabilising the care market	CoL	0	0	0	0
Total		**178,726**	**100%**	**228,418**	**100%**

Agreed approach to the use of the iBCF funding to increase capacity and stability in the market

In light of significant financial pressures in Adult Social Care services nationally, the Government announced the improved BCF (iBCF) which provides non recurrent funding to assist with the financial pressures on adult social care. The iBCF was announced in the Spring Budget of April 2017 and the allocation for the City of London is £179,000 for 2017/18 and £138,000 for 2018/19.

The iBCF grant is given direct to local authorities subject to the conditions set out in the grant determination which is made under Section 31 of the Local Government Act 2003. Local authorities are required to use the funding to meet adult social care need, reduce pressures on the NHS and stabilise the care market.

The plans for the funding are set out in the table of schemes above (table 6).

BCF milestones

Table 10: BCF Milestones

Milestone	**Date**
BCF plan submitted	11 September
BCF plan agreed	TBC
S75 signed	30 November

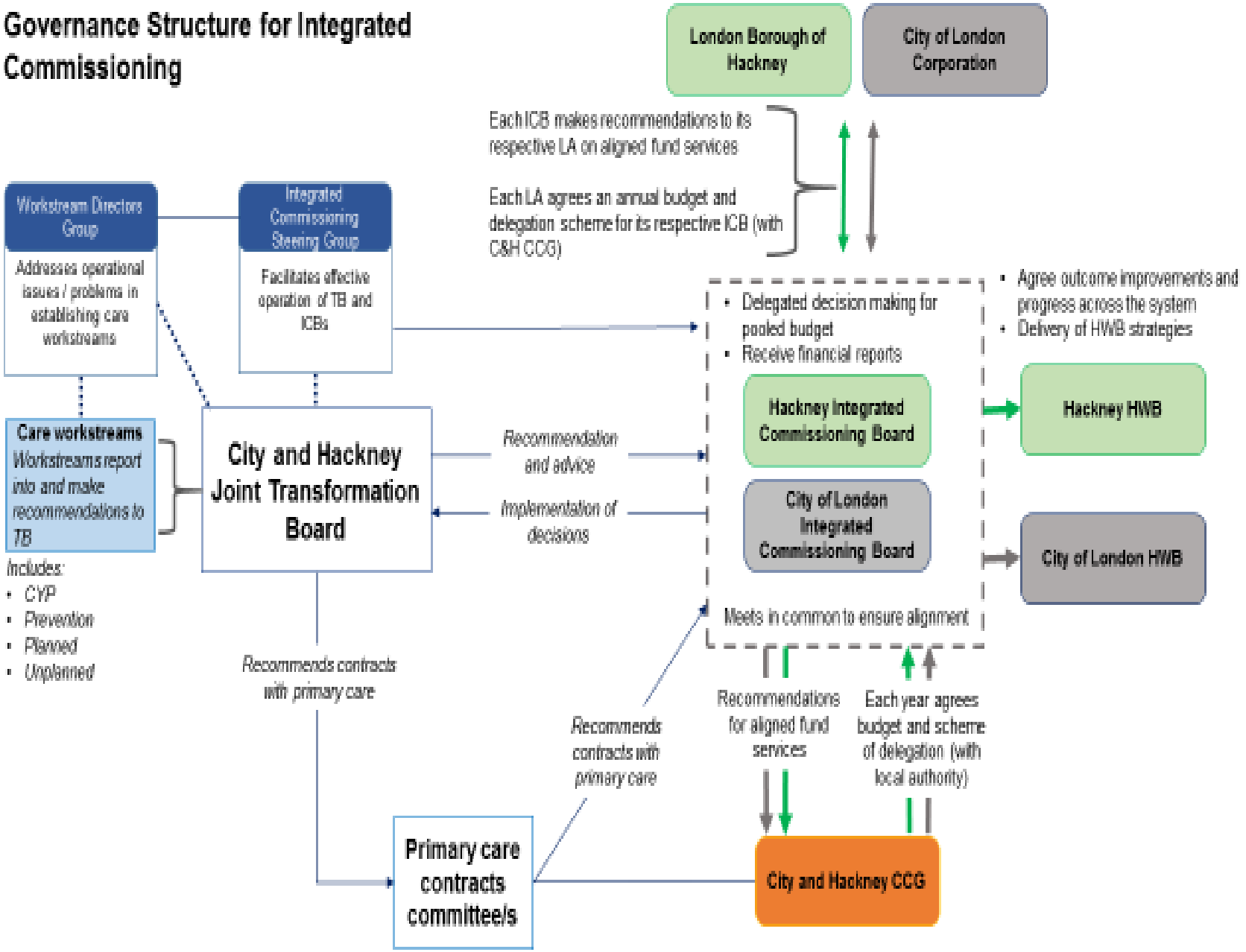
Programme Governance

As part of the new integrated commissioning arrangements, the local authorities will be the host parties for any pooled budgets, including BCF. For the City of London, the internal Integration Programme Board will oversee the City of London Corporation commissioned project. There will also be a core operation group responsible for the administration of the BCF which will consist of the CCG and both City of London Corporation and the London Borough of Hackney.

The BCF Operational Group will report on achievement of metrics and any scheme issues to the Unplanned and Planned Care workstreams. Overall performance and any recommendations will subsequently be made to the Transformation Board and Integrated Commissioning Boards.

The diagram below sets out the overarching governance for integrated commissioning.

Governance Structure for Integrated Commissioning



Risk

Assessment of Risk and Risk Management

Financial Risk

Financial overspends on services will be the responsibility of the lead commissioner and will not be funded through the pooled fund.

Financial underspends on the pooled funds will be managed as follows:

- For the capital spends, underspends will be retained by the City of London Corporation and applied in accordance with scheme requirements
- For the revenue streams, if there are underspends within the pooled fund, the under spends will be retained by each lead commissioner on a scheme by scheme basis in accordance with the scheme requirements

Delivery Risk

Failure to deliver the inputs required to deliver KPIs will be borne by the Partner failing to deliver.

A detailed risk register can be found on page 38.

Risk Management Framework & Governance Arrangements

A comprehensive risk register will be in place for the BCF pooled fund to manage or mitigate known and emerging risks associated with the development and implementation of the BCF Plan.

Each BCF scheme risk Register will be reviewed by the lead commissioner. The CCG will provide the City of London Corporation with a risk log for the services for which it is lead commissioner. This will coincide with performance data submissions as required in the integrated commissioning arrangements.

An overall risk register for the BCF will be presented to the Transformation Board. Significant risks around the BCF will be escalated to the Health and Well Being Board as appropriate.

The Risk Register will also be kept under review in both health and social care individual governance frameworks.

Table 11: Risk Register

Risk		Likelihood	Potential impact	Overall risk factor	Mitigating actions	Action owner
1	The extent of cultural and organisational change required to achieve effective integration will not be achieved	2	4	8	The BCF has been in place for a number of years and has established a good basis for working together which the new integrated commissioning arrangements build on. Further cultural and organisational change is being addressed as part of the work within integrated commissioning arrangements	Worstream Directors and SROs
2	Staffing shortages within the system or single points of failure where key staff are relied on	3	4	12	Work with providers to ensure they have contingency plans in place to deal with key roles and key staff leaving	Commissioners
3	Severe weather or outbreak of particular condition in community – impacting on admissions, falls etc	3	4	12	Winter plans have been developed by partners	The Unplanned Care Board (our local A&E Delivery Board)

4	New neighbourhood model does not reflect City needs / requirements	2	4	8	City of London Corporation sit on the working group for the neighbourhood model	City of London Corporation
5	Lack of consensus for the new neighbourhood (care) model which delays the scheme and the associated outcomes	2	4	8	Resources are being allocated to the project to ensure robust business case is developed and project plan is in place to develop and implement model. Steering Group is also part of formal governance structure of the Unplanned Care Board	Enhanced Primary Care Working Group / Unplanned Care Board
6	Provider failure	1	3	3	City of London has a fairly stable market but the market is small and there are some potential single points of failure. This is managed through good contract management and relationships with providers	Commissioners
7	Failure to deliver High Impact Change Model actions	2	3	6	Detailed action plan is being prepared which will be monitored by the City of London's internal Integration Programme Board	Integrated Discharge Project Group / Unplanned Care Board
8	Information flow and data is not robust	2	4	8	Discussions underway to strengthen relationships with out of area hospital discharge teams to address issue	Commissioners

9	Difficulties finding suitable residential and nursing placements	1	4	4	The numbers of residential placements purchased is relatively low but more effective demand modelling is being put in place to manage this more effectively. Residential and continuing care are being considered as part of the planned care workstream and any joint commissioning could give the City of London Corporation more security to access placements	Commissioners
10	Poor quality of data upon which the outturn of data is calculated	2	4	8	Bespoke data analysis commissioned to support unplanned care workstream and the establishment of the neighbourhood model. Regular monitoring	BCF Operational group and Information Working Group for Unplanned Care Board

National Metrics 2017 - 19

Table 12: National Metrics

Metric	Performance 2014/15	Performance 2015/16	Performance 2016/17	Target 2017/18	How target was set
Non-elective admissions (general and acute)	572	443	600	713	Using figures set out by NHSE (note there is a discrepancy between this figure and the excel template which was prepopulated prior to the CCG's resubmission of NEA figures within the operating plan
Permanent admission to residential care	4	12	3	10	Considering number of people who are being supported at home but who are becoming frailer
Still at home 91 days after discharge from hospital	100%	79%	89%	85%	Based on past performance around re-admissions but taking into account that some people will pass away
Total days of Delayed Transfers of Care (actual not rate)	188	228	794	237	Set as part of the national modelling

Approval and Sign Off

The proposed schemes for the City of London BCF and iBCF were considered by the City of London Integrated Commissioning Board on 2 August 2017 and recommended to the City of London Health and Wellbeing Board tfor approval.

The City of London Health and Wellbeing Board approved delegated authority to the Chair of the Board, in conjunction with the Director of Community and Children's Services to sign off the BCF plans if deadlines were such that sign off fell outside of the normal cycle of Health and Wellbeing Board meetings.

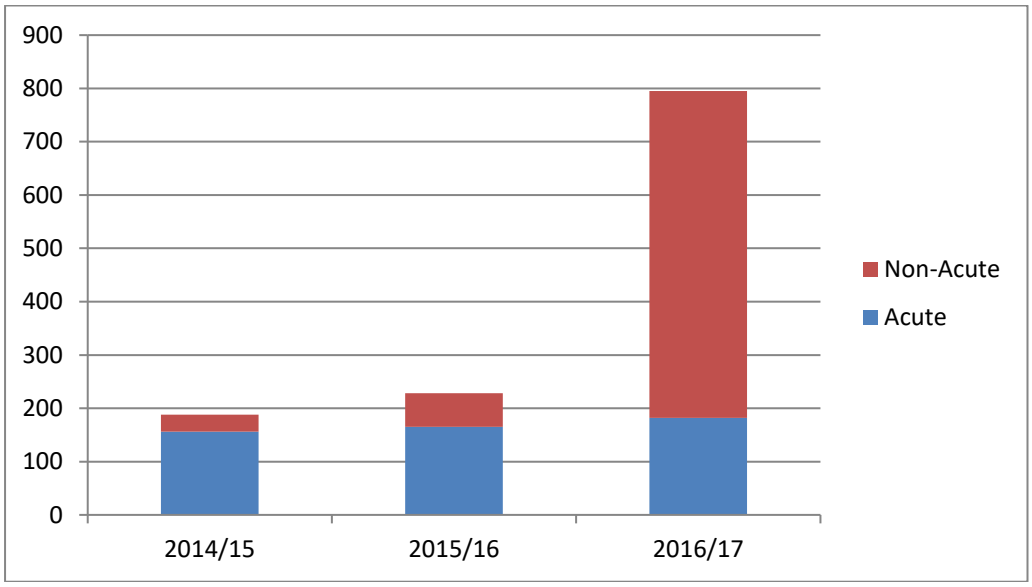
The Chair of the Health and Wellbeing Board, in conjunction with the Director of Community and Children's Services approved this submission on 8 September 2017 and a full copy of the document was circulated to the Board for their information at the meeting of 22 September 2017.

Appendix 1

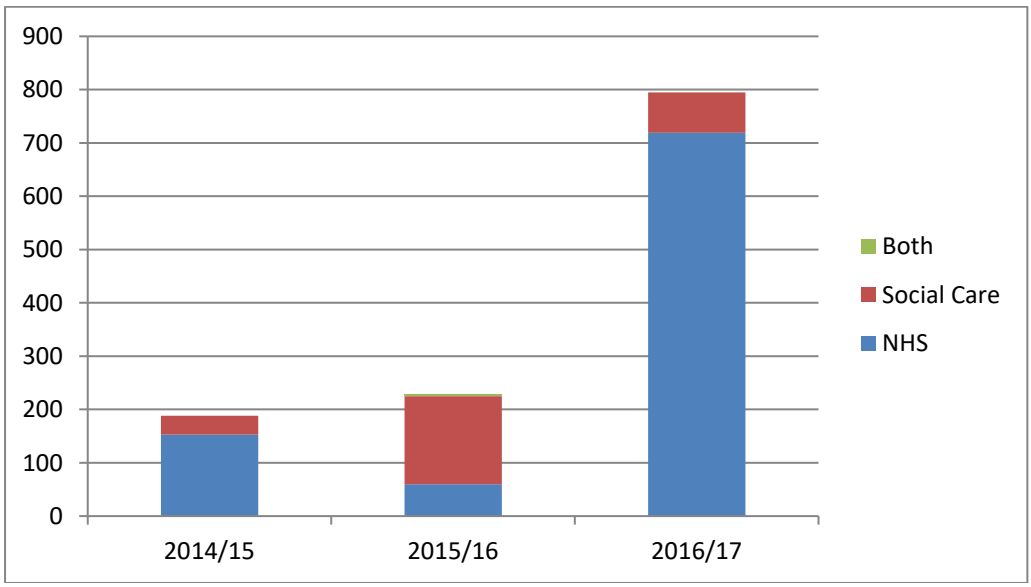
City of London Corporation DTOC Plan

For City of London residents, delays attributable to social care have been minimal over the last three years and some of these have been contested as they have not matched local figures. In the last financial year, there were increased numbers of delayed days in the non-acute sector attributable to the NHS.

Delayed Transfers of Care (days) 2014/15 – 2016/17 – by Type of Care



Delayed Transfers of Care (days) 2014/15 – 2016/17 – by responsible organisation



DTOC Targets 2017 / 18

Quarter	Target
1	91 (actual)
2	80
3	34.5
4	31.5
Total	**237**

DTOC Plan

As noted earlier in this document, going forward, DTOCs will be seen as a system wide responsibility rather than that of an individual organisation and will be addressed as part of the integrated commissioning arrangements.

As can be seen from the graph above, in 2016/17 there were a high number of delayed days in the non-acute sector attributed to the NHS. The majority of these were in the mental health sector.

Through BCF funded and other services, the City of London Corporation aims to maintain its good performance on DTOCs and contribute to a system wide approach to minimising the number of DTOCs. Although the City of London has a number of schemes which are key in helping minimise the risk of any DTOCs, it has also developed a HICM Action plan and has identified a number of areas of further work contributing to the DTOC action plan

Services and projects include:

- A Care Navigator who supports safe hospital discharge through being involved in discharge planning, carrying out initial assessments which are then used by social workers and linking patients up with relevant community based support services
- A Reablement Plus scheme to facilitate out of hours and early hospital discharge where safe. The scheme can be used to facilitate discharge to assess
- Mental Health Reablement Project to support people living with long term mental health conditions to move into more independent living settings with links into community services to prevent admissions to hospital and as a result any Delayed Transfers of Care. As part of the contract the provider (East London Foundation Trust) is able to assist in discharge and attends ward rounds to be aware of City of London patients
- Free services and support networks out of hours for those discharged from mental health services. These are provided by East London Foundation Trust and include a 24 hour crisis helpline, a crisis café and a service user support network
- Working with rough sleepers who are to be discharged from hospital – referred through the Greenhouse Project, a specialist service for rough

sleepers in Hackney or direct to the City of London Corporation which has its own accommodation pathways for those with City connections
- Support carers in their caring role so that they can accept people back home with support where necessary

Further areas of work (in addition to the High Impact Change Model Action plan below) are also underway:

- Review of DFGs, adaptations and assistive technology to identify if any pathways or processes could be strengthened to help facilitate discharge
- Mental health commissioning is being considered as part of the integrated commissioning arrangements with one area of work being improving discharges in the planned care workstream
- Work is currently underway with the Royal London Hospital to develop a protocol for the agreement of these figures before they are submitted to NHS England (this is already in place with University College Hospital).

The High Impact Change Model action plan can be found below.

City of London Corporation High Impact Change Model Action Plan

Impact Change	Summary	Objective	Actions	Status	Lead	Timescale
Early discharge planning	Early discharge planning is good and begins as soon as a notification is received from the hospital. Care navigator visits all these patients on the ward and carries out the initial assessment. Default to reablement service for all unless full social care assessment needed straight away. Reablement Plus service (up to 72 hours of 24 hour	Develop placement without prejudice	• Discuss with two relevant CCGs • Establish protocol, provision and process for placement without prejudice	In progress	City of London Corporation	• December 2017
		Strengthen relationships with Royal London Hospital	• Establish relationships with appropriate discharge staff • Provide details of pathways for City residents in terms of discharge • Work with provider to ensure they provide Sitrep	In progress	City of London Corporation	• October 2017

	care) can be provided for out of hours or urgent discharge. Ongoing issues about communication with some providers and technical issues around securely sharing information. Limited access to bed based intermediate care which can be an issue for the City where the structure and status of some residential properties make it difficult to provide intermediate care at home		data to City for sign off before submission			
		Identify if any additional services required to deal with discharge from A&E	• Undertake review and profile of number of City residents discharged from A&E • Consider potential measures if issue identified e.g. take home and settle type service	To start	City of London Corporation	• December 2017
		Ensure access to equipment does not hinder discharge	• Review access and processes for hospital staff to have access to City of London equipment at weekends	To start	City of London Corporation	• December 2017
		Identify if there is anything that Adult Social Care can do to assist with NHS	• Review the City of London NHS attributable delays and	To start	City of London Corporation	• December 2017

		attributable delays	identify profile and any particular issues • Identify measures to address any issues identified e.g. more information and advice to self-funders			
		Identify if assistive technology can play greater role in facilitating discharge	• Undertake review of current use of AT (completed August 2017) • Build into assessment and support planning processes • Realign commissioning around preventative offer including AT	In progress	City of London Corporation	• August 2017 • December 2017 • 2018

		Identify if DFG and adaptations can play greater role in facilitating discharge	• Undertake review of process and DFG use	In progress	City of London Corporation	December 2017
		Explore options for bed based intermediate care where required	• Explore feasibility of a care hub in the City of London	In progress	City of London Corporation	December 2017
Systems to monitor patient flow	Not applicable as there is no acute hospital within the City of London boundaries	*No actions required* *The City of London is part of the Integrated Discharge Project comprised of the C&H CCG, London Borough of Hackney, Homerton University Hospital Foundation Trust and East London Foundation Trust. Broad actions of this group, and the CCG's winter plan will support systems to monitor patient flow within the wider health system.*				
Multi-disciplinary, multi-agency teams (including voluntary and community sector)	There is good multi-disciplinary team working including reports from the hospital OT to ASC on the needs of person being discharged, ASC and care navigator attending	Ensure access to wider range of voluntary sector services which could help facilitate discharge e.g. house clearance	• Consider as part of development work around the neighbourhood model	In progress	Unplanned Care Board	TBC
		Identify in patients who may benefit from	• Carry out review of profile of	To start	City of London Corporation	• 2018

	practice MDTs and specific mental health MDT and regular meetings with housing and estate managers to help people maintain tenancies Voluntary sector in City of London is small but there are a number of commissioned services who provide support to people upon discharge.	preventative services	inpatients and A&E attenders • Develop process and provision of preventative services to this group			
Home First / Discharge to Assess	The City of London has a Reablement Plus service which can provide 24 hour social care support (with clinical support	Raise more awareness amongst professionals of the Reablement Plus service	• Awareness raising campaign using variety of channels	In progress	City of London Corporation	• Ongoing

	alongside if required) for up to 72 hours to facilitate out of hours discharge, urgent discharges and admission avoidance. Where people are discharged urgently or out of hours, social care is provided until the next working days when a social care assessment can take place. Residential and nursing placements straight from hospital are rare and discouraged where support has not been					

	tried at home first.					
Seven-day services	The social care out of hours service is provided by the London Borough of Hackney on behalf of the City of London Corporation The Reablement Plus service can facilitate out of hours and weekend discharges	No actions required				
Trusted Assessors	In terms of social care trusted assessors, the Care Navigator carries out assessments of people being discharged from hospital which are then used by	Joint assessments are being considered as part of the wider system's work and City of London Corporation is linked in with the work that the London ADASS network is co-ordinating to streamline discharges.				

	the Social Workers as the basis of an assessment when necessary. The Reablement Workers are trusted assessors for basic equipment. The City of London Corporation is very responsive in carrying out assessments once aware of discharge.	
Focus on choice	There are no residential or nursing homes within City of London boundaries so there is no choice for residents who wish to remain	No actions required

	within the City of London. However the national choice guidance is applied to people who need a placement. There is a spot purchase arrangement for residential care which means that there is no constraint in relation to a block contract as long as it meets the choice directive policy. The City of London Corporation also offers choice and a personalised focus through personal	

	budgets and direct payments.	
Enhancing health in care homes	Not applicable as there are no care homes within the City of London boundaries.	No actions required

PART TWO – SCHEME SPECIFICATIONS

City and Hackney Clinical Commissioning Group Schemes

Scheme ref no.
2.1
Scheme name
Neighbourhood Model

A robust business case must be accepted by the workstreams and TB in order to progress this model.

The Neighbourhood Steering group signed off the principles of the model and configuration, which was then endorsed by the Unplanned Care Workstream.

A workshop was held by the Transformation Board on the 10 November 2017 to:

- Approve principles of neighbourhoods
- Agree working assumption of eight neighbourhoods
- Consider and recommend an approach to implementation
- Note governance arrangements

Proposed Neighbourhood Mode

A full business case will come back to December Transformation Board meeting.

Investment requirement

The following amounts have been nominally allocated to the Neighbourhood Model; however, as stated above this depends on approval of a business case. Additional business cases may be developed to support other pressures faced by the Unplanned Care Workstream.

£ 2017/18	**£ 2018/19**
40,081	40,798

Scheme ref no.

3.1.1, 3.1.2, 3.1.3, 3.1.4 - Overview

Scheme name

Long Term Conditions (LTCs)

What is the strategic objective of this scheme?

This scheme directly enhances the integrated care vision in Hackney of more independence and better quality of life. This scheme is expected to target patients with the most common LTCs and reduce their chances of hospital admission.

Overview of the scheme

City and Hackney CCG has an existing enhanced service for long term conditions (LTCs) which provides incentives to general practice to deliver quality enhancements. Improving the quality of care for patients with LTCs is essential for decreasing mortality especially cardiovascular and respiratory mortality, decreasing ambulatory care sensitive admissions, and improving support for patients and their experience. The LTC LES and its predecessors have been strikingly successful as the CCG is now in the top quintile of CCGs for achievements, whereas the PCT was for many years at the very bottom. The following schemes included in the BCF are part of wider LTCs LES in City and Hackney.

- Acute COPD Early Response Service (ACERS)
- Bryning Day Unit/Falls Prevention
- Asthma
- Palliative care - Out of hospital service

Please refer to individual Annex for details for each of the above services.
Annex 1 – Scheme ref no 3.1.1
Annex 1 – Scheme ref no 3.1.2
Annex 1 – Scheme ref no 3.1.3
Annex 1 – Scheme ref no 3.1.4

The delivery chain

Further to the existing LTC LES scheme, City and Hackney CCG is commissioning the above services to improve outcomes for people with these conditions.
Homerton University hospital is commissioned to provide:

- Acute Cardiorespiratory Enhanced & Responsive Service (ACERS)
- Bryning Day Hospital Urgent clinic
- Falls Post
- Asthma

St Joseph Hospice is commissioned to provide:

- Palliative care - Out of hospital service

The evidence base

15.4 million people in England (over a quarter of the population) have a long term condition, and an increasing number of these have multiple conditions (the number with three of more is expected to increase from 1.9m in 2008 to 2.9m in 2018). People with LTCs use a significant proportion of heath and care services (50% of all GP appointments and 70% of days spend in hospital beds), and their care absorbs 70% of hospitals and primary care budgets in England. Long term conditions are the leading causes of death and disability in the population of City and Hackney. Large numbers of patients in City and Hackney have been diagnosed with a long term condition – *Section 3: Case for Change – Table 3 and 4.*

Long term conditions such as coronary heart disease, stroke and cancer are among the leading causes of premature death locally and make a major contribution to the differences in life expectancy between Hackney

and average of England. Circulatory diseases contribute the highest numbers of years of life lost (YLL) of any causes to men Hackney and are the largest single cause of long-term ill health and disability.

City and Hackney has high levels of deprivation and population diversity, which is relevant considering strong links between long term conditions, deprivation (diabetes is more likely to occur in areas experiencing greater levels of deprivation: the rate of diabetes complications is 3.5 times higher among people in social class V compared with those in social class I), lifestyle factors and the wider determinants of health, and the higher prevalence of some long term conditions in particular ethnic groups:

- Type 2 diabetes is up to 6 times more likely in people of South Asian descent
- Type 2 diabetes is up to three times more likely in African and Afro-Caribbean people
- South Asians have a 50% greater risk of premature death from CHD and stroke (the highest prevalence of CHD in City and Hackney in is South Asians)
- Although African-Caribbean populations have a lower than national average risk of CHD, they have a 3 fold higher risk of stroke and a higher risk of hypertension (the highest prevalence of stroke and hypertension in City and Hackney is in people of African-Caribbean descent)

People with long-term conditions are intensive users of health and social care services. It is estimated that the treatment and care of those with long-term conditions accounts for 69% of the primary and acute health care spend in England

Mortality from LTCs in City and Hackney is higher than national rates. Mortality rates for cardiovascular disease have been steadily declining in the UK since the 1960"s and while City and Hackney's rates have shown a similar decline, the gap between local rates and the national rates are as wide as ever. Deprivation is strongly associated with high CVD mortality. The local under 75 mortality rates from CVD and stroke are 90.4 and 17.0 per 100,000 populations respectively, which are both significantly above London and England rates. The directly standardised mortality rate for CVD which is considered preventable is 55.3 per 100,000 populations, which is also significantly above the rate for England (40.6 per 100,000 populations). Around 180 people die each year in City and Hackney of CVD. Mortality rates from heart failure, diabetes and chronic renal failure are also significantly higher in City and Hackney than nationally.

City and Hackney historically have low rates of diagnosing long term conditions. Undiagnosed conditions are linked with increased morbidity and greater hospital admissions. Prevalence of diabetes across England is 4.6%, in City and Hackney it is only 4.1%; this is increasing over time but the gap with England remains. Prevalence of other diagnosed conditions is also low compared to the England or London averages: QOF data suggests City and Hackney are in the lowest 5 centiles in the country for identifying epilepsy, CHD, COPD, CKD, stroke, asthma and hypertension

City and Hackney has higher premature mortality from respiratory disease than nationally, and reducing this is one of the CCG's strategic priorities. Recorded prevalence of COPD is low (1.0% cf 1.7% nationally in 2012/13), against a higher smoking prevalence than the national average (32% compared to 21%). The DH 2012 strategy "An outcomes strategy for COPD and Asthma in England" recommends the commissioning of a community based detection programme focusing on patients at higher risk of COPD to improve diagnosis.

The risk stratification of City and Hackney population shows 13,045 high risk patients. Further analysis of these patients highlight 980 patients with COPD at high risk.

Investment requirement

Sch Ref	Scheme Name	£ 2017/18	£ 2018/19
3.1.1	Acute Cardiorespiratory Enhanced & Responsive Service (ACERS)	20,093	20,475
3.1.2	Bryning Day Unit/Falls Prevention	13,879	14,143
3.1.3	Asthma	3,045	3,112
3.1.4	Palliative Care – Out of Hospital Service	20,358	20,745
Total		**57,384**	**58,474**

Impact of scheme

See Annex 1 – Scheme ref no 3.1.1/2/3/4

Feedback loop

See Annex 1 – Scheme ref no 3.1.1/2/3/4

What are the key success factors for implementation of this scheme?

See Annex 1 – Scheme ref no 3.1.1/2/3/4

Scheme ref no.

3.1.1

Scheme name

Adult Cardio and Respiratory Emergency and Responsive Service (ACERS)

What is the strategic objective of this scheme?

This service comes under Scheme 3.1. Long Term Conditions, which is initiated as a direct result of City and Hackney Vision of more independence and better quality of life. COPD is among the top LTCs in City and Hackney *(Section 3: Case for Change – Table 4)*.

The objectives of the service are:

- the streamlining and standardisation of COPD care across City & Hackney in order to ensure equity of access, treatment and outcome
- the delivery of Consultant and Nurse clinical leadership for the City & Hackney COPD service in association with GP leadership
- the delivery of rapid and high quality community-based acute COPD care to patients who might otherwise need to access emergency or secondary care service
- the intensive management of inpatient COPD discharges so as to minimise lengths of stay and to ensure as much care as possible is delivered in patients' own homes
- the delivery of a responsive and effective admission avoidance service for COPD patients based on individualised short-term care packages
- the creation of appropriate End of Life care packages for COPD patients based upon acknowledged best practice
- the delivery of a service framework which integrates COPD care across City & Hackney thereby fully utilising existing services, building partnerships between providers and encouraging innovation and development
- the creation of a sustainable specialised service with highly qualified multi-disciplinary team working
- to ensure excellent continuity of care through full GP, Community Matron and Adult Community Services involvement and ongoing education, training and development
- the provision of ongoing education, training and development across the local health community

Overview of the scheme

Service model

1. Primary Care Support

b) To work with primary care to offer community support and advice in the management of COPD in primary care.

c) Refer patients to the ACERS where additional ongoing education and support is needed up and beyond that of the COPD LES or QOF annual review

d) Appropriate timely feedback and communication between ACERS and general practice

e) Offer ongoing education and support to practices as requested (as outreach visits to GP practices, education sessions for primary care staff in addition to a minimum of one centrally held training session

per year)

1. Community-based Rapid Response

f) Provide a 24-hour advice and referral line (accessible to Community Matrons, GPs, Emergency Care Practitioners, Paramedics and identified COPD patients)
g) A specialist COPD practitioner to visit patients in their homes (within 2-4hrs in between 09.00 and 18.00, the following morning if not) in order to assess their condition, ensure optimal therapy was instituted and arrange appropriate on-going care
h) Review and use care plans where appropriate, liaising with GP colleagues regarding updates

1. Community Clinics

i) Nurse Led Community clinics – review any patients discharged from the service with complications or specific ongoing care needs to ensure their care plans were functioning appropriately
j) Provide proactive case management to those at risk patients with moderate, severe and complex needs, ensure the coordination of care for these patients in liaison with clinical colleagues across the local health community (including but not restricted to GPs, Community Matrons, District Nurses, Psychology services, Smoking Cessation Services) and participate in multi-disciplinary review meetings
k) The clinics will offer a rapid access assessment service for COPD patients referred by GPs and Community Matrons.
l) Provide regular information and feedback to the multi-disciplinary team on patient management
m) Provide management of patients with exacerbations in the community
n) Provide and deliver the following services to the at risk patients:
    a. identifying warning signs with the patient/carer to support self-management and/or urgent GP review
    b. reviewing medication and adapting as required
    c. educating patients on the use of inhaler and oxygen techniques
    d. supporting use of rescue packs
    e. supporting medication compliance
    f. monitoring, review and follow-up arrangements
    g. educating and empowering patients and carers with self-management
    h. onward referral to pulmonary rehabilitation if appropriate (with home visits for support if needed)
o) Provide targeted education and support to patients, carers and clinical staff
p) Referrals to other internal ACERS services such as the Home Oxygen and/or Pulmonary Rehabilitation will occur as required
q) The clinics should utilise the input of all the practitioners with a special interest in COPD so as to create an integrated and multi-disciplinary clinic environment for patients at a practice or consortium level

1. Pulmonary rehabilitation

ii. Pulmonary rehabilitation service runs groups at the following sites Homerton Hospital and at 2 community sites: Clissold and Britannia Leisure centres. Inclusion criteria for the service is any patient with a chronic respiratory conditions limited by exertional dyspnoea.

iii. All patients are assessed pre and post attending a group, to determine exercise capacity, health related quality of life and anxiety and depression levels.

iv. The PR Service run rolling groups, and staffed by a Specialist Respiratory Physiotherapist and COPD specialist Nurse. The group combines an individually prescribed exercise program and an multidisciplinary education program as per National Guidelines (BTS PR guideline 2013 and NICE Management of COPD guideline 2010).

v. Total capacity of the service per year is 252 patients, per session this is broken down into Homerton 12, Britannia 18 and Clissold 12 (6 groups x 8 weeks each). However DNA, UTA and mobility level of patient effect these numbers.

vi. The PR service also provides a home pulmonary rehabilitation-based program for patients unable to exercise in a group environment with the goal of referring into a PR group or another community exercise based group on completion of this.

vii. The PR service also provides post exacerbation pulmonary rehabilitation as appropriate, following National Guidelines.

1. Interventions with A&E

r) Provide support and education in the Homerton A&E department and to other City and Hackney urgent care providers to ensure a high quality evidence based response to managing acute COPD presentations and to support the development of standards and a pathway (a key aspect of this will be to ensure that communication between emergency services and primary care are built into the COPD care pathway both in hours and out of hours and this will also include 1:1 and group teaching sessions for ward and ACERS staff)

s) To ensure good communication between emergency and respiratory departments and primary care following acute presentation and adjustments to care plans.

t) Take immediate referrals for management of patients attending A&E with exacerbations (prior to admission) and provide initial case management and stabilisation

u) Develop protocols to ensure secondary care identifies/notifies the ACERS team of patients in hospital with COPD exacerbations presenting at A&E within 24 hours of their admission.

v) Patients are then assessed by a member of the ACERS team and an appropriate care plan agreed (with input from GP, where appropriate) and implemented (home visits from both nursing and therapy staff to provide intensive input during the acute phase of their exacerbation, follow up within the community and care plan to include self-management, management in the community, what to do to prevent future crises and prevent future attendances at A&E).

w) Each patient would have a named and contactable individual with direct responsibility for their care.

x) A full review of patients who have presented at A&E with COPD exacerbation by following up patients within a week of discharge (including supporting patients to register with a GP if unregistered) and supporting care plan reviews

1. Early Supported Discharge

y) As above, within 24 hours of admission (working with A&E, ACU and other Homerton wards), a ACERS nurse in conjunction with a Respiratory Consultant would assess the needs of each patient in order to develop a post-discharge care plan

z) The focus of this service would be on ensuring discharges within the first 48 hours post-admission (patients with longer lengths of stay would be also be included).

aa) The involvement of GPs and Community Matrons (and other allied health professionals with experience in managing patients with COPD including nurses, physiotherapists, occupational therapists and generic health workers) early in the increased level of community-based medical, nursing and social support for discharged patients should ensure that early discharges become sustainable.

bb) Arrangements would be put in place to ensure that any patients requiring urgent re-admission were fast-tracked.

cc) NICE data suggests that the benchmark population rate for eligibility of an assisted discharge scheme would be 0.06% per annum (60/100,000). This is based on a mean non-elective admission rate of 210 per 100,000 population for exacerbations of COPD and a 30% uptake rate for assisted discharge. For City and Hackney (with a population of 280,000) the average number is likely to be 150 per year (on average equating to 6 per year for an average sized practice [list size of 10,000], but dependent on demographic factors such as age and smoking and the high rate of under diagnosed COPD in the population).

dd) The length of care in the community may vary but studies indicate that on average each patient requires 7 days of care in the community as part of a single episode of assisted discharge. The total number of community based care is therefore 420 days per annum per 100,000 population. It is anticipated that the patients who have been through the assisted discharge scheme would then be referred onto the community pulmonary rehabilitation programme and Community Matrons as appropriate.

1. End of Life Care

ee) For those patients in whom death was deemed to be imminent, the team would work with the local hospice provider and / or the adult community nursing service

ff) For appropriate patients identified by the ACERS team, contact would be made with the relevant GP and St Joseph's Hospice Community Palliative Care team to agree a way forward on discussing developing an Advance Care Plan indicating preferred place of care and preferred place of death

(including how to optimise continuity of care, symptom control and carer support) with patients. This may involve liaison with Community Matrons, social and voluntary sectors.

gg) Refer patients as appropriate to St Joseph's Hospice Community Palliative Care team

hh) Input to Breathing Space clinics at St Joseph's for patients with COPD in their last years of life

The delivery chain

Homerton Hospital is commissioned by City and Hackney CCG to provide the community COPD service for City and Hackney patients.

The evidence base

See Annex 1 – Scheme ref no 3.1

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£ 2017/18	**£ 2018/19**
20,093	20,475

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Medium
Admissions to residential and care homes	N/A
Effectiveness of reablement	N/A
Delayed transfers of care	Medium

Feedback loop

Process Measures		
Item	Target	Comments
Number of referral to ACERS team (source/for what service element)	1800 per annum	
Number of training sessions for GP practice staff	2 per annum	
Number of patients attending A&E reviewed and care plan developed	70	
Number of referrals to pulmonary rehabilitation	200 per annum	
Number of home visits	3,000	
Report number of patients referred to inpatient smoking cessation and community smoking cessation and receive feedback on patients who have attended	N/A	Data from inpatient and community teams

Record smoking status of patients known to the service	N/A	Record on RiO

Patient Measures		
Item	Target	Comments
Patient experience (annual survey)	50 per annum	
CAT/HAD scores (pre- and post-ACERS intervention)	50 per annum 75% of patients reducing their CAT score pre- to post-intervention	

Clinical Measures: Contribution to overarching outcomes, no specific targets

- Reduction in A&E attendances for COPD
- Reduction in emergency admissions for COPD
- Reduction in readmissions
- Reduction in LOS for COPD patients

KPIs for whole year presented quarterly to City and Hackney CCG Respiratory Board. Any issues raised to Long Term Conditions Programme Board. Annual report (including audits undertaken and performance improvement) presented alongside.

What are the key success factors for implementation of this scheme?

- Recruitment of skilled staff
- Agreement of evaluation framework
- Engagement of primary care staff – in diagnosis of patients, adherence to pathways/guidance, working with early discharge plans
- Engagement of A&E staff – establish links with ACERS staff for patients presenting to A&E with exacerbations of COPD
- Establishment and embedding of 24/7 advice and referral line for use by health professionals
- Engagement of St Joseph's hospice – for links around end of life care

Scheme ref no.

3.1.2

Scheme name

Bryning Day Unit/Falls prevention

What is the strategic objective of this scheme?

Bryning assessment and rehabilitation unit is a complementary service run by Homerton University Hospital. The unit targets elderly patients identified through risk stratification and aims to reduce the emergency admissions.

Overview of the scheme

The Bryning Unit has a multidisciplinary team consisting:

- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Social workers; and
- Nursing staff.

Their specialist skills in elderly care complement the highly experienced and knowledgeable consultants in Homerton Hospital to provide comprehensive multidisciplinary assessments.

A weekly programme of clinics and groups is run to provide assessment, rehabilitation and support for older people with complex problems.

Services available

- ***Medical clinics***

  Our specialist consultant geriatricians hold multi-disciplinary clinics to thoroughly assess and ensure any health problems the patient is experiencing are investigated and addressed.
- ***Leg ulcer clinic***

  This is a specialist, nurse-led clinic for people with complex leg ulcer or deterioration of an existing leg ulcer.
- ***Falls clinic***

  Specialist multi-disciplinary clinics for people who have had one or more falls, or are at risk of falling. The main aim is to identify the causes of falls, to prevent future falls.
- ***Falls group***

  Our physiotherapist and occupational therapist run a four–week group for people who have fallen. This includes specific advice and a twice-weekly exercise programme and relaxation session to improve confidence, muscle strength and ability to cope with falls in the future.
- ***TIA (Transient Ischaemic Attack) clinic***

  TIA is the medical term for a suspected minor or a short -lived stroke.
- ***Parkinson's disease and movement disorder clinic***

  Specialist multi-disciplinary clinic for people with suspected or known Parkinson‘s disease or other conditions that can affect movement and muscle control.
- ***Continence clinic***

  Specialist nurse-led clinic for people who have urinary problems. A full assessment is provided with various investigations. Nurses then recommend how they can best manage their incontinence.

The delivery chain

The service is provided by Homerton University Hospital and commissioned by City and Hackney CCG.

The evidence base

See Annex 1 – Scheme ref no 3.1

Investment requirements

£ 2017/18	£ 2018/19
13,879	14,143

Impact of scheme

The scheme is aimed to reduce emergency admission through complex needs and falls.

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Medium
Admissions to residential and care homes	Low
Effectiveness of reablement	Medium
Delayed transfers of care	Low

Feedback loop

Monitored through Homerton UHFT's annual acute contract.

What are the key success factors for implementation of this scheme?

Already in place

Scheme ref no.

3.1.3

Scheme name

Asthma

What is the strategic objective of this scheme?

The service objectives are:

1. **A long term aim** will be to reduce the number of people with asthma who die prematurely through a proactive approach to early identification, diagnosis and intervention, and proactive care and management at all stages of the disease, with a particular focus on disadvantaged groups and areas of prevalence and **this relates to our LTC board outcome of reducing under 75 years mortality from respiratory disease per 100,000 population.** Although it is expected that this service will contribute to this outcome, it is not anticipated that any changes in this measure will be observed during the lifetime of this contract. (KPIs 4,5,6,7,9)
2. To improve the respiratory health and well-being of all communities and minimise inequalities between communities.(KPIs 9,12,13)
3. To enhance quality of life for people with asthma, across all social groups, with a positive, enabling experience of care and support right through to the end of life.(KPIs 8,13,14)
4. To ensure that people with asthma, across all social groups, receive safe and effective care, which minimises progression, enhances recovery and promotes independence.(KPIs 7,8)
5. To ensure that people with asthma, across all social groups, are free of symptoms because of prompt and accurate diagnosis, shared decision making regarding treatment, and on-going support as they self-manage their own condition to reduce the need for unscheduled health care and risk of death.(KPIs 10,11,12)

Overview of the scheme

This service will support improvement in primary care management of asthma as well as a more structured approach to asthma care within the Homerton Hospital with a focus on self-management and effective communication. According to the INHALE benchmarking tool for asthma emergency department (ED) attendances and hospital admissions for asthma (per 100 patients on the asthma register) for residents in City

and Hackney are significantly worse than the national average.

This service will also offer asthma expertise in the community in order to train health professionals, educate asthmatic patients in their own environment and integrate the provision of asthma care across the primary and secondary care sectors. The ACERS team at HUHFT work in a similar model on COPD and they have been shown to be very successful in reducing re-admissions and bed days from COPD.

The Service

The service will be available to patients over the age of 18 years registered with a City and Hackney GP.

This service will lead asthma management in primary care working closely with the lead asthma respiratory consultant at HUHFT and lead GP for asthma within City &Hackney. The service will address 9 key areas in excellent quality asthma care which are taken from best commissioning practice. The 9 areas include:

1. *Information for patients:* Working with Asthma UK to ensure that all information with regards to asthma is made available at the time of need.
2. *Accurate and timely diagnosis:* The service will ensure that primary care clinicians are adequately skilled to make an accurate diagnosis of asthma and have access to the required diagnostic facilities and expertise.
3. *Supporting self-management:* To ensure that written individualised self-management plans are a key element of asthma care for all patients through structured and tailored education programme for asthma. Ensure practices are using self-management plans.
4. ***Structured review by asthma-trained clinicians:*** To ensure that structured reviews are based on evidence based guidance and there is a regular programme of education for all involved in the care of people with the condition.
5. *Optimising medication:* Develop ways in which clinicians and pharmacists need to consider how to achieve improved outcomes for people with asthma, while minimising wasteful use of medicines.
6. *Severe/brittle/difficult-to-control asthma:* Work with current services to ensure that the specialist services are available for all within this group, which may comprise only 5-10% of the asthma population, but use up to 80% of the costs of asthma care.
7. *Managing acute and life-threatening episodes:* Education in the emergency departments and with other healthcare settings who have access to specialist advice and expertise in managing acute asthma, and good communication between emergency and respiratory departments, to ensure continuity of care.
8. *Avoiding hospital admissions and emergency department attendances:* To work with HCP's to develop a pathway to ensure that all healthcare professionals should be working with patients to ensure that loss of asthma control is identified early and appropriate steps are taken to regain control to avoid a full attack developing. A key aspect of this will be to ensure that communication between emergency services and primary care are built into the asthma care pathway.
9. *Following up acute episodes:* A full review of the patients post exacerbation of ED visit should be followed up. And where patients do not have a registered GP to work with HUHFT to access primary care services and follow-up.

The service will include:

- Undertaking visits to the ED to review asthma patients and working with the ED to develop a clear pathway for asthma patients attending the ED to include primary care follow-up and review.
- Developing a tailor-made education package for asthma patients focusing on asthma annual reviews and self-management advice including the local incentive scheme for asthma as a benchmark.
- Undertaking visits to practices to identify and review complex asthma patients within primary care – and acting as an expert in treatment and education, including working alongside practice nurses to educate / supervise their practice.
- Undertaking a current audit of asthma practice using the NICE clinical standards as a

benchmark.

- Providing regular updates and teaching sessions in group and 1:1 sessions for ward, primary care and ACERS staff.
- Acting as the clinical champion for asthma within primary care.
- Working with the respiratory consultant to develop and update the CHARM guidelines for Asthma Management.

All of which would contribute to improving outcomes for patients and reducing ED attendances/admissions.

The delivery chain

It is expected that the postholder will work within the framework of the existing COPD service arrangement in order to complement and share the expertise and expand the remit of the ACERS to cover both asthma and COPD. Therefore the post holder will be located in the ACERS team and have managerial support by the ACERS Nurse Consultant as well as from the Asthma respiratory Consultant and professional nursing leadership.

The evidence base

There are around 1,000 deaths from asthma a year in the UK, the majority of which are preventable. The UK has the highest prevalence of asthma in the world, at around 9-10% of adults. Asthma costs the NHS an estimated £1 billion a year. It is estimated that around 80% of spending on treating those with asthma is spent on the 20% with the severest symptoms. There is a 6 fold variation in admission rates across England for adults with asthma.

Many people with asthma are not achieving freedom from symptoms, with a recent large scale survey reporting that around 35% of adults with asthma had had an asthma attack in the previous 12 months.

Asthma is a long-term common chronic inflammatory disease of the airways which affects more than 1 in 5 households in the UK and around 5% of the population in City and Hackney. Asthma responds well to appropriate management and is principally managed in primary care; however ineffective management can lead to poor health outcomes including emergency hospital visits and admissions. Asthma cannot be cured, but for most people it can be effectively managed with preventive therapy.

Clinicians should be supporting people to make the right choices to manage their asthma, by giving them information about their condition and providing clinical expertise. Asthma varies from day to day and from person to person, so managing it daily is not a straightforward process. People need help to recognise when their asthma is worsening and when they need access to the expertise of the NHS. When they do have contact with a healthcare professional, the aim must be to make the interaction as productive as possible and this means within a partnership of care based upon a process of shared decision making. Inputs of care must also be integrated across the traditional boundaries of hospital and community-based services. We know that Asthma costs to the NHS are an estimated £1 billion a year, with poorly controlled asthma more expensive for the NHS than well controlled asthma. A patient whose asthma exacerbates and requires hospital treatment is likely to cost 3.5 times that of a patient who does not.

An audit of the asthma admissions carried out at Homerton hospital has shown a gradual increase in the number of asthma patients attending the emergency department and subsequently admitted for an acute exacerbation of asthma. This service will support improvement in primary care management of asthma as well as a more structured approach to asthma care within the Homerton Hospital with a focus on self-management and effective communication. According to the INHALE benchmarking tool for asthma emergency department (ED) attendances and hospital admissions for asthma (per 100 patients on the asthma register) for residents in City and Hackney are significantly worse than the national average.

This data also shows that a number of asthmatics attend the ED for repeat inhaler prescriptions and a further 100 of them have attended twice or more in a year. There is also clear evidence that a significant number of asthmatics have not been on preventive therapy and many of them are complex patients who are difficult to reach using the existing follow up arrangements. There is a clear need to improve asthma care in the community to reduce ED visits and hospital admissions. A further recent study by Barts Health specialist community pharmacist undertaken in about 150 patients with airways disease has confirmed that expert

review of the care and modification of medication has also resulted in a significant savings of around £32K on prescribing costs and reinforces the need for patient focussed expert asthma care and medicines management in the community.

There is wide variation in achievement of asthma QoF targets and asthma prevalence (table one).

This service will offer asthma expertise in the community in order to train health professionals, educate asthmatic patients in their own environment and integrate the provision of asthma care across the primary and secondary care sectors. The ACERS team at HUHFT work in a similar model on COPD and they have been shown to be very successful in reducing re-admissions and bed days from COPD.

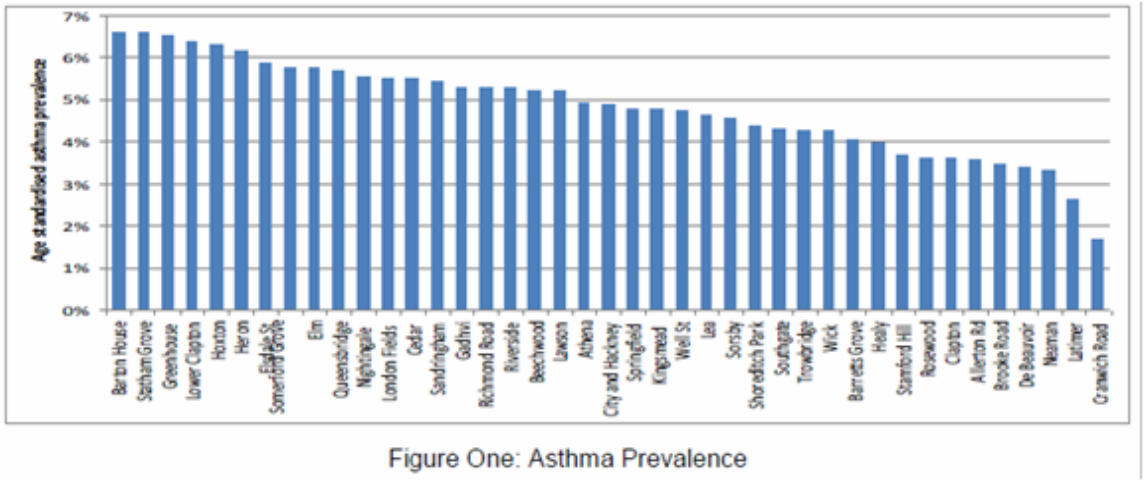


Figure One: Asthma Prevalence

- Link to NHS Outcomes Framework domains & Indicators

This proposal supports the combined CCG and HUHFT objectives of preventing unnecessary attendances at ED, reducing readmissions and reducing length of stay through building the number of asthma patients seen in the community rather than acute services.

Investment requirements

£ 2017/18	£ 2018/19
3,045	3,112

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	Low
Admissions to residential and care homes	N/A
Effectiveness of reablement	N/A
Delayed transfers of care	N/A

Feedback loop

Performance indicator	Indicator/Quality Requirement	Format & Frequency	Consequences of breach
1. Total number of patients attending A&E with primary diagnosis	Record activity (C+H patients only)	Quarterly report	Formal report re: reason and action

	of asthma			plan
	2.Total number of patients admitted	Record activity (C+H patients only)	Quarterly report	
	3.Total City & Hackney patient medication requests	Record activity (C+H patients only)	Quarterly report	
	4.Number of GP practices visits	Minimum 1 per practice per year (pro rata if project runs for less than 1 year)	Quarterly report	
	5.Number of training sessions for GP practice staff	Minimum 25 (pro rata if project runs for less than 1 year)	Quarterly report	
	6.Number of Formal Study Days Organised	Minimum 3 per year (pro rata if project runs for less than 1 year)	Quarterly report	
	7.Number of complex patients in primary care reviewed	Record activity (C+H patients only)	Quarterly report	
	8.Number of patients with severe asthma with personal asthma action plan	100%	Quarterly report	
	9.Record demographic details of clients using the service to enable equity audit	Ongoing data collection	Ongoing	
	10. Reduction in A&E attendances for asthma	5% on baseline (435)	Quarterly report	
	11. Reduction in emergency admissions for asthma (HUHFT reporting number of admissions with a primary diagnosis of asthma)	10% on baseline (110)	Quarterly report	
	12. Monitor number of patients who die of an asthma exacerbation	No target	Ongoing	
	13. Improvement in patients quality of life, measured via the asthma control test	75% of patients showing improvement	2 week sample audit	
	14. Patient satisfaction with service measured via service specific survey	80% of patients satisfied with service	Quarterly report	

What are the key success factors for implementation of this scheme?

Risk and brief explanation	Mitigating actions
Unable to recruit suitably trained staff	Wide recruitment campaign, target existing respiratory staff from a current London Network and aim to backfill post if on secondment perspective.
Long term funding post	Appropriate auditing and cost efficiency of savings needed from day one, along with appropriate evaluation to ensure appropriate data for long term investment.
Unable to fulfil KPI performance and make the recommended cost saving as suggested.	Part of risk share – pilot project to assess feasibility and learning from this. Ensuring appropriate audit, review and reporting mechanisms

Scheme ref no.

3.1.4

Scheme name

Palliative Care – Out of Hospital Service

What is the strategic objective of this scheme?

The aim of the service is to provide high quality Specialist Palliative Support to patients in the community in the last years, months and days of life, to enable patients to maintain their identify and independence during the changing phases of their illness, which includes:

- Expert assessment, advise, care and support for patients and carers
- Expert assessment, advise, support and education for health and social care staff caring for patients with Specialist Palliative Support for Last Years, Months, Days of Life Care needs
- Improvement to the quality of care to all patients which respects their wishes in regard to their preferred place of care and death

Overview of the scheme

The service commissioned will:

- Be comprised of the core members of the Specialist Palliative Support for Last Years, Months, Days of Life Care team as defined by NICE Supportive and Palliative Care Guidance with clear and timely processes for accessing the extended Specialist Palliative Support for Last Years, Months, Days of Life Care team
- Carry out ongoing assessment of needs using the four domains of care: physical, psychological, spiritual and social
- Use care planning, including advanced care planning, to meet identified needs
- Provide ongoing assessment and recording of patient and carer preferences for care including location for care and death.
- Have a minimum of weekly multidisciplinary team meetings for review of patients' needs and care planning
- Be involved in monthly GP based / lead multidisciplinary team meetings with wider health care team
- Communicate assessment and care planning to the referrer and wider health and social care team in a timely manner
- Coordinate care where specialist palliative care worker is identified as the key worker for a patient and liaise with local key worker when specialist palliative care team worker is not the key worker
- Provide care that is culturally and spiritually sensitive with access to translation and advocacy services when a patient's first language is not English
- Provide and promote care using the best practice tools Provide support and advice to staff in other services caring for patients with Specialist Palliative Support for Last Years, Months, Days of Life Care needs
- Deliver education regarding best practice in Specialist Palliative Support for Last Years, Months, Days of Life Care. This includes identification and assessment of patients' palliative care needs; communication skills, symptom management, Advance Care Planning and the diagnosis of dying
- Undertake assessment of carer needs and ongoing referral to support networks as required
- Provide comprehensive medical and nursing cover to deliver care twenty four hours a day seven days a week
- Undertake assessment of bereavement needs and onward referral and signposting to local bereavement support services

The following criteria are in addition to the criteria above and specific to services delivered in different care settings.

Specialist Palliative Support for Last Years, Months, Days of Life Care Unit

- Available to patients with complex problems in any of the four domains that cannot be managed adequately in other community settings and who would benefit from the continuous support of a multi-disciplinary Specialist Palliative Support for Last Years, Months, Days of Life Care team
- Timely and comprehensive communication with referrers and GPs following admission to the unit

- Timely and comprehensive discharge planning for patient returning home following an episode of care in the unit
- Assessment of need in the last days of life and provision of care in line with the recently published guidance of the Leadership Alliance for Care of the Dying.
- Provision of medical interventions to manage complex symptoms using a variety of interventions.
- Clear processes for death certification preventing inappropriate referral to the coroner
- Provision of bereavement care to families and carers after a death in the in-patient unit
- Provide for medication and pharmacy needs for patients while on the ward and supply medication to take home on discharge

Community Specialist Palliative Support for Last Years, Months, Days of Life Care Service

- Provision of expert clinical advice to GPs and community health care staff including attending GP based MDT meetings at a practice and quadrant level
- Receive referrals from other staff (GP, community nursing, acute staff) of patients who have been identified as approaching the last years of life (who may have either generalist support needs and those with more specialist palliative care needs – subject to initial assessment) and to provide holistic assessment of patients' and carers' care, social and spiritual care needs
- Each CNS to hold a caseload of patients
- Effective individualised advance care planning, including support to other staff in creation of ACPs and CMC records, review of plans/records created by others and updating where necessary
- Signpost patients to other support from St Jo's
- Identify and support other professionals to identify when pts are deteriorating and reassess care needs as necessary
- Management of complex symptoms and signpost to sources of advice for increasing care needs/symptom worsening (to reduce unnecessary admissions to hospital)
- Assist in the prevention of any unnecessary hospital admissions
- Facilitating speedy discharge from hospital where appropriate, working with the Elderly Care Unit, and other wards, to improve the process of discharge and the care provided to patients once back in the community
- Identify and support other professionals to identify when pts are approaching last weeks/days of life and reassess care needs as necessary
- Coordination of services, in the last days of life, urgently as appropriate, including access to advice, non-medical prescribing, authorisation chart and access to medicines
- Support patients to be cared for and die in preferred place
- To advise and support nurses, doctors, GP's and other members of the wider health and social care team providing care to the patient and their carer/family, including joint patient visits where required
- Training and education to the non-specialist workforce (as above)
- Provide particular support to care/residential homes to ensure processes in place for accessing advice both in hours and out of hours, and staff feel confident on who to contact in case of deterioration (named CNS for each care home, support visits, raising awareness of urgent support/advice services, attendance at relevant care home/practice MDT, case management of patients including care home visits, support to staff in discussing future palliative care with patients/families, training for staff on advance care planning and identification/management of last years of life, deterioration and last weeks/days of life, encourage and support care staff in completing advance care plans for care home patients and in avoiding unnecessary hospital admissions/diagnostics at end of life
- Signpost families/carers to appropriate pre- and post-death bereavement support

Day care Specialist Palliative Support for Last Years, Months, Days of Life Care service

- Provision of day care to prevent hospital admission
- Provision of care across the four domains that enable the patient to avoid unnecessary hospital admissions and to focus on achieving the patient's choice of care and quality of life.
- Provide ongoing information and explanation patients and carers as the patients disease progresses to empower them to make informed choices and signpost to services
- Provide support to patient providing effective symptom control to enable them to remain at home and achieve quality in their life.
- Provide opportunity for cares to have a respite from their caring activities

- Provision of bereavement care to families and carers after a death of a patient using the day care facilities

Accessibility/acceptability
The service will have referral processes to ensure that patients in need of Specialist Palliative Support for Last Years, Months, Days of Life Care services are able to access and receive support from the service.

The service will be staffed by a work force that is competent in the delivery of Specialist Palliative Support for Last Years, Months, Days of Life Care including skills in communication, cultural awareness, promotion of dignity and with respect for patient wishes and preferences. The service will be responsive to age, culture, faith and ideology, disability and gender issues in relation to palliative care dealing with them in a sensitive and inclusive way. The service will have processes to ensure that specific cultural and religious beliefs relating to Specialist Palliative Support for Last Years, Months, Days of Life Care are respected at all stages of the care pathway and in the period after death.

The Service will provide interpreting services, inclusive of sign language interpreting, to ensure that all patients receive equal access to health and advice in accordance to their level of clinical need. Interpreting by family members or friends is not acceptable except in exceptional circumstances

Interdependencies
Continuity of care across care settings is essential to ensure that patients' identified needs continue to be met despite a change in care setting. Therefore assessments and care planning undertaken by the specialist palliative care service need to be communicated with other services involved with the patient. Key interdependencies are listed in the local Specialist Palliative Support for Last Years, Months, Days of Life Care pathways and include:

- Acute services including A&E, wards and out-patient departments
- Primary health care teams including district and community nursing and GPs, community matrons
- Long term conditions and specialist teams such as heart failure, COPD in acute and community settings
- Specialist Palliative Support for Last Years, Months, Days of Life Care (in other locations)
- Rapid response and urgent care teams, Out of Hours services including GPs, district and community nursing, specialist palliative care
- London Ambulance Service
- Social Services including case managers
- Coroners and funeral directors
- Voluntary and third sector organisations
- Service provided by the independent sector such as care homes

<u>Referrals</u>

Referrals will be received from – GPs, Community nursing teams, Integrated Independence Team, secondary care, and care homes, referrals are also accepted directly from patients and those significant to them

<u>Referral Process:</u>

- All referrals through First Contact team (telephone referrals are accepted). First contact teams working hours are 08.00-18.00 Monday to Friday. For urgent out of hours admission please call 0300 30 30 400.

- First contact team may contact referrer for further information. The patient will not be contacted until this information has been received. Minimum information is required before a referral can be actioned: a GP summary, last clinic letter where appropriate and confirmation of patient consent to referral.

- **Urgent referrals**: If the patient is considered to have urgent (RED) needs (significant and uncontrolled symptoms or thought to be in the last days of life) the patient will be contacted and where necessary have a face-to-face assessment within 24 hours, even outside of the first contact teams working hours. This may be before the MDM discussion has taken place. The patient will still

be discussed at the next Multi-Disciplinary meeting (MDM) which are held at 09.00 Monday to Friday.

- **All other community and inpatient referrals:** all non-urgent referrals are contacted by phone to ensure they are aware that St Joseph's have the referral and have an initial needs assessment within 24 hours to ensure there is no unreported urgent need. The patient will be given the 24/7 advice and support number at this time and the assessment process explained. If the patient has no unidentified urgent needs then they will be informed that they will be contacted by the First contact team who will conduct a full telephone assessment where the patient or their advocate will have an opportunity to express their concerns , issues and expectations of the support St Joseph's can offer them. The patient will then be discussed at the MDM the following day. If the referral is accepted, they are given a RAG rating for admission or contact with the community team, depending on their level of need. Soon (Amber) within 3 days or Routine (Green) within 7 days and passed to the relevant team.

Response times for urgent and non-urgent referrals:

- Patients with urgent (RED) need (significant and uncontrolled physical symptoms or in thought to be dying in next few days) will be contacted and admitted, subject to bed availability or seen in the community within 24 hours of referral

- For non-urgent referrals to supportive care the patient's needs will be assessed by the end of the next working day by the First contact team. The patient will be discussed at the MDM meeting and if the referral is accepted they are allocated to the appropriate service who will make the initial contact with the patient to arrange an assessment or admission within 3 days for Soon (AMBER) or 7 days for Routine (GREEN). If the patient is unable to participate in the assessment the information will be obtained from a relevant family member and/or health care professional, (the team does have access to interpretation services)

Communication with the GP

The GP will be contacted on the day the referral is received.

If the patient is referred to the community palliative care team the GP will receive a summary within 3 days of the face-to-face assessment.

Eligibility Criteria

- Any adult patient/s who have active and or progressive, life-limiting illness, and are experiencing difficulties related to that illness from within the catchment area.
- Young adults aged 16-18 for whom access to adult services is appropriate within the catchment area

- The patient requires Specialist Palliative Support for Last Years, Months, Days of Life Care needs that cannot be met by non-specialist staff
- The patient has distressing symptom(s) that are not responding to current treatment regimes
- The patient has multiple symptoms recognised as being difficult to control which are not responding to current treatment regimes
- The disease is perceived to be rapidly progressive by the multi-disciplinary team, the patient or his/her family
- The course of the illness is developing in an unexpected way that is not related to active treatment
- The patient or family are suffering due to psycho-social or spiritual distress due to the diagnosis, symptoms, treatment, prognosis of the disease, or the facing of death

The service should actively engage with other health and social care providers to ensure all patients with complex needs have access to expert advice and support.

Exclusion Criteria

Any referred patient that does not meet the referral criteria.

Discharge

Patient should be discharged by the Community Palliative Care team when:

- Specialist palliative support intervention is on longer required or need is being met by another service. Discharge should be discussed with the patient/carer and ensure they are aware that they can re-refer.
- Patient moves outside service area
- A patient dies

Prevention, Self-Care and Patient and Carer Information
Patients will be included in the development and implementation of care plans and in continuous re-evaluation of their needs and care requirements. These care plans will include review of needs, preferences for place of care and death and satisfaction with care provided. Patients and carers will be encouraged to take part in self-care, monitoring and active participation in their care plans and carers will be encouraged to utilise bereavement and psychology services as required.

The service will have available and offer to patients the following written information

- Description of the service including operation times, remit of service and contact telephone numbers
- Key contact information
- Emergency contact details
- Practical information about what to do when the patient dies
- Information in languages other than English, as required by the local population
- Information in format other than written for those unable to read the written word
- Letters regarding their care in line with the Patients Charter 2000

The delivery chain

St Josephs Hospice services will be delivered in all care settings including the community, care homes and extra sheltered care housing, the hospice, community hospitals, hostels for the homeless and mental health services

Inpatient care in will be provided 24 hours a day, 365 days a year.

The Community service will provide a visiting service during core hours (9am to 5pm) 7 days a week and access to Specialist Palliative Support for Last Years, Months, Days of Life Care advice 24 hours a day 365 days a year.

Support services (e.g. counselling, psychology, physiotherapy, occupational therapy) will be provided during core hours (9am to 5pm), 5 days a week as a minimum and as required by individual patient needs.

The evidence base

NICE Quality Standards for End of Life Care for Adults https://www.nice.org.uk/guidance/qs13

NICE guidelines on Care of the Dying Adults in the Last Days of Life https://www.nice.org.uk/guidance/ng31

Gold Standards Framework

Five Priorities for Care (Leadership Alliance for Care of Dying People):
https://www.england.nhs.uk/ourwork/qual-clin-lead/lac/

National EOLC Ambitions (http://endoflifecareambitions.org.uk/):

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff prepared to care
6. Each community is prepared to help

Investment requirements

£ 2017/18	£ 2018/19
20,358	20,745

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	N/A
Effectiveness of reablement	N/A
Delayed transfers of care	N/A

Feedback loop

Performance Indicator	Indicator	Threshold	Method of measurement	Frequency of Monitoring
Service User Experience	Service user satisfaction Carer satisfaction Number of complaints and compliments received % of complaints acknowledged within 5 days % investigated within agreed timescale with complainant Experience improvement plan – number of complaints resulting in service change	80% satisfaction 100% 100%	Service user survey Review of complaints Review of complaints	Quarterly
Care closer to home	Average LOS	<16 days		
Reducing Inequalities	Number of patients with cancer and non-cancer diagnosis on caseload including ethnicity	To achieve 30-50% mix	Reporting of patient diagnosis	Quarterly
Reducing Barriers	Patient ethnicity	30-50% from BME groups	Report on patient ethnicity	Quarterly
Personalised Care Planning	% Patients with a document advanced care	100% 80%	Report on % offered discussion	Quarterly

	plan offered by third contact with the Hospice % Patients expressed preference of place of death		Report on & with documented ACP or PPOD	
Outcomes				
Integrated Coordinated Care	% Patients dying in place of choice	70%	Caseload data	Quarterly
Performance & Productivity				
Improving Productivity	Average length of stay	<16 days	Reporting ALOS	Quarterly
Patient safety and service quality	Provider information return on: · Serious Incidents; · Complaints by type · Healthcare associated infections; and, · 4 patients harms measures: Falls, pressure ulcers (grades 1-4), Urinary tract infections in patients with a catheter, and, Venous thrombo-embolism (VTE).		Report on numbers and type for complaints and pressure ulcers	Quarterly
Access	Provision of care against hospice care pathways - with specific detail on use of respite beds within STJH		Report on numbers following each pathway and respite day beds used	Quarterly
Additional Measures for Block Contracts				
Staff turnover rates	Number of staff leaving and starting work at hospice (clinical)		Reporting	Annual
Sickness levels	Number of working days lost to sickness in clinical and non-clinical staff		Staffing report	Annual
Agency and bank spend	Exception reporting		Reporting	Annual
Contacts per FTE	Not applicable			
Activity				

What are the key success factors for implementation of this scheme

This scheme is already in place.

Positive engagement between:

- Acute services including A&E, wards and out-patient departments
- Primary health care teams including district and community nursing and GPs, community matrons
- Long term conditions and specialist teams such as heart failure in acute and community settings
- Specialist Palliative Support for Last Years, Months, Days of Life Care (in other locations)
- Rapid response and urgent care teams, Out of Hours services including GPs, district and community nursing, specialist palliative care
- London Ambulance Service
- Social Services including case managers
- Coroners and funeral directors
- Voluntary and third sector organisations
- Service provided by the independent sector such as care homes

Scheme ref no.
3.2
Scheme name
Paradoc
What is the strategic objective of this scheme
To reduce avoidable emergency admissions
Overview of the scheme

The aim of this project is to extend the three month pilot of a joint response to defined groups of patients in the community with urgent and primary care needs. The response will be provided by an OOH GP with a LAS Paramedic in a response car. The target groups of patients are those who have a low threshold for seeking emergency care for urgent care conditions by calling 999:

- patients conveyed to ED by Ambulance who are subsequently discharged home or have a zero length of stay
- patients who call 999 with primary care/ urgent care needs that do not require an emergency ambulance/ paramedic response
- frequent callers/ attenders
- exacerbations of long term conditions

The key objective of this initiative is to ensure patients receive the most appropriate response in terms of seeing the right healthcare professional at the right time. It is also critical that they are aware of all local primary care provision allowing referral and interaction as appropriate.

London Ambulance Service respond to patients with complex, chronic and co-existing conditions that will often have acute episodes or exacerbations that require a level of assessment/ intervention beyond the normal scope of ambulance clinicians / paramedics. These cases are often conveyed to hospital but some could be managed more appropriately at home with rapid input by a GP.

Conversely the AMPDS call-handling tool results in an ambulance response to patients triaged as “life threatening” due to their telephone presentation, but where the face to face assessment will often find the patient in need of Primary/Urgent Care.
Currently ambulance clinicians in City and Hackney have limited options available to facilitate the successful referral of patients to other providers and services. As a consequence, this results in the easy and risk adverse option of an unnecessary conveyance to an Emergency Department. PARADOC offers a more appropriate solution to this cohort of patients. It will also provide support to ambulance clinicians for patients will clinical need but refuse A&E.

It is anticipated that the joint response service will run 7 days a week from mid-afternoon to the early hours of the morning, in line with trends in LAS call demand. Initially 2pm to 2am has been considered with GPs operating split shifts of 6 hours. Weekends may need to be different hours although further discussion is required to agree the optimum shift pattern. Further detailed analysis of LAS call demand and outcomes within the CCG footprint is required to verify the hours of operation by day of week. The service will not respond to calls in public places or workplaces, it will only respond to patients at home (including nursing and care homes).

Referral to PARADOC

To achieve outcomes that support admission avoidance and non- conveyance to an ED, it is essential that PARADOC is tasked to appropriate calls. PARADOC will respond to 999 calls that have either been:

1. Reviewed by a Clinical Team Leader in the Clinical Hub within the LAS control room, this will include an assessment using Manchester Triage, where the outcome suggests the patient is in need of a GP assessment but unlikely to need conveyance to hospital
2. Assessed on scene by an ambulance clinician (Paramedic or EMT), including use of Paramedic Pathfinder assessment tool and Pre Hospital Early Warning Score , where the outcome indicates the patient is in need of a GP assessment/ urgent care but unlikely to need conveyance to hospital

3. Named patients who are frequent 999 callers or frequent ED attenders

Patient Conditions/ indications for referral to PARADOC

Using the referral approach described above, a wider range of patients can be seen by PARADOC, for example:

- exacerbations of COPD
- UTI
- elderly "scared and home alone". Patients with a low threshold for seeking urgent care
- Patients with pre-existing/ multiple health needs with urgent care needs, e.g. chest infection
- heart failure
- non traumatic back pain
- paediatric patients with minor ailments (LAS currently takes all patient under 2 years of age to hospital and has a very low threshold for taking any child under 16 to A and E, irrelevant of condition)
- chest pain where cardiac cause can be excluded
- abdominal pain
  - diarrhoea and Vomiting
  - flu symptoms
  - diabetics
  - medication issues
  - patients refusing consent to be conveyed to hospital but allowing on scene assessment/treatment
  - risk stratification for mental patients suffering from depression, to avoid A&E
  - advice, analgesics and possible antibiotics for patients post minor operations
  - allergic reactions
  - end of Life Care patients
  - post – hospital discharge patients, e.g.post op wound infections (avoidance of readmission)
  - patients in nursing homes and care homes without priority symptoms
  - patients with a CMC record

The delivery chain

London Ambulance Service will be the lead provider for the PARADOC service supported by CHUHSE who will provide the GP and other identified resources.

The evidence base

The case for change essentially relates to managing rising demand by providing a smarter and different response, thus ensuring there are appropriate resources available to meet the differing needs of patients.

The London Ambulance Service is commissioned to provide a pan-London emergency ambulance service, handling approximately 1.8 million 999 calls a year that result in over 1 million emergency responses. There is a year on year increase in Cat A workload, YTD this is trending at around 7% pan – London. Cat A calls are generally more resource intensive, thus providing a good level of service to less urgent patients is problematic during surges in demand. Typically there is a surge in demand over the winter period due to an increase in alcohol related calls over the festive period, seasonal flu and viral illness, exacerbations of chronic illness due to cold weather. The table below shows the increase in Cat A work load and total incidents from Winter 11/12 to Winter 12/13 in the Homerton Operational Area:

Month	Cat A Incidents 12/13	Cat A Incidents 11/12	% Difference Cat A	Incidents 12/13	Incidents11/12	% Difference
Oct	**1578**	**1385**	**13.94%**	**3906**	**3640**	**7.31%**
Nov	**1560**	**1429**	**9.17%**	**3790**	**3617**	**4.78%**
Dec	**1719**	**1597**	**7.64%**	**3725**	**3874**	**-3.85%**
Jan	**1544**	**1352**	**14.20%**	**3761**	**3499**	**7.49%**
Feb	**1474**	**1435**	**2.72%**	**3542**	**3481**	**1.75%**

Mar	**1595**	**1558**	**2.37%**	**3951**	**3854**	**2.52%**

NB: The number of incidents in Winter 12/13 will be reduced by use of DMP.
The total number of incidents by category in the City and Hackney CCG area from October 2012 to March 2013 is shown in the table below:

	Cat A	Cat C1	Cat C2	Cat C3	Cat C4	Total Incidents
City and Hackney CCG	**7683**	**1108**	**5036**	**1756**	**3127**	**18710**

In 32% of cases, patients are not conveyed to an ED however evidence from the Physician Response Unit (PRU) shows that a greater number of patients do not need to be taken to hospital. The Physician Response Unit is based at the Royal London and consists of a Doctor (HEMs rotation) and LAS Paramedic, operating Monday – Friday 8am – 4pm. PRU data collected over a 6 month period (Nov 12 – April 13) showed the following outcomes:

- 48% referred to GP
- 17% referred to specialist
- 4% no follow up required
- 24% conveyed by ambulance to ED
- 7% deceased (cardiac arrest and major trauma)

Unlike the PRU, this proposal uses a GP in place of an ED/HEMS clinician and therefore will be more efficient as the service will able to directly deal with the types of call the PRU refers to GPs. By ensuring the joint response service is tasked to the most appropriate urgent calls, the number of patients requiring conveyance to acute care will be minimal.
PARADOC can provide an alternative pathway that ambulance clinicians, both in the control room and on the road, will be able to refer to with ease and with confidence. PARADOC will offer a solution to those patients where the on scene ambulance clinician doesn't believe the patient is appropriate to be left at home without further assessment by a more appropriate clinician (i.e. a Doctor) but may not need A&E.

Investment requirements

£ 2017/18	**£ 2018/19**
18,322	18,670

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	Low
Effectiveness of reablement	N/A
Delayed transfers of care	N/A

Feedback loop

Key performance indicator	**Target**	**Comment**
Minimum activity level- number of calls attended by PARADOC	Trajectory Weeks 1 and 2 - Average of 46 patients per week Weeks 3 and 4 - Average of 55 patients per week Weeks 5 onwards: Average of 63 patients per week	

Non-conveyance/ referral to an Emergency Department	75% of all cases?	Difficult to ascertain the current conveyance levels for these patient groups and ultimately therefore the improvement delivered through the service

What are the key success factors for implementation of this scheme?

Risk and brief explanation	Mitigating actions
Availability of suitable Doctors	Current level of GP engagement with CHUHSE has been excellent and so it is expected recruitment should not be an issue
Technology solution for Adastra	Utilising the process CHUHSE have undertaken in preparation for go-live for ooh likely to be similar
Appropriate tasking to calls	Close collaboration and feedback to be delivered to LAS in the management of call distribution
Ability to develop a joint service governance framework	Utilise experience gained through similar initiatives currently running

Scheme ref no.

4.1

Scheme name

Adult Community Rehab Team (ACRT)

What is the strategic objective of this scheme?

The service aims to provide specialist inter-disciplinary rehabilitation to clients with community goals over the age of 18 with a physical or neurological impairment. Clients who are living with one or more long term condition(s) that would benefit from slow-stream, rehabilitation would benefit being seen by ACRT. The service encourages self- management and can offer therapy case management to enable clients to stay living in their chosen environment.

The team aim to prevent unnecessary hospital admissions and achieve reductions in length of stay by facilitating timely discharge for clients with long term conditions and/or slow stream rehabilitation needs when leaving hospital.
For clients with complex needs requiring medical intervention and/or review, joint working arrangements are in place with both Homerton Geriatric Consultants and a Neurology Consultant.

The service also offers advice and support to carers, family and friends of service users to maximise the function and wellbeing of ACRT clients.

Overview of the scheme

ACRT bases itself on The Social Model of Disability which puts the client at the forefront emphasising independence and choice whilst respecting clients' dignity. This is why intervention is not time limited and is based on clients' own goals and desired achievements. Therapists work with clients to help improve their ability to participate in normal day-to-day activities in order to minimise the impact of living with a disability.

The amount of rehabilitation provided is determined by the client's needs and goals. Clients with progressive conditions may require on-going reviews by their therapists and vulnerable clients will be placed on a review register to ensure appropriate reviews take place. Clients who require equipment as part of the rehabilitation process can be prescribed equipment by ACRT therapists.

The team operate as one but work according to 2 different pathways – neurological and physical conditions and although clinically the two groups of therapists work within different clinical specialties, operationally they work according to the same policies and procedures.

Robust screening protocols mean that all senior therapists are skilled in receiving referrals and prioritising accordingly, regardless of a neurological or physical background. All 1-2-1 clients are assessed using the same Single Assessment Process and the same goal setting procedures.

Clients are seen in the place that is most appropriate to them. This may be at home, work, college, local leisure centre or on site at St Leonard's. Rehabilitation can include Physiotherapy, Occupational Therapy, Speech and Language Therapy, Clinical Neuropsychology, Psychological Therapies and Consultant Allied health Professional (AHP) in Neurological Rehabilitation.

Neurological conditions

Any client with a progressive (e.g. Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease) or non-progressive (e.g. stroke, Traumatic Brain Injury) condition can be seen by any of the specialist neurological therapists. Other conditions that are shown to benefit a neurological approach to rehab are those such as those diagnosed with Medically Unexplained Symptoms (e.g. Conversion Disorder).

The AHP Consultant in Neurological Rehabilitation is responsible for co-ordinating the neurological rehabilitation pathway for clients requiring placement in tertiary centres. As part of this pathway the AHP Consultant works alongside the neurological conditions side of ACRT to facilitate discharge to the community and also to provide support to the clinicians in the management of clients with complex neurological rehabilitation needs. This aspect of the role includes support to integrate rehabilitation, nursing and social care. The AHP consultants involved in clinical research and evaluation of the rehabilitation pathway. The AHP Consultant holds a monthly community neurology clinic with a Consultant Neurologist which provides a

responsive service to clients living in the community with neurological conditions. Clients receive a neurology review as part of the multidisciplinary team and this allows clients equal access to neurology services and supports the team's principle of facilitating clients with complex disability to remain at home. The AHP Consultant holds a clinical caseload that involves a case management approach for clients with complex neurological rehabilitation needs. The AHP Consultant also supports the management of neurological clients who require are eligible for Continuing Health Care needs alongside the Continuing Health Care Team.

Physical conditions

Clients with any physical condition who require a community-based rehabilitative approach can be seen by the specialist physical conditions team. Services and Pathways include: Falls and Osteoporosis Care Pathway, Balance Group, Pulmonary Rehab, Lymphoedema, Physiotherapy for adults with mental health difficulties, Housebound service for clients with chronic pain, Hand Therapy and Obesity.

Population covered

The service is provided for City and Hackney GP registered population and people who are not registered with any GP but resident of City and Hackney. If the service does see anybody not covered by the above criteria they need to ensure that they charge the host commissioner and not count within City and Hackney activity targets.

Any acceptance and exclusion criteria and thresholds

Acceptance

- Adults aged 18 upwards
- Registered with a City and Hackney GP
- Clients who are unable to access out-patient therapy services requiring community assessment
- Clients with primarily a physical disability or neurological diagnosis (progressive or non-progressive)
- Clients who require management and/or rehabilitation of physical or neurological progressive or non-progressive long term conditions that will benefit function and mental well-being

Exclusion

- Clients under 18 years old
- Clients without a City and Hackney GP (except those neuro rehab clients under the AHP consultant who may reregister with a different GP)
- Hospital in-patients
- Is currently open to another therapy team for the same intervention
- Has needs that would be better met by an intensive approach to rehabilitation (signpost to IIT)
- Requires immediate assessment (within less than 5 days) due to high risk of hospital admission or to facilitate discharge (signpost to IIT)
- Has primarily medical needs and/or an acute medical condition that will prevent them from participating in rehabilitation
- Clients who do not require rehabilitation
- Refusal by client for assessment/intervention by team
- Requires OT equipment provision only - signpost to Social Services OT
- Has primarily social issues - sign post to Social Services
- Requires Psychological input only - Primary Care Psychology - referral via GP

Interdependence with other services/providers

The team liaises with GPs, Consultants and therapists (at Homerton, Barts and RLH, St Joseph's Hospice and the National Hospital for Neurology and Neurosurgery), carers, Community Nurses, other Homerton University Hospital NHS Foundation Trust providers (e.g. Locomotor and Wheelchair Service), Community Palliative Care Team, Healthwise, Greenwich Leisure Limited (GLL) and the Access Team at LBH. The team also works closely with the voluntary sector, including the Stroke Survivors Project, Ability Bow, Headway East London, Rehab UK and the Stop Falls Network. These services have full access to the professionals within the team for support and advice and are a vital link in a number of different care pathways. Local leisure

centres and third sector networks often provide the exit pathway for clients who have completed all clinical rehabilitation.

The delivery chain

See above

The evidence base

- Shepperd S, Illiffe S. 2006. Hospital at home versus inpatient hospital care. The Cochrane Database of Systematic Reviews.
- Kendall E, Buys N, Larner J. 2000. Community based service delivery in rehabilitation: the promise and the paradox. Disability and Rehabilitation. 22(10):435-45.
- Finkenflugel H, Wolffers I, Huijsman R. 2005. The evidence base for community-based rehabilitation: a literature review. International Journal of Rehabilitation Research 28(3):187-201.vHartley S, Finkenflugel H, Kuipers P, Thomas M. 2009. Community-based rehabilitation: opportunity and challenge. Lancet 374(9704):1803-1804.

Investment requirements

£ 2017/18	**£ 2018/19**
79,393	80,902

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	N/A
Admissions to residential and care homes	High
Effectiveness of reablement	High
Delayed transfers of care	Medium

Feedback loop

NHS Outcomes Framework Domains and Indicators

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

Local defined outcomes

- All urgent clients are contacted within 2 working days and seen within 5 working days
- All non-urgent clients seen within 5 weeks
- All GPs and clients are sent a letter confirming their referral and waiting time for assessment
- All clients given the opportunity to set goals within 4 weeks of initial assessment
- All clients requiring intervention for longer than 10 weeks will be reviewed
- On discharge, clients, GPs and referrers are sent a report outlining their goals, intervention to date and discharge plans
- Provide ACRT clients (1:1 and groups) the opportunity to provide feedback about service they have received by offering satisfaction questionnaires and inviting attendance to User Involvement Group
- All clients with complex rehabilitation needs referred to the AHP consultant seen within 1 week of referral
- All clients discharged from AHP Consultant rehabilitation programmes to suitable long term or community placements without unnecessary delays in rehabilitation placements

- The AHP Consultant/ neuro navigator will coordinate and support timely access to, provision of, and discharge from specialist rehabilitation settings without unnecessary delays.
- The AHP consultant/ neuro navigator will provide specialist advice, assessment and support to the continuing healthcare team for people with complex neurological conditions.

Reporting Requirements

Reporting Requirement	**Frequency of reporting**	**Method for the delivery of the report**	**Information Source**
90% of urgent clients seen within 1 week	Monthly	Electronically	RiO
90% of non-urgent clients seen within 5 weeks	Monthly	Electronically	RiO
90% ethnicity recording	Monthly	Electronically	RiO
Less than 10% DNAs	Monthly	Electronically	RiO
15256 client attendances per year	Monthly	Electronically	RiO
AHP consultant/ neuro navigation intervention commenced within 1 week of referral.	Monthly	Electronically	RiO
All clients discharged from level 1 specialist neuro rehab units to long term rehabilitation or community placements/home are reviewed within 3 months of discharge by AHP Consultant/ neuro navigator	Monthly	Electronically	AHP consultant submit quarterly returns (Spreadsheet)

What are the key success factors for implementation of this scheme?

Given the interdependence of various services providers, the key success factor of this scheme is the positive engagement between all relevant providers at any given time related to a given case.

Scheme ref no.

5.4

Scheme name

Adult Community Nursing

What is the strategic objective of this scheme?

The overall function of this service is to provide high quality closer to home aimed at improving or maintaining health, promoting independence and self-care and avoiding hospital admissions.

Overview of the scheme

NHS City & Hackney commission the Adult Community Nursing (ACN) service to provide nursing care, case management, advice and education, to residents over the age of 18 years.

The ACN Service is responsible for providing a service to all City and Hackney residents, primarily in their own homes, in clinics and residential care settings. This includes those residents registered with City & Hackney GPs, residents without a GP and residents who are registered with a GP outside of the borough.

The ACN service is made up of several component parts:

- Integrated community matrons and district nursing teams
- Specialist services
- Discharge planning and continuing care teams

District nurses

The district nursing team will focus on the provision of high quality clinical care for service users within their own home and associated leg ulcer clinics. The teams will enable service users to maximise their health and wellbeing to ensure hospital admissions are kept to a minimum and time spent in hospital is reduced. The teams will work very closely with social care and voluntary care organisations to ensure the needs of people living in Hackney and City are met.

The teams will provide a palliative care service and ensure that service users that wish to die in their own home are assisted to do this and that all care is provided in a timely and supportive manner. The End of Life pathway will be implemented and when appropriate the Liverpool care pathway instigated ensuring that the service user, GP and carers/relatives are fully involved in all decisions. All patients will be treated with dignity and respect at all times.

These teams operate Mon – Sunday 08.30hrs – 23.00hrs. There is no on call facility for outside of these hours.

Community Matrons

The community matrons will support patients with long term conditions in both preventive work and the effective management of these conditions to reduce hospital admissions and bed days in hospital. The community matrons will manage a case load to ensure the service users care is consistent and of a high quality.

These teams operate on a Mon – Fri basis 09.00 – 17.00hrs with no on call facility

Nurse Specialist Teams

Tissue Viability & Wound Management

The team will deliver a service to ensure wound care is evidence based and that all staff within the services are skilled in providing wound management. They will work alongside the district nursing teams to assess, advise and review wound care including pressure ulcers. They will work actively with the teams to ensure the most up to date and appropriate pressure relieving equipment is purchased for service users where appropriate.

Continence/Parkinson's/Multiple Sclerosis/Learning Disabilities

The team will work with service users to enable them to maintain an independent lifestyle. They will ensure that appropriate equipment is provided in a timely manner and that reviews are undertaken to ensure that it meets the service user's needs.

Service users will be assisted to manage their condition, they will be aware of where and when to seek help to prevent deterioration and hospital admission.

Specialist teams operate Mon – Friday 09.00 – 17.00hrs with no on call facility.

Discharge Planning & Continuing Care

The team will support the continuing care process including reviews of all patients in non NHS care homes and completion of documentation for CCP.

The team will work very closely with all neighbouring hospitals to ensure the timely discharge home of all end of life patients by ensuring a care package is in place and all equipment is in the home.

Telehealth

Telehealth has been described as 'the delivery of health related services enabled by the use of technology without the need for travel.'

The use of Telehealth by the community teams will continue to be utilised and reviewed re its effectiveness and for those services users who will benefit from the system, full use of it will be implemented within their home.

Referral criteria

The service is provided for clients 18 years old above who are primarily housebound. All referrals are via a generic email address or fax number.

All referrals will be accepted from all health care professionals. Self-referrals will also be accepted if appropriate. All patients referred to the service are visited and assessed in order to develop an individualised care plan. There are criteria for priority for admission to the service. The service recognises that different types of patients require different response times and this is determined by using a priority rating system (as below):

- High Priority - These patients are seen within 4 hours.
- Medium Priority - To respond within 24 hours and to visit within 48 hours
- Low Priority - To respond within 48 hours and arrange visit.

Specialist Teams:

These services receive referrals from all health care providers. Each referral will be assessed and triaged as appropriate.

Exclusion criteria

The following groups of patients will not be accepted for care provision by the Adult Community Nursing service:

- Patients below the age of 18 years
- Patients with no nursing need
- Patients resident outside City and Hackney area/boundaries, except in the case of Continuing Care patients, who will be assessed for their continuing care needs if they are within City & Hackney boundaries at the time the assessment was required, regardless of where they normally reside.
- Where a patient funded by NHS City and Hackney as NHS Continuing Healthcare receives a service above and beyond the maximum service provided by Adult Community Nursing the service will agree funding prior to provision of service.

- For patients that are in a Hackney Nursing Home, in a nursing bed and in receipt of RNCN contribution and are recorded on the RNCN Database the service will be reimbursed for the costs of continence products.

For patients funded by NHS City and Hackney who meet the NHS Continuing Care criteria the provider will be reimbursed for specialist equipment costs incurred, Such as suction pumps and ventilators, this does not apply to small equipment such as gloves and dressings

Discharge

Once the nursing intervention is completed and the patient no longer requires the nursing service, the patient is discharged from Adult Community Nursing care.

- Care package achieved
- Patient/carer can self-manage condition safely and independently
- Care package declined by patient and following consultation and agreement from the GP that it is appropriate to withdraw ACN input
- Transfer to other Health Care setting
- Referral to more appropriate service
- Patient death

The service will send all discharge letters to referrers and GPs within 24 hours of discharge.

The delivery chain

Commissioner
City and Hackney CCG

Provider
Homerton University Hospital

The evidence base

National Priorities

- The Health Bill 2011
- Our Health Our Care Our Say (2006): - Our NHS, Our Future (DOH, 2008)
- The Black Report 2008
- **National Service Framework for Long Term Conditions (DOH, March 2005)**
- National Service Framework for Older People (DOH, March 2001)
- National Service Framework for Diabetes
- **Royal College of Physicians.** *National clinical guidelines for stroke,* **2nd edition.**
- Falls – The Prevention of Falls in Older People (NICE, November 2004)
- Standards for Better Health (2004)
- **NHS Plan (DOH, 2000)**
- Mental Capacity Act 2005 (DOH)
- **National Framework for NHS Continuing Healthcare and NHS funded care (DOH 2007)**
- Good Practice in Continence service (DOH 2000)
- Essence of Care—Benchmarking for Continence bladder and bowel care.
- Health Care Commission Standards for Better Health—National Programme of standards to be achieved, performance monitoring, overall PCT performance rating.
- Government Public Service Agreement (PSA) target to reduce emergency bed days through improved care in primary and community settings.
- The Government Seven Principles for Supporting Self Care 2/5/08.
- Lord Ara Darzi's 10 year vision for "High quality Care for All" 30/6/08.
- Transforming Community health services - Enabling new patterns of provision (DH 2009)
- 2020 vision – A future for District Nursing (Queen's Nursing Institute 2009)

Local Policies

- Older People's Dignity Charter (adopted by THC Board)
- Partnership Boards: Older People, Physical Disabilities.

Joint Strategic Needs Analysis (JSNA 2014)

- DOH & Policy in CHCCG, LBH, HUH & ELFT: Safeguarding Adults – Protection of Vulnerable Adults.
- Urgent Care Strategy CHCCG
- End of Life Care Strategy (Liverpool Care Pathway & Case Management
- City & Hackney Falls Pathway
- Wound Management
- PCT Annual Report 2008: Improving patient experience, staff satisfaction and public engagement.

Investment requirements

£ 2017/18	**£ 2018/19**
161,408	169,364

Impact of scheme

Impact on Better Care Fund Metrics:

Non-elective admissions (General and Acute)	High
Admissions to residential and care homes	Medium
Effectiveness of reablement	Medium
Delayed transfers of care	Medium

Feedback loop

Refer to schedule 6

What are the key success factors for implementation of this scheme?

- Good partnership working between clinicians and health professionals across primary and secondary care
- Patient and user involvement and control in planning of their care

City of London Schemes

Scheme ref no.
COL 1
Scheme name
Care Navigator
What is the strategic objective of this scheme
To ensure safe hospital discharge for City of London residents.
Overview of the scheme
The City of London Corporation first piloted the Care Navigator post from January 2015 funded through S256 and BCF funding. The Care Navigator post is responsible for co-ordinating services and supporting City of London residents who may need it when being discharged from hospital to support safe hospital discharge. The service aims to support 6o people a year. Given the importance and impact of the role, the City of London Corporation is continuing with the role, funded through the Better Care Fund. The Care Navigator post is provided through Age Concern City of London who have an established history of Care Navigator posts across their network and have the infrastructure to support development of the role. The Care Navigator role includes: • Working with discharge teams and families to ensure a smooth and safe discharge to home and community based services or to other care as required. This helps avoid delayed transfers of care and ensures a safe hospital discharge with the relevant follow on services in place. • Working with GPs to build a picture of the most vulnerable cohort of frail elders who have frequent admissions via A&E and present high risk of falls and targeting a co-ordinated multi-disciplinary community approach with the aim of providing support and intervention to avoid hospital admission. • Alerting GPs to all known admissions, especially emergency admissions, overnight or at weekend, and also ensure discharge dates are passed on with sound knowledge of the social care support plan. • Tracking the discharge of patients through the hospital system, and ensuring care is available to commence when the person returns home, if required. The Care Navigator also follows up with pharmacy ensure any new prescriptions are available for discharge. They also ensure this information is passed to the GP along with the discharge summary from the ward • Building links with clinical staff including senior medics, nurses and discharge teams to ensure the profile of the City of London is raised to facilitate understanding and provide an essential pathway and road map for all discharges of City patients back into the community. • Mobilising reablement and our commissioned domiciliary reablement agency who will cover out of hours and weekend discharges where required. • Identifying how we can improve our preventative work to reduce unnecessary admissions still further. This would involve further work with commissioned providers to extend preventative and early intervention support, to avoid social isolation and related deterioration. • Supporting the Multi-Disciplinary Teams and care planning meeting led by GPs. The Care Navigator works across different health trusts and CCGs including the Homerton hospital, the Royal London and Bart's Hospital, University College London Hospital and at times St Thomas' hospital. It also involves GP practices within the City and Hackney, Tower Hamlets, Camden and Islington CCGs where City of London residents are registered. The care navigator will have responsibility for facilitating discharge for our residents from hospitals, including private hospitals, outside the City and Hackney CCG area.
The delivery chain

The Care Navigator is provided through Age Concern London who have an established history of care navigator posts across their network and have the infrastructure to support development of the roles.

The evidence base

Integrated Care in the City of London – Tricordant 2014. This research and subsequent report was undertaken independently for the City by expert consultants, and has identified the risks to the delivery of integration arising from the breadth and complexity of care pathways for City of London residents. It also explored the role that Care Navigators could play.

Investment requirements

£60,000 from the pooled BCF budget

Impact of scheme

Impact on Better Care Fund Metrics, Patient/user experience:

Permanent admissions to residential and care homes	High
Effectiveness of reablement (still at home after 91 days)	High
Delayed transfers of care from hospital	High
Avoidable emergency admissions	High

Outcomes from the scheme which are part of the contract requirements include:

- Enhancing the quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Safeguarding adults whose circumstances make them vulnerable
- Ensuring that people have a positive experience of care and support. Ensuring people's care, safety and dignity is respected at all times.

Feedback loop

Feedback from, and monitoring of the work of, the Care Navigator will provide significant insight into the barriers experienced at delivery level and our success in mitigating them. Our understanding and knowledge of our small service user population allows for the identification of specific issues within individual care pathways rather being reliant on the implications of higher level data.

The City of London Corporation's Adult Advisory Group of carers and care service users will also provide qualitative intelligence on the direct experience of care integration and any issues experienced.

Local Performance Indicators around care navigators have been added to the ASCOF suite of performance indicators and reported on monthly at internal management team meetings.

There are regular 6 monthly review meetings held between Age Concern City of London and the City of London Corporation.

What are the key success factors for implementation of this scheme?

Effective communication and sharing of information

Scheme ref no.

COL 2

Scheme name

Reablement Plus

What is the strategic objective of this scheme?

To prevent hospital admissions and to facilitate safe hospital discharge out of hours and when someone requires a further assessment (Discharge to Assess)

Overview of the scheme

The City of London Reablement Plus Service joins up health and social care services together in a rapid response service that aims to avoid acute admission to hospital and to ensure safe discharge home from hospital during weekends and bank holidays and when a further assessment may be required.

The Reablement Plus Service has two strands:

- The hospital Admission Avoidance Service. This service provides 24 hour home-based support for up to 72 hours for those most at risk of acute admission to hospital. It includes intensive home care support with an assessment and installation of minor aids and adaptations.
- Supported Hospital Discharge Service. This service provides intensive home care support and installation of minor aids and adaptation's for up to 72 hours to support safe discharge home. It can also facilitate urgent discharges with any social care assessment then being carried out at home.

The services are available from 17:00 on Fridays and across weekends and bank Holidays. The service provides a prompt handover to Adult Social Care colleagues by 9am the next working day.

The service is provided by a Domiciliary Care Agency working in partnership with City of London Adult Social Care Team. The service is managed by a Reablement Plus Coordinator, who will discuss cases and gather all relevant details and reports. They will then arrange and manage the appropriate support and care until the handover back to Adult Social Care colleagues takes place.

GPs, District Nurses, Modern Matrons, the Out of Hours Emergency Duty Team and the City of London Adult Social Care Team can all make direct referrals to the Admission Avoidance Service and the Supported Hospital Discharge Service.

In addition Clinical Ward staff, including Accident and Emergency can make direct referrals for the Supported Hospital Discharge Service.

The delivery chain

The service is provided by a Domicillary Care Agency

The evidence base

This service has been designed to respond to the drivers of reducing hospital admissions and providing seven day services across the health and social care system.

In developing a proportionate approach, the City of London has developed the Reablement Plus model to ensure that good performance on Delayed Transfers of Care is maintained when more discharges may be at weekends and that any admissions can be minimised wherever safe and possible to do so.

Investment requirements

£65,000 from the City of London pooled budget

Impact of scheme

Impact on Better Care Fund Metrics:

	Permanent admissions to residential and care homes	
	Effectiveness of reablement (still at home after 91 days)	N/A
	Delayed transfers of care from hospital (incl. MH)	HIGH
	Avoidable emergency admissions	HIGH

Feedback loop

Regular monitoring meetings are held with the provider.

What are the key success factors for implementation of this scheme?

- External partners using the scheme

Scheme ref no.

COL 3

Scheme name

Mental Health Step Down and Mental Health Floating Support Worker

What is the strategic objective of this scheme?

For people living in supported living arrangements to reach their full potential and maintain an independent life

Overview of the scheme

This scheme works with City of London residents with chronic mental health conditions who live in supported living arrangements. The aim of the scheme is to help them reach their full potential including moving to more or fully independent living situations.

A specialist mental health occupational therapist from the East London Foundation Trust works with individuals in an asset based approach with the person concerned to identify what they would like to achieve in terms of their next steps.

The occupational therapist then works with the person and with other organisations to implement a plan to achieve this and support the person concerned in the most appropriate way. A support worker provides some of the practical support in implementing the plan.

It is also proposed to employ a floating mental health support worker to support people when they move into their new accommodation and communities to ensure that the relevant support that they need is in place and that people are able to integrate into local communities and achieve their full potential.

The delivery chain

The services are provided by the East London Foundation NHS Trust

The evidence base

Reablement aims to work collaboratively with service users to maximise long-term independence, choice, quality of life and wellbeing.

The City and Hackney Rehabilitation and Recovery Service has extensive experience in offering reablement services, with a portfolio of projects across a range of serttings.

The service seeks to ensure that service users are appropriately placed, able to access treatment and community mental health services, and have the opportunity to develop skills and independence.

Investment requirements

- £120,000 from the City of London pooled budget

Impact of scheme

Impact on Better Care Fund Metrics:

Permanent admissions to residential and care homes	HIGH
Effectiveness of reablement (still at home after 91 days)	
Delayed transfers of care from hospital (incl. MH)	
Avoidable emergency admissions	HIGH

Feedback loop

Quarterly monitoring meetings with commissioner. Adult Social Care Team Manager also meets regularly with the service provider and colleagues from housing to discuss individual cases and the outcomes from those.
What are the key success factors for implementation of this scheme?
• Ensuring people are fully integrated into their local communities

Scheme ref no.

COL 4

Scheme name

Carers' Support

What is the strategic objective of this scheme?

To provide specialist independent support, information and advice for adult carers living in the City of London to support them in their caring role and promote their health and wellbeing

Overview of the scheme

The City of London has a longstanding history of offering support to carers that includes a robust carer assessment process, a cohort of carers managing their own individual budgets (non-means tested) and the provision of a commissioned service to provide support to carers.

In July 2015, Carers' UK undertook work for the City of London Corporation to develop a detailed evidence base on caring in the City of London and to refresh the Carers' strategy.

A contract for Carers' support was due to be retendered and, as a result of the evidence base, was refocused to ensure it targeted a broader range of carers' and provided a broader range of support. The new contract (the Reach Out Network) includes three early intervention and prevention services to support adults with additional needs, carers and people with dementia.

The City Carers Service element will provide specialist independent help, advice and support for adult carers living in the City of London to support them in their caring role. The service will include group and one to one support sessions and innovative models of support. Recognising the diverse needs of carers in the City of London, the City of London Corporation is looking for innovative and flexible proposals for carer identification and engagement providing support, including supporting carers who work, male carers and BME carers. The providers will also work with partners such as the City Advice Service and Adult Social Care.

The requirements of the contract are to provide:

- Outreach and engagement of carers
- Identifying needs and referring service users to other services
- Facilitation of peer support groups for carers
- Provision of practical and emotional support for carers
- Information and training for carers
- Respite and emergency planning
- Reducing social isolation and raising the profile of carers in the City

The new contract began in September 2016.

The delivery chain

The service is provided by a specialist voluntary sector organisation

The evidence base

The City of London commissioned Carers UK to refresh the existing Carers' Strategy and this included development of an evidence base. A summary profile of carers in the City of London is provided below.

- 567 informal carers living in the City of London are identified through census 2011 data. This is approx. ten times as many as those known to services provided by the City of London Corporation. This total accounts for 7.8 per cent of the City population, compared to 8.4 per cent of the London population and 10.2 per cent across England

- 21 per cent of carers provide care for 20 hours or more per week. This is lower than London (36.9 per cent) and England (36.4 per cent). 12.2 per cent of carers provide care for 50 or more hours per

week. This is also lower than London and England

- the most significant carer populations are in the Barbican (281) and Golden Lane (101) areas but there is wide variation in the percentage of carers in the population across the City of London

- the Barbican and Golden Lane have the highest number of carers providing 20 hours or more hours of care per week. However, by comparison, the Barbican has a much higher population of low intensity carers (providing less than 20 hours a week) than Golden Lane. Overall, the majority of carers in the City of London are providing low intensity care (455)

- 5 in 10 carers are male compared to 4 in10 in London and England. 6 in 10 people providing unpaid care for 50 or more hours a week are female

- the age profile of carers in the City of London peaks between 50 and 64. 38.9 per cent of carers are in that age group and 15.9 per cent of people aged 50 to 64 are carers. Analysis of data shows how the intensity of the caring role changes as carers get older. 17.1 per cent of carers aged under 65 are providing 20 or more hours of care per week; for carers aged 65 and over this jumps to over 30 per cent

- in the City of London, 29.2 per cent of the carer population is from BME groups. 5.4 per cent of the BME population provide unpaid care, compared to 9.6 per cent of the White British population

- the proportion of carers aged 16 and over in full-time employment is 45.5 per cent, lower than the 61.4 per cent of non-carers aged 16 and over. Carers are more likely to be in part-time employment; 15.0 per cent of carers are in part-time work compared to 8.7 per cent of non-carers

- The proportion of carers in employment differs significantly depending on the intensity of their caring role. 7 in 10 people providing unpaid care for 1 to 19 hours a week are in some type of employment compared to less than 2 in 10 who provide care for 50 or more hours per week

- 2 in 10 carers in the City of London report being in not good health compared to 1 in 10 non-carers. 4 in 10 people providing 20 or more hours' unpaid care per week report not being in good health; this increases to 6 in 10 carers aged 65 and over. More than 110 carers in the City (including more than 50 aged 65 and over) declare their health to be not good. This includes around 30 who declare their health to be bad or very bad

- carers who are known to City of London Corporation services are more likely to be those providing higher levels of care (more than 20 hours weekly), those whose caring role is impacting on their health and wellbeing, and those who are older carers

- there were 20 carers claiming Carer's Allowance in the City of London in November 2014 using existing claimant count figures and take up rate. It is estimated that 11 carers are missing out on a total of £35,521 a year

- 53.6 per cent of carers in the City of London said they have some social contact but not enough or little social contact and feel socially isolated

- national research showed that Pakistani and Bangladeshi carers can experience greater levels of isolation. The 2011 Census revealed that there are at least 35 carers of Pakistani and Bangladeshi origin living in the City of London.

Investment requirements

£10,000 from the City of London pooled budget

Impact of scheme

-
- **Impact on Better Care Fund Metrics:**
-

Permanent admissions to residential and care homes	HIGH

Effectiveness of reablement (still at home after 91 days)	MEDIUM
Delayed transfers of care from hospital (incl. MH)	MEDIUM
Avoidable emergency admissions	MEDIUM

-

Feedback loop

The biannual ASCOF carers' survey gives a number of metrics which will be monitored to assess improvements in the health and wellbeing of carers. These include:

- Number of carer assessments
- Number of carers on the Adult Social Care carers' register
- Carer reported quality of life
- Proportion of people use services and their carers who reported they had as much social contact as they would like
- Overall satisfaction of carers with social services

The City's Service User Engagement Strategy provides a framework the City will use to understand the experience of residents using health and care services. This will enhance the formal surveying required for the ASCOF.

The City's Adult Advisory Group of carers and care service users will also provide qualitative intelligence on the direct experience of carers and any issues experienced.

Carers are also involved in user groups and in our Adult Advisory Group and are able to directly impact service design and delivery. Carers were represented in the commissioning process for the carers group, information and advice tender and the carers respite tender. Co-production is a key element of all commissioning going forward and started with our commitment to carers' representation.

What are the key success factors for implementation of this scheme?

- Reaching a wider range of carers in the City of London

Scheme ref no.

COL 5

Scheme name

Disabled Facilities Grant

What is the strategic objective of this scheme?

To support disabled people to live more independently in their own home

Overview of the scheme

This funding will be allocated to our existing Disabled facilities Grant scheme which is delivered through a local Home Improvement Agency.

Disabled Facilities Grants are for disabled people who need to make changes to their home, for example to:

- widen doors and install ramps
- improve access to rooms and facilities - eg stairlifts or a downstairs bathroom
- provide a heating system suitable for your needs
- adapt heating or lighting controls to make them easier to use

To be eligible for a Disabled Facilities Grant someone living in the property must be disabled. The applicant or person living in the property must:

- own the property or be a tenant
- intend to live in the property during the grant period (which is currently 5 years)

Landlords can also apply for a grant if they have a disabled tenant.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service is commissioned by the City of London and provided through a Home Improvement Agency.

The evidence base

The DFG is a mandatory scheme

The following pieces of legislation relate to adaptations for disabled people:

- The Housing Act 1985
- The Housing Grants, Construction and Regeneration Act 1996
- Chronically Sick and Disabled Persons Act 1970
- NHS and Community Care Act 1990

Investment requirements

£28,034

Impact of scheme

The delivery of this scheme will support the delivery of the metrics set out in the Better Care Fund plan.

Permanent admissions to residential and care homes	High

Effectiveness of reablement (still at home after 91 days)	
Delayed transfers of care from hospital (incl. MH)	
Avoidable emergency admissions	High

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Feedback from works carried out and the impact this has made

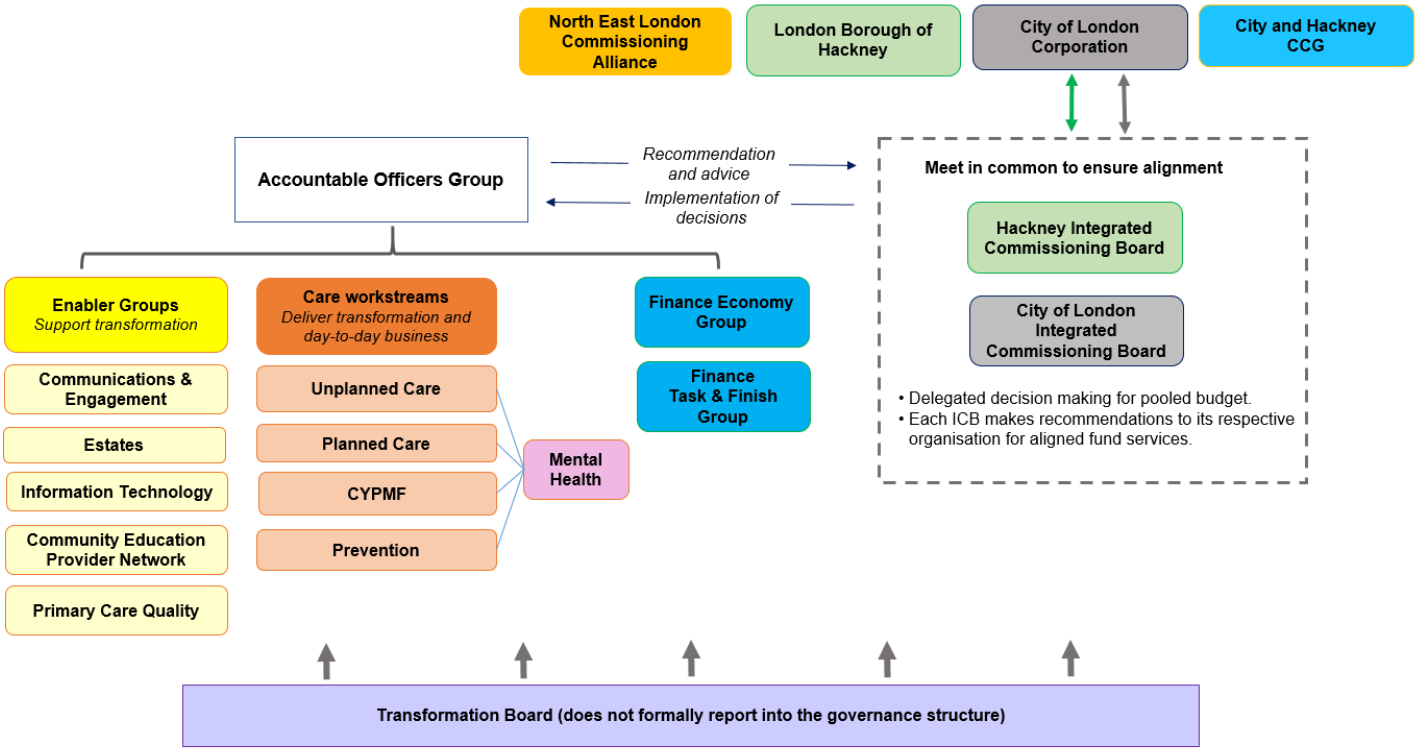
What are the key success factors for implementation of this scheme?

Services of the Home Improvement Agency

PART THREE – BCF Reporting Requirements and Governance

Reporting requirements

Reporting and monitoring of performance will be in line with NHS England reporting requirement and produced on a quarterly basis.



SCHEDULE 7 – EXIT PLANNING OBLIGATIONS

1. General Arrangements

1.1 Upon termination of this Agreement (in whole or in part) the Parties agree to co-operate with each other in accordance with Clause 26.5.1 (Termination) of this Agreement, to ensure the orderly unwinding of the integrated and joint activities so as to minimise disruption to all Service Users and relevant staff, and to each commit sufficient resources to implement the Exit Plan.

1.2 For the avoidance of doubt:

1.2.1 this Agreement may only be terminated (in whole or in part) in accordance with Clause 26 of this Agreement; and

1.2.2 the contents of this Exit Plan are without prejudice to the provisions of this Agreement.

2. Guiding Principles

In carrying out the winding down of the integrated and joint activities the following guiding principles shall apply to the extent that they are appropriate and in accordance with applicable Law and any NHS of local authority guidance at the time the unwinding takes place.

For the avoidance of doubt, these principles will not apply to the extent that any matter has been dealt with under Section 3 below.

2.1 Stage 1:

2.1.1 Exiting Party to notify both the other Party in accordance with Clause 26.1 (Termination) of this Agreement and the Integrated Commissioning Board of its intention to terminate this Agreement. Other Party to acknowledge exit notification; or

2.1.2 Parties mutually agree in writing that the unwinding of this Agreement is in the best interests of Service Users.

2.2 Stage 2: Parties to determine the scope and nature of the exit requirements and establish an exit team with representatives from both parties who are reasonably familiar with the day-to-day functioning of this Agreement.

2.3 Stage 3: Parties to obtain approval/authorisation in accordance with their internal governance arrangements to initiate the unwinding process.

2.4 Stage 4: Parties to allocate relevant resources to the exit team in order to establish a detailed exit plan covering the extent of the Services to be unwound.

2.5 Stage 5: Parties to re-establish commissioning arrangements in accordance with their statutory duties or put in place arrangements for transfers to a third party.

2.6 Stage 6: The Parties shall agree the contents of any public announcement regarding the dissolution of the integrated and joint activities.

2.7 Stage 7: Notice of confirmation that this Agreement has been wound down in relation to all or part of the integrated and joint activities.

3. Consequences of Termination applicable to exit

3.1 Upon termination of this Agreement (in whole or in part), the following will apply in all instances:

3.1.1 Premises and assets shall be returned to the contributing Party in accordance with the terms of any leases, licences or other such applicable agreements;

3.1.2 Service Contracts: shall be dealt with in accordance with the provisions of Clauses 26.5.2, 26.5.3 and 26.5.4 of this Agreement;

3.1.3 ICB: shall continue to operate pursuant to Clause 26.5.5 of this Agreement, as applicable;

3.1.4 Overspends/Underspends: shall be dealt with in accordance with the provisions of Clauses 6.7.10, 12 and the Financial Framework.

3.1.5 Disputes: any disputes shall be dealt with in accordance with Clause 27 of this Agreement.

3.1.6 Data Protection: data shall be returned and / or destroyed in accordance with the plans set out in Schedule 8 (Data Processing Activities) which shall be populated with the required information where the provisions of sub-clauses 31.4 to 31.13 of Clause 31 (Information Sharing and Data Protection) of this Agreement apply.

SCHEDULE 8 - DATA PROCESSING ACTIVITIES

(to be completed in the event that clause 31.4 to clause 31.13 "Information Sharing and Data Protection" of this Agreement applies).

The details of the Processing taking place under this Agreement (in a Controller to Processor situation) is set out below.

Data Subjects
[Insert the categories of persons whose Personal Data will be Processed under the Agreement]

Categories of Personal Data
[Insert the categories of Personal Data that will be Processed under the Agreement]

Special Categories of Personal Data
[Insert the Special Categories of Personal Data that will be Processed under the Agreement]

Processing purposes
[Insert the purposes for which data will be Processed under the Agreement]

Nature of Processing
[Insert the type of Processing that will occur under the Agreement]

Duration of the Processing
[Insert the duration for which Personal Data will be Processed under the Agreement]