URGENT DECISIONS

Thursday, 31st March, 2022, 10.00 am

Members: Councillor Lucia das Neves – Cabinet Member for Health, Social Care, and Well-Being

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

3. SECTION 75 NHS ACT 2006 HEALTH AND SOCIAL CARE LEAD COMMISSIONING AND POOLED FUNDS PARTNERSHIP AGREEMENT BETWEEN THE COUNCIL AND NCL CCG (PAGES 1 - 116)

The Chair of Overview and Scrutiny has agreed that the decision is both reasonable in all the circumstances and that it should be treated as a matter of urgency. The s. 75 Partnership Agreement expired on 1 March 2022 and provides a framework for lead commissioning, pooled budgets and integrated services as set out within the scope of the National Health Services Act 2006. It is imperative for this Agreement to be extended for a further term and the Agreement provides for this. There are several joint arrangements between the Council and the CCG that are currently in place across Haringey, detailed in a series of Schedules to this overarching Agreement, to best meet the needs of local residents with specific additional health and care needs.

These Schedules require the overarching Partnership Agreement to be in place in order to enable them to continue. As noted above, the Agreement expired on 1 March 2022 and it is imperative it is extended. With the changes to the health and care landscape set out in the Health and Care Bill currently going through Parliament, it was anticipated that the requirements for the s. 75 Partnership Agreement would differ and therefore an extension might not be required in its current form. This has turned out not to be the case, hence the urgency in requesting this extension be approved.

Given the above, it is not practicable to comply with the 28-day notice requirement in Part Four, Section D, Rule 13 of the constitution or the 5-day notice period requirement for key decisions. This is set out in Part Four, Section D, Rule 17, of the Constitution. As set out below, the decision is urgent and time critical in accordance with Part 4 Section H paragraph 18 (a) and 18 (b).

Please be advised that the Chair of Overview and Scrutiny has further agreed that the call-in procedure shall not apply to this urgent decision. This is because the decision is urgent and any delay in implementation caused by the call-in procedure would seriously prejudice the Council's or the public's interests as there is a need to continue with the current health and social care partnership arrangement between the Council and the CCG. This decision is considered to be urgent as extension of the agreement would enable the Council and CCG to continue with the existing commissioning and service provision arrangements and for the benefit of local residents. The Chair of Overview and Scrutiny Committee has agreed that the decision is both reasonable in all circumstances, and that it should be treated as a matter of urgency. This is in accordance with Part 4, Section H, and Paragraph 18 (a) and (b) of the Council Constitution.

4. SECTION 75 NHS ACT 2006 HEALTH AND SOCIAL CARE HARINGEY LEARNING DISABILITY PARTNERSHIP AGREEMENT (PAGES 117 - 192)

The Chair of Overview and Scrutiny has agreed that the decision is both reasonable in all the circumstances and that it should be treated as a matter of urgency. The s. 75 Haringey Learning Disability Partnership Agreement provides a framework for an integrated service for adults with learning disabilities in Haringey as set out within the scope of the National Health Services Act 2006. The existing s. 75 agreement which governs the integrated service has expired. In order to ensure that the contractual framework is in place to enable both the partners' continued funding for and the Council's continued management of the integrated service, it is necessary to renew the agreement urgently and by 1 April 2022. Without the contractual framework which enables funding transfers between the NHS and the Council, payments from partners will be at risk. Likewise, the Council's ability to manage the integrated service as a single entity across the partnership will be constrained.

With the changes to the health and care landscape set out in the Health and Care Bill currently going through Parliament, it was anticipated that the

requirements for the s. 75 Partnership Agreement would changes and that therefore an extension might not be required in its current form. This has turned out not to be the case, hence the urgency in requesting this extension be approved. Given the above, it is not practicable to comply with the 28-day notice requirement in Part Four, Section D, Rule 13 of the constitution or the 5-day notice period requirement for key decisions. This is set out in Part Four, Section D, Rule 17, of the Constitution. As set out below, the decision is urgent and time critical in accordance with Part 4 Section H paragraph 18 (a) and 18 (b).

Please be advised that the Chair of Overview and Scrutiny has further agreed that the call-in procedure shall not apply to this urgent decision. This is because the decision is urgent and any delay in implementation caused by the call-in procedure would seriously prejudice the Council's or the public's interests as the s. 75 Haringey Learning Disability Partnership Agreement, which provides a framework for an integrated service for adults with learning disabilities in Haringey has expired. This decision is considered to be urgent as approval to enter into and continue the partnership agreement would enable the Council, the Barnet, Enfield and Haringey Mental Health Services Trust, Whittington Health Services NHS Trust, and the North Central London Clinical Commissioning Group to continue to provide the integrated service arrangement and meet their respective obligations, in particular, relating to payments and funding. The Chair of Overview and Scrutiny Committee has agreed that the decision is both reasonable in all circumstances, and that it should be treated as a matter of urgency. This is in accordance with Part 4, Section H, and Paragraph 18 (a) and (b) of the Council Constitution.

5. SECTION 75 NHS ACT 2006 HEALTH AND SOCIAL CARE COVID-19 HOSPITAL DISCHARGE PARTNERSHIP AGREEMENT (PAGES 193 - 220)

The Chair of Overview and Scrutiny has agreed that the decision is both reasonable in all the circumstances and that it should be treated as a matter of urgency. Partners are keen to vary the s. 75 Hospital Discharge Partnership Agreement to ensure that additional funding very recently made available in light of the Covid-19 pandemic can be used most effectively to respond to local need and support the longer-term sustainability of health and social care.

The proposal for a variation to enable additional funding to be safeguarded for local residents has recently come forward and partners have had to act at pace to ensure that Councils can agree to accept the additional funding as indicated. Given the above, it is not practicable to comply with the 28-day notice requirement in Part Four, Section D, Rule 13 of the constitution or the 5-day notice period requirement for key decisions. This is set out in Part Four, Section D, Rule 17, of the Constitution. As set out below, the decision is urgent and time critical in accordance with Part 4 Section H paragraph 18 (a) and 18 (b).

Please be advised that the Chair of Overview and Scrutiny has further agreed that the call-in procedure shall not apply to this urgent decision. This is because the decision is urgent and any delay in implementation caused by the call-in procedure would seriously prejudice the Council's or the public's interests as the variation of the 75 Hospital Discharge Partnership Agreement would ensure that additional funding very recently made available in light of the Covid-19 pandemic can be used most effectively to respond to local need and support the longer-term sustainability of health and social care. This decision is considered to be urgent as the Council needs to accept the additional funding as soon as possible to enable additional funding to be safeguarded for local residents. The Chair of Overview and Scrutiny Committee has agreed that the decision is both reasonable in all circumstances, and that it should be treated as a matter of urgency. This is in accordance with Part 4, Section H, and Paragraph 18 (a) and (b) of the Council Constitution.

Fiona Rae, Acting Committees Manager
Tel – 020 8489 3541
Email: fiona.rae@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Wednesday, 30 March 2022

Agenda Item 3

Report for: Cabinet Member Signing – 31 March 2022

Title: Section 75 NHS Act 2006 Health and Social Care Lead Commissioning and Pooled Funds Partnership Agreement between the Council and NCL CCG

Report authorised by: Charlotte Pomery, Assistant Director Commissioning

Lead Officer: Charlotte Pomery, Assistant Director Commissioning

Ward(s) affected: All

Report for Key/ Non Key Decision: Key Decision

1. Describe the issue under consideration

1.1 Haringey Council (the Council) and North Central London Clinical Commissioning Group (the CCG) have had in place since March 2017 a model of commissioning and pooled budgets supported by a partnership agreement under S.75 of the National Health Services Act 2006. The partnership agreement sets out shared outcomes and objectives, and contains detailed schedules enabling:

i. Lead commissioning for specified care groups
ii. Pooled budgets for specified care groups

1.2 The partnership agreement acts as a framework for a range of schedules, which has allowed flexibility and adaptability and ensured that the commissioning and pooled budgets in place meet local need. The partnership agreement was initially in place for five years with the option to extend for a further two years. As the agreement expires at the end of March 2022, this report proposes use of the further 2 year extension period.

2. Cabinet Member Introduction

2.1 N/A

3. Recommendations

3.1 Cabinet is asked:

3.1.1 To approve the extension of the existing Section 75 Partnership Agreement between the Council and the CCG (Section 75 NHS Act 2006 Health and Social Care Lead Commissioning and Pooled Funds Partnership Agreement between the Council and NCL CCG) which provides for lead commissioning and pooled budgets across a range of schedules.

3.1.2 To delegate to the Assistant Director for Commissioning, after consultation with the Lead Member for Health, Social Care and Well-Being, the authority to finalise and agree the terms of the extension.

4. Reasons for decision

4.1 The s. 75 Partnership Agreement has supported greater levels of integration between the NHS and the Council by enabling lead commissioning and pooled budgets across partners within a strategic framework as set out in the National Health Services Act 2006.

4.2 It remains the case that over the past five years of the Partership Agreement's operation, local residents have continued to call for integration of health and care provision locally to support a better experience and to improve outcomes. By focusing on arrangements for pooling funding and integrating commissioning, the s. 75 Partnership Agreement already in place has enabled fuller integration creating greater strategic coherence to the joint work being developed. The Partnership Agreement in and of itself does not lead to changes to models of service delivery and any consultation on any redesigned services has taken place separately.

4.3 The s. 75 Partnership Agreement will expire if the extension is not put in plae, which would undermine the joint approaches which continue to be developed as part of the work to create an Integrated Care System and a local Place-based Partnership in line with the Health and Care Bill, currently making its way through Parliament. The vision set out in the Partnership Agreement aligns with the focus on integration at both place and system indicated in the Bill's current provisions and both signatories support the proposed extension.

5. Alternative options considered

5.1 Consideration was given by officers to allowing the s. 75 Partnership Agreement to lapse at the end of its current term, in March 2022. This approach, however, would risk the joint arrangements and increasing drive towards greater integration reflected by both local working patterns and national policy.

5.2 Consideration was also given to a deeper strategic review of the s. 75 Partnership Agreement currently in place, but as the Government in its recently published Integration White Paper has committed to a review of the legislation covering pooled budgets (ie section 75 NHS Act) it is felt that a wider review could risk being out of kilter with the government's approach.

6. Background information

6.1 The s. 75 Partnership Agreement has served a very necessary purpose in providing the framework for enabling the CCG and the Council to work together in a more joined up way – and paved the way for more joined up working across the NHS too. The approach taken was an ambitious one, which is borne out by the current policy imperatives to work more closely together across the NHS and local government and to build better health and wellbeing outcomes for local residents.

6.2 These policy imperatives are set out in key documents which shape the policy landscape for health, care and integration, which itself is currently undergoing significant change. These documents provide a framework for change and innovation built on the NHS Long Term Plan which set out ambitions for more joined up approaches from a resident and service redesign perspective. The three key policy documents are the Health and Care Bill, the Integration White Paper and Building Back Better, the Adult Social Care Reform White Paper. Each of them has at its heart greater integration, a committed focus to addressing health inequalities and meaningful participation of residents, users and patients in the services affecting them. Locally, the establishment of a North Central London Integrated Care System and a Haringey Place Partnership through the Health and Wellbeing Board will both be visible manifestations of the most recent developments. These models commit partners to working together in a genuinely integrated way to achieve better outcomes for residents and to achieve cost efficiencies in our approach.

6.3 The vision and outcomes in the Partnership Agreement continue to be relevant for local partners, notably the focus on improving health and care outcomes, addressing health inequalities and investing in prevention and early intervention.

6.4 The Schedule attached at Appendix 2 sets out the funding patterns for 2021/2022 which will act as the baseline for future spending against the s. 75 Partnership Agreement going forward. In summary, the Council's contribution is £67, 509, 204 and for the CCG is £82, 762, 701 and the Schedule details how these contributions are to be spent proportionately across the partnership.

7. Contribution to strategic outcomes

7.1 These proposals support Haringey's Borough Plan 2019 – 2023 to improve health and wellbeing outcomes for local residents and are also in line with current national policy and legislation furthering integration between the NHS and local government.

8. Statutory Officer comments (Director of Finance (including procurement), Head of Legal and Governance, Equalities)

8.1 Finance

8.1.1 This report is seeking the approval of Cabinet to extend the partnership agreement between the Council and the CCG. The original partnership agreement from March 2017 expires at 31st March 2022, and this report proposes use of the further 2 year extension period until 31st March 2024.

8.1.2 The total budget in 2021/22 is £149.3m which comprises of £81.8m and £67.5m contribution from the CCG and LBH respectively.

S75 Budget	2021/22

	£m
Gross CCG Contribution	81.8
Gross LBH Contribution	67.5
Total Budget	149.3

8.1.3 Funding will be met from a combination of CCG contribution and the Council's reveneue budget within Adults and Health. This will contribute to meet the allocated expenditure within the S.75 arrangements over the financial year 2021/22.

8.2 Legal

8.2.1 Under Section 75 of the NHS Act 2006 and associated regulations, CCGs and local authorities can enter into partnership agreements that allow for lead commissioning, pooled budget and integrated provision where this will likely lead to an improvement in the way functions are discharged. The partnership agreement between the Council and the CCG includes provision for the extension of the agreement for "further period(s) of two (2) years provided that the aggregate of all such extensions does not exceed four (4) years (Clause 3)".

8.3 Procurement

8.3.1 Strategic Procurement notes the contents of this report and supports the recommendations

8.4 Equalities

8.4.1 The council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not

8.4.2 The three parts of the duty apply to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

8.4.3 Although it is not enforced in legislation as a protected characteristic, Haringey Council treats socioeconomic status as a local protected characteristic.

8.4.4 The proposed decision is to extend the existing S. 75 Partnership Agreement between the Council and the CCG which provides for lead commissioning and pooled budgets across a range of schedules

8.4.5 The s. 75 Partnership Agreement has served a very necessary purpose in providing the framework for enabling the CCG and the Council to work together in a more joined up way with a committed focus to addressing health inequalities and meaningful participation of residents, users and patients in the services affecting them.

8.4.6 For residents with protected characteristics, this approach will therefore seek to advance equality of opportunity, eliminate discrimination and foster good relations.

9. Use of Appendices

9.1 Appendix 1 contains the s. 75 partnership agreement.

9.2 Appendix 2 contains the Schedule of payments for 2021/2022 to support the Agreement.

10. Local Government (Access to Information) Act 1985

Not applicable.

Appendix 1

DATED **1st March 2017**

SECTION 75 OF THE NATIONAL HEALTH SERVICE ACT 2006
PARTNERSHIP AGREEMENT

BETWEEN

THE LONDON BOROUGH OF HARINGEY

AND

HARINGEY CLINICAL COMMISSIONING GROUP

FOR THE COMMISSIONING OF LEARNING DISABILITY SERVICES, ADULT MENTAL HEALTH SERVICES, CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES, INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCREASE SAFETY SERVICES AND BETTER CARE FUND SERVICES AND OTHER AGREED SERVICES

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SECTION 75 OF THE NATIONAL HEALTH SERVICE ACT 2006
PARTNERSHIP AGREEMENT

between

LONDON BOROUGH OF HARINGEY

and

HARINGEY CLINICAL COMMISSIONING GROUP

Commencing 1st March 2017

PART 1

Preamble

THIS IS AN AGREEMENT BETWEEN

(1) **THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF HARINGEY** of River Park House, 225 High Road, Wood Green, London N22 8HQ (referred to herein as "the Council")

and

(2) **THE HARINGEY CLINICAL COMMISSIONING GROUP** (known as Haringey CCG) of River Park House, 225 High Road, Wood Green, London N22 8HQ (referred to herein as "the CCG")

BACKGROUND

(A) The Council is a Local Authority and by virtue of section 2 of the Local Authority Social Services Act 1970 the Council is responsible for the provision of social care services for adults and children who are ordinarily resident in its area.

(B) The CCG is established under the Health and Social Care act 2012 and is responsible for commissioning services to meet the health needs of persons who are patients of the providers of primary medical services in the area of the CCG.

(C) Section 82 of the National Health Service Act 2006 requires Local Authorities including the Council and NHS bodies including the CCG, when exercising their respective functions, to co-operate to secure and advance the health and welfare of people of England and Wales.

(D) The Council and the CCG ("Partners") have agreed, pursuant to Section 75 of the National Health Service Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 to enter into this overarching Partnership Agreement which currently provides for:

i) The Partners to establish and maintain a pooled fund and lead commissioning arrangements for the commissioning of learning disability services for adults who are resident in the

London Borough of Haringey (described in Part 2 Schedule 1 of this Partnership Agreement);

ii) The Partners to establish and maintain a pooled fund and lead commissioning arrangements for the commissioning of adult mental health services for resident in the London Borough of Haringey (described in Part 2 Schedule 2 of this Partnership Agreement);

iii) The Partners to establish and maintain a pooled fund and lead commissioning arrangements for the commissioning of long term conditions and older people's services, including those identified in the Better Care Fund Plan dated June 2016, for adults who are resident in the London Borough of Haringey (described in Part 2 Schedule 3 of this Partnership Agreement);

iv) The Partners to establish and maintain a pooled fund and joint commissioning for the commissioning of child and adolescent mental health services for the residents of the London Borough of Haringey (described in Part 2 Schedule 4 of this Partnership Agreement); and

v) The Partners to establish and maintain lead commissioning arrangements for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for the residents of the London Borough of Haringey (described in Part 2 Schedule 5 of this Partnership Agreement).

(E) The Services and functions that the Partners have agreed to be delivered under this Section 75 Partnership Agreement are set out in the Schedules in Part 2 of this Agreement. As the Partners develop further partnership arrangements, the Schedules may be varied or supplemented to include other services which the Partners consider would be better provided through the partnership arrangements under this Agreement.

(F) The Partners are satisfied that the Partnership Arrangements are likely to lead to an improvement in the way in which their functions are exercised in relation to the provision for and meeting care and support needs and health services and the management of associated funds.

(G) The Partners are satisfied that the Partnership Arrangements are likely to further the shared objectives of reducing health inequalities and improving health and wellbeing and that these arrangements contribute to fulfilment of objectives set out in the Health and Wellbeing Strategy and Out of Hospital Strategies.

(H) The Partners have consulted such persons and/or bodies as appear to them to be affected by the Partnership Arrangements and in accordance with Regulation 4(2) of the Regulations.

(I) The Partnership Arrangements do not affect the liability of the Council or the CCG for the exercise of their respective functions, or any power or duty to recover charges for the provision of any services in the exercise of any Local Authority function.

(J) The Council is responsible for the resident population of Haringey and the CCG is responsible for the population who are registered with a General Medical Practitioner approved to operate within the boundaries of Haringey, and who are constituted members of the CCG. Appendix 2 lists the approved General Medical Practitioners who are constituted members of the CCG for the purposes of this Agreement.

(K) The provision of the Individual Services secured by the Pooled Fund, within the powers of the Council and the CCG, shall be limited to Eligible Service Users.

(L) The policies and guidance referred to within this document are current at time of the commencement of the agreement. Where such policies and guidance are updated or superseded, the agreement will be amended to reflect these changes. If new policy or guidance requires material changes to the Agreement, the Partners shall endeavour to vary the Agreement accordingly.

(M) The Council and the CCG have obtained the necessary consents and approvals to enter into this Agreement and the Partners have approved the terms and conditions of this Agreement.

SIGNATURES

THE SIGNATURES BELOW indicate complete and unconditional acceptance of all the above terms and conditions in Parts 2 and 3 of this Agreement by both *the Council* and the *CCG*.

Signed on behalf of

The Lord Mayor and Burgesses of the London borough of Haringey of, River Park House, 225 High Road, Wood Green, London N22 8HQ

by:

Zina Etheridge ……..

Deputy Chief Executive, London Borough of Haringey

on ……..

Signed on behalf of

NHS Haringey Clinical Commissioning Group (Haringey CCG) of River Park House, 225 High Road, Wood Green, London N22 8HQ

by:

Sarah Price ……

Chief Officer, Haringey Clinical Commissioning Group

on …….

IT IS AGREED AS FOLLOWS:

1 Definition and Interpretation

Definition

1.1. In this Agreement the following expressions will have the following meanings:

"the 2006 Act"	means the National Health Service Act 2006
"Agreement"	means this Agreement between the Council and the CCG comprising these terms and conditions, together with all Schedules and Appendices attached hereto
"Aims and Objectives"	has the meaning ascribed to it in Clause 4.3
"Aligned Fund"	means those monies available for the pooled budget in respect of an Individual Service, as specified in the relevant Schedule of Part 2, which are made up of separate Contributions by the Partners and out of which payments may be made by the Lead Commissioner towards expenditure incurred in the exercise of the Lead Commissioner Functions in respect of that Individual Service
"Aligned Fund Arrangements**"**	means the establishment and maintenance of Aligned Funds as described in Clause 6 (Aligned Fund Arrangements), Clause 10 (Financial Contributions), Clause 11 (Overspends and underspends) and Part 2
"Best Value Duty"	means the duty imposed on the Council by Section 3 of the Local Government Act 1999 in relation to, inter alia, any one (1) or more of the Services
"Bribery Act"	the Bribery Act 2010 and any subordinate legislation made under that Act from time to time together with any guidance and codes of practice issued by the relevant Regulatory Body concerning the legislation
"Budget"	means the statement of total approved funds required to operate the Partnership

	Arrangements in any one Financial Year
"Clinical Commissioning Group"	means a clinical commissioning group established as a corporate body pursuant to Chapter A2 of Part 2 of the 2006 Act
"Commencement Date"	means 1st March 2017
"Contributions"	means the respective financial contributions of the Partners in accordance with Clause 5 (Pooled Fund Arrangements), Clause 10 (Financial Contributions) and Part 2, for use by the Lead Commissioner in connection with the Lead Commissioning of the Services in fulfilment of the Lead Commissioner Functions and in accordance with the terms of this Agreement
"Eligibility Criteria"	means the joint eligibility and assessment procedure criteria for an Individual Service as set out in Part 2
"Eligible Service Users"	means those residents of Haringey for whom the Council or CCG are responsible and who require the needs of an Individual Service(s) and who otherwise meet the Eligibility Criteria
"Excluded Functions"	means any exclusions set out in the Regulations
"Finance and Performance Partnership Board"	means the accountable body established by the Partners pursuant to Clause 12, being the group responsible for the Partnership Arrangements
"Financial Year"	means 1 April to 31 March
"Guidance"	means the guidance on partnership arrangements under section 75 of the 2006 Act published by the Department of Health
"Indirect Losses"	means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.
"Individual Service"	means one of the constituent services set out in Part 2 which is allocated an Aligned Fund or

	Pooled Fund by the Partners and which together comprise the Services
"Individual Service Budget"	means the budget allocated by the Partners to an Individual Service
"Initial Term"	means the period of five (5) years commencing on the Commencement Date
"Joint Executive Team"	means the senior officers group established by the Partners pursuant to Clause 12, being the group responsible for overseeing the Partnership Arrangements
"Joint Finance and Commissioning Management Group"	means the lead commissioner and pooled fund manager group established by the Partners pursuant to Clause 12, being the group responsible for implementing the Partnership Arrangements
"Lead Commissioner"	means the Partner carrying out Lead Commissioning in respect of an Individual Service, as set out in Part 2, and, where a Pooled Fund is to be entered into in respect of such Individual Service (as identified in Part 2), the Partner who is responsible for the accounts and audit of such Pooled Fund (as described in Regulation 7(4) of the Regulations)
"Lead Commissioning"	means the mechanism by which the Lead Commissioner commissions the Services for both the Council and the CCG as further detailed in Part 2
"Lead Commissioner Functions"	means the Community Care Functions and the NHS Functions in relation to the provision of, or making arrangements for the provision of, the Services to meet the needs of the Eligible Service Users, but excluding the Excluded Functions
"Lead Commissioning Arrangements"	means the Lead Commissioning arrangements set out in this Agreement and more particularly described at Clause 7 (Lead Commissioner Arrangements) and Part 2
"Legislation"	means a statute, statutory provision or subordinate legislation

"NHS Functions"	means those functions of the CCG specified in Regulation 5 of the Regulations as are exercised in the provision of, or making arrangements for the provision of, the Services, excluding the Excluded Functions
"Nominated Commissioning Manager"	means the individual responsible for overseeing specific service programmes as set out in Part 2 in relation to the Partnership Arrangements, having been delegated this function by the Nominated Director
"Nominated Director"	means the individual referred to in Clause 5.8 being an officer of the Lead Commissioner responsible for managing the Pooled Fund(s) and Non Pooled Fund(s) on behalf of the Partners and submitting to the Partners quarterly reports and annual returns and other information, who may in turn delegate this function to the relevant Commissioning Manager for the Individual Service(s)
"Part 2"	means the Schedules of Part 2 of this Agreement which detail the Individual Services
"Partners"	means the Council and the CCG and "Partner" means either the Council or the CCG*;* the term includes the organisation(s), their employees, agents and sub-contractors
"Partnership Arrangements"	has the meaning ascribed to it in Clause 4.2
"Performance Measures"	means those performance measures in respect of the Partnership Arrangements, as set out in Part 2 or as otherwise agreed in writing by the Partners
"Pooled Fund"	means the pooled fund in respect of an Individual Service as set out in the relevant Schedule of Part 2, which is made up of Contributions by the Partners and out of which payments may be made by the Lead Commissioner towards expenditure incurred in the exercise of the Lead Commissioner Functions in respect of that Individual Service

"Pooled Fund Arrangements**"**	means the establishment and maintenance of Pooled Funds as described in Clause 5 (Pooled Fund Arrangements), Clause 10 (Financial Contributions), Clause 11 (Overspends and underspends) and Part 2
"Pooled Fund Manager**"**	shall have the meaning ascribed to it in Clause 5.14
Prohibited Acts:	the following constitute Prohibited Acts: (a) to directly or indirectly offer, promise or give any person working for or engaged by the Authority or the CCG a financial or other advantage to: (i) induce that person to perform improperly a relevant function or activity; or (ii) reward that person for improper performance of a relevant function or activity; (b) to directly or indirectly request, agree to receive or accept any financial or other advantage as an inducement or a reward for improper performance of a relevant function or activity in connection with this Agreement; (c) committing any offence: (i) under the Bribery Act; (ii) under legislation creating offences concerning fraudulent acts; (iii) at common law concerning fraudulent acts relating to this Agreement or any other contract with the other Partner; or (iv) defrauding, attempting to defraud or conspiring to defraud the other Partner.
"Regulations**"**	means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (Statutory Instrument 2000 No. 617) and any amendments thereto and subsequent re-enactments thereof
"Representative"	a Partner's employee, agent or subcontractor and any employee of the other partner who is seconded to a partner and is acting in accordance with that Partner's instructions.
"Services"	means the Individual Services together

“Social Care Functions”	means the Council's health related functions specified in Regulation 6 of the Regulations in relation to the provision of, or making arrangements for the provision of, the Services, but excluding the Excluded Functions
“Working Days”	any day other than Saturday, Sunday, a public or bank holiday in England.

Interpretation

1.2 In this Agreement (except where the context otherwise requires):

1.2.1 Any reference to this Agreement includes all its Parts, Appendixes and Schedules of, or to, this Agreement which form part of this Agreement and will have effect as if set out in full in the body of this Agreement but not including the table of contents which is provided for convenience of reference only and will not be construed as part of this Agreement. ;

1.2.2 Any reference to a Schedule or an Appendix is to a Schedule or an Appendix of or to this Agreement;

1.2.3 Any reference to a clause is to a provision of this Agreement that is uniquely identifiable by a preceding number and clauses may be nested so that a clause may contain subordinate clauses each uniquely identifiable by a subordinate preceding number and any reference to a clause includes all other clauses nested within that clause;

1.2.4 Any reference to a paragraph is to a paragraph of a Schedule or an Appendix to this Agreement (as appropriate)*;*

1.2.5 **Any reference to Legislation will be construed as referring to such Legislation as amended and in force from time to time and to any Legislation which re-enacts or consolidates (with or without modification) any such Legislation provided that, unless the Partners agree otherwise, as between the Partners, no such amendment or modification will apply for the purposes of this Agreement to the extent that it would impose any new or extended obligation, liability or restriction on, or otherwise adversely affect the rights of, any Partner*;***

1.2.6 **Any reference to a person or body will not be restricted to natural persons and will include natural persons, firms, partnerships, companies, corporations, associations, organisations, governments, states, foundations and trusts (in each case whether or not having separate legal personality);**

1.2.7 **Clause headings of all kinds including those that stand above, run into or appear to the side of clauses are provided for convenience of reference only and will not be construed as part of this Agreement or deemed to indicate the meaning of the clauses to which they relate or in any other way affect the interpretation of this Agreement or include the unique identifying numbers that precede every clause;**

1.2.8 **Where any conflict may arise between the provisions contained in this Agreement and any Schedules or other documents referred to herein, the provisions of this Agreement will prevail, except for any Legislation or other law or regulation which will prevail over the provisions of this Agreement;**

1.2.9 **Use of the singular will include the plural and use of the plural will include the singular;**

1.2.10 Use of any gender will include the other genders;

1.2.11 Any phrase introduced by the terms "including", "include", "in particular" or any similar expression will be construed as illustrative and will not limit the sense of the words preceding those terms; and

1.2.12 References to a Partner, or any other person, includes a reference to that Partner's or person's successor and permitted assigns.

2. Duration of Agreement

2.1 This Agreement shall come into force on the Commencement Date and shall continue for the Initial Term (and such further period(s) as may be agreed by the Partners pursuant to Clause 3 (Extension of Partnership Agreement), unless terminated earlier in accordance with the terms of this Agreement.

3. Extension of Partnership Agreement

3.1 Subject to this being permissible under the then regime relating to public procurement in force in England and Wales, with effect from the end of the Initial Term of this Agreement, the Partners may extend the period of this Agreement in accordance with this Clause 3 for further period(s) of two (2) years provided that the aggregate of all such extensions does not exceed four (4) years.

Notice of Extension

3.2 Where a Partner wishes to extend the period of this Agreement pursuant to Clause 3.1, it shall serve not less than twelve (12) months' notice in writing (prior to the date this Agreement is due to expire) to this effect on the other Partner and that other Partner shall respond in writing within thirty (30) days of the date such notice is served as to whether it wishes to agree to such extension.

3.3 Where the Partner on whom the notice was served pursuant to Clause 3.2 agrees to the proposed extension, this Agreement shall continue on the same terms as existed on the day before the Agreement would otherwise have expired but for such extension.

3.4 Where the Partner on whom the notice was served pursuant to Clause 3.2 declines the proposed extension or fails to give a written response within thirty (30) days of the date the notice is served, this Agreement shall not be extended and shall expire at the end of the Agreement period then current, unless terminated earlier in accordance with the terms of this Agreement.

3.5 Extension notices pursuant to Clause 3.2 shall be served on:

3.5.1 The CCG: Chief Officer of NHS Haringey Clinical Commissioning Group.

3.5.2 The Council: Deputy Chief Executive

4. The Partnership Arrangements

4.1 The Partners wish to ensure that services for people with health, wellbeing and social care needs are planned, commissioned and provided in an integrated manner. The primary aim of this Agreement is to ensure the most cost-effective use of the combined resources of the Partners to address the health and care needs of people who are their responsibility.

4.2 The Partners have agreed that, with effect from the Commencement Date, the partnership arrangements are to comprise:

4.2.1 Lead commissioning and the establishment and maintenance of pooled fund for the commissioning of learning disability services for eligible adults resident in Haringey as set out in Part 2 Schedule 1 and in accordance with the terms of this Agreement;

4.2.2 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of mental health

services for eligible adults resident in Haringey as set out in Part 2 Schedule 2 and in accordance with the terms of this Agreement;

4.2.3 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of long term conditions and older people's services, including those services identified in the Better Care Fund 2016/17, for eligible adults resident in Haringey as set out in Part 2 Schedule 3 and in accordance with the terms of this Agreement

4.2.4 Joint commissioning and the establishment and maintenance of a pooled fund for the commissioning of child and adolescent mental health services for the residents of the London Borough of Haringey (described in Part 2 Schedule 4 of this Partnership Agreement);

4.2.5 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for eligible adults resident in Haringey as set out in Part 2 Schedule 5 and in accordance with the terms of this Agreement.

AIMS AND OBJECTIVES

4.3 The Partners' agreed aims and objectives of the commissioning arrangements (including for the purposes of Regulation 7(3) (a) of the Regulations) are to ensure that:

4.3.1 the commissioning of the Services is based on an agreed picture of needs rather than historical service configurations;

4.3.2 the commissioned Services present good value for money and best value;

4.3.3 the Services seek to promote emotional and physical good health and work to overcome social exclusion;

4.3.4 the Services are culturally competent in meeting the needs of people from black and minority ethnic communities;

4.3.5 a whole systems approach is taken to the commissioning and provision of the Services by preventing duplication of such services and to make more effective use of the current resources (e.g. integrated care pathways);

4.3.6 robust arrangements to collect performance management information are established and maintained and that the information is used to evaluate performance against targets, monitoring both the effectiveness of the commissioning process and the commissioned Services.

4.3.7 It should be noted that further aims and objectives specific to individual services are set out in Part 2.

4.4 Nothing in this Agreement shall affect the liabilities of the Partners to any third parties for the exercise of their respective functions and performance of their respective obligations.

4.5 On entering into this Agreement, the Partners shall jointly give notification of this Agreement to the Health and Social Care Joint Unit of the Department of Health. The notification shall be in the form annexed hereto as Appendix 3 (Form of Notification to the Department of Health), subject to such amendments as may be agreed in writing between the Partners. The Partners shall arrange for such notification to be updated on an annual basis, so as to reflect any variations to this Agreement.

4.6 The Partners may agree to enter into arrangements for the joint commissioning of system-wide initiatives. The terms of any such agreement will be set out in writing by way of a variation to this Agreement, or in a separate written agreement between the Partners.

5 Pooled Fund Arrangements

5.1 The Partners agree that this Clause 5 shall apply where Pooled Funds are to be used in respect of an Individual Service as allowed for in Part 2.

5.2 The Partners acknowledge that they are entering into the Pooled Fund Arrangements pursuant to section 75(2)(a) of the 2006 Act and Regulation 7 of the Regulations. The Partners hereby agree that with effect from the Commencement Date they shall establish and thereafter during the period of this Agreement maintain a Pooled Fund for revenue expenditure in respect of the relevant Individual Service (the "**Pooled Fund Functions**") in accordance with the terms of this Agreement, the Partners being satisfied that the Pooled Fund Functions are a combination of NHS Functions and Social Care Functions.

5.3 The Partners agree to develop an annual Joint Strategy and Savings plan to ensure that there is transparency over the budgets, investments and savings in respect of the relevant pooled and aligned funds.

Partner Contributions

The Partners shall make Contributions annually to each Pooled Fund. The Contribution to each Pooled Fund of each Partner shall, for the first Financial Year of the Partnership Arrangements be as set out in the relevant Schedule of Part 2, and thereafter shall be determined in accordance with Clause 10 (Financial Contributions) of this Agreement and the relevant Schedule of Part 2. The Partners may agree in writing that further services become included in the Pooled Fund Functions for meeting the needs of Eligible Service Users where the additional services meet the Aims and Objectives.

5.5 The persons in respect of which the Pooled Fund Functions may be exercised shall be the Eligible Service Users.

5.6 The agreed aims and outcomes of the Pooled Fund Arrangements shall be the Aims and the Objectives respectively.

Host Partner Responsibilities

5.7 The “host partner” for the purposes of the Regulations for each Pooled Fund shall be the Lead Commissioner. The Lead Commissioner will comply in all respects with the Regulations, the Guidance and any other relevant laws, regulations or guidance in the exercise of its functions as “host partner”.

5.8 The obligations of the Lead Commissioner as “host partner” pursuant to the Regulations shall be deemed to have been fulfilled if such reports, returns and information as are referred to therein are submitted to the Joint Executive Team (or successor body) by the Nominated Director or Nominated Commissioning Manager in accordance with the timings set out in the Regulations.

5.9 The standing orders and standing financial instructions of the Lead Commissioner as notified to the other Partner from time to time shall apply to the management of the Pooled Fund.

5.10 The Lead Commissioner shall be responsible for establishing the necessary financial and administrative support to enable the effective efficient management and effective monitoring and audit of the Pooled Fund.

5.11 The Lead Commissioner shall also be responsible for establishing appropriate accounting arrangements for any Contributions transferred by the other Partner to enable effective monitoring and audit, and to comply with all relevant NHS or local authority guidance, including without limitation those relating to controls assurance. These arrangements shall comply with the relevant partner’s standing orders and rule so as to be within vires of that partner’s Constitution.

5.12 The Lead Commissioner shall provide such information as deemed necessary by the Partners and the Joint Executive Team to enable such effective monitoring and reporting.

5.13 The Lead Commissioner shall provide the other Partner with the necessary information it requires to meet the other Partner's controls assurance requirements.

Pooled Fund Manager's Responsibilities

5.14 The Lead Commissioner shall appoint the Nominated Commissioning Manager as the "pooled fund manager" for the purposes of the 7(4) of the Regulations for each of the Pooled Funds in respect of each Individual Service (the "**Pooled Fund Manager**") and the Pooled Fund Manager will be responsible for:

5.14.1 effectively and efficiently managing the Pooled Fund on behalf of the Partners*;*

5.14.2 authorising payments from the Pooled Fund in accordance with the Pooled Fund Functions and description of the Individual Services, as set out in the Schedules at Part 2;

5.14.3 submitting at a minimum quarterly reports and annual returns in timescales agreed by the Joint Executive Team on the relevant Pooled Fund in accordance with the Guidance and the Regulations and setting out in detail the income and expenditure from the Pooled Fund and other information by which the Joint Executive Team can monitor the use and effectiveness of the Pooled Fund;

5.14.4 ensuring that actions taken in respect of the relevant Pooled Fund are in line with the annual Joint Strategy and Savings Plan

5.14.5 ensuring that management arrangements and reporting for the Pooled Fund comply with audit requirements.

5.15 The Pooled Fund Manager shall be responsible for managing the Budget of the Pooled Fund and forecasting and reporting to the Joint Executive Team upon the targets and information in accordance with the relevant Schedule of Part 2 and any Performance Measures or further targets which the Partners may agree from time to time. Reporting will include progress against the agreed Services objectives plus information on actual or likely overspends and underspends, this to include monthly reporting in the case of any variances of or in excess of plus or minus 1% of an agreed Budget.

5.16 Where the Partners agree in writing, and in accordance with the terms of this Agreement, the Partners may be jointly responsible (in the proportions of their respective Contributions to the Pooled Fund for the current Financial Year) for any costs, claims, expenses or liabilities in excess of the Pooled Fund at any time incurred.

5.17 The Partners will provide whatever information is deemed necessary to enable effective auditing of the Pooled Fund. The Lead Commissioner will arrange for the audit of the accounts of the Pooled Fund Arrangements each year and will require the Audit Commission (or successor body) to make arrangements to certify an annual return of those accounts under section 28(1) (d) of the Audit Commission Act 1998.

Use of Pooled Funds

5.18 The monies in the Pooled Funds:

5.18.1 may be expended on the Functions in such proportions as the Partners shall agree is necessary to undertake the Lead Commissioner Functions and to procure or otherwise provide the Services;

5.18.2 shall be spent in accordance with any restrictions agreed in writing between the Partners from time to time; and

5.18.3 are specific to the Partnership Arrangements and shall not be used for any other purpose.

6. Aligned Fund Arrangements

6.1 The Partners agree that this Clause 6 shall apply where Aligned Funds are to be used in respect of an Individual Service as identified in Part 2.

6.2 The Partners hereby agree that with effect from the Commencement Date they shall establish and thereafter during the period of this Agreement maintain an Aligned Fund for revenue expenditure incurred in the exercise of the Lead Commissioner Functions in respect of the relevant Individual Service (the "**Aligned Fund Functions**") in accordance with the terms of this Agreement, the Partners being satisfied that the Aligned Fund Functions are a combination of NHS Functions and Social Care Functions.

Partners Contributions

6.3 The Partners shall make Contributions annually to each Aligned Fund. The Contribution to each Aligned Fund of each Partner shall, for the first Financial Year of the Partnership Arrangements be as set out in the relevant Schedule of Part 2, and thereafter shall be determined in accordance with Clause 10 (Financial Contributions) of this Agreement and the relevant Schedule of Part 2. The Partners may agree in writing that further services become included in the Aligned Fund Functions for meeting the needs of Eligible Service Users where the additional services meet the Aims and Objectives.

6.4 The persons in respect of which the Aligned Fund Functions may be exercised shall be the Eligible Service Users.

6.5 The agreed aims and outcomes of the Aligned Fund Arrangements shall be the Aims and the Objectives respectively.

6.6 The standing orders and standing financial instructions of the Lead Commissioner as notified to the other Partner from time to time shall apply to the management of the Aligned Fund.

Lead Commissioner Responsibilities

6.7 The Lead Commissioner shall be responsible for establishing the necessary financial and administrative support to enable the effective efficient management and effective monitoring and audit of the Aligned Fund.

6.8 The Lead Commissioner shall also be responsible for establishing appropriate accounting arrangements for any Contributions transferred by the other Partner to enable effective monitoring and audit, and to comply with all relevant NHS or local authority guidance, including without limitation those relating to controls assurance. These arrangements shall comply with the relevant partner's standing orders and rule so as to be within vires of that partners Constitution.

6.9 The Lead Commissioner shall provide such information as deemed necessary by the Partners and the Joint Executive Team (or successor body) to enable such effective monitoring and reporting.

6.10 The Lead Commissioner shall provide the other Partner with the necessary information it requires to meet the other Partner's controls assurance requirements.

Nominated Commissioning Manager Responsibilities

6.11 The Lead Commissioner shall appoint the Nominated Commissioning Manager as the manager for each of the Aligned Funds in respect of each Individual Service Manager will be responsible for:

6.11.1 effectively and efficiently managing the Aligned Fund on behalf of the Partners*;*

6.11.2 ensuring that actions taken in respect of the relevant Aligned Fund are in line with the annual Joint Strategy and Savings Plan

6.11.3 authorising payments from the Aligned Fund in accordance with the Aligned Fund Functions and description of the Individual Services, as set out in the Schedules at Part 2;

6.11.3 setting out in detail the income and expenditure from the Aligned Fund and other information by which the Joint Executive Team can monitor the use and effectiveness of the Aligned Fund;

6.11.4 ensuring that management arrangements and reporting for the Aligned Fund comply with audit requirements.

6.12 The Nominated Commissioning Manager shall be responsible for managing the Budget of the Aligned Fund and forecasting and reporting to the Joint Executive Team upon the targets and information in accordance with the relevant Schedule of Part 2 and any Performance Measures or further targets which the Partners may agree from time to time. Reporting will include progress against the agreed Services objectives plus information on actual or likely overspends and underspends, this to include monthly reporting in the case of any variances of or in excess of plus or minus 1% of an agreed Budget.

6.13 Where the Partners agree in writing, and in accordance with the terms of this Agreement, the Partners may be jointly responsible (in the proportions of their respective Contributions to the Aligned Fund for the current Financial Year) for any costs, claims, expenses or liabilities in excess of the Aligned Fund at any time incurred.

7. Lead Commissioner Arrangements

7.1 The Partners agree that with effect from the Commencement Date the Partners shall enter into Lead Commissioning Arrangements, as set out in Part 2, in accordance with this Agreement, the Regulations and the Guidance. For each Individual Service, the Partner which shall be the Lead Commissioner and shall exercise the NHS Functions in conjunction with the Social Care Functions will be identifed in the relevant Schedule of Part 2.

7.2 The persons in respect of whom the Lead Commissioner may carry out Lead Commissioning shall be the Eligible Service Users.

7.3 The agreed aims and outcomes of the Lead Commissioner Arrangements shall be the Aims and the Objectives.

7.4 The Lead Commissioner shall in performing the Lead Commissioner Functions comply with the requirements of this Agreement, the Regulations, the Guidance and any other relevant laws, regulations or other governmental guidance.

7.5 Excluding any of the Services which are commissioned from a Pooled Fund, the Lead Commissioner may only commission Services under the NHS Function from the CCG's Contributions for the relevant Individual Service and under the Community Care Function from the Council's Contributions for the relevant Individual Service.

7.6 The Lead Commissioner shall, subject to the provisions relating to overspends and underspends in Clause 11 below, only commission Individual Services using funds from the corresponding Individual Service Budget.

7.7 The Nominated Commissioning Manager for each Individual Service or her delegated representative shall be the person responsible for tendering contracts for that Individual Service with any appropriate providers on behalf of the Partners. All contracts or service level agreements for jointly commissioned services will be entered into in the name of and executed by the Lead Commissioner.

7.8 Where the Council is the Lead Commissioner, it shall ensure that all contracts that include provision to commission the Services under the NHS Functions shall include a provision that those parts of contracts which relate to the commissioning of the Services under the NHS Function shall upon expiry or termination of this Agreement either expire or terminate or, at the sole option of the CCG, be assigned from the Council to the CCG upon the same terms mutatis mutandis as the original contract.

7.9 Where the CCG is the Lead Commissioner, it shall ensure that all contracts that include provision to commission the Services under the Community Care Function shall include a provision that those parts of contracts which relate to the commissioning of the Services under the Local Authority Function shall upon expiry or termination of this Agreement either expire or terminate or, at the sole option of the Council, be assigned from the CCG to the Council upon the same terms mutatis mutandis as the original contract.

8. Staffing Arrangements

8.1 In the event that upon commencement of this Agreement, during the term of this Agreement or upon termination or expiry of all or part of this Agreement, the Transfer of Undertakings (Protection of Employment) Regulations 2006 (the "**Regulations**") are determined or alleged to apply, then the Partners will be entitled to rely upon the following indemnities:

Indemnities in favour of the Transferee

8.1.1 The Partner from whom employees will transfer pursuant to the Regulations (the "**Transferor**") shall indemnify and hold harmless the Partner to whom employees will transfer pursuant to the Regulations (the "**Transferee**") against any liabilities or claims that the Transferee incurs or suffers from relating to:

8.1.1.1 any determination or allegation that the employment of any of the Transferor's employees transfers to the Transferee pursuant to the Regulations in connection with the operation of this Agreement (including in respect of any claims under the Regulations by or on behalf of the transferring employees, or in respect of any claims relating to the employment of termination of employment of the transferring employees, whether arising prior to, on or after the transfer date (including, without limitation, any unfair

dismissal liabilities or any liabilities relating to pension rights and obligations)); and

8.1.1.2 any act, fault or omission (or any alleged act, fault or omission) of the Transferor in relation to any employee or former employee of the Transferor whether arising prior to or after the transfer date (including, without limitation, any unfair dismissal liabilities);

8.2 For the avoidance of doubt, there is intended to be no double recovery under the indemnities set out in Clause 8.1

8.3 The Partners may agree to the secondment of staff to carry out the Lead Commissioner Functions. The terms of any such agreement will be set out in writing by way of a variation to this Agreement, or in a separate written agreement between the Partners.

8.4 The Partners may agree to jointly appoint staff to carry out the Lead Commissioner Functions. The terms of any such agreement will be set out in writing by way of a variation to this Agreement, or in a separate written agreement between the Partners

9. Charging

9.1 The Council retains the power to charge Eligible Service Users for certain of its functions (and such functions shall be notified to the CCG) and it is agreed that in accordance with the Guidance the income therefrom shall be paid to the Council by the CCG subject to the Partners agreeing the functions and payments that relate to the Council's power to charge. Such sums received by the Council shall not form part its contribution to the Pooled Funds.

9.2 Nothing in this Agreement shall detract from the principle that NHS services are free at the point of delivery and may not be charged for.

9.3 The Partners may establish and maintain a charging policy and protocol to ensure that the delivery of health care through the performance of any NHS Functions pursuant to this Agreement shall remain free at the point of delivery whilst ensuring that effective procedures exist to facilitate the exercise by the Council of its charging function.

9.4 The Partners acknowledge that there may be occasions where an adjustment to the Pooled Funds is required to reflect the relationship between income (held outside of the Pooled Funds) and expenditure (within the Pooled Funds) where, for example, there are significant reductions or increases in activity leading to variations in income and expenditure.

9.5 Where a package of NHS Functions commissioned services and Social Care Functions commissioned services are being provided to an Eligible Service User and the Social Care Functions commissioned services are being charged, the Lead Commissioner will require that frontline assessment staff with responsibility for the care of the said Eligible Service User will explain to the Eligible Service User as early as practically possible that the NHS Functions commissioned services continue to be provided free to avoid any misunderstanding that the NHS Function commissioned services are being charged for.

10. Financial Contributions

10.1 The Partners shall no later than 1st April of each Financial Year during the period of this Agreement confirm their respective Contributions to each Pooled Fund for that Financial Year.

10.2 The Partners shall use their reasonable endeavours in each Financial Year during the period of this Agreement to agree draft Budgets by each 1st February for the following Financial Year.

10.3 The Contributions by the Council and by the CCG to the Pooled Funds and the Aligned Funds for the period from the Commencement Date to the end of the first Financial Year are set out in Part 2.

10.4 When determining the Partners' Contributions to the Pooled Funds and the Aligned Funds in Financial Years subsequent to the first Financial Year, it is the intention of the Partners, in normal circumstances, to apply the following principles of joint business planning to provide assurance about the adequacy of resources:

10.4.1 Identifying prevailing levels of activity and cost drivers for the services to be provided;

10.4.2 Identifying trends and other financial and non-financial factors likely to influence costs of the services;

10.4.3 Identifying the scope for securing efficiencies and synergies in the delivery of services; and

10.4.4 considering the affordability of Partner Contributions in the context of Joint Strategy and Savings Plans, overall available resources and their prioritisation.

10.5 In determining the required budget for the year and the relevant Partner Contributions, the Partners shall negotiate and jointly agree appropriate changes in the Individual Services, including the identification of efficiencies and management actions so that expenditure will be covered by the Partners' Contributions for the new Financial Year. These changes will be reported as part of the formal reporting process.

10.6 In the event the Partners are unable to agree the Partner Contributions in accordance with this clause 10, this Agreement may terminate in accordance with clause 19.2.1.

11. Overspends and underspends

11.1 Where in the course of a Financial Year it appears that an overspend of any Individual Service Budget is likely at the end of the said Financial Year and the Partners have recognised that overspend, the Joint Executive Team will manage the Individual Service Budget by, in sequential order:

11.1.1 taking action to reduce expenditure;

11.1.2 identifying underspends that can be vired; and

11.1.3 asking for greater Contributions from the Partners.

11.2 The Pooled Fund Manager will notify partners of an existing or anticipated overspend, and for identifying recommendations for mitigation, in timescales agreed by the Joint Executive Team.

11.3 Anticipated overspends of Individual Service Budgets that are part of a Pooled Fund will be apportioned in accordance with the percentage Contribution of each Partner to the Individual Service Budget unless the Partners agree in writing to an alternative approach.

11.4 Anticipated overspends of Individual Service Budgets that are part of an Aligned Fund will be apportioned on a case by case basis following joint agreement between the Partners.

11.5 Where in the course of a Financial Year it appears that an underspend of any Individual Service Budget is likely at the end of the said Financial Year, the Joint Executive Team will manage the Individual Service Budget by, in sequential order:

11.5.1 viring to rectify overspends

11.5.2 returning their respective Contributions to the Partners proportionate to their respective Contributions, in order to meet individual cost pressures;

11.5.3 agreeing improvements to the Services; and

11.5.4 carrying forward for use against any previously agreed objectives for future Financial Years

11.6 The Pooled Fund Manager will be responsible for notifying partners of an existing or anticipated underspend in timescales agreed by the Joint Executive Team and making recommendations for mitigations.

11.7 Subject to clause 11.5, the Partners shall not make any reductions to their respective funding levels until it has been agreed through the Clinical Commissioning Group's Governing Body for the Clinical Commissioning Group*'s* investment level and the Council's Cabinet or relevant Cabinet Member for the Council's funding level. Neither Partner will reduce their Contribution without giving the other Partner not less than six (6) months' written notice of their intention to do so, and each party should have regard to any representations or observations made by the other party.

11.8 Subject to clause 11.6 and 11,7 should exceptional circumstances require urgent significant unilateral change to funding levels during a Financial Year, outwith the agreed Joint Strategy and Savings Plan, the adverse financial implications of any contractual commitments or other unavoidable financial impact to a Partner arising from such unilateral change will be met by the organisation making the unilateral funding change.

11.9 If a Partner is considering making an urgent significant unilateral change in accordance with clause 11.8 above (the "Proposing Partner"), to assist in its consideration as to whether or not to implement the unilateral change, the other Partner shall, upon request, supply to the Proposing Partner any such information reasonably requested, including but not limited to its considered estimate of the potential financial implications arising from the unilateral change, the Service areas that will be affected and the information used to substantiate the estimate of the potential financial implications.

11.10 If, as a result of an urgent significant unilateral change made in accordance with clause 11.8 above, a Proposing Partner is required to make a payment to the other Partner, such payment shall be subject to the Partner seeking costs:

11.10.1 mitigating its losses; and

11.10.2 evidencing the actual financial impact with written invoices or other such evidence reasonably required by the Proposing Partner;

11.11 Where one Partner provides to the other Partner a taxable supply, the Partner providing that taxable supply will provide the other Partner with a Value Added Tax invoice for that taxable supply. The Partners confirm that the Partnership Arrangements have not been designed to avoid tax in any way. These arrangements may with the agreement of the Partners be amended from time to time in accordance with any advice and options for local protocols offered from HM Customs and Excise under guidance affecting partnership arrangements.

Capital Purchases

11.12 This Agreement does not provide any mechanism for making capital purchases. If the Partners decide at any time throughout the duration of this Agreement that it is necessary to make capital purchases then the Partners will agree this separately in writing.

12. Governance arrangements

12.1 Oversight of the Partnership Arrangements will be carried out by the Finance and Performance Partnership Board which will meet at least quarterly, in February, May, August and December. The Board will be co-chaired by a GP Governing Body Member and by a Member of the Council. The membership will comprise the following:

From the CCG:

- GP Governing Body Member (the "Co-Chair")

- Lay Member of the Governing Body who shall be qualified for membership due to holding qualifications, expertise or experience such as to enable him or her to express informed views about financial management and audit matters and who shall lead on audit, remuneration and conflict of interests matters (the "Deputy Chair")
- Accountable Officer
- Chief Finance Officer
- Director of Commissioning

From the Council:

- the Lead Member for Adults and Health
- Deputy Chief Executive
- Assistant Director of Commissioning
- Director of Adult Services
- Chief Finance Officer

12.2 The quorum for the Partnership Board is at least three members from the CCG including a GP or Lay GB member and one CCG officer) and three members from Haringey Council (including the lead Member for Adults and Health and one Council officer).

12.3 The Finance and Performance Partnership Board will have delegated approval from the CCG Governing Body by the delegated budgetary authority vested in the CCG Governing Body members of the Finance and Performance Partnership Board to make financial allocation decisions relating to the Section 75 Pooled Budgets to an agreed level.

12.4 The Finance and Performance Partnership Board will have delegated approval from the Council by the delegated budgetary authority vested in the council members of the Financial and Performance Partnership Board)to make financial allocation decisions relating to the Section 75 Pooled Budgets.

12.5 For financial issues outwith the delegated authority of the Board, members of the Board will make recommendations to the CCG Governing Body and the Council's Cabinet.

12.6 Reporting to the Finance and Performance Partnership Board will be the Joint Executive Team, which is the officer group with oversight of the Partnership Arrangements. The Team will be co-chaired by the Deputy Chief Executive of the Council and the Chief Officer of the CCG. In addition to the co-chairs, the membership of the Joint Executive Team will include senior officers of the CCG and the Council.

12.7 The Lead Commissioners will report to the Joint Executive Team for both their pooled fund manager and lead commissioner functions and report on their areas of responsibility as required.

12.8 A Joint Commissioning and Finance Management Group will meet at least every two months to monitor expenditure and performance of the Partnership Arrangements and prepare reports to the Joint Executive Team.

12.9 Monthly monitoring of activity and expenditure will be undertaken by the Lead Commissioner so that early warning can be given and action taken to address any concerns arising.

12.10 An annual report on the implementation of this Agreement shall be provided to the Health and Wellbeing Board.

12.11 Individual Services may also wish to report annually to the service specific partnership boards on the delivery of the Aims and Objectives through the mechanism of this Agreement.

12.12 The role of the Deputy Chief Executive of the Council and of the Chief Officer of the CCG shall be to:

12.12.1 resolve jointly any actual or potential conflicts of interest relating to this Agreement;

12.12.2 address sub-standard performance as described in Clause 13 (Standards of Service and Monitoring);

12.12.3 agree strategies for media contact;

12.12.4 receive notices served on their respective Partner Organisation; and

12.12.5 take part in the first stage of the dispute resolution procedure set out in Clause 14 (Governing Law and Dispute Resolution);

13. Standards of Service and Monitoring

13.1 In the event that either Partner shall have any concerns about the operation of the Partnership Arrangements or the standards achieved in connection with the carrying out of the Partnership Arrangements it may convene a review with the other Partner with a view to agreeing a course of action to resolve such concerns.

Performance measures

13.2 The Partners will be accountable for the efficiency and effectiveness of the commissioning process and for Services commissioned under this Agreement by reference to Performance Measures. The Partners will monitor the effectiveness of the Partnership Arrangements and use measures of performance to develop their work. The Lead Commissioner will be responsible for ensuring that the Performance Measures demonstrate:

13.2.1 how far the aims of the Partnership Arrangements are being achieved;

13.2.2 the extent to which the outputs including timescales and milestones are being met;

13.2.3 the extent to which agreed Aims and Objectives are being fulfilled, and targets met;

13.2.4 the financial inputs and outputs;

13.2.5 the extent to which the exercise of the flexibilities in Section 75 of the 2006 Act is the reason for improved performance, or a reduction in the performance of the Services;

13.2.6 how the Partnership Arrangements compare with the previous arrangements, and other approaches to providing the Services.

13.3 The Joint Finance and Commissioning Management Group will meet at least every two months to review the performance measures. Pooled fund managers will be responsible for providing reports as required by the Joint Executive Team to give assurance that these measures are being met and that action is being taken to address under achievement where this occurs.

13.4 The Partners shall each exercise the required degree of care, skill and diligence in accordance with best practice in relation to performance of their duties under this Agreement, and will meet their obligations under this Agreement in accordance with the relevant laws, regulations and guidance.

13.5 The Partners shall review the operation of the Partnership Arrangements and all or any procedures or requirements of this Agreement on the coming into force of any relevant statutory or other Legislation or guidance affecting the Partnership Arrangements so as to ensure that the Partnership Arrangements comply with such Legislation.

Best value duty

13.6 The Council is subject to the Best Value Duty. The Social Care Functions will be subject at all times to compliance with the Best Value Duty.

13.7 **The CCG shall ensure that any requirements which the Council reasonably requires to meet its Best Value Duty are incorporated and reflected in its delivery and performance of the Social Care Functions. This is only insofar as this is subject to the Council's Contributions being sufficient to cover any increased costs. For the avoidance of doubt, this may include efficiency savings or reconfiguration of the Services and the Partners shall undertake any appropriate consultation prior to implementation.**

Clinical governance duty

13.8 Th**e Council shall ensure that any of the Services commissioned through this Agreement comply with expected requirements for clinical governance and controls assurance to which the CCG is subject. The CCG** is subject to a duty of clinical governance, which (for the purposes of this Agreement) shall be defined as a framework through which it is accountable for assuring the quality of services commissioned and to promote a continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. The Council acknowledges that clinical governance (as described above) applies to the treatment of NHS patients. Such patients are entitled to expect to receive services which are part of a clinical governance system irrespective of where they are treated. The Partnership Arrangements will therefore be subject to ensuring that there are clinical governance obligations included in contracts commissioned by the Lead Commissioner where relevant to the particular services commissioned. The Council shall use reasonable endeavours to co-operate with all reasonable requests from the CCG, which the CCG considers necessary in order to fulfil its clinical governance obligations.

13.9 Where the Council, acting as Lead Commissioner, is undertaking procurement and contracting on behalf of the CCG, the form of

contract and performance requirements therein will be developed with regard to the requirements of NHS contracts and of the CCG.

13.10 For the avoidance of doubt, this Agreement in no way releases either Partner from any requirement to comply with the general law or any internal standing order, by-law, policy, financial procedure or decision of the Council or the CCG which is inconsistent with this Agreement.

13.11 Each Partner shall be entitled to make representations and recommendations to the other Partner relating to the other Partner's performance of its obligations under this Agreement. Each Partner will in good faith give due regard to the other Partner*'s* representations and recommendations, and shall promptly respond, in writing, giving reasons why such representations and/or recommendations were or were not followed.

13.12 Sub-standard performance will in the first instance be addressed through the Joint Executive Team and thereafter referred as indicated in Clause 14 below.

14. Governing Law and Dispute Resolution

14.1 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter, shall be governed and construed in accordance with English Law and subject to the exhaustion by the Partners of the dispute resolution procedure set out in this Clause 14, the Partners hereby submit to the exclusive jurisdiction of the English courts.

14.2 Any dispute concerning this Agreement shall be first referred in writing to the Deputy Chief Executive for the Council and the Chief Officer for the CCG who shall enter into good faith negotiations to resolve the matter.

14.3 In the event that the dispute remains unresolved on the expiry of twenty eight (28) days from the date of the referral under Clause 14.2, or such longer period as the Partners may agree, the dispute

shall be referred to the Cabinet Member for Adult Social Care and Health, or for Children's Services (as appropriate), and the Chair of the CCG who shall enter into good faith negotiations to resolve the matter.

14.4 In the event that the dispute remains unresolved on the expiry of twenty eight (28) days from the date of the referral under Clause 14.2, or such longer period as the Partners may agree, the Partners shall jointly refer the dispute to a mediator appointed by the Centre for Effective Dispute Resolution ("CEDR").

14.5 The mediator shall determine the rules and procedures by which the mediation shall be conducted save that:

14.5.1 each Partner shall be entitled to make a written statement of its case to the mediator prior to the commencement of the mediation, provided that such statement shall be provided to the mediator not less than fourteen (14) days or such other period as may be agreed by the mediator before the mediation is to commence; and

14.5.2 within fourteen (14) days of the conclusion of the mediation the mediator shall provide a written report to the Partners which report shall set out the nature of the dispute and the nature of its resolution if any.

14.6 The mediator shall be entitled to be paid their reasonable fee, which the Partners shall pay in equal shares.

14.7 Neither Partner may commence court proceedings in relation to any dispute concerning this Agreement until fourteen (14 days) after mediation in accordance with Clause 14.5 has failed to resolve the dispute, provided that either Partner's right to issue proceedings is not prejudiced by a delay and nothing in this Clause 14 shall prevent either Partner applying to the court for injunctive or other interim or equitable relief.

15. Complaints

15.1 As soon as reasonably practicable following the Commencement Date, and in any event within six months following the Commencement Date, the Partners will agree and operate a joint complaints protocol relating to the Lead Commissioner Functions. The application of such a joint complaints protocol will be the preferred method to deal with complaints, without prejudice to a complainant's right to use either of the Partners' statutory complaints procedures where applicable.

15.2 Prior to the Partners agreeing a joint complaints protocol or if the Partners agree to cease operating any such joint complaints protocol (without agreeing a replacement system), the following will apply:

15.2.1 where a complaint wholly relates to one or more of the Council's Social Care Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council;

15.2.2 where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the CCG;

15.2.3 where a complaint relates partly to one or more of the Council's Social Care Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the CCG, in line with local joint protocol;

15.2.4 where a complaint cannot be handled in any way described above or relates to the operation of the Partnership Arrangements by the Joint Executive Team or the content of this Agreement, then the Joint Executive Team will set up a complaints subgroup to examine the complaint and recommend remedies.

15.2.5 Where there is disagreement between the Partners as to whether the complaint relates wholly to the CCG's NHS Functions or wholly to the Council's Social Care Functions or whether or not it should be reviewed under the local joint complaints protocol then the dispute resolution procedure in clause 14 will be evoked.

15.3 All complaints relating to the Lead Commissioner Functions shall be reported by the Partners to the Joint Executive Team and on to the Finance and Performance Partnership Board as appropriate.

15.4 The Partners are obliged to fully comply and cooperate with any requests for information and investigations undertaken by the Parliamentary and Health Service Ombudsman.

16. Regulation and Inspection

16.1 The Partners shall cooperate with any investigation undertaken by the Care Quality Commission, the Health Service Commissioner and/or the Local Government Commissioner for England or any regulatory authority/body.

16.2 The Partners shall cooperate with any audit undertaken by the Audit Commission (or any successor body), the Department of Health, NHS England and/or any local government audits.

16.3 The partners shall notify each other as soon as is reasonable practicable that a Regulatory or Auditors' investigation has commenced.

17. Information Sharing

17.1 Both Partners shall follow and ensure that the Partnership Arrangements comply with all Legislation and regulations as described in clause 21 and guidance on information sharing produced by the Government, NHS England, NHS Digital, HSCIC and the Information Commissioner.

17.2 Each Partner shall establish and keep operational and ensure that there are kept operational:

17.2.1 procedures (including forms) for handling Eligible Service User access and consent;

17.2.2 documentation for Eligible Service Users which explains their rights of access, the relevance of their consent, rules and limits on confidentiality, and how information about them is treated; and

17.2.3 such additional policies procedures and documentation as shall be necessary in order to meet the purposes, guidance and requirements of Government and of all relevant data protection Legislation as they apply to the Partners and the Partnership Arrangements.

17.3 The Partners shall in the performance of their obligations under this Agreement comply with any Information Sharing Agreements in place between the council and CCG.

17.4 As soon as reasonably practicable following the Commencement Date, and in any event within six months following the Commencement Date, the Partners will agree and operate a joint Information Sharing Protocol relating to the Lead Commissioner Functions.

18. Serious and Untoward Incidents

Adults

18.1 Both Partners acknowledge that the Safeguarding Vulnerable Groups Act 2006 and Multi-Agency Policy and Procedures to Protect Vulnerable Adults from Abuse shall apply to the Services.

18.2 The Partners acknowledge that serious and untoward incidents may occur in relation to the Services. In the case that the allegation relates to:

18.2.1 the Services, then the allegation shall be handled in accordance with the relevant Partner's serious and untoward incident policy;

18.2.2 if the allegation refers to a Partner itself then the allegation shall be handled in accordance with the relevant partner's serious and untoward incident policy.

18.3 In cases where there the allegation refers to both partners or there is uncertainty as to which partner has responsibility this case shall be referred to the Joint Executive Team for a decision and a joint investigation if required

18.4 Any incidents being investigated by a Partner shall be notified as soon as reasonably practical by that Partner to the Joint Executive Team, who shall be kept informed of all stages of the investigations.

18.5 The Partner leading the investigation shall make the Council's and CCG's Press Office (or equivalent) aware of any situations that may have an impact on the Council or CCG.

Children

18.6 Both Partners acknowledge that the Children Acts 1989 and 2004 apply to the Services. All Services shall adhere to the current and any future statutory framework (Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HM Government, March 2015) and London Child Protection Procedures.

18.7 Any serious incidents regarding children that involve Individual Services shall be investigated in accordance with Legislation, London Child Protection Procedures and the relevant Partner's serious and untoward incident policy.

18.8 Where an allegation relates to a member of staff from one of the Partners itself, then the case shall be referred to the Local

Authority Designated Officer for Allegations against staff working with children.

18.9 Any serious incidents involving children or the death of a child known to Individual Services shall be reported to the Designated Nurse for Safeguarding Children for the CCG and the Head of Children Safeguarding for the Council.

18.10 In the event of a death or serious injury of a child, the Local Safeguarding Children Board shall consider whether a serious case review is required in accordance with Legislation. Both Partners shall ensure that full cooperation is given to the review.

Assistance

18.11 Each Partner shall provide to the other, all reasonable assistance required in relation to the investigation of any serious and untoward incident in relation to the Services.

19. Termination

19.1 Either Partner may:

19.1.1 terminate this Agreement; or

19.1.2 terminate this Agreement solely in so far as it relates to an Individual Service or Individual Services (in which case the provisions of this Agreement as to termination shall mutatis mutandis apply),

19.1.3 by giving not less than twelve (12) months' written notice to the other Partner.

19.2 Either Partner (the "First Partner**") may terminate this Agreement by giving not less than three (3) months' notice in writing to the other Partner if:**

19.2.1 the Partners cannot agree the Budget for any subsequent Financial Years;

19.2.2 the other Partner commits a material breach of a provision of this Agreement and (where such breach is capable of remedy) fails to remedy such breach within two calendar months of a written notice being given which requires such breach to be remedied and which states that it is the intention of the notifying Partner to terminate this Agreement forthwith if the breach is not so remedied;

19.2.3 either Partner is exercising its rights to termination under clause 21.9.1.4;

19.2.4 the Services persistently fail to meet the Performance Measures or any standards required by law or guidance or which have been agreed by the Partners;

19.2.5 the other Partner suffers an Event of Force Majeure (as defined in Clause 21.18.1) and such Event of Force Majeure persists for more than thirty (30) days following the service of the notice referred to at Clause 21.18.4.(b);

19.2.6 the First Partner's fulfilment of its obligations under this Agreement would be in contravention of any guidance from any Secretary of State issued after the date hereof;

19.2.7 the fulfilment of the Partnership Arrangements would be ultra vires; or

19.2.8 the Partners are unable to agree a variation to this Agreement in accordance with Clause 21.3 (Entire Agreement, Variations and Change Control) so as to enable either/both Partners to fulfil its/their obligations in accordance with law and guidance.

19.3 Either Partner (the "**First Partner**") may terminate this Agreement immediately following writing notice to the other Partner if the other Partner commits a material breach of a provision of this Agreement which is not capable of remedy.

19.4 Where this Agreement is terminated by a Partner under either Clause 19.1 or 19.2 (Termination) on the other Partner, each Partner shall (unless the Partners agree in writing otherwise) continue to perform its obligations under this Agreement throughout the relevant termination notice period.

19.5 Upon termination or expiry of this Agreement howsoever occurring, the Partners will be entitled to a proportion of any monies held by the Lead Commissioner with regard to any of the Individual Services included in Part 2. The entitlement with regard to each Pooled Fund will be in proportion to each Partner's contribution to that Pooled Fund, and the Lead Commissioner(s) will pay such amount to the other Partner within thirty (30) days of the date that this Agreement terminates or expires, subject always to the terms in relation to the continuing liabilities set out at Clause 19.6 below.

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

19.6.1 The Council and the CCG shall continue to be liable to purchase the various Individual Services set out in Part 2 in accordance with the terms of this Agreement to fulfil all existing obligations to third parties;

19.6.2 The Partners shall remain liable to operate the Pooled Fund and joint commissioning arrangements in accordance with the terms of this Agreement so far as is necessary to ensure fulfilment of their obligations;

19.6.3 Each Partner shall remain liable to contribute that proportion of the cost of each Individual Service which either is its proportionate Contribution in the current or most recent Financial Year. If such Contribution has not at the date of notice of termination yet been confirmed, the Partners' liability will be based on their respective contributions in the immediately preceding Financial Year;

19.6.4 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to Eligible Service Users, employees, the Partners and third parties;

19.6.5 Any assets purchased from any of the Pooled Fund will be disposed of by the relevant Lead Commissioner for the purposes of meeting any of the costs of winding up the Services or where this is not practicable such assets will be shared proportionately between the Council and the CCG according to the level of past contributions to the Pooled Fund;

19.6.6 upon expiry or termination of this Agreement, monies in the Pooled Fund shall continue, notwithstanding termination, to be used by the Pooled Fund Manager to pay for any of the Services delivered by third parties under contracts approved by the Joint Executive Team . Thereafter any underspend (including any interest) shall be returned to the Partners pro rata to their Contribution. Any overspend shall be borne by the Partners pro rata to their Contributions provided that where and to the extent any overspend is caused or contributed to by either Partner acting in breach of the terms of this Agreement, such Partner shall be fully responsible for such element of the overspend;

19.6.7 the Joint Executive Team 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

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

19.7 Where a Partner is entitled to terminate this Agreement pursuant to Clause 19.2 and the circumstances giving rise to such right relate to a particular Individual Service or Individual Services, the Partner may at its sole option choose to terminate this Agreement solely in so far as it relates to such Individual Service or Individual Services and the provisions of this Agreement as to termination shall mutatis mutandis apply.

20. Indemnity and Limitation of Liability

20.1 For the avoidance of doubt, clause 5.16 will only apply to expenditure of Pooled Funds for the provision of the Services and the Pooled Funds shall not be drawn down for indemnification purposes under this clause.

20.2 Each Partner (the "Indemnifying Partner**") will fully indemnify the other (the "**Indemnified Partner**") against all losses, costs, expenses, damages, liabilities, actions, claims or proceedings at common law or under Legislation which arise as a result of or in connection with any act, default, negligence, breach of contract or breach of statutory duty, in relation to this Agreement or any Individual Services contract, on the part of the Indemnifying Partner, its staff, officers or agents, except and to the extent that such losses, costs, expenses, damages, liabilities, actions, claims or proceedings arise out of the act, default, negligence, breach of contract or breach of statutory duty in relation to this Agreement or any Individual Services contract, on the part of the Indemnified Partner.**

20.3 Neither Partner excludes or limits its liability for death or personal injury caused by negligence, or fraudulent misrepresentation.

20.4 Subject to Clause 20.2, neither Partner will be liable for any Indirect Losses suffered by the other Partner whether such Indirect Losses or the potential for such Indirect Losses were made known to the Partner or not and the limit of each Partner*'s* aggregate liability to the other under this Agreement in any twelve month period shall not exceed one million pounds (£1,000,000). For the purposes of this Clause 20.4, twelve month periods shall be measured from the Commencement Date and anniversaries thereof.

20.5 If any third party makes a claim or intimates an intention to make a claim against either Partner*,* which may reasonably be considered as likely to give rise to an indemnity under Clause 20.2, the Indemnified Partner that may claim against the Indemnifying Partner will:

20.5.1 within 3 working days give written notice of that matter to the Indemnifying Partner specifying in reasonable detail the nature of the relevant claim. Such notice shall be given to the Director of Commissioning at the CCG if the CCG is the Indemnifying Partner or the Assistant Director of Commissioning at the Council if the Council is the Indemnifying Partner;

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

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

20.6 For the avoidance of doubt, the Indemnified Partner shall be under a duty to mitigate any loss in accordance with the principles of common law and the indemnity given at Clause 20.2 above shall not extend to losses, costs, expenses, damages, liabilities, actions, claims or proceedings incurred by reason of or in consequence of any negligent act or omission, misconduct or breach of this Agreement committed by the Indemnified Partner.

20.7 Each Partner shall ensure that they maintain appropriate insurance arrangements in respect of employers' liability, liability to third parties and other insurance or risk pooling arrangements to cover their liability under this Agreement.

21. Other provisions

21.1 Confidentiality

21.1.1 Except as required by law and specifically pursuant to Clause 21.8 (Freedom of Information Act 2000), each Partner agrees at all times during the continuance of this Agreement and after its termination to keep confidential any and all information, data and material of any nature which either Partner may receive or otherwise obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of the other Partner, its employees, agents and/or any other person with whom it has dealings including any client, patient or Eligible Service User of either Partner. For the avoidance of doubt this clause shall not affect the rights of any workers under Section 43 A-L of the Employment Rights Act 1996.

21.1.2 The Partners agree to provide or make available to each other sufficient information limited to the extent necessary concerning their own operations and actions and concerning client, patient and Eligible Service User information (including material affected by the Data Protection Act in force at the relevant time) to enable efficient operation of the Partnership Arrangements (which include the Services).

21.1.3 The Partners will ensure that the provision of the Services complies with all relevant data protection legislation regulations and guidance and that the rights of access by Eligible Service Users to their data are observed and as set out in clauses 21.7 and 21.8.

21.2 Public Relations

21.2.1 The Partners will co-operate and consult with each other in respect of matters involving public relations in so far as reasonably practicable having regard to the nature and urgency of the issue involved. The parties may agree Protocols of the handling of public relations from time to time.

21.3 Entire Agreement, Variations and Change Control

21.3.1 The terms herein contained together with the contents of the Schedules under Part 2 constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on either Partner.

21.3.2 No agreement or understanding varying or extending any of the terms or provisions of this Agreement shall be binding upon either Partner unless in writing and signed by a duly authorised officer or representative of the Partners.

21.3.3 If at any time during the Term of this Agreement:

(a) the Council or CCG requests in writing any change to the Services described or the manner in which the Services are commissioned; or

(b) if a change to the manner in which an Individual Service is or the Services are commissioned is required by operation of NHS or local government law through statutes, orders, regulations, instruments and directions made by a Secretary of State in relation to the NHS Functions or the Social Care Functions respectively or others duly authorised pursuant to statute or other changes in the law which

relate to powers, duties and responsibilities of the Partners and which have to be complied with, implemented or otherwise observed by the Partners in connection with their functions then,

(c) the Partners will investigate the likely impact of any such change on an Individual Service, the Services or any other aspects of this Agreement and shall prepare a report in writing within a reasonable period of time of receipt of a change request;

21.3.4 Any report prepared by the Partners pursuant to Clause 21.3.3(b) shall include:

(a) a statement of whether the change will result in an increase or decrease in Contributions to the relevant Pooled Fund or Non-Pooled Fund by reference to the relevant component elements of the Individual Service(s) the subject of the change;

(b) a statement of the individual responsibilities of the Partners for any implementation of the change;

(c) a timetable for the implementation of the change;

(d) a statement of any impact on and any changes required to the Individual Service or Services;

(e) details of any proposed staff and employment implications; and

(f) the date for the validation or expiry of the report.

21.3.5 Where the Partners are unable to agree on the terms of the report then the dispute resolution provisions set out at Clause 14 (Governing Law and Dispute Resolution) in this Agreement shall apply.

21.3.6 If agreement in principle to the change(s) is reached, the Partners shall confirm in writing their decision to proceed with the change(s) referred to in the said report and shall agree a formal variation of this Agreement in accordance with Clause 21.3.2 (Entire Agreement, Variations and Change Control) of this Agreement.

21.3.7 The Partners shall comply with their respective duties to consult on any change in, or addition to, the Services in accordance with the Regulations.

21.4 No Partnership

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

21.4.2 Except as expressly provided otherwise in this Agreement, neither Partner will have authority to, or hold itself out as having authority to:

(a) act as an agent of the other;

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

(c) bind the other in any way.

21.5 Contracts (Rights of Third Parties) Act 1999

21.5.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

21. 6 Notices

21.6.1 Any notice of communication hereunder shall be in writing.

21.6.2 Any notice or communication to the Council hereunder shall be deemed effectively served if sent by registered post or delivered by hand to the Council at the address set out above and marked for the Chief Executive of the Council or to such other addressee and address notified from time to time to the CCG for service on the Council.

21.6.3 Any notice or communication to the CCG hereunder shall be deemed effectively served if sent by registered post or delivered by hand to the address set out above and marked for the attention of the Managing Director of the CCG or to such other addressee and address notified from time to time to the Council for service on the CCG.

21.6.4 Any notice served by hand delivery shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted it shall be sufficient to prove that the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice forty eight (48) hours after the time it was posted.

21.7 Data Protection

21.7.1 The Partners acknowledge their respective duties under the Data Protection Act 1998 (the "DPA") and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

21.7.2 To the extent that the Lead Commissioner is acting as a Data Processor (as such term is defined in the DPA) on behalf of the other Partner, the Lead Commissioner shall, in particular, but without limitation:

(a) only process such Personal Data (as such term is defined in the DPA) as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the other Partner under this Agreement;

(b) put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage or theft to such Personal Data having regard to the state of technical development and the level of damages that may be suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;

(c) take reasonable steps to ensure the reliability of employees who will have access to such Personal Data; and

(d) not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of the other

Partner at Director level at the CCG and Assistant Director level at the council.

21.8 Freedom of Information Act 2000

21.8.1 Each Partner acknowledges that the other Partner is subject to the requirements of the Freedom of Information Act 2000 (the "FOIA") and the Environmental Information Regulations (the "EIR") and each Partner shall assist and cooperate with the other (at their own expense) to enable the other Partner to comply with these information disclosure obligations.

21.8.2 Where a Partner receives a "request for information" under either the FOIA or EIR (as defined under those Acts) ("the Recipient Partner") in relation to information which it is holding on behalf of the other Partner ("the Responsible Partner"), it shall (and shall procure that its sub-contractors shall):

(a) transfer the request for information to the Freedom of Information Lead of the Responsible Partner as soon as practicable after receipt and in any event within two Working Days of receiving a request for information;

(b) Advise the requestor that that the request has been passed on to the Responsible Partner organisation for handling.

(b) provide the Responsible Partner with a copy of all information in its possession or power in the form that the Responsible Partner requires within five (5) Working Days (or such other period as may be agreed) of the Responsible Partner requesting that information; and

(c) provide all necessary assistance as reasonably requested to enable the Responsible Partner to respond to a request for information within the

time for compliance set out in the EIR or section 10 of the FOIA, as relevant.

21.8.3 The Recipient Partner agrees to indemnify and keep indemnified the Responsible Partner against all costs, claims, damages or expenses incurred by the Responsible Partner or for which the Responsible Partner may become liable due to any failure by the Recipient Partner to comply with any of its obligations under clause 21.8.2.

21.8.4 Where a Partner receives a request for information which relates to the Agreement, it shall inform the other Partner of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving a request for information. The Partner receiving the request will be responsible for responding to it.

21.8.5 If either Partner determines that information must be disclosed pursuant to Clause 21.8.9 it shall notify the other Partner of that decision at least two (2) Working Days before disclosure.

21.8.6 Each Partner 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.

21.8.7 If the Partners disagree as to which Partner shall be responsible for dealing with a request for information concerning functions which the Partners jointly carry out, the Freedom of Information Leads of each Partner shall enter into good faith negotiations to resolve the matter within three (3) Working Days of the Partner receiving the request for information informing the other Partner. No referral for this purpose should be made less than ten (10) Working Days before the statutory deadline to respond to such a request for information.

21.8.8 In the event that the dispute remains unresolved after referral to the Freedom of Information leads of each Partner, or if no referral is made more than ten (10) Working Days before the statuary deadline to response to a request for information, the Partner who receives the request for information shall be the Partner responsible for dealing with the request.

21.8.9 Each Partner acknowledges that the other Partner may be obliged under the FOIA to disclose Information:

(a) without consulting with the other Partner, or

(b) following consultation with the other Partner and having taken its views into account.

21.9 Prevention of Bribery

21.9.1 Each Partner:

(a) shall not, and shall procure that any of its Representatives shall not, in connection with this Agreement commit a Prohibited Act;

(b) warrants, represents and undertakes to the other Partner that it is not aware of any financial or other advantage being given to any person working for or engaged by it, or that an agreement has been reached to that effect, in connection with the execution of this Agreement, excluding any arrangement of which full details have been disclosed in writing to it before execution of this Agreement.

21.9.2 Each Partner shall:

(a) if requested by the other Partner, provide the other Partner with any reasonable assistance,

that the other Partner may reasonably request, to enable the other Partner to perform any activity required by any relevant government or agency in any relevant jurisdiction for the purpose of compliance with the Bribery Act;

(b) within 5 Working Days of the Commencement Date, and annually thereafter, certify to each other in writing compliance with this Clause **Error! Reference source not found.** by the r elevant Partner and its Representatives and all persons associated with it or other persons who are supplying goods or services in connection with this Agreement.

(c) The Lead Commissioner shall include provisions in any future service contracts requiring compliance by service providers with the requirements of the Bribery Act.

(d) If any breach of this clause is suspected or known, each Partner must notify the other Partner immediately.

If one Partner notifies the other Partner that it suspects or knows that there may be a breach of this clause, the Parties will respond promptly to any enquiries, co-operate with any investigation, and allow the other Partner to audit books, records and any other relevant documentation.

21.9.3 Either Partner may terminate this Agreement by written notice with immediate effect if the other Partner or its Representatives (in all cases whether or not acting with the Partner's knowledge) breaches clause 21.9.1.

21.10 Equality Duties

21.10.1 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful

discrimination, harassment and victimisation, and to advance equality of opportunity and foster good relations between different groups.

21.10.2 The Lead Commissioner agrees to adopt and apply policies in its carrying out of the Lead Commissioner Functions to ensure compliance with its equality duties.

21.10.3 The Lead Commissioner shall take all reasonable steps to secure the observance of this clause by all servants, employees or agents of the Lead Commissioner and all service providers employed in delivering the Services described in this Agreement.

21.11 *c*onflicts of Interest

21.11.1 Each partner will observe its own Conflict of Interests' procedures in matters relating to the partnership agreement and its functions

21.12 Severability

21.12.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

21.13 Changes in Legislation

21.13.1 Partners may review the operation of the Agreement and all or any procedures or requirements of this Agreement on the coming into force of any Legislation or guidance affecting the provision of the Services so that the commissioning of the Services under this Agreement complies with such Legislation or guidance.

21.14 Assignment or Transfer

21.14.1 This Agreement and any rights and conditions contained in it may not be assigned or transferred by either Partner without the prior written consent of the other Partner except to any statutory successor to the relevant function.

21.15 Waivers

21.15.1 The failure of any Partner to enforce at any time to or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision.

21.15.2 No waiver in any one or more instance of a breach of any provision hereof shall be deemed to be a further or continuing waiver if such provision in other instances.

21.16 Costs

21.16.1 Each Partner shall be liable for their own respective costs in relation to this Agreement.

21.17 Further acts

21.17.1 The Partners agree to do or procure to be done all such further acts and things and execute or procure the execution of all such other documents as either Partner may from time to time reasonably require for the purpose of giving full effect to the provisions of this Agreement and the intentions of the Partners as expressed in this Agreement, and the Partners will at all times act and deal in good faith towards each other in respect of all matters the subject of this Agreement.

21.18 Force majeure

21.18.1 Where a Partner is affected by an event or circumstance which is beyond the reasonable control of the Partner, including without limitation war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake, and which directly causes that Partner to be unable to comply with all or a material part of its obligations under this Agreement (an "Event of Force Majeure"), it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

21.18.2 Subject to Clause 21.18.1, the Partner claiming relief shall be relieved from liability under this Agreement to the extent that because of the Event of Force Majeure it is not able to perform its obligations under this Agreement.

21.18.3 The Partner claiming relief shall serve initial written notice on the other Partner immediately it becomes aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event.

21.18.4 The Partner claiming relief shall then either:

(a) serve a detailed written notice within a further seven (7) days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it; or

(b) in the event it reasonably believes that the effects of the Event of Force Majeure will make it impossible for the Partnership Arrangements

to continue, serve notice of this to the other Partner and either Partner may then terminate this Agreement in accordance with Clause 19.2.5 of this Agreement.

APPENDIX 1

JOINT INFORMATION SHARING PROTOCOL

TO BE INSERTED

APPENDIX 2

NHS HARINGEY CCG MEMBER PRACTICES

The following General Medical Practitioners are members of the Haringey CCG and are approved to operate within the boundaries of Haringey.

Practice Name	Address
157 Medical Practice -Dr Ramani [157MP]	157 Stroud Green Road, N4 3PZ
Alexandra Surgery [AS]	125 Alexandra Park Road, N22 4UN
Allenson House Medical Centre [AHMC]	Weston Park, N8 9TB
Arcadian Gardens NHS Medical Centre [AGMC]	1 Arcadian Gardens, N22 5AB
Bounds Green Group Practice [BGGP]	Gordon Road, N11 2PF
Bridge House Medical Practice [BHMP]	96 Umfreville Road, N4 1TL
Broadwater Farm Community Health Centre [BFCHC]	2a Willan Road, N17 6BF
Bruce Grove Primary Care Health Centre [BGPCHC]	461-463 High Road, N17 6QB
Charlton House Medical Centre [CHMC]	581 High Road, N17 6SB
Chestnuts Park Surgery, The Hurley Group [CPS]	Laurel's Healthy Living Centre 256 St Ann's Road, N15 5AZ
Christchurch Hall Surgery [CHS]	20 Edison Road, N8 8AE
Crouch Hall Road Surgery [CHRS]	48 Crouch Hall Road, N8 8HJ
Dowsett Road Surgery [DRS]	57 Dowsett Road, N17 9DL
Dr Sivas Practice - 326 Phillip Lane [DSP]	326 Philip Lane, N15 4AB
Dukes Avenue Practice [DAB]	1 Dukes Avenue, N10 2PS
Evergreen House Surgery [EHS	22 Cheshire Road, N22 8JJ
Fernlea Surgery [FS]	114 High Road, South Tottenham, N15 6JR
Grosvenor Road Surgery [GRS]	23 Grosvenor Road, N10 2DR
Grove Road Surgery [GRS]	1 Grove Rd, N15 5HJ

Havergal Surgery [HS]	9-10 Havergal Villas Green Lanes, N15 3DY
Highgate Group Practice [HGP]	44 North Hill , N6 4QA
Hornsey Park Surgery [HPS]	114 Turnpike Lane , N8 0PH
JS Medical Practice [JSMP]	107 Philip Lane , N15 4JR
Laurels Medical Practice, The Laurels Healthy Living Centre [LMP]	256 St Anns Road , N15 5AZ
Lawrence House Surgery [LHS]	107 Philip Lane, N15 4JR
Morris House Group Practice [MHGP]	Lordship Lane Primary Care Health Centre, N17 6AA
Morum House Medical Centre [MHMC]	3-5 Bounds Green Road, N22 8HE
Myddleton Road Surgery [MRS]	52 Myddleton Road, N22 4NW
Old Surgery (572 Green Lanes) [OS]	572 Green Lanes, N8 0RP
Park Road Surgery [PRS]	153 Park Road, N8 8JJ
Queens Avenue Surgery [QAS]	46 Queens Avenue, N10 3BJ
Queenswood Medical Practice [QMP]	Hornsey Central Neighbourhood Health Centre, N8 8JD
Rutland House Surgery [RHS]	40 Colney Hatch Lane, N10 1DU
Somerset Gardens Family Health Care [SGFH]	4 Creighton Road, N17 8NW
Spur Road Surgery [SRS]	1 Spur Road, N15 4AA
Stuart Crescent Health Centre - Dr Dave Branch [SCHCB]	Stuart Crescent, N22 5NJ
Stuart Crescent Health Centre - High Road Branch[SCHC]	Stuart Crescent, N22 5NJ
Surgery - Dr Ansari (618 Green Lanes) [SDA]	618 Green Lanes, N8 0SD
Surgery - Dr ATM Hoque (26 Westbury Ave) [SCH]	26 Westbury Avenue, N22 6RS
Surgery - Dr Kundu (18 St John's Road) [SDK]	18 St Johns Road, N15 6QP
Surgery - Dr Raja (625 Green Lanes) [SDR]	625 Green Lanes , N8 0RE
Surgery - Dr Sampson (625 Green Lanes)	625 Green Lanes , N8 0RE
Tottenham Medical Practice [TMP]	759 High Road, N17 8AH
Tynemouth Road Health Centre [TRHC]	Tynemouth Road, N15 4RH
Vale Practice [VP]	50-66 Park Road, N8 8SU
West Green Road Surgery [WGRS]	339-341 West Green Road, N15 3PB

Westbury Medical Centre [WMC]	205 Westbury Avenue, N22 6RX

APPENDIX 3

FORM OF NOTIFICATION TO THE DEPARTMENT OF HEALTH

ROCR/OR/0226 **Licence Expiry Date:**

The use of this collection has been approved by the Review of Central Returns Steering Committee – ROCR.

This is a Mandatory collection from clinical commissioning groups and NHS Trusts. Monitor, Independent Regulator of Foundation Trusts, has provided approval for a voluntary collection.

NOTIFICATION FORM
SECTION 75 PARTNERSHIP ARRANGEMENTS

ROCR/OR/0226

Licence Expiry Date: 8 June 2010

To be completed for each partnership arrangement and updated annually for amendment of a partnership arrangement.

This form below should be sent to the Health and Social Care Joint Unit, c/o CSIP ICN, Department of Health, Room 304 Wellington House, Waterloo Road, London SE1 8UJ.

Email: MB-HSD-SCJU@dh.gsi.gov.uk

1. NAMES OF THE STATUTORY PARTNERS **(Officers & Organisations)**	**Chief Officer, NHS Haringey CCG** **Deputy Chief Executive, London Borough of Haringey**
2. DATE OF AGREEMENT	1st March 2017
3. DATE WHEN PARTNERSHIP IS INTENDED TO START OR DATE OF ANNUAL UPDATE FOR DH IF	1st March 2017

THIS HAS BEEN PREVIOUSLY NOTIFIED	
4. TITLE OF OFFICER RESPONSIBLE FOR THE PARTNERSHIP	Chief Officer
5. CONTACT NAME	Sarah Price
6. CONTACT TEL. NO.	020 3688 2725
7. WHICH FLEXIBILITIES ARE BEING USED? • **LEAD COMMISSIONING (LC)** • **POOLED FUNDS (PF)** • **INTEGRATED PROVISION (IP)**	**LC** **PF**

8. WHICH CARE GROUP OR CATEGORY DOES THE PARTNERSHIP SERVE?	Adults with learning disabilities Adults with mental health needs Children and young people with mental health needs The Better Care Fund / Long Term Conditions and Older People Violence Against Women and Girls
9. SUMMARY OF KEY OBJECTIVES **(DO NOT COMPLETE AGAIN IF PREVIOUSLY NOTIFIED AND THESE REMAIN UNCHANGED AT THE TIME OF ANY ANNUAL UPDATE)**	The Partners wish to ensure that services for people with health, wellbeing and social care needs are planned, commissioned and provided in an integrated manner. The primary aim of this Agreement is to ensure the most cost-effective use of the combined resources of the Partners to address the health and care needs of people who are their responsibility.
10. CONTRIBUTIONS **IDENTIFY THE FINANCIAL CONTRIBUTION**	**NHS Haringey CCG: £72.27m**

OF EACH PARTNER <u>SEPARATELY</u> **(<u>To be updated by notification annually</u>)**	**London Borough of Haringey: £38.53m**

OVERARCHING SECTION 75 NATIONAL HEALTH SERVICE ACT 2006 HEALTH AND SOCIAL CARE PARTNERSHIP AGREEMENT

between

LONDON BOROUGH OF HARINGEY

and

NHS HARINGEY CLINICAL COMMISSIONING GROUP

Commencement Date: 1st March 2017

FOR THE COMMISSIONING OF LEARNING DISABILITY SERVICES, ADULT MENTAL HEALTH SERVICES, CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES, INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCREASE SAFETY SERVICES, AND BETTER CARE FUND SERVICES

PART 2

SCHEDULE OF INDIVIDUAL AGREED SERVICES

The Schedule of Agreed Services is agreed on an annual basis and should be read in conjunction with PART 1 of this Agreement

PART 2

SCHEDULE 1

LEARNING DISABILITIES SERVICES

Part 2, Schedule 1
Section A: Summary

SCHEDULE OF AGREED SERVICES 2016-17	
Name of Service	**Community Learning Disabilities Service**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	Council Lead Commissioning with an Aligned Budget
Delegated Function	**Health Function** – The commissioning of Learning Disabilities Services on behalf of Haringey Clinical Commissioning Group
The Services	Haringey Council will act as the strategic lead for learning disabilities for itself and for Haringey Clinical Commissioning Group, ensuring that national and local priorities are reflected in commissioning decisions and leading on market and service developments that support the strategic intent of the partners. The lead commissioners' specification is included in the **addendum (part 1)** attached to this schedule. Haringey Council will also commission on behalf of itself and Haringey CCG a Community Learning Disabilities Team. Haringey Council will manage budgets to fund the commissioning of the staffing in this service and additional placements and packages required to meet the needs of users of the service. The specification for the service is set out in the **addendum (part 2)** to this schedule.
Aim of Service(s)	The aim of the services are to support people with learning disabilities by commissioning services that seek to build resilience, promote independence, support balanced risk taking in the context of being safe, are innovative in approach and reduce the need for statutory services over time.
Outcome of Service(s)	Outcomes are set out in full in the specification and include: • Reduced inpatient activity by 50% • Reduced average length of stay for all admissions • No use of residential care except where no other option is available

	• Support planning that helps users of the service to achieve their outcomes and goals, promotes independence and control and involves them at all stages • Access to positive behaviour support for all patients of all ages with challenging behaviour • Reduction in the use of out of area placements and increased support for care closer to home • Increased use of Personal Integrated Care Budgets and Direct Payments • Elimination of/reduction in existing health inequalities • Transformation of care and culture working towards a life course approach with local services built around the individual and integrated approaches as the norm • Increased employment, education and vocational activity for people with learning disabilities • Effective engagement with users and carers to inform service delivery and improvement • Increases in numbers of people with a learning disability with a Health Action Plan
Strategy/Framework Documents (if applicable)	• Building the Right Support • The Care Act, 2014 • The Mental Health Act, 1983 • The Mental Capacity Act, 2005
Eligibility and Assessment Procedures	As set out in the addendum.
Key Performance Indicators	For each of the services commissioned we will develop an agreed set of local KPIs in addition to any existing national indicators.
Resources for managing the partnership	
	No staff or other resources are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments. Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.
Budgets	**Financial year: 2016/17**

Service line	LBH contribution (£000s)	CCG contribution (£000s)	Total (£000s)	Pooled or aligned
Community Learning Disabilities Team staffing	688	2,040	2,728	Aligned
Learning disabilities care purchasing budgets	18,320	7,113	25,432	Aligned
Council directly provided learning disability services	2,407	0	2,407	Aligned
Total	**21,415**	**9,153**	**30,568**	**Aligned**

Part 2 Schedule 1

Section B: Learning Disabilities Lead Commissioning Specification

1. Introduction

1.1 This specification sets out the roles and responsibilities of the London Borough of Haringey ('the council') as lead commissioner ('the lead') for learning disabilities under the section 75 agreement between the council and Haringey Clinical Commissioning Group ('the CCG').

1.2 Full transfer of lead commissioning responsibilities should take place by April 2017 but the partners will work together to reach this point in a phased way.

1.3 The specification reflects current national guidance. The specification is subject to review in light of amendments to this guidance.

1.4 The specification reflects current commissioning developments and is also subject to annual review.

2. Understanding and responding to the need and demand in the local health and care economy.

2.1 The lead will work with public health, performance and business intelligence, children's services and the service itself to ensure that needs assessments are undertaken as necessary to understand projected demand and relevant demographic profile of the client cohort, including through transitions.

2.2 Given levels of co-morbidity and known challenges, it is particularly important that needs of people with learning disabilities (PWLD) in mainstream health services are captured at the primary care and acute level. This should be included in any analysis as needed to inform commissioning of services.

2.3 The national programme for learning disabilities, Transforming Care, includes within it a specific focus on the inpatient cohort, including children and those within forensic service. This requires commissioners to have a clear understanding of the numbers and needs within this group to inform the development of services that support discharge. Commissioners are also required to fully understand the needs of people at risk of admission to inform commissioning of preventative services. The lead will ensure that there are robust systems in place to support this.

3. Lead on the development of the strategic commissioning intentions of the Council and the CCG, reflecting these in all service specifications.

3.1 Strategic commissioning intentions are informed by the principles and guidance set out in the national Valuing People Strategy, the National Autism Strategy, the national Transforming Care programme, the NCL Transforming Care Plan, the Haringey and Islington Health and Well Being Partnership and a range of local strategies including the Health and Well Being Strategy, the council's corporate plan and the CCG's annual commissioning intentions.

3.2 The lead will represent the Council and the CCG in respect of learning disabilities. This will include being the representative at the NCL Transforming Care Implementation Group and at the NCL Transforming Care Board. The lead will work with NCL partners to agree the optimal geographical footprint for the range of service developments needed to deliver strategic commissioning intentions.

3.3 Many of the above mentioned developments are at a very early stage. As they become more concrete, the lead will develop Haringey structures for ensuring that relevant stakeholders meaningfully co-produce or are involved in the development of a local vision and objectives that support all service developments regardless of agreed geographical footprint.

4. **Ensure the sufficiency and quality of market provisions to meet need.**

4.1 The market for learning disabilities services falls into four key categories which are in different stages of development:

4.1.1 **Learning disabilities inpatient provision** - this market is very high cost, located at distance, under developed and often of poor quality. It is likely that an NCL or even London wide approach might be required to improve that position.

4.1.2 **Supported housing, supported living and residential care arrangements** including Shared Lives - the council has recently reviewed its supported housing provision and tendered for a supported living framework. Other boroughs have also developed frameworks which it may be possible to join if of benefit.

4.1.3 **Meaningful activity** including day opportunities/support to enter employment or volunteering. This is under review as part of the council's medium term financial strategy.

4.1.4 **Community Learning Disabilities Teams** – this included in **section 5** below.

4.2 The lead will be expected to build on existing developments to deliver the required market. In doing so, the lead will be informed by the principles of 'Building the Right Support' guidance, including that services should be person centred, based on positive behavioural support models and sufficiently flexible to be purchased with personal or personal health budgets.

5. Contribute to the transformation and re-design of services in line with the agreed strategic commissioning intentions.

5.1 The work under this heading falls into four broad categories:

5.1.1 **New service developments** which support the delivery of the NCL Transforming Care Plan including crisis intervention teams, the crash pad and positive behavioural support which may be commissioned over varying geographical footprints. As noted in **paragraph 3.3,** many of these

developments are at their early stages and will require significant commissioner input to deliver.

5.1.2 **Re-design of the Community Learning Disabilities Partnership** – an outline specification as already agreed between the council and CCG commissioners is attached in **appendix 1**. The lead will work with the Haringey Learning Disabilities Partnership (HLDP) to develop and deliver this specification and ensure that it is consistent with NCL wide developments and Transforming Care principles. The lead will develop KPIs, monitoring and reporting for the service. See **section 6** below for the element of the specification related to pooled budget delegation to HLDP**.**

5.1.3 **Responsibilities in relation to individual inpatients and patients at risk of admission** – NHSE have set out detailed guidance on the responsibilities of CCGs in relation to this cohort. The lead will be expected to take on these responsibilities. The key activities are as follows:

5.1.3.1 **Organisation, chairing and servicing of Care and Treatment Reviews** (CTRs) of inpatients and patients at imminent risk of admission 'blue light' CTRs) in line with NHSE guidance.

5.1.3.2 **Submission of the Transforming Care tracker** – in liaison with the HLDP, the lead will ensure that submissions are made in line with national deadlines and contain sufficiently robust information to give assurance that patients are being proactively managed towards discharge.

5.1.3.3 **Development of the At Risk of Admission Register (ARAR)** – HLDP are responsible for holding this register. However, there is work underway across NCL to ensure consistency of definitions and interventions and the lead will be expected to support this work.

5.1.4 **Delivery of the council's transformation programme –** This responsibility sits with council commissioners under existing arrangements. It is expected that the lead will continue to deliver this programme in line with council corporate objectives and to ensure that the programme supports wider Transforming Care objectives.

6. As pooled fund manager, manage the pooled budget to support and enable the strategic commissioning intentions.

6.1 The principles of management of the pooled budget are set out in the section 75 agreement, in sections 10 and 11. Of specific note for learning disabilities budgets is as follows:

6.1.1 The outline CLDT specification includes delegation of pooled budgets for packages to the service. This approach is untested and presents new financial risk to the CCG. Delegation should only be agreed subject to assurance of the budgetary controls described in the outline specification. The lead is expected to implement this element of the specification in shadow form over at least a six month period and put in place measures to mitigate risks.

6.1.2 There is an existing historic pooled budget for staffing. The lead will be the point of contact with HLDP should there be business cases made for additional staffing.

7. Deliver savings as set out in the Council's MTFS and the CCG's QUIPP Plans

7.1 As set out in sections 10 and 11 of the section 75 agreement, each year a Joint Investment and Savings plan will agreed between the council and the CCG and the lead will be expected to implement this for learning disabilities.

8. Lead on reporting to and liaising with the relevant local bodies

8.1 The section 75 agreement sets out detailed performance management and reporting requirements for the lead commissioner including through a newly established Joint Commissioning and Finance Management Group, the Joint Executive Team and the Joint Haringey Finance and Performance Partnership Board.

8.2 The lead commissioner will operate within these reporting mechanisms to ensure strong oversight of both finance and outcomes.

9. Lead on reporting to and liaising with national bodies e.g. NHSE or CQC

9.1 It should be noted that the Transforming Care programme has a very high profile nationally and is subject to regular assurance from NHSE. The lead will be expected to act as the contact for NHSE in this regard.

9.2 NHSE may additionally require updates as part of their routine quarterly assurance meetings with the CCG, completion of ad hoc templates and self-assessment frameworks which the lead will be expected to co-ordinate.

Part 2 Schedule 1

Section C: HARINGEY COMMUNITY LEARNING DISABILITY TEAM (CLDT) SERVICE OUTLINE SPECIFICATION

1. Strategic vision

1.1 Haringey Clinical Commissioning Group (the CCG) and London Borough of Haringey (the Council) wish to commission a Community Learning Disability Team (CLDT) service which supports our strategic vision for adults and transitioning children with learning disabilities for whom they have they a responsibility.

1.2 Our aim is support people with learning disabilities by commissioning services that seek to build resilience, promote independence, support balanced risk taking in the context of being safe, are innovative in approach and reduce the need for statutory services over time. We will do this in partnership and as part of a whole-system transformation to improve care for all people with learning disabilities.

1.3 We expect the CLDT to work closely and in full partnership with service users and carers to identify the goals and outcomes which are important to them and which promote their independence, enable them to live in the community and support them to lead ordinary lives. As a partnership, we expect the provider of the service to adopt an integrated approach which ensures seamless delivery of health and social care to people accessing the service and minimises barriers to delivering joined up care and support. To enable this, the specification is supported by a pooled budget which will enable the service to work in creative and innovative ways to deliver outcomes for users that matter to them, engage them in wider civic life and keep within the budget allocated.

1.4 This specification will be supported by a Delivery Plan which details how the provider will offer an integrated approach will delivers against the requirements of this specification, drives changes in workforce culture and operates within the budget available.

2. Principles

2.1 We wish to commission services based on the principles set out in the national guidance, Building the Right Support. These principles are as follows:

2.2 People should be supported to be independent and to have a **good and meaningful everyday life** - through access to activities and services such as early years services, education, employment, social

and sports/leisure; and support to develop and maintain good relationships.

2.3 Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

2.4 People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

2.5 People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

2.6 People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

2.7 People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

2.8 People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

2.9 When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or 'offending' behaviour, liaison and diversion schemes in the criminal justice system, and a

community forensic health and care function to support people who may pose a risk to others in the community.

2.10 When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

2.11 In addition, people should receive care closer to home which promotes their independence.

3. Outcomes for users

3.1 Outcome 1: Promoting independence

- I want to live at home and as independently as possible
- I want to do as much for myself as I can including managing my own health and wellbeing needs
- I want be as active and as healthy as I can
- I want to set my goals and outcomes and work to achieve them with support where necessary
- I want my friends and family to be involved in my care and to make new friends and relationships
- I want to be able to go outside my home to lead an ordinary life including employment, education, leisure and social relationships

3.2 Outcome 2: Help in a crisis

- I want short term help when I am in a crisis to enable me to do the things I could do before the crisis
- I want to be independent and return home as quickly as possible

3.3 Outcome 3: Safeguarding

- I want to be free from abuse
- I want to feel safe

3.4 Outcome 4: Quality when services are necessary

- I want a responsive service, with consistency of care
- I want a service delivered by people who care
- I want a service delivered by people trained to support my condition
- I want to be involved in decisions about my care package

4. Service Outcomes supported

4.1 The expected outcomes that the service will support are as follows:

- Reduced inpatient activity by 50%
- Reduced average length of stay for all admissions
- No use of residential care except where no other option is available
- Support planning helps users of the service to achieve their outcomes and goals, promotes independence and control and involves them at all stages
- Access to positive behaviour support for all patients of all ages with challenging behaviour
- Reduction in the use of out of area placements and increased support for care closer to home
- Increased use of Personal Integrated Care Budgets and Direct Payments
- Elimination of/reduction in existing health inequalities
- Transformation of care and culture working towards a life course approach with local services built around the individual and integrated approaches as the norm
- Increased employment, education and vocational activity for people with learning disabilities
- Annual reviews as a minimum – target 100%
- Multi-disciplinary assessments and reviews
- Effective engagement with users and carers to inform service delivery and improvement
- Increases in numbers of people with a learning disability with a Health Action Plan

5. Eligibility

i) Eligibility by residence, registration and statutory duty:

Individuals resident in Haringey and/or registered with a Haringey GP (or otherwise usually resident as defined in the Responsible Commissioning guidance) are eligible for this service. For avoidance of doubt, individuals for whom the council or CCG has responsibility under the Care Act, Section 117 of the Mental Health Act or who are Continuing Health Care are also eligible for this service. This may include individuals placed in or out of the borough and those being discharged from forensic units.

ii) Eligibility by need:

The specific cohorts of individuals whom can access the service are:

a) People aged 18 and over who have a global learning disability (GLD) in community, acute, acute mental health and learning disability hospital settings.

b) **Individuals with a GLD in any of those settings who have another formal diagnosis** – for example autism, mental health or substance misuse – the CLDT will be expected to provide services to that individual in collaboration with other relevant agencies. On a case by case basis, dependent on clinical need, the CLDT may also act as the lead agency with care co-ordination responsibility for that individual.

c) **Individuals in any of those settings who have an unclear or disputed GLD diagnosis**, the CLDT is expected to offer support and advice to other relevant agencies and to provide services to the individual if professionals agree this to be of clinical benefit. This will need to be agreed on a case by case basis between professionals involved in the patient's care.

d) **Under-eighteens in the community and residential schools transitioning to the CLDT service from children's teams** - the CLDT should offer advice support and take an active part in transition planning for these individuals including leading the Transition Team

6. Services offered

6.1 The following services will be offered in a way consistent with the principles set out in Building the Right Support. In a person centred, multi-disciplinary, and integrated way and in accordance with all guidance and clinical guidelines associated with the council and CCG's statutory duties and the relevant professional bodies, the service will provide the following:

a) Assessment of health and social care needs.

b) Integrated pathways for service users with multiple and complex needs and challenging behaviour, including those with physical health needs.

c) The development of care and support plans to meet those needs which specify expected outcomes and timescales for progress towards achieving these.

d) Referral to Haringey's Brokerage Team which will design and broker packages of care which meet the identified health, care and support needs.

e) Regular multi-disciplinary review and revision as necessary of those care plans at least annually.

f) Care co-ordination which is proactive and part of an multi-disciplinary approach.

g) Provision of learning disability specialist treatment and care which meets the needs of those using the service, including nursing, social work, psychology, positive behaviour support, occupational therapy, speech and language therapy and psychiatry.

h) Support to individuals to ensure that they access employment or meaningful activity, have secure income and accommodation and positive social networks.

i) Preventing and responding to crises, including maintaining a register of people at risk of hospital admission.

j) Support to service users to access mainstream health and care services, including for their physical health.

k) Liaison and support to families and carers as part of a person centred care planning process.

7. Recommendations to the Council and CCG in relation to specific statutory duties

7.1 The CLDT will deliver services to ensure that the council and CCG are compliant with their statutory duties under all relevant legislation. These are:

a) Acceptance or discharge of a S117 duty

b) Application for a Deprivation of Liberty order

In both these cases, it is expected that the CLDT will make full clinical recommendations to the CCG and council to enable these bodies to make the necessary approvals and decisions in relation to these duties. The CLDT is expected to take full responsibility for organising assessments and reports and preparing documentation in relation to these duties as necessary.

Continuing Healthcare (CHC)

7.2 The CLDT will undertake CHC assessments and reviews in full accordance with national guidance and make recommendations to the CCG as regards eligibility or otherwise for individuals who have met the threshold. The CLDT will present the outcome of assessments and reviews to Haringey's Eligibility Panel in accordance with the agreed terms of reference.

8. Budget

8.1 The CLDT will manage a pooled budget, allocated by the Lead Commissioner. The aim of the pooled budget is to enable the CLDT to

offer an integrated approach which ensures joined up delivery of health and social care and better outcomes for service users. It is expected that each of the salary and care purchasing elements of the budget will be considered as a pool to enable an integrated workforce to be developed and care and support planning which meets needs rather than follows separate health or social care requirements.

8.2 The CLDT will ensure that the pooled budget is managed effectively and will report monthly to the Lead Commissioner for Learning Disabilities on the budget, including identifying any risk of over or under spends arising.

8.3 The CLDT will report to the Lead Commissioner in the format required which meets the requirements of both the Council and the CCG.

9. Monitoring and delivery

9.1 The Lead Commissioner for Learning Disabilities will meet at least monthly with the CLDT to monitor delivery against the requirements of this specification and to ensure the targets and outcomes are on track for achievement.

9.2 The CLDT will develop a Delivery Plan to share with the Lead Commissioner which shows how it will meet the service requirements set out here, including how the workforce will be shaped to reflect the requirements for an integrated approach set out in this specification.

9.3 During this meeting, the Lead Commissioner will review progress on managing within the budget, savings targets, projected activity and performance levels and person centred outcomes. Any variance will be reported in a timely manner at these monthly monitoring meetings to enable mitigating action to be taken.

10. Quality assurance

10.1 The CLDT will be accepted to deliver high quality services in accordance with all relevant standards of care. The CLDT will have an internal quality assurance framework which complies with relevant guidance and includes as a minimum clinical governance structures, clinical audit, policies for serious untoward incidents, safeguarding and complaints, monitoring of service user and workforce experience and satisfaction, risk management and workforce development.

11. Liaison and interface with other services

11.1 The CLDT is expected to act as a source of expertise in relation to people with learning disabilities. It will act as a point of advice and support to other agencies in making reasonable adjustments to their services including primary care services, acute and mental health

inpatient provision, mental health and general community services and council services.

12. Supporting CCG and council returns

12.1 The council and CCG are expected to make returns to NHS England, the Department of Health and Department of Communities and Local Government. These include the monthly submission to NHSE about progress in relation to the discharge of inpatients and the annual Learning Disabilities and Autism Self Assessments. The CLDT is expected to provide accurate and full information that is held by the service in a timely way in accordance with the requirements of the returns and to offer support and advice to commissioners as necessary. The CLDT may be requested to join meetings with these government departments as required.

13. Purchase of packages of care

13.1 The CLDT will be responsible for approving spend on packages of care within the allocated budget to meet health and social care needs identified through the assessment and care planning process. To give assurance of quality and cost effectiveness of these packages, the CLDT will work directly with Haringey's Brokerage Team, with appropriate senior management oversight. The Brokerage Team will:

a) Identify potential providers/cost benchmarking

b) Set up packages of care as appropriate to meet user need and in line with the principles and outcomes set out in this specification.

c) Quality check providers' proposed care plans – to include, compliance with person centred principles and positive behaviour support approaches, least restrictive options, appropriate risk management, goals which maximise independence, clear interventions to address needs, clear outcomes for the service user in relation to these needs and clear timescales for progress and review.

d) Have in place clear processes for raising quality concerns found as a result of the review or in between reviews and issues associated with safeguarding, incidents and CQC inspections.

13.2 In addition, the CLDT will carry out:

a) Robust review processes including a forward plan of annual reviews, an internal assurance process for ensuring the quality of the review and that the review has robustly considered how

independence can be maximised and least restrictive options for the service user.

b) Robust financial monitoring and reporting on year to date and forecast spend.

c) Systems for identifying risks of overspend and developing clear recovery plans to bring the budget in line with allocation.

14. National legislation, Guidance and Good Practice

14.1 It will remain the responsibility of the service provider to be aware of current and changing legislation governing and informing the delivery of services, and will remain the responsibility of the service provider to ensure that it complies with all and any changes to national legislation and published guidance on good practice

PART 2

SCHEDULE 2

ADULT MENTAL HEALTH SERVICES

Part 2, Schedule 2
Section A: Summary

Name of Service	Adult Mental Health Services
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	CCG Lead Commissioning with an Aligned Budget
Delegated Function	**Local Authority Function** – The commissioning of adult mental health services on behalf of the London Borough of Haringey
The Services	Haringey CCG will commission on behalf of itself and Haringey CCG a range of services and pathways which enable the implementation of priorities 1, 3 and 4 of the Haringey Mental Health and Well Being Framework (the framework).* Haringey CCG will manage a pooled budget to support this. The lead commissioner's specification is included in the **addendum** attached to this schedule. **These are the priorities relating to adults, there is a separate schedule under this section 75 agreement for CAMHS which sits under another schedule of this agreement.*
Aim of Service(s)	The overall aim is that all residents in Haringey are able to fulfil their mental health and wellbeing potential which includes ensuring the following: • **A prevention and early help offer** based on working with communities to build emotional resilience, to tackle root causes of mental illness such as unemployment, low levels of education and reduce social isolation, stigma and discrimination; • **Effective, evidence based primary care mental health** services - models focusing on multidisciplinary teams based in communities and arranged as 'hubs'. • **Secondary and specialist services** that are commissioned based on the outcomes, with co-ordinated single point of entry with information

	about services, waiting times and support to access services readily available to service users, carers and professionals. • A **whole system approach** to integration and enablement
Outcome of Service(s)	• **Improved resilience and self-confidence** ○ Access to appropriate settled accommodation ○ Engaged in paid and sustained employment and/or other meaningful activity ○ More people with mental health problems will have good physical health • **More people will have good mental health** ○ Strong social networks and reduced isolation ○ Fewer people will suffer avoidable harm and die by suicide ○ Fewer people will experience stigma and discrimination • **Increased activity in low intensity, lower cost resources** ○ There is a choice of readily accessible resources available that meets a range of needs and preferences ○ Pathways to (including access standards) and availability of resources understood by all stakeholders ○ Reduced activity in intensive, high cost resources
Statutory Guidance / Strategy / Framework Documents (if applicable)	The Care Act, 2014 The Mental Health Act, 1983 The Mental Capacity Act, 2005 Haringey Joint Mental Health and Wellbeing Framework
Eligibility and Assessment Procedures	Various dependent on specific service.
Key Performance Indicators	For each of the services commissioned we will develop an agreed set of local KPIs in addition to any existing national indicators.
Resources for managing the partnership	
	Mental Health Enablement Lead – Jointly funded post Council contribution: £39k CCG contribution: £39k Other than this, no staff are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments.

	Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.
Budgets	

Service line	**LBH contribution (£000s)**	**CCG contribution (£000s)**	**Total (£000s)**	**Pooled or aligned**
BEH MHT contract and staffing	1,401	29,952	31,353	Aligned
NHS contracts	0	4,671	4,671	Aligned
Other Contracts	228	339	567	Aligned
Council Directly Provided Services	1,013	0	1,013	Aligned
Care Packages	11,627	5,788	17,415	Aligned
Total	**14,269**	**40,750**	**55,019**	**Aligned**

Part 2, Schedule 2

Section B: Lead Commissioning Specification

1. Introduction

1.1. This specification sets out the roles and responsibilities of the Haringey Clinical Commissioning Group (the CCG) as lead commissioner ('the lead') for mental health under the section 75 agreement between the London Borough of Haringey (the council) and the CCG.

1.2. Full transfer of lead commissioning responsibilities should take place by April 2017 but the partners will work together to reach this point in a phased way.

1.3. The specification reflects current local and national guidance. The specification is subject to review in light of amendments to this guidance.

1.4. The specification reflects current commissioning developments and is also subject to annual review.

2. Understanding and responding to the need and demand in the local health and care economy.

2.1. The lead will work with public health, performance and business intelligence, children's services and the service itself to ensure that needs assessments are undertaken as necessary to understand projected demand and relevant demographic profile of the client cohort, including through transitions.

2.2. Given levels of co-morbidity and known challenges, it is particularly important that needs of people with mental health in mainstream health services are captured at the primary care and acute level. This should be included in any analysis as needed to inform commissioning of services.

2.3. The Haringey Mental Health and Wellbeing Framework is the local strategic framework for mental health and sets out the different strands of activity which are required to be co-ordinated by the lead. The framework requires commissioners to have a clear understanding of the numbers and needs within this group to inform the development of services that support prevention, enablement, discharge and ongoing support. Commissioners are also required to fully understand the needs of people at risk of admission to inform commissioning of preventative services. The lead will ensure that there are robust systems in place to support this

3. Lead on the development of the strategic commissioning intentions of the Council and the CCG, reflecting these in all service specifications.

3.1. Strategic commissioning intentions are informed by the principles and guidance set out in national programmes and strategies and in the local framework described above, in the NCL Sustainability and Transformation Plan, the Haringey and Islington Well Being Partnership and a range of local strategies including the Health and Well Being Strategy, the council's corporate plan and the CCG's annual commissioning intentions

3.2. The lead will represent the Council and the CCG in respect of mental health and this will include being the representative at regional, sub-regional and local strategic meetings. The lead will work with NCL partners to agree the optimal geographical footprint for the range of service developments needed to deliver strategic commissioning intentions.

3.3. Many of the above mentioned developments are at a very early stage. As they become more concrete, the lead will develop Haringey structures for ensuring that relevant stakeholders meaningfully co-produce or are involved in the development of a local vision and objectives that support all service developments regardless of agreed geographical footprint.

4. Ensure the sufficiency and quality of market provisions to meet need.

4.1. The market for mental health provisions falls into distinct categories which are in different stages of development and which are set out in the Mental Health and Wellbeing Framework and the Haringey Enablement Programme. The lead will be required to ensure and develop a high quality, financially sustainable and responsive market to meet identified needs across a range of areas including:

- Crisis response
- In-patient provision
- Primary care
- Supported housing, supported living and residential care
- Meaningful occupation
- Community Mental Health Teams

4.2 The lead will be expected to build on existing developments to deliver the required market. In doing so, the lead will be informed by the principles of the Mental Health and Wellbeing Framework, including that services should be person centred, based on enablement models and sufficiently flexible to be purchased with personal and/or personal health budgets.

5. Contribute to the transformation and re-design of services in line with the agreed strategic commissioning intentions. The work under this heading falls into four broad categories:

- New service developments which support the delivery of the Mental Health and Wellbeing Framework
- Re-design of the services delivered currently by the BEH MHT
- Responsibilities in relation to individual inpatients and patients at risk of admission
- Delivery of the council's transformation programme

6 As pooled fund manager, manage the pooled budget (if agreed) to support and enable the strategic commissioning intentions.

6.1 The principles of management of the pooled budget are set out in the section 75 agreement, in sections 10 and 11. Of specific note for mental health budgets is as follows:

6.1 The specification may include delegation of pooled budgets for packages to the service. This approach is untested and presents new financial risk to partners. Delegation should only be agreed subject to assurance of the budgetary controls described in the outline specification. The lead is expected to implement this element of the specification in shadow form over at least a six month period and put in place measures to mitigate risks.

7 Deliver savings as set out in the Council's MTFS and the CCG's QUIPP Plans

7.1 As set out in sections 10 and 11 of the section 75 agreement, each year a Joint Investment and Savings plan will agreed between the council and the CCG and the lead will be expected to implement this for mental health.

8 Lead on reporting to and liaising with the relevant local bodies

8.1 The section 75 agreement sets out detailed performance management and reporting requirements for the lead commissioner including through a newly established Joint Commissioning and Finance Management Group, the Joint Executive Team and the Joint Haringey Finance and Performance Partnership Board.

8.2 The lead commissioner will operate within these reporting mechanisms to ensure strong oversight of both finance and outcomes.

9 Lead on reporting to and liaising with national bodies e.g. NHSE or CQC

9.1 It should be noted that existing reporting and liaison requirements will remain in place.

9.2 NHSE may additionally require updates as part of their routine quarterly assurance meetings with the CCG, completion of ad hoc templates and self-assessment frameworks which the lead will be expected to co-ordinate.

PART 2

SCHEDULE 3

LONG TERM CONDITIONS AND OLDER PEOPLE'S SERVICES, INCLUDING BETTER CARE FUND

Part 2, Schedule 3

Section A: Summary

Name of Service	
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	CCG Lead Commissioning with an aligned budget
Delegated Function	Haringey Council delegates commissioning responsibility for the Better Care Fund to Haringey CCG.
The Service	Long Term Conditions and Older People's services, including The Better Care Fund
Aim of Service(s)	The Haringey Better Care Fund (BCF) is developing a health & social care system in which all adults are supported to live healthy, long and fulfilling lives. Haringey Clinical Commissioning Group (CCG) and the London Borough of Haringey (LBH) want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible. This will be achieved by a reorientation of health and social care provision from reactive and fragmented care (mainly provided in acute and institutional settings) to proactive and integrated care (mainly provided in people's homes and by primary, community and social care). The Haringey BCF will not define people by their disabilities, but by their abilities, their potential and what they can do for themselves, with and without support. A lead commissioner's specification is in development and will be completed by April 2017.
Outcome of Service(s)	The BCF is measured against six outcome measures: • Reduction in Non-Elective Admissions (NELs)

	• Reduction in the number of delayed transfers of care (DTOC, delayed days) • Reduction in the number of non-elective admissions for falls related injuries • Reduction in rate of permanent admissions (65+) into residential and nursing care • Increase in proportion of patients discharged into reablement/ rehabilitation services still at home 91 days following discharge • Increase in the proportion of patients who felt that they have received enough support to manage their long term health conditions
Strategy/Framework Documents (if applicable)	• Haringey Better Care Fund (BCF) Narrative Plan 2016-17 • Haringey BCF 2014-16 (http://www.haringeyccg.nhs.uk/about-us/better-care-fund.htm)
Eligibility and Assessment Procedures	• These are in development and will be agreed by April 17
Key Performance Indicators	• 2.6% reduction in Non-Elective Admissions (NELs) • 8% reduction in the number of delayed transfers of care (DTOC, delayed days) • 3.9% reduction in the number of non-elective admissions for falls related injuries • 7% reduction in rate of permanent admissions (65+) into residential and nursing care • 1.8% increase in proportion of patients discharged into reablement/ rehabilitation services still at home 91 days following discharge • 2.2% increase in the proportion of patients who felt that they have received enough support to manage their long term health conditions
Resources for managing the partnership	
	A joint commissioning post (Commissioning Lead – Better Care Fund) will oversee the programme management of the Better Care Fund and be the lead commissioner. This post is line managed and employed by Haringey CCG and reporting to Haringey CCG and Haringey Council. A Commissioning Project Officer – Better Care Fund will report to the Commissioning Lead – Better Care Fund. A joint commissioning Data Analyst Post shall be managed and employed by Haringey Council. The Better Care Fund shall meet the agreed salary costs of all three Joint Posts; the budget for which is as indicated in Scheme 4 (BCF Programme).

Pooled budgets				
Service line	**LBH contribution**	**CCG contribution**	**TOTAL**	**Pooled or aligned**
Social Care Team (LBH)		£252,000	£252,000	Aligned
Whittington ICTT/ Nursing		£6,771,095	£6,771,095	Aligned
Locality Team		£1,041,253	£1,041,253	Aligned
MDT		£89,000	£89,000	Aligned
Overnight District Nursing Service		£150,000	£150,000	Aligned
Dementia Day Opportunities		£475,000	£475,000	Aligned
Whittington falls service		£58,000	£58,000	Aligned
Palliative Care		£300,000	£300,000	Aligned
Rapid Response		£250,000	£250,000	Aligned
Reablement		£3,042,905	£3,042,905	Aligned
Step down		£625,000	£625,000	Aligned
Home from Hospital		£150,000	£150,000	Aligned
MH Navigator		£40,000	£40,000	Aligned
7 Day Social Worker		£146,067	£146,067	Aligned
Cavell Ward		£1,254,233	£1,254,233	Aligned
Neighbourhoods Connect		£160,000	£160,000	Aligned
Information, Advice and Guidance (IAG)		£55,000	£55,000	Aligned
Self-Management Support		£116,600	£116,600	Aligned
Interoperable IT		£22,095	£22,095	Aligned
BCF Programme		£175,000	£175,000	Aligned
Principal Social Worker		£60,000	£60,000	Aligned
VBC IPU Support		£69,496	£69,496	Aligned
Disabled facilities grant	£1,818,000		£1,818,000	Aligned
Carers		£1,067,000	£1,067,000	Aligned
Contingency		£1,332,740	£1,332,740	Aligned
TOTAL BCF	**£1,818,000**	**£17,702,484**	**£19,520,484**	Aligned
Stroke Services	£44,062	£84,955	£129,017	Aligned
Handyperson Service	£22,166	£38,000	£60,166	Aligned
Total Total	**£1,884,228**	**£17,825,439**	**£19,709,667**	Aligned

PART 2

SCHEDULE 4

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

SUMMARY

Name of Service	**Child and Adolescent Mental Health Services**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	Joint Commissioning with Aligned Budget; CCG Lead Commissioner
Delegated Function	**Local Authority Function** – The commissioning of Child and Adolescent Mental Health Services on behalf of the London Borough of Haringey
The Services	Haringey CCG will commission on behalf of itself and Haringey Council a range of services and pathways which enable the implementation of priority 2* of the Haringey Mental Health and Well Being Framework (the framework). Haringey CCG will manage a pooled budget to support this. **This is the priority relating to CAMHS, there is a separate schedule under this section 75 agreement for adult mental health which sits under Priorities 1, 3 and 4 of the framework.*
Aim of Service(s)	• To provide appropriate mental health support for children and young people, delivering the right service at the right time • To meet and deliver the outcomes outlined in Haringey's CAMHS Transformation Plan
Outcome of Service(s)	The CAMHS Transformation Plan identifies the following outcomes: 1. Integrated and comprehensive commissioning under an agreed local framework for all provision, delivering transparency, accountability and value 2. An early intervention approach that provides access to non-stigmatised triage and signposting with a focus on community support which avoids over-medicalising children and young people and that builds a system of support in natural contexts such as school and home.

	3. A coordinated preventative approach for children and young people, parents/carers and families through systems around the child working well together to support emotional wellbeing across the children's workforce. 4. Improved access to the right service at the right time with better support for vulnerable children and young people to access appropriate support 5. Flexible services that meet the preferences and developmental needs of children and young people 6. Child and Adolescent Mental Health Services with the tools to provide an efficient and up-to-date response to the population with a well-trained and competent workforce for delivery 7. Better inter-agency working and improved communication with referrers and better discharge planning 8. More focused work that reduces dependency and promotes resilience and enablement 9. Improved crisis planning and pathways that provide timely support and robust follow up 10. Clear protocols for cross-boundary issues and working between child and adult services 11. Better engagement with under-represented communities/groups
Strategy/Framework Documents (if applicable)	• Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing (DH) • Haringey CAMHS Transformation Plan
Eligibility and Assessment Procedures	Various dependent on specific service
Key Performance Indicators	• For each of the services commissioned we will develop an agreed set of local KPIs in addition to any existing national indicators.
Resources for managing the partnership	
	Children and Young People's Vulnerable Children's Joint Commissioning Manager Other than this, no staff are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments.

	Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.

Pooled budgets

Service line	LBH contribution	CCG contribution	TOTAL	Pooled Or Aligned	
Barnet, Enfield and Haringey Mental Health Trust (Specialist CAMHS- Generic, AOT)	£0	£2,436,203*	£2,436,203*	Aligned	
Tavistock and Portman Specialist Child & Adolescent Services	£0	£412,930*	£412,930*	Aligned	A
Extra-Contractual Referrals/Non-Contracted Activity	£0	£31,166	£31,166	Aligned	
Primary Care CAMHS/CAMHS in GP Surgeries	£0	T	T	Aligned	
Royal Free (Eating Disorders & Generic)	£0	£256,280 ED £25,000 Gen***	£281,580 ED ***	Aligned	
SLAM (CIPP)	£0	£25,000***	£25,000***	Aligned	
Whittington Paediatric Mental Health Liaison Team	£0	**	**	Aligned	
North Mid University Hospital Child and Adolescent Paediatric Liaison Team	£0	**	**	Aligned	
CAMHS Transformation Projects- Various Providers	£0	£991,718	£991,718	Aligned	
Commissioning Budgets					
Tavistock and Portman First Step (LAC)	£362,921	T	£362,921 T	Aligned	
Barnet, Enfield & Haringey Mental Health Trust (CAMHS LD, Youth Offending)	£172,000	T	£172,000 T	Aligned	
Multi-Systemic Therapy	£114,000	£0	£114,000	Aligned	
Open Door	£46,500	£123,991 + T	£170,941 T	Aligned	
CYPS Budgets					
Barnet, Enfield and Haringey Mental Health Trust (Edge of Care)	£38,800	£0	£38,800	Aligned	
Public Health Budgets					
Young Minds	£21,200	£0	£21,200	Aligned	
Whittington PIPs	£69,000	£235,000*	£304,000*	Aligned	
Total	**£824,421**	**£4,537,288**	**£5,361,709**		

*: Reference costs/estimations only as part of block contracts.

**: Within Acute Tariff

***: Cost/Volume (Estimated)

T: CAMHS Transformation Funding 16/17 allocation - £991,718 included in line' **CAMHS Transformation Projects- Various Providers'**

PART 2

SCHEDULE 5

INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCREASE SAFETY SERVICES

INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCREASE SAFETY SERVICES

SCHEDULE OF AGREED SERVICES 2016-17	
Name of Service	**Independent Domestic Violence Advocacy (IDVA) and the Identification and Referral to Increase Services (IRIS)**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	Council Lead Commissioning with an Aligned Budget
Delegated Function	**Health Function** – The commissioning of the IRIS on behalf of Haringey Clinical Commissioning Group
The Services	Haringey Council will commission on behalf of itself and Haringey CCG a joint IDVA and IRIS function. Haringey Council will manage a pooled budget to fund the commissioning of the staffing and interventions in this service and additional placements and packages required to meet the needs of users of the service. A summary of the service is set out below.
Aim of Service(s)	The aim of the service is to support people affected by domestic violence by commissioning services that seek to build resilience, promote independence and support a balanced risk approach.
Outcome of Service(s)	Outcomes are set out in full in the specification and include: A. Improved access to justice and experience of the criminal justice system for all victims/survivors/clients of DV/A who report to the police – including reducing case attrition and providing support at the Specialist DV Court B. Victims/survivors/clients are satisfied with the service C. Victims/survivors/clients experience a reduction in risk and have increased feelings of safety D. Reduced harm to victim/survivor/client (and their children) E. Incidents of repeat victimisation identified and responded to

<table>
<tr><td></td><td>F. Male victims appropriately screened/identified and able to access as required specialist national and Pan London services
G. Victims/survivors/clients/service user supported to increase their (and their children's) safety and control over their lives, by working with them to develop appropriate safety plans and providing practical safety measures
H. Improved emotional, mental and physical health of victims/survivors/clients and support to access resources to maintain their health and wellbeing
I. Victims/survivors/clients/service user supported to regain autonomy and control of their lives</td></tr>
<tr><td>Strategy/Framework Documents (if applicable)</td><td>• VAWG Strategy (in development)
• Communities Strategy
• National Strategy</td></tr>
<tr><td>Eligibility and Assessment Procedures</td><td>As set out in the specification, contained within the contract.</td></tr>
<tr><td>Key Performance Indicators</td><td>For the IDVA/IRIS service there is an established set of local KPIs and national indicators set out in the contract.</td></tr>
<tr><td colspan="2">Resources for managing the partnership</td></tr>
<tr><td></td><td>No staff or other resources are transferred or seconded between the partners as a result of this agreement.

The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments.

Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.</td></tr>
<tr><td>Pooled Budgets</td><td>Financial year: 2016/17
<table>
<tr><th>Service line</th><th>LBH contribution (£000s)</th><th>CCG contribution (£000s)</th><th>Total (£000s)</th><th>Pooled or aligned</th></tr>
<tr><td>IDVA</td><td>147</td><td>0</td><td>147</td><td>Aligned</td></tr>
<tr><td>IRIS</td><td>0</td><td>47</td><td>47</td><td>Aligned</td></tr>
<tr><td>Total</td><td>147</td><td>47</td><td>194</td><td>Aligned</td></tr>
</table></td></tr>
</table>

Addendum

IDVA and IRIS specification
Summary: Aims and Objectives
(As set out in the contract and specification)

A key element of delivering the revised Domestic Violence Pathway for Haringey, as endorsed by the Haringey Violence Against Women and Girls Strategy Group, is to ensure sufficient and focused capacity for independent domestic violence advocacy across the borough. The key aim of this Partnership Agreement is to support delivery of enhanced and joined up capacity across the borough to respond to the needs of women affected by domestic violence through the joint commissioning of Identification and Referral to Improve Safety (IRIS) and IDVA provision in Haringey. This Agreement enables the Council to act as lead commissioner of a joined up IRIS and IDVA service to strengthen the response to women affected by domestic violence and support a joint approach across the borough. A single commission which ensures that future provision across the IDVA and IRIS service is delivered jointly will ensure a more joined up experience for women using the service. This will in turn increase effectiveness and efficiency, reduce duplication and decrease the amount of fragmentation in the system.

An Independent Domestic Violence Advisor (IDVA) is a specialist domestic violence professional who supports victims at the highest risk of murder or serious injury. Their job is to make the victim and their family as safe as possible. They stand alongside victims and make sure they get whatever help they need.

Experts in high risk domestic violence, IDVAs provide vital emotional and practical support to victims. They deal with everything from getting an injunction to sorting out money to having the locks changed. Their job is to make sure the victim is safe – and they do whatever it takes.

The main purpose of Independent Domestic Violence Advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. They are pro-active in implementing the plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and

remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short- to medium-term to put them on the path to long-term safety. They receive specialist accredited training and hold a nationally recognised qualification.

Since they work with the highest risk cases, IDVAs are most effective as part of an IDVAs service and within a multi-agency framework. The IDVA's role in all multi-agency settings is to keep the client's perspective and safety at the centre of proceedings. Studies have shown that when high risk clients engage with an IDVA, there are clear and measurable improvements in safety, including a reduction in the escalation and severity of abuse and a reduction or even cessation in repeat incidents of abuse.

The IRIS project provides resources in general practice so that staff at all levels can be trained in identifying those who are at risk of or may be experiencing domestic violence. The project is successful as an Advocate Educator (AE) will be recruited to provide training to practice staff and will be integrated into the wider IDVA services.

The AE will raise awareness of VAWG issues, provide training so the practice staff can effectively use the HARKS software, and will support victims of domestic violence by referring them into the IDVA service as appropriate. The AE will be integrated into the provider organisation, ensuring continuity of service, while at the same time having a distinct role within the pathway.

The specification for this single, unified service is contained in the contract for the service which reflects the aims and objectives set out above.

Part 2, Schedule 5

Section 2: The NHS and the Council's Functions and Responsibilities for services for Violence Against Women and Girls

Introduction

1. This schedule sets out the Functions of both the CCG and the Council relevant to the provision of the Services. It also sets out the scope of delegation of functions to the Designated Body required to enable it to ensure the provision of the Services.

The Council's Functions:

2. The Council's Functions relevant to the provision of the Services are:

To agree to the arrangements so that the provision of a joint IRIS and IDVA service for women affected by domestic violence is embedded as an essential component of the revised domestic violence pathway approved by the Haringey Violence Against Women and Girls Strategy Group.

To act as the Designated Body and commissioning Lead.

To discuss and agree the service requirements annually with the nominated CCG Officer/s.

To embed the service requirements into the main contracts with the designated and appropriate providers.

To ensure delivery of the service requirements and standards as part of the regular contract performance meetings; raising any issues or concerns about the Service from the CCG with the provider/s and feeding back issues from the providers to the nominated CCG Officer/s. The Council should invite the CCG officers to contract performance meetings if appropriate or necessary.

To forward agreed monitoring data in the agreed format from the provider to the nominated CCG Officer/s.

To make payments for the Service to the provider at the level agreed with the CCG as part of the regular contract payments.

To invoice the CCG at the agreed rates and for the appropriate volume of activity undertaken by the provider on a quarterly basis.

The CCG's Functions:

4. The CCG's Functions relevant to the provision of the Services are:

To set out the service requirements and service and staff standards and requirements annually for discussion and agreement with the Council.

To ensure identified GPs work effectively with the commissioned IRIS IDVA service, providing the Advisors with the requests and relevant information for the activity.

To liaise directly with the advisors and advocate educators on operational and quality matters for specific cases and panels, raising any general concerns with the Council to be addressed via contract performance meetings.

To scrutinise monitoring return from the providers and confirm to the Council that they reflect and meet the requests made directly to the providers by the CCG.

To provide and/or authorise appropriate training for the providers.

To pay the invoices received from the Council.

Scope of Delegation to the Designated Body

5. The following functions are delegated to the Designated Body by the CCG**:**

To commission the providers best placed to deliver the service
To embed the service requirements into the main contracts
To performance manage the providers
To pay the providers
To provide appropriate service and financial reporting to the Council
To invoice quarterly at the agreed rates for the Council's contribution

Report for: Cabinet Member Signing – 31 March 2022

Title: Section 75 NHS Act 2006 Health and Social Care Haringey Learning Disability Partnership Agreement

Report authorised by: Charlotte Pomery, Assistant Director Commissioning

Lead Officer: Charlotte Pomery, Assistant Director Commissioning

Ward(s) affected: All

Report for Key/ Non Key Decision: Key Decision

1. Describe the issue under consideration

1.1 Haringey Council (the Council), Barnet, Enfield and Haringey Mental Health Trust (the Mental Health Trust), Whittington Health NHS Trust (the Trust) and North Central London Clinical Commissioning Group (the CCG) work together in partnership to deliver the Haringey Learning Disabilities Partnership (the Partnership). This Partnership operates as an integrated service hosted by the Council. The Partnership is supported by a health and social care partnership agreement under S.75 of the National Health Services Act 2006. The agreement has since lapsed and approval is sought an updated agreement.

1.2 The overall aim of the integrated service arrangements is to ensure that services for people with learning disabilities are planned, commissioned and provided in an integrated manner. The Agreement, presented here for approval, supports this aim by enabling an integrated service offer, underpinned by pooled funds and a lead commissioning arrangement described in Haringey's s. 75 commissioning partnership agreement.

2. Cabinet Member Introduction

2.1 N/A

3. Recommendations

3.1 The Cabinet Member is asked:

3.1.1 To approve the draft Section 75 NHS Act 2006 Partnership Agreement (Haringey Learning Disability Partnership Agreement) attached at Appendix 1 between the Council, the Mental Health Trust, the Trust and the CCG which provides integrated service arrangements for adults with learning disabilities hosted by the Council.

3.1.2 To delegate to the Director of Adults and Health, after consultation with the Lead Member for Health, Social Care and Well-Being, the authority to finalise and agree any further details within the Section 75 Partnership Agreement between the parties.

4. Reasons for decision

4.1 The s. 75 Partnership Agreement has supported greater levels of integration between the NHS and the Council by enabling an integrated service for adults with learning disabilities in Haringey within the framework set out in the National Health Services Act 2006. However,

the Agreement has now expired and its approval is urgently required to ensure the integrated service can continue to develop and to facilitate partner contributions to the pooled fund which underpin its operations.

4.2 The integrated service ensures that adults with learning disabilities are able to access integrated health, care and support services which meet their needs in a joined up and holistic way. The integrated service helps to support parity of esteem between mental and physical health and supports the most efficient use of resources across partners.

4.3 Partners have taken the opportunity to refresh the s. 75 Partnership Agreement to ensure that it aligns with the work being developed to create an Integrated Care System and a local Place-based Partnership in line with the Health and Care Bill, currently making its way through Parliament. The proposed five year period for the Agreement will support a sustainable approach to integration which is in line with the wider policy and legislative landscape for health and care delivery over the coming years.

5. Alternative options considered

5.1 Consideration was given by officers to redesigning the service to separate out the elements which together create the integrated service. This approach, however, would by its very nature undo the joint arrangements which enable a holistic offer to adults with learning disabilities in Haringey and was therefore disregarded.

6. Background information

6.1 The s. 75 Partnership Agreement has served a very necessary purpose in providing the framework for enabling the Council and the NHS to work together in a more joined up way to meet the needs of adults with learning disabilities. This approach is in line with the current policy landscape for health, care and integration, which itself is currently undergoing significant change. As set out in the NHS Long Term Plan, the ambitions for more joined up approaches from a resident and service redesign perspective are reflected in the integrated service described here.

6.3 The host for the Partnership is the Council as the lead for learning disabilities set out in central government policy since Valuing People (‘A New Strategy for Learning Disability for the 21st Century’**)** was first published as a government White Paper in March 2001, by the then Department of Health. Through the Partnership Agreement, partners agree to ensure that:

6.3.1 the integrated provision is based on an agreed picture of needs rather than historical service configurations

6.3.2 the integrated service presents good value for money and best value

6.3.3 the integrated service seeks to promote emotional and physical good health and works to overcome social exclusion

6.3.4 the service is culturally competent in meeting the needs of people from black and minority ethnic communities

6.3.5 a whole systems approach is taken to commissioning and provision by preventing duplication and making more effective use of the current resources (e.g., integrated care pathways)

6.3.6 robust arrangements to collect performance management information are established and maintained and that information is used to evaluate performance against targets, monitoring both the effectiveness of the commissioning and the delivery process and the integrated service.

6.4 The Partnership Agreement identifies the core functions which the Partnership will deliver as Social Care, NHS Community Health Care (nursing, speech and language therapy, physiotherapy, occupational therapy and psychology), Continuing Health Care Nurse Assessment and Consultant Psychiatry. Managed together and delivered as a partnership these functions meet the wider needs of adults with learning disabilities in Haringey.

6.5 The Partnership Agreement also covers all components necessary for the effective delivery of an integrated service including approaches to staffing, a pooled fund, other resources including accommodation, information governance, performance and resolution of disputes. By adopting the outcomes set out above as its framework, the Partnership Agreement ensures these components are set within a person-centred and holistic approach.

6.6. The Partnership Agreement is supported by a Pooled Budget which in its first year will follow the pattern of contributions set out below and which is anticipated to follow in subsequent years.

S75 Scheme Plan 2021/22 - HLDP

Haringey Summary

Scheme name	Comissioner	Budget 20/21	Contribution CCG	Contribution LA	Budget 21/22	Contribution CCG*	Contribution LA	Budget Uplift CCG	Budget Uplift LA
Pooled Budgets									
BEHMHT - LD Psychiatry	CCG	264,760	264,760	0	264,760	264,760	0		
HLDP services - Staffing - LB Haringey	Joint	2,196,282		995,835	2,696,504		1,462,084		466,249
HLDP services - Staffing - Whittington			780,000			803,400		23,400	
HLDP services - Staffing - BEH			420,447			431,021		10,574	
Pooled Staffing Total		**2,461,042**	**1,465,207**	**995,835**	**2,961,264**	**1,499,181**	**1,462,084**	**33,974**	**466,249**
Haringey Council - Day Opportunities	LA	1,596,420	0	1,596,420	1,596,420	0	1,596,420		
Haringey Council - Linden Residential home	LA	2,100	0	2,100	2,100	0	2,100		
Winkfield Centre	LA	0	0	0	202,498		202,498		202,498
Chad Gordon Autism / Waltheof Day Centre	LA	0	0	0	175,195		175,195		175,195
Pooled Day Centre Total		**1,598,520**	**0**	**1,598,520**	**1,976,213**	**0**	**1,976,213**	**0**	**377,693**
Pooled Total		**4,059,562**	**1,465,207**	**2,594,355**	**4,937,477**	**1,499,181**	**3,438,297**	**33,974**	**843,942**

6.7 The Partnership Agreement reflects a risk share arrangement which allows for local arrangements if there is an anticipated over or under spend of less than 5%. Where there is an under-spend greater than 5% at the end of the Year, then the Commissioning Partners can carry that amount into the next Year, or it will be apportioned to the Commissioning Partners based on their contributions for that Year and returned. If there's a forecast over-spend greater than 5%, this will be accounted for in the Commissioning Partners' accounts in proportion to their contributions to the Pooled Fund that year; additional contributions will be given in the following Financial year to make good the over-spend. If the Partners agree they cannot provide that additional funding, the Finance Group will agree alternative budget reductions to cover the value of the over spend.

6.8 The Partnership Agreement is for a period of up to 5 years from the commencement date and there is the option to extend for a further period.

7. Contribution to strategic outcomes

7.1 These proposals support Haringey's Borough Plan 2019 – 2023 to improve health and wellbeing outcomes for local residents and are also in line with current national policy and legislation furthering integration between the NHS and local government.

8. Statutory Officer comments (Director of Finance (including procurement), Head of Legal and Governance, Equalities)

8.1 Finance

8.1.1 This report is seeking the approval of Cabinet to deliver the Haringey Learning Disabilities Partnership under the S.75 as an integrated service hosted by the Haringey Council for the period 1st April 2021 to 31st March 2022. The total 2021/22 pooled budget is £4.937m which comprises of £1.499m and £3.438m contribution from the NHS and LBH respectively.

Pooled Budget	**2020/21 £m**	**2021/22 £m**
Gross NHS Contribution	1.465	1.499
Gross LBH Contribution	2.594	3.438
Total Pooled Budget	**4.060**	**4.937**

8.1.2 Funding will be met from a combination of NHS contribution and LBH General Fund within Adult Social Care. There is sufficient pooled budget to meet the allocated expenditure over the financial year 2021/22.

8.2 Legal

8.2.1 Section 75 of the NHS Act 2006 allows NHS bodies and local authorities to pool their resources, delegate functions, integrate service provision and transfer resources from one party to another. The section permits:
a) pooled fund arrangements for services for specific client group;
b) delegation of functions – lead commissioning: where health and local authorities delegate functions to one another and there is a lead commissioner locally and c) Delegation of functions – integrated provisions: where health and social care services are integrated and provided from a single managed lead provider. The proposed integrated service provision partnership agreement for adults with learning disabilities and with the Council acting as the host partner is within the scope of Section 75 of the Act and the associated regulations.

8.3 Procurement

8.3.1 Strategic Procurement notes the contents of this report and supports its recommendations.

8.4 Equalities

8.4.1 The Equality Act (2010) legally protects people from discrimination in the workplace and in wider society. The Act replaced previous anti-discrimination laws and introduced the term 'protected characteristics' to refer to the following nine groups that are protected under the Act:

· Age

· Disability

· Gender Reassignment

· Marriage and Civil Partnership

· Pregnancy and Maternity

· Race

· Religion or Belief

· Sex

· Sexual Orientation

8.4.2 Under this Act Haringey Council has a Public Sector Equality Duty to have due regard to the need to:

· Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act

· Advance equality of opportunity between people who share those protected characteristics and people who do not

· Foster good relations between people who share those characteristics and people who do not

Although it is not enforced in legislation as a protected characteristic, Haringey Council treats socioeconomic status as a local protected characteristic.

8.4.3 The proposed decision is to approve the S. 75 Partnership Agreement between the Council, the Mental Health Trust, the Trust and the CCG which provides integrated service arrangements for learning disabilities hosted by the Council.

8.4.4 The Partnership enables the Council and NHS to work together in a more joined up way to meet the needs of adults with learning disabilities. The partners agree to a set of commitments that will improve equality of opportunity for residents with learning disabilities (protected characteristic of disability). This includes more joined-up approaches for service design, commitment to promote health outcomes and reduce social exclusion and consideration of intersectionality through a culturally competent service that meets the needs of people from black and minority ethnic communities.

9. Use of Appendices

9.1 Appendix 1 contains the s. 75 partnership agreement.

10. Local Government (Access to Information) Act 1985

10.1 Not applicable.

APPENDIX 1:

HARINGEY LEARNING DISABILITY SERVICE PARTNERSHIP 2021-2026

DRAFT

AGREEMENT BETWEEN:

1. The Mayor and Burgesses of London Borough of Haringey;

And

2. Barnet, Enfield and Haringey Mental Health NHS Trust
3. Whittington Health NHS Trust
4. North Central London Clinical Commissioning Group

For delivery of Integrated Services for Adults with Learning Disabilities in Haringey

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THIS PARTNERSHIP AGREEMENT DATED 1 APRIL 2021 AND IS MADE BETWEEN:

(1) The Mayor and Burgesses of **The London Borough of Haringey** of Civic Centre, High Road, Wood Green, London N22 8LE ('the Council');

And

(2) Barnet, Enfield and Haringey Mental Health NHS Trust of St Ann's Hospital, St Ann's Road, London, N15 3TH ('the BEH-MHT')

(3) Whittington Health NHS Trust of Magdala Avenue, London N19 5NF ("the Whittington")

(4) North Central London Clinical Commissioning Group, Laycock PDC, Laycock Street N1 1TH

Together called "the Partners" within the Haringey Learning Disability Partnership ("HLDP").

1. WHEREAS:

1.1 On 1st March 2017, the Council entered into a Section 75 National Health Service Act 2006 Partnership Agreement for a term of 5 years with Haringey Clinical Commissioning Group which is now defunct and succeeded by North Central London Clinical Commissioning Group (the CCG). The Agreement provided for the commissioning of learning disability services and the establishment and maintenance of pooled fund for this purpose. The Council is the Lead Commissioner.

1.2 Further to the above Agreement, the Council, CCG, Barnet, Enfield and Haringey Mental Health NHS Trust (BEH-MHT) and Whittington Health NHS Trust (Whittington) hereinafter referred to as "the Partners" have agreed, pursuant to Section 75 of the National Health Service Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 to enter into an Integrated Learning Disability Services Partnership Agreement. This integrated service provision is to be referred to as the Haringey Learning Disability Partnership (HLDP) and which will be funded through a Pooled Fund.

1.3 The Partners are satisfied that the integrated services partnership arrangements are likely to lead to an improvement in the way in which their functions are exercised in relation to the provision for and meeting care and support needs and health services and the management of associated funds.

1.4 The Partners are satisfied that the partnership arrangements are likely to further the shared objectives of reducing health inequalities and improving health and wellbeing and that these arrangements contribute to fulfilment of objectives set out in the Service Specification in Schedule 1.

1.5 The Partners have consulted such persons and/or bodies as appear to them to be affected by the Partnership Arrangements and in accordance with Regulation 4(2) of the Regulations.

1.6 The partnership arrangements do not affect the liability of the Partners for the exercise of their respective functions, or any power or duty to recover charges for the provision of any services in the exercise of any Local Authority function.

1.7 The provision of the Individual Services secured by the Pooled Fund, within the powers of the Partners, shall be limited to Eligible Service Users.

1.8 The policies and guidance referred to within this document are current at time of the commencement of the agreement. Where such policies and guidance are updated or superseded, the agreement will be amended to reflect these changes. If new policy or guidance requires material changes to the Agreement, the Partners shall endeavour to vary the Agreement accordingly.

1.9 The Partners have obtained the necessary consents and approvals to enter into this Agreement and the Partners have approved the terms and conditions of this Agreement.

2. DEFINITIONS AND INTERPRETATION

2.1 Reference in this Agreement to the terms set out in this Clause shall have the following meanings:

Act	Means The National Health Service Act 2006 as amended
Arrangements	Means the arrangements described at Clause 5 of this Agreement
BEH-MHT	Means Barnet, Enfield and Haringey Mental Health NHS Trust
Best Value	Means the duty imposed on the Council by Section 3 of the Local Government Act 1999 in relation to, inter alia, any one (1) or more of the Services
Carer	Means someone of any age who, without payment, unconditionally gives help and support to a Service User or a person who would be eligible for HDLP Integrated Services if they choose to receive them
Clinical Governance	Means the Trusts' duty to improve the quality of health services and safeguarding high standards of care
Commencement Date	Means the 01 April 2021
Commissioning Partner	Means the Council and NCL CCG
Delivery Agreement (Service Level Agreement)	Means this Delivery Agreement and Schedules attached hereto

Executive Group	Means the group consisting of the Partners acting through their respective delegated officers whose terms of reference are attached to this Agreement at Schedule 2
Expenditure/ Finance Group	Means the group consisting of the Expenditure/ Finance managers as provided for in Clause 9.0 and whose Terms of Reference are attached to this Agreement at Schedule 2
Expenditure/ Finance Plan	Means the plan relating to use of the Pooled Fund drawn up in accordance with Clause 9.0
Financial Year	Means a year commencing on 01 April in one calendar year and ending on 31 March in the subsequent calendar year
Governance Arrangements	Means the arrangements for governance of the Partnership Meeting Group and other related groups, as referred to in Schedule 2
HLDP	Means Haringey Learning Disability Partnership
HLDP Integrated Service	Means the services developed and provided through funding made available through the Pooled Fund and through any other relevant funds as may become available during the duration of this Agreement (for e.g. 'external funding' secured or other centrally allocated grants or funds) for the provision of the HLDP Integrated Service, more particularly described in Schedule 1 (Service Specification)
Health Related Functions	Means such of those health related functions referred to in Regulation 6 of the Partnership Regulations
Head of Service	Means the Head of HLDP
Host Partner	Means the Council acting as Host Commissioner which in this case is the London Borough of Haringey

NHS Functions	Means the NHS functions referred to in Regulation 5 of the Partnership Regulations (subject to the exclusions referred to therein).
NCL CCG	Means **NHS North Central London Clinical Commissioning Group** the NHS body responsible for commissioning health services in Haringey, and providing care management to NHS Continuing Healthcare fully funded clients.
NHS Provider Trust/s	Means BEH-MHT National Health Service Trust and Whittington Health National Health Service Trust

Partners or Partner	Means the Council, NCL CCG, the NHS Provider Trusts (Whittington Health and the BEH-MHT) together or individually as the context requires
Partnership	Means the arrangements agreed by the Partners in this Agreement for the purpose of providing the HDLP Integrated Services pursuant to the Partnership Regulations and Section 75 of the Act
Partnership Arrangement(s)	Means the arrangements for the provision of the HDLP Integrated Services as set out in this Agreement
Partnership Meeting Group	Means the Joint Partnership Group - a multi-agency Partnership Meeting Group representing all service user groups including people with learning disabilities with the Council acting as lead and including Representatives from the Council, NCL Clinical Commissioning Group, NHS Provider Trusts (Whittington Health and BEH-MHT), People with a Learning Disability, Carers, local Voluntary Sector representatives, carers and others, as appropriate.
Partnership Regulations	Means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000/617)
Pooled Fund Manager	Means such officer responsible for managing the Pooled Fund and shall be the Head of Service
Pooled Fund	Means the Pooled Fund established pursuant to Regulation 7(1) of the Partnership Regulations
Premises	Means any building or premises owned or leased by either of the Partners and used in relation to the HLDP Integrated Service
Quarter	Means the following periods in each Financial Year: Quarter 1 - 01 April to 30 June Quarter 2 - 01 July to 30 September Quarter 3 - 01 October to 31 December Quarter 4 - 01 January to 31 March
Representative	Means the nominated representative of the Partners of sufficient seniority and of the discipline required in the particular context
Service Contractors	Means the contractors with whom the Partners contract or arrange for HLDP Integrated Services to be provided pursuant to this Agreement
Service Specification	Means the Specification which is attached at Schedule 1.

People with a Learning Disability who use HLDP services	Means adults aged 18 + who meet the HLDP Integrated Service eligibility criteria for people with a Learning Disability, who are 'ordinarily resident' in Haringey. These may also include such other people as may be agreed between the Partners, including (without limitation) people who are eligible for assessment for the HLDP Integrated Services
Strategic Commissioning	Means the strategic process of planning, developing and commissioning services based on needs of the population
Whittington Health NHS Trust	Means Whittington Health NHS hospital Trust

2.2 Reference to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

2.3 The headings of the clauses in this Agreement are for reference purposes only and shall not be construed as part of the Agreement or deemed to indicate the meaning of the relevant clauses to which they relate.

2.4 The Schedules in this Agreement are an integral part of this Agreement and references to Schedules are references to the Schedules to this Agreement and a reference to a paragraph is a reference to the paragraph in the Schedule containing such reference.

2.5 Reference to a person or body shall not be restricted to natural persons and shall include a company corporation or organisation.

2.6 The masculine includes the feminine and vice versa.

2.7 The singular includes the plural and vice versa.

3. COMMENCEMENT, DURATION AND REVIEW OF THE AGREEMENT

3.1 The Agreement shall come into force on the Commencement Date.

3.2 The Agreement shall be for a period of up to 5 years from the Commencement Date ("Contract Period") subject to earlier termination in accordance with the terms of this Agreement or at law or to extension in accordance with Clause 3.2A.

3.2A The Contract Period may be extended for a further period of up to 24 months if the Partners agree in writing to such an extension. The same terms and conditions as those contained within this contract shall apply to any extension of the Contract Period subject to the provisions of Clause 18.

3.3 Upon expiry or earlier termination of this Agreement, the Partners will agree and observe a detailed exit strategy to facilitate the orderly winding down or

efficient handover, or other arrangements, in respect of the HLDP Integrated Services and projects procured from the Pooled Fund. The exit strategy prepared shall address all the consequences of termination including:

- Implications for People with a Learning Disability who use HLDP services;
- Implications for each Partner;
- The relationship with Service Contractors;
- Personnel issues;
- The financial impact of termination;
- All other relevant issues.

3.4 Upon expiry or earlier termination of this Agreement, the remaining funds in the pool will be apportioned in proportion to the Council's and CCG's contribution to the Pooled Fund for that Financial Year and returned to the both commissioning partners. The Commissioning Partners agree to make any necessary payments to the Pooled Fund, or to each other, to reflect the correct apportionment of funds on the date of termination of this Agreement.

3.5 For the purposes of Clause 3.4, the total sum will include contributions made to the fund for the year in question, and any sums 'rolled forward' from the previous Financial Year.

3.6 This Agreement shall be subject to periodic review as detailed at Clause 18.

3.7 Any review under this Agreement will seek to monitor the effectiveness of the Arrangements detailed at Clause 5 and will be in accordance with the provisions of Clause 18.

4. THE AGREEMENT, AIMS AND OBJECTIVES

4.1 The Partners wish to ensure that services for people with learning disabilities are planned, commissioned and provided in an integrated manner. The primary aim of this Agreement is to ensure the most cost-effective use of the combined resources of the Partners to address the health and care needs of people with learning disabilities who are their responsibility.

4.2 The Partners' agreed aims and objectives of the partnership arrangements (including for the purposes of Regulation 7(3) (a) of the Regulations) are to ensure that:

4.2.1. the integrated provision of the services is based on an agreed picture of needs rather than historical service configurations;

4.2.2. the integrated services present good value for money and best value;

4.2.3. the integrated services seek to promote emotional and physical good health and work to overcome social exclusion;

4.2.4. the services are culturally competent in meeting the needs of people from black and minority ethnic communities;

4.2.5. a whole systems approach is taken to the commissioning and provision of the Services by preventing duplication of such services and to make more effective use of the current resources (e.g., integrated care pathways);

4.2.6 robust arrangements to collect performance management information are established and maintained and that the information is used to evaluate performance against targets, monitoring both the effectiveness of the commissioning and the delivery process and the integrated services.

4.3 On entering into this Agreement, the Partners shall jointly give notification of this Agreement to the Health and Social Care Joint Unit of the Department of Health. The notification shall be in the form annexed hereto as Appendix 3 (Form of Notification to the Department of Health), subject to such amendments as may be agreed in writing between the Partners. The Partners shall arrange for such notification to be updated on an annual basis, so as to reflect any variations to this Agreement.

5. PARTNERSHIP ARRANGEMENTS FOR DELIVERY OF THE HLDP

INTEGRATED SERVICES

5.1 With effect from the Commencement Date:

The Partners agree to maintain and deliver the HLDP Integrated Service provision arrangements for eligible adults with learning disabilities. The Council shall be the Host Partner.

5.1.1. The Partners agree to establish and maintain a Pooled Fund for the purpose of the HLDP Integrated Service and the exercise of the NHS Functions and Health-Related Functions associated with provision of the HLDP Integrated Services.

5.1.2. The Partners agree that the Arrangements shall be governed by the structures as set out at Schedule 3 and Schedule 4 and shall cover the following functions:

a) Social care.

b) NHS Community Health Care (nursing, speech and language therapy, physiotherapy, occupational therapy and psychology).

c) Continuing Health Care Nurse Assessor.

d) Consultant Psychiatry

5.1.3. The Partners agree that the Pooled Fund will be used to fund HLDP Integrated Services.

5.1.4. The Partners agree that expenditure from the Pooled Fund shall be in accordance with the terms of this Agreement.

5.2 For the purposes of the implementation of the Partnership Arrangements, the NCL CCG hereby delegates the exercise of the NHS Functions to the Council to exercise alongside the Council's Health-Related Functions and act as integrated provider of the services and functions in Paragraph 5.1.3 above and set out in Schedule 1 (Service Specification).

6. STAFFING ARRANGEMENTS

6.1. Staff employed by each Partner shall continue to be employed by the respective Partner, subject to operational arrangements as set out in Schedule 4 below (Operational Arrangements).

6.2. Secondment

6.2.1 The Trusts and NCL CCG shall second employees ('Secondee Employees') to the HLDP Integrated Service for the period as agreed between the Partners ('Secondment Period').

6.2.2 During the Secondment Period the Seconded Employees shall:

a) provide the HLDP Integrated Services whilst continuing to be employed by the NHS Provider Trusts (BEH-MHT and Whittington Health) or NCL CCG respectively;

b) perform the duties assigned to them by the HLDP Integrated Service within the general scope of their current or revised job title, job descriptions and conditions;

(i) devote the whole of their time, attention and skill to their duties for the HLDP Integrated Service under this Agreement; and

(ii) adhere to all lawful and reasonable directions given to them by the HLDP Integrated Service.

6.2.3 The Seconded Employees will be subject to the same conditions of employment that exist in their employment with the Trusts or NCL CCG in relation to all matters including, but not limited to, hours of work, training, annual leave and sickness.

6.2.4 During the Secondment Period the Council as Host Partner agrees to pay the NHS Provider Trusts (BEH-MHT and Whittington Health) and NCL CCG an amount equal to remuneration in accordance with the expenditure arrangements of the Pooled Fund and in line with the objectives and obligations of the substantive employing Partner and specifically in relation to this Agreement including:

a) The salary, including any bonus elements applicable paid by the NHS Provider Trusts (BEH-MHT and Whittington Health) and NCL CCG to the Seconded Employees;
b) National Insurance contributions payable by the NHS Provider Trusts (BEH-MHT and Whittington Health) and NCL CCG in respect of a Seconded Employee's salary; and
c) The pensions contributions paid by the NHS Provider Trusts (BEH- MHT and Whittington Health) and NCL CCG in respect of a Seconded Employee's pension arrangements.
d) Any overhead cost as instructed by CCG commissioners

6.2.5 Any other employment costs, such as redundancy costs, must be approved, funded and agreed in writing (and recorded as amendments to this Agreement) as otherwise all such costs will remain the responsibility of the substantive employing Partner.

6.2.6 The sums payable under clause 6.2.4 shall accrue on a day-to-day basis and be payable at monthly intervals commencing one month from the start of the Secondment Period. On termination of this Agreement all sums due and owed by the Council as Host Partner under this clause shall be paid immediately to the relevant Trust [NHS Provider Trusts (BEH-MHT and Whittington Health)] and NCL CCG as part of the agreed exit strategy.

6.3 Appointment to Management posts

6.3.1 The management posts will be recruited by a joint panel with Representatives from all Partners. Post-holders may be employed by either Partner(s) to this Agreement and any such NHS staff will be seconded to the HLDP Integrated Service (Host Partner - the Council) for day-to-day line management arrangements. To avoid anomalies and difficulties with 'differentials' the grading structure of the Host Partner will be applied to these and any other designated joint appointments, subject to agreement by the Executive Group. Where appropriate, recruitment panels should also include other key stakeholders, such as People with a Learning Disability and Carers.

6.3.2 Where the post-holder is from a health background and employed by one of

the Provider NHS Trusts (BEH-MHT and Whittington Health) or from NCL CCG, the post-holder will be seconded to the HLDP Integrated Service under existing NHS terms and conditions of service and salary, subject to 6.3.1 above and by agreement of the Executive Group.

6.3.3 All employees will be operationally managed on a day-to-day basis within the management structure set out in Schedule 3 and the operational arrangements of Schedule 4.

7. NON-FINANCIAL CONTRIBUTIONS

7.1. The Council will provide and make available to the Arrangements corporate services as appropriate, including but not limited to, senior management support, finance and HR.

7.2. The NHS Provider Trusts (BEH-MHT and Whittington Health) will provide and make available to the Arrangements corporate services as appropriate, including but not limited to, HR and Payroll functions and senior management support.

7.3. Except where approved as part of the Expenditure/ Finance Plan referred to in Clause 9, the non-financial contributions referred to in Clauses 7.1 to Clause 7.2 will not be funded from the financial contributions referred to.

7.4. This Agreement includes a specific Schedule on Estates, Premises, Running Costs, Supplies & Facilities (Schedule 5).

8. EXPENDITURE AND ADMINISTRATION OF POOLED FUNDS

Use of Pooled Funds

8.1 Subject to agreement between the Partners, the monies in the Pooled Fund may be expended on the exercise of NHS Functions and Health-Related Functions in different proportions to that which the Partners have contributed to the Pooled Fund.

Pooled Fund Manager

8.2 The Council will act as Host Partner for the purposes of Regulations 7(4) and (6) of the Partnership Regulations and will provide the financial administrative systems for the Pooled Fund.

8.3 The Pooled Fund Manager of the Pooled Funds for the purposes of Regulation 7(4) of the Partnership Regulations shall be appointed in accordance with the provisions of Clause 6.4.1.

8.4 The Pooled Fund Manager will also be the Head of Service.

8.5 The Pooled Fund Manager will report to:

8.5.1 the Council's Assistant Director Adult Social Services; and

8.5.2 the Executive Group.

8.6 The Pooled Fund Manager will be responsible for:

8.6.1 managing the Pooled Fund, including making payments from the pool, subject to Clause 9.7; and

8.6.2 submitting to the Partners Quarterly reports and an Annual Return on the Pooled Funds by 1 May of the following year, and all other information required by the Partners, in order to monitor the Pooled Funds; and

8.6.3 providing monthly budget 'call-over' update reports, as required.

8.7 The Partners will assist the Pooled Fund Manager to keep the accounts of the Pooled Fund by making available to the Pooled Fund Manager any relevant financial information relating to the Arrangements of this Agreement.

9. EXPENDITURE/ FINANCE PLAN

9.1. Each Partner shall designate an Expenditure Manager to carry out matters assigned to them by the Partners pursuant to this Agreement.

9.2. The Expenditure Managers together shall form the Expenditure/ Finance Group whose terms of reference are detailed at Schedule 2. The Expenditure/ Finance Group will meet on a Quarterly basis and report to the Executive Group twice yearly.

9.3. The Expenditure Group shall agree a proposed Expenditure/ Finance Plan for the Pooled Fund for each Financial Year which shall not exceed the total contribution by the Partners to the Pooled Fund for that Financial Year having first consulted with the Executive Group.

9.4. The Expenditure/ Finance Group shall submit the proposed Expenditure/ Finance Plan to the Executive Group for their consideration and approval.

9.5. In the event that the Expenditure /Finance Group cannot agree a proposed Expenditure/ Finance Plan by the end of the first Financial Year in respect of the subsequent Financial Year then the matter shall be referred to the Executive Group.

9.6. The Partners shall through the Executive Group consider and unanimously approve the proposed Expenditure/ Finance Plan or make such amendments as

the Partners deem necessary having due regard to the comments of the Partnership Meeting Group.

9.7. The Partners agree that all expenditure from the Pooled Fund shall be made in accordance with the Expenditure/ Finance Plan approved by the Executive Group and, as appropriate, will share relevant information with the Partnership Meeting Group.

9.8. In the event of any substantial change in funding arrangements (e.g. change in national grant allocation within the particular financial period) in respect of the HLDP Integrated Services, any Partner may call an 'extraordinary' meeting of the Executive Group to consider the implications and agree appropriate actions.

10. GENERAL PROVISIONS ON UNDER-SPENDS AND OVER-SPENDS

10.1. In the event of an anticipated total under-spend in the Pooled Fund in accordance with the Expenditure/ Finance Plan within any Financial Year of less than 5% then the Expenditure/ Finance Group may by agreement re-deploy such amounts to be used for the purposes of the Pooled Fund.

10.2. In the event of an anticipated total under-spend in the Pooled Fund in accordance with the Expenditure/ Finance Plan within any Financial Year of more than 5% then the Expenditure/ Finance Group shall agree a revised Expenditure/ Finance Plan and submit it to the Executive/ Finance Group for approval and in default of such revised Expenditure/ Finance Plan being agreed by the Expenditure/ Finance Group within a reasonable time then the matter will be referred to the Executive/ Finance Group for determination.

10.3. In the event that there is an under-spend of the Pooled Fund at the end of any Financial Year then the Commissioning Partners may by agreement (subject to all legal and accounting requirements) carry over such amount to be utilised in the Pooled Fund in the next Financial Year, and in the absence of such agreement then the under-spend shall be apportioned in proportion to the Commissioning Partners' contributions to the Pooled Fund for that Financial Year and returned to the respective Partners.

10.4. For the purposes of this Clause 10 the Council's contribution for that Financial Year shall be the Council's actual contribution to the Pooled Fund.

10.5. For the purposes of this Clause 10 the NHS Provider Trusts (BEH-MHT and Whittington

Health) contribution shall be the amount that the NHS Provider Trusts (BEH-MHT and Whittington Health) is regarded as having contributed to the Pooled Fund in accordance with Schedule 6.

10.6. The Partners agree that in the event of any over-spend in excess of the approved Expenditure/ Finance Plan the Expenditure/ Finance Group will put in place mitigating action to contain over-spends and will report all over-spends to the Executive Group.

10.7. Any over-spends at the end of any Financial Year will be accounted for within the Commissioning Partners' own accounts and in proportion to the contributions to the Pooled Fund with additional contributions to be given in the following Financial year to make good the over-spend.

10.8. In the event that the Partners agree that they cannot provide additional funding to the Pooled Fund in the manner described at 10.7, the Expenditure/ Finance Group will agree alternative budget reductions to cover the value of the over- spend.

11. VAT

11.1 The Council's VAT regime will apply in respect of the Arrangements.

12. AUDIT AND RIGHT OF ACCESS

12.1. The Council, as Host Partner is responsible for the audit of the Pooled Funds accounts. All such audits will be shared with the Expenditure/ Finance Group and reported to the Executive Group.

12.2. The Council will arrange for the audit of the accounts in relation to the Pooled Fund and in accordance with the requirements of the Local Audit and Accountability Act 2014.

12.3. This audit must be supported by evidence that the management reports of the contributing Partners identify and show how the Pooled Fund is fulfilling the Arrangements detailed in Clause 5 above.

12.4. The Partners shall promote a culture of probity and sound financial discipline and control in relation to the Agreement.

12.5. The Provider NHS Trusts (BEH-MHT and Whittington Health) and NCL CCG shall provide the right of access to the Partners' internal and external auditors in respect of matters concerning the Pooled Fund including but not limited to any document, information or explanation they require from any employee, member or contractor of the Provider NHS Trusts (BEH-MHT and Whittington Health) in order to carry out their duties. This right is not limited to financial information or accounting records. If any person is concerned about giving access to non-financial information, they may request a discussion with the senior officer of the person requesting the information prior to disclosure.

12.6. The right of access under Clause 12.5 applies equally to Premises or equipment used in connection with the functions covered by this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

12.7. In line with the Department of Health reporting timetable, the Council shall provide audited memorandum accounts to the NHS Provider Trusts (BEH-MHT and Whittington Health) authorised finance officers as and when requested.

13. LIABILITIES AND INSURANCE

13.1. In the event of any complaint or enquiry, or any liability which arises in connection with this Agreement, about any act or omission of any of the Partners or their employees, agents or contractors in relation to the Arrangements, or other term of this Agreement, where as a result a Partner/s (the first Partner/s) becomes liable for the acts or omissions of another Partner/s (the defaulting Partner), its employees, agents or contractors:

13.1.1 The liability of the first Partner/s and any associated costs and losses will be that of the defaulting Partner who shall indemnify the first Partner for all reasonable costs (including legal costs) of the first Partner.

13.1.2 In the event of a dispute under this Clause 13, the matter will be referred to the dispute resolution process described in Clause 27.

13.2. Each Partner shall ensure that it maintains policies of insurance [or in the case of the NHS Provider Trusts (BEH-MHT and Whittington Health)], equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from these Arrangements.

13.3. The NHS Provider Trusts (BEH-MHT and Whittington Health) shall maintain the following levels of insurance:

13.3.1 public liability insurance in a sum of not less than £2,000,000 (two million pounds) for any one occurrence or series of occurrences arising out of any one event;

13.3.2 employer's liability insurance in a sum of not less than £10,000,000.00 (ten million pounds) for any one occurrence or series of occurrences arising out of any one event and which complies with the Employers' Liability (Compulsory Insurance) Act 1969 and the Road Traffic Act 1972; and

13.3.3 professional indemnity insurance in a sum of not less than £1,000,000 (one million pounds) for any one occurrence or series of occurrences arising out of any one event.

13.4. The NHS Provider Trusts (BEH-MHT and Whittington Health) shall maintain liability insurance cover for all Seconded Employees.

13.5. The Council shall maintain public liability insurance against injury or damage to

the Seconded Employees or their property.

13.6. If any third party makes a claim or intimates an intention to make a claim against either *Partner*, which may reasonably be considered as likely to give rise to an indemnity under Clause 30.1, the Indemnified *Partner* that may claim against the Indemnifying *Partner* will:

13.6.1 within 3 working days give written notice of that matter to the Indemnifying Partner specifying in reasonable detail the nature of the relevant claim;

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

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

13.7. For the avoidance of doubt, the Indemnified Partner shall be under a duty to mitigate any loss in accordance with the principles of common law and the indemnity given at Clause 30.1 above shall not extend to losses, costs, expenses, damages, liabilities, actions, claims or proceedings incurred by reason of or in consequence of any negligent act or omission, misconduct or breach of this Agreement committed by the Indemnified Partner.

13.8. Each Partner shall ensure that they maintain appropriate insurance arrangements in respect of employers' liability, liability to third parties and other insurance or risk pooling arrangements to cover their liability under this Agreement.

14. CONTRACTING

14.1 This Agreement is for the delivery of service and as such the Partners will enter into contractual arrangements for the provision of the HDLP Integrated Services approved through the process described in Clause 8 and Clause 9. The contract will be in the name of the Council and will be made in accordance with the organisation's Contract Standing Orders, Financial Regulations, Procurement Code of Practice and will at all times be subject to domestic law.

15. JOINT WORKING PROTOCOLS

15.1 The Partners have agreed to establish a series of joint protocols to govern procedural matters of the partnership arrangements established by this Agreement, which will support achievement of the Arrangements described in Clause 5.

15.2 In the event of any conflict between the joint protocols and this Agreement, this Agreement shall prevail.

15.3 The Parties agree to use all reasonable endeavours to develop joint working protocols as shall be required for the sharing of Information with other agencies and third parties in so far as they relate to this Agreement or subsequent contracts made in accordance with Clause 14.

16. STANDARDS OF CONDUCT

16.1 The Partners will comply with and will ensure the Arrangements comply with statutory national and local requirements and other guidance on conduct and probity and will ensure good corporate governance including the Partners respective Standing Orders and Standing Financial Instructions.

17. STANDARDS SERVICE 17.1.

Best Practice

The Partners agree that central to the effective and efficient application and compliance of this Agreement are the following core principles:

a. Strengths based Approach to health and social care
b. A dual focus of best outcomes for service users & carers and value for money for all commissioned care and support
c. Delivery of the highest quality clinical and social care;
d. Assured practice governance;
e. Maintenance and development of equality and equal opportunities;
f. Implementation and development of Safeguarding policies and procedures;
g. Adherence to the practice standards in the Mental Capacity Codes of Practice, Deprivation of Liberty Safeguard Code of Practice, Mental Health Code of Practice, National Framework for Continuing Healthcare and NHS-funded Nursing Care, Care and Support Statutory Guidance and any other successor guidance documents.
h. Implementation and development of 'personalisation' to include Direct Payments and Assistive technologies

17.2. Best Value

17.2.1 The Council is subject to the duty of Best Value under the Local Government Act 1999. The Arrangements will therefore be subject to the Council's obligations for Best Value and the NHS Provider Trusts (BEH- MHT and Whittington Health) will co-operate with all reasonable requests from the Council which the Council considers

necessary in order to fulfil its Best Value obligations.

17.3. Clinical Governance

17.3.1 In addition to the arrangements detailed at Schedule 2 it is recognised that the NHS Provider Trusts (BEH-MHT and Whittington Health) and NCL CCG are subject to a duty of Clinical Governance. The Joint Head of Service for the HLDP shall be responsible for assessing, managing and reporting any clinical risk to the partners and to the Executive Group. The Executive Group will be responsible for monitoring and clinical governance. The Arrangements will be subject to the following clinical governance obligations:

a. Implementing risk management strategies and taking action to ensure adverse risks are avoided;
b. Openly investigating and learning lessons from adverse events;
c. Ensuring People with a Learning Disability have all the information they need about their care;
d. Ensuring health and social care professionals are supervised, and are up- to-date in their practices;
e. Ensuring all professional groups have clear Quality Practice Standards (QPS) in relation to all their activities;
f. Ensuring all professional groups participate in audit of clinical practice;
g. Developing and sharing good practice to ensure continuous improvements in clinical and social care practice.

17.4. Equality and Equal Opportunities

17.4.1 In providing the HLDP Integrated Services, the Partners shall comply in all respects with the Equality Act 2010 ("the 2010 Act") together with all applicable amendments, regulations and Codes of Practice or any future

or other legislation which concerns discrimination in employment and service delivery (the "Equalities Provisions") and shall in particular comply with the public sector equality duty under Section 149 and shall have due regard to the need to:

a. eliminate discrimination (whether direct or indirect), harassment, victimisation and any other conduct that is prohibited by or under the 2010 Act;

b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

c. foster good relations between persons who **share a** relevant protected characteristic and persons who do not share it.

17.4.2 The Partners shall take all reasonable steps to ensure that their employees,

agents and sub-contractors employed in the provision of the HLDP Integrated Services shall carry these out in accordance with the obligations imposed on the Contractor by Condition 17.4.1.

17.4.3 Where in connection with this Arrangement , NCL CCG, the BEH-MHT and/or the Whittington are required to provide the HDLP Integrated Services on the Council's premises where the Council's employees are required to carry out work, they shall comply with the Council's own employment policy and codes of practice relating to racial discrimination and equal opportunities, copies of which may be obtained from the Council.

17.4.4 NCL CCG, the BEH-MHT and/or the Whittington shall notify the Council immediately in writing upon becoming aware of any investigation or proceedings brought against it under the Equalities Provisions.

17.4.5 If requested to do so by the Council, NCL CCG the BEH-MHT and/ or the Whittington shall fully co-operate with the Council at its own expense in connection with any legal proceedings, ombudsman inquiries or arbitration in which the Council may become involved arising from any breach of the Council's duties under the Equalities Provisions due to the alleged acts or omissions of NCL CCG, the BEH-MHT and/ or the Whittington or their personnel employed in and about the provision of the HDLP Integrated Services.

17.5. Safeguarding

17.5.1 Partners are committed to support and maintain safeguarding for the HLDP Integrated Service, implementing agreed policies and procedure in respect of all vulnerable adults, informed by legislation, statutory and other guidance and local procedures (such as, the Care Act 2014, Care and Support Statutory Guidance, Pan London Adult Safeguarding Policy and Procedure (ADASS), the Mental Capacity Act 2005, Mental Capacity Code of Practice, Deprivation of Liberty Safeguards Code of Practice and the Mental Capacity (Amendment Act) 2019 (Liberty Protection Safeguards 2020).

17.6. Personalisation

The Partners are committed to supporting and maintaining person centred planning and Strengths Based Approach to health and social care. The Partners are also committed to 'personalisation', giving people more independence, choice and control through high-quality and personalised health and social care services, whereby people with a Learning Disability are able to commission their own services and to live independently.

17.7. General Principles

The Partners shall undertake the Arrangements in accordance with the standards stated in this Agreement. The Partners will in relation to this Agreement:

a) treat each other with respect and equality of esteem;
b) where permitted by law and by this Agreement be open about the performance and financial status of each other;
c) provide early information and notice about relevant problems.

18. MONITORING, REPORTING AND REVIEW

18.1. The Partners will jointly monitor the effectiveness of the Arrangements through first, the Expenditure/ Finance Group, the Executive Group and report as appropriate to the Live Well Board and Health and Wellbeing Board, which acts in an advisory role.

18.2. The key performance targets for this Agreement are based on the national social care and/or health standards and measures; and relate to the outcomes and outputs as specified in the Service Specification for this Agreement which is attached as Schedule 1.

18.3. Performance against these targets (agreed in the Service Specification) will be monitored by the Council's Adult Services Department Management Team and reported by exception to the Executive Group.

18.4. At the end of two Quarters (twice yearly) in each Financial Year the Pooled Fund Manager, supported by the Expenditure/ Finance Group, shall submit an Income and Expenditure/ Finance report to the Executive Group.

18.5. At the end of two Quarters (twice yearly) and in accordance with the Expenditure/ Finance Plan the Council as Host Partner for the HLDP Integrated Services shall submit a monitoring report to the Executive Group detailing:

18.5.1 Financial activity and forecasting.

18.5.2 Performance data as outlined in 18.2, additionally where relevant:
a) Activity data for the HLDP Integrated Services;
b) Service development and improvement;
c) Waiting times;
d) Complaints;
e) Incidents.

18.6. The Partners agree to review and prepare a report on the Arrangements at the end of each Financial Year to include an evaluation of the exercise of the NHS Health-Related Functions, the LA Functions and of performance and service delivery against agreed performance measures, targets and priorities. This should include views of staff and

service user and carers gathered over the course of the year.

18.7. This Agreement shall be reviewed annually through a 'desktop' review arrangement overseen by the Joint Head of Service and the Joint Lead Commissioning Officer on behalf of the Executive Group and the outcomes reported to the Executive Group for their approval.

18.8. A full review of the HLDP and the Agreement will take place in year three (2023/24) of this Agreement (2021-2026), and will include consultation with all relevant stakeholders, including Service Users.

18.9. In the event that this Agreement is extended in accordance with Clause 3.2A subsequent reviews will take place thereafter at such intervals and on such dates as agreed by the Representatives and approved by the Executive Group.

18.10. The Partners may, in addition, review the operation of this Agreement on the coming into force (or in anticipation of the coming into force) of any relevant statutory or other legislation or guidance affecting the terms of this Agreement so as to ensure that the terms of this Agreement comply with such legislation or guidance.

18.11. The Agreement may be reviewed in monitoring the effectiveness of the Arrangements detailed at Clause 5.

19. SUB STANDARD PERFORMANCE

19.1. In the event that any Partner(s) shall have any concerns on the operation of the Arrangements or the standards achieved in connection with the carrying out of the objectives of this Agreement, it may convene a review with the other Partner(s) with a view to agreeing a course of action to resolve such concerns.

19.2. Nothing in this clause 19 shall prejudice the Partners' rights to terminate this agreement pursuant to the provisions therein.

20. COMPLAINTS

20.1. The Partners own statutory complaints procedures shall apply to the Arrangements. The Partners agree to assist one another in the management of complaints arising under these Arrangements. Each Partner shall inform the other Partners about any specific complaint relating to a Service User eligible for the HDLP Integrated Services relating to this Agreement

20.2. People with a learning disability placed in a residential or nursing home by another authority/ commissioner will be subject to the relevant complaints procedures of that placing authority and of the particular residential/ nursing home provider. The Partners of this Agreement may assist (by agreed arrangement in each individual case), as appropriate.

21. OMBUDSMAN

21.1. If a complaint is made to any Partner by a third party relating to the exercise of NHS Functions and Health-Related Functions associated with the provision of the Services, the Local Government Ombudsman or the NHS Ombudsman may have the power to investigate such complaint and the Partners will co-operate in such investigation.

21.2. In circumstances where a Partner/s (the first Partner/s) is found guilty of mal-administration or injustice by either Ombudsman in respect of a matter arising through the act or default of another Partner/s (the defaulting Partner/s), the defaulting Partner/s will indemnify the first Partner/s to the extent attributable to such act or default.

22. INFORMATION SHARING

22.1. The Partners will comply with and ensure that the Arrangements comply with all legislation regulations and guidance on information sharing produced by the Government, NHS England, NHS Digital, HSCIC and the Information Commissioner and in accordance with the multi-agency Haringey Information Sharing Protocol.

22.2. This will include co-operation and compliance with operational arrangements in respect of the use of the respective Partners' Case Management Information Systems.

22.3. All partners will use the council's established electronic database (Mosaic) for recording all service user information.

22.4. The Partners shall in the performance of their obligations under this Agreement comply with any Information Sharing Agreements in place between the Partners.

23 CORRUPTION

23.1. No Partner shall offer, give or agree to give to any employee or member of another Partner any gift or consideration at any time as an inducement or reward:

a) For doing or not doing any act in relation to the obtaining or performance of this Agreement or any other agreement connected to this Agreement with another Partner;

b) For showing or not showing favour or disfavour to any person in relation to this or any other agreement with another Partner.

23.2. If any Partner/s (or anyone acting on any Partner's/s' behalf or to its knowledge) does any of the acts referred to in Clause 23.1 or commits any offence under the

Bribery Act 2010 or under Section 117(2) of the Local Government Act 1972, the other Partner shall be entitled:

a) To terminate this Agreement by serving notice on the other Partners; and
b) To require the first named Partner/s, to procure the termination of any sub-contract or agency agreement if the relevant act is that of the first named Partner's/s' sub-contractor or agent.

23.3. In exercising its rights and remedies under this Clause 23, each Partner shall act in a reasonable and proportionate manner having regard to such matters as the gravity of the offence committed and the identity of the person committing the offence.

23.4. Any Partner shall promptly inform the other Partners of occurrence of any such prohibited act or offence of which it becomes aware.

24. TERMINATION

24.1 Any Partner may at any time by notice in writing to the other Partners, terminate this Agreement as from the date of service of such notice if:

24.1.1 The other Partner/s commit a material breach of any of its obligations hereunder which is not capable of remedy; or

24.1.2 The other Partner/s commit a material breach of any of its obligations hereunder which is capable of remedy but has not been remedied within a specified reasonable period of time (given the nature and circumstance of such breach) after receipt of written notice from the terminating Partner requiring remedy of the breach; or

24.1.3 The Executive Group are unable to unanimously agree the Expenditure/ Finance Plan pursuant to Clause 9 by 30 September for that year and each of the remaining 4 years.

24.2 Any Partner may by written notice to the other Partners terminate this Agreement if:

24.2.1 As a result of any change in law or legislation it is unable to fulfil its obligations hereunder;

24.2.2 Its fulfilment of its obligations hereunder would be in contravention of any guidance from any Secretary of State issued after the date hereof;

24.2.3 Its fulfilment of its obligations would be ultra vires, and Partners shall be unable to agree a modification or variation to this Agreement so as to enable the Partner to fulfil its obligations in accordance with law and guidance.

24.3 In the case of notice pursuant to Clause 24.2.1 or 24.2.2 the Agreement shall terminate after such reasonable period as shall be specified in the notice having regard to the nature of the change referred to in Clause 24.2.1 or the guidance referred to in Clause

24.2.2 as the case may be. In the case of notice pursuant to Clause 24.2.3, the Agreement shall terminate with immediate effect.

24.4 Any Partner may terminate this Agreement, on not less than 12 months' written notice, given by one Partner to the others.

24.5 This Agreement may otherwise be terminated by mutual agreement of the Partners.

24.6 Termination of this Agreement (whether by 'passing out' of time or otherwise) shall be without prejudice to the Partners' rights, in respect of any antecedent breach.

24.7 In the event of termination of the Agreement, the Partners shall, where possible, observe the exit strategy described in Clauses 3.33 & 3.3. The remaining funds will be apportioned as described in Clause 3.5.

25 CONFIDENTIALITY

25.1. "Confidential Information" shall mean all information disclosed by one Partner to another, orally, in writing or in electronic form relating to this Agreement that is not in the public domain (except where disclosure is in the public domain due to a breach of this clause).

25.2. Subject to the provisions of the FOIA (Freedom of Information Act) and any other applicable legislation, no Partner shall, without the prior written consent of the Partner to which the information relates, publish or disclose to any person, or permit any such disclosure by any of its employees or representatives, any Confidential Information received by it in relation to the Arrangements or Services, and dealt within overarching Haringey Information Sharing Protocols.

25.3. The Partners will jointly establish and keep operational procedures, policies and documentation as shall be necessary in order to meet the purposes, guidance and requirements of Government and of all relevant data protection and access to information legislation.

25.4. In addition, the Partners will jointly establish and keep operational procedures and policies for handling Service User access and consent to include but not limited to:

i. documentation for people with a learning disability who use HLDP services explaining their rights of access,

ii. documentation for people with a learning disability who use HLDP services explaining the relevance of their consent, rules and limits on confidentiality

26 DATA PROTECTION

26.1. All Partners shall throughout the term of the Agreement comply with the provisions of the Data Protection Act 2018 ('DPA 2018') or any subsequent amendment thereto and shall ensure that its agents and employees are trained in

and comply with the data protection principles set down in the DPA 2018 in relation to this Agreement.

26.2. Where either of the Partners process personal data, including sensitive data (as defined in the DPA 2018); the written consent to that processing by the data subject shall be obtained which shall specifically include consent to processing by the Partners for the purposes of this Agreement.

26.3. The Partners agree that where they act as data controller (as defined in the DPA 2018) as regard to personal data they shall have in place at all times and maintain, appropriate technical and organisational security measures governing the processing of personal data.

26.4. A defaulting Partner shall indemnify to the extent of that party's default to the other Partner, it's employees or agents against the cost of dealing with any claims made in respect of any information subject to the DPA 2018, which claims would not have arisen but for some act, omission or negligence on the part of the defaulting Partner, his employees or agents.

27 FREEDOM OF INFORMATION ACT (FOIA)

27.1. The Partners recognise that all Partners are subject to FOI and that the Council is subject to legal duties which may require the release of information under FOIA or any other applicable legislation or codes governing access to information and that the Council may be under an obligation to provide information on request. Such information may include matters relating to, arising out of or under, this Agreement in any way. In so far as is reasonably possible and practicable the Council will consult with Partners regarding the release of information as a result of this Agreement.

27.2. Notwithstanding anything in this Agreement to the contrary, in the event that the Council receives a request for information under the FOIA or any other applicable legislation governing access to information, the Council shall be entitled to disclose all information and documentation (in whatever form) as is necessary to respond to that request in accordance with the FOIA or other applicable legislation governing access to information. The Partners shall co-operate with the Council in respect of any requests which are made under the FOIA or other legislation.

27.3. The Council shall not be liable for any loss, damage, harm or other detriment however caused arising from the disclosure of any information relating to this Agreement under FOIA or other applicable legislation governing access to information

28 WAIVER

28.1. The failure of any Partner to enforce at any time or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision.

28.2. No waiver inany one or more instances of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.

29 GOVERNING LAW

29.1. This Agreement shall be governed by and construed in accordance with English Law.

30 DISPUTES

30.1. In the event of a dispute between the Partners in connection with this Agreement the Partners shall in the first instance, and in line with best practice, conduct an options appraisal and make recommendations to the Executive Group for a resolution.

30.2. If the Executive cannot reach and consensus decision to satisfy all interests, partners shall refer the matter to their HPB Representative or a nominated deputy, who shall endeavour to settle the dispute between themselves.

30.3. In the event that the Representatives (or their nominated deputies) cannot resolve the dispute between themselves within a reasonable period of time (and at a maximum of six months) having regard to the nature of the dispute, the matter will be referred to the Chief Executives or equivalent of the Parties for resolution.

30.4. In the event that the dispute cannot be resolved by the Parties as described above, the matter shall be referred for mediation. The Partners will identify and agree an appropriately qualified and independent mediator, within a reasonable period of time, having regard to the complexity and urgency of the particular dispute. In the event that the Partners cannot jointly agree a mediator, the Council shall have power to appoint a mediator of its choice, having due regard to the complexity and urgency of the situation.

30.5. In the event that the dispute is still unresolved within a reasonable period of time with regard to the nature of the dispute and having followed the procedure above, the Agreement may be terminated by any Partner on written notice to the other Partners.

31 ASSIGNMENT AND SUBCONTRACTING

31.1. The Partners may not assign mortgage transfer sub-contract or dispose of this Agreement or any benefits and obligations hereunder without the prior written consent of the other except to any statutory successor in title to the appropriate statutory functions.

32 NO LEGAL PARTNERSHIP

32.1 Nothing in this Agreement shall create or be deemed to create a legal partnership or the relationship of employer and employee between the parties.

33 NOTICE

33.1. Any notice or communication shall be in writing.

33.2. Any notice or communication to the relevant Partner, shall be deemed effectively served if sent via email registered post or delivered by hand at the address set out above and marked for either the Director of Adults and Health of the Council, Executive Director of Strategic Commissioning at NCL CCG, or the Chief Executives of the Trusts or to such other addressee and address notified from time to time to the other Partners.

33.3. Any notice served by hand shall be deemed to have been served on the date it is delivered to the addressee. Where notice is served by registered post, it shall be sufficient to prove that the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice 48 hours after the time it was posted.

34 THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

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

35 SEVERANCE

35.1. If any provision of this Agreement becomes or is declared by any court of competent jurisdiction to be invalid or unenforceable in any way, such unenforceability shall in no way impair or affect any other provision of this Agreement allow which will remain in full force and effect.

36 FORCE MAJEURE

36.1. A Partner to this Agreement shall not be liable to the other Partners nor held in breach of the Agreement if that Partner is prevented, hindered or delayed in the performance of its obligations under the Agreement by any act of God, war, riot, civil commotion, explosion, fire, radiation, accident, government action, interruption in the supply of

power, labour dispute -other than a dispute concerning a Partners' employees or the employees of its sub-contractors, epidemic or other circumstances beyond the control of the Partner which prevents a Partner from, or hinders or delays a Partner in, performing its obligations under this Agreement (and which the application of due diligence and foresight could not have prevented).

36.2. If due to any of the circumstances listed in Clause 36.1 any Partner is prevented, hindered or delayed in the performance of their obligations in accordance with the Agreement that Partner shall as soon as reasonably practicable notify the other Partners in writing of such prevention, hindrance or delay and the reasons therefore whereupon the operation of the Agreement shall be suspended.

36.3. The suspension of the operation of the Agreement shall continue during the period (and only during the period) that such prevention, hindrance or delay due to the circumstances listed in Clause 36.1 continues. Upon those circumstances ceasing to prevent, hinder or delay the performance of the obligations of the Partner relying upon it that Partner shall give written notice to the other Partners of this fact.

36.4. If either of the Partners is prevented from performing their obligations due to any of the circumstances listed in Clause 36.1 for longer than one month then any Partner may immediately terminate the Agreement upon service of one month's written notice to the other Partners and the provisions of Clauses 3.3 and 3.4 shall apply.

37 ENTIRE AGREEMENT

37.1. This Agreement, the Schedules and the documents annexed to it or otherwise referred to in it constitutes the entire agreement between the Partners with respect to the subject matter hereof and shall supersede all previous communications representations understandings.

38 VARIATION

38.1. No variation of the terms or provisions hereof shall be binding upon any Partner unless made in writing and signed by a duly Representative of each Partner and approved by the Executive Group.

39 CONFLICT

39.1. Where there shall be a conflict between the terms of the main body of this Agreement and those stated in the Schedules those stated in the main body of this Agreement shall prevail.

IN WITNESS WHEREOF the parties have executed this Agreement as a deed on the day and year first before written.

EXECUTED ON BEHALF OF THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF HARINGEY BY AFFIXING ITS COMMON SEAL HEREUNTO BY ORDER]

Authorised Officer

EXECUTED AS A DEED BY BARNET ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST]

Authorised Officer

Authorised Officer

EXECUTED AS A DEED BY WHITTINGTON HEALTH NHS TRUST]

Authorised Office

Schedule 1:

HLDP Service Specification

Haringey Learning Disability Partnership (HLDP) Service Specification 2021-2026

1. National and Local Context

1.1. National Context

This specification should be seen within the context of national and local guidance, strategy and legislation relating to people with learning disabilities.

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

This government guidance sets out four guiding principles:

- Rights: People with learning disabilities and their families will have the same human rights as everyone else
- Independent Living: All disabled people should have greater choice and control over the support they need to go about their daily lives; greater access to housing, education, employment, leisure and transport opportunities and to participation in family and community life
- Control: Being involved in and in control of decisions by having information and support to understand the different options and their implications and consequences, so people can make informed decisions about their own lives
- Inclusion: Being able to participate in all the aspects of community – to work, learn, get about and meet people, be part of social networks and access goods and services – and to have the support to do so

1.1.2 The Care Act (2014)

Under the Care Act, the HLDP must ensure that people with learning disabilities who are 'ordinarily resident' in the area:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- can get the information and advice they need to make good decisions about care and support
- have a range of provision of high quality, appropriate services to choose from and are protected from abuse or neglect and must consider:
    - what services, facilities and resources are already available in the area (for example local voluntary and community groups), and how these might help local people
    - identifying people in the local area who might have care and support needs that are not being met

- identifying carers in the area who might have support needs that are not being met and consider their eligibility for support in their own right

- In fulfilling this role, the HLDP must also work within the key aims and principles of the Care Act:
  - Promoting Wellbeing
  - Preventing, reducing and delaying needs
  - Ensuring access to care and support is fair and transparent
  - Ensuring people are in control of their care and support

1.1.3 Building the Right Support and the National Service Model, 2015

The HLDP has a key role in ensuring people with learning disabilities can live ordinary lives in their communities. The Transforming Care programme has set out how to achieve this for people with challenging behaviour and/or mental health conditions, built on 9 principles described in Building the Right Support and the National Service Model, 2015. These principles apply to all people with learning disabilities:

1.1.3.1 People should be supported to have **a good and meaningful everyday life** - through access to activities and services such as early years services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.

1.1.3.2 Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

1.1.3.3 People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

1.1.3.4 People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

1.1.3.5 People should have a choice about where and with whom they live – with **a choice of housing** including small-scale supported living, and the offer of settled accommodation.

1.1.3.6 People should get **good care and support from mainstream NHS services**, using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

1.1.3.7 People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

1.1.3.8 When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or 'offending' behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community.

1.1.3.9 When necessary, when their health needs cannot be met in the community, they should be able to access **high-quality assessment and treatment in a hospital setting**, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

1.1.4 Other National Standards Policy Drivers

There are a number of other legislations, national and professional standards and government services for people with learning disabilities, the most relevant of which are listed below:

i. Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline [NG11] 2015.
ii. Mental health problems in people with learning disabilities: prevention, assessment and management (NG54) 2016
iii. Fulfilling and rewarding lives: The Strategy for Adults with Autism in England 2010;
iv. Care Quality Council National Minimum Standards;
v. Equality Act 2010;
vi. Mental Capacity Act, 2005;
vii. The Mansell Report Services for people with learning disability and challenging behaviour or mental health needs, DH 2007;
viii. Pan London Safeguarding Adults Multi Agency Procedures 2015;
ix. Working together to safeguard children 2015
x. Children's and Families Act 2014
xi. NHS Long Term Plan 2019

1.2 Local Context

1.2.1 NHS North Central London Clinical Commissioning Group (the CCG) and London Borough of Haringey (the Council) wish to commission Haringey Learning Disability Partnership (HLDP), an integrated community service which supports our strategic vision for adults and transitioning children with learning disabilities for whom they have responsibility.

1.2.2 Our vision is for adults with a learning disability in Haringey, and their carers, to be able to lead their best lives. They benefit from the Haringey Learning Disability

Partnership who work to reduce inequalities, provide specialist and responsive help, and strive to empower our residents to have choice and control over their lives. We will do this in partnership and as part of a whole-system to improve care for all people with learning disabilities.

1.2.3 Assessment, care planning and formulation of interventions will be provided by a multi-disciplinary team. The multi-disciplinary team will include - but not limited to, a range of skills - social work, nursing, continuing healthcare nursing, occupational therapy, speech and language therapy, physiotherapy, clinical psychology and psychiatry. As of December 2020 HLDP supported 774 residents with a learning disability.

1.2.4 The HLDP is moving towards greater integration as this refresh of the agreement also brings the staffing of learning disability psychiatry and continuing healthcare nursing into the partnership service specification. We aspire to integrate learning disability health and social care purchasing budgets in the next phase of the partnership for greater integration and more joined-up support for our residents with a learning disability and their families/ carers.

1.2.5 We expect the HLDP to work closely and in full partnership with service users and carers to identify the goals and outcomes which are important to them, which enable them to live in the community and support them to lead their best lives. As a partnership, we expect the providers of the service to adopt an integrated approach which ensures seamless delivery of health and social care to people accessing the service and minimises barriers to delivering joined up care and support. The HLDP will deliver health and social care services and interventions in a holistic and person centred way, with health and social care staff working together with the aim of providing services and/or coordinating services around each individual service user.

1.2.6 To enable this, the specification is supported by a pooled budget enabling the service to work in creative and innovative ways to deliver outcomes for users and engage them in wider civic life. Resources to support people with learning disabilities are under considerable pressure. Adult social care and health budgets have not kept pace with the population growth. The HLDP must operate with finite resources and apply principles of efficiency, effectiveness and best value to all they do in order to make best use of limited public resources and in

order to ensure the equitable allocation of those resources and keep within the allocated budget.

1.2.7 The team supports people with a diagnosed learning disability who are aged 18+ and ordinarily resident in Haringey (social care) or have a Haringey GP (health team). They have an eligibility criteria for accessing support directly from the team, however the HLDP also provides a learning disability facilitation and champion role, supporting all Haringey residents with a learning disability to have a good life.

1.2.8 As a Community Learning Disability Service, the HLDP services are provided in the community, either in a service user's home or in another community setting appropriate to the support or intervention being offered. The HLDP is not intended for patients in acute or other specialist health settings, however is HLDP patients are admitted to any hospital, they remain on the HLDP caseload. However, it may in-reach into those services and support those services to ensure good joint working and smooth transfer between settings. The HLDP will also work jointly with primary, secondary healthcare services, social, housing, leisure and employment services and a wide range of community-based social care and health services in all sectors in order to arrange service delivery around the needs and best interests of the service user.

1.2.9 The HLDP should not provide an alternative or parallel provision to mainstream services, but should always aim to facilitate access to mainstream services for the majority of people with a learning disability in Haringey.

2. Background to Partnership

2.1 The integration of health and social care services for people with· learning disabilities has been policy of successive governments and local partners, and remains a key driver for future improvements in the delivery of health and social care services, nationally and locally.

2.2 The Section 75 Partnership Agreement, sets out the contractual arrangements for the establishment of a pooled staffing budget and integrated provision of learning disabilities services in Haringey, under the title of Haringey Learning Disabilities Partnership (HLDP), with Haringey Council as lead organisation in the Partnership.

2.3 The HLDP was established in October 2003 and further developed through a series of Partnership Agreements established via Section 75 of the National Health Service Act 2006. Section 75 Agreements make provision for prescribed NHS bodies and prescribed local authorities to enter into prescribed arrangements in relation to the exercise of prescribed functions of the NHS bodies, and prescribed health-related functions of the local authorities.

2.4 Initially, the HLDP partners included the local authority (Haringey Council) and the two local National Health Service (NHS) trusts {NHS Haringey Primary Care Trust (PCT) and Barnet Enfield & Haringey Mental Health NHS Trust}, with Haringey Council as the lead partner.

2.5 In April 2011, a deed of variation was signed by all parties to take cognisance of the fact that Whittington Health NHS Trust became a new provider. This was the result of the split of the provider and commissioning arms of NHS Haringey PCT and the joining of the provider arm with the Whittington Health NHS Trust. NHS Haringey PCT was renamed NHS Haringey under the Agreement as the commissioning arm. This was approved by the Leader of Haringey Council in April 2012.

2.6 Subsequently, new legislation, in the form of the Health and Social Care Act 2012, resulted in some significant changes within the NHS. Service commissioning and procurement changes saw the transfer of commissioning functions from PCTs to newly formed GP-led Clinical Commissioning Groups (CCGs) at a local level. The NHS Commissioning Board which has taken on certain central/ national NHS commissioning responsibilities will also regulate the commissioning activities of CCGs. On 01 April 2013 CCGs took on existing PCT contracts and are now responsible for commissioning of secondary medical services in local areas. As such, the Haringey CCG became the key commissioning partner in the revised Section 75 Agreement. Haringey CCG is now defunct and succeeded to by North Central London CCG (the CCG).

2.7 Therefore, the core partners to this agreement are the two commissioning and funding bodies (Haringey Council and NCL CCG) and the service provider/ delivery bodies (Haringey Council; Whittington Health NHS Trust; and Barnet, Enfield and Haringey Mental Health NHS Trust) and Haringey Council will continue as the lead partner in the HLDP.

3. Vision

3.1 This vision has been created by everyone in the partnership through a series of workshops and teams completing their own team visions and outcomes.

Our vision is that:

"People with a learning disability in Haringey, along with their carers, are able to lead their best lives, with the support from HLDP who work to reduce inequalities, provide specialist and responsive help, and who strive to empower our residents to have choice and control over their lives."

4. Outcomes

4.1 These high level outcomes sit at the heart and guide everything we do. The HLDP works in a person-centred way with Haringey's adults with a learning disability and their families so that:

- People with a learning disability and their families/ carers have equal opportunities in life.
- People with a learning disability and their families/ carers have choice and control over their lives.
- People with a learning disability and their families/ carers have good health and mental health outcomes.

4.2 These three outcomes are central to the way the HLDP will work with their clients and deliver services. Below clarifies the reason for these outcomes to be addressed by the team and how they will go about delivering these outcomes for people with a learning disability and their carers.

4.3 **Equal Opportunities:** We know people with a learning disability have numerous barriers to equal participation and opportunities in society. They die on average 20 years earlier than the rest of the population. They have higher rates of mental illness, more long term conditions and other co-morbidities, yet poorer access to healthcare and poorer rates of early diagnosis and treatment. They experience barriers to employment affecting their socio economic status and limiting their access to the other wellbeing outcomes associated with employment. They are more likely to live with greater restrictions on their freedom and deprivations of liberty. They are more likely to be victims of crime and abuse and yet have greater barriers to justice. They are considerably more likely to have their children taken into care. They face stigma and institutional challenges throughout their lives.

4.4 The HLDP provides health care and facilitation; commissions housing, day opportunities and employment; working with client's they develop individual plans to support people on their life journeys. In order to have the biggest impact on people with a learning disability the HLDP must work in a holistic way looking at all the factors in an individual's life that can be optimised, in order to level the playing field and bring equal opportunities closer to home.

4.5 **Empowering Choice and Control:** People with a learning disability do not have the same choice and control over their lives compared to the general population. This has come about as a result of the very real limitations of some people's intellectual capacity/ disability, and a health and social care culture of zero risk built up over decades of safeguarding and risk management. These conditions exist today and with good reason. However, the HLDP is working to move the dial towards greater client choice and control. They will use their interventions to review and at times challenge the erosion of an individual's right to lead their own life.

4.6 The team will do this through encouraging positive risk taking, helping to develop people's independent living skills, providing person-centred and strengths based support that sees people in terms of ability rather than disability, recommending use of direct payments or other individualised commissioning options, providing preventative and early help /support wherever possible to individuals and/ or their families to stop needs deteriorating and so they can maintain their independence and control.

4.7 **Improving Health and Mental Health Outcomes:** People with a learning disability and often their carers have worse health outcomes than the general population and die on average 20 years . They are much more likely to experience mental illness and have physical health needs including long term conditions. Haringey has a higher percentage than the rest of England and London[1] of people with a learning disability and diagnosed mental illness. The HLDP will work to improve and narrow the gap in terms of outcomes for this population through responsive and specialist help, diagnosis, assessment, treatment, supporting and educating mainstream health services, consulting on complex cases, maintaining and improving people's health and safety, preventing and reducing people's admittance to hospitals.

5. Guiding Principles

The HLDP service will be guided by the following principles:

5.1 Support for people will be **Person Centred**, meaning that people will be fully involved in planning and all decisions relating to their care and support

5.2 **Family carers** will be fully involved in planning and decisions and kept informed of changes in need and/or changes in support, in line with the wishes of service users.

5.3 People should have **choice and control** over how their health and care needs are met.

[1] Perera et al., *Mental and physical health conditions in people with intellectual disabilities: Comparing local and national data*, December 2019, https://onlinelibrary.wiley.com/doi/abs/10.1111/bld.12304

5.4 Support will focus on **improving clearly defined individual health & well-being outcomes**

5.5 Interventions will be **effective and based on evidenced practice** and established care pathways that deliver better outcomes.

5.6 Services will be offered in an **integrated and seamless** way, across the HLDP and with other specialist and universal services.

5.7 Services delivered will be **equitably distributed based on the assessed need** of people needing services.

5.8 Care and support should be focused on providing support in the client's local area wherever possible. People should have a choice of where and with whom they live. Where avoidable the HLDP will work to prevent unnecessary hospital admissions; and support discharge from the point of admission.

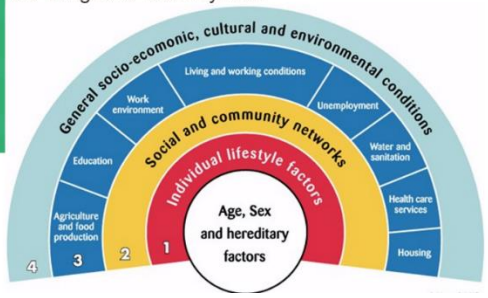
Taking a Public Health Approach

Public Health 'Place Based Approach' to tackle inequalities

START · LIVE · AGE WELL HARINGEY BOROUGH PARTNERSHIP

Haringey has taken a public health place based approach to reducing inequalities. The Learning Disability Partnership is integral to improving life opportunities for many residents with a learning disability.

This sits at root of Borough Partnership approach and our Integrated Care System



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5.9 The HLDP will work in a person centred way seeing the individual and their

unique characteristics, needs and wants as the focus of their support. However a person does not exist in a vacuum and the HLDP will also take into consideration their situation including socio economic. The following describes the approach that the HLDP uses in the delivery of our support in order to meet the outcomes above for our clients:

5.9.1 **Early Intervention and Prevention:** ours is a system that is person-centred, giving residents the opportunity to identify challenges and access support at the earliest possible point. Through a strong network of staff and volunteers we work with residents to catch problems early, preventing them from developing and becoming more serious;

5.9.2 **Integrated Working:** working in Haringey, we strive to form part of a multi-disciplinary team that covers the entire system. We celebrate the diversity of experience and expertise across our workforce, and we recognise the value in sharing information and working with colleagues to strengthen the overall support we provide to our residents;

5.9.3 **Locality Working:** Haringey has a strong sense of place, and a rich and diverse community and voluntary sector. Our services have an in-depth understanding of the local landscape, and draw on existing assets, expertise and support networks to provide residents with localised care and support, in the setting that feels most comfortable to them;

5.9.4 **Strengths-Based Approach:** we are person-centred, and are committed to promoting individual aspirations, enhancing independence and wellbeing and maximising autonomy. We work collaboratively with residents to agree their ideal outcomes, drawing on their strengths and assets, and encouraging them to be not just users, but also co-producers of the services provided.

5.9.5 The learning disability partnership is responsible for providing care and support to those who meet their **eligibility criteria**, but they also have a role to champion the health and wellbeing of all people with a learning disability, particularly through early intervention and prevention providing support to universal services in the ‘Healthy, safe and well’ tier.

5.9.6 The HLDP plays a vital role in **promoting and ensuring specialist advice is available to universal services** to offer any necessary reasonable adjustments for the benefit of all people with learning disabilities in the area. In addition, HLDP will work directly with those people who are most likely to experience barriers to achieving those outcomes without specialist support.

6 Needs analysis

6.1 There are an estimated 1.2 million people with learning disabilities in England, of which 286,000 are children and young people under the age of 18, with a learning disability (Emerson et al. 2012). This means that roughly 20 people in every thousand have a learning disability (2% of the general population). The majority live without support from specialist learning disability services – for instance, of the roughly 1 million adults with a learning disability, it is estimated that 189,000 (21%) are known to learning disability services. (Emerson et al. 2012). In Haringey this equates to approximately 5000 people with learning disabilities in the borough. The proportion of residents is similar to that for the NCL CCG, and for London as a whole. Approximately 1000 people with LD are known to the service and of this group between 700 and 800 people receive services from the HLDP in any one year, in relation to their learning disability. Of these adults, 7% are aged over 65 years, 56% live in the community with help at home, 25% of people live in supported living or supported housing settings and the about 19% in residential or nursing care.

6.2 Below is a snapshot of need in Haringey across the whole population. This was taken in 2019.

Haringey LONDON

Haringey Snapshot

HOUSING

- In terms of tenure, the proportion of Haringey residents that are renting from a private landlord has increased since 2011 (now 34%), while the proportion renting from LA has decreased (now 20%).
- Haringey has the third highest rate of households in Temporary Accommodation in London, and the population outnumbers the availability of housing by approximately 12,000 people.

PEOPLE

- Haringey is a highly diverse borough. 38% of residents are from BAME groups and 26% identify as "white other". 180+ languages are spoken.
- Deprivation levels are high, particularly in the northeast of the borough.
- GCSE attainment has improved comparative to England, but is below London, there are notable attainment gaps.
- Life expectancy in the borough is in line with the London average, though there are stark differences among different groups.
- Haringey residents report higher levels of life satisfaction than SNs or London, though there are higher rates of serious mental illness.

PLACE

- Facilities are good, with a range of cultural events and good transport links. Haringey also now has 25 Green Flag Parks.
- The rate of knife crime with injury is the highest in London.
- 78% of residents say they have good friendships and/or associations in their local area, while 83% say relations between different ethnic and religious communities are good.
- Haringey has reduced its carbon emissions by 36% since 2005, and emissions are below London and UK levels.

LOCAL ECONOMY

- Jobs density in Haringey is relatively low, although the unemployment rate has improved to be just above the London average.
- Wages in Haringey are lower than average, and there are a larger number of JSA and ESA claimants than the London average.
- 5.5% of residents have no qualifications, lower than the London average
- Median hourly pay in Haringey is 3.7% below the London average; we also have the second largest proportion of residents earning below the London Living Wage of all Inner London boroughs

6.3 People with a learning disability experience significant health inequalities. They are on average likely to die 20 years before people without a learning disability. They are much more likely than the general population to have mental and physical health conditions which further reduces their life opportunities. In 2020, HLDP provided support to 774 people with a learning disability. This is a fraction of the total learning disability population in Haringey, as it relates to those they directly support who meet their eligibility and those who are Care Act eligible and/or those with additional health needs not met within universal health services. This is an increase of 33% of clients open to the HLDP since 2013 due to population increase. The needs of this population are also growing more complex as Haringey is successful at discharging people from long stay hospital, and more children and young people are surviving infancy with very complex health needs due to medical and technological advancements. This means HLDP have to provide support for more people of greater complexity within the same staffing resources.

6.4 The historical data show that the prevalence of diagnosed learning disabilities in Haringey has been increasing by around 0.017% year on year. A 2019 study comparing the mental and physical health conditions of people with intellectual disabilities to the general population shows that whilst London has higher than average mental health conditions compared to the rest of the UK, Haringey had even higher levels of mental illness compared to London[2]:
"[The data] indicates that the proportion of people with a diagnosis of severe mental illness was considerably higher compared to those without intellectual disabilities, across Haringey (14.1% vs. 1.3%), London (10.8% vs. 1.1%) and nationally (8.1% vs. 0.9%)."

[2] Perera et al., *Mental and physical health conditions in people with intellectual disabilities: Comparing local and national data*, December 2019, https://onlinelibrary.wiley.com/doi/abs/10.1111/bld.12304

7. Service User Outcomes and Service / Team Functions

7.1 Teams within HLDP - The HLDP have a range of teams within it who work to improve specific and joint outcomes for people and work in a way to deliver different but seamless health and social care support for people with a learning disability and their families in Haringey. Combined, these individual client outcomes and functions deliver improved outcomes for our residents with a learning disability. Each activity working to improve conditions under one or more of the outcomes:

- People with a learning disability and their families/ carers have equal opportunities in life.
- People with a learning disability and their families/ carers have choice and control over their lives.
- People with a learning disability and their families/ carers have good health and mental health outcomes.

7.2 Social Work

Service user Outcomes

- Provide help to people when needed, including signposting to other services and/or other HLDP clinical and professional support
- Assess needs and develop a plan together including short term and/or life goals
- Provide opportunities for client's reflection, including reflecting on significant life events; and supporting them to act, or choose not to, in shaping their future
- Enable service users to consider risks and balance these and opportunities in their life and offering advice or support them to take positive risks.

Team Functions

- **Respond to referrals: being the 'front door' to the service**
- **Assessments:** understand the needs of service users through: Care Act Assessment, carers assessment, CHC assessment, MCA assessment, MH assessment, DoLS assessment, Human Rights Act assessment and other specialist assessments
- **Support planning:** mapping out how service users meet their needs
- **Reviews:** in collaboration with the service user and their network to consider whether their support continues to be appropriate or if changes are needed: 6 week reviews, annual review, emergency reviews (unplanned), review of Safeguarding and DoLS and others.
- **Longer term case management:** work with service users and families on more complex issues to resolve longer term outcomes
- **Safeguarding service users from abuse neglect:** work with service users to assess risk and look at protection planning with them
- **Transition Planning**: Undertaking a screening and initial assessments for young people with LD in transition to determine eligibility for the service
- **Duty:** communicating with service users and carers for cases where there is no allocated worker.

7.3 Day Services

Service User Outcomes

HLDP provides day opportunities for people, with learning disabilities and dementia at four different sites in the borough: Ermine Road Community Hub, Chad Gordon Campus, Winkfield Road Resource Centre and Haynes Dementia centre, with the following outcomes:

- Socially and intellectually stimulating day time activities
- Skills development through individually designed programmes of learning and training opportunities
- Community and leisure opportunities
- Health improvement activities
- Volunteering and work opportunities
- Respite support to parents who in work

Team Functions

- **Ermine Road Centre** is dedicated to people with profound with physical profound and multiple disabilities (PMLD) with an emphasis on improving health and wellbeing for people with complex health needs.
- **A Community Development Pathway (CDP)** is being established for more people to access an outreach, community based model of day opportunities for people with mild to moderating needs.
- **Chad Gordon Campus** caters for autistic people with and without learning disabilities. **#Actually Haringey** provides pre and post diagnostic support both in person and online. **Haringey Opportunities Project (HOP)** is a collaboration between the LHDP and C404, an independent PBS provider that supports autistic people with a learning disability who have present with behaviours that challenge.
- **Winkfield Road Centre** offers drop in opportunities to a range of vulnerable adults including people with learning disabilities. It also hosts a mixture of statutory and third sector projects that supports all vulnerable adults in the community, such as the Disability Action Haringey (DAH) https://www.d-a-h.org/ which supports people with their Direct Payments.

- **Haynes Centre provides** support to people with dementia both on outreach model and within the centre.

7.4 Nursing

Service user Outcomes

- Safe discharge from hospital (MH and Physical)
- Prevent and reduce unnecessary admissions to hospital, but promote coordination where this is clinically appropriate (MH and physical).
- Professional, timely, and high-quality nursing intervention, where there is an identified need.
- Positively promote participation in annual health checks and national screening and vaccination programmes.
- A person-centred approach based on individual strengths and potential, to support wellbeing and improve quality of life
- Health facilitation and support to primary care on implementation of health checks

Team Functions

- Contribute to Care Act Needs assessment
- Specialist Nursing assessment
- CHC Assessment (Aligned activity by CCG Assessor / Excluded from the Pool for now)
- Assessments and observations in relation to mental health needs such as anxiety, depression, challenging behaviours, ect…
- Epilepsy clinics
- Health education and promotion
- Facilitate hospital discharges (general hospitals)
- Transition Planning: Undertaking a screening and initial assessments for young people with LD in transition to determine eligibility for the service
-

7.5 Assessment and Intervention Team (AIT)

Service User Outcomes

- Support safe discharge from psychiatric hospitals (MH)
- Prevent and reduce unnecessary admissions to hospital, and promote coordination where this is clinically appropriate (MH)
- Help individuals and their families through difficult periods including mental health crises

Team Functions

- Ensure prompt responses to referrals
- Regular review of risk assessments
- Regular completion of HoNOS-LD (Health of the Nation Outcome Scale – LD)
- Where clinically advised, service users to have a Positive Behaviour Support Plan
- Ensure prompt responses to discharges
- Ensure service users who are admitted to hospital have regular contact with community team

7.6 Psychology

Service user Outcomes:

Enabling service users with complex needs to live independent lives with expert support to address their psychological need through:

- Screening for LD service eligibility, in relation to the PBS definition of LD
- Undertaking cognitive assessment where required
- Undertaking specialist psychological assessment of behavioural presentations such as functional analysis of behaviour, anxiety depression, ect…
- Support universal and secondary care to ensure reasonable adjustments to enable people with learning disabilities to access services
- Teach, advise, and support mainstream and other specialist services

Team Functions

- Direct support to people and their families when their needs cannot be met by mainstream service alone, including liaison with mainstream and children/transition services
- Assess and formulate needs to inform support planning
- Plan evidence based interventions including a variety of treatments and therapy
- Support service providers and others in the provision of longer term support for people with complex and continuing health needs
- Provide emergency and crisis support, sometimes in partnership with mental health colleagues
- Transition Planning: Undertaking a screening and initial assessments for young people with LD in transition to determine eligibility for the service.

7.7 Speech and Language Therapy

Service User Outcomes

- Provide evidence based assessment and intervention for communication and dysphagia.
- Specialist communication and dysphagia support plans.
- Support people with a learning disability to remain healthy at home and decrease unplanned hospital admissions due to aspiration pneumonia/ chest infections/ malnutrition/ dehydration.
- Promote and support staff/carers to set up total communication environments to enable people with a learning disability to have more autonomy, choice and control in their everyday life.

Team Functions

- SLTs to meet the Royal College of Speech and Language Therapists (RCSLT) national guidelines for responding to a dysphagia referrals.
- Maintain active review list of dysphagia cases.
- Prioritise screening of new referrals to ensure timely response.
- Delivery regular dysphagia and communication training to professionals, carers, parents and managers.
- Continued professional development undertaken by all Speech and Language Therapists to maintain up to date evidence base.
- Working in a multi-disciplinary way to provide holistic and person-centred interventions.
- Transition Planning: Undertaking a screening and initial assessments for young people with LD in transition to determine eligibility for the service

7.8 Occupational Therapy

Service User Outcomes

- Support with Engaging in activities meaningful to the person including leisure, sensory functional, exercise, social opportunities.
- Increasing level of independence in all areas including ADLs, travel, skills, mobility, work ect.
- Maintaining and or improving their health and safety. Understanding of risks, equipment, physical health-mental health-spiritual health.
- Enabling and facilitating access to mainstream services and opportunities, including supported employment, housing, Health and social services, social and leisure activities amongst others.
- Supporting people living in appropriate community settings, including Transforming Care cohort and others living with family/ supported living/ nursing home/ Shared Lives 1. Engaging in activities meaningful to the person. Leisure, functional, exercise, social, sensory.

Team Functions

- Specialist assessments, observations, interventions, liaisons with family-carers, MDT, training, making recommendations, advocacy for reasonable adjustments.
- Support plan to improve independence.
- Minor adaptations
- Transition Planning: Undertaking a screening and initial assessments for young people with LD in transition to determine eligibility for the service.

7.9 Physiotherapy

Service user Outcomes:

- Reduce health risks & improve quality of life
- Enhance, optimise &, maintain independence / physical presentation
- Engaging in increased physical activity
- Prevent emergencies / injuries
- Reduce hospital admissions/reduce lengths of hospital stays.

Team Functions:

- 24-hour postural assessment and management
- Community level respiratory management
- Make the adjustments
- Support positive access to and responses from mainstream physiotherapy/relevant healthcare services
- Engaging, building relationships
- Falls Prevention & intervention
- Management of mobility
- Closer relationship with mainstream community therapy team
- Assessment/provision of specialist equipment
- Spasticity/Hypertonia Management

7.10 Psychiatry

Service User Outcomes

- Stable mental health
- Recovery from mental illness
- Improved quality of life

- Reduction in challenging behaviour
- Reduction of symptoms of ADHD and functional impairment
- Diagnosis and signposting to relevant resources
- Enabling carers and staff to have a better understanding of diagnoses, treatment and current and ongoing issues including side-effects of treatment
- Seek expert level support and advice from other professionals
- People receiving diagnosis can get appropriate support
- Reduce hospital admissions

Team functions

- Diagnose and treat people with intellectual disability and mental illness
- Advice/manage/support people with intellectual disability and challenging behaviour
- Diagnose and treat/manage people with ADHD and intellectual disability
- Diagnose autism in people with intellectual disability
- Diagnose dementia and treat as appropriately in people with intellectual disability
- Reduce psychiatric inpatient admission and support people to recover from mental illness in people with ID in the community as practical as possible

7.11 Business Support / Administration

Service User Outcomes

- To support the day to day running and efficiency of the HLDP, in order that the HLDP teams are able to best support their clients.

Team Functions:

- Maintain high quality communications
- Service contact, and delivery.
- Provide administrative support to the teams
- Coordinate Complaints, SAR, FOI, LeDer – delivered within timescale
- Implement efficient systems and processes for the HLDP: Access to systems, Updates/changes.
- Understand and help implement staff policies e.g. health and safety, flexible working
- Organise staff inductions, mandatory training etc.

8. Standards of care

All teams and services will work to the standards of care stipulated within the relevant professional and government guidance such as those from NICE guideline as listed below:

- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline [NG11] 2015.
- Autism spectrum disorder in adults: diagnosis and management Clinical guideline [CG142].
- Dementia: assessment, management and support for people living with dementia and their carers NICE guideline [NG97].
- Mental health problems in people with learning disabilities: prevention, assessment, and management (NG54) 2016.
- NICE guideline that covers diagnosing, treating and managing epilepsy (CG137)
- ADHD in People with Intellectual disability- Royal College of Psychiatrists – College Report 230
- Social work Standards.

9. Integrated Care Pathways and multi-disciplinary working

The teams within the HLDP teams operate on a multi-disciplinary basis, coming together to work holistically in a person-centred way to ensure the best outcomes possible for service users and carers. The HLDP has also developed a number of thematic integrated care pathways for their clients in order that they can bring together different teams professional knowledge and experience creating better outcome for the client. This way of working is in practice and should become the norm, looking at other pathways that would benefit from a multi-disciplinary approach to improve outcomes for our residents, and be an effective way of working for the teams, who learn skills and knowledge from each other. The current pathways in use within the HLDP are:

9.1 Transition and Initial Assessment Pathway: Led by Psychology and Social Work with contributions from Nursing and Therapy teams. The purpose is to determine eligibility under the Care Act and to a specialist LD service. All referrals are screened for LD eligibility and offered a Care Act Assessment. HLDP will contribute to the preparing for adulthood (PfA) strategy.

9.2 **ComPhy Pathway:** (complex physical health): Led by Speech and language therapies, physiotherapy, occupational therapy, social work and nursing and offering assessment and support for people with Profound, multiple and complex physical health needs

9.3 **Mental Health Pathway**: Led by Psychiatry, psychology, Social work and nursing: Proactive identification, diagnosis and effective treatment of people with LD and MH needs.

9.4 **Positive / Challenging Behaviour Pathway:** Led Psychology and Nursing offering Positive Behaviour Support, enabling individuals with LD and their families, carers and staff in care home staff to make accurate observations, assessment of behaviours that challenge, identify triggers and establishing proactive approaches for addressing these.

9.5 **Epilepsy Pathway**: Led by psychiatry and Nursing, in improving the quality of life outcomes for people with epilepsy.

9.6 **Dementia Pathway:** Led by psychiatry, nursing, social care and day opportunities, enabling improved care co-ordination and quality of life for people with dementia**.**

9.7 **Primary and Hospital care Pathway:** Led by Nursing, enabling people with LD to have good access and effective support from all health care providers.

9.8 **Sexual Health Education and Relationship:** Led by Nursing, enabling and supporting people with LD to have appropriate sexual health advice and guidance

10. Locality Working Model

HLDP is a community based multi-agency specialist secondary care service that is available to people with a learning disability with and assessed eligible need. It works across the borough. While the service appreciates the benefits of working within a locality model it is too small a resource to be split across the three localities. However, HLDP will have nominated leads in each locality particularly in relation to social work in order to embrace the locality approach.

11. Outcomes and Performance Framework for HLDP

HL HLDP is commissioned to work towards and deliver the vision outlined above and the following high level outcomes

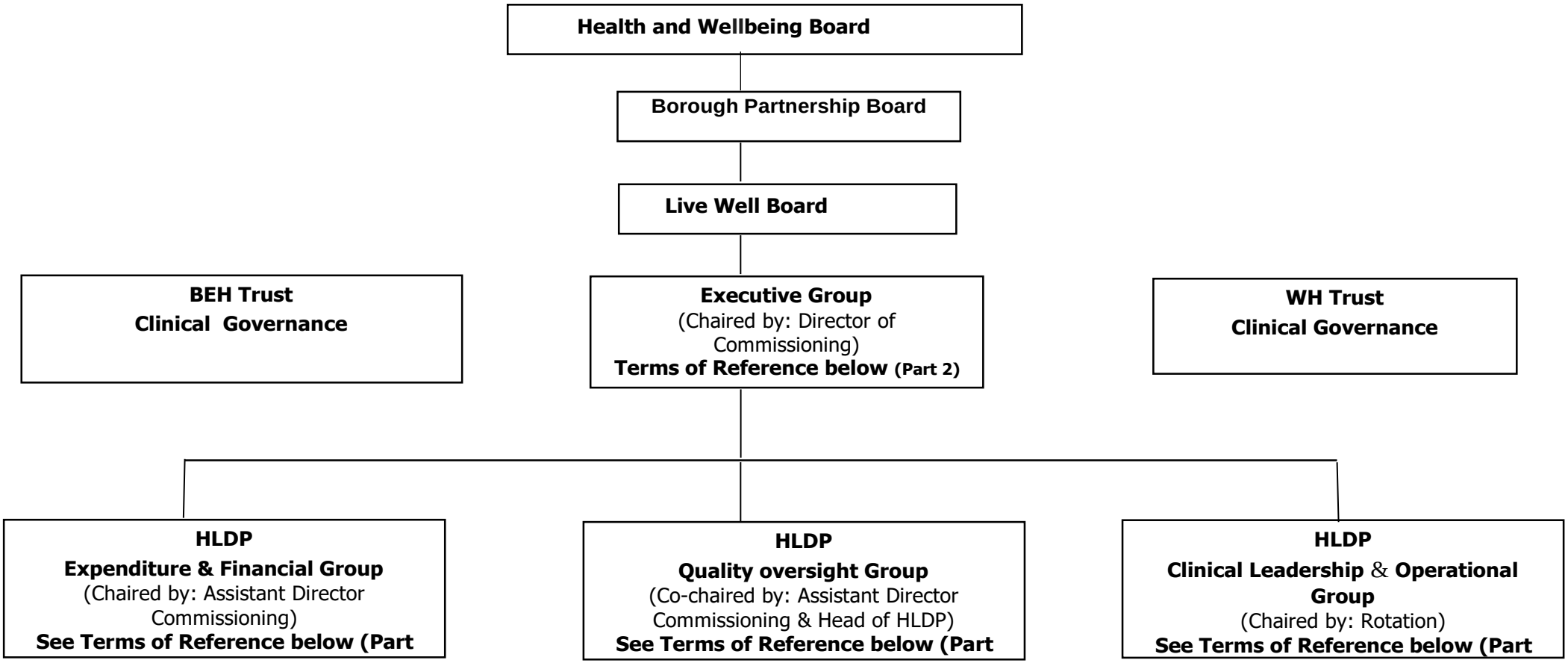
1. People with a learning disability and their families/ carers have equal opportunities in life.
2. People with a learning disability and their families/ carers have choice and control over their lives.
3. People with a learning disability and their families/ carers have good health and mental health outcomes.

12. HLDP Performance and outcomes measures:

All Performance management and service improvements must demonstrate how they improve life outcomes for people. The main performance management tool that HLDP uses is the Adult Social Care Outcomes Framework (ASCOF) that measures all health and social care activities at a local level and is used to compare our performance against our statistical neighbours and nationally. HLDP is piloting a set of health specific measures that will be integrated with ASCOF performance measures in order to provide a fuller view of the productivity and impact of the of the HLDP service. This will be subject to regular reviews. The table below sets out the main outcomes and measures:

Outcome 1		Outcome 2		Outcome 3	
PwLD have good opportunities in life		**PwLD have choice and control over their lives**		**PwLD have good Physical health and mental health outcomes**	
Objectives	**Measures**	**Objectives**	**Measures**	**Objectives**	**Measures**
Being innovative and connected with the community - Knowledge of range of opportunities, Connected Communities, social prescribing, universal services, primary care, assistive technology, peer support	Increase in the number of referrals for assistive technology, Connected Communities and other community support services	**Promoting levels of independence** – Supporting choice and control, strengths based, developing skills, improving mobility, positive risk approach	Increase in the number of Direct Payments and Personal health budgets, increasing referrals for assistive technologies and minor equipment. Communication plans	**Ensuring specialist assessment and where possible securing an early diagnosis** in relation to Autism, ADHD, Dementia, Epilepsy and other prevalent conditions	number of people with confirmed diagnoses where the implications have been explained to the service users, families, carers and staff. Annual health checks.
A right to a home- Least restrictive and settled accommodation, adaptations, Assistive Technology, special equipment, advocating tenancy rights and responsibilities	AT referrals, Settled Accommodation %, Specialist equipment / Major and minor adaptations	**Teaching, guiding and advising** – To service users, other professionals, clinicians, providers, families, primary care & universal services	Summary of teaching guiding or advising carried out by team e.g. to service users, carers, staff and their outcome/ purpose, feedback	**Preventing and reducing unnecessary hospital admissions** – Admissions avoidance register, AIT, COMPhy pathway	TCP; on At Risk Register, number in psychiatric hospital placements, number of admissions and discharges - cumulative COMPhy: number on pathway admitted to hospital and comparison. Hospital passports
Valuing and supporting our families and carers – Valuing their expertise and input, support, advice and assessment of need	carer feedback regularly collected from across MDT - questions relate to outcomes and values, Carer assessments % and in time	**Respecting people's individuality** – Striving for their equality, respecting their diversity, their decisions, what is meaningful to them, their communication style, understanding their sensory needs; and reflecting deeply on issues of capacity, consent and other people's 'best interest'	User and carer feedback on HLDP support. Mental Capacity assessments/ Best Interest decisions. Advocacy referrals. Number of Safeguarding concerns raised and S42 enquiries completed Sensory / communication support (SALT)	**Emergency response** – Crisis planning and crisis management, managing high levels of risk	
Timely and responsive support – Assessments within appropriate timescales, preventing emergencies or injuries, reacting to deterioration	% assessments completed within 28 days (by both Health and Social Care teams for , CHC, carers, and others. Number of reviews completed	**Promoting Safer Choices** – Supporting people evaluate risks and take positive risks and mitigate against risks of harm	Number of safeguarding concerns reported and Enquiries completed . Enabling people to step to least restrictive support levels	**Crisis and Recovery** – Managing sudden or incremental changes in mental and/ or physical health	Number of AIT cases, Number of CPA co-ordinated / reviewed. Number of hosp admissions avoided.
Growing Older with a Learning Disability – Dementia pathway, nursing care, palliative care,	Number on dementia pathway, number in nursing care, average mortality rate for HLDP compared to NCL and London averages	**Reviews** – Setting individual goals and outcomes, measuring progress, responding to changing situations, use of episodes of care	reviews carried out number and within time for CHC, Social Care and Carers	**Assessment and individualised treatment and therapy**	Number or specialist health assessment and their duration
Transition from Children to Adult Services – Preparing for adulthood through assessment, support, advice, goals, setting expectations that change is the norm	% of referrals from Children's, and % who receive a service and cost Number of young people (18-25yrs) with an active EHCP	**Working towards economic independence and wellbeing –** Enabling and ensuring continuing education, training and employment opportunities, promoting work for all its wellbeing outcomes	% in paid employment. % in volunteering roles. % of people in training and FE and proportion with a recorded qualifications	**Maintaining and improving people's health and safety –** eating and drinking, falls prevention, epilepsy pathway, ADHD clinic..	Number of people accessing : dysphagia assessment with an active management plan, epilepsy support, falls prevention Physiotherapy
Moving accommodation – Reviewing if needs require a step up/ step down, supporting families through moving out, family breakdown	Tracking movement in client accommodation type over the year. Number of people stepped down to least restrictive care	Improving service user experience of the HLDP and associated services	Service user feed back. Number of LeDeR reviewed in the team. Service improvement from lessons learnt from LeDeR and SAR reviews	**Bereavement** – Support with death of clients, carers and staff	Number of deaths at home, deaths in hospital, reviews outstanding. Number of referrals for counselling support

SCHEDULE TWO
GOVERNANCE ARRANGEMENTS FOR HLDP



Part 1: Health and Wellbeing Board

The Health and Wellbeing Board accepted on 21 May 2013 the governance structure to deliver the outcomes of the Health and Wellbeing Strategy. The Health and Wellbeing Senior Officers Group consists of the Director of Public Health, Director of Adult and Housing Services, Director of Children Services and the Chief Officer of Haringey's Clinical Commissioning Group (CCG). Full terms of reference of the health and wellbeing board can be accessed at the Council's Constitution at Part Three - Responsibility for Functions Section B – Full Council & Non-Executive Bodies available here : https://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=873&MId=7972&info=1&MD=Constitution and includes the following.

The Board will have a key strategic role in promoting and coordinating joint commissioning and integrated provision between the partners to the Agreement.

For the purpose of advancing the health and wellbeing of the people in Haringey, the Board will encourage the partners to this arrangement to work in an integrated manner and closely together.

The Board will provide advice, assistance or other support as it thinks appropriate for the purpose of encouraging this section 75 of the NHS Act 2006 partnership arrangement.

PART 2: EXECUTIVE GROUP and ToR

1. Alms and Objectives

1.1 The Executive Group comprises senior managers and clinical/ medical staff of the Partners (Haringey Council and NCL CCG), Whittington Health NHS Trust; the BEH-MHT NHS Trust.

1.2 The key aim of the Executive Group is to oversee the implementation of 'Valuing People' and 'Valuing People Now' within the context of other local and national strategic frameworks.

1.3 To over the delivery of the HLDP services in line with the service specifications in Schedule one.

Specifically, this will include;

- Overseeing the management of the Section 75 Agreement, covering integrated Service provision and the Pooled Fund;
- Overseeing the delivery and development of HLDP (for e.g. developing local services for people with challenging needs and people with complex physical needs).
- Monitoring and raising standards by improving the quality, responsiveness and clinical effectiveness of the Services;
- Receiving regular performance reports in relation to both national and locally agreed indicators;

- Overseeing the Pooled Fund by receiving regular updates from the Pooled Fund Manager and the Expenditure/ Finance Group and developing plans addressing any variance;
- Agreeing the budget in advance of each financial year;
- Ensuring that all of the required plans of the Partners are developed and reported;
- Ensuring that all employees, including seconded employees, receive appropriate line management and clinicalsupervision;
- Supporting the role of the Partnership Meeting Group and sub-groups;
- Overseeing the implementation and monitoring of relevant local operational strategic plans and commissioning strategies;
- Considering the implications of national and local recommendations to service quality and development;
- Overseeing the resolution of any relevant disputes, or when this is not possible, referring such issues to the Chief Executives or equivalent of the Partners to the Agreement for resolution;
- Undertaking other relevant functions as may be deemed appropriate by the Partners.

2. Reporting Arrangements and Accountabilities

2.1 The Executive Group shall report to the Health and Wellbeing Board and to the provider-side NHS Provider Trusts (BEH-MHT NHS Trust and Whittington Health NHS Trust), as appropriate.

2.2 Individual members of the Executive Group shall remain accountable to their own organisation and professional body for ensuring that robust risk management, clinical governance and (Human Resources) HR procedures/ mechanisms are in place.

3. Tasks

3.1 The tasks of the Executive Group will be reviewed and agreed annually and where possible in conjunction with business planning cycles of the Partners.

4. Membership

4.1 The membership of the Executive Group will comprise of the following Representatives or equivalent from each Partner;

Organisation	Role
Haringev Council	Director Commissioning (Chair)
Haringev Council	Assistant Director Adult and Health
Joint Appointment NCL CCG / Council	Head of Service
Joint Appointment NCL CCG / Council	LD Lead commissioning Officer
Whittington Health NHS Trust	Associate Director, Professional and Business Development (Executive Nurse)
BEH-MHT	Assistant Director
Haringey Council	Head of Finance
Whittington Health NHS Trust	Head of Provider Finance

Any other representatives to be confirmed by the Executive Group

5. Meetings

5.1 The Executive Group will meet quarterly. Dates for meetings will be set at the start of each financial year. Exceptional meetings can be convened with the consent of the Chair.

5.2 The members of the group will agree the role of Chair at the start of each year.

Administration & Attendance

5.3 Attendance by non-members is at the invitation of the Chair. Other staff/ managers/ Representatives may be invited to attend to discuss specific agenda items.

5.4 The agenda papers and minutes of meetings will be available to the public via the Council's website subject to confirmation at each meeting.

5.5 By agreement of the meeting, papers will be converted to 'accessible' version to ensure that relevant information is passed to People with a Learning Disability.

Decision-making and Quorum

5.6 All decisions of the Executive Group must be unanimous. Where there is a difference that cannot be resolved this must be referred to the Chief Executive or equivalent of all Partners for resolution.

5.7 The quorum required for the Executive Group shall be one member representative of each of the Partners, not including joint appointments.

PART 3: EXPENDITURE/ FINANCE GROUP

Function

1. To provide clear operational leadership in respect of the management of the Pooled Fund.
2. To ensure active and effective input and partnership from each of the Partners.
3. To ensure robust financial administrative systems are in place and used for the effective management of the Pooled Fund.
4. To ensure all financial processes align with those of the Host Partner and other Partners.
5. To receive and consider monthly reports on activity (including budget spend, projections and forecasts).
6. To monitor budget activity and prepare relevant reports (including activity, projections and forecasts) for consideration at quarterly Executive Group meetings.

Business Plan

1. To agree an annual Expenditure/ Finance Plan for the Pooled Fund for each Financial year in accordance with the Section 75 Agreement having first consulted with the Executive Group, Clinical Leadership & Operational Group (CLOG) .
2. To ensure that all expenditure from the Pooled Fund is made in accordance with the Expenditure/ Finance Plan.
3. To prepare and submit the annual Expenditure/ Finance Plan to the Executive Group for their consideration and approval

Accountability

1. To be accountable to the Executive Group.
2. To ensure effective communication between the relevant Partners, the Executive Group, the Clinical Leadership & Operational Group and the Partnership Meeting Group.

Frequency of Meetings

1. The group will meet monthly and this will be reviewed annually. Dates for meetings will be set at the start of the year.

Membership

1. Members of the Group will include the Pooled Fund Manager and one nominated Representatives from each of the Finance Departments of the Partners.
2. The members of the group will agree the role of Chair at the start of each year.

PART 4: - CLINICAL LEADERSHIP OPERATIONS GROUP (CLOG)

Aim

1. To provide clinical and operational leadership across the HLDP.
2. To ensure practice effectiveness.
3. To oversee and direct the work of the Health and Social Care multi-disciplinary teams.
4. To ensure effective and responsive services
5. To develop and maintain integrated care pathways
6. To ensure effective communication with all service user groups, teams and partner organisations.

Objectives

- To ensure all request / referrals are screened in timely manner and responded to appropriately
- To ensure all service users have access high quality and timely multi-disciplinary assessments and support plans.
- To engage service users and carers to elicit their views about impact of services.

- To ensure all teams deliver on agreed service user outcomes, and service performance targets.
- To audit all service functions and identify service improvement goals for all areas
- To investigate complaints, draw out the lessons from these and disseminate the learning to all teams.
- To participate in mortality (LeDeR) reviews and Safeguarding Adult Reviews (SAR) and ensure that lessons learnt from such events are disseminated to all teams.
- To maintain up to date record of all service interventions.
- To undertake adult safeguarding enquiries in timely manner and in line with the Care Act 2014
- To monitor, evaluate and report service and budget performance reports

Reporting arrangements

- To provide monthly service and budget performance reports to the Executive Group
- To provide monthly service budget, workforce and service improvement reports to Council's Departmental Management Team meetings

Key relationships

Members of the HLPD will be delegated to contribute to a range of groups in order to meet its service objectives including:

- LeDeR
- Health and safety and Quality Assurance Board
- Service and Budget Performance Call Over meetings
- Trust Professional and clinical governance group meetings
- Health and safety Committee

Membership

CLOG is led by the joint head of service and comprise the service leads or team managers of each service area:

- Lead Social Workers
- Lead Nurse
- Consultant Psychiatrist
- Lead Psychologist
- Day Services Manager
- Administration Manager
- Lead Therapist (also the lead S&LT) including lead OT and Physio)
- LD Joint Commissioning Lead

Administration of Business

CLOG meets as a monthly huddle using the Perform Plus approach to carry out the following functions:

- Recognise and celebrate successes,
- Communicate key information
- Consider team performance
- Identify and prioritise problems
- Identify opportunities
- Progress actions and
- Survey the views of members

CLOG will also:

- ensure that all service areas hold daily / weekly huddles as appropriate to fulfil the same purpose
- hold a monthly service wide meeting to engage all teams and staff

- hold a monthly problem solving meeting to address key areas that require further development and set clear operational standards
- ensure that the service holds a monthly carers forum and regular (weekly or fortnightly) carers surgery supported by the head of service & all service leads

PART 5: HLDP QUALITY ASSURANCE OVERSIGHT GROUP
Haringey Learning Disability Quality Oversight Group
July 2021

Purpose

The Haringey Joint Learning Disability Quality Group will be set up to oversee strategic quality issues affecting people with a learning disability who are resident or ordinarily resident in Haringey (i.e. placed out of area by social care).The Group will seek to coordinate and agree learning/ recommendations from quality issues that arise to drive service improvements. It will be proactive in feeding any learning into service improvement using commissioning and/ or operational levers and monitoring progress. The group will be strategic in focus, meaning it will identify long-term or overall

positive aims and outcomes from local and national practice (both good and bad) to drive improvements across health and social care service for people with a learning disability.

The group will have a particular focus on service improvement, it will make recommendations and monitor their implementation. The group will agree which quality agenda items are suitable for discussion but broadly they should meet one or more of the following criteria:

- Complex (e.g. Involving multiple agencies and/ or lots of different issues are identified and hard to easily untangle)
- High Risk (e.g. possibly leading/ led to client death, or provider failure)
- Systemic (e.g. Found across a service or services)
- Innovative / Best practice (e.g. considered to be an example of excellence that we can learn from, or being implemented nationally (new policy) and needs local oversight on implementation)

Items that should be regularly part of the agenda include (but are not limited to);

- Learning and recommendations from LeDER mortality reviews,
- Reducing use of restraint including STOMP/STAMP
- Improving quality of care for LD Providers e.g. training
- Quality assurance of LD provision, especially out of area
- Improving care for people with a learning disability using universal services
- Providers at risk of failure
- Changes in legislation or new guidance affecting quality or safety for people with a learning disability
- Including and strengthening the user's voice to help shape quality improvements
- Patient/ client pathways and improving effectiveness of these locally

Scope

Covering health and social care services that Haringey residents with a learning disability use. This includes those living out of area, but ordinarily resident of Haringey (with social care responsibility). And residents with a learning disability who are not known to the HLDP.

The group initially will look at concerns for adults but aspires to include young people aged 14+ (link to annual health checks) as transition is a key time when things can go wrong.

This group will not duplicate other existing groups and will feed into these groups wherever possible e.g.

Safeguarding Adult Board, Safeguarding Adults Review, transitions groups.

The group will not share patient names or identifiable information, nor get too involved in detail, but remain high level, focusing on 'what do we need to do better in Haringey to improve quality of service for people with a learning disability, and how do we do it?'

The group will cover quality issues relating to people with a learning disability and autism, but not those who are autistic without a learning disability as this is quite a distinct group and requires different stakeholders.

Attendees

- Joint Assistant Director of VAC Commissioning, NCL CCG and Haringey Council – Chair
- Joint Lead Commissioner of Learning Disability and Autism, NCL CCG and Haringey Council – Deputy Chair
- Head of the HLDP, Haringey Council – Deputy Chair
- Assistant Director of Quality, NCL CCG Haringey Directorate
- Lead LD Nurse, HLDP Haringey Council and Whittington Hospital
- Deputy Manager of HLDP Social Care Team with Safeguarding Management Responsibility, Haringey Council
- Head of Brokerage and Quality Assurance, Haringey Council
- Commissioning and Safeguarding Officer, Haringey Council
- Adult Safeguarding Designated Lead, NCL CCG Haringey Directorate
- Whittington Hospital Safeguarding Adults Lead
- Representative from LeDER Programme - NCL CCG
- Consultant Psychiatrist, HLDP and BEH
- User advocacy – links to user group involvement

Meeting frequency and management

Assistant Director of Vulnerable Adult and Children (VAC) Joint Commissioning to Chair. Lead LD Commissioner and/or Head of HLDP to deputise.

The group will meet every two months, but additional/ exceptional meetings can be arranged by agreement of the Chair and Deputy Chairs to discuss urgent and concerning issues that may arise.

All members of the meeting can put forward agenda items, but the agenda is finalised by the Chair.

Governance

This group will become a formal subgroup of the Learning Disability Executive meeting. There will need to be highlight reports drafted for the Learning Disability Executive Group and presented at least twice a year. Members of the group will be nominated by the Chair to help work on this. Items that arise that are cause for concern, or good practice/ positive change should be escalated to the Learning Disability Executive meetings as and when these occur. The process for getting these onto the LD Executive agenda is to submit them to the Head of the HLDP and or Joint Lead Commissioner for LD who will then submit them to the Chair of the LD Executive.

Review

These terms of reference will be reviewed annually.

SCHEDULE THREE

HLDP TEAM (PARTNERSHIP TEAM)

Operational Staffing
The following staff groups form part of the service delivery of HLDP teams as at December 2021
Head of Service

- Joint Head of service – 1wte / Grade: PO8 Joint (NCL CCG and LBH) appointment & employed by the council

Nursing - Employed by WH NHST Trust

1. Lead Nurse – 1wte / Grade: Band8B
2. AIT Nurse Manager - 1wte Grade: Band 7
3. Hospital Liaison Nurse - 1wte Grade : Band 7
4. LD Nurses - 4.5wte Grade: Band 6
5. LD Nurse - 1wte Grade: band 5

Nursing – Employed by BEH Trust

6. LD Nurses - 2wte Grade: Band 6

Nursing – Employed by NCL CCG

7. CHC Nurse Assessor - 1wte Grade: Band 7 (Exclude from the Pooled Fund for now)

Psychology - Employed by BEH NHS Trust

1. Lead Psychologist 1wte / Grade: band 8B /
2. Clinical Psychologist 1 wte Band 8A
3. Clinical Psychologist 1 wte Band 7
4. Assistant Psychologist 2 wte Band 5 (18 months fixed term contracts)

Psychiatry -Employed by BEH NHS Trust

1. Consultant Psychiatrist 2 wte
2. Trainee doctors 3wte rotating (short 3-6 month contracts)

Social Work - Employed by LBH

1. Social work Team Managers 3 wte / Grade: PO7
2. Assistant Team Managers / Senior Practitioners 2 wte / Grade P05
3. Social workers 20wte Grade SW0 Spine Point 38
4. Service Finding /Reviewing officers 3 wte / Grade P01 Spine Point 28
5. Community Support Officers 2wte / Grade: S01: Spine Point 25

Speech and Language Therapist - Employed by WH NHST Trust

1. Lead Therapist - 1wte band 8A
2. Speech and Language Therapist - 1 wte Band 7

3. Speech and Language Therapist - 1 wte Band 6

Occupational Therapist

1. Lead OT - 1wte band 7 Employed by WH NHST Trust
2. OT – 1wte band 6 Employed by BEH NHS Trust
3. OT - Assistant 1wte Employed by WH NHST Trust

Physiotherapy

1. Physiotherapist - 1wte band 7 Employed by WH NHST Trust

Administrative team - Employed by WH NHST Trust

1. Admin manager - 1wte Band 5
2. Admin and clerical officer - 1wte band 4
3. Admin and clerical officer - 1wte band 2 (2 part time officers)

Administrative team - Employed by LBH

4. Medical Admin officer 1 wte - Grade: SC5 Spine point 15

Day Services - Employed by LBH

1. Service manager - 1wte Grade: P07
2. Haynes Center: Team Manager – 1wte Grade:P04
3. Ermine Road Center: Hub manager – 1wte Grade:P04
4. Chad Gordon Campus: Manager – 1 wte Grade:P04
5. Community Development Pathway Manager – 1wte – Grade:P04

SCHEDULE 4:
OPERATIONAL ARRANGEMENTS

OPERATIONAL ARRANGEMENTS FOR THE HLDP INTEGRATED SERVICE

1. Recruitment of staff
2. Line management and professional supervision
3. Grievance and disciplinary arrangements
4. Trade Union recognition
5. Health and safety arrangements

1. RECRUITMENT OF STAFF

1.1 The Head of Service is a joint post between the CCG and the council accountable to the Assistant Director of Adult and Health in LBH.

1.2 Recruitment of staff vacancies within the Partnership is the responsibility of the Head of Service. The Head of Service is jointly accountable for health and social care staff, in accordance with the HR policies of each partner organisation and required to use the appropriate recruitment procedures for the substantive employing Partner.

1.3 The following posts form part of the HLDP service senior Clinical Leadership Operational Group (CLOG) who report to the Head of Service and provide line management support and supervision to different professional staffing groups:

Service Area / Teams	Post Title	Grade	Substantive Employing Partner
Day Opportunities / Services	Service Manager (1wte)	PO7	Haringey Council
Social Work	Team Managers (3wte)	PO7	Haringey Council
LD Medical Team	Consultant Psychiatrist (2wte)	Consultant	BEH MH NHS Trust
LD Therapy lead	Lead Therapist (1wte)	Band 8a	WH NHS Trust
LD Nursing	Lead Nurse (1wte)	Band 8b	WH NHS Trust
LD Psychology	Lead Psychologist (1wte)	Band 8b	BEH MH NHS Trust
Administration	Team Manager (1wte)	Band 5	WH NHS Trust

1.4 Post-holders may be employed by their existing employer and will be seconded to Haringey Council for day-to-day line management arrangements in order to maintain their contractual agreements. Any future appointment can be made jointly using any partner HR policies.

1.5 Panels for interviews must include Representatives of the Partners as appropriate and a clinical specialist for any clinical appointments. Where appropriate interview panels should also include a Service User and/ or a Carer.

1.6 Induction for new staff employed by any Partner will include the opportunity for clarification on the terms of secondment. This will include receiving a copy of this Schedule.

1.7 All recruitment processes should comply with good HR practice and relevant legislation.

2. LINE MANAGEMENT & PROFESSIONAL SUPERVISION

It is recognised that there may be a need for additional professional supervision, where the line manager is from a different professional background and in particular with consideration of clinical staff, and as such the HLDP agree to provide a professional supervisor where appropriate.

2.1 Line Management

2.1.1 The role of the line manager is, in consultation with the professional supervisor, as described in 2.2.1 below:

- To manage the workload of individuals, and respective work units
- To manage the day-to-day operation of individuals and work units, including annual leave, sickness absence, and discipline, within the agreed policies of the employing partner and within the best interests of the Services
- To manage the day-to-day performance of individuals and work units, including target setting, delivery and monitoring
- To ensure that staff performance, appraisal and review systems are in place, occur at the agreed frequency, and include both line management and professional inputs
- To be responsible for budgets within identified schemes of delegated financial responsibility
- To assume delegated responsibility for health and safety matters

2.1.2 The line manager will formally manage all staff under his remit. The standard frequency for meetings will be monthly, unless this is formally varied. All formal meetings are in addition to day-to-day contact, which might also include

supervision, advice and support.

2.1.3 Accountability and managerial structure for the Services is as outlined in Schedule 3.

2.2 Professional Supervision

2.2.1 The Service Manager will ensure that there are systems in place to ensure that all clinical and professional staff receive the appropriate professional supervision in line with locally and nationally agreed policies and frameworks.

2.2.2 There will be an identified professional supervisor drawn from each of the following professions: social work, nursing, psychology, speech & language therapy, physiotherapy, music therapy and occupational therapy.

2.2.3 The professional supervisor may be drawn from within or outside the HLDP.

2.2.4 It is recognised that within the Trusts there are clear and established policies and procedures for clinical supervision and the Partners will endeavour to ensure that these arrangements are maintained.

2.2.5 The role of the professional supervisor is to ensure that, within the relevant team operation and structure there is:

- Appropriate clinical and professional support and professional development provided to team members of that profession
- Appropriate and timely advice and direction to an individual team member or manager as and when requested with regard to making professional judgements on a case.

2.2.6 Where the identified professional supervisor and the line manager are not the same person, there will be '3-way' meetings to:

a) Review workload management, and the relationship between organisational and professional eligibility and criteria and priorities. Workload management must take account of both individual work, group work, and indirect work (e.g. stafftraining).

b) Agree on appraisal, and Personal Development Plans (PDP's). PDP's should include:

- Training and study leave
- On-going professional development, which may include professional networks.

2.2.7 It will be the responsibility of the line manager to ensure that '3-way' meetings are held between the individual member of staff, the line manager, and the professional supervisor. '3-way' meetings will take place no less frequently than once every six months, unless this frequency is formally varied by agreement between the Partners.

RESPONSIBILITY	LEAD	
	Line Manager	**Professional Supervisor**
Workload management	X	
Setting and monitoring objectives	X	
Clinical Supervision		X
Assessing continuing professional development needs		X
Leave (including annual, study, special leave)	X	
Work performance - general **	X	
Work performance - clinical/ professional		X
Appraisal	X	X
Absence management	X	
Confirmation of probation	X	

** General - refers to time keeping, record keeping, sickness etc.

2.2.8 It is recognised that whilst there are several identified responsibilities for both the line manager and the professional supervisor it is expected that the line manager and the professional supervisor co-operate together to ensure that a positive and productive working relationship is established.

2.2.9 The Partners agree that no targets can be set in relation to clinical and professional practice or outputs, without the engagement of the professional supervisor.

3 GRIEVANCE & DISCIPLINARY ARRANGEMENTS

3.1 Where a member of staff from either Partner wishes to raise a grievance this should be investigated according to the procedure of the employing Partner.

3.2 Where any employee is the subject of disciplinary proceedings this will be carried out in accordance with the procedure of the employing Partner.

3.3 The Service Manager will ensure that early warning is given to all Partners where disciplinary action is being considered.

3.4 If the line manager considers that further action which could include action on disciplinary or competency is necessary they should do this in full consultation with the professional supervisor. No action can be taken on any matter relating to clinical actions or outputs without the engagement of the professional supervisor.

4 TRADE UNION RECOGNITION

4.1 All trade union arrangements will be maintained. All Partners' branches of unions shall, where appropriate, represent the individual interests of their respective branch members.

5 JOINT CONSULTATION

5.1 When major re-organisation or re-structuring is proposed it is important that, where possible, joint consultation with the relevant staff representatives (including trade unions) is put in place.

6 HEALTH & SAFETY ARRANGEMENTS

6.1 The Partners have a duty of care to ensure that there are in place proper arrangements for the Health and Safety for all their employees, providing the Services under this Agreement and for clients/ People with a Learning Disability and Carers using these Services.

6.2 he Council, as Host Partner for this Agreement, will take lead responsibility for ensuring that arrangements meet all requirements laid down in Health and Safety legislation.

6.3 The Council will ensure that Operational Policies are reviewed and monitored to reflect both statutory requirements, and the operational needs of a multi-agency service.

6.4 The Partners recognise the need to have in place policies to maximise the safety of staff in dealing with unpredictable clients/ People with a Learning Disability or clients/ People with a Learning Disability known to be violent or abusive: The Council will lead on ensuring that policies in place are consistent across the Service.

6.5 Notwithstanding Schedule 5 below (Estates, Office Premises & Facilities), responsibility for premises, and associated Health and Safety requirements, responsibilities and liabilities, remain with the owners of those premises, unless otherwise specified in any associated lease or contractual agreement.

SCHEDULE 5
Estates, Office Premises, Running Costs, Supplies & Facilities

1. Historically and for the previous Section 75 Agreement (2010-2013) the Haringey Learning Disabilities Partnership (HLDP) had a 'quid pro quo'/ 'in kind' arrangement for the use of premises (buildings and offices) by the respective HLDP Partners (HS and Haringey Council);

2. The original partners were Haringey Council (Host Partner); NHS Haringey (PCT) and Barnet, Enfield and Haringey Mental Health NHS Trust. Subsequently, when Whittington Health NHS Trust became a new provider, a deed of variation was signed to include Whittington Health in April 2011;

3. Following the inclusion of Whittington Health NHS Trust within the Section 75 Agreement in April 2011, initially, Edwards Drive buildings were handed over to NHS Property Services department (regional/ national department) before Whittington Health took on responsibility for the site in April 2013.

4. In the future, provision of estates, office premises, running costs, supplies and facilities may continue to be provided by the relevant Partners on an 'in kind' basis but that will be considered and reviewed by the Executive Group during the life of this Agreement in order to ensure that they that appropriate commissioning and charging regime are applied.

SCHEDULE SIX

FINANCIAL CONTRIBUTIONS

1. The financial contributions from the commissioning partner organisations, on behalf of the council the NHS Trusts, are shown in the table below prepared for the SLA review based on outturn figures for 2020/21.
2. The value for BEHMHT and WHT contracts in 2021/22 has been uplifted by 5% from their 20/21 value by the CCG, from £1.2m to £1.234m.
3. In future years, the finance values may increase in line with any increases made available by the CCG in line with NHS contracting guidance which
   will be passed through by the Council.

S75 Scheme Plan 2021/22 - HLDP

Haringey Summary

Scheme name	Comissioner	Budget 20/21	Contribution CCG	Contribution LA	Budget 21/22	Contribution CCG*	Contribution LA	Budget Uplift CCG	Budget Uplift LA
Pooled Budgets									
BEHMHT - LD Psychiatry	CCG	264,760	264,760	0	264,760	264,760	0		
HLDP services - Staffing - LB Haringey	Joint	2,196,282		995,835	2,696,504		1,462,084		466,249
HLDP services - Staffing - Whittington			780,000			803,400		23,400	
HLDP services - Staffing - BEH			420,447			431,021		10,574	
Pooled Staffing Total		**2,461,042**	**1,465,207**	**995,835**	**2,961,264**	**1,499,181**	**1,462,084**	**33,974**	**466,249**
Haringey Council - Day Opportunities	LA	1,596,420	0	1,596,420	1,596,420	0	1,596,420		
Haringey Council - Linden Residential home	LA	2,100	0	2,100	2,100	0	2,100		
Winkfield Centre	LA	0	0	0	202,498		202,498		202,498
Chad Gordon Autism / Waltheof Day Centre	LA	0	0	0	175,195		175,195		175,195
Pooled Day Centre Total		**1,598,520**	**0**	**1,598,520**	**1,976,213**	**0**	**1,976,213**	**0**	**377,693**
Pooled Total		**4,059,562**	**1,465,207**	**2,594,355**	**4,937,477**	**1,499,181**	**3,438,297**	**33,974**	**843,942**
Aligned budgets									
Haringey Council - Haynes Day Centre					532,200		532,200		532,200
CHC Learning Disab(<65) - Fully Funded	CCG	2,285,986	2,285,986	0	2,635,782	2,635,782	0	349,796	
CHC- Adult Joint Funded	CCG	1,796,934	1,796,934	0	1,556,000	1,556,000	0	(240,934)	
CHC Nurse Assessor								0	
LD - Section 117: CCG	CCG	1,182,632	1,182,632	0	1,400,000	1,400,000	0	217,368	
CHC-Learning Disab(<65) - Additional PHB	CCG	2,901,720	2,901,720	0	4,260,516	4,260,516	0	1,358,796	
Non-CHC Learning Disabilities	CCG	2,668,371	2,668,371	0	1,219,242	1,219,242	0	(1,449,129)	
Respite / Edwards Drive	CCG	496,600	496,600	0	496,600	496,600	0		
LD 18-64 Care Costs	LA	25,457,511	0	25,457,511	25,823,702	0	25,823,702		366,191
LD 65+ Care Costs	LA	1,676,816	0	1,676,816	1,627,359	0	1,627,359		(49,457)
Transforming Care: care package top-ups	CCG	254,400	254,400	0	286,000	286,000	0	31,600	
Aligned Total		**38,720,970**	**11,586,643**	**27,134,327**	**39,837,401**	**11,854,140**	**27,983,261**	**267,497**	**848,934**
Total Pooled & Aligned Budgets		**42,780,532**	**13,051,850**	**29,728,682**	**44,774,878**	**13,353,321**	**31,421,558**	**301,471**	**1,692,876**

Note re LA uplifts:

HLDP services - Addition funding secured

LA Day Services - LD day services at Winkfield, Waldehof Gdns and Haynes have included in the 21/22 agreement.

END OF AGREEMENT

Item for: Cabinet Member Signing – 31 March 2022

Title: Section 75 NHS Act 2006 Health and Social Care Covid-19 Hospital Discharge Partnership Agreement

Report authorised by: Charlotte Pomery, Assistant Director Commissioning

Lead Officer: Charlotte Pomery, Assistant Director Commissioning

Ward(s) affected: All

Report for Key/ Non Key Decision: Key Decision

1. Describe the issue under consideration

1.1 Haringey Council (the Council) working in partnership with the four other local authorities (Barnet, Camden, Enfield and Islington) within the North Central London sub-region and the North Central London Clinical Commissioning Group (the CCG) have had in place since March 2020 a partnership agreement under S.75 of the National Health Services Act 2006 in response to the global Coronavirus pandemic.

1.2 The Partnership Agreement acts as a framework for a range of schedules and already covers three Schemes designed to support effect hospital discharge arrangements between the NHS and local government. It was introduced with the support of the Department for Health and Social Care (DHSC) over the period to March 2022. Partners have now determined that a further 3 Schemes, 4, 5 and 6, as detailed in the attached variation, will continue to support smooth discharge arrangements between partners. This report therefore seeks the approval of Cabinet to the partnership agreement and the additional Schemes now deemed to be required.

2. Cabinet Member Introduction

2.1 N/A

3. Recommendations

3.1 The Cabinet Member is asked:

3.1.1 To approve Haringey Council's participation in the existing Section 75 Partnership Agreement (Covid-19 Hospital Discharge Partnership Agreement) between the Councils of North Central London and the CCG which provides for lead commissioning and pooled budgets across a range of schedules.

3.1.2 To approve the variation to include three further Schemes, 4, 5 and 6, as set out in Appendix 2.

3.1.3 To delegate to the Assistant Director Commissioning, after consultation with the Lead Member for Health, Social Care and Well-Being, the authority to finalise and agree any further schedules to the Section 75 Partnership Agreement between the Councils of North Central London and the CCG.

4. Reasons for decision

4.1 The s. 75 Partnership Agreement has supported greater levels of integration between the NHS and the Councils of North Central London by enabling lead commissioning and pooled budgets across partners within a strategic framework as set out in the National Health Services Act 2006.

4.2 The Agreement has enabled additional NHS funding to be made available to local government through the CCG to support hospital discharge arrangements during the Coronavirus pandemic. Given the existing pressures on both the NHS and local government social care such support is required to meet local need.

4.3 The Council will fail to benefit from significant additional funding being made available to support local social care arrangements should the approvals sought not be forthcoming. The vision set out in the Partnership Agreement aligns with the partnership work, effective use of pooled budgets and integrated working at pace which have been features of the Covid response across North Central London.

5. Alternative options considered

5.1 Consideration was given by officers to suggesting the Council does not participate in this s. 75 Partnership Agreement. However, this approach would reduce the funding available to the local authority to support residents being discharged from hospital and directly therefore affect the funding available to the wider adult social care cohort.

6. Background information

6.1 The s. 75 Partnership Agreement has served a very necessary purpose in providing the framework for enabling the CCG and the North Central London Councils to work together in a more joined up way at pace and at scale during the Covid-19 pandemic. This has both paved the way for more joined up working across the NHS but critically enabled holistic care to be made available to local residents throughout the pandemic, and indeed for the next period.

6.2 For the variation to the Partnership Agreement for the Long Length of Stay Reduction scheme (**"Scheme 4"**) and Transfer of Care Hubs (**"Scheme 5"**) the NCL CCG and the London Boroughs of Haringey and of Enfield have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements covering all these two schemes.

6.3 For Additional Discharge Funds (**"Scheme 6"**) the NCL CCG and the London Boroughs of Barnet and of Haringey have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements covering all these two schemes.

6.4 The Councils will be the lead commissioner for services as detailed in Appendix 2 and shall comply with the requirements of this Scheme Specification and adhere to the national guidance pertaining to the Services.

6.5 The aim and outcomes set out in the Partnership Agreement continue to be relevant for local partners, notably the focus on partnership working to support the following outcomes:

- facilitating quick discharge of patients who are clinically suitable for discharge;
- facilitating rapid mobilisation of care and support packages;
- maintaining capacity in acute and community hospitals for the care of patients with Covid-19 who require hospitalisation;
- supporting the reablement and recovery of residents
- supporting increased demand and to support safe and effective discharge pathways

6.6 The wider policy imperatives are set out in key documents which shape the policy landscape for health, care and integration, which itself is currently undergoing significant change. These documents provide a framework for change and innovation built on the NHS Long Term Plan which set out ambitions for more joined up approaches from a resident and service redesign perspective. The three key policy documents are the Health and Care Bill, the Integration White Paper and Building Back Better, the Adult Social Care Reform White Paper. Each of them has at its heart greater integration, a committed focus to addressing health inequalities and meaningful participation of residents, users and patients in the services affecting them. Locally, the establishment of a North Central London Integrated Care System and a Haringey Place Partnership through the Health and Wellbeing Board will both be visible manifestations of the most recent developments. These models commit partners to working together in a genuinely integrated way to achieve better outcomes for residents and to achieve cost efficiencies in our approach.

7. Contribution to strategic outcomes

7.1 These proposals support Haringey's Borough Plan 2019 – 2023 to improve health and wellbeing outcomes for local residents and are also in line with current national policy and legislation furthering integration between the NHS and local government.

8. Statutory Officer comments (Director of Finance (including procurement), Head of Legal and Governance, Equalities)

8.1 Finance

8.1.1 This report is seeking the approval of Cabinet to the hospital discharge partnership agreement and the additional Schemes, 4, 5 and 6, to continue to support integrated discharge arrangements between LBH and NCL CCG for the period 1st April 2022 to 31st March 2023. The Table shows the allocations for each NCL Local Authority, with LBH receiving and projected to spend £5.557m.

Organisation	Scheme 4	Scheme 5	Scheme 6	Total
	21/22 (£'000)	21/22 (£'000)	21/22 (£'000)	21/22 (£'000)
Barnet	**2,300**	**1,131**	**4,722**	**8,153**
Camden	**2,085**	**619**	**3,211**	**5,915**
Enfield	**2,508**	**580**	**3,964**	**7,052**
Haringey	**1,872**	**471**	**3,214**	**5,557**
Islington	**816**	**417**	**2,889**	**4,122**
Total Spend	**9,581**	**3,218**	**18,000**	**30,799**

8.1.2 Funding will be met from additional NHS funding and made available to LBH and other authorities through the CCG. This will contribute to meet the additional expenditure within LBH arising from hospital discharge arrangements over the financial year 2022/23.

8.2 Legal

8.2.1 Under Section 75 of the NHS Act 2006 and associated regulations, CCGs and local authorities can enter into partnership agreements that allow for local authorities to perform health related functions where this will likely lead to an improvement in the way these functions are discharged. The proposed partnership agreement and the Council's participation in Scheme 6 as the lead commissioner is within the scope of the Act.

8.3 Procurement

8.3.1 Strategic Procurement notes the contents of this report and supports the recommendations herein.

8.4 Equalities

8.4.1 The Equality Act (2010) legally protects people from discrimination in the workplace and in wider society. The Act replaced previous anti-discrimination laws and introduced the term 'protected characteristics' to refer to the following nine groups that are protected under the Act:

- Age
- Disability

- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

8.4.2 The council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not

8.4.3 The three parts of the duty apply to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

8.4.4 Although it is not enforced in legislation as a protected characteristic, Haringey Council treats socioeconomic status as a local protected characteristic.

8.4.5 The proposed decision is to approve the S.75 Partnership Agreement between the Council and the CCG which provides for lead commissioning and pooled budgets for a range of vulnerable residents in Haringey. The Partnership Agreement enables the Council and the CCG to work together in a more joined up way to meet the needs of adults with a range of health and care needs to better meet their needs.

9. Use of Appendices

9.1 Appendix 1 contains the proposed variation to the s. 75 Agreement.

10. Local Government (Access to Information) Act 1985

APPENDIX 1:

COVID-19 HOSPITAL DISCHARGE FUNDING - SCHEME DESCRIPTION – (BOROUGH)

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

1 OVERVIEW OF INDIVIDUAL SERVICE(S)

1.1 The Services shall be known as the Covid-19 Enhanced Hospital Discharge Services (the **"Services"**) and shall include Funding Scheme 1, Scheme 2 and Scheme 3 and the Locally Enhanced Discharge Fund as described in further detail below.

1.2 Funding **"Scheme 1"** for the Services was introduced on 19 March 2020 in response to the global Covid-19 pandemic

https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/

1.3 Further updated arrangements for the Services (**"Scheme 2"**) were introduced to cover the period from 1 September 2020 to 31 March 2021.

1.4 The Department of Health and Social Care then further extended the arrangements to cover quarter 1 and quarter 2 (1 April 2021 to 30 September 2021) and then again to include quarter 3 and quarter 4 (1 October 2021 to 31 March 2022) financial year (**"Scheme 3"**). The arrangements are set out in the Department of Health and Social Care guidance: Hospital discharge and community support: policy and operating model (first published on 21 August 2020 and last partially updated on 19 October 2021 to incorporate details of the national discharge funding settlement for quarters 3 and 4 of 2021 to 2022):

https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

1.5 To support the Discharge Requirements (Scheme 1, 2 and 3), a range of measures have been introduced including a commitment that the NHS will fully fund the cost of new and extended out of hospital health and social care support packages during Scheme 1. For Scheme 2, on-going care and support needs for anyone being discharged from hospital without an existing care package (i.e. for persons with new or additional care needs) will be provided free of charge for up to a maximum of six weeks from the point of discharge, as long as the package/placement commenced before 31 March 2021.

1.6 Under Scheme 3, the financial arrangements for patients discharged or using discharge services will be as follows: (i) people discharged between 1 April 2021 and 30 June 2021 (inclusive) will have up to six weeks of funded care; and (ii) people discharged between 1 July and 31st March 2022 (inclusive) will have up to four weeks of funded care.

1.7 This Scheme Specification sets out the process that will be established through which the CCG will reimburse the Council for the cost incurred by delivering the Discharge Requirements.

1.8 For Covid-19 Enhanced Hospital Discharge Services NCL CCG and the London Borough of Camden (the Council) have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements covering all three schemes as well as the Locally Enhanced Discharge Fund (defined in paragraph 1.12 below).

1.9 For the Long Length of Stay Reduction scheme (**"Scheme 4"**) and Transfer of Care Hubs (**"Scheme 5"**) NCL CCG and the London Boroughs of Barnet and Enfield (the Council) have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements covering all these two schemes.

1.10 For Additional Discharge Funds (**"Scheme 6"**) NCL CCG and the London Borough of Barnet (the Council) and the London Borough of Haringey (the Council) have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements covering all these two schemes.

1.11 The Councils will be the lead commissioner for services as detailed below and shall comply with the requirements of this Scheme Specification and adhere to the national guidance pertaining to the Services.

Scheme Number	Scheme Name	Lead Commissioner
1, 2 and 3	Covid 19 Enhanced Discharge Services	Each Individual borough
4	Long Length of Stay Reduction	Enfield Council
5	Transfer of Care Hubs	Barnet Council
6	Additional Discharge Fund	Barnet Council on behalf of the North (Barnet and Enfield) Haringey Council on behalf of the South (Camden, Haringey, Islington)

1.12 Long Length of Stay Reduction Scheme (Scheme 4) Transfer of Care Hubs (Scheme 5) and Additional Discharge Fund (Scheme 6) Schemes are collectively form the **"Locally Enhanced Discharge Fund"**.

2 AIMS AND OUTCOMES

2.1 The overall aim of the Discharge Requirements is to implement the revised funding model for care and support packages during the Enhanced Discharge Services Period.

2.2 The implementation of the Services (in accordance with the Discharge Requirements) will support the following outcomes:

- facilitating quick discharge of patients who are clinically suitable for discharge;
- facilitating rapid mobilisation of care and support packages;
- maintaining capacity in acute and community hospitals for the care of patients with Covid-19 who require hospitalisation;

- supporting the reablement and recovery of residents
- supporting increased demand and to support safe and effective discharge pathways

3 THE ARRANGEMENTS

3.1 The Partners have agreed to implement the following arrangements in relation to the Covid-19 Hospital Discharge Service:

3.1.1 lead commissioning; and

3.1.2 the establishment of a process for NHS England to reimburse the Council for the costs incurred as set out in this Agreement.

3.1.3 The establishment of the Locally Enhanced Discharge Fund with nominated Lead Commissioners on behalf of the NCL Health and Social Care System.

4 **FUNCTIONS**

4.1 For the purposes of implementing this Scheme Specification the CCG delegates to the Council its functions under:

4.1.1 section 3(1)(b) of the 2006 Act of arranging for the provision of other accommodation for the purpose of any service provided under the 2006 Act;

4.1.2 section 3(1)(e) of the 2006 Act of arranging for the provision of such other services or facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness as are appropriate as part of the health service. In each case in so far as the Council considers such services/provision to be necessary to meet the requirements of the person for whom the care and support is provided.

4.2 The CCG and the Council agree that the above delegation from the CCG to the Council will:

4.2.1 likely lead to an improvement in the way in which these functions are discharged during the Covid-19 pandemic; and

4.2.2 improve health and well-being.

4.2.3 improve health inequalities across North Central London

4.2.3 achieve greater value for money

5 SERVICES

5.1 The Council shall arrange for the provision of the following Services in relation to Scheme 1, 2 and 3 and Locally Enhanced Discharge Fund (Scheme 6)

5.1.1 Care Home placements – in a residential or nursing home registered with the Care Quality Commission

5.1.2 Care home beds – the securing through a temporary block contract of additional care home capacity

5.1.3 Other care accommodation placements – in other bed based accommodation (excluding hospice) e.g. Supported Living

5.1.4 Domiciliary/home care - services provided in a person's home

5.1.5 Reablement and/or intermediate care - Services are generally provided in the person's own home or care home, is intervention that involves intensive, time-limited assessment and/or therapeutic work over a period of time.

5.1.6 Day Care - Day Care Facilities may be called Day Hospitals, Centres, Facilities or Units.

5.1.7 Respite care - term used for services designed to give carers a break from caring.

5.1.8 Transport - Any separate transport costs such as patient transport (PTS), volunteer drivers, taxis, local authority transport to enable the hospital discharge or meet the ongoing packages of support.

5.1.9 Other - Typically, equipment, adaptations and deep cleaning

5.1.10 Long Length of Stay Reduction (Scheme 4);

5.1.11 Transfer of Care Hubs (Scheme 5);

5.1.12 Facilitate joint assessment of discharges

5.1.13 Prevent admission to hospital

5.2 The Council shall arrange the provision of the Enhanced Hospital Discharge Services for the benefit of:

5.2.1 those persons the CCG has responsibility to provide services for under Sections 3(1A) and 3(1B) of the 2006 Act; and

5.2.2 those persons the Council has responsibility to provide services for regardless of age or primary support reason

and whose requirement for a Funded Package arises during the Enhanced Discharge Services Period to facilitate discharge from, or to prevent admission to (Scheme 1 only – please refer to Appendix 1 to this Scheme Specification), hospital as set out in the Discharge Requirements. The definition and criteria for an admission avoidance (for Scheme 1) are set out in Appendix 1 to this Scheme Specification.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 The Council shall ensure that when commissioning Funded Packages it makes the patient and their families and/or carers aware that following the end of the

Enhanced Discharge Services Period the patient may be required to pay for all or some of their future care needs.

6.1.2 The Council will commission care and support to in order to fully meet the objectives of the Discharge Requirements and pause assessing individuals in relation to their health and social care needs (scheme 1).

6.1.3 The CCG will continue to commission care and support in order to fully meet the objectives of the Discharge Requirements and pause assessing individuals in relation to their health and social care needs (scheme 1).

6.1.4 The Scheme 2 guidance instructs that the majority of patients should be assessed under the Care Act or for Continuing Health Care (CHC) outside of an acute setting. They will be eligible for up to 6 weeks of non - chargeable care while assessments take place.

6.1.5 The available period of funding for Scheme 3 reduces from 6 to 4 weeks from 1 July 2021 and includes amendments from Scheme 2 requirements.

6.1.6 [Locally Enhanced Discharge Fund Scheme 4: Long Length of Stay (LLOS) Reduction Scheme.

This scheme will enable early supported discharge for those in acute trusts whose needs can be better supported outside of hospital. This reduces LLOS in hospital and promotes recovery in a more therapeutic environment.]

6.1.7 [Locally Enhanced Discharge Fund Scheme 5: Transfer of Care Hubs.

Transfer of Care Hubs are mandated in the Discharge Guidance and enable timely discharge from acute hospitals. They determine discharge pathways in consultation with the person and their advocates, ensure relevant services are linked up in order to provide appropriate care and support and are co-located with acute partners to ensure ease of communication and enhanced multi-disciplinary working. Transfer of Care Hubs ensure information essential to continue delivery of care and support is communicated and transferred to the relevant partners on discharge.

6.1.8 Locally Enhanced Discharge Fund Scheme 6: Enhanced Discharge Services will support additional discharge costs for the system that are not funded by the hospital discharge scheme.

6.2 Contracting Arrangements

6.2.1 The Council, as Lead Commissioner, will utilise a range of commissioning approaches to deliver the Enhanced Hospital Discharge Services. This will include existing block contracts and framework agreements, 'spot' contracted care, directly delivered care services as well as new contracts put in place through urgency procedures in response to Covid-19.

6.2.2 Under this arrangement, the Council will commission or vary contracts with providers as required. The Partners will manage the Services using the established

governance processes agreed between the Council and CCG and set out in the Agreement. Updates on these additional commissioned services will reported through the Community Operational Group (prev. Non-acute gold) committee, which is explained in further detail in paragraph 10 below.

6.2.3 The Council shall ensure that it reimburses those providers providing the Enhanced Hospital Discharge Services in a timely fashion paying particular attention to the financial pressures on providers during the Covid-19 pandemic. In complying with this obligation the Council shall refer to guidance issued by the Local Government Association, ADASS, and the Care Provider Alliance on social care provider resilience during Covid-19.

6.2.4 Enfield Council will act on behalf of the NCL System as the Lead Commissioner for the Long Length of Stay Reduction Scheme and is responsible for distributing the funding across the system to delivery this service

6.2.5 Barnet and Haringey Councils will act on behalf of the NCL System as Lead Commissioners for the additional pooled Discharge Funds over and above national funding available and are responsible for distributing this funding across the system to deliver this service

6.2.6 Barnet Council will act on behalf on the NCL System as Lead Commissioner for the Transfer of Care Hubs pooled fund and is responsible for distributing this funding across the system to deliver this service

7 FINANCIAL CONTRIBUTIONS[1]

7.1 The Covid-19 Hospital Discharge Scheme is being implemented in response to the Covid-19 pandemic and to give effect to the Discharge Requirements.

7.2 During the Enhanced Discharge Services Period eligibility assessments for beneficiaries of the services provided under the Covid-19 Hospital Discharge Scheme and the cost of care packages or enhancements to existing packages under the Covid-19 Hospital Discharge Scheme shall be funded from central funding provided to the CCG by NHS England & Improvement.

7.3 For Scheme 1, Assessments should be completed by no later than 31 March 2021, with all costs transferred to usual funding arrangements by this date,

7.4 The Scheme 2 and Scheme 3 arrangements will fund the additional cost of care packages and enhancements to existing packages, in accordance with the timescales set out in paragraphs 1.3 to 1.6 above, over and above pre-existing (planned) Council and/or CCG expenditure.

7.5 Locally Enhanced Discharge Fund Scheme 4 Long Lengths of Stay Reduction Scheme will fund services as specified in 6.1.6

7.6 Locally Enhanced Discharge Fund Scheme 5 Transfer of Care Hubs will fund services specified in 6.1.7

7.7 Locally Enhanced Discharge Fund Scheme 6 Enhanced Discharge Services will fund services specified in 6.1.8

7.8 NCL CCG and the Council shall:

7.8.1 comply with any requirements and any guidance issued by HM Government and/or the NHS relating to the funding of the Covid-19 Hospital Discharge Scheme after the end of the Enhanced Discharge Services Period; and

7.8.2 work together in good faith to give effect to any such requirements and/or guidance.

7.9 The total value of the Services under Scheme 1 (excluding workforce costs) is £55.841m as set out in the table below:

Hospital Discharge Spend – Scheme 1 (Table 1)

Organisation	Scheme 1 19/20 (£'000)	Scheme 1 20/21 (£'000)	Total Scheme 1 (£'000)
Barnet Council	49	11,795	**11,845**
Camden Council	7	6,185	**6,192**
Enfield Council	133	5,616	**5,749**
Haringey Council	14	6,330	**6,344**
Islington Council	21	5,625	**5,646**
NCL CCG	132	19,934	**20,066**
Total Spend	**356**	**55,485**	**55,841**

*Excludes Workforce funding

7.10 The total value of the Services for Scheme 2 relating to discharges during the period 1 September 2020 to 31 March 2021 is £8.41m as set out in the table below. Scheme 2 continued to reimburse for the period 1 April 2021 to 30 June 2021 (inclusive), up to a maximum of 6 weeks, costs of care and support for individuals discharged up to and including 31 March 2021, provided the package/placement commenced on, or before, 31 March 2021.

2020-21 Hospital Discharge Spend - Scheme 2 (Table 2)

Organisation	Scheme 2 20/21	Scheme 2 21/22	Total Scheme 2
	(£'000)	(£'000)	(£'000)
Barnet Council	1,190	0	1,190
Camden Council	473	5	478
Enfield Council	831	28	859
Haringey Council	1,479	120	1,599
Islington Council	1,173	179	1,352
NCL CCG	2,675	255	2,930
Total Spend	**7,821**	**587**	**8,408**

*Scheme 2 includes up to 6 weeks funding for individuals discharged by 31/03/21

7.11 The total value of the Services for Scheme 3 national funding is as follows:

2021-22 Hospital Discharge Spend - Scheme (Table 3)

Organisation	Scheme 3 21/22 (£'000)
Barnet Council	1,850
Camden Council	831
Enfield Council	1,659
Haringey Council	3,493
Islington Council	2,020
NCL CCG	10,865
Total Spend	**20,717**

The above table is an estimate of costs based on Month 10 January 2022 forecast outturn to be claimed from national funding available. The final amount may be subject to change.

7.12 [In addition to national funding available from NCL CCG in accordance with the Services/Discharge Requirements for the Locally Enhanced Discharge Fund, NCL CCG will contribute the following amount to the Locally Enhanced Discharge Fund:]

2021-22 Long Lengths Of Stay Reduction Scheme Wards – Scheme 4 (Table 4)

Organisation	Scheme 4 21/22 (£'000)
Barnet	2,300
Camden	2,085
Enfield	2,508
Haringey	1,872
Islington	816
Total Spend	**9,581**

* Long Lengths of Stay Reduction Scheme Wards, Scheme 4 to Enfield Council as Commissioning Lead

2021-22 Transfer of Care Hubs – Scheme 5 (Table 5)

Organisation	Scheme 5 21/22 (£'000)
Barnet	1,131
Camden	619
Enfield	580
Haringey	471
Islington	417
Total Spend	**3,218**

* Transfer of Care Hubs Scheme 5 to Enfield Council as Commissioning Lead

2021-22 Additional Discharge Fund – Scheme 6 (Table 6)

Organisation	Scheme 6 21/22 (£'000)

Barnet	4,722
Camden	3,211
Enfield	3,964
Haringey	3,214
Islington	2,889
Total Spend	**18,000**

* Additional Discharge Fund, scheme 6 - Barnet Council as Commissioning Lead in the North (Barnet and Enfield)
** Haringey Commissioning lead in the South (Camden, Haringey, Islington)

7.13 The funding identified to each borough within scheme 6 (additional discharge fund) is indicative only and may be varied on review of monitoring information, through the review process in terms of the amounts allocated to each borough. The use of the funding may also be varied, within the review process, through prior approval of a business case signed off by both the Local Authority and CCG, in accordance with their SFIs, where the proposal demonstrates further reductions to discharge delays from hospitals, improved outcomes for residents and supports the sustainability of the Local Authorities and CCG.

7.14 The Partners acknowledge and agree that this Scheme Specification only covers the Services provided in accordance with the Covid-19 Hospital Discharge Scheme and the enhanced Discharge Fund and therefore does not reflect all discharge and it is recognised that there may be individual arrangements in place for other discharge related services and costs that do not form part of this Scheme Specification, for example, the discharge match funding scheme.

7.15 The indicative additive funding elements for Discharge Schemes 4, 5 and 6 will be will be subject to review process, as set out in this Scheme Specification.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The Council shall ensure that:

8.1.1 all support provided under the national Covid-19 Hospital Discharge Scheme is recorded at an individual level;

8.1.2 all agreed budgets funded through the national Covid-19 Hospital Discharge Scheme are recorded at an individual level;

8.1.3 in regards to the national Covid-19 schemes 1, 2 and 3 all reasonable monitoring and/or reporting information required by the CCG to report to NHSE&I or the Department of Health and Social Care is provided promptly and in any event within reasonable time frames stipulated.

8.1.4 expenditure is accounted for in accordance with existing regulatory and financial governance arrangements including the use of ordinary organisational financial controls.

8.1.5 ensure that submissions are accurate and include the additional cost of care and support commissioned in response to the Enhanced Hospital Discharge Services and in-line with the Discharge Requirements and the requirements set out in this Scheme Specification.

8.1.6 any liability relating to claims made, to the extent not covered by the Discharge Requirements, shall be dealt with in accordance with the terms of the Agreement.

8.1.7 Enfield Council is Lead Commissioner for the pooled fund contribution for the Long Lengths of Stay Reduction (Scheme 4), and is responsible for the distribution of this funding across the NCL system in accordance with council implementations of this scheme. A review of this pooled fund will be undertaken at month 6, 9 and 12 of the financial year 2022/23. As part of this review NCL CCG reserves the right to claw back any funding that has not been utilised in line with this service. NCL recognise that Enfield Council is operating as lead Council for this fund and is therefore not responsible for the delivery of this service in the other four NCL councils being Barnet, Camden, Haringey and Islington.

8.1.8 Barnet Council is Lead Commissioner for the pooled fund contribution for Transfer of Care Hubs (Scheme 5), and is responsible for the distribution of this funding across the NCL system in accordance with council costs incurred. A review of this pooled fund will be undertaken at month 6, 9 and 12 of the financial year 2022/23. As part of this review NCL CCG reserves the right to claw back any funding that has not been utilised in line with this service. NCL recognise that Enfield Council is operating as lead Council for this fund and is therefore not responsible for the delivery of this service in the other four NCL councils being Barnet, Camden, Haringey and Islington.

8.1.9 Barnet and Haringey Councils are the Lead Commissioners for the pooled fund contribution for the Additional Discharge, (Scheme 6), and are responsible for the distribution of this funding across the NCL system in accordance with costs actually incurred. Distribution of this fund is coordinated through the NCL Directors of Adult Social Services. A review of this pooled fund will be undertaken at months 6, 9 and 12 of the financial year 2022/23. As part of this review NCL CCG reserves the right to claw back any funding that has not been utilised in line with this, service. NCL recognise that Barnet and Haringey Councils are operating as lead Councils for this fund and are therefore not responsible for the delivery of this service in the other three NCL councils being Camden, Enfield and Islington.

8.1.10 Lead Councils on pooled funds (Barnet, Enfield and Haringey) will support claw back but are not responsible for the funding that has been identified for claw back from other NCL Councils.

8.1.11 All partners agree to act in good faith, open book and transparent and cooperatively in regards to this agreement

8.2 The CCG shall:

8.2.1 For the Covid-19 national schemes administer the reimbursement process on behalf of NCL CCG and the North Central London Councils (including the Council)

8.2.2 For the Covid-19 national schemes maintain records of the cost and activity associated with the enhanced discharge process reporting these in line with requirements set out by NHSE&I.

8.2.3 For the Covid-19 national schemes submit claims for reimbursement to NHSE&I in accordance with reporting and reimbursement requirements set out in the Discharge Requirements.

8.2.4 For the Covid-19 national schemes reimburse the Council in line with the Discharge Requirements, and while discharge funding remains available to CCGs from NHSE&I.

8.2.5 not be held responsible or accountable for any liabilities arising through the claiming of any costs, for reimbursement, by Councils that are not in-line with the Discharge Requirements.

8.3 The Council shall:

8.3.1 For the Covid-19 national schemes submit a section 75 monthly template to the CCG no later than the 5th working day of the month for which reimbursement is being requested.

8.3.2 For the Covid-19 national schemes submit fully completed finance placement returns to the CCG on the 5th working day of each month unless otherwise agreed by partners.

8.3.3 For the Covid-19 national schemes submit invoices, in arrears, to the CCG for reimbursement where partners are in agreement that the submitted monthly schedule is to be reimbursed.

8.3.4 For the Covid-19 national schemes where it is unable (acting reasonably) to comply with the timescales for submissions in paragraph 8.3.2, the CCG may submit an estimate of costs. The Council acknowledges and agrees that the CCG may submit the estimate to NHSE/I and the CCG will not be accountable for any variances that could arise, nor any queries from NHSE/I once actual submissions are received. Where such costs have not been reimbursed to the Council, the Council will need to provide further evidence and information in compliance with the Discharge Requirements in order to obtain reimbursement for such costs.

8.3.5 For the pooled fund contributions the lead Council will manage these funds on behalf of the NCL system and a review process undertaken at month 6, 9 and 12 of the financial year 2022/23.

8.4 Payment and Reconciliation process:

8.4.1 For the Covid-19 national schemes the CCG shall reimburse the Council the costs set out in reimbursement claims in line with current and future guidance while funding remains available.

8.4.2 For the Covid-19 national schemes invoices will be paid by the CCG 30 days after the date of receipt of the invoice, in accordance with standard NHS payment terms, subject to the CCG receiving funding for the Services from NHSE&I.

8.4.3 For the Covid-19 national schemes 1, 2 and 3 submission of costs should be cumulative, for each individual scheme, and reconciliations should occur to ensure accuracy of claims.

8.4.4 For the Covid-19 national schemes the cumulative nature of returns will allow for adjustments to reimbursement claims within the following month's claim.

8.4.5 For the Covid-19 national schemes where funds need to be repaid or clawed back to either the CCG or to NHSE&I (or both) then the Council will take responsibility for refunding the payment within 30 days of notification either through the issuing of a credit note where this is a feasible option or through making alternative arrangements to repay the amount claimed back.

8.4.6 For the Covid-19 national schemes any future retrospective audit on the expenditure and any claims requiring repayment of funds, if not claimed in-line with the Discharge Requirements, will be the responsibility and liability of the claiming organisation.

8.4.7 There will be no further reimbursements relating to Scheme 1 made in 2021/22 or for reimbursements made relating to 2020/21 over and above what is reported in final Scheme submissions for that year (as set out in table 1 above).

8.4.8 Reimbursement for costs under Scheme 2 will continue for up to 6 weeks in 2021/22 for those discharged from hospital up to and including 31 March 2021. There will be no further reimbursements relating to Scheme 2 made in 2021/22 or for reimbursements made relating to 2020/21 over and above what is reported in final Scheme submissions for that year (as set out in table 2 above).

8.4.9 Reimbursement for costs under Scheme 3 will continue in line with guidance and timescales set out in paragraph 1.5 above.

8.4.7 For the Covid-19 national schemes any costs associated with hospital discharge scheme should be transparent, auditable and traceable back to individual patients or other costs allowable in accordance with the published national guidance.

8.4.8 Locally Enhanced Discharge Fund will be invoiced in full at month 12 of the financial year 2021/22

8.4.9 In recognition of the considerable pressures being experienced in Health and Social Care as a result of Covid-19 and additional reporting requirements of the national discharge schemes the reconciliation of the Locally Enhanced Fund will be in months 6, 9 and 12 of the financial year 2022/23.

8.4.10 The review of the Locally Enhanced Discharge Fund will be a jointly agreed process between NCL CCG and the Lead Commissioner.

8.4.11. Claw back of any funds will be from the organisation that is holding the fund in accordance with the reviews

8.4.11 Any redirection of Locally Enhanced Discharge Fund from the schemes detailed in this agreement will need to be agreed by NCL CCG, meet shared outcomes and demonstrate value for money

8.4.12 Locally Enhanced Discharge Fund is expected to be fully utilised in the financial year 2021/22, should locally pooled funding not be fully utilised this will form part of

the review process and if jointly agreed between NCL CCG and the Lead Council funds redirected to the financial year 2022/23 enhanced discharge services.

9 VAT

9.1 The Council's VAT regime will apply to this Service

9.2 Neither party is acting as an agent for the other in respect of VAT.

10 GOVERNANCE ARRANGEMENTS

10.1 During the COVID-19 pandemic, NCL CCG with system partners established governance across the NCL footprint. Ultimately, System Management Board (prev. System Gold) approved commissioning of additional capacity for the system. Operational and strategic leadership to support commissioning of additional capacity was through Community Operational Group (prev. Non-acute Gold Group) which will have oversight the Services and be responsible for:

10.1.1 Developing plans to ensure the Council and CCG secure additional capacity within the aims of the COVID-19 Enhance Hospital Discharge Services; and

10.1.2 Monitoring and making decisions based on the demand and capacity of commissioned services, acute hospitals and the Integrated Discharge Team(s) and within each of the Discharge Pathways 1,2 and 3 (as set out in the Discharge Requirements).

Arrangements will continue to be overseen by subsequent, or replacement, groups in the event of the cessation of current groups

10.2 Members of Community Operational Group (or subsequent group) will include representation from operational and strategic leads across CCG, LA's and providers.

10.3 Reporting progress to Community Operational Group but remaining accountable to Executive Management Team and Local Authority Cabinet. The S75 task and finish group comprising of Camden LA (representing all NCL boroughs) and CCG leads has been established with the aim of getting agreement on the arrangements for schemes 1, 2 and 3.

In the case of dispute the following process should be followed

a)	Informal escalation meetings held at director level (x2)
b)	Formal escalation meeting
c)	Escalation to Executive Director of Strategic Commissioning and LA representatives (if formal escalation unsuccessful)
d)	Escalation to CCG Accountable Officer and LA CEO (if Exec Director escalation unsuccessful)
e)	GB Members and Councillor meeting to be arranged (Prior to external escalation)
f)	Escalation to NHSEI national team (for Schemes 1, 2 and 3)

10.5 This arrangement will be approved through the NCL CCG Governing Body and the appropriate authority within each LA based on their scheme of delegation and standing orders.

11 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements	Comments
Premises		None	
Assets and equipment		None	
Contracts		None	
Central support services	Resources required to manage and process the expenditure reporting required	None	

CCG Contribution

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

12 STAFF

12.1 At this stage of service development, it is not the intention that any CCG staff will transfer to the Council under the TUPE regulations.

12.2 Council staff to be made available to the arrangements:

12.2.1 Council social care staff will arrange the Enhanced Hospital Discharge Services

12.3 CCG staff to be made available to the arrangements:

12.3.1 CCG staff including CHC and UEC commissioners have been temporarily deployed to the Integrated Discharge Services (IDT). These resources ensured improvement in mobilising the hospital Discharge Requirements across NCL.

12.4 NCL CCG has been allocated non-recurrent £1.34m for the Deferred CHC Assessment workforce funding, to be accessed via the reimbursement approach for the COVID-19 Hospital Discharge Service Requirements. This funding can be used to recruit staff over and above the usual assessment staff that the health and social care system would employ to manage deferred NHS CHC assessments.

12.5 The Deferred CHC Assessment workforce funding of £1.34m is to be shared between partners. The funding attributable to NCL CCG is £726k and to NCL Councils is £614k. The amount to

Councils allocation will be billed and held and distributed by Barnet Council and is to be allocated as follows:

Local Authority	Allocation (£)
Barnet	170,000
Camden	83,000
Enfield	140,000
Haringey	111,000
Islington	111,000

12.6 NCL CCG has provided an Accelerator fund of £309k to support Integrated Discharge Teams

The amount allocated to Councils is as follows and should be billed for in-line with requirements for Discharge Schemes 1, 2 and 3:

Local Authority	Allocation (£)
Barnet	80,000
Camden	46,500
Enfield	45,500
Haringey	82,000
Islington	55,000

13 ASSURANCE AND MONITORING

13.1 All costs should be evidenced and substantiated should this information be audited.

13.2 Costs should be identifiable to individual patients although this might not be possible in all cases – for example where beds have been purchased but were not subsequently needed or costs relate to other allowable expenditure.

13.3 For the Covid-19 national schemes as the Lead Commissioner, the Council will monitor the performance of the services commissioned to deliver the Enhanced Hospital Discharge Services. For all existing services this will be through existing monitoring procedures.

14 LEAD OFFICERS

14.1.1 For the Covid-19 national Schemes 1, 2 and 3

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	DASS – *details to be added*			
CCG	Sarah Mansuralli Executive Director –	4th Floor 250 Euston Road	07557319123	Sarah.Mansuralli@nhs.net

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
	Strategic Commissioning	London NW1 2PG		

14.1.2 For the Long Lengths of Stay Reduction Scheme, Scheme 4 and Transfer of Care Hubs, Scheme 5 as follows

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	xxx Director of Adult Social Care Enfield Council			
CCG	Sarah Mansuralli Executive Director – Strategic Commissioning	4th Floor 250 Euston Road London NW1 2PG	07557319123	Sarah.Mansuralli@nhs.net

14.1.3 For Additional Discharge Fund, Scheme 6

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Dawn Wakeling Director of Adult Social Care Barnet Council			
CCG	Sarah Mansuralli Executive Director – Strategic Commissioning	4th Floor 250 Euston Road London NW1 2PG	07557319123	Sarah.Mansuralli@nhs.net

15 REGULATORY REQUIREMENTS

15.1 The provision of any personal care provided as part of any Enhanced Discharge Services needs to be registered under the 2008 (the "Registered Provider"). The Council shall be responsible for ensuring that the 'Registered Provider' which delivers services under contract to either partner organisation, complies with such registration requirements.

16 INFORMATION SHARING AND COMMUNICATION[2]

Monthly submission data to be broken down to client level will be shared with the CCG to ensure that a robust reimbursement process is in place.

Submissions to be made in accordance with this agreement.

Reasonable requests for information from all parties will be dealt with within jointly agreed timescales

17 DURATION AND EXIT STRATEGY

17.1 The arrangements for the Covid-19 Hospital Discharge Scheme may only be varied:

17.1.1 in accordance with the variation provisions in the Partnership Agreement; and

17.1.2 where such variation complies with the requirements of the Discharge Requirements and/or any Future Discharge Requirements.

17.2 This Scheme may not be terminated otherwise than in accordance with paragraph 17.3.

17.3 The Covid-19 Hospital Discharge Scheme shall, unless varied to give effect to Future Discharge Requirements, terminate on the date on which the Discharge Requirements cease to apply.

17.4 The Partners acknowledge that as at the date of this Agreement they are not in a position to determine all the exit arrangement for the Covid-19 Hospital Discharge Scheme. The Partners agree that except as otherwise set out in this clause 10 they shall:

17.4.1 keep under review the Discharge Requirements and any Future Discharge Requirements;

17.4.2 consider how to give effect to the requirements of any Future Discharge Requirements, where relevant; and

17.4.3 develop and agree a transfer plan in relation to the variation of the Enhanced Discharge Services Scheme:

(a) appropriate mechanisms for maintaining service provision;

(b) allocation and/or disposal of equipment;

(c) responsibilities for debts and ongoing service contracts;

(d) responsibility for any liabilities which have been accrued by the Host Partner/Lead Commissioner;

(e) premises arrangements;

(f) record keeping arrangements;

(g) information sharing arrangements and requirements;

(h) staffing arrangements;

(i) appropriate processes to be initiated in the run up to and following the end of the Enhanced Discharge Services Period.

17.5 The Partners further agree that they shall within 7 working days of being notified of the end date for the Enhanced Discharge Support Service the Partners shall meet to:

17.5.1 implement any agreed transfer plan or in the absence of an agreed transfer plan agree and implement such a plan which shall include, as a minimum, arrangements to transfer to the existing Funded Packages onto the future funding arrangements; and

17.5.2 consider the need for any other Individual Schemes to be introduced as a result of this termination of this Individual Scheme.

17.6 The monies which have been made available by the NHS pursuant to the Discharge Requirements may only be used to pay for the costs of the Services under the Covid-19 Financial Reporting Guidance as being eligible for this funding.

17.7 The Partners will at all times act in good faith to ensure claims for reimbursement meet the reimbursement requirements for Schemes 1 – 3 in accordance with the terms of the Discharge Requirements.

17.8 In the event of discharge demand resulting in expenditure exceeding the available allocation for Scheme 3, the Partners will identify a proportionate methodology to share the risk of the financial shortfall equitably.

17.9 In the event of expenditure exceeding the available allocation for Scheme 3 as a result of partners claims for reimbursement not meeting the requirements of the allowable cost criteria as set out in this document and Appendix 3, the responsible organisation(s) will be responsible for mitigations.

Appendix 1 – Admission Avoidance (Scheme 1 only)

The following definitions have been adapted from the financial guidance re COVID -19 (April 20) and the Discharge Guidance (March 20)
1. Individual at home experiences a significant change of need and requires a new or increased domiciliary or residential package to prevent admission to hospital.
2. Individual in care home, experiences a significant change in need and requires additional support to prevent admission to hospital, therefore a new or enhanced package commences. This will include the move from a residential to a nursing home provision.
3. Existing NHS CHC funded (including fast track) individual deteriorates and requires an enhanced care package to prevent admission to hospital.

Criteria which underpins the definitions

- Without a new or increased funded package there is a significant likelihood of admission to an acute hospital setting
- Assessment of need must be person centred
- The individual must have an altered health need which requires assessment by a social care and health professional.
- Changes in the individuals health status, result in a significant change to their normal package of care i.e. there is a change in need.
- Social care support will normally be provided alongside the management of an acute medical condition
- *Covid-19 monies to fund* new package or enhancement to existing package

Process for identification for COVID funding (admission avoidance – Scheme 1 only)

- The rationale for COVID funding needs to be identified and recorded against one of the above definitions
- The practitioner should clearly state the period of time the additional care is required for, including either a review date, or a date when the additional care should stop
- The change in health need should be recorded in the individuals records
- The altered cost of the care package needs to be recorded on the template (Mark – please can you advise on the name of the template and any additional guidance)

Financial Assessment
Care package set up using Covid-19 monies are to be provided without financial assessment or means testing.

Appendix 2 – Hospital Discharge Scheme Funding Scheme 2 – Requirements

On-going care and support needs for anyone being discharged from hospital without an existing care package will be provided free of charge for up to six weeks for the duration of the scheme to allow for post-discharge recovery and support services, and any assessments of ongoing care needs and financial eligibility determinations to be made.

The financial governance arrangements for Scheme 2 shall be conducted/managed in accordance with those set out in this document

Any costs associated with Scheme 2 should be transparent, auditable and traceable back to individual patients,

The Scheme 2 guidance instructs that the majority of patients should be assessed under the Care Act or for Continuing Health Care (CHC) outside of an acute setting. They will be eligible for up to 6 weeks of non - chargeable care until the assessment takes place.

Restarts: people who return to an existing package of care following discharge will return to their normal business as usual funding arrangements and as such no element will be funded by the HDS2 scheme.

Admission Avoidance is not to be reimbursed under Scheme 2, however, urgent community response services for people who would otherwise be admitted into hospital for up to 48 hours while individuals are transitioned into other ongoing care and support pathways.

Scheme 2 ends on 31 March 2021, however reimbursements will continue for up to 6 weeks of care of care and support for those discharged on or before 31 March 2021. Further guidance on the arrangements for the completion and wind down of the scheme in April-May 2021 will be required where the period of eligibility continues from a March 2021 discharge.

Scheme 2 funding will not pay for:

- Long term care needs following completion of a Care Act and/or NHS CHC assessment
- Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital
- Pre-existing (planned) Council or CCG expenditure on discharge services e.g. Reablement and Intermediate Care funded in baselines

Appendix 3 – Hospital Discharge Scheme Funding Scheme 3 – Requirements

The Scheme 3 funding is available for up to six weeks (until 30 June 2021), reducing to four weeks (between 1 July and 31 March 2022) and is to fund some of the cost of post-discharge recovery and support services/ rehabilitation and reablement care following discharge from hospital while assessment of ongoing care needs is undertaken.

The national discharge fund is available to fund the additional costs of:

- Services that support the new or additional needs of an individual on discharge from hospital.
- Designated care settings for those discharged from acute care who are COVID-positive and cannot return directly to their own care home until 14 days of isolation has been undertaken.
- The additional funding available to support delivery of hospital discharge should only be used to fund activity arising from the programme that is over and above activity normally commissioned by CCGs and local authorities.

The financial governance arrangements for Scheme 3 shall be conducted/managed in accordance with those set out in this document.

Any costs associated with Scheme 3 should be transparent, auditable and traceable back to individual patients,

The Scheme 3 guidance instructs that the majority of patients should be assessed under the Care Act or for Continuing Health Care (CHC) outside of an acute setting. They will be eligible for up to 6 (or 4) weeks of non - chargeable care until the assessment takes place.

Restarts: people who return to an existing package of care following discharge will return to their normal business as usual funding arrangements and as such no element will be funded by the HDS3 scheme.

National discharge funding provided should be separately identified within the agreement and monitored to ensure funding flows correctly. It should be pooled alongside existing local authority and CCG planned expenditure on discharge support – the funding is intended to meet additional costs arising from the national discharge fund only.

Admission Avoidance is not to be reimbursed under Scheme 3.

Scheme 3 is currently set to end on 30 September 2021, however reimbursements will continue for up to 4 weeks of care of care and support for those discharged on or before 30 September 2021. Further guidance on the arrangements for the completion and wind down of the Discharge Scheme are expected in September 2021.

Scheme 3 funding will **not** pay for:

- Long-term care needs following completion of a Care Act and/or NHS CHC assessment.
- Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital.
- Pre-existing (planned) local authority or CCG expenditure on discharge services e.g. Reablement, Intermediate Care and other short and long-term care funded in baselines

- Any Admissions avoidance schemes or packages of care for individuals not discharged from hospital
- Discharge costs post discharge after six weeks (until 30 June 2021), reducing to four weeks (between 1 July and 31 March 2022)

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