Bevan Brittan

Dated **2015**

NORFOLK COUNTY COUNCIL

and

NHS NORWICH CLINICAL COMMISSIONING GROUP

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

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THIS AGREEMENT is made on day of 2015

PARTIES

(1) **NORFOLK COUNTY COUNCIL** of County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH (the **"Council"**)

(2) **NHS NORWICH CLINICAL COMMISSIONING GROUP** of City Hall, Norwich, Norfolk, NR2 1NH (the "**CCG"**)

BACKGROUND

1. The Council has responsibility for commissioning and/or providing social care services on behalf of the population of Norfolk.

2. The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the city of Norwich.

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

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

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

6. The aims and benefits of the Partners in entering in to this Agreement are to:

   a) improve the quality and efficiency of the Services;

   b) meet the National Conditions and Local Objectives including;

National Conditions

- Protection for social care services (not spending)
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

The national metrics underpinning the Pooled Fund will be:

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes;
- Effectiveness of Reablement;
- Delayed transfers of care;
- Total non-elective emergency admissions;

- Patient/service user experience; and
- Estimated diagnosis rate for people with Dementia

Local objectives (moving towards)

GP localities
Helping GPs work together in four city clusters in Norwich, each with about 50,000 patients. We'd expect to see shared GP services if Practices desire this.

Integration
Building mental health, community nursing, therapy, and social care services around the same localities – meaning more care is provided closer to people's homes. It will ensure patients receive 'joined-up' services based around their needs, rather than based around traditional organisational boundaries. We'd like to see seven day access to some community-based services where possible. For example Case Management for Patients with Complex Health and Care Needs is a service that runs for five days a week but will be extended to seven day working. People with several serious conditions are given much closer support at home to keep them safe and well.

Technology
Harnessing new ways of providing care and making the NHS more efficient, and bringing modern information and communication systems to your local NHS services.

Communities
Providing more support for self-care, carers, voluntary organisations and communities to deliver support to people locally. The CCG has guaranteed to maintain funding of at least £500,000 a year for the voluntary sector – and increase that where it can.

Integration in Norwich will be delivered, with support of GP practices, with a focus for planning to the four areas of Norwich already used for delivering community health services by the community provider. This means planning is increasingly being based on populations of 50,000: big enough for a critical mass of service, but with greater sensitivity to local circumstance and connectivity between local professionals and services.

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

d) drive forward integration between health and social care at a local level.

7. The CCG has carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

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

1. DEFINED TERMS AND INTERPRETATION

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 20, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

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

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

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

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

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

Commencement Date means 00:01 hrs on 1st April 2015.

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

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

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

(c) which is a trade secret.

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

Financial Contributions means the financial contributions made by each Partner to the Pooled Fund(s).

Financial Year mean 1 April- 31 March.

Force Majeure Event means one or more of the following:

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

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

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

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification. [1]

Host Partner means the Council as host of the Pooled Fund.

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

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

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

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

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

Law means:

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

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

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

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

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

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

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

Month means a calendar month.

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

[1] Here and in the definition of NHS functions the widest definition is used; this needs to be cut down in the relevant specification so that the purpose must be fulfilled by use of the function

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

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 7.

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

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

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

Performance Payment Arrangement means the arrangement described in schedule 5.

Permitted Expenditure has the meaning given in Clause 7.

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

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

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

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

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

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

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

SOSH means the Secretary of State for Health.

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

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

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

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

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

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

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

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

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

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

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

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

2. TERM

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

2.2 This Agreement shall continue for one year unless it is terminated in accordance with Clause 18. If it is agreed that a Pooled Fund will continue beyond 31 March 2016, the Partners shall work together to establish a timetable to agree its terms by the end of this Agreement period, and draft those terms in accordance with Central Government guidelines.

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

3. GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

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

4. PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to pool funding from which to commission services, as described in the Individual Schemes, as aligned commissioning.

4.2 There may however be opportunities from time to time for the Partners to consider funding other schemes and to establish one or more of the following:

4.2.1 Lead Commissioning Arrangements;

4.2.2 Integrated Commissioning;

4.2.3 Joint (Aligned) Commissioning

4.2.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities").

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

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

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

5. FUNCTIONS

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

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

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

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

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Partnership Board.

6. COMMISSIONING ARRANGEMENTS

6.1 Where there are commissioning arrangements in respect of an Individual Scheme, the relevant Partner shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to their nominated Provider pursuant to the terms of each Service Contract, as appropriate.

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

Appointment of a Lead Commissioner

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

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

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

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

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

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

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

6.4.7 undertake performance management and contract monitoring of all Service Contracts;

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

6.4.9 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements.

7. ESTABLISHMENT OF A POOLED FUND

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

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

7.2 It is agreed that the monies held in the Pooled Fund(s) shall be contributed and expended as described in schedule 1 ("Permitted Expenditure").

7.3 Future financial contributions will jointly be agreed at the Partnership Board in sufficient time as to meet both Partners' financial planning. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Partnership Board minutes and recorded in the budget statement as a separate item.

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

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

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

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

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

7.6.3 appointing the Pooled Fund Manager;

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

8. POOLED FUND MANAGEMENT

8.1 The Partners agree that the Council shall:

8.1.1 provide the financial administrative systems for the Pooled Fund;

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

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

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

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

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

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

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

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

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

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

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

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

9. RISK SHARE ARRANGMENTS AND OVERSPENDS

Risk share arrangements

9.1 The partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

9.2 Subject to Clause 9.1, the Host Partner shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

9.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 9.4.

9.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the Schedule 2 and Schedule 3 shall apply.

10. VAT

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

11. AUDIT AND RIGHT OF ACCESS

11.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

11.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection

with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

12. LIABILITIES AND INSURANCE

12.1 To the extent permitted by Law and, subject to any agreement between the Partners relating to the Flexibilities and the VAT position regarding ICES described in schedule 3, neither Partner shall be liable to the other for a Loss arising out of or in connection with this Agreement.

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

13. STANDARDS OF CONDUCT AND SERVICE

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

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

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

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

14. CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

15. GOVERNANCE

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

15.2 The Partners have established a Partnership Board to:

- Provide strategic direction of the BCF at a local level
- Provide oversight and scrutiny of the BCF schemes
- Provide a platform for future integration

15.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 15 and Schedule 2.

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

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

15.6 The Health and Wellbeing Board shall be responsible for ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

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

16. REVIEW

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

17. COMPLAINTS

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

18. TERMINATION & DEFAULT

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

18.2 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 19.

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

19. DISPUTE RESOLUTION

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

19.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 19.1, at a meeting convened for the purpose of resolving the dispute.

19.3 If the dispute remains after the meeting detailed in Clause 1919.2 has taken place, the Partners' respective Chief Officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

19.4 If the dispute remains after the meeting detailed in Clause 19.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model

Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

19.5 Nothing in the procedure set out in this Clause 19 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

20. FORCE MAJEURE

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

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

20.3 As soon as practicable, following notification as detailed in Clause 20.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 20.4, facilitate the continued performance of the Agreement.

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

21. CONFIDENTIALITY

21.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 21, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

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

21.1.2 the provisions of this Clause 21 shall not apply to any Confidential Information which:

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

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

21.2 Nothing in this Clause 21 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

21.3 Each Partner:

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

21.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 21.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 21;

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

22. FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

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

22.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 22 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

23. OMBUDSMEN

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

24. INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 2, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

25. NOTICES

25.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 25.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

25.1.1 personally delivered, at the time of delivery;

25.1.2 sent by facsimile, at the time of transmission;

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

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

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

25.3 The address for service of notices as referred to in Clause 25.1 shall be as follows unless otherwise notified to the other Partner in writing:

25.3.1 if to the Council, addressed to the Executive Director of Adult Social Services;

Tel: 01603 223175
Fax: 01603 223096
E.Mail: harold.bodmer@norfolk.gov.uk

and

25.3.2 if to the CCG, addressed to the Chief Executive Officer;

Tel: 01603 751642
Fax: 01603 751640
E.Mail: jo.smithson@nhs.net

26. VARIATION

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

27. CHANGE IN LAW

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

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

27.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 19 (Dispute Resolution) shall apply.

28. WAIVER

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

29. SEVERANCE

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

30. ASSIGNMENT AND SUB CONTRACTING

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

31. EXCLUSION OF PARTNERSHIP AND AGENCY

31.1 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.

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

31.2.1 act as an agent of the other;

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

31.2.3 bind the other in any way.

32. THIRD PARTY RIGHTS

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

33. ENTIRE AGREEMENT

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

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

34. COUNTERPARTS

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

35. GOVERNING LAW AND JURISDICTION

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

35.2 Subject to Clause 19 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

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

THE CORPORATE SEAL of **THE NORFOLK COUNTY COUNCIL** was hereunto affixed in the presence of:)

Signed for on behalf of **NORWICH CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

Part 1 – Services Schedule

To achieve the conditions and metrics attached to the Better Care Fund the following schemes are to be delivered:

Primary Care

1. **Development of Primary Care Localities -** GP Practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access are being developed.

2. **Risk Stratification System, including Primary Care Data -** A risk stratification tool has been adopted and, using this, practices are being supported to identify and manage patients at high risk of hospital admission. Exploring technological solutions, care plans will incorporate primary care and social care data into the model.

Community Health & Care Services

3. **Integration of Community Health & Care Teams in CCG Localities** - Integrated Community Services - Community, Mental Health, and Social Care Services will be reshaped to the same locality footprints as primary care. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination (below) we will place the responsible GP at the heart of an integrated virtual health and care team.

4. **Care Co-Ordination Teams (CCG Localities) -** The model of care coordination in Norwich has been tested for the last two years. Staff within Norfolk County Council – largely funded by the CCG – coordinate and organise a range of health and care interventions for patients identified as being at high risk of hospital admission, and those approaching end of life, in accordance with a care plan agreed with the patient. The service will be extended to seven day working, linking in with a clinical coordination role and capacity increased to enable care coordination for 2% of the population at greatest risk (approximately 3,500 patients).

5. **Seven Day Response for Patients with Complex Health and Care Needs –** The Your Norwich model will be one service with a number of capabilities including rapid response, Homeward (virtual Ward – see 12 below), Community IV and care management. The services will be provided on a seven day basis.

6. **Falls Prevention -** . Following the success of a multi-agency falls reference group which reviewed the way falls are managed, monitored and prevented, a new falls coordination group has been set up to ensure that falls prevention remains a priority and is embedded in all relevant work being undertaken. A dashboard will be used to monitor local falls data and the impact of pathway improvements. Delivery of these improved services will be aligned with the plans for primary care locality work and will embed falls prevention work in all appropriate projects.

7. **Seven Day Social Care Assessment and Care Management (community) –** Norwich's ambition is to build on the existing out of hours service for community social care. Norfolk County Council and Norfolk Community Health and Care (NCH&C) are working jointly to ensure seven-day cover will be part of their integration of staff. For social care, a first step will be to consider extended hours opening to supplement the out of hours service already provided. NCC reablement staff are already

able to arrange and switch on social care packages of care when needed outside normal office hours.

8. **Integrated End of Life Care -** A more integrated range of palliative care services will be developed which includes community support, daytime services, specialist palliative care nursing and beds, rapid response and 24/7 care. Care at home services will be enhanced to support families more effectively with an emphasis on keeping people in their own homes if appropriate in accordance with their choice. Work is progressing on developing an electronic patient care record that can be shared between health and social care professionals.

9. **Integrated Dementia Care -** The advice, information and support services for people with dementia, their family and carers is being reviewed as is the range and commitment to providing intermediate care community beds for dementia clients (both health and social care), including dedicated respite beds. A new housing with care scheme with separate dementia care beds has been commissioned using Homes and Community Agency funding and is planned to open in 2016. Dementia is recognised as a long-term condition and better support will be developed through local multi-disciplinary team engagement. The dementia care pathway will be improved and services strengthened for those able to live independently. Development of dementia friendly communities in Norwich will be sought, potentially aligning this with the Healthy Norwich initiatives.

10. **Integrated Community Mental health Services** - Community mental health services will be shaped and delivered in the locality footprints. Mental health service provision will be embedded in the four integrated health & care teams and will work proactively with partners to reduce demand on the unplanned care system. The service will need to be operational 7 days a week to contribute to the reduction of unplanned admissions and to support timely discharge. The IAPT service is being re-procured with effect from 1 April 2015 and is specified to include integration with primary care.

11. **Integrated Support for People with Long-term Conditions –** Analysis of the Norwich population shows that unplanned acute admissions for people with long-term conditions remains a concern. The effective management of admissions is key to improving the patient experience and our ability for shifting resources in the health and social care system into the community. Social care services will be protected by remodelling reablement, help at home services and other social care services during 2015/16 using Transformation Funding.

Intermediate Care

12. **Seven Day Supported Discharge & Intermediate Care Management -** A new approach to intermediate care is being developed to enable quicker discharge home and to provide a step up faciity, with coordinated packages of health and social care to support reablement and recovery. The use of early supported discharge home direct from an acute setting will be increased, using 'virtual ward' methodology to ensure the patient receives appropriate medical and nursing care during their period of recovery to further reduce the risk of readmission. Seven day and extended hours supported discharge and intermediate care management will be set up. The most vulnerable patients will be targeted.

Community Assets

13. **Supporting Self-Care (Education, Tools & Resources) -** A partnership approach to patients, families, and communities in Norwich will be developed, investing to equip patients and carers with the knowledge and skills for sustainable self-care, and ensure health professionals work with patients to develop self-management plans, including lifestyle changes. Better and more accessible information, advice and advocacy will be provided so that people are best placed to arrange their own care including through use of personal budgets.

14. **Development of Voluntary and Community 'Pre-Primary' Intervention Fund to maintain health, wellbeing, and independence -** The voluntary and not-for-profit sector will play a stronger role in the delivery of care both upstream and in partnership with statutory health and care provision; and communities will be supported to identify and harness their internal assets: knowledge, skills, relationships, and facilities. Norwich CCG is working with Age UK Norwich to deliver a new and innovative model of care and support which will target the most vulnerable people in the city. This will involve the voluntary sector working as a part of the multi-disciplinary team. A local voluntary sector information hub will be developed to assist with care navigation. Norwich CCG and Norfolk County are supporting a successful multi-agency Ageing Better Big Lottery initiative known locally as Getting On In Norwich. This is led by the voluntary sector and is focused on promoting an asset-based community development approach for older people living in Norwich. It will invest £4.5m over six years.

15. **Carers –** Norwich CCG recognises the pivotal role that carers play in supporting friends and relatives and will aim to build on the newly commissioned jointly funded Carers Agency Partnership to ensure that the countywide arrangements are delivered in the best way for Norwich and to ensure that the partners are well-prepared to respond to proposed new statutory responsibilities embodied in the Health and Social Care Act. A new cross county carers strategy has been agreed working with the Carers Council for Norfolk. Action plans are being developed and actioned.

16. **Housing Support** – The existing partnership work between health (including public health), housing and social care aligned to our Healthy Norwich initiative will be built on to ensure that people are well supported to live independently at home. This includes further development and improvement of a wide range of support including supported housing, disability adaptations, community equipment services, assistive technology and the work of Home Improvement Agencies.

Part 2– Financial Contributions

Revenue Funding Contributions to the Pooled Fund:

The Norfolk BCF brings together a minimum £56.381m revenue funding and £6.080m capital funding. This revenue funding will be provided by clinical commissioning groups and the capital funding by NCC.

In addition to this, the council will add £0.516m funding to the pool as its part of the Integrated Community Equipment Service.

£11.721m revenue funding will therefore enter the Norwich pooled fund.

A further £1.040m could enter the pool subject to the achievement of performance against Total non-elective emergency admissions targets. These arrangements are covered within schedule 5.

£11.205m will be provided by the CCG. NCC, as host, will invoice the CCG, quarterly in advance as follows:

April 2015 - £2.8012m

July 2015 - £2.8012m

October 2015 - £2.8012m

January 2016 - £2.8012m

Payments from the Pooled fund:

Of the £11.721m funding:

- £7.905m will be paid from the pooled fund to NCC
- £2.495m will be paid from the pool to the CCG.
- £1.321m will be retained within the Pool for ICES

The timing of this funding transfer will happen in-line with the income contributions to the fund.

To claim its funding from the pool the CCG will invoice NCC as follows:

April 2015 - £0.62375m

July 2015 - £0.62375m

October 2015 - £0.62375m

January 2016 - £0.62375m

To claim its funding from the pool NCC will raise journals as follows:

April 2015 - £1.97625m

July 2015 - £1.97625m

October 2015 - £1.97625m

January 2016 - £1.97625m

To support the integrated approach to the schemes the following funding from the Pooled Fund has been agreed:

	Funding for each partner		
Scheme	**NCC**	**CCG**	**Total**
NCH1	0.043	0.959	1.002
NCH2	5.318	1.006	6.324
NCH3	1.805	1.175	2.980
NCH4	0.739	0.159	0.898
	7.905	**3.300**	**11.205**
P4P	Subject to performance*		1.040
Total			**12.245**

*The payment for performance funding is articulated in Schedule 5.

The above scheme level split is as in accordance with the Better Care Fund December submission to NHS England. In the event that the specifications of each scheme develop away from this plan, both Partners reserve the right to alter the respective scheme splits via agreement at the Partnership Board.

Each Partner will spend their respective funding in 15/16 as follows:

The Council

The Council will continue to invest in areas previously agreed under the 2014/15 Section 256 Agreement:

Area of Spend	£'m
1. Protecting access to social care services and care packages which enable people to manage long term health conditions and disabilities including dementia against the background of rising needs through demographic pressures	1.315
2. Continuing to provide social work assessment and care planning within integrated health and care arrangements in community settings	0.261
3. Continuing to provide equipment and specialist sensory support services	0.202
4. Maintaining services to improve mental health outcomes	0.227
5. Continuing to provide effective early interventions and support to prevent increases in need, reduce the likelihood of acute hospital admissions, impact on the range of factors which can trigger health crises and defer moves to higher care settings	1.495
6. Contributing to timely hospital discharges and recovery from ill health and injury	0.81
7 Ensuring that support and care is provided safely and that the market for provision of social care and other relevant services is able to respond to changing needs	0.034
Sub Total	**4.344**

And will provide investment funding into the following areas:

Area of Spend	£'m
Purchase of Care via residential, day care and domiciliary care packages	1.708
Supporting Carers	0.435
Reablement via NFRS	0.951
Care Act implementation	0.468
Sub-Total	**3.562**
ICES	0.516
Total	**4.078**

Total NCC Expenditure	**£'m**
Section 256 Expenditure	4.344
Other investment funding	3.562
Sub-Total	**7.905**
ICES	0.516
Total	**8.421**

CCG

Area of Spend	£'m
GP Care Homes initiative	0.372
Your Norwich integrated community service model	1.996
Medicine management service	0.053
Care co-ordination	0,074
Community equipment	0.805
Total	**3.300**

Capital Funding Contributions to the Pooled Fund:

- £6.080m of capital funding will enter the 5 Norfolk pooled funds. It will be provided to the Better Care Fund pool by the Council as follows:

    - £2.327m Social Care Capital Grant:
        - £0.871m of this funding will be ring-fenced for the implementation of the Care Act;
        - £1.456m will be deployed within the Council's capital programme.

    - £3.753m Disabled Facilities Grant (DFG):
        - For 2015/16, this funding transfers to upper-tier authorities, via the Better Care Fund, so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users;
        - Lower-tier authorities have a statutory duty as local housing authorities to provide DFGs to those who qualify for it. The duty is to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under;
        - The statutory duty remains with lower-tier authorities in 2015/16 and therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet this duty.
        - The funding to each lower-tier authority is fixed as:

            - Breckland 0.535m
            - Broadland 0.414m
            - Great Yarmouth 0.567m
            - King's Lynn and West Norfolk 0.759m
            - North Norfolk 0.595m
            - Norwich 0.472m
            - South Norfolk 0.410m

        - The seven district councils do not split evenly across the 5 locality CCG boundaries. No attempt will be made to split this funding in this way but for clarity engagement will be required in line with the following table of interest:

Table of vested interest		Partners					
		NCC	GY&W CCG	North Norfolk CCG	South Norfolk CCG	West Norfolk CCG	Norwich CCG
District Council	**Breckland**	✔			✔	✔	
	Broadland	✔		✔			✔
	Great Yarmouth	✔	✔				
	King's Lynn and West Norfolk	✔				✔	
	North Norfolk	✔		✔			
	Norwich	✔					✔
	South Norfolk	✔			✔		

- The Partners agree to keep all the capital allocations in one Norfolk wide pool.
- In order to provide assurance on local planning, the Council will provide the CCG with information on its planned programme of spend on Housing with Care via the Partnership Board.
- Any asset acquired through capital expenditure will be wholly owned by the Council.
- The Council, as host, will be responsible for ensuring appropriate capital accounting arrangements are adhered to.

Part 3 - Hosting

The Host Partner for the Pooled Fund is the Council, and the Pooled Fund Manager, being an officer of the Host Partner is the relevant locality Head of Integrated Commissioning.

The Pooled Fund Manager will be supported in their role by officers within the Council, including the Budgeting and Accounting and Business Intelligence and Performance Services.

The Pooled Fund Manager will be the officer with delegated authority to approve the payments from the Pooled Fund. The level of delegated authority will be in line with that contained within the Council's financial regulations and procedures and contract standing orders.

The Council, as host, will produce pooled fund accounts for its own statutory accounts. To enable the CCG to comply with its own accounting requirements and deadline, the Council will provide an unaudited income and expenditure schedule. The format and specific timing of this report will need to be agreed at the local partnership board by December 2015. Each Partners will remain responsible for organising their own external audit.

The funds relating to the Pooled Fund will be held in the Council's main bank account. Each individual pool will have its own cost centre within the Council's Financial Management system, Oracle FIMS.

Management accounts will be provided…..[To be agreed]

Will need to alter the following when known level of hosting

What monitoring arrangements are in place?
Who will produce monitoring reports?
What is the frequency of monitoring reports?
What management costs can legitimately be charged to pool?

The contributions to and from the Pooled Fund will be exempt from VAT. Each Partner's own VAT regime will apply to the usage of funding once received.

The Council has a facility to carry forward funds should there be an underspend within the Pooled Fund. The decision to carry forward funding or reimburse Partners must be agreed at the Partnership Board in prior to both partners year end.

PART 4 – AGREED SCHEME SPECIFICATIONS

Scheme ref no.
N1
Scheme name
Primary Care
What is the strategic objective of this scheme?
To identify patients at highest risk of hospital admission and focus on prevention to reduce unplanned admissions
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
1. **Development of primary care localities** - GP Practices are being supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared primary care services for older patients, and those with long term conditions; with a focus on keeping patients independent, well, and at home. In particular, GP practices are being encouraged to increase their dementia assessment rates. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access are being developed. 2. **Risk stratification system, including primary care data** – A risk stratification tool has been adopted and, using this, practices are being supported to identify and manage patients at high risk of hospital admission. Exploring technological solutions, care plans will incorporate primary care and social care data into the model.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This scheme is being led by Norwich CCG with and has both a clinical (David Goldser) and scheme lead (Karin Bryant). Progress meetings are scheduled monthly and GP practice representatives are engaged through their four locality groups.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• Risk stratification tool used to identify patients at highest risk of unplanned or frequent hospital admissions • National guidelines • Care coordinators feedback For further evidence please refer to NCH1 Evidence Base Template via this link: Annex 1 – Evidence for Norfolk schemes
Investment requirements
£1.002m (15/16 only)
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Part 2 Tab 6: Local Metric – This scheme will have a significant impact on increasing the diagnosis

of dementia in Norwich. The expectation is with much earlier diagnosis and support over the long term this will start to deliver financial benefits, although this is not expected or modelled for the short term.
- Part 2 Tab 6: Patient & Service User Experience of Care: Providing diagnosis earlier and proactive community support will ensure that people experience of care in this area will be improved.

Additional Benefits of this scheme that will contribute to the overall ambitions of the wider programme include:
- Reduction in unplanned admissions
- Increased focus on prevention
- Care plans accessible to integrated team
- Increased service provision covering 7 days
- Improved flow between the different levels of service provision

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Feedback is sought from professionals, patients and their families / carers and is reported through the 'Your Norwich' programme board each month.

What are the key success factors for implementation of this scheme?

- Unplanned admissions are reduced
- Care plans accessible to all professionals involved in patient's care
- Urgent care needs can be met 7 days a week
- Improved satisfaction of patients and families

Scheme ref no.

N2

Scheme name

Community Health and Care Services

What is the strategic objective of this scheme?

To create and deliver an integrated health and care system that supports the population of Norwich to remain living independently with a good quality of life for as long as possible and to deliver high quality person-centred services effectively through working together.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

1. **Integration of community health & care teams in Norwich localities** - Integrated community services - community, mental health, and social care services are being reshaped to the same locality footprints as primary care. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination (below) we will place the responsible GP at the heart of an integrated virtual health and care team.

2. **Care co-ordination teams (CCG localities) -** The model of care coordination in Norwich has been tested for the last two years. Staff within Norfolk County Council – largely funded by the CCG – coordinate and organise a range of health and care interventions for patients identified as being at high risk of hospital admission, and those approaching end of life, in accordance with a care plan agreed with the patient. The service will be extended to seven day working, linking in with clinical co-ordination and capacity increased to enable care coordination for 2% of the adult population at greatest risk (approximately 3,500 patients).

3. **Seven day response for patients with complex health and care needs –** The Your Norwich model will be one service with a number of capabilities including rapid response, Homeward (virtual Ward – see 12 below), Community IV and care management. The services will be provided on a seven day basis.

4. **Falls prevention** – Following the success of a multi-agency falls reference group which reviewed the way falls are managed, monitored and prevented, a new falls coordination group has been set up to ensure that falls prevention remains a priority and is embedded in all relevant work being undertaken. A dashboard will be used to monitor local falls data and the impact of pathway improvements. Delivery of these improved services will be aligned with the plans for primary care locality work and will embed falls prevention work in all appropriate projects.

5. **Seven day social care assessment and care management (community) –** Norwich's ambition is to build on the existing out of hours service for community social care. Norfolk County Council and Norfolk Community Health and Care (NCH&C) are working jointly to ensure seven-day cover will be part of their integration of staff. For social care, a first step will be to consider extended hours opening to supplement the out of hours service already provided. NCC reablement staff are already able to arrange and switch on social care packages of care when needed outside normal office hours.

6. **Integrated end of life care -** A more integrated range of palliative care services will be developed which includes community support, daytime services, specialist palliative care nursing and beds, rapid response and 24/7 care. Care at home services will be developed to support families more effectively with an emphasis on keeping people in their own homes if appropriate and in accordance with their. Work is progressing on developing electronic patient care records that can be shared between health and social care professionals.

7. **Integrated dementia care –** The advice, information and support services for people with dementia, their family and carers is being reviewed as is the range and commitment to providing intermediate care community beds for dementia clients (both health and social care), including dedicated respite beds. A new housing with care scheme with separate dementia care beds has been commissioned using Homes and Community Agency funding and is planned to open in 2016. Dementia is recognised as a long-term condition and better support will be developed through local multi-disciplinary team engagement. The dementia care pathway will be improved and services strengthened for those able to live independently. Development of dementia friendly communities in Norwich will be sought, potentially aligning this with the Healthy Norwich initiatives.

8. **Integrated community mental health services** - Community mental health services will be shaped and delivered in the locality footprints. Mental health service provision will be embedded in the four integrated health & care teams and will work proactively with partners to reduce demand on the unplanned care system. The service will need to be operational 7 days a week to contribute to the reduction of unplanned admissions and to support timely discharge. The IAPT service is being re-procured with effect from 1 April 2015 and is specified to include integration with primary care.

9. **Integrated support for people with long-term conditions –** Analysis of the Norwich population shows that unplanned acute admissions for people with long-term conditions remains a concern. The effective management of admissions is key to improving the patient experience and the ability to shift resources in the health and social care system into the community. Social care services will be protected by remodelling reablement, help at home services and other social care services using Transformation Funding.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The workstreams above are supported by both a clinical and programme lead and the programme groups are meeting monthly. The programme leads are managed by James Elliott, Director of Clinical Transformation at Norwich CCG, Karin Bryant, Assistant Director of Clinical Commissioning and Mick Sanders, Head of Integrated Commissioning. A range of providers involved is being, or will be involved, including Norfolk Community Health and Care, Norfolk and Norwich University Hospital, Norfolk and Suffolk

Foundation Trust, East of England Ambulance Service Trust, Norfolk County Council, independent care providers and voluntary and community sector providers.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Analysis of unplanned admissions and identification of the 2% most vulnerable people through use of a risk stratification tool. Please see also separate document covering the evidence base.

For further evidence please refer to NCH2 Evidence Base Template via this link: Annex 1 – Evidence for Norfolk schemes

Investment requirements

£6.324m (15/16 only)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Part 2 Tab 4: This scheme will have a significant impact on reducing 'All non-elective Admissions' in Norwich.
- Part 2 Tab 4: This scheme will have a significant impact on reducing 'permanent residential care admissions' in Norwich
- Part 2 Tab 6: Local Metric – This scheme will have a moderate impact on increasing the diagnosis of dementia in Norwich
- Part 2 Tab 6: Patient & Service User Experience of Care: by supporting people in Norwich to remain living independently with a good quality of life for as long as possible, this scheme will have a strong impact in this area.

Additional Benefits of this scheme that will contribute to the overall ambitions of the wider programme include:

- Patients receive a coordinated approach to their care, improving their experience and outcomes
- Patients being at high risk of hospital admission are identified and a co-ordinated approach taken to reduce admissions
- Patients at end of life are able to remain in their own homes
- Reduction in falls and improved falls pathways
- To establish an integrated approach to dementia
- Maintaining independence for dementia patients as long as possible
- Increased access to mental health services through a range of community locations
- Use of acute mental health service reduced
- Improved quality of life for people with long term conditions
- Increased use of technology to improve service

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Feedback from professionals, patients and their families/ carers
- Number of acute unplanned admissions decreased
- More people are supported to die in their place of choice
- Reduction in number of falls
- Dementia awareness increased

What are the key success factors for implementation of this scheme?

- Acute admissions are reduced
- Number of falls is reduced
- Number of people dying in their place of choice is increased

- More people with dementia are supported to live independently

Scheme ref no.
N3
Scheme name
Intermediate Care
What is the strategic objective of this scheme?
Faster discharge from hospital with coordinated and effective packages of health and social care to support reablement and recovery
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A new approach to intermediate care is being developed to enable quicker discharge home and to provide a step up facility, with coordinated packages of health and social care to support reablement and recovery. The use of early supported discharge home direct from an acute setting will be increased, using 'virtual ward' methodology to ensure the patient receives appropriate medical and nursing care during their period of recovery to further reduce the risk of readmission. Seven day and extended hours supported discharge and intermediate care management will be set up.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This scheme will be supported by both a clinical and programme lead. The programme leads are James Elliott and Claire Leborgne of the Norwich CCG. Providers involved will be Norfolk Community Health and Care, Norfolk and Norwich University Hospital, Norfolk and Suffolk Foundation Trust, Norfolk County Council and independent care providers.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• Some evidence has been gained through the Domino programme • Evidence from implementation of virtual ward in West Norfolk • Analysis of community beds review which showed Norwich as under-resourced • The availability of Acute beds and the emphasis on reablement For further evidence please refer to NCH3 Evidence Base Template via this link: Annex 1 – Evidence for Norfolk schemes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£2.980m (15/16 only)
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Part 2 Tab 4: This scheme will have a significant impact on reducing Delayed Transfers of Care in Norfolk and is one of 5 schemes designed to have a Norfolk wide impact on DTOC. • Part 2 Tab 6: Patient & Service User Experience of Care: Ensuring that people are discharged in a timely manner will ensure that people's experience of care in this area is improved.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
• Feedback from professionals, patients and their families/ carers

- Shorter stays in hospitals
- Increase in reablement activity

What are the key success factors for implementation of this scheme?

- A proposed model is in place to respond to 2014 winter pressures
- Reduced length of stay for patients in acute hospital

Scheme ref no.

N4

Scheme name

Community Assets

What is the strategic objective of this scheme?

To promote sustainable self-care particularly harnessing the knowledge and skills of the voluntary sector and also further develop and improve a wide range of support to help people live independently at home.
.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

1. **Supporting self-care (education, tools and resources) -** A partnership approach to patients, families, and communities in Norwich will be developed, investing to equip patients and carers with the knowledge and skills for sustainable self-care, and ensure health professionals work with patients to develop self-management plans, including lifestyle changes. Better and more accessible information, advice and advocacy will be provided so that people are best placed to arrange their own care including through use of personal budgets.

2. **Development of voluntary and community 'pre-primary' intervention fund to maintain health, wellbeing, and independence -** The voluntary and not-for-profit sector will play a stronger role in the delivery of care both upstream and in partnership with statutory health and care provision; and communities will be supported to identify and harness their internal assets: knowledge, skills, relationships, and facilities. Norwich CCG is working with Age UK Norwich to deliver a new and innovative model of care and support which will target the most vulnerable people in the city. This will involve the voluntary sector working as a part of the multi-disciplinary team. A local voluntary sector information hub will be developed to assist with care navigation. Norwich CCG and Norfolk County are supporting a successful multi-agency Ageing Better Big Lottery initiative known locally as Getting On In Norwich. This is led by the voluntary sector and is focused on promoting an asset-based community development approach for older people living in Norwich. It will invest £4.5m over six years.

3. **Carers –** Norwich CCG recognises the pivotal role that carers play in supporting friends and relatives and will aim to build on the newly commissioned jointly funded Carers Agency Partnership to ensure that the countywide arrangements are delivered in the best way for Norwich and to ensure that the partners are well-prepared to respond to proposed new statutory responsibilities embodied in the Health and Social Care Act. A new cross county carers strategy has been agreed working with the Carers Council for Norfolk. Action plans are being developed and actioned.

4. **Housing support** –The existing partnership work between health (including public health), housing and social care aligned to our Healthy Norwich initiative will be built on to ensure that people are well supported to live independently at home. This includes further development and improvement of a wide range of support including supported housing, disability adaptations, community equipment services, assistive technology and the work of Home Improvement Agencies.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The integrated commissioning team led by Mick Sanders, Head of Integrated Commissioning for Norwich, is working closely with Norwich CCG, Norfolk County Council, Norwich City Council, voluntary and community sector organisations, supported housing providers, Carers Council for Norfolk and other

partners to coordinate this scheme reporting to the CCG "Your Norwich" Board as well as to Norfolk County Council's Director of Community Services. This scheme will also link to other initiatives throughout Norfolk through the Integrated Commissioning Team meetings.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- The right advice and assistance needs to be in place to enable people to support themselves to live independently at home
- Budget and demographic pressures point to further investment in local communities

For further evidence please refer to NCH4 Evidence Base Template via this link: Annex 1 – Evidence for Norfolk schemes

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£0.898m (15/16 only)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Part 2 Tab 4: This scheme will have a significant impact on increasing the effectiveness of Reablement in Norwich. (Reablement services are already performing at 87% effectiveness. This scheme will help maintain this high performance and deliver improvements.)

Additional Benefits of this scheme that will contribute to the overall ambitions of the wider programme include:

- Reduction in unplanned admissions
- Enabling patients to remain well, independent and in their own homes for longer
- Meeting policy requirements, achieving cost efficiencies and greater independence for patients
- Greater use of the voluntary and community services to support
- Shorter length of stay in hospital

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Feedback from professionals, voluntary and community sector, patients and their families/ carers.

What are the key success factors for implementation of this scheme?

- More patients remain well and independent in their own homes for longer
- Unplanned admissions are reduced
- Voluntary sector and community services play a greater part in patients' health and wellbeing

SCHEDULE 2 – GOVERNANCE

1 Partnership Board

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

1.1.1 NHS Norwich Clinical Commissioning Group, being the Chief Executive Officer and Chief Finance Officer or their deputies to be notified in writing to the Chair in advance of any meeting;

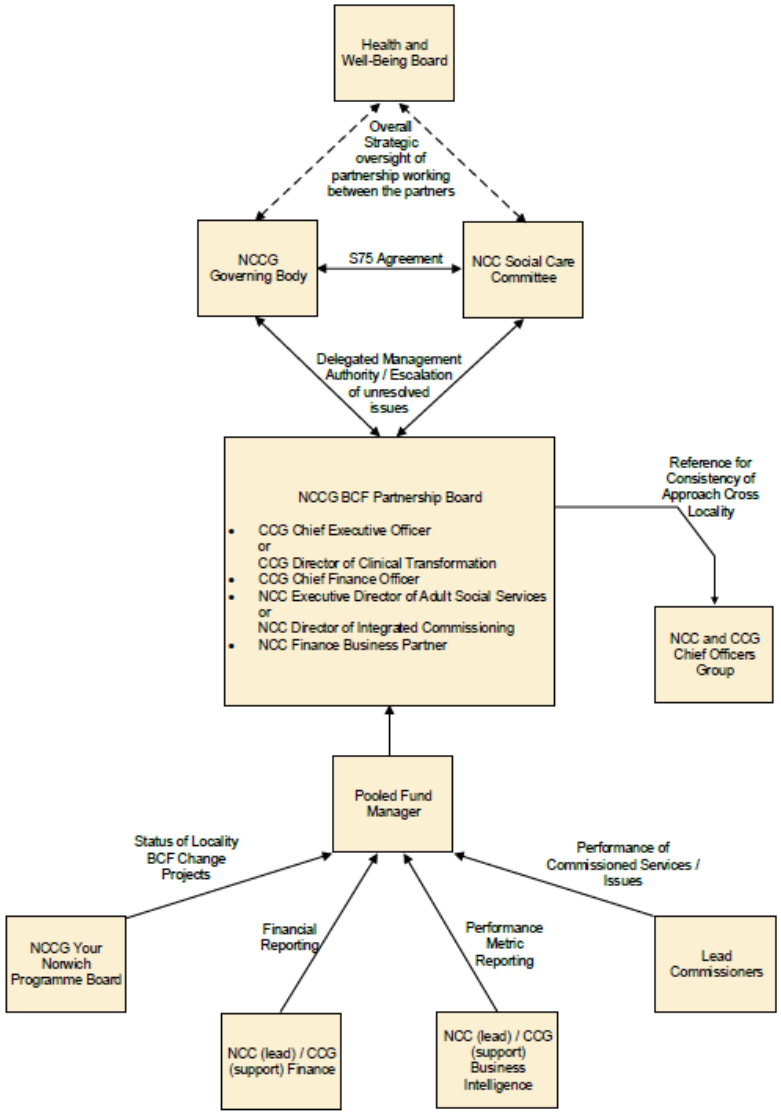
1.1.2 the Council, being the Executive Director Adult Social Services and Finance Business Partner or their deputies to be notified in writing to the Chair in advance of any meeting;

1.1.3 The Head of Integrated Commissioning will attend meetings in the role of Pooled Fund Manager

Norwich Clinical Commissioning Group – Norfolk County Council

BCF Pooled Fund - Section 75 Agreement

Principal Governance Relationships



2 Role of Partnership Board

2.1 The Partnership Board shall:

2.1.1 provide strategic direction on the Individual Schemes and adherence to the Better Care Fund National Conditions;

2.1.2 receive the financial and activity information and agree any corrective action as is required;

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

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

2.1.5 review and agree annually a risk assessment and a Performance Payment protocol, including the maintenance of a local risk register;

2.1.6 review and agree annually revised Schedules as necessary;

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

2.1.8 Jointly agree allocation of pooled funds for individual services and variations from the baseline as the year progresses and in response to specific changes in priority;

2.1.9 Ensure correct representation of 'payment for performance' measures each quarter and necessary transfers of funding take place between health and social care organisations;

2.1.10 Manage shortfalls in funding resulting from partial or non-achievement of Payment for Performance targets in accordance with agreed risk sharing arrangements;

2.1.11 Identify opportunities for further development of pooled funds and Commissioning activities;

2.1.12 Agree the arrangements for termination or extension of this agreement in line with central government guidelines for the Better Care Fund;

2.1.13 Task the Pooled Fund Manager with producing regular reports to the Health and Wellbeing Board alongside the 4 other Norfolk CCG pooled funds.

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

3 Meetings

3.1 The Chair for the Partnership board will be decided upon at the first meeting of the board.

3.2 The Partnership Board will meet six weekly at a time to be agreed and following receipt of each report of the Pooled Fund Manager.

3.3 The quorum for meetings of the Partnership Board shall be a minimum of one representative from each of the Partner organisations.

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

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

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

4 Delegated Authority

4.1 The Partnership Board is authorised within the limits of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

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

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

5 Information and Reports

5.1 The Pooled Fund Manager shall supply to the Partnership Board on a monthly basis the financial and activity information as required under the Agreement. The Council's finance department will collate financial reporting and management accounts monthly representing both CCG and Council information together. The Council's Business Intelligence and Performance department will collate performance reporting monthly representing information sourced directly and from the CCG (or if appropriate its Commissioning Support Unit). The CCG, as Partner, agrees to supply sufficiently detailed evidence of their expenditure and activity relating to the Pooled Fund in a timely basis to meet the reporting requirements of the Partnership Board, Health and Well Being board, national reporting requirements and any other reports required and to enable the Council to fulfil its obligations in this Agreement and in Law.

5.2 No identifiable personal data shall pass between Partners. Should this requirement change during the Agreement term then the Partnership Board shall agree an appropriate information protocol before such information is shared.

5.3 Both Partners shall retain adequate records to enable future information requests for a period of no less than 6 years.

6.4 Both Partners information shall only be used for its original intended purpose. Others uses must be agreed in advance at the Partnership Board.

6 Post-termination

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

SCHEDULE 3– RISK SHARE AND OVERSPENDS

1. Pooled Funding

    a. The dynamics of the operation of the Pooled Fund are to limit the risk of overspend to each Partner.
    b. Any cash sums paid from the Pooled Fund directly to the Council or CCG will be fixed and agreed in advance.
    c. Any resulting overspend in the service areas and/or individual schemes being invested in by each Partner will be at the risk of that said investing Partner.
    d. In accordance with clause 12, no overspend by either Partner will be at the liability of the other.
    e. ICES will be dealt with separately and is covered below at point 3.

Should additional contributions to the Pooled Fund be agreed within the Financial Year, the following applies:

Overspend

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

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

(a) whether there is any action that can be taken in order to contain expenditure;

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

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

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

2. Payment for Performance

    a. The funding related to Performance Payment Arrangements will be distributed as per the relevant schedule.
    b. In the event the performance is not sufficient as to release the funding described in section 6 Performance arrangements, the funding will be retained by the CCG and spent in consultation with the Health and Wellbeing Board.
    c. Overspends which occur in relation to any Performance Payments shall, subject to alternative provisions in the relevant Performance Payment Arrangement, be at the liability of that Partner who has been awarded the funding.

3. ICES

    a. The payment for ICES services will now be included within the Pooled Fund.
    b. The Council will add revenue funding to the amount provided by the CCG to enable the Pooled Fund to pay the service provider directly.
    c. The Council will recover all VAT associated with this contract, where applicable.
    d. The CCG will only be required to provide its net funding contribution as a result of the VAT recovery.
    e. In the event that HMRC deems the actions taken by this Pooled Fund with regard to VAT recovery to be inappropriate, the resulting liability will be at the expense of the Partner whose VAT is not recoverable, regardless of which Partner physically pays the service provider.

f. The service provider will raise all invoices to the Council as Host Partner. Each invoice will show the breakdown between Health and Social Care costs in accordance with the ICES invoice specification model.
g. Expenditure for ICES will still be monitored by the respective Partners as appropriate.
h. In the event of an Over/underspend relating to the ICES services the cost/benefit will be calculated using the invoices.
    i. Should an Overspend occur the Partner responsible for said Overspend will be required to make an equivalent additional contribution to the Pooled Fund;
    ii. Should an Underspend occur the Partner responsible for said Underspend has the option to:
        1. have the equivalent funding returned, or
        2. have the funding carried forward as an underspend within the Pooled Fund.

SCHEDULE 4 - JOINT WORKING OBLIGATIONS

a. LEAD COMMISSIONER OBLIGATIONS

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

1. *The Lead Commissioner shall notify the other Partner if it receives or serves:*

   a. *a Change in Control Notice;*

   b. *a Notice of a Event of Force Majeure;*

   c. *a Contract Query;*

   d. *Exception Reports*

   and provide copies of the same.

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

   e. *CQUIN Performance Reports;*

   f. *Monthly Activity Reports;*

   g. *Review Records; and*

   h. *Remedial Action Plans;*

   i. *JI Reports;*

   j. *Service Quality Performance Report;*

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

   a. *an Activity Management Meeting;*

   b. *Contract Management Meeting;*

   c. *Review Meeting;*

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

4. *The Lead Commissioner shall not:*

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

   b. *vary any Provider Plans (excluding Remedial Action Plans);*

   c. *agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;*

   d. *give any approvals under the Service Contract;*

   e. *agree to or propose any variation to the Service Contract (including any Schedule or Appendices);*

   f. *suspend all or part of the Services;*

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

h. serve any notice;

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

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

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

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

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

i. OBLIGATIONS OF THE OTHER PARTNER

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

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

   a. resolve disputes pursuant to a Service Contract;

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

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

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

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

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

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

4. – PERFORMANCE ARRANGEMENTS

The Pooled Fund has some specific performance targets against it:

Metric	Definition of metric	Source
Total non-elective admissions (general & acute), all-age	Number of first finished consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which: • patient classification = ordinary admission; • admission method = emergency admission, maternity admission, other admission (codes 21-83); • episode number = 1. Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care. General & Acute specialties; • include: 100-192, 300-460, 502, 504, 800-834, 900 and 901 • exclude: 501, 700-715.	NHS Monthly Activity Return data. Local CCG dashboards also SUS, to enable operational management. Results derived from MAR and SUS will yield different results. Population taken from 2014 ONS mid-year population estimates.
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Numerator: Number of council-supported permanent admissions of older people to residential/nursing care Denominator: Size of the older people population in area (aged 65 and over)	Social Care dataset. All information is taken from CareFirst. CCG for placement derived from GP surgery of service user. Population and placement information for GY & Waveney is for Norfolk only. Population taken from 2014 ONS mid-year population estimates.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Numerator: The number of older people aged 65 and over discharged from hospital at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. Denominator: The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital	Social Care dataset. All information is taken from CareFirst.
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	Numerator: The total number of delayed transfers of care (for those aged 18 and over) for each month included Denominator: 2014 ONS mid-year population estimate	Norfolk county wide and hospital data taken from monthly sitreps. Rates are not available by Trust as populations not available at hospital level. Population taken from 2014 ONS mid-year population estimates.
Patient/Service User metric: support from local services or organisations to help manage long-term health condition(s)	Local measure – to be confirmed	Q32 from the GP Survey: in the last 6 months have you had enough support from local services or organisations to help manage your long-term health condition(s)? Please think about all services and organisations not just health services.
Local metric: Estimated diagnosis rate for people with dementia (% and numbers).	Local measure – to be confirmed	Data taken from NHS England Primary care web tool, Dementia prevalence calculator.

Targets have been agreed for both Norfolk and the locality for these metrics as follows:

	Baseline			Target		
Metric	Times period for baseline	Norfolk	Norwich	Times period for target	Norfolk	Norwich
Total non-elective admissions (general & acute), all-age	1st January 2014 to 31st December 2014 (from CCG plans - actual not yet available)	91,764	20,727	1st January 2015 to 31st December 2015	88,552	20,002
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	2013/14	776.4 (1,556)	764.7 (169)	2015/16 (CCG targets are max number of admissions based on uniformly applied rate)	661.1 (1,387)	153
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	2013/14	87.0%	85.1%	2015/16	90.00%	90.00%
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	2013/14	30,397		2015/16	28,388	
Patient/Service User metric: support from local services or organisations to help manage long-term health condition(s)	2012/13	71.4%	73.6%	2015/16	72.8%	75.2%
Local metric: Estimated diagnosis rate for people with dementia (% and numbers).	2012/13	40.9% (5,754)	39.3% (584)	2015/16	67.0%	67.0%

The delivery and achievement of one target; reduction in Non-Elective Admissions (general and acute), has a financial consequence for the Pooled fund. £1.040m will be held by the CCG subject to levels of achievement as noted below.

The Performance Payment Arrangement will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 2015/16 against a baseline of Q4 2013/14 to Q3 2014/15.

The assessment of achievement and subsequent actions will be quarterly and in arrears.

- May 2015 (based on Q4 2014/15 performance)
- August 2015 (based on Q1 2015/16 performance)
- November 2015 (based on Q2 2015/16 performance)
- February 2016 (based on Q3 2015/16 performance)

Baseline			
Q4 (Jan 14 - Mar 14)	**Q1 (Apr 14 - Jun 14)**	**Q2 (Jul 14 - Sep 14)**	**Q3 (Oct 14 - Dec 14)**
5,120	5,212	5,066	5,329
5,120	10,332	15,398	20,727

Target			
Q4 (Jan 15 - Mar 15)	**Q1 (Apr 15 - Jun 15)**	**Q2 (Jul 15 - Sep 15)**	**Q3 (Oct 15 - Dec 15)**
5,066	5,073	4,801	5,064
5,066	10,139	14,941	20,004

At each 'payment point' described above, CCGs will release money into the Pooled Fund on the basis of performance to date, against the above target. The performance data will be provided to the Partnership Board and formally agreed in order to release the funding.

Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned full-year reduction against the baseline). The relationship between payment and progress toward target will be directly linear (e.g. achieving 30% of the target will release 30% of the funding). There will be no additional payment for performing beyond the target.

The steps to calculating the quarterly payment are:

a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction; then

b. multiply that by the size of the performance pot available; and

c. subtract any performance payments made for the year to date.

Note: The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter. [Not agreed by NCCG]

Once the payment is made into the Pooled Fund, the monies will become available to the Council to commission against services as they consider appropriate. Should the council have not the full value of these funds within the financial year it reserves the right to carry the funding forward.

In the event that no level of performance is achieved, the monies will be retained by the CCGs to be spent in consultation with the Health and Wellbeing Board.

For the other Better Care Fund performance targets, any financial saving accruing from this improved performance will be to the benefit of that Partner currently incurring the relevant expenditure.

5. – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

[To be completed]