Dated 31 October 2023

DEVON COUNTY COUNCIL

and

NHS DEVON (INTEGRATED CARE BOARD)

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

BETTER CARE FUND

Contents

Individual Scheme Specifications form an Appendix to this Agreement (Appendix 1).

THIS AGREEMENT is made on 31 October 2023

PARTIES

(1) Devon County Council of County Hall, Topsham Road, Exeter EX2 4QD (the **"Council"**)

(2) NHS Devon (Integrated Care Board) of County Hall, Topsham Road, Exeter EX2 4QD (the **"NHS DEVON (INTEGRATED CARE BOARD)"**)

Each a **"Partner"** and together the **"Partners"**

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of Devon excluding Plymouth and Torbay.

(B) The NHS DEVON (Integrated Care Board) has the responsibility for commissioning health services pursuant to the 2006 Act in the region of Devon including Plymouth and Torbay.

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

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

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

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

a) improve the quality and efficiency of the Services.

b) meet the National Conditions and Local Objectives; and

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

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

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

1 DEFINED TERMS AND INTERPRETATION

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

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.

Accident & Emergency Board (A&E Board) refers to five NHS-led planning groups (one county-wide and four boards covering the local health economies of Northern Devon, Eastern Devon, Western Devon and Southern Devon) with a particular emphasis on addressing waiting lists, delays in transfers of care for people who no longer need to be in hospital and winter pressures. These Boards bring together local providers, commissioners and social care organizations.

Accountable officer means an officer of any local authority, NHS Devon (Integrated Care Board), NHS provider or community interest company given delegated authority to make decisions on the detailed allocation of a specific part of the Better Care Fund. Accountabilities are normally assigned at the individual scheme level.

Adult Social Care Discharge Grant: means the grant allocated by Department for Levelling Up, Housing and Communities (DLUHC) to Devon County Council and NHS Devon Integrated Care Board (ICB). Use of this grant is subject to conditions set by the DLUHC in grant determination 31/6645 which must be observed when determining the allocation of this funding. Additional external reporting requirements also apply.

Affected Partner means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreed Purposes: the performance of obligations under this Agreement; the delegation and fulfilment of Functions; achieving Integrated Commissioning, Joint (Aligned) Commissioning, and Lead Commissioning Arrangements; the delivery of Services; and the delivery of Individual Schemes.

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price.

Authorised Officer 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.

NHS Devon (Integrated Care Board)means NHS Devon (Integrated Care Board)

NHS Devon (Integrated Care Board)Statutory Duties means the duties of the NHS Devon (Integrated Care Board)pursuant to sections 14P to 14Z2 of the 2006 Act

Capital Expenditure is an amount spent to acquire or improve an asset, including buildings, vehicles, equipment and ICT, that generates economic value beyond a 12 month period.

Capital Pool is that part of the Better Care Fund ring-fenced for capital expenditure. The Disabled Facilities Grant can only be used within this Pool.

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

Commencement Date means 00:01 hrs on 1 April 2023.

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 which relates to any patient or his treatment or medical history.

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

(c) which is a trade secret.

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

Controller, processor, data subject, personal data, personal data breach, processing and appropriate technical and organisational measures: as set out in the UK Data Protection Legislation in force at the time.

Data Discloser: a party that discloses Shared Personal Data to the other party.

Data Protection Legislation: the UK Data Protection Legislation and any other European Union legislation relating to personal data and all other legislation and regulatory requirements in force from time to time which apply to a party relating to the use of Personal Data (including, without limitation, the privacy of electronic communications).

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

Disabled Facilities Grant may refer either to (i) capital grant paid to a local authority via the Better Care Fund that may be used only for the purposes that a capital receipt may be used for in accordance with regulations made under section 11 of the Local Government Act 2003, or (ii) capital grant paid by a local authority to an individual in support of the local authority's duty to offer assistance under the Housing Grants, Construction & Regeneration Act 1996 or its discretionary powers under the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002. Technical guidance related to the Better Care Fund requires the first kind of DFG to be used as a source of funding for the second kind of DFG. Use of this grant is subject to conditions set by the DLUHC in grant determinations 31/6672 and 31/6833, which must be observed when determining the allocation of this funding.

Emergency Hospital Admissions means all non-elective hospital admissions (rates given are per 100,000 of the population)

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

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

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

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

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

(h) any other event;

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

Functions means the NHS Functions and the Health Related Functions

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

Host Partner means the Partner that will host the Pooled Fund and shall be the Council unless the Partners agree otherwise in writing.

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.

Hospital Discharge Programme means the expenditure associated with the discharge of people from hospital to health and social care settings.

Improved Better Care Fund Grant (iBCF) means the grant allocated by Department for Levelling Up, Housing and Communities (DLUHC) to Devon County Council. Use of this grant is subject to conditions set by the DLUHC in grant determination 31/6644, which must be observed when determining the allocation of this funding. Additional external reporting requirements also apply.

Improved BCF Pool means the pool used to fund activities from the improved Better Care Fund Grant.

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 Project means a sub-set of activities and expenditure within an Individual Scheme – see more detailed definition below.

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. Schemes may be sub-divided into projects, which do not have separate specifications, but which feature in the more detailed reporting of expenditure from within the Better Care Fund required by NHS England or the DLUHC

Integrated Care Board means an NHS group within the One Devon Partnership that takes on the planning functions previously held by clinical commissioning groups.

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

BCF Leadership Group means the joint coordinating commissioning group responsible for review of performance and oversight of this Agreement as set out in Schedule 2

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(s) 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.

Locality budget means a sub-set of either the Improved Better Care Fund Grant Pool or the Revenue Pool assigned to one of four localities within Devon North, East, West & South), which is used for reporting and budgetary control purposes. Financial controls (e.g. those governing virements) apply to the individual schemes within the locality budget, rather than the locality budget as a whole.

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

Month means a calendar month.

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

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

One Devon Partnership means a new committee that includes a range of organisations and groups who can influence people's health, wellbeing and care.

Overspend means any expenditure from a pool within the Pooled Budget in a Financial Year that which exceeds the Financial Contributions to that pool for that Financial Year.

Partner means each of the NHS Devon (Integrated Care Board)and the Council, and references to "**Partners**" shall be construed accordingly.

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

Permitted Expenditure is expenditure on the following:

…the Contract Price;

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

…Third Party Costs;

…Approved Expenditure

…management costs (if agreed by the BCF Leadership Group)

…management costs (where the management provided by a Partner is above the level provided prior to the Commencement Date)

Permitted Recipients: the parties to this agreement, the employees of each party, and any third parties engaged to perform obligations in connection with this agreement.

Pool means the grouping of Individual Schemes used to determine the risk sharing arrangements as set out in Schedule 3

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 the s151 officer of the Council who is the Host Partner for the Pooled Fund unless the Partners specify otherwise in writing.

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

Revenue Pool means the pool used to fund activities not funded by the Disabled Facilities Grant or improved Better Care Fund Grant.

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

Section means a sub-set of schemes within a budget Pool that are grouped together for budget management purposes. See locality budget.

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

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

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

Shared Personal Data: the personal data to be shared between the parties under clause 27.1 of this agreement. Shared Personal Data shall be confined to the following categories of information relevant to the following categories of data subject:

a. Key items of information which could be used to establish a person's identity:

- Name

- Address including postcode

- Date of Birth

- Other Dates (i.e. death, diagnosis)

- Sex

- Ethnic Group

- NHS Number

- Local Identifier (i.e. hospital or GP Practice Number or personal identification number (Social Care)

- National Insurance Number

- Diagnosis/treatment

- Physical and mental health

b. Sensitive personal data, including:

- the racial or ethnic origin of the data subject,
- his political opinions,
- his religious beliefs or other beliefs of a similar nature,
- whether he is a member of a trade union
- his physical or mental health or condition,
- his sexual life,

the commission or alleged commission by him of any offence, or proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings.

SOSH means the Secretary of State for Health.

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

Underspend means any Financial Contributions made to a pool within the Pooled Budget in any Financial Year which exceeds the expenditure of that pool for that Financial Year.

UK Data Protection Legislation: all applicable data protection and privacy legislation in force from time to time in the UK including the General Data Protection Regulation ((EU) 2016/679); the Data Protection Act 2018; the Privacy and Electronic Communications Directive 2002/58/EC (as updated by Directive 2009/136/EC) and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended.

VAT Guidance: means the guidance contained in Pooled Budgets: A Practical Guide for Local Authorities and the National Health Service (Third Edition) (CIPFA, 2017).

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. In the event that a different definition applies in individual scheme specifications, this will be noted in the specification itself.

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 (1) year, unless it is terminated earlier in accordance with Clause 21.

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

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 …provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

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

4.1.1 …Lead Commissioning Arrangements;

4.1.2 …the establishment of the Pooled Fund

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

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

4.3 The NHS Devon (Integrated Care Board) delegates to the Council and the Council agrees to exercise on the NHS Devon (Integrated Care Board) behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

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

5 FUNCTIONS

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

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

5.3 Where the Partners add a new Individual Scheme to this Agreement an outline Scheme Specification for each Individual Scheme in the form set out in Schedule 1 shall be completed and agreed between the Partners in writing.

5.4 Scheme Specifications shall be updated in accordance with clause 29 (Variation) following:

5.4.1 … … any change in Lead Commissioner or Provider;

5.4.2 … any Service Contract re-tendering exercise (even where there has been no change in provider); and or;

5.4.3 …the issue of any variation order pertaining to a Service Contract.

5.5 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.

5.6 The introduction of any Individual Scheme will be subject to business case approval by the BCF Leadership Group, or in the case of iBCF Grant schemes, by the named accountable officers

5.7 Copies of Scheme Specifications shall be provided to both parties to this agreement, and a master list of all Scheme Specifications shall be held by the Pooled Fund Manager. Scheme Specifications as at the start of the financial year are contained in Appendix 1, which is contained in a separate file in electronic versions of this document.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

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

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

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

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

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

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

Appointment of a Lead Commissioner

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

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

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

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

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

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

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

6.7.7 …undertake performance management and contract monitoring of all Service Contracts;

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

6.7.9 …keep the other Partners and the BCF Leadership Group regularly informed of the effectiveness of the arrangements including any Overspend or Underspend.

6.7.10 …provide the other Partners with electronic copies of all Service Contracts and any other contracts that are entered into pursuant this agreement and individual reports on each Service commissioned by the Lead Commissioner.

6.8 Each Lead Commissioner shall designate an accountable officer for each Individual Scheme, with responsibility for ensuring its delivery and with delegated authority to make decisions in respect of the budget allocated to that Scheme, subject to any written instructions that the BCF Leadership Group may issue. For Schemes within the iBCF Pool, two accountable officers may be nominated to make joint decisions regarding detailed budget allocations. All such decisions must be reported in writing to the Pooled Fund Manager, who may seek additional information regarding planned expenditure and the timing of that expenditure in order to assist with the overall financial management of the Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such a Pooled Fund for expenditure as set out in Schedule 3 and to spend the funds in that Pooled Fund on the Scheme Specifications as set out in Schedule 5.

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

7.3 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.

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

7.5 The Host Partner shall be the Partner responsible for:

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

7.5.2 …providing the financial administrative systems for the Pooled Fund; and

7.5.3 …appointing the Pooled Fund Manager;

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

8 POOLED FUND MANAGEMENT

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

8.1.1 …the day to day operation and management of the Pooled Fund;

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

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

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

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

8.1.6 …preparing and submitting to the BCF Leadership Group (by email if there is no meeting scheduled) Quarterly reports (or more frequent reports if required by the BCF Leadership Group) and an annual return about the income and expenditure from the Pooled Fund together

with such other information as may be required by the Partners and the BCF Leadership Group to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

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

8.2 In carrying out their responsibilities as provided under Clause 8.1, the Pooled Fund Manager shall have regard to the recommendations of the BCF Leadership Group and shall be accountable to the Partners.

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the NHS Devon (Integrated Care Board) and the Council to the Pooled Fund for the Financial Years of operation shall be as set out in Schedule 3.

9.2 Financial Contributions for subsequent financial years will be determined by the BCF Leadership Group with the endorsement of the Health and Wellbeing Board, subject to any approvals required by each Partner under its internal rules and regulations. A separate agreement document shall be produced for each Financial Year not covered by the current Agreement.

9.3 No provision of this Agreement shall preclude the Partners from making additional contributions to the Pooled Fund from time to time by mutual agreement. Any such additional contributions shall be explicitly recorded in BCF Leadership Group minutes, including whether they are non-recurrent or not and recorded in the budget statement as a separate item.

9.4 The funds in the Pooled Fund shall be spent on the Services as set out in Schedule 5.

10 NON FINANCIAL CONTRIBUTIONS

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

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of services from the Pooled Fund.

Overspends in the Pooled Fund

11.2 The Lead Commissioner for each Scheme shall manage expenditure on that Scheme from the Pooled Fund, making reasonable efforts to ensure expenditure does not exceed the funds allocated from the Pooled Fund that funds the Scheme (as detailed in Schedule 5)

11.3 The Lead Commissioner 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 BCF Leadership Group in accordance with Clause 11.4.

11.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the BCF Leadership Group is informed as soon as reasonably possible and the provisions of Schedule 3 shall apply.

Underspends in the Pooled Fund

11.5 Underspends shall be treated as set out in Schedule 3. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

12 CAPITAL EXPENDITURE

12.1 The spending of funds on capital expenditure must be agreed by the Partners.

13 VAT

13.1 Where the Council is appointed as Host Partner, the Partners agree to adopt the principal arrangements whereby the lead body's VAT regime applies (previously known as "Partnership Structure (a)) as described in the VAT Guidance through which the Council purchases goods and services for the Partnership and the Council recovers any VAT which may be incurred under its VAT regime. Where the NHS Devon (Integrated Care Board) is appointed as Host Partner the Partners agree that the Host Partner acts as agent for the other Partners (previously known as "Partnership Structure (b)) as described in the VAT Guidance through which the Host Partner will either arrange for invoices for goods and services to be sent directly to the other Partners or will purchase goods and services then invoice the other Partners.

14 AUDIT AND RIGHT OF ACCESS

14.1 Both 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 in accordance with its statutory requirements.

14.2 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.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 shall apply only to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the BCF Leadership Group.

15.3 If any third party makes a claim or intimates an intention to make a claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 15, the Partner that may claim against the other indemnifying Partner will:

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

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

15.3.3 …give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such

premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

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

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

16 STANDARDS OF CONDUCT AND SERVICE

16.1 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).

16.2 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.

16.3 The NHS Devon (Integrated Care Board) is subject to the NHS Devon (Integrated Care Board) 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 their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund are therefore subject to ensuring compliance with the NHS Devon (Integrated Care Board) Statutory Duties and clinical governance obligations.

16.4 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.

17 CONFLICTS OF INTEREST

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

18 GOVERNANCE

18.1 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.

18.2 The Partners have established a BCF Leadership Group to carry out the functions set out in Schedule 2.

18.3 The BCF Leadership Group is based on a joint working group structure. Each member of the BCF Leadership Group 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 BCF Leadership Group to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 2.

18.4 The terms of reference of the BCF Leadership Group shall be as set out in Schedule 2.

18.5 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.

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

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

19 REVIEW

19.1 Save where the BCF Leadership Group agrees alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and the provision of the Services no later than 3 Months before the end of each Financial Year.

19.2 Subject to any variations to this process required by the BCF Leadership Group, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2. Annual Reviews will be conducted to ensure the deployment of resources fully supports improvements in performance against the BCF metrics and delivery of the national conditions.

19.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause. A copy of this report shall be provided to the BCF Leadership Group. Adjustments as a result of the reviews will be made to the financial schedule and S75 agreement as required with the aim of achieving benefit in savings or redistribution of resources.

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

20 COMPLAINTS

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

21 TERMINATION & DEFAULT

21.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

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

21.3 If any Partner ("Failing Partner") fails to meet any of its obligations under this Agreement, the other Relevant Partner(s) (if more than one acting jointly) may by notice require the Failing Partner to take such reasonable action within a reasonable timescale as the other Relevant Partner(s) may specify to rectify such failure. Should the Failing Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 22.

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 13,14,15,21,22,23,25,27,31,32 and 38.

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

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

21.6.1 …the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users,

employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

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

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

21.6.4 …where a Service Contract held by a Lead Commissioner relates in full or partially to services which relate to the other Partner's(s') Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.6.5 …the BCF Leadership Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.6.6 …termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner(s) already accrued, prior to the date upon which such termination takes effect.

21.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

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

22.2 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.3 If the dispute remains after the meeting detailed in Clause 22.2 has taken place, the Partners' respective chief executives 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.

22.4 If the dispute remains after the meeting detailed in Clause 22.3 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 mediation, any Partner may give notice in writing (a **"Mediation Notice"**) to the other Partners 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. No 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.

22.5 Nothing in the procedure set out in this Clause 22 shall in any way affect any Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

23.1 No Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by any other Partner or incur any liability to any 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 under this agreement by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner(s) 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.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, 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 23.4, facilitate the continued performance of the Agreement.

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

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, 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:

24.1.1 …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

24.1.2 …the provisions of this Clause 24 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.

24.2 Nothing in this Clause 24 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.

24.3 Each Partner:

24.3.1 …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

24.3.2 …will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

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

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

25.1 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.

25.2 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 24 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

26 OMBUDSMEN

26.1 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.

27 DATA PROTECTION AND INFORMATION SHARING

27.1 **Shared Personal Data.** This clause sets out the framework for the sharing of personal data between the parties as controllers. Each party acknowledges that one party (referred to in this clause as the **Data Discloser**) will regularly disclose to the other party Shared Personal Data collected by the Data Discloser for the Agreed Purposes.

27.2 **Effect of non-compliance with UK Data Protection Legislation.** Each party shall comply with all the obligations imposed on a controller under the UK Data Protection Legislation, and any material breach of the UK Data Protection Legislation by one party shall, if not remedied within 30 days of written notice from the other party, give grounds to the other party to terminate this agreement with immediate effect.

27.3 Particular obligations relating to data sharing. Each party shall:

27.3.1 ensure that it has all necessary notices and consents in place to enable lawful transfer of the Shared Personal Data to the Permitted Recipients for the Agreed Purposes;

27.3.2 provide information as required under article 13 and article 14 of the General Data Protection Regulation to any data subject whose personal data may be processed under this agreement. This includes giving notice that, on the termination of this agreement, personal data relating to them may be retained by or, as the case may be, transferred to one or more of the Permitted Recipients, their successors and assignees;

27.3.3 process the Shared Personal Data only for the Agreed Purposes;

27.3.4 not disclose or allow access to the Shared Personal Data to anyone other than the Permitted Recipients;

27.3.5 ensure that all Permitted Recipients are subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this agreement;

27.3.6 ensure that it has in place appropriate technical and organisational measures, reviewed and approved by the other party, to protect against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data and shall provide written notice to the other if it becomes aware of a Personal Data Breach involving Shared Personal Data.

27.3.7 not transfer any personal data received from the Data Discloser outside the European Union unless the transferor:

(a) complies with the provisions of Articles 26 of the GDPR (in the event the third party is a joint controller); and

(b) ensures that (i) the transfer is to a country approved by the European Commission as providing adequate protection pursuant to Article 45 of the GDPR; or (ii) there are appropriate safeguards in place pursuant to Article 46 GDPR; or (iii) Binding corporate

rules are in place or (iv) one of the derogations for specific situations in Article 49 GDPR applies to the transfer.

27.4 **Mutual assistance.** Each party shall assist the other in complying with all applicable requirements of the UK Data Protection Legislation. In particular, each party shall:

27.4.1 consult with the other party about any notices given to data subjects in relation to the Shared Personal Data;

27.4.2 promptly inform the other party about the receipt of any data subject access request;

27.4.3 provide the other party with reasonable assistance in complying with any data subject access request;

27.4.4 not disclose or release any Shared Personal Data in response to a data subject access request without first consulting the other party wherever possible;

27.4.5 assist the other party, at the cost of the other party, in responding to any request from a data subject and in ensuring compliance with its obligations under the UK Data Protection Legislation with respect to security, personal data breach notifications, data protection impact assessments and consultations with supervisory authorities or regulators;

27.4.6 notify the other party without undue delay on becoming aware of any breach of the UK Data Protection Legislation;

27.4.7 at the written direction of the Data Discloser, delete or return Shared Personal Data and copies thereof to the Data Discloser on termination of this agreement unless required by law to store the personal data;

27.4.8 use compatible technology for the processing of Shared Personal Data to ensure that there is no lack of accuracy resulting from personal data transfers;

27.4.9 maintain complete and accurate records and information to demonstrate its compliance with this clause 27 and allow for audits by the other party or the other party's designated auditor; and

27.4.10 provide the other party with contact details of at least one employee as point of contact and responsible manager for all issues arising out of the UK Data Protection Legislation, including the joint training of relevant staff, the procedures to be followed in the event of a data security breach, and the regular review of the parties' compliance with the UK Data Protection Legislation.

27.5 **Indemnity**. Each party shall indemnify the other against all liabilities, costs, expenses, damages and losses (including but not limited to any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal costs (calculated on a full indemnity basis) and all other reasonable professional costs and expenses) suffered or incurred by the indemnified party arising out of or in connection with the breach of the UK Data Protection Legislation by the indemnifying party, its employees or agents, provided that the indemnified party gives to the indemnifier prompt notice of such claim, full information about the circumstances giving rise to it, reasonable assistance in dealing with the claim and sole authority to manage, defend and/or settle it.

27.6 **Information Sharing Protocol.** The Partners will follow the Information Sharing Protocol set out in Schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law.

28 NOTICES

28.1 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 28.3 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:

28.1.1 …personally delivered, at the time of delivery;

28.1.2 …sent by facsimile, at the time of transmission;

28.1.3 …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

28.1.4 …if sent by electronic mail, at the time of transmission 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.

28.2 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).

28.3 The address for service of notices as referred to in Clause 28.1 shall be as follows unless otherwise notified to the other Partners in writing:

28.3.1 …If to the Council, addressed to the Chief Officer for Adult Care and Health, County Hall, Topsham Road, Exeter, Devon, EX2 4QD.

28.3.2 …If to the NHS Devon (Integrated Care Board) addressed to Director of Commissioning, NHS Devon (Integrated Care Board), The Annexe, County Hall, Topsham Road, Exeter EX2 4QD.

29 VARIATION

29.1 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.

30 CHANGE IN LAW

30.1 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.

30.2 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.

30.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

31 WAIVER

31.1 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.

32 SEVERANCE

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

33 ASSIGNMENT AND SUB CONTRACTING

33.1 The Partners shall not subcontract, 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.

34 EXCLUSION OF PARTNERSHIP AND AGENCY

34.1 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.

34.2 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:

34.2.1 …act as an agent of the other;

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

34.2.3 …bind the other in any way.

35 THIRD PARTY RIGHTS

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

36 ENTIRE AGREEMENT

36.1 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.

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

37 COUNTERPARTS

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

38 GOVERNING LAW AND JURISDICTION

38.1 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.

38.2 Subject to Clause 22 (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 arise 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 **DEVON COUNTY COUNCIL**)
)
was hereunto affixed in the presence of:)
Authorised Signatory

Name:
Post:

Signed for on behalf of **NHS DEVON (INTEGRATED CARE BOARD)**

Authorised Signatory
Name: Bill Shields
Post: Interim Chief Executive & Chief Finance Officer

36 ENTIRE AGREEMENT

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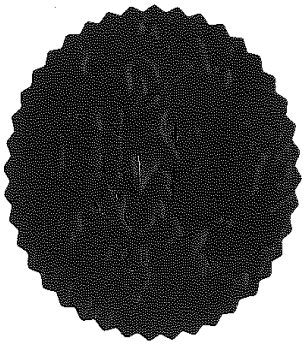
IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **DEVON COUNTY COUNCIL**)
)
was hereunto affixed in the presence of:)
Authorised Signatory
Name: MEGAN GRAY
Post:



Signed for on behalf of **NHS DEVON (INTEGRATED CARE BOARD)**

DOCUMENT No. 519936

Authorised Signatory
Name:
Post:

25

SCHEDULE 1– SCHEME SPECIFICATION TEMPLATE EXAMPLE

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

1 OVERVIEW OF INDIVIDUAL SERVICE

Insert details including:

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

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

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

3 THE ARRANGEMENTS

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

(a) *Lead Commissioning;*

(b) *Integrated Commissioning;*

(c) *Joint (Aligned) Commissioning;*

(d) *the establishment of one or more Pooled Funds as may be required.*

4 FUNCTIONS

Set out the Council's Functions and the NHS DEVON (INTEGRATED CARE BOARD)'s Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

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

5 SERVICES

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

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

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

Contracting Arrangements
Insert the following information about the Individual Scheme:

[1] This may be limited by service line –i.e. individuals with a diagnosis of dementia. There is also a significant issue around individuals who are the responsibility of the local authority but not the NHS DEVON (INTEGRATED CARE BOARD) and Vice versa

(a) *relevant contracts*

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

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

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

7 FINANCIAL CONTRIBUTIONS

Financial Year 202?…./202?

Revenue	
Capital	

Financial resources in subsequent years will be determined in accordance with the Agreements for those years.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

(1) *[(1) As in the Agreement with the following changes) Management of the Pooled Fund*

Are any amendments required to the Agreement in relation to the management of Pooled Fund
Has the budget been agreed?
How will changes to the budget level be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the scheme's budget manager require training?
Have the scheme managers' delegated powers been determined?

(1) *Is there a protocol for disputes3)Audit Arrangements*

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

(1) *Whose external audit regime will apply4)Financial Management*

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?
Will there be a facility to carry forward funds?
How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?
What management costs can legitimately be charged to pool?

What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
What closure of accounts arrangement need to be applied?][2]

9 VAT

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

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

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

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

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

[2] Although some of the information overlaps with the information that is included in the main body of Agreement, each Scheme needs to be considered in order to determine whether the overarching arrangements should apply and to seek authorisation from the BCF Leadership Group if this is not the case.

11 NON FINANCIAL RESOURCES (IF ANY)

Council contribution

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

NHS Devon (Integrated Care Board) Contribution

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

12 STAFF

Consider:

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

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to NHS Devon (Integrated Care Board).

If the staff are being seconded to the NHS Devon (Integrated Care Board) this should be made clear

***NHS Devon (Integrated Care Board) staff* to be made available to the arrangements**

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

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

13 ASSURANCE AND MONITORING

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

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3 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the NHS Devon (Integrated Care Board) budget and the Council budget on such a basis that there is no "mixing" of resources

4 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the NHS Devon (Integrated Care Board) budget and the Council budget on such a basis that there is no "mixing" of resources

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

14 LEAD OFFICERS

Partner	*Name of Lead Officer*	*Address*	*Telephone Number*	*Email Address*	*Fax Number*
Devon County Council					
NHS Devon (Integrated Care Board)					

There will be some schemes where lead officers are only drawn from one or two of the partners.

15 INTERNAL APPROVALS

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

16 RISK AND BENEFIT SHARE ARRANGEMENTS

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

17 REGULATORY REQUIREMENTS

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

18 INFORMATION SHARING AND COMMUNICATION

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

Consultation – staff, people supported by the Partners, unions, providers, public, other agency
Printed stationery

19 DURATION AND EXIT STRATEGY

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

(1) *Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreemen1) maintaining continuity of Services) allocation and/or disposal of any equipment relating to the*

Individual Scheme) responsibility for debts and on-going contracts) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements)) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

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

20 OTHER PROVISIONS

Consider, for example:

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

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Signed by	Devon County Council *Sample only*	*Sample only*
Date	*Sample only*	*Sample only*
On behalf of	NHS Devon (Integrated Care Board) *Sample only*	*Sample only*

Schedule 2 - Terms of Reference
Better Care Fund Leadership Group

revised 25.08.23 (v8.2)

1. Purpose

The BCF Leadership Group provides system leadership and oversight of all Better Care Fund arrangements between Devon County Council and NHS Devon ICB (for the area covered by DCC).

The group is also responsible for the performance management of the Hospital Discharge Programme funding pooled within the Better Care Fund.

Members have delegated authority from their organisation to make recommendations regarding the BCF.

2. Membership and attendance at meetings

The following (or nominated deputy) shall attend each meeting and have voting rights:

- DCC Deputy Director of Integrated Adult Social Care (Commissioning)
- DCC Head of Integrated Adult Social Care
- NHS Devon Locality Director (South & West)
- NHS Devon Locality Director (North & East)

Regular attendees (without voting rights):

- NHS Devon Deputy Director of Commissioning Out of Hospital
- Royal Devon University Healthcare NHS Foundation Trust, Community Services Divisional Director
- Torbay and South Devon NHS Foundation Trust (tbc)
- University Hospitals Plymouth NHS Trust (tbc)
- DCC Deputy Director Finance
- NHS Devon Associate Director of Finance (Northern and Eastern)
- DCC Head Accountant – Health
- Chair of BCF Business Group
- Chair of BCF Hospital Discharge Transformation Group
- DCC Project Manager

Papers to be copied to:

- DCC Director of Integrated Adult Social Care

The group may invite other officers as required to support reporting on progress and inform key decisions.
The DCC Deputy Director of Integrated Adult Social Care (Commissioning) will chair the meetings.

3. Quorum

The following must be present for decisions to be made by voting:

- All those possessing voting rights, shown above (or their nominated representative)

Decisions of the BCF Leadership Group shall be made unanimously. Where unanimity is not reached then the item in question will be referred to the next meeting of the Group. If no unanimity is reached on the second occasion, then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the s.75 Agreement. The matter can be escalated in accordance with DCC/ICB governance arrangements at any point.

Where a partner is not present a matter may be discussed, and those present may make and record a conditional decision pending written agreement from the absent partner (N.B. subject to quorum requirements).

4. Purpose and responsibilities

a. Ensure that direction and planning for the BCF are in line with the priorities identified in the ICS Integrated Care Strategy as well as national requirements

b. Set direction, agree priorities and provide oversight and assurance of the BCF pooled fund. This will include oversight of the review and evaluation of all BCF investment including evidence of value for money, impact and outcomes.

c. The commitment or redeployment of resources associated with related BCF programmes within limits delegated by statutory partners to the individual officers. To include oversight of the monitoring, reporting and scrutiny of BCF spending to ensure value for money and that investments reflect the ICS Integrated Care Strategy.

d. Performance and budget management of the Hospital Discharge programme funding that is pooled within the BCF.

e. Coordinate and provide information to committees of the partner statutory organisations and to the Health and Wellbeing Board as required

5. Frequency

Meetings will be every month (or as required).

Urgent decisions may be made by email correspondence if a face to face meeting is unable to be convened.

6. Accountability, authority and reporting

The Devon Health and Wellbeing Board has overall accountability for the BCF in its area, in line with national reporting requirements.

Key decisions relating to the BCF are made by the joint DCC and ICB Executives Group.

The BCF Leadership Group reports and makes recommendations for decisions to the Executives Group. BCF Leadership Group members are accountable to their respective organisations and report to:

- ICB Senior Executive Team

- DCC Corporate Leadership Team (Finance and Resources Board)

The BCF Leadership Group has oversight of the following sub-groups:

- **BCF Business Group**

Takes action on behalf of Leadership Group; co-ordinates activities to ensure all planning and reporting requirements are met, including discharge reporting. This will include coordination of the review and evaluation of all BCF investment including evidence of value for money, impact and outcomes.

- **Devon Hospital Discharge Transformation Board**

Delivery of transformation of all hospital discharge arrangements, not just that within the BCF, responsible for managing HD activity and maintaining spend within budget. The Board also reports to the ICS Urgent Care Board.

- **Devon Hospital Discharge Finance Steering Group**

Monitoring of HDP spend within budget (members also attend the Hospital Discharge Transformation Board as appropriate).

Authority is exercised by the individual officers on behalf of the organisations to whom they are accountable and within their delegated limits. Within these parameters, decisions can be made at the meetings.

Each member is accountable for ensuring all appropriate internal decision-making bodies are appropriately engaged. They are also accountable for dissemination of information from BCF Leadership Group back to their respective organisations.

7. Post-termination

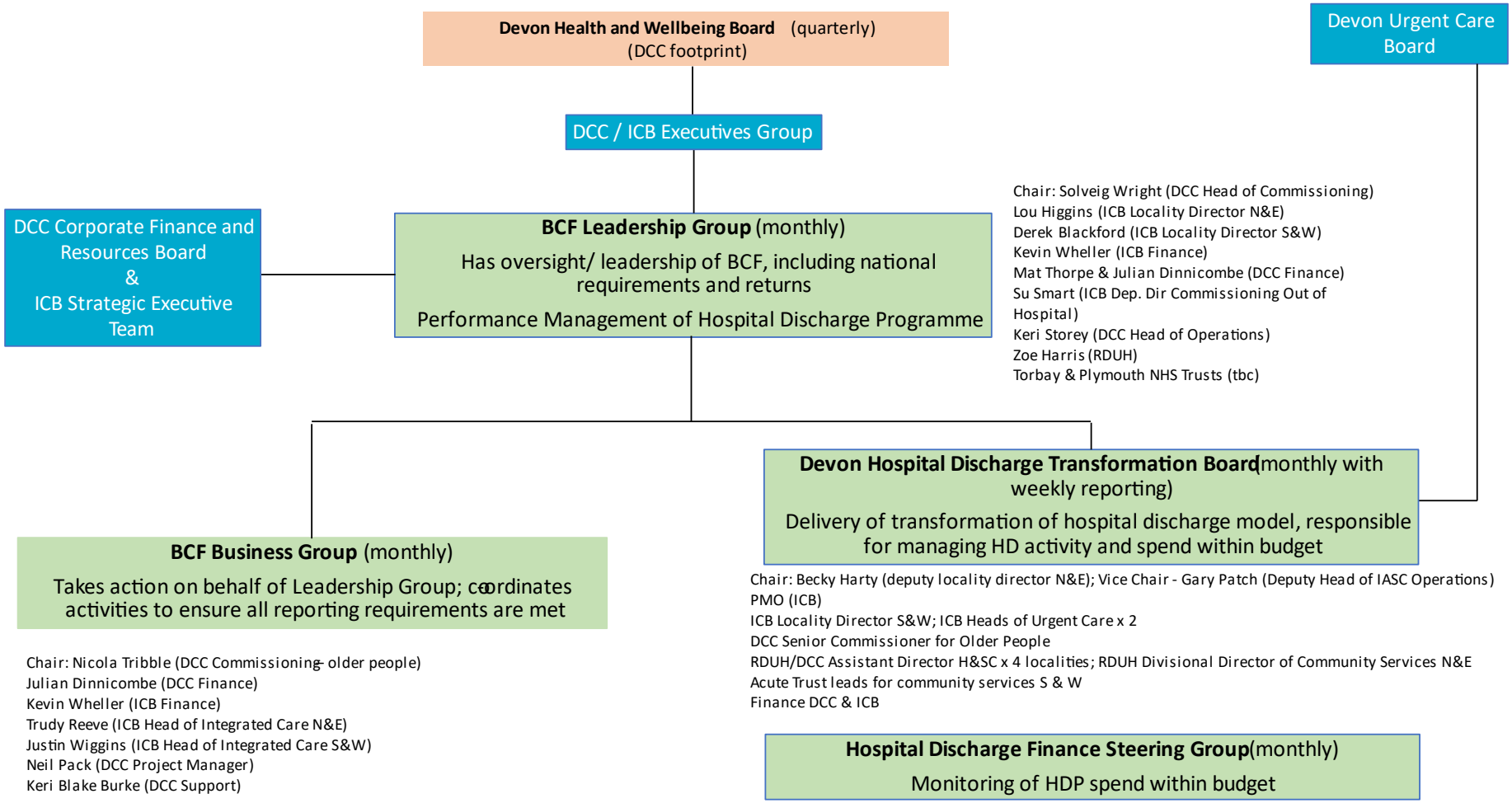
The BCF Leadership Group shall continue to operate in accordance with this Schedule following any termination of this Agreement to fulfil the duties required under this schedule but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

8. Review

The BCF Leadership Group will review these terms of reference annually or more frequently if BCF national guidance or ICS governance arrangements require.

Leadership Group TOR – Version History

Version	Date	Author	Change Ref	Sections Affected
Draft V0.01	15/05/15	JB	Initial draft	All
Draft V0.02	15/05/15	AG	Initial draft review	All
Draft V0.03	18/05/15	JB	2nd draft review	All
Draft V0.04	27/05/15	AG	3rd draft review	All
Draft V0.05	03/06/15	AG	4th draft review	All
Final v1.0	02/07/15	AG	Final version	All
Revised	12/02/16	KDD	Revised version	1.2, 3.4, 4.2, 5.2, 6.2
Revised	05/05/16	PL	Revised terms of reference for finance representatives and financial reporting	3.2, 5.1.5
Final v1.1	26/9/16	JL	New Attendee added	2
Refresh V2	22/03/17	Solveig Sansom	Refresh 2016/17	All
Refresh V3	21/11/17	Solveig Sansom	Refresh for 2017/18	All
Refresh V4.0	7/10/19	Neil Pack	Refresh for 2019/20 (approved March 2019)	All
Refresh V5.0	5/10/20	Neil Pack	Refresh for 2020/21 (approved October 2020)	2,3, 4(b),5
Refresh V6.0	27/10/21	Neil Pack	Refresh for 2021/22 (approved August 2021)	2, 3. Change from JCCG to Leadership Group (from Jan '21)
Revised v7.0	21/2/22	Neil Pack	Amended membership (added CCG Deputy Director & Deputy Locality Director)	2.
Revised v7.1	21/4/22	Neil Pack	Amended chair resulting from recent appointments & additional distribution	2.
TBC	Sept '22	Neil Pack	Re-draft in progress	2,3
V8	May 2023	Solveig Wright	Amended membership, reporting, meeting frequency and added in HD fund management arrangements	All
V8.1	31/07/23	Solveig Wright	Inclusion of joint DCC/ICB Executives Group to which the Leadership Group reports	6.
V8.2	25/8/23	Neil Pack	Changes to ICB membership & additional acute trust reps. as attendees	2.


Devon Health and Wellbeing Board (quarterly)
(DCC footprint)
Devon Urgent Care Board
DCC / ICB Executives Group
DCC Corporate Finance and Resources Board & ICB Strategic Executive Team
BCF Leadership Group (monthly)
Has oversight/ leadership of BCF, including national requirements and returns
Performance Management of Hospital Discharge Programme
Chair: Solveig Wright (DCC Head of Commissioning)
Lou Higgins (ICB Locality Director N&E)
Derek Blackford (ICB Locality Director S&W)
Kevin Wheller (ICB Finance)
Mat Thorpe & Julian Dinnicombe (DCC Finance)
Su Smart (ICB Dep. Dir Commissioning Out of Hospital)
Keri Storey (DCC Head of Operations)
Zoe Harris (RDUH)
Torbay & Plymouth NHS Trusts (tbc)
Devon Hospital Discharge Transformation Board (monthly with weekly reporting)
Delivery of transformation of hospital discharge model, responsible for managing HD activity and spend within budget
BCF Business Group (monthly)
Takes action on behalf of Leadership Group; coordinates activities to ensure all reporting requirements are met
Chair: Nicola Tribble (DCC Commissioning- older people)
Julian Dinnicombe (DCC Finance)
Kevin Wheller (ICB Finance)
Trudy Reeve (ICB Head of Integrated Care N&E)
Justin Wiggins (ICB Head of Integrated Care S&W)
Neil Pack (DCC Project Manager)
Keri Blake Burke (DCC Support)
Chair: Becky Harty (deputy locality director N&E); Vice Chair - Gary Patch (Deputy Head of IASC Operations)
PMO (ICB)
ICB Locality Director S&W; ICB Heads of Urgent Care x 2
DCC Senior Commissioner for Older People
RDUH/DCC Assistant Director H&SC x 4 localities; RDUH Divisional Director of Community Services N&E
Acute Trust leads for community services S & W
Finance DCC & ICB
Hospital Discharge Finance Steering Group (monthly)
Monitoring of HDP spend within budget

SCHEDULE 3 – CONTRIBUTIONS TO THE POOLED FUND, RISK SHARE AND OVERSPENDS

1. Structure of the Pooled Budget

1.1 The overall budget will be sub-divided into three pools: a Capital Pool, an Improved BCF Pool and a Revenue Pool. This division exists solely to recognise the restrictions placed on the use of grants from central government. Revenue expenditure can be incurred in the Improved BCF Pool and the Revenue Pool.

1.2 The amounts allocated to each Pool at the start of the financial year shall be as follows:

Table 1

2023-24

Contributions	Carry-forward	23-24 sources	**Revenue**	Carry-forward	23-24 sources	**Capital**	**Total**
	£	£	£	£	£	£	£
Devon County Council	6,652,088	7,649,000	**14,301,088**			**0**	**14,301,088**
Devon County Council - ringfenced grants		33,210,373	**33,210,373**		8,964,862	**8,964,862**	**42,175,235**
NHS Devon ICB		74,683,097	**74,683,097**			**0**	**74,683,097**
	6,652,088	**115,542,470**	**122,194,558**	**-**	**8,964,862**	**8,964,862**	**131,159,420**

Application	Carry-forward	23-24 sources	**Revenue**	Carry-forward	23-24 sources	**Capital**	**Total**
	£	£	£	£	£	£	£
Capital - Central			**0**		8,964,862	**8,964,862**	**8,964,862**
iBCF		29,126,836	**29,126,836**				**29,126,836**
Discharge funding	2,000,000	14,020,537	**16,020,537**				**16,020,537**
Revenue - Central		66,331,830	**66,331,830**				**66,331,830**
Revenue - Localities		10,715,355	**10,715,355**				**10,715,355**
	2,000,000	**120,194,558**	**122,194,558**	**-**	**8,964,862**	**8,964,862**	**131,159,420**

1.3 The detailed allocation between localities and to individual schemes is set out in Schedule 5 to this agreement.

2 Virements

2.1 Virements are permitted within each Pool, subject to agreement by the BCF Leadership Group, or in the case of the Improved BCF Pool, by the named accountable officers.

2.2 In reaching decisions on any virement between schemes within each Pool, including decisions on where to invest any uncommitted funds, the BCF Leadership Group or accountable officers will take into account:

2.2.1 …geographical boundaries and effect on overall spending of the fund in relation to contributions to it; and

2.2.2 …the objectives of the Better Care Fund

2.3 If a virement is made under this paragraph 2 of Schedule 3, then the BCF Leadership Group or accountable officers will make any corresponding amendments needed to Table 1 of Schedule 3 and Schedule 5 to ensure any virement does not cause an Overspend or Underspend.

3 Overspends

3.1 If there is an Overspend in the Revenue Pool, the Partners will meet the percentage of the Overspend amount for that Pool set out in Table 2

Table 2

NHS Devon (Integrated Care Board)	50%
Devon CC	50%
Total	100%

3.2 The Capital Pool will be used solely to make fixed contributions to specified projects: as a result, the issue of overspending should not arise. Allocations to projects must fall within the total amount available in the Capital Pool.

4 Underspends

4.1 All parties agree that the money should be used for the benefit of the health and wellbeing of the people within the administrative area of Devon County Council

4.2 If there is an Underspend in either the Revenue Pool or the Improved BCF Pool the percentage of the Underspend amount set out in Table 2 for that Pool will be returned to the Partners. The Relevant Partners can agree to then carry forward any Underspend to the next Financial Year if they wish to do so.
Decisions on the specific use of a carry forward from these pools will be subject to the agreement by the BCF Leadership Group.

4.3 The Capital Pool is funded by central government grants for capital purposes. If there is an Underspend in the Capital Pool that relates to the use of these grants, that funding can only be used for capital purposes in a future financial year or returned to central government. Therefore, any unspent capital grant will be carried forward to the following financial year, subject to permission from the relevant Government Department to do so.

5 Additional contributions managed via the BCF governance arrangements

5.1 One of the contracts included in the Fund is a dementia support contract. The scope of this contract has been extended to cover the Torbay area. In recognition of that wider scope, NHS Devon (Integrated Care Board) will contribute an additional £110,000. Although not strictly part of the Fund itself because Torbay lies outside the Fund's boundaries, the additional contribution will be managed in the same way as the Fund itself and is subject to the same governance and risk-share arrangements.

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

Part 2 – LEAD COMMISSIONER OBLIGATIONS

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

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

1.1 a Change in Control Notice;

1.2 a Notice of a Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

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

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report

2.7 Service Contracts entered into (electronic only);

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

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

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

4 The Lead Commissioner shall not:

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

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

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

4.4 give any approvals under the Service Contract;

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

4.6 suspend all or part of the Services;

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

4.8 serve any notice;

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

without the prior approval of the other Partners (acting through the BCF Leadership Group) such approval not to be unreasonably withheld or delayed.

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

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

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

Part 3– OBLIGATIONS OF THE OTHER PARTNER

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

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

1.1 resolve disputes pursuant to a Service Contract;

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

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

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

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

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

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

SCHEDULE 5 - INDIVIDUAL SCHEME VALUES

	Total	Locality				
		Central	East	North	West	South
	£	£	£	£	£	£
Capital	**8,964,862**	**8,964,862**	**0**	**0**	**0**	**0**
Disabled Facilities Grant						
Disabled Facilities Grant	8,964,862	8,964,862				
Winter Pressures	**0**	**0**				
Winter Pressures (part of iBCF grant)	0	0				
Revenue	**77,047,185**	**66,331,830**	**5,288,300**	**2,286,000**	**1,306,355**	**1,834,700**
Care Act duties (non carer)						
Care Act duties (non carer)	142,000	142,000				
Dementia Diagnosis						
Dementia Alzheimer's Contract	49,290	49,290				
Dementia Café	32,000	32,000				
Dementia Capable Communities	0	0				
Dementia Partnership	0	0				
Enabler						
CCT Co-ordination for the virtual ward	413,000		191,000		145,000	77,000
Community Support Contracts	216,000	216,000				
Devon Doctors	72,000		72,000			
Exeter Acute Community Team	671,000		671,000			
Finance and Project Support for Better Care Fund	58,000	58,000				
Joint Agency Business Support and programme management costs	19,000			19,000		
LD Review Team	146,000	146,000				
LD Specialist Team	262,000	262,000				
MH Out of area placements	1,000,000	1,000,000				

Revenue continued	Total	Locality				
		Central	East	North	West	South
	£	£	£	£	£	£
Enabler infrastructure - Hospital Discharge services						
Discharge Support Devon Partnership Trust	34,000		34,000			
Hospital discharge facilitation	347,000				97,000	250,000
ND4 Com Hosp Discharge Co-ord	125,000			125,000		
ND7 Pathfinder	118,000			118,000		
Onward Care	319,000		319,000			
Order Communication System CHC posts	44,000		44,000			
Enhanced Carers offer						
Action for Children Family Based Respite Care	0	0				
Carers	3,898,000	3,898,000				
Enhanced Community Equipment Service						
Adult Equipment Store	6,909,049	6,909,049				
Additional one-off funding	0	-				
Children Equipment Store	678,000	678,000				
Frailty and Community Care						
Care Home Team Roll Out	50,000		50,000			
Community Services for NHS Devon ICB	34,020,886	34,020,886				
Connected Communities and Supported Volunteering	41,000	41,000				
District Nurse Support to residential homes	195,000			195,000		

Revenue continued	Total	Locality				
		Central	East	North	West	South
	£	£	£	£	£	£
DTOC	0	0				
Rapid Response Domiciliary Care						
Rapid Response Domiciliary Care	3,303,000		1,909,000	615,000	330,000	449,000
Single Point of Co-ordination						
Community Hub	30,000			30,000		
Single Point of Co-ordination	414,000			110,000	145,000	159,000
Social Care Reablement						
Social Care Reablement	873,355		500,300	171,000	80,355	121,700
Step Up Step Down Care						
ED2 Home Based Reable WEB H@Home	324,000		324,000			
ED3 Home Based Reable Wakeley	443,000		443,000			
ED5 Home Based Reable Mid Devon	471,000		471,000			
Exeter Step Up Step Down Beds	0		0			
Home based Intermediate Care	1,287,000				509,000	778,000
Mid Step Up Step Down Beds	0		0			
ND1 Personal care inc Dom	150,000			150,000		
ND2 Home Based Intensive Rehab	653,000			653,000		
ND8 Recuperative Placements	100,000			100,000		
Recuperative Care	0				0	0
Stroke Early Supported Discharge	100,000		100,000			
Wakeley Step Up Step Down Beds	0		0			
WEB Step Up Step Down Beds	0		0			
Frailty and Community Care	160,000		160,000			

Revenue continued	Total £	Locality				
		Central £	East £	North £	West £	South £
Support to social care						
Support to social care	17,292,390	17,292,390				
SWAS FT Right Care, Right Place						
SW Ambulance FS Trust Right Care	191,000	191,000				
Unallocated (must be ASC services)	1,396,216	1,396,216				
Hospital discharge programme	**16,020,537**	**16,020,537**				
Revenue - iBCF grant	**29,126,836**	**29,126,836**				
Support to social care	29,126,836	29,126,836				
Grand Total	**131,159,420**	**120,444,065**	**5,288,300**	**2,286,000**	**1,306,355**	**1,834,700**

SCHEDULE 6 – BETTER CARE FUND

BETTER CARE FUND PLAN **in** **http://www.devonhealthandwellbeing.org.uk/jsna/bcf/**

SCHEDULE 7 – POLICY FOR THE STANDARDS OF BUSINESS CONDUCT AND MANAGEMENT OF CONFLCITS OF INTEREST

1. **Better Care Fund**

1.1 This policy is in addition to the standards of business conduct and managing conflicts of interest set out in the NHS Devon (Integrated Care Board) constitution and Devon County Council's Constitution.

1.2 Engagement of providers is vital to ensure the success of the Better Care Fund. Some service providers can attend sub groups established by the BCF Leadership Group, such as the BCF Business Group. This results in a situation whereby they are present when decisions regarding services they perform are made or recommendations are agreed to be put forward to the BCF Leadership Group.

1.3 To mitigate this conflict of interest the parties must recognise that:

(i) Any sub groups established by the BCF Leadership Group will not be a decision making group unless delegated by the BCF Leadership Group. In that context, the authority of sub-groups is derived from the individuals present. Although such groups will help to ensure that the voices of interested parties are listened to and considered, the decision or recommendation rests with the commissioning parties.

2. **Standards of Business Conduct**

2.1 Employees, Members, Committee and Sub-committee members of the parties should uphold the utmost standard of business conduct in all their dealings with and pertaining to this section 75 agreement. They should act in good faith and in the interests of the population of Devon and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles).

2.2 They must comply with their own party's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest.

2.3 Individuals contracted to work on behalf of the parties or otherwise providing services or facilities to the parties will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

3. Conflicts of Interest

3.1 As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, and the Localism Act 2011, the parties will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the parties will be taken and seen to be taken without any possibility of the influence of external or private interest.

3.2 Where an individual, i.e. an employee, Member, Governing Body Member, or a member of a Committee or a Sub-Committee of the parties or its Governing Body or its Council has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the parties considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this policy.

3.3 A conflict of interest will include:

3.4 Disclosable pecuniary interests including:

(i) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

(ii) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

3.5 Interests other than disclosable pecuniary interests:

(i) a non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

(ii) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

(iii) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

3.6 If in doubt, the individual concerned should assume that a potential conflict of interest exists.

4. Declaring and Registering Interests

4.1 The parties will maintain their own registers of the interests which will be made available to the BCF Leadership Group.

4.2 Copies of the register are available from individual parties' websites.

4.3 Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the governing body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

4.4 Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

5. Managing Conflicts of Interest: general

5.1 Individual members of the group, the governing body, committees or sub-committees, the committees or sub-committees of its governing body and employees will comply with the arrangements determined by the group for managing conflicts or potential conflicts of interest.

5.2 The Chair of the BCF Leadership Group will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.

5.3 Arrangements for the management of conflicts of interest include the following:

(i) when an individual should withdraw from a specified activity, on a temporary or permanent basis;

(ii) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

5.4 Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Chair of the BCF Leadership Group.

5.5 Where an individual member, employee or person providing services to the group is aware of an interest which:

(i) has not been declared, either in the register or orally, they will declare this at the start of the meeting;

(ii) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.

5.6 The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

5.7 Where the chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

5.8 Any declarations of interests, and arrangements agreed in any meeting will be recorded in the minutes.

5.9 Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

5.10 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with each parties' Governance Lead on the action to be taken.

5.11 This may include:

(i) requiring another of the group's committees or sub-committees, the group's governing body or the governing body's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

(ii) inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the governing body or committee / sub-committee in question) so that the group can progress the item of business:

5.12 These arrangements must be recorded in the minutes.

6. Managing Conflicts of Interest: contractors and people who provide services to the group

6.1 Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

6.2 Anyone contracted to provide services or facilities directly to the parties of this agreement will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

7. Transparency in Procuring Services

7.1 The parties recognise the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The parties will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

SCHEDULE 8 – INFORMATION SHARING PROTOCOL

The Information Sharing Protocol can be found at:

https://devoncc.sharepoint.com/:w:/s/InformationGovernance/ETdKg4W4T6lOoZFHtgnIi8wB1SivCAwlu7LEpYfo9OMUdQ?e=afmB2j

Appendix 1 – Scheme specifications

- **a – Enhanced Carers Offer Services Schedule**

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

21 OVERVIEW OF INDIVIDUAL SERVICE

The Enhanced Carers Offer scheme is focused on enhancing the skills and experiences of carers in the community to ensure prevention measures are taken and avoidable hospital admissions can be reduced.

22 AIMS AND OUTCOMES

The refreshed strategy for carers, builds on the national strategy and the requirements of the Care Act 2014 has four primary outcomes:

1. Supporting those with caring responsibilities to identify themselves as Carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
2. Enabling those with caring responsibilities to fulfil their educational and employment potential.
3. Personalised support both for Carers and those they support, enabling them to have a family and community life.
4. Supporting Carers to remain mentally and physically well.

and a commitment to promoting equality (see section on access below)

The intended outcomes include enhanced self-care, independence and peer support for carers, and effective working with carers as expert partners in care, contributing to the sustainability of formal services.

23 THE ARRANGEMENTS

Devon County Council is the lead commissioner for this scheme but delivers the programme through joint commissioning arrangements and through a Carers Strategy Delivery Board which has significant carer involvement.

24 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board) hereby delegate the exercise of the NHS Functions to the Council to exercise alongside the Council's Health-Related Functions and act as lead commissioner for:

- Provision of short breaks for carers and
- Provision of health and wellbeing checks for carers and
- Other services for carers, as agreed between the Partners.
- Other services for carers - developmental.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.

The Council shall provide the Services or procure them through external providers and, working closely with its NHS partners, shall be accountable to the NHS bodies for the NHS Functions for the benefit of Service Users:
a) to ensure the proper discharge of the Partners' Functions;
b) with reasonable skill and care, and in accordance with best practice guidance;
c) in all respects in accordance with the Aims and Outcomes, the performance management framework, the provisions of this Agreement, in accordance with its standing orders or other rules on contracting; and(d) in accordance with all applicable Law.

Services under development

- Peer Support: Support to carers most at risk of emergency admission to hospital or caring for those at most risk of emergency admission to hospital or other care setting.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Devon County Council is the lead commissioner for this scheme.

Contracting Arrangements

Contracts which fall under this scheme include the contract with Westbank (providing services under contract as Devon Carers), carers health and wellbeing checks commissioned with Westbank, GPs and Pharmacies. Additional support for working age carers is contracted for with the Devon Citizens' Advice Bureau.

Breaks are now provided as follows:
a) replacement care is provided (except in limited circumstances), by direct purchase or via a Direct Payment for replacement care via the care management service of DCC to the cared-for person;
b) alternative forms of break are provided primarily by making Direct Payments to carers for support packages agreed with Devon Carers or DCC care management services.

Contracts are agreed with the lead commissioner, Devon County Council.

Additionally, some training for carers in self-care is contracted for with Self Care UK through NHS Devon (Integrated Care Board) contracting arrangements.

Additionally, we have identified that the following groups are less likely to make use of carers' services:

- Male carers
- Black and Minority Ethnic group carers
- Working age carers
- Gypsy and Traveller carers
- Lesbian, Gay, Bi-sexual and Trans-gender carers

Access

A review of national and local documents and consultation identifies the following adult groups as most likely to have the most substantial needs, be at risk or to have urgent needs:
• Those caring for more than 50 hours per week

- Those over the age of 65
- Those caring for someone with a deteriorating physical condition, or with mental health problems, and/or multiple conditions
- Those caring for a child with special needs in transition to adulthood
- Working Carers, and those of working age where entering or maintaining work is an issue
- Those caring for someone at the end of life
- Those providing substantial care whilst being themselves ill or disabled

The Devon priority groups for support are:
- Those adult Carers (including Parent Carers) whose caring responsibilities are placing them, their safety or health, or the sustainability of their caring role at risk;
- Young Carers (< age 18 years) especially in the younger age groups, where the young person is potentially in need or at risk, and where social care is required by adults in the family;
- Carers aged over 80 (NHS 5 year forward view)

As a consequence of the Care Act 2014, new arrangements have been put into place to meet the new national eligibility criteria. A range of assessments are offered, including supported self-assessment, and the new "carer offer" has a mix of universally available services, services targeted to prevent needs arising or becoming worse, and those that are governed by the eligibility threshold. Assessments that determine eligibility will be undertaken either by Devon Carers or by the Council's care management service.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5 of the s75 agreement.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of the s75 agreement for the Better Care Fund, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the s75 Agreement for the Better Care Fund shall apply.

Where NHS Devon (Integrated Care Board) the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.2 of the main body of the s75 agreement for the Better Care Fund shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The County Carers Strategy Board is tasked, through our joint commissioning arrangements, to provide governance for the Strategy. It has been running successfully for a number of years, is chaired by a Senior Manager from the Council and has a high % of carers among its membership.

It is expected to act on and resolve delivery issues but to escalate any appropriate issues to the BCF Leadership Group or to member organisations as appropriate. Reports will be provided from time to time to the Health and Well-Being Board to update on progress against the objectives of the strategy.

Reports are also made to the Health and Wellbeing Board.

NON-FINANCIAL RESOURCES

There are no non-financial resources in this scheme.

STAFF

The Joint commissioning Carers Lead is employed by the NHS Devon (Integrated Care Board) and funded from the carers partnership contributions which will cover all expenses relating to the post.

A prevention development post is also funded short term funded from the carers partnership contributions which will cover all expenses relating to the post to work on the commitments in this agreement. Employment of this post and of necessary support staff is by Devon County Council.

Delivery staff are employed by Devon Carers. They undertake Carer Health and Wellbeing Checks and deliver other carer services.

Employees of primary care practices and pharmacies undertake Health and Well-Being Checks.

Employees of Devon Citizen's Advice Bureau deliver advice to working age carers under contract. Employees of and contractors to Self Care UK deliver some training services under contract to NHS Devon (Integrated Care Board)and funded through the overarching S75 agreement.

There are no TUPE considerations for this scheme.

ASSURANCE AND MONITORING

The commissioners actively monitor the contracts with Devon Carers and Primary Care and Pharmacies through regular contract monitoring meetings. A set of criteria are reported on at each quarterly meeting and reported to the Carers Strategy Board.

These contract review meetings are convened by the carers lead, who reports to a Senior Manager in the Council.

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD	01392 383000	Solveig.wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to this scheme are set out in schedule 3 of the s75 agreement for the Better Care Fund.

REGULATORY REQUIREMENTS

This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of the s75 agreement for the Better Care Fund.

DURATION AND EXIT STRATEGY

As per clause 21 of the main s75 agreement for the Better Care Fund.

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

a. Detailed scheme specifications are listed in contracts with service providers. Extracts are given below.

<u>What is the service?</u>

The enhanced services will be aligned with Primary Care (as now), acute Hospitals and integrated Health/Social Care Hubs.

Care Pathways will be aligned to provide for maximum early identification of carers in relation to all Long Term Conditions and Dementia, to maximise preventive effect of commissioned services. E.G Carer Recognition Tool has been developed and tested and is being rolled out.

Targeted work will be undertaken to ensure that community and acute services work with carers as expert partners in care to maximise the impact of carers services in preventing unnecessary admissions.

Commissioned Carers services will work more closely with the PALS services to assist carers with more difficult aspects of negotiating NHS services for their cared-for people.

The Commissioned services will include
Information and Advice Service {scope is information , advice and encouragement to access all services available for carers including peer support, nationally-available helplines and support, services available to carers but not funded through this agreement (e.g. advocacy services, language support for service access) }:

- Carer helpline with live availability six days per week through a single telephone number
- Website access – enhanced services planned through this route include direct access to peer support, online training including health improvement, caring safely plus information as Newsletter
- Newsletter (includes online option for sustainability)- enhanced offer will include more information and encouragement to self-care and timely access to preventive services.
- Information and Advice service will support carers to encourage early diagnosis if dementia where appropriate.

- Carers Health and Wellbeing Checks Service – an enhanced and health/social care integrated form of the statutory Carer Assessment covering carer's health risks, support to access preventive health care and early diagnosis of serious conditions which may threaten the sustainability of the caring role –delivered in part in/by GP Practices, encouraging carer identification. Targeting prevention of carer breakdown (indicators admission to long term residential care, emergency hospital admissions).

- Carers support workers: engaged in 1:1 intervention proportionate to need, solution-focussed work to enable carers to achieve nationally prescribed outcomes and maintain the caring role. Provided in a variety of ways including at advice "clinics" based in/in association with GP Practices across Devon (targeting admissions to long term residential care). Increasing the focus on co-work with GP Practices will enable a greater focus on carers identified as a higher risk of hospital admission themselves and carers of people identified as at higher risk of hospital admission (cf references in submission to Devon Stratification Tool). Increasing links with Health and Social Care Hubs will further increase this and enable more structured work with carers of people with complex long-term conditions at an early stage. These links will enable better targeting of additional commissioned services via prioritised Carer Health and Wellbeing Checks.

- Breaks – including emergency access to a break, market development to increase the range of breaks options available to improve access. Targeting prevention of carer breakdown (indicators admission to long term residential care, emergency admissions)

- Training for carers –
    - to support cared-for person and as expert partners in care, understanding how best to support the cared-for person in relation to particular health conditions (targeting indicators of preventable emergency admissions and long-term residential care)
    - self-care for carers- tackling common risks for carers (see below), particularly preventing back injury, falls among older carers, and combatting depression. It is intended to significantly increase investment in this area; exact level of investment under active consideration. (Targeting prevention of carer breakdown and indicators of emergency hospital admissions and admissions to residential care.¬ Services for young carers including: engagement, information and advice; young carer assessment; promotion of welfare; outings and breaks; drop in clubs; and school clubs aimed at improving overall outcomes

- Emergency card, contingency planning and access to services in an emergency – helps prevent unnecessary admissions of cared-for people to residential care (though numbers would be very low) and reduces carer anxiety.

- Hospital discharge service for carers – at point of discharge of cared for person and/or carer at six weeks after discharge –by referral and direct access by carers- enhancements to include targeted promotion work on carer identification in acute

Hospitals and increase of capacity in system as identification improves (targeting indicator of delayed transfers of care).

- Promotion of the carer's agenda to public, third and private sectors and the community at large to encourage informal and community support.

- Quality assurance of services, improving consistency and preventive effect

Target audience demographic

We know from the 2011 Census that (all Carers):

- 84,492 people in Devon are Carers
- 9,831Carers provide 20 to 49 hours unpaid care a week
- 18,412Carers provide 50 or more hours unpaid care a week

and for Younger Carers:

- 4,882 under 24 year olds provide unpaid care, of these 1,646 are aged 15 or under
- 3,921 under 24 year olds provide 1 to 19 hours unpaid care a week, (1,404 aged 15 or under)
- 529 under 24 year olds provide 20 to 49 hours unpaid care a week, of these 144 are aged 15 or under
- 432 under 24 year olds provide 50 or more hours unpaid care a week, of these 98 are aged 15 or under

According to our own estimates (using the Census data) there are likely to be 2629 Young Carers aged under 18. We consider the Census data is likely to substantially under-represent the numbers of Young Carers in the community as Devon Carers are already in touch with more than this number.

A review of national and local documents and consultation identifies the following adult groups as most likely to have the most substantial needs, be at risk or to have urgent needs:

- Those caring for more than 50 hours per week
- Those over the age of 65
- Those caring for someone with a deteriorating physical condition, or with mental health problems, and/or multiple conditions
    - Those caring for a child with special needs in transition to adulthood
    - Working Carers, and those of working age where entering or maintaining work is an issue
    - Those caring for someone at the end of life
    - Those providing care whilst being themselves ill or disabled

The Devon priority groups for support are:

- Those adult Carers (including Parent Carers of children with additional needs) whose caring responsibilities are placing them, their safety or health, or the sustainability of their caring role at risk (thus increasing risks of emergency hospital admissions and admissions to residential care);
- Young Carers (< age 18 years) especially in the younger age groups, where the young person is potentially in need or at risk, and where social care is required by adults in the family.

Public Health Devon have provided the following information; highlighted lines have been used in prioritising actions and areas for investment (other areas to be subject of individual interventions):-

Issue	% identified in Carers UK study	Devon Carers Estimate (Number)
Given up work to care	45%	38,196

Faced depression	61%	51,776
Struggle financially	49%	41,594
Have back problems	20%	16,976
Have high blood pressure	10%	8,488
Carers in fuel poverty	65%	55,120
Had difficulty paying essential utility bills	74%	62,752
Had cut back on buying food	52%	42,610

Describe geographical coverage
The administrative area of Devon County Council.

However, Carer Health and Wellbeing Checks may also be provided to carers whose cared-for person lives outside the administrative County of Devon but who are registered with a GP Practice in Devon where that GP Practice is participating in the Scheme.

Projected volume of service users
We project 18,000. Of these, we project 3,000 young carers under 18.

PART 2 – CURRENT AGREED SCHEME SPECIFICATIONS – CONTRACT EXTRACTS

b Enhanced Community Equipment Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

1 OVERVIEW OF INDIVIDUAL SERVICE

The Community Equipment Service (CES) supports the transformational change of health and social care by providing the necessary equipment and technology to enable people to live independently and be safely cared for in their own home. This allows them to self-manage their health and independence and identifies any exacerbation of their condition in accordance to their care plans.

AIMS AND OUTCOMES

The general aims and outcomes are to deliver responsive, timely, person centred, Health and Social Care provision of Adult Community Equipment Services, Minor Adaptation Services, Children's Bespoke Community Equipment Services, Simple Speech and Language Communication Aids, Telecare and the Independent Living Centre to Service Users.

Adult Community Equipment Services, Minor Adaptation Services, Children's Bespoke Community Equipment Services, Simple Speech and Language Communication Aids (which are not covered by the NHSE specialist commissioning specification), Telecare and the Independent Living Centre will promote faster recovery from illness, support end of life care at home, prevent unnecessary acute hospital admissions, support timely discharge from hospital, prevent unnecessary admission into long term residential care, and maximise independent living of Service Users.

Services will be provided to Service Users on the basis of an assessment undertaken by the relevant Parties Representative(s).

Services will be time unlimited to support the assessed needs of Service Users.

The pathway to the provision of Services will be well understood by the Parties Representatives, Service Users, carers and their families.

To set and monitor Services against Performance Measures as agree with the Partners: such measures may be amended by agreement between the Partners from time to time.

By working in partnership, a strategic approach to planning and reviewing Services and co-ordination of Services between Parties will be developed, thereby improving the efficiency and effectiveness of the Services.

THE ARRANGEMENTS

Devon County Council are the lead commissioners for this scheme.

FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board)hereby delegates the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

The services covered by this Specification were tendered during 2016-17, with a new contract coming into effect on 1st June 2017. Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.

The Council shall procure the Services and shall be accountable to the NHS Devon (Integrated Care Board)for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Devon County Council is the lead commissioner for this scheme.

Contracting Arrangements

Contracts which fall under this scheme include the current contract with Millbrook Healthcare Limited (adults, children's, minor adaptations and Telecare service-.
The memorandum of agreement between Royal Devon University Healthcare NHS Foundation Trust and Devon County Council for the independent living centre also forms part of this scheme.

Contracts are agreed with the lead commissioner and the provider who retain the right to retender the service and change the provider during the duration of the s75 agreement for the Better Care Fund.

A monthly performance and finance meeting takes place with the Provider as well as a monthly Devon Independent Living Integrated Service (DILIS) Board that brings together operational, commissioning and provider leads. The DILIS Board is the governance group for the Community Equipment contract and also engages in wider service development in relation to community equipment and technology enabled care (TECS).

The contracts can be terminated with 3 months' notice in line with the legal framework set out within it.

Access

The target demographic for this service is

- Older People
- People who are acutely or terminally ill
- People with long term conditions

- People with mental health problems
- People with dementia or cognitive impairment
- People with learning disabilities
- People with physical disabilities
- Children and Young People with a range of additional needs
- People with speech and language problems

The Care Act requirements will be met in assessing the individuals eligibly for the scheme

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5 of the s75 Agreement for the Better Care Fund.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of the s75 agreement for the Better Care Fund, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the s75 agreement for the Better Care Fund shall apply.

Where NHS Devon (Integrated Care Board) the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.2 of the main body of the s75 agreement for the Better Care Fund shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The CES and Assistive Technology groups meet monthly to assess the scheme. They send their findings to the BCF Leadership Group who retain responsibility for delivering the Better Care Fund.

NON FINANCIAL RESOURCES

There are no non-financial resources in relation to this scheme.

STAFF

Staff on this scheme will continue to be employed by the same organisation. There are no TUPE considerations.

ASSURANCE AND MONITORING

There are a number of Key Performance Indicators to assess the impact of this scheme. These are included in the individual contracts. As contracts are retendered these Key Performance Indicators may alter.

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD	01392 383000	Solveig.sansom@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to this scheme are the same as the Central pooled fund schemes as set out in schedule 3.

REGULATORY REQUIREMENTS

This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of the s75 agreement for the Better Care Fund.

DURATION AND EXIT STRATEGY

As per clause 21 of the main s75 agreement for the Better Care Fund

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – CURRENT AGREED SCHEME SPECIFICATIONS – CONTRACT EXTRACTS

The Service Specification and Service Agreement for community equipment services is available from the lead officer.

Part 1c – SWASFT Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

SWASFT Right Care 2 is a continuation and expansion of an existing successful scheme within South Western Ambulance (SWASFT) around "Non-Conveyance". Callers to 999 will receive assessment, advice and treatment proportionate to their need but with the specific aim of treating the patient in their own home or as close as possible to their own home rather than take them to the Emergency Department (ED).This contributes to the BCF vision and is in line with key guidance (Keogh Urgent and Emergency Care Review) and the direction of travel for the NHS Devon (Integrated Care Board) aligning with the Transforming Community Services work stream and the NHS Devon (Integrated Care Board) Commissioning Framework. Evidence that 40% of A&E attendances are discharged with no action and the Lightfoot review showed that in the south-west in 12/13 there were 69,000 short-stay (<3days) admissions discharged with no procedure undertaken. This accounts for 34%of all ambulance admissions for SWASFT when they are already operating at 54% non-conveyance.

2 AIMS AND OUTCOMES

Callers to 999 will be triaged by trained personnel with a high proportion of clinical input using NHS pathways and then identified for a range of options to be delivered by SWASFT.
These include:

- "Hear and Treat" – patients are advised over the telephone of their best self-treatment options.
- "See and Treat" – an ambulance crew will attend the patient and undertake appropriate treatment to safely manage their condition without taking them to ED. This will include seeking advice and guidance from clinical staff in the SWASFT Clinical Hub, the patient's GP or senior clinicians (usually consultant) at ED over the telephone. The growing use of telemetry supports live transmission of information such as output from a 12-lead ECG and continual development enhances the diagnostic available at the scene – currently trialling rapid mobile Troponin test to rule out NSTEMI cardiac patients.

3 THE ARRANGEMENTS

The contract between NHS Devon (Integrated Care Board) South West Ambulance Service Foundation Trust forms part of this scheme.

4 FUNCTIONS

No functions of the NHS are delegated as a result of this scheme.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

SWASFT will be continuing the selection of interventions already being undertaken with Right Care, Right Place, Right Time which include:

- Hear & Treat – where patients are advised on self-care through qualified HCP in the Clinical Hub
- See & Treat whereby the ambulance crew assess, treat and discharge the patient at the scene of the call (usually home).

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

This service is commissioned by NHS Devon (Integrated Care Board)without the involvement of either of the other parties to this agreement.

Contracting Arrangements

All the contracting arrangements rest with the NHS Devon (Integrated Care Board).

Access

The target demographic for this service is all users of the 999 service.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) the Host Partner for the Pool (or locality section of the Revenue Pool) which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

This will be monitored with the monthly contract review meetings between NHS Devon (Integrated Care Board)and SWASFT.

NON FINANCIAL RESOURCES

There are no non financial resources invested in to this scheme.

STAFF

There are no staff employed through this scheme.

ASSURANCE AND MONITORING

SWASFT provide monthly performance information to NHS Devon (Integrated Care Board)to inform the contract review meetings.

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council and	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD	01392383000	Solveig. Wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

All contracts must be signed in line with the organisations scheme of delegation.

RISK AND BENEFIT SHARE ARRANGEMENTS

The contract is fixed price which limits the risk borne by the parties.

REGULATORY REQUIREMENTS

This scheme compiles with the regulatory health framework.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of this agreement.

DURATION AND EXIT STRATEGY

The duration and exit strategy are set out in the contract between the NHS Devon (Integrated Care Board) and South West Ambulance Foundation Trust.

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

b. These are set out in the contract between the NHS Devon (Integrated Care Board) and South West Ambulance Service Foundation Trust.

Part 1d – Rapid Response Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

1 OVERVIEW OF INDIVIDUAL SERVICE

Rapid Response is a service that provides support at home to clients who are undergoing acute medical crisis and/or sudden carer breakdown.

a) Support is provided to clients who are End of Life and wish to remain at home to die. Another support is provided for unpredicted hospital discharges.
b) Rapid response provides support for up to 7 days to the client (average length of service is 5 days) – with the emphasis being on rehabilitation and the goal of returning the client to former levels of ability.
c) Co-ordination of the client's care with input from involved parties to ensure that the client's needs are met. Regular contact is maintained with the client's GP and/or Community Nurses.
d) Where clients are not making progress or deteriorating then we liaise with their GP and other professionals involved to ensure that – with the client's consent – the appropriate actions are taken This could be medical admission, or arranging ongoing support etc.

2 AIMS AND OUTCOMES

The strategic objective of the Rapid Response scheme is to prevent unplanned admissions to bed-based care and to support end of life clients to remain at home, where this is their wish. This will help deliver the BCF vision by ensuring that people are enabled to stay at home with support over a crisis period, maximising recovery and rehabilitation.

Rapid Response is available for up to seven days to adults who are undergoing an acute physical health crisis or a sudden carer breakdown situation, where with appropriate support and services, it is possible to maintain them in their own home environment. The service is also available to support unpredicted discharges from hospitals, and to provide support for End of Life patients to be able to die at home if they choose.

Referrals to Rapid Response are currently taken from any health or social care professional, with the proviso that the patient has been seen Face to Face by the referrer in the 24 hours prior to the referral. Referrals are taken, co-ordinated, and reviewed by the Team Leader Assistants.

Patients are supported at home by Support Workers who are clinically trained to HCA Band 3 level and provide both clinical support as well as personalised support with personal activities of daily living with a rehab ethos.

Night sit support to the patient is also provided when needed through Agency.

3 THE ARRANGEMENTS

This is a jointly commissioned service, which is provided by the Royal Devon University Healthcare NHS Foundation Trust and Torbay and South Devon NHS Foundation Trust.

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the Council hereby delegates the exercise of the Council Health-Related Functions to the NHS Devon (Integrated Care Board)within their respective areas to exercise alongside the NHS Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The NHS Devon (Integrated Care Board) agrees to act as lead commissioner of the Services listed in clause 0

The NHS Devon (Integrated Care Board) shall ensure that the Services are provided and shall be accountable to the Council for the Council's Health-Related Functions for the benefit of Service Users:

1. to ensure the proper discharge of the Parties' Functions;
2. with reasonable skill and care, and in accordance with best practice guidance;
3. in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
4. in accordance with its standing orders or other rules on contracting; and
5. in accordance with all applicable Law.

The NHS Devon (Integrated Care Board) confirms that it shall, from the Commencement Date, commission the Trusts to be the Service Providers for the Term by way of separate agreements

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements
NHS Devon (Integrated Care Board) is the lead commissioner for this scheme.

Contracting Arrangements
All the contracting arrangements rest with the NHS Devon (Integrated Care Board)

Access

The target demographic for this service is predominantly the frail and elderly population.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where the NHS Devon (Integrated Care Board) is the Host Partner for the Pool from which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Better Care outcomes report monitors the Better Care Fund Indicators for the Devon County Council area and provides an overview of the whole system and includes the following sections:

a) Overview and indicator summary with trends and benchmarking.
b) A dashboard showing current monthly in-year performance
c) Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local Council district within Devon, by the NHS Devon (Integrated Care Board) and localities and by inequality characteristics such as deprivation. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.

Supplementary monthly dashboards are provided for localities to allow a detailed consideration at the four locality A&E Boards, based around each of the local health economies (Eastern, Northern, Western and Southern) within the Devon STP which are made up of senior leaders of the health and social care system. These Boards collaboratively identify gaps in service; plan, commission and coordinate activities aimed at improving system resilience and patient flow; and consider the best use of available resources.

NON-FINANCIAL RESOURCES

There are no non-financial resources invested in to this scheme.

STAFF

Any staff costs borne by Devon County Council are recharged to Royal Devon University Healthcare NHS Foundation Trust.

ASSURANCE AND MONITORING

There are a number of Key Performance Indicators to assess the impact of this scheme.

- Reduced hospitalisation and placement rates,
- Enablement of the management of more complex conditions in people's own homes by the primary health care team and partners.
- Providing and supporting patient choice to remain at home, with support

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD	01392 383000	Solveig.wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

- All contracts must be signed in line with the organisations scheme of delegation.

RISK AND BENEFIT SHARE ARRANGEMENTS

The scheme follows the same risk arrangements as detailed in schedule 3.

REGULATORY REQUIREMENTS

This scheme compiles with the regulatory health framework. This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of this agreement.

DURATION AND EXIT STRATEGY

As per clause 21 of the main agreement

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS – CONTRACT EXTRACTS PRE NHS DEVON FORMATION IN APRIL 2019

Part One: Aims and Objectives

1.1 Aims

This Specification sets out the commissioning requirements of NHS Devon (Integrated Care Board) and Devon Adult Social Care for a Rapid Response care service across Devon delivered as part of the integrated health and social care complex care teams

The aims of the service are:

1. To prevent vulnerable adults being inappropriately admitted into hospital or care home at the point of crisis by the provision of a response service integrated with complex care teams and supported by primary care that can provide the individual and their carer with a real choice to remain at home.
2. To provide a coordinated response that ensures that the rapid response care service is delivered in a timely way, is effectively coordinated and linked with other services provided by the provider to ensure the smooth transition of individuals between services and to ensure that services are more responsive and personalised for the individual.

3. To deliver a good quality, cost effective, safe and evidence-based service.

1.2 Evidence Base

The service will apply and/or support evidence-based practice and will be informed by national and local drivers for change for example:

- Current DoH policy and guidelines, delivery of national key targets & NSF & NICE guidelines
- CQC registration requirements
- Gold Standards Framework and Liverpool Care Pathway for people at the end of life
- Essence of Care
- Infection Control Standards e.g. hand hygiene audits
- Locality commissioning plans and locally agreed care pathways
- The Devon Joint Strategic Plan and subsidiary action and operational plans
- The integration of health and social care delivery in Devon through the continuing development of localities and clusters

The commissioning specification is supported by the joint Health and Wellbeing Strategy 2013–16.

1.3 General Overview

The service will be monitored in accordance with the NHS Standard Contract which is cross referenced with the NHS Operating Framework. Priorities for local KPIs, and continuous service improvement targets are agreed by local commissioners.

This specification describes expected outcomes and preferred models of service; it does not prescribe delivery methods outside the recommended care pathways.

The provider must comply with the standards outlined within this specification. Compliance with the outcomes, standards, inputs and outputs described below must be demonstrated through an agreed performance management framework.

This service will comply with the NHS Devon (Integrated Care Board)'s contractual conditions in relation to Equality and Diversity.

1.4 Objectives

The objectives of the commissioning specification are:

- To provide equitable outcomes and adequate levels of service across Devon, working across cluster/locality boundaries where necessary.
- To provide a timely, flexible and responsive service
- Actively promote the delivery of a good quality Rapid Response Care service integrated with nursing, and therapy services as part of Complex Care Teams
- A Rapid Response care service delivered to individuals at home that responds to crisis appropriately and in a timely way, in and out of hours, to avoid unnecessary admissions to hospital, hospice or care home.
- Provide a service that meets individual assessed needs and preferences and supports family carers.
- To closely align and work collaboratively with Primary Care, NHS and social care services in and out of hours
- To link to and complement re-ablement and rehabilitation services developing greater integration and co-ordination of care preventing inappropriate or unnecessary use of in-patient services.
- To increase productivity in order to maximise responsiveness, flexibility and support patients' individual needs by using a range of skills available in teams.
- To deliver personalised care, with a high degree of user and carer involvement ensuring wherever possible the service enables and supports people and their carers in managing their care.
- Work in partnership with a range of statutory and voluntary providers.
- To provide the service in accordance with all existing policies of the provider

1.5 Expected Outcomes

The service will achieve the following service outcome:

- The Rapid Response Service will contribute to a reduction in inappropriate and unplanned admissions into hospital, care home or hospice.

Eligible individuals and their carers will experience the following individual outcomes:

- ***Prompt access*** to the rapid response care service (within 4 hours of referral).
- Have the ***choice*** to receive the care & treatment they need at home rather than be admitted to hospital (Number of patients remaining at home who might otherwise have been admitted to hospital)
- Have ***simplified, timely*** (fast track) ***access to other CCT and primary care services as appropriate*** to their needs whilst receiving the rapid response care service (improved response times/waiting times to other CCT, rehabilitation and primary care services)
- ***Experience*** well-coordinated and ***seamless service delivery*** across health and social care (patient and care feedback)
- ***Experience a good quality service*** (complaints and compliments)
- Upon discharge signposting that enables them, where appropriate, to ***manage their own care (self-care) and support needs***.
- Be ***supported if they are at risk*** of, or have been, abused (safeguarding alerts)

Key Performance Indicators for Rapid Response Care in Devon

Key Performance Indicator	Description
Number of individuals supported	Numbers of individuals receiving at least one contact by RR care worker
Number of individuals supported by Night Service	Numbers of individuals receiving at least one care visit or night sit.
Number of individuals who would have otherwise been admitted into hospital within 12 hours	
Number of individuals who would otherwise have been admitted to a care home (short stay) within 12 hours	Numbers of short stay/respite/emergency admissions avoided
Number of referrals declined	Number of referrals which did not result in a contact by a RR care worker (by reason – i.e. inappropriate referral or lack of capacity)
Response times	Time from receipt of referral to first contact by RR support worker
Length of time in the service	Time (in calendar days) from receipt of referral to discharge
Outcome on discharge from the service	Outcome destination on discharge
Utilisation	• % of direct patient contact time vs noncontact time
Outcome measures	• % of patients whose hospital admission was avoided. • % of patient who did not need personal care services upon discharge. • % of patients needing less personal care upon discharge • % of patients needing the same or more personal care upon discharge • % of patients admitted into hospital with 30 days
Patient outcomes	• Patient reported outcome measures (PROM) (what did the patient want from the service) will be recorded on each patient's support plan • % patients achieving their PROM • The Service Provider will maintain systems for the monitoring of patient satisfaction and will collect individual outcome information

PART 2 – AGREED SCHEME SPECIFICATIONS – CONTRACT EXTRACT (SOUTH DEVON & TORBAY AREA)

Service:	Rapid Response Care Service
Commissioner Lead:	Jenny Turner
Service Provider Lead:	Sarah Mackereth
Commences:	1st April 2016
Date of Review:	1st April 2022

1 POPULATION NEEDS

1.1 National/local context and evidence base

This Specification sets out the commissioning requirements of NHS Devon (Integrated Care Board) and Devon Adult Social Care for a Rapid Response care service that will support the Local Multiagency Teams (LMATS).

The service will apply and/or support evidence-based practice and will be informed by national and local drivers for change for example:

- Current DoH policy and guidelines, delivery of national key targets & NSF & NICE guidelines
- CQC registration requirements
- Gold Standards Framework and the priorities for care of the dying person
- Essence of Care
- Infection Control Standards e.g. hand hygiene audits
- Locality commissioning plans and locally agreed care pathways
- The Devon Joint Strategic Plan (2008) and subsidiary action and operational plans
- The integration of health and social care delivery in Devon through the continuing development of localities and clusters

This commissioning specification is supported by the aims of NHS Devon (Integrated Care Board)'s strategic plan and the local targets and national conditions of the Better Care Fund:

- Supporting people to stay at home and active promotion of care closer to home with a single point of access
- Ensuring care, sensitivity and dignity at the end of life
- 0% increase in admissions
- Reduction in delayed transfers of care
- Reduction in long term admissions to care homes
- Protecting social services
- 7day community services to support discharge from hospital and prevent unnecessary admissions at weekends
- Safe and secure sharing of data in the best interests of people who use the service, supporting safe, seamless care
- Carer specific support and prevention of admission to hospital for the people they care for

C. 2 OUTCOMES

2.1 NHS Outcomes Framework domains & Indicators

Domain 1	Preventing People from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

2.2 Locally defined outcomes

Eligible individuals and their carers will experience the following individual outcomes:

- Prompt face to face contact with the Rapid Response service (within 4 hours of referral when requested by referrer)
- People to receive the care and treatment they need at home rather than be admitted to hospital (Number of patients remaining at home who might otherwise have been admitted to hospital)
- Have simplified, timely referral to other LMAT and primary care services as appropriate to their needs whilst receiving the Rapid Response service
- A well-coordinated and seamless Rapid Response service delivered as part of wider health and social care services (patient and carer feedback)
- Experience a high quality service (complaints and compliments)
- Signposting upon discharge that enables them, where appropriate, to manage their own care (self-care) and support needs
- Be supported if they are at risk of abuse, or have been abused (safeguarding alerts)

3 SCOPE

3.1 Aims and objectives of service

The aims of the service are:

- To prevent adults at the point of crisis, being inappropriately admitted into hospital, hospice or care home. This will be achieved by the provision of a Rapid Response service supporting LMATs and supported by primary care that allows the individual and their carer to remain at home.
- To provide a Rapid Response service that is effectively coordinated and linked with other services that smooth the transition between services and provides responsive personalised care.
- To deliver a high quality, cost effective, safe and evidence-based service.
- To provide support up to a maximum of 25% capacity to assist with reduction in delayed discharges from NHS hospitals and/or NHS contracted care home placements when individuals are medically fit to be discharged.

The objectives of the service are to:

- Provide a Rapid Response service delivered to individuals at home that responds to crisis appropriately, in and out of hours, to avoid inappropriate admissions to hospital, hospice or care home.
- Provide equitable outcomes and expected levels of service across South Devon, working across locality boundaries where necessary.
- Provide a timely, flexible and responsive service (see hours of operation) in accordance to the terms and conditions of the specification therein.
- Actively promote the delivery of a high-quality Rapid Response service supporting nursing, therapy and social care services as part of LMATs.

- Provide a service that meets individual assessed needs and preferences (where reasonably possible) and supports family carers.
- Closely align and work collaboratively with Primary Care, other NHS Trusts, and social care services in and out of hours.
- Link to and complement re-ablement and rehabilitation services developing greater integration and co-ordination of care preventing inappropriate or unnecessary use of in-patient services.
- Increase productivity (see KPI's) in order to maximise responsiveness, flexibility and support patients' individual needs by using a range of competencies which effectively meets the provision of care requirements in accordance to the specification therein, defined in job descriptions.
- Deliver personalised care, with a high degree of user and carer involvement ensuring wherever possible the service enables and supports people and their carers in managing their care.
- Provide the service in accordance with all existing policies of the Service Provider.

3.2 Service description/care pathway

A single point of referral call handling and coordination (SPOC) which undertakes:

- Referral taking
- Initial deployment of Rapid Response Support Workers (and/or agency worker where appropriate and capacity allows)
- Collaboration where appropriate with community nursing, therapy and other services
- Notification of case details to the LMAT coordinator to share information for effective transfer of care.
- Identification of a key worker (often the referrer) and support for coordination of the care and treatment during the rapid response episode.
- To ensure all relevant parties are kept informed of changes to communicate up-to-date position and/or any change in circumstances for effective partnership working/patient experience.
- To support the referrer to review the care within 72 hours.
- Notification to the key worker/referrer that the patient is to be discharged from the service

An unplanned rapid response care service (rapid intervention for initial assessment) which undertakes:

- A first response which may include initial care/support alongside augmenting the initial assessment of needs and risks previously undertaken by the referrer and the call handler within the SPOC.
- Care and support to effectively meet the provision of service requirements defined in the specification therein, aligning to the job description/job specification of the Rapid Response Support Worker.
- Supports access to community equipment (restricted list of simple aids) and telecare as appropriate.
- Subject to appropriate additional training and clinical governance and in accordance to the requirements/expectations of the service, CQC and legislative requirements, support with a range of tasks (in addition to personal care) can be provided (e.g. monitoring pulse, taking of urine samples, dressings, basic stoma care, and medicine management).
- Support for nursing staff and End of Life specialist staff responsible for supporting end of life care in accordance to the requirements/expectations of the service, CQC and legislative requirements.

A planned care service (provision of routine services with expected interventions as per the care plan) which undertakes:

- Identification of a key worker (who may be the initial referrer) with clinical responsibility to link with the Rapid Response Team Leader, Team Leader Assistant (TLA) or Service Manager to contribute to the joint review of the service intervention and the coordination of the service.
- Based upon the needs and risk assessments referred to in the above, to agree a Rapid Response care plan between the patient (and carer where appropriate), key worker and Rapid Response Team Leader/TLA (review team).
- Referral to other health and social care services/interventions as appropriate.
- Review of the patient's condition and circumstances and of the appropriateness of the Rapid Response care plan. Where required the care plan should be adjusted.
- Liaison/referral as appropriate should any ongoing care/treatment be required.

The Service Provider will be responsible for ensuring clear referral processes.

The Service Provider will ensure that there is at all times (including OOH) appropriate support to the Rapid Response service including clinical support (from GP or Devon Doctors) to the first responder and where necessary a further assessment will be carried out by appropriately trained and experienced health professionals.

Medical responsibility rests with the patients GP (or Devon Doctors OOH), consequently the patients GP should be kept informed as to the progress of the intervention. Similarly, the referrer (if not the GP) shall be kept informed.

The Service Provider will ensure that all staff (contracted workers) meet the required competencies to deliver the provision of services defined within the specification (within the agreed job descriptions and person specifications) and any necessary clinical supervision/accountability.

The Rapid Response service will work to locality populations. Teams may, at their discretion, be orientated to groups of LMATs depending on the operational efficiency of the service.

The service will be expected to use approved needs and risk assessment, care planning and goal setting tools, to enable the consistent and reliable transfer of patient information between services and professionals.

The service will be expected to ensure accurate and timely record keeping and documentation including individual patient records. The service should have a centrally held record system with patient-held records of assessments and care provided. The service is expected to support South Devon and Torbay's IT strategy to work towards a single community care record.

Service model

- Management overseen by a health and social care manager e.g. Operational Manager
- Single point of contact (Access and Co-ordination)
- Access to assessment and care planning support from members of the wider LMAT including Occupational Therapy & Community Nursing and links through to Community Psychiatric Nursing as required
- Rapid Response Team leaders, TLA or Service Manager responsible for front line management of support workers
- Rapid Response Support Workers

Delivery of Care Provision

The Service Provider shall meet the service elements as defined under the auspices of this Service Specification, which include the following:

- The service provision shall be available 24 hours, 7 days per week, however the levels of service provision will vary in accordance to the terms of this service specification therein

- The delivery of care provision shall be provided between 07:00 – 22:00 hours 365 days per year
- The delivery of care provision shall not exceed 4 visits per day plus a night sit within a 24 hour period, in exceptional circumstances this may be extended through negotiations and agreement with the Service Provider
- Night sitting service (delivery mechanism to be agreed with ICO)
- The Service Provider shall deliver this service up to a maximum of a 7 day period with the provision of a 72 hour review process. In exceptional circumstances, the Service may extend this timeframe in consultation with the Referrer/Key Worker which meets the best interests of the patient
- These exceptions will be monitored to inform service development with an agreed absolute limit of a 6 week duration
- A single point of contact for call handling and referral coordination shall be delivered/arranged by the Service Provider (available as a minimum 08:00hrs – 18:00hrs Monday - Friday and 09:00hrs – 17:00hrs on weekends and bank holidays)
- An unplanned rapid response care service to individuals and their carers at point of crisis.
- A planned care service following the initial unplanned response for up to 7 days (referral to end of service) which might include night sitting services as required.
- Between 2200 – 0700 the current response is a night sitting service. The Service Provider is expected to work with the commissioners of the service to develop more flexible night time service models should evidence based need be demonstrated.

Response time, Detail and Prioritisation

All referrals, which have successfully met the service criteria, requiring an urgent intervention from the Service will receive an initial assessment visit within a 4-hour period of referral acceptance (or later if requested by the referrer) during the core operational hours (07:00-22:00). A support plan will be initiated at the point of referral acceptance and completed within a 24hr period. The Support Plan will identify a named Key Worker, assessed care needs, expected outcomes and review plan.

The Service (call handler) shall review progress with the referrer within a 2-hour period of referral acceptance to facilitate the provision of regular communication links with the referrer (and other significant professionals) throughout the initial response until a Key Worker is identified.

Planned support from the Service (up to 7 days) shall be scheduled by an appropriate representative from the Service in consultation with the Key Worker and Referrer within 24hours.

Referral route, criteria and sources

All referrals to the service will be via coordination response/services arranged or provided by the Service Provider.

The service will accept referrals from the following:

- A primary care professional e.g. GP, Practice Nurse & Out of Hours Medical Service
- LMAT / Adult Care Services professionals/Care Direct Plus
- Community and Acute Hospitals
- MIU, onward care teams, urgent care centres
- SWAST
- Specialist Nurses/Therapists
- Hospice or specialist palliative care Service Provider
- Emergency Duty Team

In compliance with the referral process, access to the Service may only be accepted by Health/Social Care professionals who have conducted a face-to-face needs-led assessment with the patient within a 24-hour timeframe of the referral submission. The service shall support

the facilitation of hospital discharge or prevention of admission to effectively meet the patient's assessed clinical care needs in accordance to the Support Plan agreed between the Referrer and the Service Provider. The scope may expand as the service develops in agreement between the Commissioner and the Service Provider.

Referrals will only be accepted where access to appropriate medical support from the patients GP has been agreed. The referral will be rejected in the absence of clinical support/accountability.

The service shall accept referrals via telephone only at present with additional information received via an agreed electronic secured communications links (email) (the scope may expand to other sources as the service develops in agreement between the Commissioner and the Service Provider). All referrals must be recorded with an outcome accept/decline. The Service Provider will record all referrals declined/referred back or signposted on.

Discharge Criteria and Planning

The Rapid Response care plan will be reviewed by the identified key worker within 72 hours i.e. at a half-way point in order to determine and plan future provision required to meet care needs identified subsequent to the expiry of the 7 day period.

Patient and carer information may be shared with the LMAT, specialist end of life care Service Providers and with other relevant professionals (with consent) as appropriate in order to support effective care planning.
Referral and hand-over to other Health or Social Care services will be timely and appropriate in order to prevent deterioration of the patient's condition and to prevent unnecessary hospital or long term care admission.

Discharge from the Rapid Response service will normally take place within 7 days and when:
- The patient is no longer at risk of unnecessary admission to hospital or care home
- The need for care and treatment can be adequately met by business as usual (BAU) community services
- Rehabilitation has been provided as much as possible for up to 7 days
- Care should be transferred/provided in an alternative setting

On discharge from the service the Service Providers will ensure the following:
- Involvement of patients and carers in decisions regarding their discharge plan
- Written discharge plans that are constructed with patients and carers and other professionals involved in the provision of services on discharge
- The GP, referrer and LMAT is informed within 24 hours of discharge and a discharge letter sent electronically
- That any ongoing care/treatment if required is accessed as appropriate.

Prevention, Self-Care and Patient and Carer Information

The service will:
- Offer appropriate information and advice to support individuals and their carers to access health promotion, self-care, carers support and primary prevention services.
- Ensure appropriate ongoing referral to a full range of prevention services as appropriate and intermediate care services including re-ablement, rehabilitation and early supported discharge services.

3.3 **Population covered**
- The service will ensure equity of access and outcome for all patients and will work across locality boundaries where necessary.
- The service applies to patients who are registered with NHS Devon (Integrated Care Board) General Practitioner within the South Devon area and who meet the access criteria.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria:

Individuals who are 18 years and over (including individuals with a learning disability) and:

- Who are at imminent risk of an inappropriate admission into hospital, hospice or care home and who are unable to access planned personal care through standard pathways
- Who may require unplanned urgent treatment and/or personal care services delivered adequately and safely by skilled unregistered staff in the home at point of crisis to prevent admission to hospital, hospice or care home (such individuals may be at home or in A&E or EAU's)
- Whereas a consequence of carer breakdown may be at risk of the above

Exclusion criteria

- Children under the age of 18 and,
- Individuals with a mental health diagnosis where reason for referral is other than physical crisis or carer breakdown
- Individuals within care homes other than in exceptional circumstances e.g. safeguarding alerts, and in agreement with the Commissioner
- Patients who have recently suffered a new CVA

3.5 Interdependencies with other services/Service Providers

d. The service will interface closely with other services and key stakeholders. This specification should be read in conjunction with all other relevant specifications related to any of the services below:

e.

Primary Care Services (and their deputising agents)
Intermediate Care Services
Early Supported Discharge Schemes
Community Hospital General Medical Inpatient Services
Acute Hospital Admission Discharge Services
Social Care Reablement
Specialist palliative Care Services e.g. Hospice Service
Other Service Providers of Palliative Care e.g. Marie Curie
Acute Hospitals
SWAST
Devon Adult Social Care
Independent sector care provision
Ambulance Services
LMATs
Care Direct Plus
Urgent Care Services – A&E, MIU, Walk-In Centres
Specialist nursing
Mental Health Services, specifically OPMH peripatetic liaison service
Care Homes (Residential and Nursing)
Prisons
Services for people with special need

The Service Provider must comply with the standards outlined within this specification. Compliance with the outcomes, standards, inputs and outputs described below must be demonstrated through an agreed performance management framework.

4. APPLICABLE SERVICE STANDARDS

Minimum Data Set (all referrals via Single Point of Coordination)

Name/D.O.B./Postcode/GP Practice
NHS Number
Referral reason (include Primary diagnosis and presenting pathology if known)
Type of service required i.e. personal care, night sitting, community equipment, etc.
Urgency of response required
Date and time of referral
Source of referral (GP, Devon Dr, Acute Hospital etc)
Referrals accepted/declined (by reason)
Date and time of first visit (initial responder)
Intensity of Workload - Number of visits per patient per day
Outcome of Intervention
Admissions Avoided (specify to where)

Key Performance Indicators

Following a review of the Rapid Response care service in March 2015, it was recommended that 6 leaner KPI's are used to measure the effectiveness of the service. These will feed the Better Care Indicator – avoidable emergency admissions.

Ref.	Key Performance Indicator	Description	Target
1.	The number of individuals supported to remain at home	Including a category for those people who died at home	600 min./per annum
2.	Of those referred to Rapid Response, the number of individuals who required a 'step-up' bed prior to return home	Use of intermediate care beds in South Devon	30 max./per annum
3.	Of those referred to Rapid Response, the number of individuals admitted to a community hospital	Including a category to identify which community hospital	30 max./per annum
4.	Of those referred to Rapid Response, the number of individuals admitted to an acute hospital	Including a category to identify which acute hospital	60 max./per annum
5.	The percentage of face-to-face contact verses non-contact time	Productivity analysis	35% (on average per annum)
6.	The individuals experience of the service	The Service Provider will maintain systems for the monitoring of patient satisfaction	QA Trends

Local metrics to assist in the development of the service

Ref.	Metric	Description	For Guidance
A.	Number of referrals	Including categories to identify *reasons*, *type* and *declined (*including why)	650 min/per annum
B.	Response Time Tier 1 Urgent POC (4-hrs) Tier 2 Over 4 Hours	 Time from referral acceptance to delivery of initial assessment Requested by the Referrer Measurement for the Commissioner to monitor to protect the RR service	 98% min. Tier 1 % Tier 2 % Min./Max. time requested
C.	Length of time in the service	Time (in calendar days) from receipt of initial assessment to discharge: 1-3 days 4-7 days 8 days – 6 weeks >6 weeks	 40%/month 60%/month Up to 25% 0%
D.	Number of individuals supported by Night Service	Numbers of individuals receiving at least one care visit or night sit	Number recorded
E.	Number of visits	Total number of face-to-face visits	4550 min./per annum

5. APPLICABLE QUALITY REQUIREMENTS AND CQUIN GOALS

This section of the contract is not included here but can be found in schedule 4 of the contract.

6. LOCATION OF SRVICE PROVIDER PREMISES

Rapid Response care services whilst linked to locality populations or to groups of LMATs, will work flexibly across LMATs depending on the operational efficiency of the service.

Bases/facilities, will be safe, accessible, equipped with functional IT systems and within a location that supports a timely unplanned response to referrals and enhances the ability to work collaboratively with other Service Providers as well as reduce the need to travel (Ref. Green Travel Plan) e.g. general practice, mental health teams and social care. The environment in which staff work i.e. patients' homes will be risk assessed at first contact.

Annex 1 – Continual Service Improvement/Innovation Plan

Continual Service Improvement/Innovation Plan

The service will be required to undertake systematic reviews and analysis of the quality of care provided, through a range of methods, including patient and carer feedback, patient involvement in service improvement, review of clinical records, clinical audit and governance arrangements.
Service Providers will have defined mechanisms to:

- Ensure PPI (or similar) involvement in service development and quality assurance.
- Respond to formal complaints within the required timescales and patient advocacy services' concerns including early resolution where appropriate, evidence of learning and service improvement
- Create formal links with patient and carer organisations

Potential areas for service development in negotiation with locality commissioners

Future service specification and developments will be led by NHS locality commissioners. They have identified the following potential areas for development.

1. Review of Single point of access and coordination - could be expanded to ensure whole system coordination
2. Direct access into the service for patients and carers and use of IT referral systems
3. Develop mobile night care service/support alongside OOH nursing. Subject to a review of the demand for 24-hour cover.
4. Develop consistent quality of night sitting support, possibly through specific contractual framework with external Service Provider(s)
5. Distinction between Rapid Response and Social Care Reablement needs to be clarified further (pathway & access)
6. Review service capacity in terms of volumes and skill mix
7. Development of provision for people with mental health and learning disability diagnosis including specialist training and in collaboration with specialist health care professionals.

The Service Provider will meet with the commissioners on an agreed basis through scheduled formal contract meetings to discuss Service Provider performance. The Service Provider will submit a report in advance of the meeting addressing the key performance indicators described in section 4. These meetings will identify areas for continuous Improvement and detail improved productivity requirements.

Part 1e– Single Point of Coordination Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

1 OVERVIEW OF INDIVIDUAL SERVICE

The service aims to provide a multi-professional single point of coordination for health and social care professionals which allows access to a range of community services via one contact number – building upon the social care single point of coordination. The single point of coordination will provide coordination and care navigation to ensure the patient gets to the right person, to the right place, at the right time (as outlined in our BCF vision). The aim will be to reduce hospital admissions and expedite discharges by making it easy for health professionals and primary care to access community services (both health and social care) and improve the integration of Health and Social Care within the Care Direct Plus Community Support Team, Primary Care and Complex Care Teams.

2 AIMS AND OUTCOMES

a) Reduced hospital admissions by making it easy for health professionals and primary care to access community services (both health and social care).
b) Improved integration of Health and Social Care within Care Direct Plus (Community Support Team), Primary Care and Complex Care Team by employment of nursing staff, taking intermediate care referrals.
c) The reorganisation of Care Direct Plus into local Community Support Teams has developed staff knowledge and awareness of local resources and professionals within their area.
d) Improved joint working, problem solving, and case resolution has reduced the duplication of referrals to separate departments.
e) Initial MDT triaging of cases at point of referral allows identification of risk, urgency and most appropriate service.
f) Efficient use of clinical hours by the filtering of low risk cases which are managed at point of referral. Reducing waiting lists and inappropriate referrals out to both the Health and Social Care Teams in the Complex Care Teams.
g) Improved feedback to GPs on interventions for each individual case that come through the Community Support Teams.
h) Through the assessment and co-ordination of services within the Community Support Team, vulnerable cases can be highlighted to avoid or prevent potential crisis.
i) Timely responses to assist professionals in need of assistance or advice, on equipment or other community services both voluntary and statutory.
j) Co-location with Rapid Response and Social Care Reablement teams and managers enhances working relationships and assists in the co-ordination of meeting individual's needs and preventing hospital admission or long stay residential care.
k) Improved access to alternative resources in both the statutory and voluntary sector allows Care Direct Plus staff to assist an individual on their pathway through the care system.
l) Enhanced the co-ordination and flow of the health and social care pathway has allowed subsequent efficiencies to release clinical time to be redirected into direct patient contact.

3 THE ARRANGEMENTS

Devon County Council is the lead commissioner for this scheme.

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS DEVON (INTEGRATED CARE BOARD) hereby delegate the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.
The Council shall procure that the Services are provided and shall be accountable to the NHS Devon (Integrated Care Board) for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Devon County Council is the lead commissioner for this scheme.

Contracting Arrangements

The costs of this scheme are staff costs of both health and social care staff. The health staff are employed by Royal Devon and Exeter NHS Foundation Trust and Torbay and South Devon NHS Foundation Trust.

Access

The target demographic for this service is

- Adults
- Older People
- People who are acutely or terminally ill
- People with long term conditions
- People with mental health problems
- People with dementia or cognitive impairment
- People with learning disabilities
- People with physical disabilities

The Care Act requirements will be met in assessing the individuals eligibly for the scheme.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) is the Host Partner for the Pool from which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Better Care outcomes report monitors the Better Care Fund Indicators for the Devon County Council area and provides an overview of the whole system and includes the following sections:

d) Overview and indicator summary with trends and benchmarking.
e) A dashboard showing current monthly in-year performance
f) Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local authority district within Devon, by NHS Devon (Integrated Care Board) and localities and by inequality characteristics such as deprivation. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.

Supplementary monthly dashboards are provided for localities to allow a detailed consideration at the three locality A&E Boards, based around each of the local health economies (Eastern, Northern, Western and Southern) within the Devon STP which are made up of senior leaders of the health and social care system which are made up of senior leaders of the health and social care system. These Boards collaboratively identify gaps in service, plan, commission and coordinate activities aimed at improving system resilience and patient flow and consider the best use of available resources.

NON FINANCIAL RESOURCES

There are no non-financial resources in relation to this scheme.

STAFF

Staff on this scheme will continue to be employed by the same organisation. There are no TUPE considerations.

ASSURANCE AND MONITORING

There are a number of Key Performance Indicators to assess the impact of this scheme.

1. Integrated referral and allocation processes for health and social care services
2. Delivery of responsive holistic assessment and intervention by health and social care team.
3. Improved outcomes for service users.
4. Cost effective outcomes of care with cost benefits to wider care system
5. Simplification and greater efficiency of process and systems.
6. Engagement and closer working relationships with primary care.
7. Greater integrated multidisciplinary working within health and social care team.
8. Joint management and information / financial reporting process for health and social care across Torbay and Southern Devon.

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD		Solveig.sansom@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

- All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to this scheme are outlined in schedule 3.

REGULATORY REQUIREMENTS

This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of the s75 agreement for the Better Care Fund.

DURATION AND EXIT STRATEGY

As per clause 21 of the main s75 agreement for the Better Care Fund.

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

f. None

Part 1f– Step –Up-Step-Down Care Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1.1 Step-Up Step- Down Care services include two elements:

1. To provide limited support in a care home environment support for individuals who are unable to stay at home and require extra support to avoid hospital admission or require short-term residential care placements following discharge to enable a period of recovery prior to returning home.
2. To provide additional support in a person's home to prevent admission

1.2 Recuperative Care is the provision of time limited support in a care home environment where people require 24-hour oversight, but their needs are straightforward and hospital care is not required. Urgent Care Beds are purchased beds in the care system outside of acute care to support patients with the recuperative care supporting them.

1.3 The service is designed to provide active rehabilitation in a person's own home for a focused period of time which may include following hospital discharge to address recent loss of function or confidence. The service also responds to or averts a medical crisis which may otherwise lead to an unscheduled hospital admission. This is an advanced community service that complements the existing Complex Care Team.

2 AIMS AND OUTCOMES

a) There continues to be an overall increase in referrals, significantly in non-urgent cases
b) Admissions to hospital have been reported to have been avoided in 24.6% in all referrals seen
c) Only 6.2% of all referrals have resulted in a placement
d) Better use of community-based resources
e) Freeing up hospital bed capacity and improved patient flow through the whole system
f) More comfortable environment for 'recuperation' than a hospital
g) Reduced length of stay in hospital for conditions not requiring acute or community stay
h) Keeps patient (usually) closer to home and support networks
i) Promotes flexibility and innovative use of funding to best meet individual patients needs
j) Promotes personalisation

3 THE ARRANGEMENTS

The scheme is commissioned under a lead commissioner arrangement.

Home based intermediate care is provided through a variation order to the contract between Torbay and South Devon NHS Foundation Trust and Royal Devon and Exeter NHS Foundation Trust and independent providers

TSDT has an "any qualified provider" agreement with care homes for placements on a spot purchase agreement on top of the main service which is home based intermediate care. There is a similar arrangement in the Northern, Eastern and Western Devon footprint.

Recuperative care is provided through Care home placements which are spot-purchased from both private and Council care homes.

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board) hereby delegate the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.

The Council shall procure that the Services are provided and shall be accountable to the NHS Devon (Integrated Care Board) for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

NHS Devon (Integrated Care Board) is the commissioner.

Contracting Arrangements
The costs of this scheme are staff costs of both health and social care staff. The health staff are employed by the community and acute Trusts.
Recuperative beds are spot purchased rather than purchased under contract.

Access

The target demographic for this service is

Recuperative Care: over 65s, where health recovery needs are straightforward; hospital care is not required; return home with support is not cost-effective; and the individual's destination is home (e.g. recovery from orthopaedic surgery; non-weight bearing fracture recovery).

Bed based intermediate care: over 18 population but focuses particularly on over 85s who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.

The Care Act requirements will be met in assessing the individuals eligibly for the scheme.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5 of the Agreement.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Better Care outcomes report monitors the Better Care Fund Indicators for the Devon County Council area and provides an overview of the whole system and includes the following sections:

- Overview and indicator summary with trends and benchmarking.
- A dashboard showing current monthly in-year performance
- Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local authority district within Devon, by NHS Devon (Integrated Care Board) and localities and by inequality characteristics such as deprivation. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.

Supplementary monthly dashboards are provided for localities to allow a detailed consideration at the four locality A&E Boards, based around each of the local health economies (East, North, West and South) within the Devon STP which are made up of senior leaders of the health and social care system. These Boards collaboratively identify gaps in service, plan, commission and coordinate activities aimed at improving system resilience and patient flow and consider the best use of available resources.

NON-FINANCIAL RESOURCES

There are no non-financial resources in relation to this scheme.

STAFF

Staff on this scheme will continue to be employed by the same organisation. There are no TUPE considerations.

ASSURANCE AND MONITORING

There are a number of Key Performance Indicators to assess the impact of this scheme.

<u>Intermediate Care Referrals:</u>
Number of urgent IC referrals received
Number of non-urgent IC referrals received
Total number of IC referrals received
Total number of referrals now “Closed”, with > 6 weeks duration
Total number of referrals still “Open”, with > 4 weeks duration (i.e., no Discharge Date)
Total number of referrals still “Open”, with > 6 weeks duration (i.e., no Discharge Date)

<u>IC Placements</u>

Total New Placements
% of all referrals resulting in new IC placement

Placement Length of Stay (Completed Placements; Contract Start to Contract End)
Number of Closed Placements with Length of Stay > 6 weeks
Number of Open Placements with Length of Stay currently > 6 weeks
Average Bed Days for completed placements
Number of placements ending in the month

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD		Solveig.wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca,harty1@nhs.net

INTERNAL APPROVALS

- All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to this scheme are set out in schedule 3 to the s75 agreement for the Better Care Fund.

REGULATORY REQUIREMENTS

This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of the s75 agreement for the Better Care Fund.

DURATION AND EXIT STRATEGY

As per clause 21 of the main s75 agreement for the Better Care Fund

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

1. Population Needs

2. National/local context and evidence base

Intermediate care can be defined as a range of integrated services provided for a limited period of time to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. The emphasis of intermediate care is on active enablement.

Some evidence that the intermediate care function is effective has begun to emerge from a number of major research programmes, although conclusions are mixed. It has been shown to reduce the use of acute hospital admissions in some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life. *(DH: Intermediate Care – Halfway Home, 2009)*

Evidence cited in the first review of intermediate care (DH, 2002) indicates some limited but generally positive evidence for the benefits of community rehabilitation teams, including specialist services for people recovering from stroke. The authors suggest that such teams should be considered as one component of a comprehensive intermediate care service, of which hospital at home forms another component.
(2)
(3) Recommendations for local authorities from the evidence available from the Partnerships for Older People Projects included a number that were important for intermediate care services *(Robertson et al, 2008):*

- Invest in the full range of interventions to promote older people's independence and well-being, including practical help, advice, activities, housing choices and transport;
- Develop systems for identifying people who are likely to need information or services (case finding) and facilitate a package of services, based on assessed need (case coordination);
- Develop rapid responses to deal with crises in people's own homes to avoid emergency admission to hospital or residential care, linked to intermediate care services;
- Facilitate timely discharge from hospital, including step-down beds in settings other than acute hospitals;
- Develop joint health and social care rapid and flexible response services, targeted at older people with mental health problems;
- Promote intermediate care rapid response services in-reaching into care homes; and
- Scrutinise and review the core spend and make investment decisions for the longer term (up to 5-10 years), based on evidence of what is effective in producing savings and improving quality of life.

A large study of community and intermediate care services for older people *(Nancarrow et al, 2008)* investigated the impact of different staffing configurations on outcomes for patients, service use and costs and staff satisfaction. Better patient outcomes (on standardised measures of dependency and daily living abilities) were found to be associated with teams that included a higher proportion of support workers and where the patients saw fewer different types of practitioners. Having greater access to technology and equipment was associated with a reduced length of stay in the service.

A national audit of intermediate care services was undertaken in August 2014 to establish a robust national evidence base as to the efficacy of intermediate care services. Results of analysis expected by end of 2014.

2. Scope

2.1 Aims and objectives of service

- The aim of the service is to maintain people at home when safe and appropriate to do so and thereby reducing admissions to hospital, reducing inpatient lengths of stay and reducing readmissions.

- To adopt a client centred approach in which the individual takes on an active role to achieve maximum independence and quality of life, with the Intermediate Care team supporting the individual to set achievable objectives to help them attain their long term goals.

g.

- To provide a zone-led intermediate care service and medical input to enable the client to remain in their own home, wherever possible; where this is not possible in a short-term nursing or residential home placement with regular therapeutic & nursing interventions.

2.2 Service description/care pathway

Intermediate care teams within Devon provide time limited multi-disciplinary rehabilitation to service users in their own homes and/or in short-term crisis intermediate care nursing or residential home placements. The teams comprise physiotherapy, occupational therapy and intermediate care support workers, with a central co-ordination function from within the locality-based teams. At present, the Intermediate Care teams in Devon do not include nursing, social care and older person's mental health.

- Intermediate Care services are for people who would otherwise have unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care or long-term residential care.
- They are provided on the basis of a comprehensive assessment resulting in a structured care plan involving active therapy and treatment.
- There is a planned outcome of maximising independence and enabling users to remain or resume living at home
- Intermediate Care services are time limited; ideally up to 6 weeks duration and comprise multi-disciplinary service provision. In Devon this is current physiotherapy and occupational therapy with other professional interventions coming from within existing health and social care services.
- Domiciliary care packages will be arranged, or existing packages of care supplemented, including the use of Social Care re-ablement, where appropriate, to support the individual to remain at home during the Intermediate Care episode. These services will be accessed via Care Direct Plus or the locality-based access points Where a person cannot be maintained at home they will, by agreement, be admitted to a nursing or residential home placement whilst their initial medical crisis is stabilised and until they are able to return home to continue their episode on Intermediate Care. A length of stay in an IC placement will, in the majority of cases, be 10 days or less; though length of stay might extend where it is assessed by the team as being essential to the overall treatment aims of that individual. In these cases, close review and monitoring will be undertaken by the team. These placements will be non-chargeable to the service user whilst they are to support the aims of Intermediate Care.
- Regular reviews of all those in receipt of new or supplementary services or placements will be undertaken & a reassessment of long-term needs will take place at the end of the Intermediate Care episode. The outcome of this assessment will be clearly communicated to the service user & they will be made fully aware that ongoing services may be chargeable subject to financial assessment.
- The Intermediate Care team will ensure that effective communication pathways are in place between hospital and community-based practitioners, clients and carers in order to provide quality and continuity of care

Devon Hours of Service & referral procedure

Services are provided:

- Individual zone-led services –

Response Times *within normal working hours*:
Urgent or crisis referrals

- Telephone call to the service user (or appropriate proxy) within 1 hour of receipt of referral
- Visit within 4 hours of receipt of referral to assess the situation and develop action plan to stabilise the immediate crisis
- Where referrals come in after 13:00 hrs Mon-Fri and/or when capacity pressures impact on ability to visit within 4 hours; the team will seek to stabilise the immediate crisis situation in

liaison with the GP (and referrer where this is not the GP), the patient and where appropriate the patient's family and/or carers within 4 hours with an assessment visit the following day. This could be by admission to an Intermediate Care nursing or residential home placement (or provision of additional community support such as Rapid Response via CDP)

-

The team will always contact the GP (and referrer where this is not the GP) to inform them of the course of action taken by the team & to ensure that a resolution can be reached for the service user in terms of stabilisation of the immediate crisis.

Non-urgent referrals

- Telephone call to the service user (or appropriate proxy) within 1 working day of receipt of referral to inform them a referral has been received
- Visit within 5 working days of receipt of referral to assess the situation and develop treatment and intervention plan with the service user.

Where capacity pressures impact on the ability to visit within 5 working days this should be communicated to the referrer and service user within 1 working day of receipt of referral and an anticipated alternative response time given.

Response times out of hours

Where a referral is made to an Intermediate care team outside of normal hours the time of referral will count *as the time the referral is received by the appropriate team on the next working day* and normal response times will then apply from that point.

Out of these hours normal out of hours services must be utilised; Emergency Duty Team (EDT); Devon Docs; Out of Hours nursing etc. Where appropriate a referral can be made by any of these services to Intermediate Care for a response on the next working day (for urgent referrals). Intermediate Care placements can also be made by Devon Docs with a referral to the appropriate Zone Team by fax for response on the next working day

Referrals are accepted from:

- GPs
- Devon Doctors
- Care Direct Plus
- Staff on A&E, MAU or EAU
- Rapid Response
- Health & Social Care Community staff including social care (Complex Care Team), community nurses and matrons
- SWAST
- Care Homes

Intermediate Care referrals within normal working hours will be received via CDP, . Referrals can also be received directly into the zone teams. Referrals will be assessed as appropriate for Intermediate Care, with support of the Intermediate Care team/Therapy Managers as required.

Urgent referrals may be made by telephone; with supplementary information provided via fax, e-mail or by telephone, fax, e-mail or written referral for a non-urgent response.

Medical responsibility remains with the patient's own GP throughout their episode of Intermediate Care except where a patient is placed in a short-term Intermediate Care placement outside of the usual area of residence and therefore out of the catchment area of the GP, agreement must be sought for a local GP to treat that patient as a temporary resident at the point the referral is made.

Any other professional involved in the clients' care previously or remain so on an on-going basis must agree to maintain their involvement and provide professional guidance and support as required.

2.3 Population covered

All patients registered with a Teignbridge, South Hams or West Devon GP practice. Where patients with a Devon GP live outside the boundary of Devon County Council for provision of social care services; assessment for provision of ongoing care needs will be accessed via Torbay Zone Teams.

2.4 Any acceptance and exclusion criteria

1. Individuals over the age of 18 years of age with a South Devon, South Hams or West Devon GP who might fall into one of the following categories:

-

a) Medical condition assessed as manageable in a community setting by the GP (or medical practitioner) in liaison with zone intermediate care teams and who would otherwise be at risk of hospital admission.

b) Would benefit from the input of a multi-professional team to meet health and/or social care needs in the short term.

c) Experiencing an exacerbation of any chronic condition requiring short-term health and/or social care input.

d) Inability to cope at home following injury or illness and requiring rehabilitation.

e) Sudden reduction in mobility perhaps following a fall, or illness or exacerbation of an existing condition.

Clients, carers and families must give informed consent to treatment by the intermediate care team and for being cared for in the community.

If clients have more specialist needs that cannot be met by the Intermediate Care team, they will access the services of other specialist staff; the specialist staff must continue to support the client to their previous extent or more so if required by the multi-professional team.

Exclusions to the Service

3. The service must not be used for clients who require acute hospital admission that cannot be safely cared for in the community except where patient has mental capacity and declined hospital admission

4. Clients who present with symptoms of new onset stroke.

5. Maternity related conditions

6. If the team's caseload and use of resources are beyond their manageable capacity. This information will be discussed with the referrer and advice given as to alternative options.

2.5 Interdependencies with other services

- Community Services
- Care Direct Plus
- Social Care (Complex Care Teams)
- Community Nursing
- Specialist Services:
- Early Supported Discharge (ESD) stroke services
- Community Neuro Services
- Older Persons Mental Health Team (OPMH)

Out of hours services:
Emergency Duty Team (EDT); provided by Devon County Council
Rapid Response Team; provided by Devon County Council
Devon Doctors

Acute Care:
South Devon Healthcare Foundation NHS Trust; A&E/EAU, Rapid Access Clinics (RAC) and wards
Derriford Hospital
Royal Devon University Healthcare NHS Foundation Trust
Primary Care

7. Applicable Service Standards

Applicable national standards e.g. NICE, Royal College

Department of Health, *NSF for Older People, supporting implementation. Intermediate Care: moving forward*, DH, June 2002.

Department of Health, *Intermediate Care – Halfway Home, Updated Guidance for the NHS and Local Authorities*, DH, July 2009

NHS Outcomes Framework National Indicator 125. *'Achieving independence for older people through rehabilitation/ intermediate care'*

8. Applicable local standards

Nursing, physiotherapy, occupational therapy and social work professionals work within the national standards and to the professional codes of ethics and conduct for their own profession as monitored by the Health Professions Council; Royal College of Nursing and Social Care Council

9. Key Service Outcomes

(I) In order to successfully measure the effectiveness of the Intermediate care service a number of measures are required, these are both outcome and process measures. The following data will be collected.

(J)

(K) Process & activity measures to be collated on the Intermediate Care (IC) Dashboard:

- Numbers of urgent & non-urgent referrals
- Sources of referral
- Average length of stay in placement
- No of bed days purchased
- Cost of bed days
- Average duration on caseload
- Average cost of intermediate care episode

There is an expectation in the next 12-18 months that the IC dashboard will capture:

- Numbers of Intermediate Care patients attending &/or being admitted to acute care
  - During the IC episode
  - Within 7/14/28 days of end of IC episode
- Numbers of patients referred to IC by the acute Trust & subsequently readmitted within 7/14/28 days

Service outcomes

- Documented achievement of individual goals *(in next 12-18 months)* ***and/or***
- Change in functional capacity before and after intervention as recorded by Barthel index
- Patient Experience

The following measures cannot be routinely measured but could be subject to periodic audit:

- Case mix of referrals
- Timeliness of responses
- Numbers of admissions to acute care prevented

There is an expectation that the intermediate care service will have a wider impact, contributing to a reduction in:

- standardised admission rate per 1000 for >65s to acute care
- average LOS or cumulative LOS in>65s in acute care
- average LOS or cumulative LOS >65's in community hospital
- long term Nursing Home and Residential Home placements

These outcomes will be measured and monitored by the appropriate Clinical Pathway Groups: The Community Services Transformation Group and the Older People Clinical Pathway Group.

Part 1g Frailty and Community Care Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 To redesign community-based services in order to manage more people in a proactive way to prevent hospital admission, reduce delayed discharges and reduce admissions to long term care. This includes the enhancement of the current primary care service to provide a single multi-disciplinary assessment service. The aim is to shift from a 'reactive' care model to a 'proactive' care model, focusing on enabling and empowering citizens, carers, and communities to support themselves and provide varying care settings dependent upon the individual's needs.

1.2 Devon CCC and the NHS implemented Complex Care Teams in 2008 across Devon in alignment with primary GP practices and their patient populations. These are multidisciplinary teams (that include social workers, community matrons, community nurses, occupational therapists, voluntary sector and community care workers) who are co-located and provide an integrated and personal approach to care. They are managed by a jointly funded post.

1.3 There are three key functions of these teams - to support people stay well and independent as possible (often with case management approach) - to support people rehab and recover - to respond in crisis

1.4 This overarching scheme includes a range of initiatives that that builds upon the CCT infrastructure: e.g. care home team roll out, community mentoring, district nurse support to residential homes, reducing falls and preventing fractures and connected communities and supportive volunteering.

1.5 This work currently provides case management/care coordination for the vulnerable and frail population as identified by the risk stratification done via the GP DES. Further population segmentation is required in the future as outlined in the case for change section and action plan to further target our approach.

1.6 The model of care involves greater collaboration between citizens, carers, voluntary sector, health and social care in community and acute settings to support older persons. This includes agree goals with patients, carers, access to individual health record and sharing of data. We are planning to enhance this in our action plan.

1.7 The South Devon service model will link an enhanced single point of coordination primarily developed to reduce reliance on the statutory sector to local Multidisciplinary Teams which will be enhanced by support from primary care, the voluntary sector, mental health and hospital consultants to deliver more preventative care and support within the community. This will link through to the enhanced virtual wards and the development of one GP practice per care home. This scheme will also focus clinical interventions earlier in the day, more pro-active care for patients most at risk of admissions, improve and enhance quality of medical care for care home patients and improve discharge planning for patients in acute and community hospitals.

1.8 The identification of individuals that would benefit from care co-ordination or case management through risk stratification will ensure identification of those individuals who require a care plan and increase supported to manage their needs.

1.9 Other additional work that is in progress that supports this:

- Working with care homes to ask them to notify the GP when a 999 call has been made, also linking with the ambulance service to try to prevent unnecessary conveyances to hospital as part of their "Right Care, Right Time, Right Place" strategy
- Changing working arrangements in practices to enable visits to be made earlier in the day in order to try to prevent overnight admissions occurring simply due to the time of day
- Care Homes – working towards one care home, one practice; extending the medication review pilot already underway; mentoring of care home staff by GPs and annual reviews of care home residents.

2 AIMS AND OUTCOMES

a) Reduction in community bed-based care and bed days.
b) Increased use of Crisis Response Team/domiciliary care/social care/Intensive Home Support Services
c) Reduction in total number of admissions to acute wards.
d) Less patients feeling a loss of independence in acute trust by giving autonomy for quick reablement in their own home.
e) Fewer resulting in overnight stays
f) Fewer emergency hospital admissions from care homes
g) An increase in the number of high-risk patients who have a care plan
h) Fewer 999 calls from care homes
i) Improved experience of patients and carers as a result of proactive case management and link to a case manager
j) Reduction in placements into long term care
k) Reduction in delayed transfer of care
l) Increase in the number of patients offered rehabilitation following discharge from hospital
m) Reduction in the number of readmissions to hospital within 91 days
n) An increase in the number of people with a dementia diagnosis

3 THE ARRANGEMENTS

Complex care teams
Commissioned by DCC and NHS Devon (Integrated Care Board)
In Eastern and Northern are jointly delivered by the Royal Devon University Healthcare NHS Foundation Trust and DCC.
In Southern Devon and Western these teams are delivered by Torbay & South Devon NHS FT, LiveWell and DCC.

Other schemes Related schemes are commissioned by DCC and the NHS Devon (Integrated Care Board) and provided by a wide range of providers.

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board) hereby delegate the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.
The Council shall procure that the Services are provided and shall be accountable NHS Devon (Integrated Care Board) for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Each element of this scheme has a lead commissioner: either Devon County Council, or NHS Devon (Integrated Care Board).

Contracting Arrangements
The costs of this scheme are staff costs of both health and social care staff. The health staff are employed by the acute and community Trusts.

Access

The target demographic for this service is

- Older People
- People who are acutely or terminally ill
- People with long term conditions
- People with mental health problems
- People with dementia or cognitive impairment
- People with learning disabilities
- People with physical disabilities

The Care Act requirements will be met in assessing the individuals eligibly for the scheme.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Better Care outcomes report monitors the Better Care Fund Indicators for the Devon County Council area and provides an overview of the whole system and includes the following sections:

g) Overview and indicator summary with trends and benchmarking.
h) A dashboard showing current monthly in-year performance
i) Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local authority district within Devon, by NHS Devon (Integrated Care Board) and localities and by inequality characteristics such as deprivation. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.

Supplementary monthly dashboards are provided for localities to allow a detailed consideration at the four locality A&E Boards, based around each of the local health economies (Eastern, Northern, Western and Southern) within the Devon STP which are made up of senior leaders of the health and social care system. These Boards collaboratively identify gaps in service, plan, commission and coordinate activities aimed at improving system resilience and patient flow and consider the best use of available resources.

NON FINANCIAL RESOURCES

There are no non-financial resources in relation to this scheme.

STAFF

Staff on this scheme will continue to be employed by the same organisation. There are no TUPE considerations.

ASSURANCE AND MONITORING

There are a number of Key Performance Indicators to assess the impact of this scheme.

Suggested metrics	Source
Prevention measures	**Patient record**
Flu vaccination uptake - Target % achieved	% of cohort receiving a vaccination
Multi -factorial falls assessments completed - Target % achieved	% of cohort receiving falls assessment
Safe at Home/Home safety assessments	% cohort offered and received an assessment
Carers health and wellbeing checks undertaken	% cohort with carer offered and received a HWB check
Mortality measure (linked to excess winter deaths)	Deaths of service users possible and could look at place of death
Quantitative measures	**Hospital and social care data**
Permanent admission to care homes (national indicator)	Social care data and would need % of cohort from patient record to compare as a rate
Temporary admissions to care homes (local indicator)	Recuperative care placements
Emergency admissions	NHS number
Emergency admissions for adult social care (ASC) conditions	NHS number
A&E attendances	NHS number
Number of falls	NHS number
Referrals for elective admissions	NHS number
Primary care contacts	Patient records
Process measures	
Numbers through service	Service records
Numbers with care plan	Patient & service records
Referrals to other services (RAC, interface geriatrician)	Patient and service records
Referrals to VCS support (e.g. befriending)	Patient and service records
Referrals to lifestyle support (e.g. strength and balance, falls clinic, stop smoking support)	Patient and service records
Qualitative measures	
Patient experience (led by Healthwatch) To include loneliness measure/outcomes star?	Qualitative questions to be agreed
% ASC users who have as much social contact as they would like	Sample survey data available but not at individual level
% carers who have as much contact as they would like	

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD		Solveig.wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to this scheme are set out in schedule 3.

REGULATORY REQUIREMENTS

This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of this agreement.

DURATION AND EXIT STRATEGY

As per clause 21 of the main agreement

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

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OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

Held within contracts with providers

Part 1h Social Care Reablement Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the s75 Agreement for the 2023-24 Better Care Fund.

1 OVERVIEW OF INDIVIDUAL SERVICE

Social Care Reablement is a service whose primary aim is to minimise the effect of disability or deterioration for people with established health conditions and/or care and support needs

Social Care Reablement is one of a range of Tertiary Prevention Services delivered or commissioned by Devon County Council.

The Social Care Reablement is a Care Quality Commission regulated service, delivering time-limited support to eligible people in their own homes which enable them to achieve personalised outcomes, maximise their independence and decrease reliance on social care and health care funding, saving costs of care.

The focus of the Social Care Reablement Service is to primarily address outcomes relating to personal care and activities of daily living.

The Service works closely with Health Community Services (e.g. Rehabilitation Teams, Intermediate Care teams) to ensure a complementary and integrated approach to supporting individuals to maximise independence within their own homes.

Social Care Reablement provides support for individuals 7 days a week between the hours of 7am and 10pm.

70% of people who access Social Care Reablement remain independent and require no domiciliary care support or residential/nursing care 91 days later. With increased capacity, higher numbers of individuals will benefit.

2 AIMS AND OUTCOMES

The Key Outcomes are;

1. Reduce the numbers of people requiring personal care support and the numbers of hours of support commissioned *(Demand for domiciliary care will be reduced, saving or minimising costs for both the individual and Council/NHS)*
2. Reduce the numbers of people with intensive personal care packages (defined as costs in excess of £200p.w.) or entering a care home on a long stay basis *(Demand for intensive personal care packages and care home placements will be reduced, saving or minimising costs for both the individual and Council/NHS)*
3. Reduce unplanned admissions into hospital or care home *(working to prevent falls/accidents within the home and work alongside NHS professions to improve self-care for people with complex long term conditions reducing costs for the NHS)*
4. Reduce rates of readmission into hospital *(by supporting hospital discharge arrangements and working in partnership with NHS professionals improving people's rehabilitation and recovery and preventing readmissions reducing costs for NHS)*
5. Improved delayed discharge rates for individuals awaiting personal care packages *(timely service delivery and joint working with NHS professionals to secure earliest safe discharge releasing hospital bed capacity)*

6. Reinforce and enhance carers ability to continue for longer in their caring roles *(providing support to carers that gives them greater resilience and confidence to continue in caring role reducing demand on Council/NHS services and funding)*

Patient and Service User experiences: The current level of complements received by the service is extremely high with excellent feedback from both the individuals themselves and their families. This is further validated by our internal Quality Assurance inspections where individuals in receipt of the service are interviewed face to face. The individuals report high quality support, well trained and empathetic staff and high levels of satisfaction with the outcomes they are able to achieve.

3 THE ARRANGEMENTS

Devon County Council delivers the Social Care Reablement Service. Devon County Council is the lead commissioner for the service.

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board) hereby delegate the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

Devon County Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.
Devon County Council shall procure that the Services are provided and shall be accountable to the NHS Devon (Integrated Care Board) for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Devon County Council is the lead commissioner for this scheme, oversees the Contracting Arrangements and monitors contract performance and quality.

Access

The target demographic for this service is

- Older People
- People who are acutely or terminally ill
- People with long term conditions
- People with mental health problems
- People with dementia or cognitive impairment
- People with learning disabilities
- People with physical disabilities

The Care Act requirements will be met in assessing the individuals eligibly for the scheme.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

The Better Care outcomes report monitors the Better Care Fund Indicators for the Devon County Council area and provides an overview of the whole system and includes the following sections:

j) Overview and indicator summary with trends and benchmarking.
k) A dashboard showing current monthly in-year performance
l) Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local authority district within Devon, by NHS Devon (Integrated Care Board) and localities and by inequality characteristics such as deprivation. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.

Supplementary monthly dashboards are provided for localities to allow a detailed consideration at the four locality A&E Boards, based around each of the local health economies (Eastern, Northern, Western and Southern) within the Devon STP which are made up of senior leaders of the health and social care system. These Boards collaboratively identify gaps in service, plan, and commission and coordinate activities aimed at improving system resilience and patient flow and consider the best use of available resources.

NON-FINANCIAL RESOURCES

There are no non-financial resources in relation to this scheme.

STAFF

Staff on this scheme will continue to be employed by the same organisation. There are no TUPE considerations.

ASSURANCE AND MONITORING

There are a number of Key Performance Indicators to assess the impact of this scheme.

Outcome	Key Performance Indicator
Reduce the numbers of people requiring personal care support and the numbers of hours of support commissioned	Numbers people on discharge and 12 months following discharge from SCR requiring; • no personal care or support , or • a reduction or in personal care or support • an increase in personal care or support
Reduce the numbers of people with intensive personal care packages or entering a care home on a long stay basis	Numbers people on discharge and 12 months following discharge from SCR requiring • intensive care and support packages (more than £200p.w.) • long stay care home placement
Reduce unplanned admissions into hospital or care home	Numbers people in 12 months following discharge from SCR admitted to hospital or Care home on unplanned basis
Reduce rates of readmission into hospital	Numbers of people receiving SCR readmitted in to hospital with 28 days.
Improved delayed discharge rates for individuals awaiting personal care packages	Time from referral* to SCR and discharge from hospital *referral when clinically ready for discharge
Reinforce and enhance carers ability to continue for longer in their caring roles	% of carers who feel their ability to continue in the caring role has been enhanced following discharge from SCR

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD	01392 383000	Solveig.wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Rebecca Harty	County Hall, Topsham Road, Exeter EX2 4QD	01803 396357	Rebecca.harty1@nhs.net

INTERNAL APPROVALS

- All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board) standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to this scheme are the same as the pooled fund schemes.

REGULATORY REQUIREMENTS

This scheme compiles with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of this agreement.

DURATION AND EXIT STRATEGY

As per clause 21 of the main agreement

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

1. Purpose and general description

1.1 This Specification sets out the commissioning requirements of Devon Adult Social Care for a social care reablement service and will form a part of the contractual framework with commissioners.

The service provides a time limited personal care service within a reablement ethos and specific goal plan that describes personal short term reablement goals.

The service contributes to the assessment of an individual's needs and the development of their long term support plan. Social care reablement is therefore offered ***before*** any decision on eligibility for longer term services either in the community or in a residential care home is made, before any resource allocation is made and before any longer term services are arranged.

Consequently, all individuals meeting the entry criteria for the service will be required to undergo a period of reablement before any offer of long term personal care support is made.

The service will maximise the individual's self-reliance and self-care skills in the following areas:

- Personal care
- Mobility
- Domestic routines e.g. meal preparation
- Self -Medication
- Self- management of their long-term condition or other health needs
- Low level psychological, emotional and personal support
- Use of community equipment (including telecare)
- Self-management and financial administration
- Social networks

The service is delivered by way of a goal plan agreed with the individual and their carer that is designed to achieve individualised reablement outcomes. Depending on the complexity of the case, goal plans may be the responsibility of the service or a shared responsibility with a suitably qualified health or social care professional. The social care reablement service will be held to account for the delivery of the outcome(s) contained within the goal plan.

Ultimately the service is to be provided to all adults 18 years and over with needs that place them at risk of loss of independence and the individual will be supported to fully maximise their potential for self-care and long-term independence and to enable them to achieve independence in an environment of their choice for as long as possible

The service will be required to respond to individuals at risk irrespective of their location who are at home, being discharged from hospital/rapid response or other intermediate care service.

In the first phase it will be targeted on older people including older people with mental health difficulties and younger people including those with a physical disability or a long term condition including early onset dementia who are approaching Adult Social Care for the first time for personal care support.

But in later phases the social care reablement service will be offered to existing recipients of personal care services who experience a significant and unplanned increase in their personal care needs; to those with complex health and social care needs and to other adult client groups.

Consequently, the service will be delivered in phases of incremental development. It is expected that each phase of development will be rigorously evaluated prior to the roll out of further phases of development

The service will be delivered to individuals meeting the entry criteria in the following phases.

1. Individuals (not including adults with learning disability or functional mental health difficulty) with non-complex needs who require personal care programmes addressing risks around personal care which may be associated with activities of daily living, domestic routines and mobility. Where necessary and in conjunction with NHS professional's health related risks will also be addressed.
2. Individuals (not including adults with learning disability or functional mental health difficulty) with complex needs who require personal care programmes as part of an integrated package of care and treatment overseen by a member of the complex care team or an NHS professional member of the community rehabilitation teams.
3. Existing recipients of personal care services (not including adults with learning disability or functional mental health difficulty) who experience a significant and unplanned increase in their personal care needs**.**
4. Adults of working age with a learning disability or mental health difficulty presenting for long term support with personal care.
5. Existing recipients of care services who are proactively identified (through case finding tools) of being at risk and in need of social care reablement and self-funding individuals meeting the entry criteria.

It is anticipated that the service will establish a development and implementation plan that ensures sufficient competence and capacity to meet the needs of individuals referred into the service at each phase of development.

The service will support the carers of the above individuals as an integral part of the service offered to the individual.

1.2 This service interfaces with the following services and service providers:

- Primary health care and complex care teams and other community health services provided by Devon County Council and the Royal Devon and Exeter NHS Foundation Trust.
- Other component parts of Devon's suite of Intermediate Care services i.e. Home based rehabilitation services, care home and day care rehabilitation, 24/7 nursing and personal care service (Rapid Response). Through a single point of coordination.
- Sensory Services
- Devon Partnership Trust – Older People Mental Health Service
- Community enabling services provided by Adult Social Care
- Care Direct and Care Direct Plus
- Community Equipment services including telecare
- Information and Preventative services i.e. libraries, leisure healthy living and health promotion, falls programmes, community mentoring, universal services etc.
- Housing and supporting people services

This service is one of the core components of an integrated network of Intermediate Care services.

Service providers are responsible for ensuring that their staff operate within national and Devon Adult Social Care policies and that these are effectively communicated and implemented in a timely way.

Service providers are responsible for ensuring they keep up to date with all policy requirements relating to their business and have effective communication and learning and development systems in place to address implementation issues.

The application of this Specification will provide a mechanism to understand the impact of social care reablement on key strategic objectives. It will ensure transparency and consistency of outcomes, service quality objectives and performance measures for individual users of the service, service providers and commissioners.

2. Social Care Reablement Objectives

2.1 Social Care Reablement: is a service whose primary objective is to reduce the overall demand for personal care services through individualised interventions designed to remove, reduce or delay the need for long term personal care support

In addition, the service will

- Delay the use of intensive personal care packages including care home admission (defined as costs in excess of £200p.w.)
- Reduce unplanned admissions into hospital or care home
- Reduce rates of readmission into hospital
- Improved delayed discharge rates for individuals awaiting personal care packages
- Reinforce and enhance carers ability to continue for longer in their caring roles
- Improve the early identification of individuals at risk of abuse, falls and dementia

3. Outcomes for Individuals

3.1 Eligible individuals will:

- Have an adequate opportunity to recover from illness and maximise their independence and self-care skills; particularly in relation to activities of daily living, personal care and mobility ***before*** any decision is reached on long term support needs
- Have an opportunity for learning, relearning or sustaining skills for daily living
- Carers will have an adequate opportunity to maximise their ability to support the cared for person.
- Have an early identification of their health needs where appropriate.
- Be able to take greater responsibility (choice and control) over how the reablement service is delivered including the goals /personal outcomes to be achieved and to make an informed choice in relation to any long term services that they may require and by so doing increase their well-being, self-esteem and sense of control.
- Be supported in accessing wellbeing and universal services
- Receive a high-quality service committed to continuous improvement
- Experience high levels of satisfaction with a service that provides a timely, prompt and reliable delivery of service.
- Be supported and safe if they are at risk of, or have been abused

4. Service Delivery

4.1 ***Entry criteria & sources***

Ultimately the service is to be provided to all adults 18 years and over with needs that place them at risk of loss of independence

However, in the first stage it will be targeted on older people including older people with mental health difficulties and younger people including those with a physical disability or a long-term condition including early onset dementia who are approaching Adult Social Care for the first time for personal care support.

But in later stages the social care reablement service will be offered to existing recipients of personal care services who experience a significant and unplanned increase in their personal care needs, to those with complex health and social care needs and to other adult client groups.

Referrals will ultimately be received via Care Direct Plus and Complex Care Teams including community rehabilitation teams, but in the first phase only referrals via Care Direct Plus will be accepted.

Referral will be via a BICCA which will capture appropriate personal information, identify the areas of need to be addressed and any salient risks.

This BICCA will be sent for the attention of the appropriate Reablement Team leader. In more complex cases the BICCA will be accompanied by a partially completed reablement goal plan specifying the goals/outcomes to be addressed. It will not specify volumes or times of provision although it may contain suggestions particularly in connection with the tasks to be performed. Volumes and times of provision are subject to agreement between the reablement service, the individual and where relevant the carer.

A detailed description of referral pathway for referrals is contained in the operational guidance

4.2 ***Exclusion criteria***

More complex health and social care cases and client groups other than older people and younger adults with a physical disability as indicted in 4.1. above; will be excluded in the first phase of development only.

4.3 ***Activity levels***

The service will need to respond to approximately 587 client per quarter or 2,348 per annum which represents all new individuals receiving personal care services funded by Adult Social Care in one year, in order to meet the demand for the *first phase of development only.*

Staffing levels should be based upon an assumption of an average 30 hour package of provision per individual over the reablement period. The provider will be responsible for managing capacity to ensure it can deliver to the required number of clients.

The service will be required to develop the required capacity to respond to later phases of development as described by the commissioners and as reflected in the joint strategic needs assessment.

4.4 ***Location of reablement in the care pathway***

The location of Reablement in the care pathway will be specified by the lead Partner. The precise arrangements may differ in each Clinical Commissioning Group area.

4.5 ***Geographic coverage and location of service***

The service will ensure equity of access in all locations throughout Devon.

Locations of care staff and administrative and management staff are at the discretion of the service provider subject to delivery of equality of access.

The service is available to any individual living in Devon who meets the entry criteria

4.6 ***Days and times of opening***

The service is accessible 7 day per week. 9-5 Monday to Friday 9 – 12 on weekends and bank holidays

The service is provided 7 days per week 7am – 10pm including bank holidays

4.7 ***Discharge criteria and planning***

Following a review of the individual's progress against reablement goals, discharge planning should be completed to allow at least 5 working days for CDP to complete the assessment, support plan, resource allocation and brokerage of any ongoing services.

The reablement team leader will be responsible for ensuring that that review takes place.

Where a therapist has set the reablement goal plan this therapist should be involved in the discharge planning alongside the reablement team leader, the individual and their carer.

The service addresses the individual's short term reablement goals. Medium term and longer term reablement goals identified by the service and requiring significantly in excess of six weeks to deliver may be specified as part of the ongoing support plan.

The reablement team leader will ensure that an up to date goal plan and service summary including recommendations are passed to CDP and or (at a later phase) CCT member.

The reablement team leader will be responsible for ensuring a satisfactory transition to a longer term support provider if such support is required.

4.7 ***The service will provide.***

- Time limited usually not exceeding 6 week, personal care programmes addressing the risks to individuals and/or carers around areas of personal care which may be linked to activities of daily living, mobility needs and sensory needs.
- Develop the individual short term reablement goal plan received from CDP/CCT to ensure it describes their personal outcomes and the agreed service provision to assist in achieving those outcomes.
- In later phases Social Care reablement goals plans will be offered as part of an integrated wider package of health and social care services including rehabilitation and intermediate care services for individuals with complex health and social care needs.
- In later phases assessments for telecare equipment and for a limited range of community equipment
- Upon discharge individuals and their carers will receive an updated copy of their reablement goal plan which will identify any ongoing reablement goals and contribute to the individual's long term social care and health support plan.
- Where ongoing personal care is required the service will ensure a planned transition to the long-term provider.
- Liaison with NHS primary care, Devon Partnership Trust services, complex care teams and rehabilitation services for those individuals with health needs including a proactive approach to early detection, advice and support for people with dementia and other long-term conditions and/or complex needs and their carers.
- Equitable outcomes for individuals across Devon through the provision of a consistent, but flexible, service model
- Provide a service that meets individual assessed physical, cultural, spiritual and psychological needs and preferences
- Timely and efficient coordination and processing of referrals, case recording, performance and financial management, staff rostering and deployment, electronic monitoring etc.
- Prompt access to falls services, community equipment services and telecare solutions
- Support, advice and information to the individual and carer that supports social networks, significant relationships, self-care and healthy living and provides a link to wellbeing and universal services.

- Consistent mechanisms for sharing information with individuals, their carers, and other service providers, for example individually held records
- Consistent mechanisms for communicating and sharing progress and issues regarding individuals with appropriate responsible persons depending on the circumstances of the case as specified in the support plan. i.e. CCT case worker, CDP, GP,CPN etc
- Active identification of ensuring protective measures in line with existing policies for
    - those with early dementia,
    - those at risk of, or have fallen in line with the Joint Devon Falls pathway
    - those at risk of abuse
    - of carers at risk

4.5 Roles and responsibilities.

Social care reablement will include a range of skill mix, roles and functions identified by the service provider to deliver an effective, efficient and safe service within agreed national and local policy requirements.

Key roles within the reablement service include;

Reablement Team Leaders who in addition to front line management responsibilities including the allocation of work to support workers, supervision and appraisal will be responsible for the development and monitoring of reablement goal plans which depending on the complexity of need may be partially developed through appropriate clinical professional input (usually occupational therapy). They will also be responsible for reporting back to CDP or the referring member of the complex care team a summary of the intervention provided, outcomes achieved and recommendation for further ongoing services if appropriate. The team leader will (subject to receiving accredited training) also assess for and delivery and installation of appropriate telecare solutions and a limited range of community equipment.

In the discharge of their roles and responsibilities reablement team leaders will be expected to work in partnership with all appropriate social care and health care professionals also involved in the individuals care.

Reablement support workers will report to reablement team leaders and will be responsible for the delivery of personal care in accordance with the written goal plan for that individual.

The service will ensure through training appraisal and supervision that the necessary competencies are delivered. They will draw on specialist input as appropriate to support individual assessment and support plans e.g. Occupational Therapy, Physiotherapy, Nursing and community psychiatric nursing etc and they will work in partnership with GP's, primary care staff and the independent and third sectors.

The service will need to ensure robust clerical and management support to the service and will need to keep its organisational structure and skill mix under review in order to deliver further phases of the reablement service as described by the commissioners.

4.6 Social Care Reablement Service will be responsible for

- Delivery of the aims and outcomes of the Social Care Reablement service as described in the specification and contracts for service.
- Delivery of a safe, well managed, quality and effective service through a competent and well -trained workforce.
- Contribute to the development of an integrated network approach to the delivery of health and social care intermediate care services
- Robust links with partners in interfacing services see section 1.2
- Quality assurance systems (incl. customer feedback and complaints), performance and financial reporting of the service against agreed standards and delivery of agreed service improvement targets

- Promotion of social care reablement with public and external partners
- Ensuring seamless transition to long term personal care providers where indicated

5. Improving Productivity and Continual Service Improvement

5.1 Key Performance Indicators (KPIs) and targets will be set for year on year improvement. The KPIs will be reported to the contract manager on a monthly basis and will require the service to address and put in place service improvements to address any areas of concern.

5.2 The following KPIs will form the performance dashboard for the Social Care Reablement Service:

- Numbers requiring no personal care, or a reduction or increase in personal care upon review at the end of the service – Stretch targets
- An increase in the percentage of contact to non-contact time to national good practice levels (set targets)
- Length of time from initial referral to the service to service delivery and length of time in service (prior to hand over to long term provider).
- Quality indicators including individual and carer feedback

5.3 In addition the provider will be expected to provide activity information relating to internal processes and productivity of teams quarterly.

5.4 The service will contribute to a range of whole system outcome indicators but in particular

- Numbers of individuals in receipt of personal care and the volume (in hours) of personal care commissioned – p.a.
- Previous reablement recipients still requiring no personal care at 6 months, 1 year and 2 years
- NI 142 increase number of individuals supported by Intermediate care
- Increase in the numbers of individuals receiving DP or IB for longer term support services
- Reductions in unplanned admissions to hospitals and in readmissions to hospital following discharge (within 30 days).
- Reductions in numbers of individuals experiencing a delayed discharge for social care reason: awaiting personal care.
- Reduction in individuals being admitted to care homes

6. Reducing Inequalities

6.1 Staff will work in a non-discriminatory way and will identify and plan to reduce or eliminate actual or potential barriers for individuals and their carers in accessing the Social Care Reablement Service.

6.2 The service will monitor services and each year and undertake a review of the equalities impact of the service to ensure equity of access and of outcomes across Devon. Where necessary the service will in partnership with the commissioners develop action plans to address any equality issue raised.

7. Areas for Service Development

7 CareFirst 6 functionality should be adopted as soon as practicable to record service activity and performance at the earliest opportunity.

7.1 The service will be developed in phases in line with the development plan for the service.

7.2 Future organisational forms including integration with NHS led models of rehabilitation Within the context of a joint health and social care intermediate care strategy may be considered at a later date.

Part 1i: Schemes within the improved Better Care Fund Grant pool

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

1 OVERVIEW

Part of the funding for the Better Care Fund comes in the form of a dedicated grant from the Ministry of Housing, Communities & Local Government called the improved Better Care Fund Grant. This funding is subject to specific conditions on use and additional reporting requirements and has been allocated to a separate Pool for ease of reference.

Use of the grant has been determined using the following principles:

- That commitments are not recurrent, and that no money will be added to system baseline budgets;
- Investments should not increase overall system costs and should be "bridging" finance to implement new models of care. An affordability test should be applied for all new activity;
- Activities should build on existing plans to secure improved system improvement, particularly in respect of delayed transfers of care.

Devon County Council will act as the Host Partner for the iBCF Grant Pool. The pool is sub-divided into a number of schemes, each of which has a designated accountable officer from the county council and , an NHS body as set out in clause 14 of this specification. Those officers shall have delegated authority to agree the allocation of funds within each scheme to individual projects. The budgets for each scheme and the initial allocation within each scheme to projects are contained in Schedule 5 of the partnership agreement.

2 AIMS AND OUTCOMES

The expected aims and outcomes for these schemes is as follows:

- Support to social care: one of the permitted uses of grant is additional support to adult social care. Part of the grant has been allocated to help fund existing adult social care which might otherwise have been reduced.
- Disability: this scheme is intended to achieve improvements in services to younger adults with physical or sensory disabilities through changes to professional practice; support in obtaining employment and housing; funding for community groups; and changes to the arrangements for young adults in transition from care previously offered by Children's Services .
- Mental Health: this scheme will seek to reduce delayed discharges relating to hospital settings managed by the Devon Partnership Trust, and also to address wider support for people with mental health needs. This will include improved support to people with dementia and their families.
- Prevention: to support the delivery of the STP prevention programme including social prescribing, frailty and falls, diabetes and healthy lifestyles.
- Market Sufficiency: one of the stated aims of the grant is to help sustain care markets. To help achieve this goal a scheme has been set up focussed on personal care in the community. The underlying objective will be to provide support for innovation in providing care. This may involve new models of care or contracting for care; additional support for training & equipment; the trialling of trusted reviewer arrangements; or specific market interventions at points of stress.
- Strategic Market Development: to support strategic plans to ensure market sufficiency within the personal care market
- Short Term Services: the scheme will facilitate the review of short-term services across Devon to enable alignment of outcomes and staffing.
- Winter Pressures: A range of schemes designed with providers to support capacity and demand throughout the winter period.
- Older People and Community Resilience & Prevention: one of the permitted uses of the grant is to reduce pressures on the NHS by reducing the incidence and duration of delays

in discharging people from hospital once they are fit to be transferred to an alternative care setting (usually referred to as Delayed Transfers of Care or DTOC). Projects within these schemes will focus on this issue, with particular reference to the most common causes of delay in each locality; the implementation of the High Impact Change model as laid out in the Better Care Fund plan; and the plans for reducing delayed transfers agreed by each hospital's Accident & Emergency Board. The Community Resilience & Prevention schemes will contribute to the reduction of admissions to hospitals to begin with.

3 THE ARRANGEMENTS

For all schemes within this Pool, both Devon County Council and the NHS Devon (Integrated Care Board) will be joint lead commissioners.

All expenditure incurred within this Pool must comply with grant conditions imposed by the Ministry of Housing, Communities & Local Government (grant determination 31/6644) and is subject to quarterly reporting to that department, in addition to reports submitted to NHS England. Since these reporting requirements are evolving, they are not set out in this Agreement but will be notified to the relevant accountable officers for each reporting cycle.

At a local level, the Devon Sustainability & Transformation Partnership may specify additional reports on either planned investments or delivery of those plans to be submitted to the Programme Executive Delivery Group (PDEG).

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board) hereby delegates the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.

The Council shall procure that the Services are provided and shall be accountable to the NHS Devon (Integrated Care Board) for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Devon County Council and the NHS Devon (Integrated Care Board) are joint lead commissioners for all schemes, unless agreed otherwise for specific projects during the year.

The details of each project will be agreed by the accountable officers listed in clause 14 below.

Any uncommitted funds will be released in line with schedule 3 for re-allocation to other projects.

FINANCIAL CONTRIBUTIONS

Financial contributions are specified in schedules 3 & 5 of the main partnership agreement.

Financial resources in subsequent years will be determined in accordance with the Agreements for those years.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the projects funded from within this Pool, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) the Host Partner for projects funded from within this Pool, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS

Each scheme will be managed jointly by the Devon County Council and NHS Devon (Integrated Care Board) accountable officers listed in clause 14. Management of individual projects may be delegated to a named officer in either the county council or the NHS body.

Budget allocations will be agreed jointly by with the Devon County Council and NHS accountable officers listed in clause 14.

Financial and progress reports for all schemes will be submitted to the BCF governance group as set out in the main body of the Partnership Agreement.

The BCF Governance Group will regularly review expenditure at project level.

NON-FINANCIAL RESOURCES (IF ANY)

There are no non-financial resources in relation to these schemes.

STAFF

Due to the nature of the underlying funding, no permanent staff will be funded from this Pool, although funds may be allocated for temporary increases in hours worked or to employ staff on fixed-term contracts. There are no TUPE considerations or potential redundancy considerations.

h.

ASSURANCE AND MONITORING

These schemes will be monitored as part of the overall Better Care Fund monitoring framework.

This arrangement has been adopted with the agreement of all parties in recognition that responding to some of the issues being addressed by schemes within this Pool – in particular, reducing delays in transfers from hospital – will be subject to frequent change in line with individual needs at any one point in time, so attempting to specify requirements in detail in an agreement that is only updated annually is likely to be counter-productive.

Additional records may be specified during to the course of the year in order to comply with evolving external reporting requirements.

Expenditure will be recorded at project level and monitored monthly.

LEAD OFFICERS

Devon County Council

Name of Lead Officer	Address	Telephone Number	Email Address
Solveig Wright	County Hall, Topsham Road, Exeter EX2 4QD	01392 383000	Solveig.wright@devon.gov.uk

NHS Devon (Integrated Care Board)

Name of Lead Officer	Address	Telephone Number	Email Address
Jane Milligan Accountable Officer	County Hall, Topsham Road, Exeter EX2 4QD	01392 652500	Jane.milligan@nhs.net

Devon Partnership NHS Trust

Name of Lead Officer	Address	Telephone Number	Email Address
Susan Smith Chief Operating Officer	Wonford House, Dryden Road Exeter EX2 5AF	01392 208866	susan.smith55@nhs.net

Royal Devon & Exeter NHS Foundation Trust

Name of Lead Officer	Address	Telephone Number	Email Address
John Palmer **Chief Operating Officer** Royal Devon University Healthcare NHS Foundation Trust	Barrack Road, Exeter, EX2 5DW	01392 402356	john.palmer13@nhs.net

Torbay & South Devon NHS Foundation Trust

Name of Lead Officer	Address	Telephone Number	Email Address
Liz Davenport Chief Operating Officer	Torbay Hospital Lowes Bridge Torquay TQ2 7AA	01803 614567	liz.davenport@nhs.net

Plymouth Hospitals NHS Trust

Name of Lead Officer	Address	Telephone Number	Email Address
Jo Beer Chief Operating Officer	Derriford Road, Crownhill, Plymouth PL6 8DH	01752 202082	joanne.beer2@nhs.net

Livewell South West

Name of Lead Officer	Address	Telephone Number	Email Address
Michelle Thomas Director of Operations	Mount Gould Local Care Centre, 200 Mount Gould Road, Mount Gould, Plymouth PL4 7PY	01752 434700	michelle.thomas6@nhs.net

INTERNAL APPROVALS

All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Schemes.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to these schemes are the same as for the rest of the Better Care Fund. Future grant allocations may vary or be subject to additional conditions regarding use of those Funds, which will be reflected in the Partnership Agreements for those years. This may result in changes to the provisional budget contributions shown in Schedule 3 or the allocations shown in Schedule 5.

REGULATORY REQUIREMENTS

These schemes comply with the Care Act 2014 and the grant conditions imposed by the Department of Communities & Local Government in Grant Determination Notice 31/6644.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of this agreement.

DURATION AND EXIT STRATEGY

As per clause 21 of the main agreement. Since the grant funding is only allocated for one year at a time, all schemes and projects within those schemes automatically lapse at 31st March of each financial year.

The provisions of the following clauses shall survive termination or expiry of this Agreement:

a) Clause 25 (Freedom of Information);

b) Clause 27 (Information Sharing);

c) Clause 24 (Confidentiality);

d) Clause 15 (Liabilities and Insurance and Indemnities); and

e) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

i. There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

j. More detailed specifications for individual projects can be found in the contracts with the providers of that service.

Part 1ij: Schemes within the Hospital Discharge Pool

Funding agreement: Hospital Discharge programme

Between Devon County Council (DCC) and NHS Devon Integrated Care Board (NHS Devon)

This document will be included in the DCC / NHS Devon Better Care Fund S75 agreement, in line with national guidance[5]

1. Hospital Discharge Programme - overview

- In 2020/21, the government provided a national hospital discharge fund via the NHS, to help cover some of the cost of post-discharge recovery and support services/ rehabilitation and reablement care following discharge from hospital.

- This funding ceased in 2021/22, with the expectation that local systems would continue to fund. During 22/23 the Devon health and care system used a combination of national funding and one-off underspends and carry-forward sums in the BCF. It was known these sums would not be available on a recurrent basis.

- For 2023/24, ICBs and LAs have each received a share of the Adult Social Care Discharge Fund to support the Hospital Discharge Programme. As part of the original hospital discharge arrangements DCC identified budget historically used to support social care cost associated with hospital discharge, this stands at £1.495m for 23/24

- NHS Devon have agreed to allocate their Continuing Healthcare (CHC) budget towards the HDP. This stands at £3m for 23/24.

- Funding available totals £12m. This agreement covers that sum plus an additional £2m contribution from each party to bring the total sum available to £16m.

2. Hospital Discharge Programme - National guidance[6]

- Section 91 of the Health and Care Act came into force on 1 July 2022. It revokes procedural requirements in Schedule 3 to the Care Act 2014 which require local authorities to carry out long-term health and care needs assessments, in relevant circumstances, before a patient is discharged from hospital.

- Local areas are required to adopt discharge processes that best meet the needs of the local population. This could include the 'discharge to assess, home first' approach. Systems should work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

- Under the Discharge to assess, home first approach to hospital discharge[7], the vast majority of people are expected to go home (to their usual place of residence) following discharge.

[5] 2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)
[6] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)
[7] Quick Guide: Discharge to Assess (www.nhs.uk)

- People who are clinically optimised and do not require an acute hospital bed, but may still require care services, are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

- Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

- Multi-disciplinary hospital discharge teams and transfer of care hubs comprising professionals from all relevant services across sectors (such as health, social care, housing and the voluntary sector), should work together so that, other than in exceptional circumstances, no one should transfer permanently into a care home for the first time directly following an acute hospital admission.

- If a person's preferred placement or package is not available once they are clinically ready for discharge, they should be offered a suitable alternative while they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they do not need acute care, including to wait for their preferred option to become available.

- Discharges from mental health hospitals are not within scope of this guidance

3. Hospital Discharge Funding Sources included in this agreement*:

1. Discharge grant – NHS Devon
2. Discharge grant – DCC
3. DCC Business as usual budget
4. NHS Devon CHC funding contribution
5. £2m contribution from NHS Devon
6. £2m contribution from DCC

	£'000's
Social Care Discharge grant – ICB	£3,442
Social Care Discharge grant – DCC	£4,084
DCC - BAU	£1,495
ICB - CHC	£3,000
Additional contribution - ICB	£2,000
Additional contribution - DCC	£2,000
Total:	**£16,021**

*See also appendix A – agreement between parties to allocate any further national hospital discharge or intermediate care funding to this hospital discharge fund.

4. Scope of activity covered by this funding agreement

In Scope
All activity funded in 2022/23 will continue to be eligible for funding
Anyone that CHC funded and discharged on the 4-week hospital discharge / discharge to assess programme will be eligible, including those end of life patients
Anyone discharged on the 4 week hospital discharge / discharge to assess programme on pathways 1, 2 and 3

To note this is an increase in eligible activity compared to 2022/23 and so it is vital that activity and spend is tightly managed as set out in this agreement in order to avoid overspend.

Out of Scope
Anyone for whom mental health is their primary diagnosis and the reason for needing care upon discharge from hospital
Anyone not discharged under the 4 week hospital discharge / discharge to assess programme

5. Governance and Performance Management

Activity and spend will be performance managed via the Better Care Fund governance arrangements detailed at Appendix B.

Local actions to ensure the budget is not exceeded will include:

- Modelling pathways and requirements based on best practice evidence and local activity 2022/23
- Confirmation of what services are in and out of scope of this funding
- Demand management programme in partnership with acute sector leads
- Review of agency contracting arrangements to minimise expensive short term agency spend

Underspend
Any underspend at year end will be treated in accordance with the Better Care Fund S75 funding agreement.

Overspend

Overspends will be treated in accordance with the Better Care Fund S75 funding agreement, however;
If the Budget is predicting an overspend and likely to imminently breach the agreed funding envelope, the parties agree that the BCF Leadership Group will inform the Chief Executives and Chief Finance Officers of all parties within 5 working days. No further spend will be undertaken without agreement of all the parties Chief Executives and Chief Finance Officers in writing should the budget appear to be at imminent risk of overspending.

Robust performance management by NHS Devon, DCC and the Acute Trusts will be required as this budget is not intended to overspend.

The hospital discharge finance group will be responsible for monitoring spend and will meet on a monthly basis. Quarterly meetings with Chief Executives and Chief Finance Officers will be scheduled to ensure timely escalation should the budget appear to be at risk of overspending. Mitigating actions to be jointly agreed by all parties.

If there is no agreement to extend funding in the event the £16m cp is reached, the system will revert to the pre-D2A position:

1. The agency focused on hospital discharge, commissioned via the social care discharge grant though the Better Care Fund, will cease. Due to the 4-week period of free service the action will need to be taken 4 weeks before the total budget is due to breach.
2. Devon County Council will start to assess individuals with a potential need for residential home within the hospital setting upon referral from the NHS Provider rather than discharging direct to the home.
3. Individuals requiring a nursing home environment will continue to be discharged, the funding of this service will rest with the ICB.

4. Individuals returning to their home environment will do so using the available short-term services, including Urgent Community or Rapid Response, Social Care Reablement and any other short-term services funded by the ICB. Social care teams may also be required to assess within the hospital environment.

Signed on behalf of DEVON COUNTY COUNCIL

Date

Angie Sinclair, Director of Finance

Signed on behalf of NHS DEVON INTEGRATED CARE BOARD

Date

Bill Shields, Chief Finance Officer

Appendix A – agreement on use of additional discharge funding

An outcome from the joint NHS Devon and Devon County Council meeting of 29th March 2023 in respect of hospital discharge and iBCF funding in 23/24, was for both organisations to agree that any further national discharge or intermediate care funding announced would be allocated to specifically address the current forecast Hospital Discharge Programme gap in this new financial year.

This is in addition to the discharge funding already stated within the recently published 2023 to 2025 BFC Policy Framework:

DCC	£4,083,537
NHS Devon ICB	£3,442,000
Total	**£7,525,537**

Signed on behalf of **DEVON COUNTY COUNCIL**

Angie Sinclair, Director of Finance

Signed for on behalf of **NHS DEVON INTEGRATED CARE BOARD**

Bill Shields, Chief Finance Officer

Part 1k – All Other Schemes Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in these schemes Specification shall have the meanings set out in the s75 Agreement for the 2023/24 Better Care Fund.

1 **OVERVIEW OF INDIVIDUAL SERVICE**

In addition to schemes a-i and k there are a number of other schemes included within the Better Care Fund. These include implementing the 2014 Care Act, Dementia diagnosis, the Disabled Facilities Grant, enablers, support to social care and scaling up of existing services. All schemes are listed in schedule 5 of the main Partnership Agreement.

The specifics relating to these schemes are set out below.

1.1 **Dementia Diagnosis**

One of the key objectives of the dementia strategy is to improve public and professional awareness and understanding of dementia and to address the stigma associated with it. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.

People with dementia and their carers and/or family members:

- Have the opportunity to meet regularly with other people with dementia and their carers.
- Experience an informal learning environment which delivers information about dementia, practical tips about coping with dementia and social networking opportunities, both within the café and outside the service.
- Have access to advice from health and social care professionals and others.
- Have been supported to access help and services from statutory partners and other voluntary organisations, experiencing an integrated approach.
- Experience emotional support from their peers which has been beneficial to them in living with dementia.
- Report that the service has helped in reducing or preventing social isolation, particularly by reducing the stigma associated with dementia.
- Have had opportunities to participate in continuous quality development and improvement of the service through feedback, review and evaluation

Dementia friendly communities development coordinator

- We are clear that dementia is a condition that needs to be understood not only by health and social care organisations but by the whole of society as well, making dementia 'everybody's business'.
  k.
- We recognise that the stigma still felt by some people with dementia discourages them from seeking the help and support they need and exacerbates feelings of loneliness and isolation.

In Devon, a number of communities are working towards becoming dementia friendly and we are keen to support collaboration, shared learning and confidence in achieving

this through this service, and to encourage others, who have not yet started, to consider taking local action.

Devon Dementia Care & Support Partnership

Role

To facilitate, and enable collaborative working in a partnership of statutory, private, and voluntary sectors within Devon to support people with dementia and their carers to live well.

Aim

The overall aim of the Partnership is to:

- Identify good practice and innovation in work practices, initiatives and projects to support those with a dementia and their carers
- Aid communication and coordination of information regarding good practice, both locally and nationally, across all sectors
- Provide a platform to sharing the above.

Functions

The Partnership will achieve its overall aims by:

- Developing Devon as a dementia-friendly County
- Facilitating improved collaboration and communication across sectors
- Providing and promoting the voice of people with a dementia and their carers
- Improving awareness and understanding of dementia within the County
- Improving training, quality and practice in key areas within and across sectors

1.2 Enabler (including when crises occur and supported discharges)

The prevention work stream is key to the universal offer to Devon residents and is expected to be an enabler and mitigation of future demands. It links to the prevention and maintenance schemes in the Better Care Fund. It includes empowering and supporting community and voluntary services, social care capital grant funding and early supported discharge from hospital schemes.

1.3 Support to social care

The vision in Devon is that people will live in supportive and inclusive communities and their physical, mental and emotional wellbeing is promoted. When circumstances make people vulnerable, they will be protected from abuse and neglect and have the maximum opportunity to regain their independence and to participate in community life. People in Devon, wherever they live, will experience good quality care and support which puts them in control and responds to their personal needs and circumstances; it is all this that we must protect. Our vision, values and priorities are stated in our vision document.

This invites individuals to look for alternative methods of support before contacting the Council for a social care assessment – a key part of our demand management strategy is community capacity, resilience and support. Our community directory offers suggestions and alternative options for individuals and their carers to consider before requesting a social care assessment. For those still requiring an assessment of need our current eligibility is set at critical and substantial with descriptors available on-line in our eligibility criteria checklist. In line with the Care Act requirements we will be refreshing our criteria following finalisation of national guidance.

We are committed to retaining our current eligibility threshold for care in Devon and this is the basis of our local definition of “protecting social care”. To evidence this we consider:

- Anticipated future demand based on known demographic changes including other known legislative or statutory requirements – we model expected costs and build those into our service and financial planning cycles.
- We consider and benchmark our current profile of spend (including unit costs) and activity and drive major service change to address areas of high cost or poor performance. An example is the Council has recently decided to cease to be a provider of residential care where unit costs were significantly higher than the

independent sector. The resultant saving is contributing to the protection of social care by ensuing eligibility criteria are sustained at the current levels.

The County Council budget has significantly reduced over the last four years and social care has made contributions to that whilst maintaining current levels of eligibility for support. The Council is looking towards demand management strategies across all areas and supporting communities to help themselves – leaving statutory services to focus on more targeted groups. There are significant investments in preventative services both at a universal and more targeted level. Specifically, voluntary sector representatives are integrated within our multi-disciplinary community complex care teams targeting known individuals at risk of crisis. This is a key part of our whole systems risk stratification and demand management approach.

1.4 Care Act

The Care Act will impact on the future landscape of adult social care and the delivery of integrated and personalised services. A Programme Board has been established with senior local Council and NHS representation to coordinate activity and manage risk. It has 8 work streams:-

(1) Operational Delivery -Increasing assessment capacity to meet expected demands.
(2) Supporting Carers - Increasing the capacity and strengthening the service offer to carers.
(3) Enhanced markets - Market management to secure high quality, sustainable and diverse markets.
(4) Prevention - Community capacity building and developing community resilience.
(5) Care accounts and charging - Developing care accounts.
(6) Financial Planning - Understanding financial implications of Dilnott changes
(7) Communications, engagement and information - Strengthening our advice and information offer.
(8) IT systems - Having IT systems capable of supporting new requirements.

The focus of the programme is to ensure that Devon is statutorily compliant for new duties from April 2015, and for the financial elements when these are brought into force (originally scheduled for April 2016, but currently on hold – provisionally, until April 2020).

The prevention work stream is key to the universal offer to Devon residents and is expected to be an enabler and mitigation of future demands. It links to the prevention and maintenance schemes in the BCF. Whilst the Council does plan for demographic and demand growth, the Care Act workstreams are key to transforming the social care offer in the county to a more personalised and efficient offer. The ICT workstream will enable individuals to complete a self-assessment and signpost individuals through an e-marketplace to providers, community groups and individuals. This will be a key demand management strategy and release BCF resources for more targeted work with those individuals identified as at risk in our population. Our workstream around enhanced markets will look to develop sustainable business models and use the Local Enterprise Partnership (LEP) to promote health and social care as a business opportunity. Our approach to personal care will be a joint one with the potential for this to be included in the BCF pooled budget at a future date. The role of the Programme Board is to ensure that interdependencies are identified in workstreams whilst allowing detailed delivery plans to be produced to ensure we meet the necessary statutory requirements.

1.5 Disabled facility grants

This is a capital grant received by the Council, which will be allocated to the district councils for funding Disabled Facilities Grants to individuals. The allocation to individual district councils will be by mutual agreement, via a working group involving members of all eight district councils and the county council.

1.6 Finance and Project support

The host of the Devon BCF (Devon County Council) will receive funding to cover the costs associated costs with administering the BCF in terms of both financial management and project support. This administration will help ensure the main elements of legal and national responsibility and requirements are met in a timely and efficient manner along with co-ordination tasks.

S75 Agreement: Co-ordinating work to create / review Devon's BCF S75 Agreement. Traditionally this has been a three year agreement but in recent years has become an annual process. To provide a legal basis for ongoing work an interim simple letter of agreement is produced confirming that DCC & ICB will proceed on the same terms as the previous year.

BCF Annual Plan: Government requires us to produce an annual plan each year to explain how the s75 Agreement will be used in that year. The s.75 Agreement cannot be finalised until the Plan has been agreed locally & nationally.

BCF Leadership Group: This is Devon's main officer governing body, which is accountable to Devon's Health & Wellbeing Board. It consists of senior officers from DCC & the ICB. Support for these meetings in the provision of papers and attend the meetings to produce minutes. Terms of Reference are held in the BCF Teams/SharePoint site & reviewed annually. The meetings are held every month & dates are set in advance for the year.

BCF Business Group: Support arranges the meetings, provide papers and attends the meetings to produce minutes. Terms of Reference are reviewed annually. The meetings are currently every month & dates are set for the year in advance.

Local Progress Reporting: iBCF budgets are managed by various managers in local areas (DCC/NHS). Finance colleagues request reports throughout the year (currently every two months) and a summary report is produced for the Business & Leadership Groups.

Government Reporting: Government usually requires a progress report to be provided each quarter. They provide a pro-forma for completion on the Better Care Exchange website, see https://future.nhs.uk/bettercareexchange/view?objectId=8236432. The information required varies depending on the requirements for each quarter. Typically six weeks to submit the report, which must be approved by the Health & Wellbeing Board (via the Chair if if reporting deadlines don't not align with Board timescales).

Other: From time to time reports are provided to the DCC Overview & Scrutiny Committee. Co-ordination and monitoring of the annual schedule.

2 AIMS AND OUTCOMES

- Compliance with the new legislative criteria
- Identification and support for those living with dementia.
- Continuation of the social care support service
- people with dementia and carers saw dementia advisers and peer support networks as having a positive impact on their wellbeing and quality of life
- demonstrator sites provided evidence of both dementia advisers and peer support networks filling a gap in service provision that often occurs after diagnosis but before there is a need for more intensive support

3 THE ARRANGEMENTS

Devon County Council delivers and commissions the majority of these services.

The disabled facility grants are passed through the County Council to the district councils.

4 FUNCTIONS

For the purposes of the implementation of the Partnership Arrangements, the NHS Devon (Integrated Care Board) hereby delegate the exercise of the NHS Functions to the Council to exercise alongside the Council Functions and act as lead commissioner of the Services.

Additional services may be brought within the scope of this Agreement during the Term by agreement.

SERVICES

The Council is the Host Partner for the Partnership Arrangements and agrees to act as lead commissioner of the Services listed in clause 4.

The Council shall procure that the Services are provided and shall be accountable to the NHS Devon (Integrated Care Board) for NHS Functions for the benefit of Service Users:

- to ensure the proper discharge of the Parties' Functions;
- with reasonable skill and care, and in accordance with best practice guidance;
- in all respects in accordance with the Aims and Outcomes, the performance management framework, and the provisions of this Agreement;
- in accordance with its standing orders or other rules on contracting; and
- in accordance with all applicable Law.

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Devon County Council is the lead commissioner for all schemes, other than:

i. Community Services for NHS Devon (Integrated Care Board) and SWASFT Right Care, Right Place in the central locality, and all schemes in the Northern, Eastern & Western localities. NHS Devon (Integrated Care Board) the lead commissioner for these schemes.

ii. Torbay and South Devon NHS Foundation Trust as the Integrated Care Organisation in the central locality and all schemes in the Southern locality. NHS Devon (Integrated Care Board) the lead commissioner for these schemes.

Any uncommitted funds will be released in line with schedule 3.

Access

The target demographic for this service is

- Older People
- People who are acutely or terminally ill
- People with long term conditions
- People with mental health problems
- People with dementia or cognitive impairment
- People with learning disabilities
- People with physical disabilities

The Care Act requirements will be met in assessing the individuals eligibly for the scheme.

FINANCIAL CONTRIBUTIONS

Contributions for the Financial Year 2023-24 are set out in schedule 5.

Financial resources in subsequent years will be determined in subsequent agreements.

FINANCIAL GOVERNANCE ARRANGEMENTS

Financial governance arrangements are as set out in the main body of this agreement, with no changes.

VAT

Where the Council is the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.1 of the main body of the agreement shall apply.

Where NHS Devon (Integrated Care Board) the Host Partner for the Pool (or locality section of the Revenue Pool) from which the funds for this service are provided, clause 13.2 of the main body of the agreement shall apply.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

It is the Programme Board that has overall accountability for delivery of the Care Act in Devon. This will have member input to ensure democratic political overview of progress. Within this programme management arrangement each workstream will be developing plans to ensure Care Act compliance of particular importance is the communications workstream that is leading on using our established user engagement forum to work with existing users and carers but also developing broader communications with the residents of Devon. They will be using national material, but also customising material for the local area. This is in addition to the Better Care outcomes report detailed below which covers all Better Care Fund indicators at both a Council wide and acute trusts' footprint.

The Better Care outcomes report monitors the Better Care Fund Indicators for the Devon County Council area and provides an overview of the whole system and includes the following sections:

m) Overview and indicator summary with trends and benchmarking.

n) A dashboard showing current monthly in-year performance

o) Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local authority district within Devon, by NHS Devon (Integrated Care Board) and localities and by inequality characteristics such as deprivation. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.

Supplementary monthly dashboards are provided for localities to allow a detailed consideration at the four locality A&E Boards, based around each of the local health economies (Eastern, Northern, Western and Southern) within the Devon STP which are made up of senior leaders of the health and social care system. These Boards collaboratively identify gaps in service, plan, commission and coordinate activities aimed at improving system resilience and patient flow and consider the best use of available resources.

NON FINANCIAL RESOURCES

There are no non financial resources in relation to these schemes.

STAFF

Staff on these schemes will continue to be employed by the same organisation. There are no TUPE considerations.

ASSURANCE AND MONITORING

These schemes will be monitored as part of the overall Better Care Fund monitoring framework.
The District councils are to provide Disabled Facility Grant information to the BCF Leadership Group who oversee the Better Care Fund.

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Devon County Council	Solveig Wright	First floor, The Annexe, County Hall, Topsham Road, Exeter EX2 4QD	01392 383000	Solveig.wright@devon.gov.uk
NHS Devon (Integrated Care Board)	Jane Milligan	The Annexe, County Hall, Topsham Road, Exeter EX2 4QD	01392 200500	Jane.milligan@nhs.net

INTERNAL APPROVALS

All parties must comply with the individual levels of authority from the Council's Constitution and the NHS Devon (Integrated Care Board)'s standing orders, scheme of delegation and standing financial instructions in relation to the Individual Schemes.

RISK AND BENEFIT SHARE ARRANGEMENTS

The risk and benefits in relation to these schemes are the same as the pooled fund schemes.

REGULATORY REQUIREMENTS

These schemes comply with the Care Act 2014.

INFORMATION SHARING AND COMMUNICATION

Information will be shared as per clause 27 of the main body of this agreement.

DURATION AND EXIT STRATEGY

As per clause 21 of the main agreement

The provisions of the following clauses shall survive termination or expiry of this Agreement:

f) Clause 25 (Freedom of Information);

g) Clause 27 (Information Sharing);

h) Clause 24 (Confidentiality);

i) Clause 15 (Liabilities and Insurance and Indemnities); and

j) Clause 19.4 (Consequences of Termination).

OTHER PROVISIONS

There are no other provisions.

PART 2 – AGREED SCHEME SPECIFICATIONS

Scheme specifications for individual schemes can be found in the contracts with the providers of that service.