Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Board

The meeting will be held at **10.30am** on **24 September 2021**

Council Chamber, Civic Offices, New Road, Grays, Essex, RM17 6SL.

Membership:

Councillors James Halden (Chair), Deborah Huelin, Barry Johnson, John Kent and Steve Liddiard

Ian Wake, Corporate Director of Adults, Housing and Health
Sheila Murphy, Corporate Director of Children's Services
Jo Broadbent, Director of Public Health
Anthony McKeever, Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its 5 CCGs
Mark Tebbs, NHS Thurrock Alliance Director, Thurrock Clinical Commissioning Group
Rahul Chaudhari, NHS Thurrock Alliance Interim Deputy Director
Kim James, Chief Operating Officer, Healthwatch Thurrock
Dr Anjan Bose, Clinical Representative, Thurrock NHS Clinical Commissioning Group
Dr Anil Kallil, Clinical Representative, Thurrock NHS Clinical Commissioning Group
Stephen Mayo, Deputy Executive Nurse: Thurrock NHS Clinical Commissioning Group
Andrew Millard, Director of Place
Julie Rogers, Chair Thurrock Community Safety Partnership Board / Director of Environment and Highways
Jim Nicholson, Chair of the Adult Safeguarding Partnership or their senior representative
Chair of the Adult Safeguarding Partnership or Senior Representative, Thurrock Local Safeguarding Children's Partnership or their Senior Representative
Tania Sitch, Director level representation of Thurrock, North East London Foundation Trust (NELFT)
Gill Burns, Director level representation of Thurrock, North East London Foundation Trust (NELFT)
Andrew Pike, Executive member, Basildon and Thurrock Hospitals University Foundation Trust
Preeti Sud, Executive Member, Basildon and Thurrock Hospitals University Foundation Trust
Michelle Stapleton, Executive Member, Basildon and Thurrock Hospitals University Foundation Trust
Alexandra Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Kristina Jackson, Chief Executive Thurrock CVS
Karen Grinney, HM Prison and Probation Service

Agenda

Open to Public and Press

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - Commissioning by sending an email to DKristiansen@thurrock.gov.uk

Agenda published on: **16 September 2021**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

↓

Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 23 July 2021 10.30am-12.30pm

Present:	Councillor Halden (Chair) Councillor Huelin Ian Wake, Corporate Director for Adults, Housing and Health Sheila Murphy, Corporate Director for Children's Services Jo Broadbent, Director of Public Health Mark Tebbs, NHS Thurrock Alliance Director, Thurrock Clinical Commissioning Group Anthony McKeever, Interim Joint Accountable Officer for Mid and South Essex CCGs Preeti Sud, Executive Member of Basildon and Thurrock Hospitals University Foundation Trust Carmel Micheals, North East London Foundation Trust (NELFT) Dr Anil Kallil, Chair of Thurrock CCG Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) Stephen Mayo, Deputy Chief Nurse, Thurrock Clinical Commissioning Group Julie Rogers, Chair Thurrock Community Safety Partnership Board/Director of Environment and Highways Karen Grinney, HM Prison and Probation Service
Apologies:	Councillor Liddiard Councillor Johnson Councillor Kent Kristina Jackson, Chief Executive, Thurrock CVS Kim James, Chief Operating Officer, Healthwatch Thurrock Andy Millard, Director for Place Andrew Pike, Executive Member, Basildon and Thurrock Hospitals University Trust Michelle Stapleton, Interim Director of Operations, Basildon and Thurrock University Hospitals Foundation Trust
Guests:	Michele Lucas, Thurrock Council Catherine Wilson, Thurrock Council Helen Farmer, Thurrock CCG

1. Welcome, Introduction and Apologies

Colleagues were welcomed and apologies were noted.

The Chair noted that some colleagues had joined the meeting virtually and advised that going forward all members will be required to attend meetings in person to reflect current legal requirements.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 28 January 2021 were approved as a correct record.

3. Urgent Items

There were no urgent items raised in advance of the meeting.

4. Declaration of Interests

There were no declarations of interest.

5. Integrated Care Systems – update

This item was presented by Ian Wake. Key points included:

- A decision has been received from the SOS that the ICS Boundary will remain at Mid and South Essex, which was widely welcomed by members.
- The Bill has now had second reading. The ICS design guidance has been published. Further guidance is expected in due course. A workshop is taking place this afternoon (23 July) to consider the structure of the ICS, roles and responsibilities.
- The Chair thanked colleagues across the ICS including Professor Mike Thorne, Anthony McKeever, BTUH, CCG colleagues and Thurrock's MP.
- The decision on Boundaries has been welcomed. There were previously 113 meetings held to consider boundaries and this decision provides the opportunity to focus on the health and wellbeing of the people of Thurrock.

RESOLVED: Members noted the verbal update.

6. Children and young people's emotional wellbeing and mental health services in Thurrock

This item was introduced by Michele Lucas (Thurrock Council) and Catherine Wilson (Thurrock Council). Key points included:

- Thurrock's plans for the mental health and wellbeing of children and young people in Thurrock are ambitious.
- The current contract has been in place since 2015 delivered through a Collaborative Commissioning Approach between the seven Clinical Commissioning Groups and three Local Authorities across the Greater Essex footprint. The current contract ends on the 31st January 2022. The re-procurement of the service commenced on 4th May 2021 in order to deliver the new contract from the 1st February 2022.
- The specification for the new service provides for local focus and priorities.
- Governance will be provided through the Brighter Futures Board.

- The core elements of the Thurrock specific delivery model include:
    - Strong integration of the workers from CAMH's into Brighter Future's to ensure greater integration and accountability.
    - Local governance through Brighter Futures, inclusive of local schools, to ensure Thurrock assets are integral to the CAMH's decision making process.
- The new wellbeing model brings together our universal responses to ensure that children and young people can access and be directed to

support whenever it is needed.

- Funding for the SWS remains a risk – Funding for a further two years has been secured. However, this is something that we will continue to review going forward.

During discussions the following points were made:

- Members supported the piece of work and recognised that the contract is one element of this work and the collaborative approach adopted across the system on this work was particularly acknowledged.
- It was recognised that the more that can be done at the local level will vital in supporting Thurrock's children and young people.
- The specification required that the new provider is in place consideration will be provided to how to ensure there are staff are seconded into Thurrock and providing services at the local level and not centrally focussed. Staff from the successful bidder should set out how they will second staff to the places within which they will be delivering services. The Board wholeheartedly agreed with the expectation of services being provided that is place focussed and not centralised.
- One outcome for the new contract is to ensure that all children and young people who meet referral criteria within 31 days. This should be demonstrated as part of successfully securing the contract.

RESOLVED: Board were made aware of the progress regarding the procurement of Child and Adolescent mental Health Services together with plans for the Thurrock model of delivery and the sustainability of that model.

7. HWB Strategy Refresh Update

This item was introduced by Jo Broadbent (Thurrock Council). Key points included:

- Statutory document which the new ICS must have regard for as part of NHS infrastructure changes at system, place and locality levels.
- The Strategy is high level and innovative. Members were provided with the proposed structure for the refreshed Strategy and an overview of the six high level domains incorporating the wider determinants of health with the vision of levelling the playing field.
- The Strategy's Strategic fit with the Local Plan, wider governance structures at system, place and locality levels as well as other key documents impacting residents of Thurrock.
- Members were provided with a summary of health outcomes for the population of Thurrock, including life expectancy and wider outcome disparities for residents living in different parts of Thurrock, and influences on people's health and wellbeing outcomes and review the outcomes framework is currently being updated.

- Overview of Domain leads and their roles, including engaging partners across the council and beyond. The aim it to identify up to five high level priorities to underpin each of the domains.
- An oversight of Governance arrangements including different groups established to drive forward the Strategy refresh, including the TICP

Strategy Group; a Council AD group, Chaired by Cllr Halden; a task and finish group and a communication and engagement group.

- The Engagement Group has recommended considering previous responses to Council consultations and engagement undertaken by CVS via Air Table approaches. The consultation will focus on high level priorities which includes the challenges for each domain and the priorities identified to date with a view to securing the public's views on their priorities.
- The current timeline provides for a Strategy launch in January. Board were asked to approve an extension of launching the Strategy until March 2022.

During discussions the following points were made:

- Members wholeheartedly welcomed the Health and Wellbeing Strategy.
- Members acknowledged the importance of the HWB Strategy and how it aligns with other key strategies including the Brighter Futures Strategy and the TICP Adult Place Based Strategy.
- The Health and Social Care Bill makes clear that the ICS must have regard for local Health and Wellbeing Strategies.
- The focus on levelling the playing field was supported by members and it was agreed that the Strategy should remain high level and strategic, identifying the key priorities under each domain.
- Members approved the proposal for the timescale extension to March 2022.

Decision

- Members were reassured that the domains will not be developed in silos and that a joined up, coordinated approach has been part of the design of the refresh.
- Members welcomed the breadth of focus of the Strategy and how priorities are being determined. Members were reassured that levelling the playing field will be reflected across the whole Strategy.
- Draft questions will be sent to the Strategy Group comprising Council Assistant Directors to help identify inequalities across the Strategy. The collective approach being adopted will support the identification of the causes of an uneven playing field. It was agreed that the questions would be circulated to Board for consideration and input prior to being sent to the AD Group. It was agreed that members would be invited to attend up to three meetings with the AD Group as part of informing the refreshed Strategy, particularly around the 'levelling up' aspect of the Strategy.

Action Secretariat

- The increased focus on anti-social behaviour and crime, creating an environment that is safe and welcoming was welcomed by members. Members recognised the importance of providing focus in the refreshed Strategy on the impact of the wider environment on health and wellbeing. Members noted that the Health and Wellbeing Strategy aligns closely with the PCC strategic priorities.
- Members welcomed the Strategy being informed by previous consultations and feedback already provided by the public through Council and wider consultation exercises.

- Consideration should be given to including implications on health and wellbeing within all Council reports going forward as part of reinforcing the importance of considering health and wellbeing across the Council's work.

Action Dem Services / Secretariat

RESOLVED: Board members

- **Commented on and approved the project scope and the arrangements for completing the strategy refresh.**
- **Approved the vision for the refresh of ''Levelling the Playing Field", with each chapter identifying ambitious actions required to do that.**
- **Approved the six domains**
    1. **Quality Care Centred Around the Person**
    2. **Staying Healthier for Longer**
    3. **Building Strong & Cohesive Communities**
    4. **Opportunity for All**
    5. **Housing & the Environment**
    6. **Community Safety**

- **Noted that operational oversight of the refresh process will be via: HWB Strategy / TICP Strategy Group, chaired by Ian Wake, AD Oversight Group, chaired by Cllr James Halden, and HWBS Engagement Group chaired by Dr Jo Broadbent.**
- **Agreed that final approval from Board could be extended from January 2022 to March 2022.**
- **That separate meeting would be set up to facilitate Board discussions with the AD Group in more detail.**

7. Brighter Futures Strategy

This item was introduced by Sheila Murphy, Thurrock Council. Key points included:

- Over the last two years the Brighter Futures Children's Partnership Board has undergone a journey of considerable significance, characterised by change and transformation, demonstrated by a desire to refresh its vision and gain clarity on the roadmap for delivery over the next five years.
- A refresh process therefore commenced in October 2020 led by the Assistant Director for Public Health, supported by a task and finish group chaired by the Executive Corporate Director for Children's Services.
- A process of need identification, narrative explanation and priority synthesis was adopted. Need was understood through the analysis of high level epidemiological data, stakeholder views and young people's voices.
- A five year strategy has now been drafted and is currently going through an agreed governance process.
- The Brighter Futures Partnership Board agreed the strategy in principal in June 2021.
- A public consultation is also being held on the strategy for an eight

week period. Consultation commenced 22nd June 2021. It is anticipated the strategy will be published by September 2021 and feed into the Health and Wellbeing Strategy.
- The work of PH Assistant Director Teresa Salami-Oru was acknowledged

During discussions the following points were made:

- Members welcomed the comprehensive strategy and the collaborative and engagement that had taken place to inform its development.
- Members considered the merits of a specific priority focussed on transitions and were reassured that transitions in young people's lives is integrated across all four priorities within the Brighter Futures Strategy. This approach ensures transitions are embedded across the Brighter Futures Strategy priorities.
- Members acknowledged the importance of supporting children and ensuring that they can catch up on issues that have impacted their development through the COVID-19 Pandemic.

RESOLVED: Board approved the Brighter Futures Strategy in principle and delegated authority to the Brighter Futures Children's Partnership Board for strategy approval and endorsement.

8. Primary Care Strategy refresh

This item was introduced by Mark Tebbs, Thurrock Clinical Commissioning Group. Key points included:

- The strategy refresh builds on the existing 2018 strategy – it does not propose an alternative strategic direction but focuses heavily on the element of collaborative working.

- The refreshed strategy takes account of local and national policy changes that have occurred since the original strategy was approved. Explicitly it takes account of:

    - The NHS Long Term Plan (2019),
    - Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (2019),
    - The Mid and South Essex Health and Care Partnership Five Year Delivery Plan (2019)
    - The Mid and South Essex Memorandum of Understanding and H&CP Outcomes Framework
    - The impact of the on-going pandemic, and
    - Recent publication of the DH&SC White Paper

During discussions the following points were made:

- Members were supportive of the Strategy refresh and the robust use of population health data to inform the priorities within PCN areas.
- The Primary Care Strategy reflects the importance of place, complimenting and supporting the work in Thurrock.
- Primary Care Networks are the future of the NHS and it is vital to ensure that PCNs are not considered as GPs but wider primary care, focussed on the whole population that a GP serves.

- The GP survey shows that satisfaction of GPs requires some additional focus. In response to the survey investment has been provided to PCNs for a project manager support to facilitate an integrated telephone system. It was acknowledged that GP practices are independent and are increasingly working as a collective across PCN geographical footprints, which was welcomed by members.
- It was recognised that the GP Satisfaction Survey should be addressed. It was agreed that consideration will be provided to how to further address the outcome of the GP Satisfaction Survey and a report will be provided at October's meeting.

  Action Thurrock CCG / Board secretariat
- Members recognised the positive progress that has been made in Thurrock over recent years and were reassured by the work across Thurrock that continues to support challenges within Primary Care.

RESOLVED: Members noted and commented upon the Primary Care Strategy refresh

9. MSE HCP Report on Learning from COVID

It was agreed that would be deferred until the next Board meeting.

Action Board secretariat

10. HWB Terms of Reference annual review

The TOR were approved by members.

The meeting finished at 12:25pm.

CHAIR……..

DATE……

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24 September 2021	**ITEM: 5**
Health & Wellbeing Board	
Mid and South Essex Health and Care Partnership Report on Learning from COVID	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Mark Tebbs, NHS Thurrock Alliance Director, Thurrock Clinical Commissioning Group	
Accountable Head of Service: N/A External partner report	
Accountable Director: N/A External partner report	
This report is public	

Executive Summary

The 'Learning From COVID-19 in Mid and South Essex Report: Understanding Drivers of Collaboration and Seeking New Ways to Tackle Inequalities' (March 21) report was produced by Kaleidoscope Health and Care. The report was the output from a number of place based stakeholder engagement events culminating in a Mid and South Essex learning event in November 2020. The stakeholder and learning events, therefore, gathered the learning from Spring and Summer 2020 when the system experienced the first waves of the pandemic.

It is therefore important to remember that these stakeholder and learning events took place during the pandemic. The systems were still adapting and managing the operational demands upon them. Many staff were exhausted. Nationally and locally awareness was growing regarding the disproportionate impact of the pandemic on our most vulnerable members of our society. The lessons were very live to the situation and therefore contain many important messages which must be recorded and help shape our approach to future service transformation. it is a credit to the system that it took time out to hold such events and record these lessons.

1. Recommendation(s)

1.1 That members of the Board note and comment on the contents of this report and accompanying documentation

2. Introduction and Background

2.1 The report summarised the learning under a number of headings:

1. When you prioritise, you can deliver significant change at pace
2. Shared purpose helped create a culture of enablement
3. Local people help local people if they are given the tools to do so
4. Strong relationships grow out of trust and connection to place
5. COVID-19 and health inequalities

2.1 The report provides a number of actions and commitments following the pandemic:

1. Work with the CVS to ensure all partners are united around the purpose and vision for reducing inequalities and teams see a connection between their work and the impact on the community.
    - Alliance leaders should work together to understand what reducing inequalities means locally
    - CVS should be central to the co-development process to ensure solutions are routed in the community
2. Embed a community focus into how services are delivered so that social value is integral part of how organisations work
    - Share learning from other anchor institutions
    - Establish measure for monitoring progress
    - Adopt the anchor institution charter
    - Set out a learning and development process to embed and maintain anchor practices
    - Provide guidance and training on how to maximise value to the local community
    - Share learnings from other anchor institutions
    - Develop a baseline and metrics for evaluating success

3. Drive the development of PCNs and neighbourhood level delivery to work differently with communities
    - Embed the engagement framework and ensure people are trained on what it means for them
    - Work closely with PCNs to support shared learning and progression
    - See opportunities for the CVS to lead programmes of work
    - Work together in place to tackle digital exclusion

4. Support staff so they can deliver their best work by role modelling the behaviours that deliver strong culture and excellent decision-making.
    - Establish flexible integrated teams
    - Look at the career development to fill gaps
    - Role model the behaviours that make for a positive culture
    - Be prepared to make difficult decisions about priorities
    - Ensure partnership staff have access to NHS staff wellbeing programme
    - Socialise new ways of working through education and preparation
    - Establish knowledge sharing and best practice fora

2.2 Thurrock Integrated Care Partnership (TICP) can already demonstrates progress against many of the place based actions and commitments outlined in the report. It is proposed that the TICP develop a task and finish group to review the actions and co-produce a response to this report to ensure that the learning is embedded locally within our local partnership arrangements.

3. Issues, Options and Analysis of Options

3.1 This report provides an update on MSE learning from COVID

4. Reasons for Recommendation

4.1 This report shares information about MSE learning from COVID with key partners in Thurrock through the Health and Wellbeing Board

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 MSE System partners to inform the contents of the report

6. Impact on corporate policies, priorities, performance and community impact

6.1 N/A External report

7. Implications

7.1 **Financial**

Implications verified by: **N/A External report**

7.2 **Legal**

Implications verified by: **N/A External report**

7.3 **Diversity and Equality**

Implications verified by: **N/A External report**

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

9. Appendices to the report

- Appendix A. Learning for MSE document

Report Author: Mark Tebbs, NHS Thurrock Alliance Director, Thurrock Clinical Commissioning Group

MARCH 2021

LEARNING FROM COVID-19 IN MID AND SOUTH ESSEX

UNDERSTANDING DRIVERS OF COLLABORATION AND SEEKING NEW WAYS TO TACKLE INEQUALITIES

Prepared by Kaleidoscope Health and Care

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APPENDICIES

PREFACE

A NOTE ON THE TIMING OF THIS REPORT

Learning is an ongoing and iterative process. What we learn today should shape our actions tomorrow, building on what we learned yesterday and the day before.

In this spirit, this report reflects the time between the first and the second waves of the Covid-19 pandemic. During this particular phase, Mid and South Essex Health and Care Partnership took the opportunity to reflect on what had happened to colleagues and those whom they work to support in the spring and summer of 2020. There was a desire to learn both from the challenges and the successes, and so enable the Partnership to prepare for what was about to happen subsequently, as well as influencing longer term plans for collaboration.

It is now clear that even greater challenges were in the near future and many of those involved in developing this report were put under further, enormous strain. Whilst their response was guided by what they had learned and was supported by networks developed during the first wave, it was perhaps inevitably undermined by exhaustion and the scale of the emergency.

It will be important to ensure that any learnings from what happened during the second wave of the pandemic are also gathered and shared. These further insights will build on the foundations of this report, and ensure that the conclusions and recommendations that follow in this report evolve, thereby ensuring the Partnership is in the best possible position to reset our approach to how we work together with our communities taking more account of the wider determinants of health.

FOREWORD

PROFESSOR MICHAEL THORNE CBE
CHAIR, MID AND SOUTH ESSEX HEALTH AND CARE PARTNERSHIP

When people talk about the 'unprecedented' nature of 2020, it's often in a negative sense. But in Mid and South Essex, alongside the many challenging aspects of the pandemic, we've seen something special and powerful emerge. Out of the chaos, we have seen our health and care teams come together quickly to make changes that we thought would take years. New services set up in days; pathways revised to keep people out of hospital and treat them where they are safest. And we've seen our communities stand up to protect neighbours and strangers who were in need.

The Covid-19 pandemic has seen us working better together than ever before and has shown us the potential that we can achieve if we focus our efforts in one direction. The experience has given us the tools we need to make a real difference to the health of our communities, even as the scale of our challenge is increasing. Research shows us that health is largely determined by broad social and economic factors.[1] As the pandemic has continued to impact people's livelihoods, we now need to look at new ways to support our communities if we want people to have better health and better lives.

[1] The Health Foundation, What makes us healthy? An introduction to the social determinants of health, March 2018. Accessed on 21.12.20 at: https://www.health.org.uk/sites/default/files/What-makes-us-healthy-quick-guide.pdf

As we move towards becoming an integrated care system (ICS), we have a strong plan to steer our programmes and services. Alongside this, we continue to learn about how we can collaborate better and that our joint reach is so much greater than the sum of our parts. To that end, we want to do more than just deliver our services – we want the way that we work together to actively contribute to better lives for our residents. As a partnership we will look after our staff and seek out ways to reduce bureaucracy and unnecessary policy so that they can work more effectively and quickly. We will also look for opportunities to deliver social value through the people we employ, the goods we buy and the land we use.

This autumn we took the time to ensure we really understood the drivers of better collaboration, what our staff and volunteers need us to do to support them, and what actions are needed to empower change in our communities.

This report reflects on what we've learned from the achievements of the past year and where challenges remain, and connects this with the path we are taking forward to become a truly integrated and caring system.

REFLECTION

> System wide events with key partners who are leading the Health and Care agenda are essential - for awareness, understanding as well as contributing to a collaborative approach.

During the first wave of Covid-19, a number of changes in working practices and policies occurred that meant it was significantly easier for people in Mid and South Essex to work together and to re-organise services. These changes made it possible for teams to be more responsive and flexible, and to deliver on priorities at pace. This ensured that hospitals had enough beds to treat Covid-19 patients, that people were looked after in the community and the public was kept as safe as possible.

In a bid to ensure that any positive developments were not lost, the partnership decided to undertake a learning process to understand what had enabled the changes in behaviour and policy that supported collaborative efforts during the pandemic. This learning would then inform action to tackle the inequalities that were deepening as a result of Covid-19. More detail about the learning process can be found in appendix 1.

LEARNINGS

WHEN YOU PRIORITISE, YOU CAN DELIVER SIGNIFICANT CHANGE AT PACE

> “During the first wave of Covid-19 it was clear that there was support for PCNs and delivery through communities, so we came together and agreed what we could accelerate and what was needed to do things differently.”

Although the health and care sectors have been moving towards greater integration for many years, the process has been slow for a multitude of reasons. Covid-19 saw a shift-change in how a range of organisations collaborated, including clinical commissioning groups (CCGs), hospitals, local authorities and community and voluntary sector (CVS) providers. New teams were created that brought together staff across organisations and worked in a responsive, reactive, client-focused, innovative and digitally-enabled way. Changes were made at pace in a way that would not have been possible previously. This was because regulatory and bureaucratic challenges were overcome but also because priorities were incredibly clear.

At the outset of the pandemic, in South East Essex, for example, the local authorities, NHS, CVS and healthwatch spoke to commissioners about what could be accelerated and what could be done differently. They created a family of professionals to implement changes to benefit local populations through Primary Care Networks (PCNs). In Basildon and Brentwood, a seven-day adult social care rota was achieved in weeks. Across all of the partnership, clinical appointments were delivered virtually.

These changes happened because the pandemic allowed staff to challenge existing rules and regulations where they conflicted with priorities. At

the time, priorities were all related to Covid-19 and ensuring that the health service was able to cope with the patients that needed treatment. Support for collaboration came from partnership-level work streams including the setting up of care home hubs, technical solutions for care homes, initiatives on homelessness and urgent care pathway reorganisation.

SHARED PURPOSE HELPED TO CREATE A CULTURE OF ENABLEMENT

Having this absolute clarity of purpose was key. This meant that everyone knew what they were supposed to be doing and how they were contributing to that goal. The challenging situation gave leaders an opportunity to create a culture that was about enablement and people felt empowered to go out and make change happen. Alongside this both staff and services users were encouraged to self-manage to a greater degree. This enabled local authorities to work with the CVS to set up food banks overnight and mobilise armies of local residents, who came out to support their neighbours (see below).

The partnership was critical in creating the infrastructure to show people how they could work together, through the Memorandum of Understanding (MoU) and guidance that showed how to marry national and regional policies with local assets to deliver a hyper-local response to need. There is now a real sense of excitement and enthusiasm for the partnership and alliances, and the role they can play in supporting a culture of empowerment, knowledge-sharing and blending resources going forward.

> “When we put our collective efforts and focus on trying to achieve a common outcome we’ve demonstrated we can do it, we just need to make it front and centre of what we do.”

> We changed from a traditional way of working to something that enabled people to make the real difference. That couldn't have happened without our willingness to release the reins and let people get on and do things.

LOCAL PEOPLE HELP LOCAL PEOPLE IF THEY ARE GIVEN THE TOOLS TO DO SO

The CVS, already expert in recruiting supporters, rose to the occasion of Covid-19 and recruited thousands of supporters to deliver food and prescriptions, work in call centres and support those in need. In addition to creating a community of volunteers, the CVS organisations reached those groups who had self-mobilised to ensure they operated safely providing skills development, guidance and insurance where needed.

Although local communities played a phenomenal part in protecting people during the pandemic, the CVS believes there is still much more it could be doing to shape services so that the right care is delivered to the right person and at the right time, especially with a shift towards prevention and a more holistic approach to health and care. For example, while there is funding to develop the social prescribing offers this does not always extend to the partners in the voluntary or third sector delivering services. Social prescribers played a significant part in pandemic but will struggle if the charity offer cannot survive.

STRONG RELATIONSHIPS GROW OUT OF TRUST AND CONNECTION TO PLACE

The pandemic saw a new paradigm for organisations working together in place and within the partnership. Local authorities came together with the CVS and PCNs to reach groups and areas not previously reached through the shielding list and utilising relationships at ward level. Technology enhanced connection between

those working together (though it also created a new disparity for those who do not have access to it).

Going forward, these relationships have consolidated in areas where they were new and strengthened in existing places. In South East Essex, for example, it has led to genuinely collaborative efforts to improve health provision for rough sleepers. Different partners are working together to share learning which in turn is helping to inform further investment/service change.

All of this was underpinned by a feeling of trust that everyone was working for the same goals and a new or renewed sense of place.

> “Communities pull together when there is a clear reason to do so.”

COVID-19 AND HEALTH INEQUALITIES

Covid-19 did not affect all equally. As the pandemic progressed, it became clear that people from poorer backgrounds and from minority ethnic groups, among others, were considerably worse affected by the disease. Considering what is well established about the factors that make people healthy (or not), this is unsurprising. People’s homes, jobs, schools, habits and communities deeply affect the likelihood of them becoming ill and the outcome when they do so.

The NHS alone cannot keep people well, in the same way it could not fight Covid-19 by itself. The central purpose of Mid and South Essex Health and Care Partnership is to unite the organisations who together can have the greatest impact on people’s wellbeing. As the pandemic continues to have a devastating effect on businesses, the partnership needs to consider what it can do beyond the services it delivers to address economic inequalities that drive poor health.

> “Inequalities will only increase with the impact of lockdown on society and the economy. Strong action needed to protect those from disadvantaged backgrounds.”

ACTIONS

With everything that has been lost in 2020, it is more important than ever that positive change is maintained and built upon. However, the challenges that the partnership now faces are significant, among them the ongoing pandemic, widening inequalities, financial constraints, an economic downturn, and an exhausted workforce.

For the learnings captured in this report to lead to tangible change, organisations across the system must be prepared to work differently and make difficult decisions.

The following chapter sets out four areas where leaders in place will need to take action to avoid lapsing back into old ways of working.

1. Work with the CVS to **ensure all partners are united around the purpose and vision for reducing inequalities** and teams see a connection between their work and the impact on the community.

2. **Embed a community focus into how services are delivered** so that social value is integral part of how organisations work

3. Drive the development of PCNs and neighbourhood level delivery to **work differently with communities**

4. **Support staff so they can deliver their best work** by role modelling the behaviours that deliver strong culture and excellent decision-making.

> “We are collaborating better than ever. **Now we need to turn that into action** starting by properly supporting the community and voluntary sector that has been so critical during the pandemic and will be so into the future.”

> “One organisation or individual can’t achieve real change in isolation. We have to have a common vision and a multi-faceted approach, statutory and nonstatutory together.”

1. ENSURE ALL PARTNERS ARE UNITED AROUND THE PURPOSE AND VISION FOR REDUCING INEQUALITIES

The pandemic gave everyone a clear goal and broke down ways of thinking that distinguished ‘us’ from ‘them’. This shared purpose and vision, more than anything else, created the basis for a decision-making framework and gave people the permission to challenge the way things had been done before. To replicate the strength of collaboration during this time, reduce barriers with governance and further improve links with the community, staff and volunteers must be 100% clear about what they are driving towards and why.

Across all of the discussions, there was a strong sense that a majority of people saw tackling inequalities as central to their work. This is not a surprise given the disproportionate impact the pandemic had on already disadvantaged groups, and the evidence highlighted by Covid-19 about the impact of economic and social circumstances on wellbeing. However, it was also clear from discussions that participants felt that to truly tackle inequalities a new approach was needed.

Leaders in each place should work together to understand what reducing inequalities means for their alliance. Co-creating understanding around purpose and vision will help to ensure that teams can see a direct link from their work all the way through to the system-wide goal of people living better lives. This will strengthen focus on activities which contribute towards reducing inequalities, and empower people to make the difficult decisions and prioritisations that will be needed in the coming weeks and months.

The vision for reducing inequalities in each place should emphasise the role in communities supporting themselves, and the **CVS should be central to the co-development process to ensure solutions are routed in the community**.

Commitments for partners:

- **Alliance leaders should work together to understand what reducing inequalities means locally.**
- **CVS should be central to the co-development process to ensure solutions are routed in the community.**

2. EMBED A COMMUNITY FOCUS INTO HOW SERVICES ARE DELIVERED

The partners within Mid and South Essex have an opportunity to support local communities beyond the services they offer. As large employers and purchasers of goods and services, and through the use of the land they own, they can create powerful positive investments in people, businesses and the environment. Creating ways of operating that aim to increase the value to local people and communities is sometimes called an 'anchor institution' approach, because it relates to organisations that are deeply embedded in a fixed place.

The partnership's vision to reduce inequalities will be strengthened if the organisations that make it up commit to working together in this way. The first step towards this will be **signing up to an anchor institution charter** that sets out the vision and key areas that organisations will focus on.

> "Every year we all commit to addressing inequalities and every year inequalities grow...we need to have a drastically different approach."

Setting the vision is the first step of this process, but ongoing work will be needed to make value for communities an integral part of how organisations work. Leaders in place will need to set out a learning and development process to embed and maintain practices that have a long term view. This must be reflected in organisations' overarching aims and objectives, and translated through to all teams. Good employment practices engender a happy (and healthier) workforce who are key to consolidating this approach. Furthermore, positive experiences of an organisation lead to recommendations and new talent being drawn in (also part of an anchor approach).

WHY ARE WE TALKING ABOUT 'ANCHOR INSTITUTIONS'?

When we say 'anchor institution', we're talking about large organisations, generally in the public sector, like hospitals, local authorities or universities. These institutions employ a high number of local people and provide services in the same area. As a result of this, there is a lot these organisations can do to impact the wellbeing of local people. This is because the things that most determine our health is not healthcare, but economic and social factors.

> “Developing career paths and training plans for young people will encourage more local applications.”

> “If we tell local businesses what we need, they may be able to adapt to create a sustainable, local supply.”

Each organisation will also have to **provide guidance and training on how to maximise value to the local community** in a variety of work practices (the draft charter identifies three potential domains; employment, procurement and working as an environmentally responsible organisation). The partnership should aim to **share learnings from other 'anchors'** within and without Mid and South Essex, about how to take action in these areas. This could include highlighting frameworks that incorporate measures for social value and examples of how recruitment can be made to deliver greater local benefit. Appendix 2 sets out some examples and further resources are listed in Appendix 3.

Key to understanding the value of any approach is to establish what the gaps are, what the anticipated change will be and how to measure the progress towards this. **Developing a baseline and metrics** should be done at partnership level to monitor progress, and in place to set targets and link to need.

It is critical that the communities whom this approach is aimed at supporting are central to shaping the desired outcomes.

Commitments for Mid and South Essex HCP:

- **Share learnings from other ‘anchor institutions’.**
- **Establish measures for monitoring progress.**

Commitments for partners

- **Adopt the anchor institution charter.**
- **Set out a learning and development process to embed and maintain 'anchor' practices.**
- **Provide guidance and training on how to maximise value to the local community.**
- **Share learnings from other 'anchor institutions'**
- **Develop a baseline and metrics for evaluating success**

3. WORK DIFFERENTLY WITH COMMUNITIES

The relationship between local populations and public services is changing, and the balance of power is slowly shifting. It is important to keep hold of what has been learned in terms of co-design and outreach with local communities, although there is still progress to be made. There is a continued effort to build from the bottom up and reach out to groups who are seldom asked or heard.

Reducing inequalities will only be possible with a further shift in how organisations understand and partner with communities. Across the partnership, organisations and alliances have made great strides in how they co-design and deliver action with residents and service users.

Embedding the engagement framework in place, and ensuring everyone is aware of the approach will help to consolidate this good practice and spread it further.

> "The opportunity to restructure and review the estates is now, particularly for CCGs."

> "Communities themselves often have a greater understanding of their needs and how to help each other than local services."

> “We need to encourage PCNs to engage more with their communities and local services and partners in both health and social care. For too long we have told people what they can have and have not asked what's important to them.”

PCNs provide a strong mechanism to bring operations closer to communities, residents and seldom reached groups. **Alliances should be working closely with clinical directors and other community leaders to support PCNs** to share learning and progress in maturity.

A challenge going forward remains an imbalance of power in the relationship between statutory and community organisations. During the pandemic, and despite stronger than previous relationships, the CVS reported being engaged belatedly in many cases and considered themselves to be a lesser partner in alliances. It is welcome that in many areas, the CVS is leading work around Theory of Change for place and that the partnership has established an engagement steering group. Alliances should continue to **seek opportunities for the CVS to lead programmes of work**.

While alliances and individual organisations are achieving impressive results in engaging with people virtually through existing social media channels, **work is still in place needed to tackle digital exclusion**, and that should be a priority going forward.

Commitments for partners:

- **Embed the engagement framework and ensure people are trained on what it means for them.**
- **Work closely with PCNs to support shared learning and progression.**
- **Seek opportunities for the CVS to lead programmes of work.**
- **Work together in place to tackle digital exclusion.**

4. SUPPORT STAFF SO THEY CAN DELIVER THEIR BEST WORK

For organisations to truly cement a community focus in their operations, all staff must understand the concept and how their roles contribute to delivering the overarching objective of reducing inequalities. From finance teams to facilities, to IT, to catering, everyone can do something with their role to improve the standing of the local community. This might be buying locally, employing locally, choosing a environmentally friendlier option or supporting communities in another way. As such, it is vital that staff not only understand this, but are supported to do their jobs to the best of their ability.

In 2020, staff have gone above and beyond to ensure that vulnerable residents and communities could shield and stay safe during the pandemic. Now as services try to rebuild while experiencing another wave, organisations must address staff wellbeing needs and resilience if they want to move forward and not back.

The partnership's Integrated Health and Care Workforce Strategy published in the summer offers good guidance for alliances for shaping action going forward, including advice on **establishing flexible integrated teams** and **looking at career development to fill gaps** (this is also part of an anchor institution approach).

> "To retain staff we need to deal with the 'what are we not going to do?' question to ensure a manageable workload for our staff."

> "As senior managers need to be very, very conscious of... comments made about staff exhaustion and feeling very stretched."

> “Digital has been a real driver for better collaboration by bringing people together more regularly and more easily to make decisions.”

> “Digital technology has made so many things possible, but the discipline about how to use it wisely is not always there.”

Digital communications enabled faster decision making and information sharing, which was positive during the pandemic. However, staff resilience is now being tested by new ways of working and concerning new work patterns. ‘Crisis mode’ has become the norm. In addition to wellbeing concerns, this means that there is a lack of headspace for strategic thinking and leadership.

The workforce strategy also includes approaches that are relevant for addressing burnout and a slide into tactical, short-termism. **Leaders must role model the behaviours that make for a positive culture**, such as expectations around work/life balance. They should also **be prepared to make difficult decisions about priorities**, and explain the reasoning behind them, to ensure that there is enough resource to do the work that is highest priority. Other approaches includes **ensuring staff working for the partnership have access to the NHS staff wellbeing programmes** that are funded already.

Despite the work that has been done to reduce and simplify governance arrangements, some confusion remains about the respective roles of the partnership, the alliances and the different organisations that are involved with each. It can be expected that not everyone needs to understand these arrangements in detail, but where it hinders collaboration, it is a problem that should be addressed. The MoU has proved to be valuable during the pandemic, in giving structure to statutory organisations wanting to work with the CVS and private sectors. However, alliances may want to do more to understand where confusion continues and provide **education and preparation to socialise new ways of working**.

Another challenge to collaboration in a number of places, was a sense that there were strong relationships at a strategic level but not among operational teams, and that this is where a culture shift was needed. Leaders in place should seek opportunities to **develop connections through knowledge sharing and best practice fora** especially in relation to business models, delivering pathways across multiple providers and decision making.

Commitments for partners:

- **Establish flexible integrated teams.**
- **Look at career development to fill gaps Role model the behaviours that make for a positive culture.**
- **Be prepared to make difficult decisions about priorities.**
- **Ensure partnership staff have access to the NHS staff wellbeing programme.**
- **Socialise new ways of working through education and preparation.**
- **Establish knowledge sharing and best practice fora.**

NEXT STEPS

Learning from experience and translating into action is a key component of quality improvement, and this process has given partners within Mid and South Essex a strong opportunity to reflect and set a new course. Above all else, people involved in this process wanted the positive changes that happened during the pandemic to sustain and deepen, so that 2020 becomes a turning point in how people work together and how equal their communities are.

The recommendations above set out what is needed to achieve this goal. Going forward, the leadership in each place and each organisation must now decide which commitments to prioritise, how to deliver them and the timescales for action. With plans in place, the potential is huge and exciting for what can be achieved to transform the lives of people in Mid and South Essex.

APPENDIX 1: LEARNING APPROACH

During November, virtual learning events for each place unpicked the successes, ongoing challenges and priorities emerging from the pandemic. The themes arising from the discussions highlighted the importance of shared purpose and vision, the role of communities in supporting themselves, the importance of clarity around governance and, more than ever, the need to prioritise staff wellbeing.

These sessions fed into a system-wide event that explored the implications of these themes for the partnership, and what they would mean in practice. The participants of the system event also discussed the opportunities that could be realised by adopting an approach to operating that would maximise social value, and so target the upstream determinants of ill health.

This report represents the stated intentions of the members of the partnership to take forward the learnings, and recommended actions that would be necessary for this to happen.

For more information about the learning approach, please contact zoe@kscopehealth.org.uk.

APPENDIX 2: ESSEX COUNTY COUNCIL ANCHOR INSTITUTION CASE STUDY

In 2019, Essex County Council (ECC) examined system opportunities to tackle deprivation through addressing the broader determinants of health. Following acknowledgment that the greatest influencer of good health has consistently been shown to derive from socio-economic factors, with the key driver of health being material wealth which is associated with higher levels of educational attainment and 'good' employment opportunities, the board agreed to explore a range of interventions to tackle these issues.

These included:

- Targeting employment positions for local people to optimise opportunities for people from disadvantaged backgrounds, or with particular health needs, or protected characteristics.
- Creating pre-employment programmes, work placements and volunteer work experience to help encourage people to consider different career paths.
- Engaging young people and supporting career development to tackle low levels of aspiration and encourage young people to consider different career paths.
- New career opportunities to review and reshape posts that do not have good progression or opportunities.

- Supporting health and wellbeing of staff, concentrating on mental health and musculoskeletal conditions, to support people to enter and remain in the workforce.
- Shifting more spend locally to boost local business and supply chains.
- Embedding social value into purchasing decisions to acknowledge businesses that contribute to creating local jobs and training opportunities, paying a living wage etc
- Recognising workforce as part of the community and seeking opportunities for staff to be ambassadors through the other roles they hold
- Encouraging public sector opportunities to drive investment in areas in need of regeneration.
- Use of estate and infrastructure development to connect services with local areas of need.

ECC has now integrated many of these approaches and is working with other anchors locally to help them also embed social value in their work practices.

It is also working with the private sector, encouraging major employers with 500+ staff to adopt an anchor approach and has secured significant investment from Innovate UK to help the development of the Horizon 120 business and innovation park in Braintree.

For more information, please contact: Laura.Taylor-Green@essex.gov.uk.

APPENDIX 3: FURTHER RESOURCES

Factors affecting wellbeing and health outcomes

1. Health Foundation, What makes us healthy? An introduction to the social determinants of health, March 2018.
https://www.health.org.uk/sites/default/files/What-makes-us-healthy-quick-guide.pdf

2. Institute of Health Equity, Health Equity in England: The Marmot Review 10 Years On, February 2020
https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

3.Improvement and Development Agency, The social determinants of health and the role of local government, 2010.
https://www.local.gov.uk/sites/default/files/documents/social-determinants-healt-25f.pdf

Embedding a community focus in delivering services

Centre for Local Economic Strategies (CLES)
Website: https://cles.org.uk/

Health Foundation
Website: https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

Report: https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

Local Government Association
Website: https://www.local.gov.uk/topics/devolution/devolution-online-hub/local-growth/leading-places

NHS Long Term Plan
Website: https://www.longtermplan.nhs.uk/online-version/appendix/the-nhs-as-an-anchor-institution/

24 September 2021	ITEM: 6
Thurrock Health and Wellbeing Board	
GP Item Part One - GP Satisfaction Survey	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Rahul Chaudhari, Deputy NHS Alliance Director, Thurrock CCG	
Accountable Head of Service: Mark Tebbs, NHS Alliance Director, Thurrock CCG	
Accountable Director: Mark Tebbs, NHS Alliance Director, Thurrock CCG	
This report is public	

Executive Summary

The paper aims to do a deep dive on primary care provision in Thurrock, discuss the GP Patient Survey results, primary care access, challenges, mitigations, support and improvement initiatives being implemented to address these challenges. The CCG commits to bringing in a detailed action plan looking to address and improve all the 9 survey domains that are used within the national primary care survey at the next board. The Health and Wellbeing Board is asked to take note of the contents of this paper and advise how primary care services can be improved further.

1. Recommendation(s)

Members are requested to take note of the contents of this paper

2. Introduction and Background

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice through a range of questions.

The survey is sent out to over two million people across the UK. In Thurrock, a total of just over 10,000 questionnaires were sent to Thurrock residents. Table below shows how many questionnaires were sent out over the last 3 years and the uptake of returned questionnaires.

Year	2019	2020	2021

No. of Questionnaires sent out	10,478	10,294	10,956
No. of Returns Completed	3,070	2,916	3,461
% Complete	29%	28%	32%
GP Registered Population	178,916	181,196	182,673
% Population questionnaires sent to	5.9%	5.7%	6.0%
% Population questionnaires completed	1.7%	1.6%	1.9%

The response rate relates to the number of GP Patient Survey questionnaires being completed and returned and this also has a variation with the highest response rate being from Stanford-Le-Hope (SLH) PCN although they had least number of questionnaires distributed out. Aveley South Ockendon and Purfleet (ASOP) PCN had the lowest response rate despite having the second highest number of questionnaires distributed. Results show ASOP PCN has consistently achieved lower percentage scores then other PCNs which may be due to the low response rate. Grays PCN and Tilbury & Chadwell PCN are ranked second and third in terms of response rate.

PCN	Stanford-Le-Hope PCN	Grays PCN	Tilbury & Chadwell PCN	ASOP PCN	TCCG	National
No. of Questionnaires sent out	1,971	4,175	2,295	2,515		
No. of Returns Completed	767	1,311	675	708		
Response rate (%)	39%	31%	29%	28%	32%	35%

3. Issues, Options and Analysis of Options

The main issues that have been identified from the GP Patient Survey have been analysed to look for trends and the table below compares the results in certain key areas from 2019 to 2020 and the trends are shown in the up and down arrows.

		POSITIVE SATISFACTION		CHANGE SINCE 2019	
No.	Question	CCG result (%)	National result (%)	CCG result (%)	National result (%)
31	Overall experience of GP practice (likely IAF indicator)	72 ↓	82 ↓	-5	-1
1	Ease of access to practice via phone	55 ↓	65 ↓	-10	-3
2	Helpfulness of practice receptionist	83 ↓	89 →	-4	0
6	Ease of use of online services	68 ↓	76 ↓	-3	-1
8	Satisfaction with appointment times available	55 ↓	63 ↓	-4	-2
16	Choice of appointment when last booked	53 ↓	60 ↓	-2	-1
17	Satisfaction with type of appointment offered	64 ↓	73 ↓	-4	-1
22	Overall experience of making an appointment	56 ↓	65 ↓	-6	-2
27	Mental health needs recognised and understood	81 →	85 ↓	0	-1

The table below does a similar analysis for trends in 2020 and 2021 and it is evident that some improvements are seen though it is recognised that there is a way to go.

		POSITIVE SATISFACTION		CHANGE SINCE 2020	
No.	Question	CCG result (%)	National result (%)	CCG result (%)	National result (%)
30	Overall experience of GP practice (likely IAF indicator)	72 →	83 ↑	0	+1
1	Ease of access to practice via phone	55 →	68 ↑	0	+3
2	Helpfulness of practice receptionist	84 ↑	89 →	+1	0
4	Ease of use of online services	66 ↓	75 ↓	-2	-1
6	Satisfaction with appointment times available	60 ↑	67 ↑	+5	+4
14	Choice of appointment when last booked	61 ↑	69 ↑	+8	+9
15	Satisfaction with type of appointment offered	75 ↑	82 ↑	+11	+9
20	Overall experience of making an appointment	60 ↑	71 ↑	+4	+6
26	Mental health needs recognised and understood	80 ↓	86 ↑	-1	+1

The key point to note is the overall experience is a key question within the survey as to an extent it incorporates all other domains/questions in to one. The %'s measure a response of 'Very Good' or 'Fairly Good' from recipients.

The graphs below show aggregated results for Thurrock PCNs and how the results compare to national and CCG averages.

CCG is working with specific practices and PCNs to carry out a deep dive of the GP Patient Survey results and identify where improvements need to be made.

There are a variety of reasons for the low GPPS results and these are listed below:-

3.1 – Primary Care Telephony

GP practices have seen a significant pressure on their telephone lines due to:

- The number of appointments provided have increased in June 2021 compared to June 2020 and June 2019.
- Added to this, the reduced walk in capacity in primary care has put additional pressure on telephone lines.
- Alongside, all the COVID vaccination queries from patients are coming into the existing and already busy GP practice telephone lines.
- Practices have been affected by COVID-19 staff outbreaks and have no access to NHS bank staff to back up the workforce with interims if required.
- The backlog created by the pandemic is significant and this is evident in the number of patients contacting the GP practice seeking treatment, advice and guidance whilst waiting for hospital care.

3.2 - Primary Care Estates

The poor quality of Primary Care estates in some parts of Thurrock is making service delivery in certain practices more challenging as Infection Protection and Control (IPC) guidelines still need to be followed in all healthcare premises. This has impacted on the patient perception of their practice's ability to deliver services.

A MSE wide workstream is looking at primary care estates per PCN and assessing how primary care estates need to be made future proof especially with the new PCN workforce that is being recruited to.

3.3 - Primary Care Workforce

Thurrock is one of the lowest under doctored areas in Primary Care. Workforce data shows a decrease in GP Partners alongside an increase in Salaried GPs with an overall small decrease in GP workforce from March 2019 to March 2021. Thurrock also has a decrease in nursing capacity in Primary Care. However, Direct Patient Care Roles and admin/non-clinical staff numbers have increased slightly from March 2019 to March 2021.

Evidence also shows that the clinical workforce in Thurrock has a significant higher proportion of older (over 55) staff compared to England and MSE average. This has had an impact during the pandemic as there have been staff who have taken early retirement and moved onto pastures new due to burnout. A proportion of practice clinical staff have also been categorised as shielding and Clinically Extremely Vulnerable (CEV) so not able to provide their services like pre-COVID times.

3.4– Primary Care Access

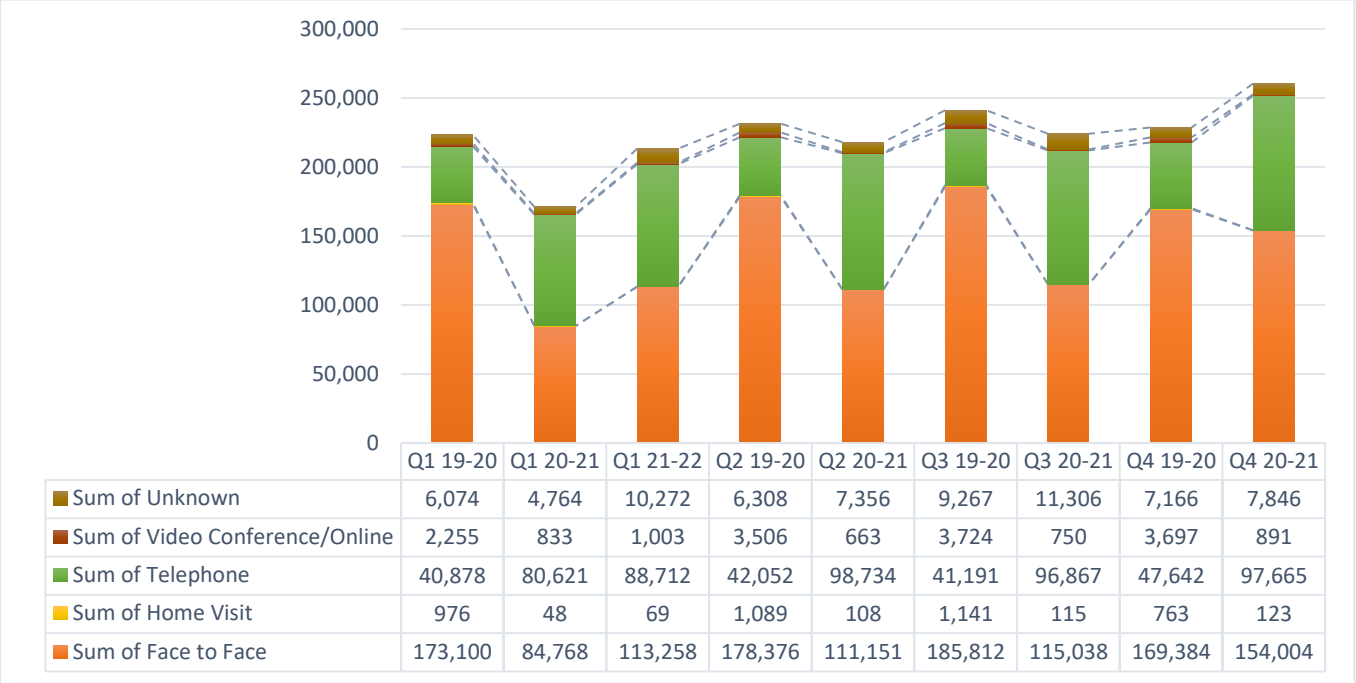
The GPPS results are directly linked to the various aspects around Primary Care access. The CCG is leading this workstream through Business Informatics analysis where the evidence shows that –

- During 2019-2020, GP practice appointments mainly comprised of face to face appointments, 78%, which makes a total of 737,536 of all appointments being face to face. Telephone appointments were mainly used for triaging or following review by care navigators
- During the COVID-19 pandemic, evidence shows an effect during quarter 1 of 2020-2021 of telephone and virtual appointments increased to 67% to total 379,142 appointments compared to 184,945 in the previous year of all appointments with a drop in face to face appointments to 56% which totalled 482,882 appointments.
- Additional digital resources were implemented into Primary Care in 20/21, improving access types for patients into Primary Care such as Online Consultation Platforms, Away from My Desk and additional laptops.
- The total number of appointments within all aspects of Primary Care (core GP services and Extended Primary Care services in evenings and weekend) totalled 922,508 during 2019-2020. A 6.5% decrease of appointments was seen within Primary Care during the pandemic year 2020-2021, totalling 862,024 appointments.

- None of the above data sets cover the Covid Vaccination Programme appointments that have been delivered mostly by Primary Care whilst delivering primary care services.
- Table below shows a year on year comparison of Quarter 1 appointments which are pre, during and post pandemic and this evidences the consistent increase in appointments delivered in Q1 2021 compared to Q1 2020 however not as high as pre-pandemic activity:-

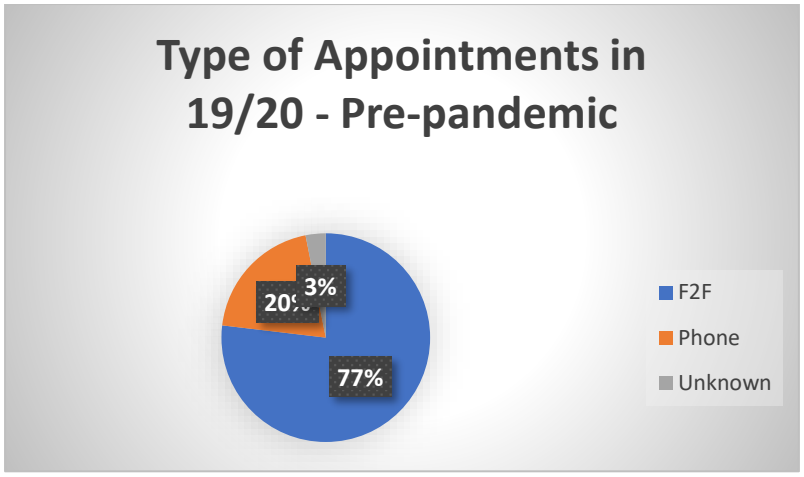
Period	Face to Face	Home Visit	Telephone	Video Conf/ Online	Unknown	Total Appts in Quarter
Q1 19-20	173,100	976	40,878	2,255	6,074	223,283
Q1 20-21	84,768	48	80,621	833	4,764	171,034
Q1 21-22	113,258	69	88,712	1,003	10,272	213,314

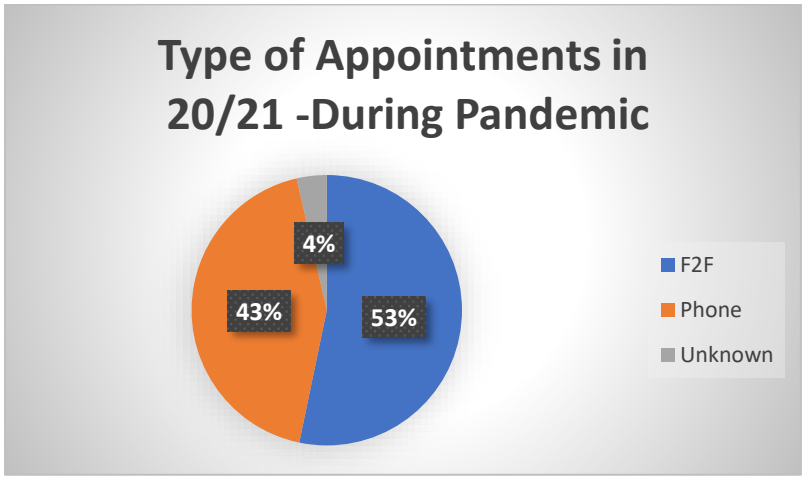
The graph below shows the above data in a clearer way and the effect the pandemic has had on service provision, that is, how the service delivery model has changed the type of appointment provided:- face to face, telephone, video or online consultation appointment.

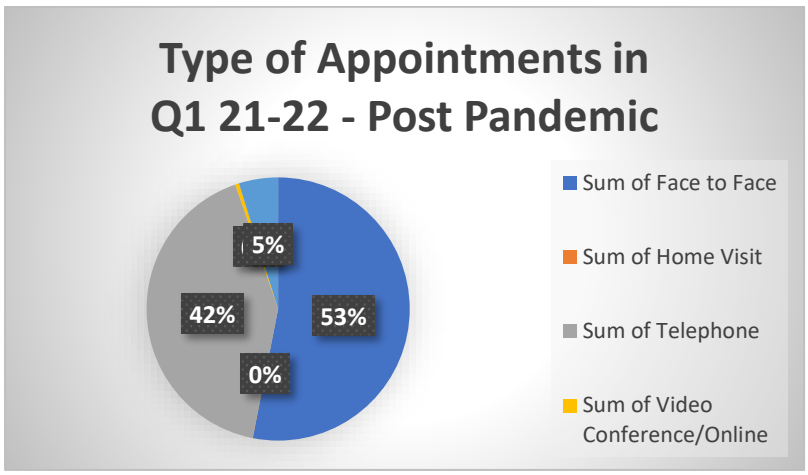


	Q1 19-20	Q1 20-21	Q1 21-22	Q2 19-20	Q2 20-21	Q3 19-20	Q3 20-21	Q4 19-20	Q4 20-21
Sum of Unknown	6,074	4,764	10,272	6,308	7,356	9,267	11,306	7,166	7,846
Sum of Video Conference/Online	2,255	833	1,003	3,506	663	3,724	750	3,697	891
Sum of Telephone	40,878	80,621	88,712	42,052	98,734	41,191	96,867	47,642	97,665
Sum of Home Visit	976	48	69	1,089	108	1,141	115	763	123
Sum of Face to Face	173,100	84,768	113,258	178,376	111,151	185,812	115,038	169,384	154,004

The pie charts below show how the type of appointments have changed during the pandemic in comparison with pre-pandemic times.







3.5– Quality and Patient Safety

CCG Quality Team is supporting improvements in the quality of Primary Care delivered to Thurrock residents by aspiring to have no CQC challenged practices in Thurrock. The dedicated input into specific practices has improved CQC rating of a specific practice from CQC Special Measures to CQC Requires Improvement and

continuous ongoing support is being provided to ensure a Good CQC rating is achieved for this practice and this is sustainable in the foreseeable future.

This detailed work will help to improve the care provided to patient and the patient experience of the service. This workstream is linked into MSE, NHS England, CQC and Healthwatch Thurrock so that learning can be shared from system partners. Similar improvement measures are also being discussed to support the only remaining CQC Special Measures practice in Thurrock.

3.6– Stakeholder Engagement

CCG is supporting the stakeholder engagement element by linking in with Healthwatch Thurrock and supporting the hosting of a Facebook Live session which took place on 1 September 2021 where patients could ask direct question to the panel comprising of local GPs, Practice Manager and Patient Liaison Manager. This session will be assessed and if deemed helpful for patients will be repeated.

CCG has engaged through the Commissioning Reference Group Forum and will continue to do so alongside GP practice-based Patient Participation Groups (PPGs) and Patient Participation Network Groups (PPNG). Links are being made with Thurrock CVS to request patient engagement through the community builders and other staff groups to ensure there are ties to the local communities. CCG is working with Communication colleagues to ensure queries regarding covid vaccination programme are channelled appropriately and all key messages are out on social media platforms and CCG/practice websites.

Engagement is also taking place through multiple forums and targeted discussion groups including

- CCG Monthly Clinical Engagement Group
- Bi-weekly Practice/CCG Call
- PCN CD Strategic Meeting
- Healthwatch Thurrock supporting patient engagement with Facebook Live session to start with followed by other sessions
- Practice Level Patient Participation Groups
- Healthwatch CVS to support with community engagement
- PCN level financial support via PCN Accelerator funding to improve access
- CCG providing specific support to CCG challenged practices with the support of Primary Care and Quality Teams
- Encouraging sharing best practice at local forums

3.7– PCN Recruitment Support

CCG are working with Primary Care Network (PCN) leads to support the recruitment to the PCN Additional Roles Reimbursement Scheme (ARRS) which supports recruitment of holistic and innovative roles such as Care Coordinators, Health and

Well-being Coaches, Paramedics, Clinical Pharmacists, Physicians Associates and First Contact Physiotherapists. The low uptake of LD and SMI Health Checks in primary care are being supported by recruitment of PCN Level Mental Health Practitioners who are supporting Primary Care to deliver these much needed checks.

Thurrock Council Public Health are supporting this work by analysing health need in relation to workforce capacity, to help ensure additional capacity is directed where it will have most impact.

3.8– PCN Accelerator Programme

Additional Funding has been provided to PCNs via the PCN Accelerator program whereby management support has been provided to progress with specific local projects which have a focused Thurrock need. For example, currently there is scoping being done for an Obesity Pilot which will provide dedicated support to specific patients who fall in certain criteria.

Some PCNs as part of their accelerator programme are also looking to scope the potential for merging back office function on a PCN footprint that will see a common telephony system for patient struggling to get through their GP phone lines.

3.9– Development of Stretched QOF

PCN Clinical Directors and CCG are in co-production with Public Health to develop stretched Quality Outcome Framework (QOF) that will see improvements in the management of long-term conditions beyond QOF thresholds.

Practice profile/score card linked to stretched QOF being developed by Public Health team - this is expected to provide practices a snapshot on missed income and potential for improvements in the management of long-term conditions whilst also improving on patient outcomes.

3.10 – MSE Workstreams

CCG working with MSE colleagues to look at innovative ways in managing the long hospital waiting list such as training and education packages for both healthcare professionals and public.

Essex Public Health teams are also working with MSE to establish referral processes for wellbeing advice for those on priority waiting lists where such support is likely to have a beneficial impact, such as orthopaedics.

The MSE Population Health Management work programme includes reviewing how preventative activity can impact on system demand and inequalities in need. It will identify the patients that need the most support so that they can receive this proactively before issues arise. This will improve patient outcomes and reduce practice workload.

It is anticipated that supporting the above workstreams will not just help to improve the GP Patient Survey results in 2022 but also improve the health and wellbeing of Thurrock residents.

4. Recommendation

5. Consultation (including Overview and Scrutiny, if applicable)

6. Impact on corporate policies, priorities, performance and community impact

7. Implications

7.1 **Financial**

N/A

7.2 **Legal**

N/A

7.3 **Diversity and Equality**

N/A

7.4 **Other implications**

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- https://gp-patient.co.uk/

9. Appendices to the report

- N/A

Report Author:

Rahul Chaudhari

Deputy NHS Alliance Director,

Thurrock CCG

Friday 24th September 2021	**ITEM: 7**
Thurrock Health and Wellbeing Board	
GP Item Part Two. Improvements in primary care Long Term Condition management	
Wards and communities affected: All	**Key Decision:** None
Report of: Vikki Ray – Senior Programme Manager (Healthcare Public Health)	
Accountable Head of Service: Emma Sanford – Strategic Lead (Public Health and Social Care)	
Accountable Director: Jo Broadbent – Director of Public Health	
This report is Public	

Executive Summary

The report provides an outline of the Stretch QOF contract for 2021-22 which seeks to incentivise general practice to make improvements in both case finding and management of selected long term conditions and an update on the LTC profile card with relation to its content and proposed implementation steps.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board note and comment upon the proposed developments in delivering improvements in long term condition management and a renewed LTC profile card.

2. Introduction and Background

2.1 The main objective of this programme is to improve population health and reduce inequalities through improved quality of LTC management in Primary Care. In this paper we detail the plans for the programme this 2021-22 and current thinking for major revisions for 2022-23 financial years.

3. Issues, Options and Analysis of Options

3.1 The Global Burden of Disease (GBD) study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm. It also reveals that the slower improvement since 2010 in years-of-life-lost is “mainly driven by distinct condition-specific trends, predominantly in cardiovascular diseases and some cancers”. Furthermore, it quantifies and ranks the contribution of various risk factors that cause premature deaths in England. The top five are: smoking, poor diet, high blood pressure, obesity, and alcohol and drug use.

These priorities have guided the NHS prevention programme as part of the NHS Long Term Plan.

3.2 The role of the NHS includes secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life.

3.3 Within Public Health we continue to develop programmes of work and support the NHS to move from reactive care towards a model embodying active population health management, and together with local authority colleagues and voluntary sector partners on the broader agenda of prevention and health inequalities.

3.4 The Annual Public Health Report (2016) quantified the effect that low levels of long term condition management were having on emergency care for specific indicators in Thurrock. Whilst the NHS GP contract 'QOF' (Quality Outcomes Framework) currently pays Practices based on the percentage of patients who receive specific, evidence based interventions and/or treatments, this is capped. The value at which it is capped is dependent upon the indicator. Mostly incentivisation happens for around 70-85% of patients receiving the intervention. Practices generally score around the level that they require for maximum payment. This either suggests that this is an "achievable" level or that Practices do not have the resources to obtain higher with no potential of funding, but has the effect of excluding 15-30% of the population and this excluded group can often include vulnerable groups and those experiencing multiple inequalities who have the greatest potential to benefit from improved quality of care.

3.5 As a result of this a Stretch QOF contract was launched in 2018 and has been reviewed/renewed annually since, incentivising practices to aspire to achieve above the maximum Quality and Outcomes Framework threshold for a subset of indicators. Diseases incentivised for management were informed by a number of long term conditions multiple regression analysis models developed by the Health Intelligence/Healthcare Public Health Team that identified and quantified the impact that significant QOF indicators had on the incidence of serious health events with a view to reducing emergency admissions to secondary care and preventing patients from having major health events, such as a Stroke. These have included Asthma, Hypertension, Atrial Fibrillation, Coronary Heart Disease, Stroke, Depression, COPD, Smoking and Diabetes. The indicators for 2021 – 22 are outlined below.

3.6 Stretch QOF 2021/22 Indicator Set

The indicators have been selected on the basis of the following:

- Public Health multiple regression analysis models indicated these indicators impacted on unplanned care admissions in Thurrock
- The indicator rationale has been nationally recognised as high impact (NICE guidance)
- Stretch QOF appears to be positively influencing general practice to complete the intervention at a rate greater than previously achieved without incentivisation
- Indicators that require a focused effort to address backlog/drop in performance attributable to the Covid pandemic
-

3.7 Blood Pressure Management - Blood pressure is a comorbidity in over 70% of the Thurrock population with a long term condition and a significant risk factor for other cardiovascular diseases if undiagnosed or poorly managed. Due to capacity and the required operational running of general practice during COVID there was a reduction in those with a recorded or well managed blood pressure in the previous QOF year, making this a high priority area for focus.

This priority is complimented by the CCG's workstream 'BP at Home' which has supplied 243 BP machines to Primary Care to loan to the most clinically vulnerable/at risk patients to monitor their blood pressures at home.

Indicator	Description
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2013 menu ID: NM68)
CHD009	The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2019 menu ID: NM191)
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2012 menu ID: NM53)
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2012 menu ID: NM54)
STIA010	The percentage of patients aged 79 years or less with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or Less (NICE 2013 menu ID: NM69)
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or Less (based on NM93)

3.8 Smoking - Smoking is noted as in the top five risk factors contributing to the burden of disease and continues to be the leading cause of premature and preventable death in England. It is also the largest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Case finding of smokers particularly in those with cardiovascular disease, respiratory disease and mental ill health is therefore a high priority. It also supports improving recording of smoking status for other programmes in the Thurrock system such as the Targeted Lung Health Check which would benefit from ensuring its full eligible cohort is identified given it invites both smokers and those who have ever smoked for a check.

Indicator	Description
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (NICE 2011 menu ID: NM38)
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 Months (NICE 2011 menu ID: NM39)

3.9 Case Finding/ Surveillance - Case finding remains crucial in identifying those requiring onward interventions to support good management of their condition. In 2021-22 we continue to incentivise blood pressure checks in those aged 45 and over to case find for hypertension. We also continue to support review of those with identified risk of developing a long term condition or those that are potentially developing greater risks as part of their existing conditions via non-diabetic hyperglycaemia blood testing and atrial fibrillation stroke risk assessments respectively.

Indicator	Description
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years (based on NM61)
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months (NICE 2017 menu ID: NM150)
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) (NICE 2014 menu ID: NM81)

3.10 Quality Management

Ensuring patients newly-diagnosed with depression receive a timely review is crucial for supporting them with the most appropriate treatment regime.

Continuing to incentivise this indicator will also help the performance of other programmes of work to improve mental health in primary care, such as the new Depression Diagnosis Pathway which aims to ensure newly-diagnosed depression patients receive wellbeing calls and has a point of contact whilst waiting for this GP review to take place.

Indicator	Description
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (NICE 2014 menu ID: NM82)
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis (Based on NM50)

3.11 New Models of LTC care for the future and how stretched QOF will need to adapt

Thurrock's transformation programme includes looking at models of care for the future, this includes a new model for LTC care in the future (at least in advance of our Integrated Medical Centres becoming operational. Work to date suggests that the main problems we need to solve in designing a new model are:

1. Early detection – we still have many patients presenting in the acute setting due to Long Term Conditions that were not pre-diagnosed in Primary Care.
2. Joined up approaches – we have many patients who receive emergency care for a LTC, are not previously known to Primary Care, and data suggests that following the emergency care a large number do not get appropriately coded on a disease register in Primary Care. This means that we are losing the ability to identify and contact these individuals for any services or interventions we may need to offer to them to reduce their risks of further urgent care or even death. For example offering flu vaccinations or annual reviews. Furthermore, following a major health event individuals are often at their most motivated to make changes to their lifestyle, we could be missing windows of opportunity with these patients.
3. Improved management – There are still far too many individuals on Primary Care Long Term Condition registers whose Long Term conditions are not well managed e.g. Clinical biomarkers are not within recommended thresholds, annual reviews are not being done, patients identified as "at risk" are not being referred to appropriate evidence based interventions.

4. Holistic care – the data shows us that of all individuals who are on registers for Long Term Conditions, in excess of 40% of them have multi-morbidities. We still review these patients in terms of each condition rather than as a whole individual.
5. Lack of a pathway – currently there is no specific LTC pathway, individuals get referred to services in a non-co-ordinated and variable way.

3.12 A new model should aim to resolve these issues. We should look to have multi-disciplinary Long Term Condition specialists who support individuals in a holistic way to manage their condition. A pathway should take a patient through stages of removing barriers before working with them to make lifestyle changes that will better support their best possible health outcomes along with clinical interventions. Existing fragmented care needs to be more accessible, co-ordinated and joined up. Individuals / patients support package should be personalised to what works for them with sustainable self-care at the heart.

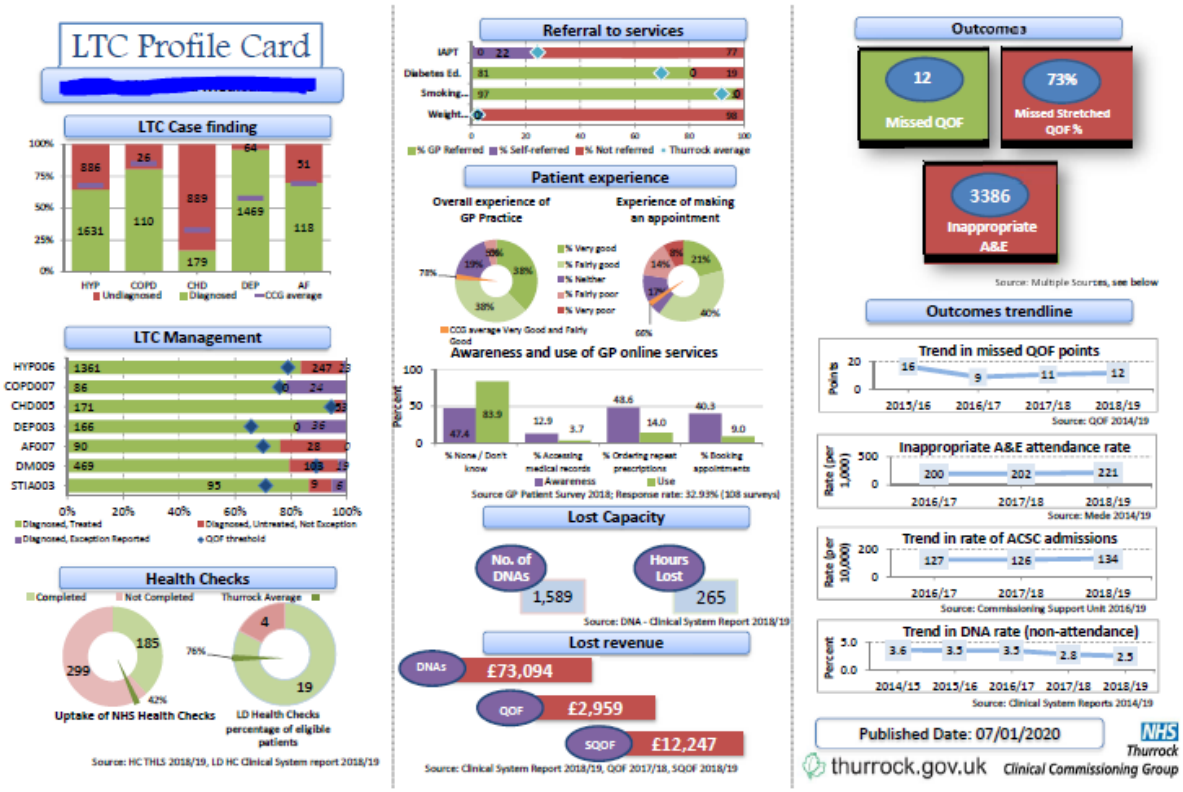
3.13 Alongside this our Stretched QOF programme will need to change, and we have started to think about these changes ready for the 2022/23 financial year. We will no longer top up individual condition indicators and look to move to incentivising a more holistic care approach which looks at individuals as a whole. We will look to bring Healthy Lifestyle contracts and the current stretched QOF contract together to do this. We will also move away from sole reliance on existing QOF indicators in favour of indicators that support this way of working (even if that means we have to generate/calculate our own). A name change will be inevitable.

3.14 The recent investment in Mental Health Primary Care practitioners has brought workers from EPUT into the PCNs so they can work closely with wider health professionals and Peer Workers from Thurrock & Brentwood MIND to improve the way mental health needs are identified and supported. The depression screening work previously described in former Health and Wellbeing Board papers will be re-invigorated in line with some work previously completed on identification of local population groups at most risk of unidentified mental ill-health, meaning it is more likely to find and treat individuals before they otherwise need more urgent care.

3.15 Long Term Condition Profile Card - The Long Term Condition (LTC) profile card was initially created by the Healthcare Public Health Improvement team in 2017 to respond to the high levels of variation within primary care across Thurrock in regards to the individual needs, available resources and overall quality of services.

3.16 Similar to a dashboard, the LTC profile card is a visual overview of each practice, focusing on the LTC case finding and management but also looks at the possible reasons why, such as lack of capacity, increased workload or lack of engagement from the practice population. Furthermore it makes links to secondary care outcomes.

Fig 1. Example LTC Profile card 2019/20

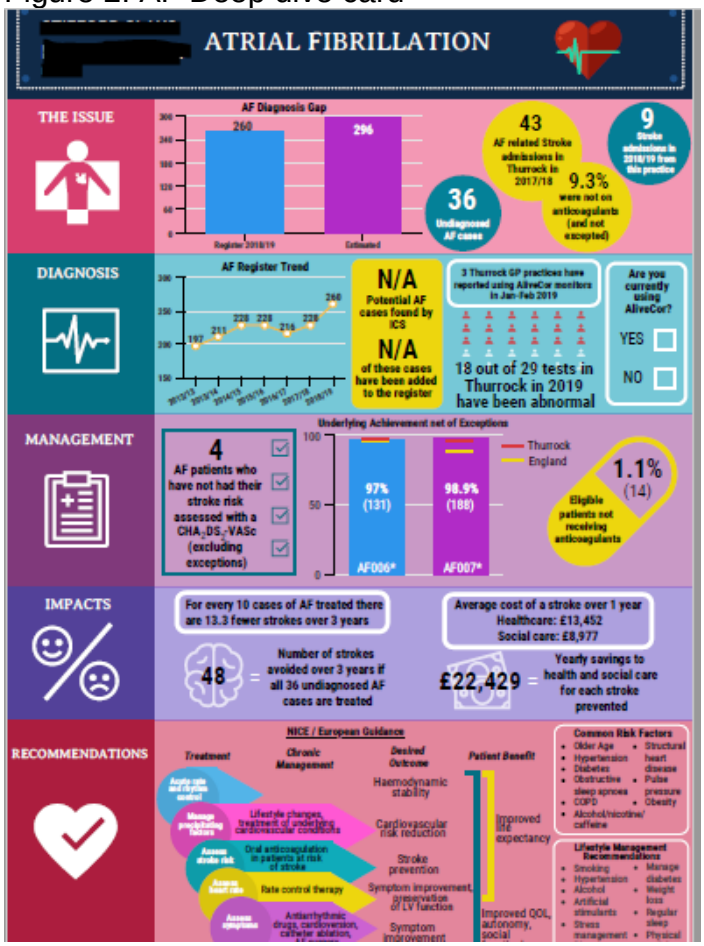


3.17 Development of the profile card for 2021 is underway and proposes the following amendments:

Section	Changes to note
LTC Case Finding	Addition of Obesity (BMI 30+)
LTC Management	Update to reflect Stretch QOF indicators for 2021-22 Visual aid of work to do (patient numbers spanning multiple indicators e.g. number of patients with 8 or more indicators still outstanding)
Outcomes Trendline	Addition of attendance rate for high users (frequent flyers)

3.18 In addition to the LTC Profile card, from 2019 the Healthcare Public Health and Intelligence Teams have been developing some ‘deep dive’ profile cards into particular areas of focus such as Atrial Fibrillation and Mental Health.

Figure 2. AF Deep dive card



3.19 For 2021 Healthcare Public Health are working with Macmillan and wider Cancer stakeholders to develop a deep dive into Cancer care which will support practices and more collectively the Primary Care Networks (PCNs) to work on improvements in early detection and diagnosis as part of their PCN directly enhanced service with NHS England.

3.20 Delivery of the LTC profile card work is not only through sharing the profile card with each practice, but includes visits to the practice, discussions with the practice managers, the GP leads and wider clinical team. It aids identification of agreed priorities and development of individualised action plans for each practice.

3.21 For 2021-22 visits with the refreshed profile cards will be scheduled for late October/early November to discuss progress to date, areas of focus and required support up to March 2022. Some of these will be done via PCN meetings as

appropriate, however individual practice visits will still happen if any of the following is true:

1. There is something specific to the practice that needs to be discussed
2. A practice specifically requests
3. A PCN requests that we visit all or some individual practices
4. The CCGs primary care team identifies a practice as being poor in terms of patient satisfaction or quality of care (including CQC reports)

3.22 For the 2022/23 financial year the profile card will need to change in line with the Stretched QOF programme.

4. Reasons for Recommendation

4.1 The Thurrock transformation piece, Stretch QOF and the Long Term Condition profile card form are key programmes of work in improving standards in Primary Care across Thurrock; one of the key public health priorities.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Public Health Leadership team, Thurrock CCG and clinical leads from Primary Care Networks have been consulted on proposals.

6. Impact on corporate policies, priorities, performance and community impact

6.1 This work dovetails with Thurrock Councils corporate priority under people and the proposed Domains 1 and 2 ‘Quality Care centred around the person’ and ‘Healthier for longer’ under the Joint Health and Wellbeing Strategy. The work seeks to address unmet physical and mental health needs and the development of an integrated health and care system that prevents and/or reduces need for health and care services.

7. Implications

7.1 Financial

Implications verified by: Mike Jones | Strategic Lead | Corporate Finance – Resources and Place Delivery

This will be met within existing agreed budgets across the Public Health Grant and the Better Care Fund.

7.2 Legal

Implications verified by: To follow

The Stretch QOF contract is commissioned to and delivered by GP practices as it is an enhancement of their existing NHS Quality and Outcomes Framework contract.

7.3 **Diversity and Equality**

Implications verified by: Becky Lee

Team Manager - Community Development and Equalities, Adults, Housing and Health Directorate

This programme of work seeks to improve quality in management of long term conditions and reduce variation in management across patients within GP practices but also to reduce the gap in variation across all practices in Thurrock and therefore supports tackling inequalities.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

Not Applicable

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):
Not Applicable

Report Author:
Vikki Ray
Senior Programme Manager – Healthcare Public Health
Adults, Housing and Health

Friday 24th September 2021	**ITEM: 8**
Health and Wellbeing Board	
Ofsted Focused Visit on children at risk from extra-familial harm; 30th June – 1st July	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Janet Simon, Interim Assistant Director Children's Social Care and Early Help	
Accountable Director: Sheila Murphy, Corporate Director of Children's Services	

Executive Summary

Ofsted introduced the Inspection of Local Authority Children's Services (ILACS) inspection framework in January 2018, which replaced the previous Single Inspection Framework (SIF) of children's services. Thurrock children's services' SIF inspection was held between 22nd February and 17th March 2016 and the service was graded 'Requires Improvement' across all judgement categories. Thurrock children's services received a full ILAC inspection between 4th and 22nd November 2019 and was rated Good across the four domains of the inspection. This report is to update the Committee on Thurrock's recent Ofsted ILACS Focused Visit undertaken between 30th June and 1st July 2021, on the local authority's arrangements for the protection of vulnerable children from extra-familial risk.

The ILACS inspection is a very detailed and robust review of all areas of practice in children's social care, early help services and education services for children educated at home as well as for children missing education. All local authorities receive a form of inspection from Ofsted once a year under the ILACS framework. The Focused visit is an opportunity for Ofsted to come into the authority and focus on one area of practice to see if practice is secure and to check the local authority is safeguarding children.

The Focused visit was announced on the 16 June 2021, two weeks before the Focused Visit began. During those two weeks the inspectors were provided with over 100 documents, copy of audits undertaken relating to the topic area in the last six months, performance data and they undertook inspection meetings with the Children's Portfolio Holder, the Chief Executive and partners working with children affected by extra familial harm. The focused visit was very thorough and inspectors examined the experience of children through the lens of social work interventions, by talking directly to social workers and examining their case work files in detail. They also met with children and young people and met with partners. The inspectors were focused on evidence of outcomes for children subject to extra familial harm and the impact social work intervention is having for children and their families. The two days of 'on-site' inspection was very intense, it thoroughly tested the practice of the service and the

corporate support and commitment from the Council as a whole for our most vulnerable young people.

The focused visit is not a judgement inspection; Ofsted as an outcome of the focused visit publishes a letter. The focused visit letter is attached as Appendix 1 and was published on the 9 August 2021. The letter states; 'Thurrock Council continues to provide effective, responsive services for vulnerable children. Children have remained a key focus for elected members and they continue to be a corporate priority.' The focussed visit letter reflects the hard work and commitment of all those striving to ensure children and their families receive good services within the Council and from partners. Ofsted commented, 'They (the local authority) have strengthened their oversight of services in response to feedback given at the last inspection, to better identify and engage with vulnerable children exposed to the risk of extra familial harm, and improved their offer of support to them and their families.' As with any inspection of services, Ofsted noted some areas for continued improvement. There are three recommendations for improvement and the partnership will be incorporating these recommendations into action plans.

The outcome of the inspection evidences that Thurrock Council and its partners, continues to provide a good service to vulnerable young people.

1. Recommendation(s)

1.1 That the Health and Well Being Board consider the Ofsted Focus Visit letter and provide comment or challenge in respect of the outcomes

1.2 That the three areas for improvement identified by Ofsted are considered by the Health and Well Being Partnership and support offered to deliver against these recommendations

2. Introduction and Background

2.1 In January 2018, a new universal inspection framework came into force for Children's services. The Inspection of Local Authority Children's Services (ILACS) focuses on the local authority (LA) functions regarding the help, care and protection of children and young people. The ILACS is a 'whole system' approach to inspection. The aim of the ILACS is to drive up improvement and catching LAs before they fall over as the underpinning principles of the framework, which is described as a system rather than a programme of inspection. ILACS attempts to take a proportionate, whole system approach to inspecting a service and this inevitably involves greater contact between Ofsted and LA's. In addition to on-site inspection activity (full inspection and focused visit inspections), the ILACS is supported and informed by an annual self-evaluation, the annual conversation and Ofsted's LA intelligence system.

The Focused Visit is part of the whole system Ofsted approach to inspection of local authority children's services. The focused visit was on the local authority's arrangements for the protection of vulnerable children from extra-familial harm.

This focus includes, children missing from home or care, children involved in criminal exploitation and by gangs, child sexual exploitation and radicalisation. The inspection included partnership working, as young people subject to extra-familial harm, require the support from police, schools and health colleagues. In the two weeks lead up to the 'on-site' inspection (the inspectors conducted the inspection virtually) documents, as requested, were sent to the inspectors, audit documentation was also provided. The inspectors conducted some interviews with key partners, the Children's Portfolio Holder and the Chief Executive. The two days 'on-site' activity included interviews with social workers, front line social work managers, reviewing case files, meetings with children and young people subject to extra-familial harm.

Whilst the focused visit is overall very positive (please see letter attached as Appendix 1), there are three recommendations to further improve practice for children subject to extra-familial harm. These are:

✓ Earlier transition planning for children in care and care leavers who are exposed to risk of child exploitation, gangs and extra-familial harm.

✓ The involvement of children in the take-up of return home interviews and the information the authority relies on to capture activity and the impact of these interviews.

✓ The arrangements for support and engagement with children at risk of extra familial harm; in particular, the agility of services to meet the diverse and complex needs of these children and their families.

These recommendations are being taken forward within partnership and service plans. The Health and Well Being Board are an important partner to assist with moving forward these recommendations.

3. Issues, Options and Analysis of Options

3.1 The Focused Visit Letter is attached as Appendix One

4. Reasons for Recommendation

4.1 Members of the Board are aware of the Ofsted Focused Visit and the recommendations to further improve practice. For the Board to have oversight of the plans against the recommendations, to support and challenge progress as appropriate.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The Ofsted Focus Visit letter is an agenda item on the Children's Overview and Scrutiny Committee on the 12 October 2021.

6. Impact on corporate policies, priorities, performance and community impact

6.1 None

7. Implications

7.1 **Financial**

Implications verified by: **N/A**

7.2 **Legal**

Implications verified by: **N/A**

7.3 **Diversity and Equality**

Implications verified by: N/A

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

9. Appendices to the report

24 September 2021	**ITEM: 9**
Health and Well-Being Board	
The Better Care Fund	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Ian Wake, Corporate Director of Adults, Housing and Health and Mark Tebbs, NHS Alliance Director for Thurrock	
Accountable Head of Service: Les Billingham, Assistance Director, Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group, was approved in 2015. The arrangement allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of care and support services.

The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home. Despite 2020/21 being a year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Scorecard were met by year-end.

This report sets out the arrangements for the Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group for 2021/22 and subsequent years. The Annual Governance Statement is also appended to the report

The Better Care Fund Plan for 2021/22 will drafted once the planning requirements have been published by NHS England, and the plan will then be submitted to the Board for approval.

1. Recommendation(s)

1.1 The Board is asked to note this report.

2. Introduction and Background

2.1 Thurrock's initial Better Care Fund Plan, and Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group, was approved in 2015. The Agreement allowed the creation of a pooled fund, to be operated in line with the terms of the Agreement, to promote the integration of care and support services.

2.2 The Council is the 'host' organisation for the pooled fund, which means that once the Section 75 Agreement is agreed it allows the funding of community health care services provided in line with the Better Care Fund Plan.

2.3 The pooled fund is overseen by the Integrated Care Partnership (previously the Integrated Commissioning Executive) made up of officers from the Council and CCG. The Partnership receives regular reports on expenditure, quality and activity. The Partnership reports on the performance of the Fund to the Health and Wellbeing Board, as well as Cabinet and the Board of the Clinical Commissioning Group.

2.4 The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home. Despite 2020/21 being a year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Scorecard were met by year-end.

2.5 This report sets out the arrangements for the Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group for 2021/22 and subsequent years. The Annual Governance Statement for the last year, 2020/21, is also appended to the report.

2.6 A further report will be presented together with the Better Care Fund Plan for Thurrock 2021/22 following the publication by NHS England of the BCF Planning Requirements for 2021-22.

3. Issues, Options and Analysis of Options

Changes to Guidance

3.1 Thurrock has had a Better Care Fund Plan and associated Section 75 Agreement in place since 2015-16. To date, the requirement has been to produce a yearly plan but this has been set aside during the COVID emergency. The Cabinet of Thurrock Council has agreed to enter into the Better Care Fund Section 75 Agreement for the current year 2021/22 in line guidance received from NHS England. The Agreement which will also be required in subsequent years will be subject to the Council's annual budget setting arrangements, and any changes to the Section 75 can be made with agreement of both parties – Thurrock Council and NHS Thurrock CCG.

Value of the Better Care Fund

3.2 The value of Thurrock's Better Care Fund for 2021/22 has been increased to £50.804m from £50.198m. This amount is made up of a £17.021m contribution from NHS Thurrock CCG, £5.046m from the Improved Better Care Fund grant and £28.377m contribution from the Council. The Fund consists of a mandatory minimum amount, and an additional contribution agreed locally by the Council and CCG. The mandated amount for Thurrock CCG in 2020/21 was £11.436m and this has been uplifted by 5.3% to £12.042m.

3.3 In future years, as part of preparations for the Better Care Fund, the Council and CCG will need to agree how much they are adding to the Fund over and above the mandated amount.

Focus of the Fund

3.4 The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes chosen for the Fund reflect this focus. The future plans are likely to continue this focus, and will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care intervention.

3.5 Despite 2020/21 being a year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Scorecard were met by year-end:

- In particular, the percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement services was 86.4% at year-end (Q4 snapshot), which is 0.1% above target and is significantly higher than the current national average of 82.0%.
- There was also a reduction in the number of older people (aged 65 and over) being permanently admitted to residential and nursing care homes in the year, with 149 admissions in the year compared to 178 in 2019/20. This equates to a rate of 619.2 per 100,000 population[1] compared to 739.7 last year, and is a reduction of 29 admissions. This is also 29 admissions under target.
- 2020/21 also saw a significant reduction in the number of long stay patients in hospital beds. In the year there has been a 38% reduction in the number of patients staying in hospital for 21 days or longer.
- Delayed transfers of care measures were suspended by NHS England throughout 2020/21 and for this reason it is not possible to report on the measures.

3.6 The year saw a reduction in non-elective activity (reduction of 14%) and A&E attendances for people aged 65+ (reduction of 26%) compared to last year. This has almost certainly been due to the impact of COVID-19 and lockdown restrictions imposed by Government which has reduced non-COVID-19

[1] Please note that a new population figure is due to be published in June 2021 that will be used to calculate the official 2020/21 outturn for this indicator. As such the rate of 619.2 is provisional and is subject to amendment.

related admissions where many patients would have been advised to stay at home and self-isolate, as well as many people being reluctant to attend NHS services due to the risk of exposure to the virus.

Overspends and Underspends in the Better Care Fund

3.7 The Section 75 Agreement sets out arrangements for overspends and underspends to the Fund. The arrangements will continue and mean that any expenditure over and above the value of the Fund will be the responsibility of either the Council or CCG depending on whether the expenditure is incurred on social care functions or health functions. Arrangements for monitoring expenditure and managing any overspend in an individual scheme are set out in detail within the Section 75 Agreement. Underspends will stay within the Pooled Fund unless otherwise agreed by both parties.

Governance

3.8 The Council continues to be the host for the pooled Fund. The management of the pooled Fund includes regular oversight by both the Council and CCG through the Integrated Care Partnership (previously the Integrated Commissioning Executive). The Partnership reports to the Health and Wellbeing Board who receive the meeting minutes at each Board meeting. A Pooled Fund Manager exists to provide regular reports covering performance, finance and risk.

Contracting arrangements

3.9 The Council, as host of the Fund, enters into contracts with third party providers – largely NHS providers. The standard NHS contract is used for these services with the Council becoming an equal commissioning partner.

The Annual Governance Statement

3.10 This Statement sets out how the Council and NHS Thurrock CCG (the CCG) are, through effective governance arrangements, complying with the responsibilities set out within the Better Care Fund Section 75 Agreement for Thurrock, and the extant Better Care Fund Operating Guidance[2]. The Statement is appended to this report.

Policy and Planning for 2021/22

3.11 The Department of Health and Social Care published the 2021-22 Better Care Fund Policy Framework on 19 August 2021. The framework sets out the national conditions, metrics and funding arrangements for the Better Care Fund (BCF) in 2021 to 2022.

3.12 The Policy Framework states that “Given the ongoing pressures in systems, there will be minimal change to the BCF in 2021 to 2022. The 2021 to 2022 Better Care Fund policy framework aims to build on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic.

[2] https://www.england.nhs.uk/wp-content/uploads/2018/07/better-care-fund-operating-guidance-v1.pdf

3.13 The continued focus on improving how and when people are discharged from hospital is described below.

3.14 The non-elective admissions metric is being replaced by a metric on avoidable admissions. This reflects better the focus of joint health and social care work to support people to live independently in their own home and prevent avoidable stays in hospital. Wider work on the metrics for the BCF programme will continue in 2021 to 2022 to take into account improvements to data collection and to allow better alignment to national initiatives such as the Ageing Well programme."

3.15 The Policy Framework also advised of the intention to undertake a full planning round in 2021 to 2022, with areas required to formally agree BCF plans and fulfil national accountability requirements. NHS England advise that the BCF Planning Requirements for 2021-22 including details of the national planning and assurance processes will be published separately in the next few weeks.

4. Reasons for Recommendation

4.1 The Section 75 Agreement must be agreed for the Council to be able to pay providers of services contained within the Better Care Fund. In the absence of guidance for 2021/22, Cabinet have agreed to the Council entering into the Agreement based on the terms set out in the previous Agreement.

4.2 As Thurrock's Better Care Fund Plan will be developed and finalised when Guidance has been received, Cabinet agreed that any final changes are delegated to the Corporate Director of Adults, Health and Housing and the Portfolio Holder for Children and Adult Social Care.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services, as required under the terms of the Health and Social Care Act 2012, was held in September and October 2014.

6. Impact on corporate policies, priorities, performance and community impact

6.1 A key aim of the Better Care Fund is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services.

This will contribute to the priority of 'Improve Health and Wellbeing' and the vision set out within the refreshed Health and Wellbeing Strategy 2016-2021.

6.2 Achieving closer integration and improved outcomes for patients, services users and carers is also seen to be a significant way of managing demand for health and social care services, and so manage financial pressures on both the CCG and the Council.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Finance Manager

The Better Care Fund consists of contributions from the Council and Thurrock CCG and are included in the body of this report. The mandated amount consists of £11.436m from NHS Thurrock CCG. Additional contributions have been confirmed and the value of the pool is £50.804m

The nature of the expenditure is an agreed ring-fenced fund. Financial risk is therefore minimised and governed by the terms set out in the Agreement. Paragraph 3.6 refers.

The Fund will be accounted for in accordance with the relevant legislation and regulations, and the agreement between the Local Authority and CCG.

Financial monitoring arrangements are in place, ensuring that auditing requirements are met, as well as disclosure in the financial statements.

7.2 Legal

Implications verified by: **Courage Emovon**

Principal Lawyer / Manager- Contracts & Procurement Team

This report outlines the arrangements for a Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group. The Council and the NHS Thurrock Clinical Commissioning Group can pursuant to regulations made by the Secretary of State as provided by Sec 75 of the National Health Service Act 2006 enter into prescribed arrangements in relation to the exercise of prescribed functions of NHS bodies and prescribed health related functions of local authorities. This arrangement can include establishment and maintenance of a pooled fund made up of contributions by one or more NHS bodies and one or more local authorities out of which payments may be made towards expenditure incurred in the exercise of both

prescribed functions of the NHS body and prescribed health related functions of the local authority. Legal Services is available to provide advice on any specific issues arising from this report.

7.3 **Diversity and Equality**

Implications verified by: **Becky Lee**

Team Manager - Community Development and Equalities

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will be developed with due regard to the equality and diversity considerations.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

2021 to 2022 Better Care Fund policy framework, Published 19 August 2021

- Available via the following link: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2021-to-2022/2021-to-2022-better-care-fund-policy-framework

9. Appendices to the report

- draft Thurrock s 75 Agreement BCF and HDI 2021
- BCF Annual Governance Statement 2020 21

Report Author:

Christopher Smith
Programme Manager
Adults, Housing and Health

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Dated **2021**

THURROCK BOROUGH COUNCIL

and

NHS THURROCK CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES BETTER CARE FUND PROGRAMME AND THE HOSPITAL DISCHARGE INITIATIVE

Contents

THIS AGREEMENT is made on day of 2021

PARTIES

(1) **THURROCK COUNCIL** of Civic Offices, New Road Grays, Essex, RM17 6SL (the **"Council"**)

(2) **NHS THURROCK CLINICAL COMMISSIONING GROUP** of 2nd Floor Civic Offices, New Road Grays, Essex, RM17 6SL(the "**CCG"**)

BACKGROUND

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

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

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

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

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future provision of health and social care services. It is also the means through which the Partners will pool funds.

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

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

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

d) In the first instance, to focus on people aged 65 years and over, in particular those at risk of hospital admission and permanent admission to residential care or nursing care;

e) Empower citizens who have choice and independence and take personal responsibility for their health and wellbeing;

f) Present health and care solutions that can be accessed close to home;

g) Commission and provide health care services tailored around the outcomes the individual wishes to achieve;

h) Focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible, and

i) Develop systems and structures that enable and deliver a co-ordinated and seamless response.

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

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

1 DEFINED TERMS AND INTERPRETATION

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

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

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

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

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

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

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

Commencement Date means 00:01 hrs on 1 April 2021

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

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

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

(c) which is a trade secret.

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

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

Financial Contributions means the financial contributions made by each Partner to the 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 for the Pooled Fund the Partner that will host the Pooled Fund

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

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

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification in Schedule 2.

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

Law means:

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

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

(f) 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

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

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

Non-Recurrent Payments means funding provided by a Partner to the Pooled Fund in addition to the Financial Contributions.

Overspend means any expenditure from the Pooled Fund in relation to an Individual Scheme in a Financial Year which exceeds the Financial Contributions for that Individual Scheme for that Financial Year.

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

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

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

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 has the meaning given in Clause 7.3.

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

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations, and as set out in the relevant Scheme Specification.

Pooled Fund Manager means such officer of the Host Partner for the Pooled Fund established under an Individual Scheme as is nominated from time to time to manage the Pooled Fund in accordance with Clause 8.

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

Provider Contracts means those contracts entered into by a Partner in order to deliver the Individual Schemes

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

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

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

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

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

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 **Integrated Care Partnership**.

TUPE means the Transfer of Undertakings (Protection of Employment) Regulations 2006

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

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

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

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

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

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

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

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

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

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

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

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

2 TERM

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

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22.

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

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish the Pooled Fund in relation to the Individual Schemes ("the Flexibilities")

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

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

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

5 FUNCTIONS

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

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

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

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

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Integrated Care Partnership, subject to any further requirement to report back to the Health and Wellbeing Board as set out in Schedule 2.

6 COMMISSIONING ARRANGEMENTS

6.1 The Partners shall comply with the arrangements in respect of commissioning as set out in the relevant Scheme Specification.

6.2 The Integrated Care Partnership will report back to the Health and Wellbeing Board as required by its terms of reference.

7 ESTABLISHMENT OF A POOLED FUND

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

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

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

7.3.1 *the Contract Price;*

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

7.3.3 *Performance Payments*;

7.3.4 *Third Party Costs;*

7.3.5 *Approved Expenditure*

("Permitted Expenditure")

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

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

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

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

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

7.6.3 appointing the Pooled Fund Manager;

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

8 POOLED FUND MANAGEMENT

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

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

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

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

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

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

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

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

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

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

8.2.7 preparing and submitting to the Integrated Care Partnership Quarterly reports (or more frequent reports if required by the Integrated Care Partnership) 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 Integrated Care Partnership to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

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

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

8.4 The Integrated Care Partnership may agree to the virement of funds between Individual Schemes.

9 NON POOLED FUNDS - NOTE THIS CLAUSE HAS BEEN DELETED AS NON-POOLED FUNDS WILL NOT BE UTILISED

10 FINANCIAL CONTRIBUTIONS

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

10.2 The Financial Contributions in each Financial Year, as set out in section 7 shall be paid to the fund in twelve (12) equal instalments receivable on the fourth working day of the month commencing April 2021.

10.3 The value of Thurrock's Better Care Fund for 2021/22 currently remains at the 2020/21 level of £50.198m and no amount of the Better Care Fund is described as 'at risk'. Financial resources in subsequent years are to be determined in accordance with the Agreement.

10.4 The Financial Contributions of the Council will be mad/e as set out in the each Scheme Specification.

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

11 FURTHER CONTRIBUTIONS

11.1 The Scheme Specification shall set out any further contributions of each Partner to cover 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).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the Individual Schemes of the Pooled Fund.

Overspends in Pooled Fund

12.2 Subject to Clause 12.1, the Host Partner for the Pooled Fund shall manage expenditure from the Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

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

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

Underspend

12.5 In the event that expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

The Pooled Fund shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

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

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the Pooled Fund.

15.2 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.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 163, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Integrated Care Partnership.

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

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

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

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

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

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

16.6 A Partner will take all reasonable steps to require that a Provider has suitable insurance cover in place, and that the Provider will maintain same, prior to that Partner entering into a Provider Contract with that Provider.

17 STANDARDS OF CONDUCT AND SERVICE

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

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

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for

continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund is therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

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

18 CONFLICTS OF INTEREST

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

19 GOVERNANCE

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

19.2 The Partners have established an Integrated Care Partnership to meet the roles and obligations set out in schedule 2.

19.3 The Integrated Care Partnership is based on a joint working group structure. Each member of the Integrated Care Partnership 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 Integrated Care Partnership to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

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

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

19.6 The Integrated Care Partnership shall be responsible for the overall approval of the Individual Scheme and Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Scheme Schedule shall confirm the governance arrangements in respect of the Individual Scheme (and related Service) and how that Individual Scheme (and related Service) is reported to the Integrated Care Partnership and Health and Wellbeing Board.

19.8 Each Scheme Schedule shall confirm the governance arrangements in respect of the Individual Scheme (and related Service) and how that Individual Scheme (and related Service) is reported to the Integrated Care Partnership and Health and Wellbeing Board.

20 REVIEW

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

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

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

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

21 COMPLAINTS

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, in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

22 TERMINATION & DEFAULT

22.1 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.

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

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

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 16, 22.6, 23, 25, 26, 27 and 28.

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

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

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of any integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

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

22.6.3 the Host Partner 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 Host Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Host Partner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Host Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Host Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

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

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

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

23 DISPUTE RESOLUTION

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

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

23.3 If the dispute remains after the meeting detailed in Clause 23.1 has taken place, the Chief Executive of the Council (or nominee) and the Accountable Officer of the CCG (or nominee) shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the CEDR Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

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

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

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

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

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

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

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

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

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

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

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

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

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

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

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

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

27 OMBUDSMEN

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

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation of this Agreement complies with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

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

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

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Corporate Director, Adults, Housing and Health, Thurrock Borough Council, Civic Offices, New Road Grays, Essex, RM17 6SL;

Tel: 01375 364029
E.Mail: iwake@thurrock.gov.uk

and

29.3.2 if to the CCG, addressed to the Chief Operating Officer, Thurrock CCG, 2nd Floor Civic Offices, New Road Grays, Essex, RM17 6SL;

Tel: 01375 365810
Email: thurrock.ccg@nhs.net

30 VARIATION

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

31 CHANGE IN LAW

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

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

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

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

33 SEVERANCE

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

34 ASSIGNMENT AND SUB CONTRACTING

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

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the

relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

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

35.2.1 act as an agent of the other;

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

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

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

37 ENTIRE AGREEMENT

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

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

38 COUNTERPARTS

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

39 GOVERNING LAW AND JURISDICTION

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

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

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

Signed for on behalf of **THURROCK COUNCIL**

_____

Authorised Signatory

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

_____

Authorised Signatory

Part 1 – SCHEME SPECIFICATION

– Template Scheme Schedule

TEMPLATE SCHEME SCHEDULE

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

1 OVERVIEW OF INDIVIDUAL SCHEME

Insert details including:

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

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

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

3 THE ARRANGEMENTS

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

(1) Lead Commissioning;
(2) Integrated Commissioning;
(3) Joint (Aligned) Commissioning;
(4) the establishment of one or more Pooled Funds as may be required.

4 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

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

5 SERVICES

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

[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 CCG and Vice versa See note [ ] above

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:

relevant contracts

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 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		

	CCG contribution	Council Contribution
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

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

8 FINANCIAL GOVERNANCE ARRANGEMENTS

[(1) As in the Agreement with the following changes:

(2) Management of the Pooled Fund

Are any amendments required to the Agreement in relation to the management of Pooled Fund
Have the levels of contributions been agreed?
How will changes to the levels of contributions be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the pooled fund manager require training?
Have the pooled fund managers delegated powers been determined?
Is there a protocol for disputes?

(3) Audit Arrangements

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

(4) Financial Management

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
Has the scale of contributions to the pool been agreed?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?
Will there be a facility to carry forward funds?

How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?
What management costs can legitimately be charged to pool?
What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
What closure of accounts arrangement need to be applied?]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

11 FURTHER RESOURCES

Council contribution

	Details	Charging arrangements[3]	Comments
Premises			

2 We note that some of the information overlaps with the information that is included in the main body of Agreement, however, we consider it is appropriate that this is considered for each Scheme in order to determine whether the overarching arrangements should apply.

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 CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

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

CCG 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 the CCG.

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

CCG staff to be made available to the arrangements

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

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

13 ASSURANCE AND MONITORING

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 CCG Budget and the Council Budget on such a basis that there is no “mixing” of resources

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

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

14 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council					
CCG					

15 INTERNAL APPROVALS

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

16 RISK AND BENEFIT SHARE ARRANGEMENTS

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

17 REGULATORY REQUIREMENTS

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

18 INFORMATION SHARING AND COMMUNICATION

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

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

19 DURATION AND EXIT STRATEGY

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

Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreement

(1) maintaining continuity of Services;

(2) allocation and/or disposal of any equipment relating to the Individual Scheme;

(3) responsibility for debts and on-going contracts;

(4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

(5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

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

20 OTHER PROVISIONS

Consider, for example:

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

PART 2 – AGREED SCHEME SPECIFICATIONS

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 1 PREVENTION AND EARLY INTERVENTION

21 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 1 Prevention and Early Intervention** (as set out in the Thurrock Better Care Fund Plan)

(b)
The objective of the Scheme is to provide an integrated response to individuals using a number of successful existing and developing initiatives. The result will be a cohesive prevention and early intervention offer spanning the community, public health, health and adult social care system. This is an enhancement of the Scheme first introduced in 2015-16 (then as BCF Scheme 4) and focused on demand management and crisis prevention.

Further details are contained in pages 28-31 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2021/22.

22 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A variation to the Standard NHS Contract with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and
- A Service Level Agreement for Thurrock Council's Provider Services.
- Contracts with various voluntary and private sector providers

23 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

24 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.

25 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- Thurrock Council Provider Services
- Voluntary and private sector providers

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

26 FINANCIAL CONTRIBUTIONS

Financial Year 2021/22	
Adults, Health & Wellbeing	322,876
Assistive Technology	150,064
Clinical Assessment	309,000
Clinical Equipmen t	240,474
Clinical Equipment PACS	283,185
Deputy Manager -Direct Payments support	41,902
Entral Feed Equipment	67,967
Exercise Referral Scheme	33,000
Local Area Co-ordination	705,021
Medieconomics Data Set	126,000
Public Health staffing - data analysis	250,000
Social Care Equipment	583,552
Social Prescribing	146,875
Stretch QOF in Tilbury	54,000
Stroke Prevention post	34,277
Voluntary Sector Organisations	624,774
Scheme 1 Prevention and Early Intervention Total	**322,876**

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

27 FINANCIAL GOVERNANCE ARRANGEMENTS

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Care Partnership within 21 days. The Integrated Care Partnership, where appropriate in consultation with the Health and Well-being Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

28 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

29 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

30 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

31 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Integrated Commissioner Unplanned Care and Re-ablement
- Commissioner for dementia and older people
- Team Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Director of Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

32 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

33 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

34 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

35 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

36 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

37 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

38 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

39 OTHER PROVISIONS

- There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 2 OUT OF HOSPITAL COMMUNITY INTGRATION

40 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 2 Out of Hospital Community Integration** (as set out in the Thurrock Better Care Fund Plan)

(b)
This scheme is aimed at improving the coordination of community heath and adult social care services so that care delivered in the community is person centred whatever the provider or the nature of the service required.

Further details are contained in pages 31-35 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2021/22.

41 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

A variation to the Standard NHS Contracts with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and for Essex Partnership University NHS Foundation Trust (EPUT) for which Castle Point and Rochford CCG is a Co-ordinating Commissioner, and

A Service Level Agreement for Thurrock Council's Provider Services.

- Contracts with various voluntary and private sector providers

42 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

43 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.

44 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- Essex Partnership University NHS Foundation Trust (EPUT)

- Thurrock Council Provider Services
- Various voluntary and private sector providers

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

45 FINANCIAL CONTRIBUTIONS

Financial Year 2021/22	
Business management –TICA	26,421
Carers Grant	248,900
Community Based Social Work	51,216
Community Psychiatric Nurse	61,889
Day Care Services	641,502
Day Hospital Assessment	826,146
Direct Payments	63,010
Domestic Abuse Intervention	39,267
Domiciliary Homecare - External Purchasing & in-house provision	12,888,515
Extra Care Housing	948,925
Fieldwork services (incl Care Act Implementation)	2,274,275
Health and Social Care Place based Implementation Assistant Director.	59,134
Integrated Care Director	132,387
Integrated Community Team (ICT)	4,684,457
Lone working devices (Provider Services)	25,000
Long term conditions - community diabetes etc	432,145
Mental Health services/joint working -MH strategy	47,139
Mental Health Support	551,276
Primary Care MDT Co-ordination	50,154
Quality & Patient Safety Nurse	58,119
Residential Placements - External Purchasing	9,585,068
RRAS - Community Carers Element	101,266
RRAS - Dementia Nurses	114,325
RRAS - General service provision	563,231
RRAS - Joint Manager & Admin Support	49,245
Safeguarding Team	615,721
Telehealth	32,456
Thurrock First	534,248
Urgent Community Response Team (RRAS)	298,143
Community Geriatricians	184,874
Scheme 2 Out of Hospital Community Integration Total	**36,188,454**

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

46 FINANCIAL GOVERNANCE ARRANGEMENTS

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Care Partnership within 21 days. Integrated Care Partnership,

where appropriate in consultation with the Health and Well-being Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

47 VAT

- The Council's VAT regime will apply to Provider Contracts
- The Council is not acting as 'agent' for NHS Thurrock CCG

48 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

49 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

50 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Integrated Commissioner Unplanned Care and Re-ablement
- Commissioner for dementia and older people
- Team Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Director of Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

51 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

52 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

53 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

54 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

55 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

56 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

57 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

58 OTHER PROVISIONS

- There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 3 DELIVERING GOOD DISCHARGE

59 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 3 Delivering Good Discharge** (or Intermediate Care as set out in the Thurrock Better Care Fund Plan)

(b)
Our vision is to improve the current intermediate care pathways in Thurrock. Thurrock adults who do not need to be in a hospital bed, but are not fit to be discharged home (Intermediate Care) can find themselves in any one of six locations across south west Essex. Thurrock residents can be discharged from hospital to intermediate care beds which can be a long way from home. We aim to simplify the inpatient options so that more people can be seen closer to home. Where a bed is not the best solution in helping to maintain independence and wellness, patients will be given support, by neighbourhood (locality based) integrated health and care community teams. These teams will aim to provide the right care, in the right place, at the right time, every time. This new care model will be facilitated by existing community health and care teams which will be developed and enhanced to increase and capability to provide a wider skill mix to enable the ethos and delivery of care closer to or at home whenever it is clinically possible.

Further details are contained in pages 35-38 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2021/22.

60 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A variation to the Standard NHS Contracts for 2016/17 with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and for Essex Partnership University NHS Foundation Trust (EPUT) for which Castle Point and Rochford CCG is a Co-ordinating Commissioner, and

- A Service Level Agreement for Thurrock Council's Provider Services.

- Contracts with various voluntary and private sector providers

61 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

62 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.

63 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- Essex Partnership University NHS Foundation Trust (EPUT)
- Thurrock Council Provider Services
- Various voluntary and private sector providers

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

(i) contract management arrangements
(ii) termination
(iii) assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

64 FINANCIAL CONTRIBUTIONS

Financial Year 2021/22	
Bridging services - from acute into community	216,275
Collins House Residential Care Home	2,297,439
Dementia Crisis Support Team - Nurse BTUH	19,062
Domiciliary Homecare - External Purchasing & in-house provision	50,000
Home From Hospital (By Your Side)	70,260
Hospital Social Work Team	941,017
Mayfield -Intermediate Care Beds	3,689,027
Medical Cover to support discharge over weekends	24,874
Reablement Team - Health Workers	1,199,994
Reablement Team - Social Workers	114,804
Red Bag Initiative	2,000
St Lukes Discharge to Assess	590,426
Older People Wellbeing - Physio & OT	108,792
Scheme 3 Delivering Good Discharge Total	**9,323,970**

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

65 FINANCIAL GOVERNANCE ARRANGEMENTS

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Care Partnership within 21 days. The Integrated Care Partnership, where appropriate in consultation with the Health and Well-being Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

66 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

67 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

68 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

69 STAFF

TUPE transfers and secondments are not expected to be required In order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Integrated Commissioner Unplanned Care and Re-ablement
- Commissioner for dementia and older people
- Team Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Director of Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

70 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

71 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

72 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

73 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

74 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

75 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

76 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

77 OTHER PROVISIONS

There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 4 DISABLED FACILITIES GRANT

78 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 4 Disabled Facilities Grant** (as set out in the Thurrock Better Care Fund Plan)

(b)
The Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants.

Further details are contained in pages 38-39 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2021/22

79 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A Service Level Agreement for Thurrock Council's Housing Services and Adults Health and Commissioning.

80 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

81 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.:

82 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts
Thurrock Council Provider Services

The Commissioners have authority to agree contract terms in line with the terms of this agreement including
(iv) contract management arrangements
(v) termination
(vi) assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

83 FINANCIAL CONTRIBUTIONS

Financial Year 2021/22	
Disabled Facilities Grant & Social Care Capital Grant	1,318,524
Scheme 4 Disabled Facilities Grant & Social Care Capital Grant Total	**1,318,524**

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

84 FINANCIAL GOVERNANCE ARRANGEMENTS

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Care Partnership within 21 days. The Integrated Care Partnership, where appropriate in consultation with the Health and Well-being Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

85 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

86 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

87 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

88 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Integrated Commissioner Unplanned Care and Re-ablement
- Commissioner for dementia and older people
- Team Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Director of Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer

- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

89 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

90 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

91 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

92 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

93 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

94 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

95 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

96 OTHER PROVISIONS

There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 5 HOSPITAL DISCHARGE INITIATIVE

97 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 5 Hospital Discharge Initiative** (as set out in the COVID-19 Hospital Discharge Service Requirements Published 19 March 2020)

(b)

97.1 The Scheme is being introduced in response to the global Covid-19 pandemic and more specifically the Government's Discharge Requirements guidance to reduce pressure on those hospitals providing acute services.

97.2 The Partners have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements.

97.3 The Council will be the lead commissioner for this scheme and shall comply with the requirements of this Scheme Specification.

97.4 A Pooled Fund will be established into which the funding for this scheme will be paid.

97.5 The Host Partner for the Pooled fund is Thurrock Council and the Pooled Fund Manager, being an officer of the Host Partner is Catherine Wilson.

(c) This Scheme is funded by the Thurrock BCF and HDI Pooled Fund in 2021/22

98 AIMS AND OUTCOMES

The agreed aims of the Scheme are:

- facilitating quick discharge of patients who are clinically suitable for discharge;
- facilitating rapid mobilisation of care and support packages;
- maintaining capacity in acute and community hospitals for the care of patients with Covid-19 who require hospitalisation;
- implementing the revised funding model for care and support packages in the Enhanced Discharge Services period.

99 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A Service Level Agreement for Thurrock Council's Provider Services.
- Contracts with various voluntary and private sector providers

100 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

101 SERVICES

The Council shall arrange the provision of the Enhanced Discharge Support Services for the benefit of:

101.1.1 those persons the CCG has responsibility to provide services for under Sections 3(1A) and 3(1B) of the 2006 Act; and

101.1.2 those persons the Council has responsibility to provide services for and whose requirement for a Funded Package arises during the Enhanced Discharge Services Period.

102 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

102.1.1 The Council shall ensure that when commissioning Funded Packages it makes the patient and their families and/or carers aware that following the end of the Enhanced Discharge Services Period the patient may be required to pay for all or some of their future care needs.

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- Essex Partnership University NHS Foundation Trust (EPUT)
- Thurrock Council Provider Services
- Various voluntary and private sector providers

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

6.2.1 The Council shall ensure that it reimburses those providers providing the Enhanced Discharge Support Services in a timely fashion paying particular attention to the financial pressures on providers during the Covid-19 pandemic. In complying with this obligation the Council shall refer to guidance issued by the Local Government Association, ADASS, and the Care Provider Alliance on social care provider resilience during Covid-19.

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

103 FINANCIAL CONTRIBUTIONS

Financial Year 2021/22

103.1 The Covid-19 Hospital Discharge Scheme is being implemented in response to the Covid-19 pandemic and to give effect to the Discharge Requirements.

103.2 During the Enhanced Discharge Services Period there will no eligibility assessments for beneficiaries of the services provided under the Covid-19 Hospital Discharge Scheme and the cost of care packages or enhancements to existing packages under the Covid-19 Hospital Discharge Scheme shall be fully funded from central funding provided to the CCGs by NHS England & Improvement.

103.3 The Partners shall:

103.3.1 comply with any requirements and any guidance issued by HM Government and/or the NHS relating to the funding of the Covid-19 Hospital Discharge Scheme after the end of the Enhanced Discharge Services Period; and

103.3.2 work together in good faith to give effect to any such requirements and/or guidance.

103.4 The exact level of the CCGs' contribution to the COVID-19 Pooled Fund is not known at this time. The CCGs' contributions will be based on the monthly expenditure submissions to NHS E&I and completed by the CCGs and the Council and more specifically, NHS England's monthly contribution to the Pooled Fund will be the total of the agreed monthly qualifying Council's expenditure, and less the amount that the partnership would ordinarily have expected to spend on reablement, intermediate care, and domiciliary care in lieu of reablement during the period already included within other schedules of the Countywide BCF agreement.

103.5 The CCG shall transfer the contribution into the COVID-19 Pooled Fund within 10 working days of those funds being received by the CCG from NHS England.

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

104 FINANCIAL GOVERNANCE ARRANGEMENTS

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Care Partnership within 21 days. The Integrated Care Partnership, where appropriate in consultation with the Health and Well-being Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

105 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

106 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

107 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

108 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Integrated Commissioner Unplanned Care and Re-ablement
- Commissioner for dementia and older people
- Team Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Director of Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

109 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

110 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

111 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Hospital Discharge Service Requirements 2019, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

112 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

113 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

114 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund and Hospital Discharge Initiative consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

115 DURATION AND EXIT STRATEGY

19.1 The arrangements for the Covid-19 Hospital Discharge Scheme may only be varied:

19.1.1 in accordance with the variation provisions in the Partnership Agreement; and

19.1.2 where such variation complies with the requirements of the Discharge Requirements and/or any Future Discharge Requirements.

19.2 This Scheme may not be terminated otherwise than in accordance with paragraph 19.3.

19.3 The Covid-19 Hospital Discharge Scheme shall, unless varied to give effect to Future Discharge Requirements, terminate on the date on which the Discharge Requirements cease to apply.

19.4 The Partners acknowledge that as at the date of this Agreement they are not in a position to determine all the exit arrangement for the Covid-19 Hospital Discharge Scheme. The Partners agree that except as otherwise set out in this clause they shall:

19.4.1 keep under review the Discharge Requirements and any Future Discharge Requirements;

19.4.2 consider how to give effect to the requirements of any Future Discharge Requirements, where relevant; and

19.4.3 develop and agree an exit/transfer plan in relation to the end/variation of the Enhanced Discharge Services Scheme no later than [ ]5 which shall take into account and identify, where relevant:

(a) appropriate mechanisms for maintaining service provision;
(b) allocation and/or disposal of equipment;
(c) responsibilities for debts and ongoing service contracts;
(d) responsibility for any liabilities which have been accrued by the Host Partner/Lead Commissioner;
(e) premises arrangements;
(f) record keeping arrangements;
(g) information sharing arrangements and requirements;
(h) staffing arrangements;
(i) appropriate processes to be initiated in the run up to and following the end of the Enhanced Discharge Services Period.

19.5 The Partners further agree that they shall within [ ] days6 of being notified of the end date for the Enhanced Discharge Support Service the Partners shall [meet to]:

19.5.1 implement any agreed [exit/transfer plan] or in the absence of an agreed exit/transfer plan agree and implement such a plan which shall include, as a minimum, arrangements to transfer to the existing Funded Packages onto the future funding arrangements; and

19.5.2 consider the need for any other Individual Schemes to be introduced as a result of this termination of this Individual Scheme.

[5] You may wish to include a longstop date.
[6] Insert what is considered to be a reasonable timescale.

19.6 The monies in the Pooled Fund which have been made available by the NHS pursuant to the Discharge Requirements may only be used to pay for the costs of those services which are listed in Annex A to the Covid-19 Financial Reporting Guidance as being eligible for this funding.

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116 OTHER PROVISIONS

There are none.

Part 2 – GOVERNANCE

0.1 Integrated Care Partnership

The membership of the Integrated Care Partnership will be as follows:

CCG:

- Mark Tebbs (NHS Alliance Director for Thurrock) or his successor
- Tendai Mnangagwa (Deputy Chief Finance Officer) or her successor

or a deputy to be notified to the other members in advance of any meeting;

the Council:

- Ian Wake (Corporate Director of Adults, Housing and Health) or his successor
- Sean Clark (Director of Finance and Information Technology) or his successor
- Catherine Wilson (Strategic Lead Commissioning and Procurement) or her successor

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

0.2 Role of the Integrated Care Partnership

0.3 The Integrated Care Partnership shall:

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

0.4 Integrated Care Partnership Support

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

0.5 Meetings

The Integrated Care Partnership will meet at least quarterly at a time to be agreed within following receipt of each Quarterly report or other reports of the Pooled Fund Manager.

The quorum for meetings of the Integrated Care Partnership shall be a minimum of two representatives from each of the Partner organisations. Attendees may attend meetings via telephone or teleconference facility.

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

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

0.6 Delegated Authority

The Integrated Care Partnership is authorised within the limit of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to authorise an officer of the Host Partner to enter into any contract for services necessary for the provision of Services under an Individual Scheme.

0.7 Information and Reports

The Pooled Fund Manager shall supply to the Integrated Care Partnership on a Quarterly basis the financial and activity information as required under the Agreement.

0.8 Post-termination

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

9 Extra-Ordinary or Urgent Meetings

If there are urgent or extra-ordinary matters to be considered the Integrated Care Partnership may choose to meet between the Quarterly interval in order to take decisions on urgent issues.

10. Annual Governance Statement

The Integrated Care Partnership will prepare an annual governance statement, which will be included in a report to the Health and Wellbeing Board, on an annual basis.

Part 3 – RISK SHARE AND OVERSPENDS

Pooled Fund Management

Overspend

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

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

- whether there is any action that can be taken in order to contain expenditure;
- whether there are any underspends that can be dealt with by virement to or from any Individual Scheme maintained under this Agreement;
- Subject to clause 3 below, how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

1.2 The Partners will adopt the position agreed by the Health and Wellbeing Board, that the Better Care Fund for 2015/16 (and any subsequent years if extended) should be fixed at the agreed value of the Pooled Fund (as set out in the Scheme Specifications), with the effect that any expenditure above the value of the Pooled Fund should fall to the Council or the CCG depending on whether the expenditure is incurred on the Health Related Functions (in which case the Council will be liable) or NHS Functions (in which case the CCG will be liable).

5 **Reputational Risk**

Both Partners have plans and policies in place to manage reputational issues. Each Partner will co-operate with the other in managing any reputational risk that may arise with that other Partner.

6. **Clinical Liability**

For the avoidance of doubt, the Partners will put in place insurance to cover Losses or Default Liability arising from clinical negligence by their respective organisations or contracts.

Part 4 – JOINT WORKING OBLIGATIONS

– CO-ORDINATING COMMISSIONER OBLIGATIONS

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

1 The Co-ordinating Commissioner shall notify the other Partners if it receives or serves:

- a Change in Control Notice;
- a Notice of an Event of Force Majeure;
- a Contract Query;
- Exception Reports
    - and provide copies of the same.

1.1 The Co-ordinating Commissioner shall provide the other Partners with copies of any and all:

- CQUIN Performance Reports;
- Monthly Activity Reports;
- Review Records; and
- Remedial Action Plans;
- JI Reports;
- Service Quality Performance Report.

1.2 The Co-ordinating Commissioner shall invite the other Partners to attend any and all:

- Activity Management Meetings;
- Contract Management Meetings;
- Review Meetings;

and, ,to raise issues reasonably at those meetings in line with the objectives of this agreement.

1.3 The Co-ordinating Commissioner shall not:

- vary any Provider Plans (excluding Remedial Action Plans);
- agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;
- give any approvals under the Service Contract;
- agree to or propose any variation to the Service Contract (including any Schedule or Appendices);
- suspend all or part of the Services;
- serve any notice to terminate the Service Contract (in whole or in part);
- serve any notice;
- agree (or vary) the terms of a Succession Plan;

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

1.4 The Co-ordinating 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.

1.5 The Co-ordinating Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution.

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

1.7 The Co-ordinating Commissioner shall report to the other Partners on the performance of the Individual Schemes in relation to:

- reduction in non-elective activity (general and acute)
- admissions to residential care homes
- effectiveness of re-ablement
- delayed transfers of care
- patient/ service user experience

– OBLIGATIONS OF THE OTHER PARTNER

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

1.8 The other Partner shall (at its own cost) provide such cooperation, assistance and support to the Co-ordinating Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Co-ordinating Commissioner to:

- resolve disputes pursuant to a Service Contract;
- comply with its obligations pursuant to a Service Contract and this Agreement;
- ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

1.9 No Partner shall unreasonably withhold or delay consent requested by the Co-ordinating Commissioner.

1.10 Each Partner (other than the Co-ordinating Commissioner) shall:

- comply with the requirements imposed on the Co-ordinating Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;
- notify the Co-ordinating Commissioner of any matters that might prevent the Co-ordinating Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Co-ordinating Commissioner to be in breach of warranty.

Part 5 – PERFORMANCE ARRANGMENTS

1. Introduction and context

Thurrock Council and Thurrock Clinical Commissioning Group (CCG) have expressed a clear intention to develop a more integrated approach to performance that encompasses the achievement of key objectives contained within the Better Care Fund (BCF) and other related enabling strategies.

This schedule outlines the approach to implementing a new health and social care performance scorecard. The primary aim of the scorecard will be to monitor the BCF core measures and related health, social care and public health measures contained within local strategies. It will also ensure a clear alignment with national outcomes frameworks.

The scorecard will provide a regular update to the Thurrock Integrated Care Partnership and Council / CCG Boards on the performance of the BCF and related priorities. It will also be presented to the Health and Well-Being Board to enable a line of sight into health and social care performance.

2. Principles

- The Integrated Care Partnership will be accountable for the scorecard and report
- Clear ownership and accountability will be established for performance measures
- Main performance monitoring tool for the Better Care Fund – replacing those currently in use
- Support integration between social care, health and public health performance measures
- Collaboration in production of the scorecard to facilitate provision of insightful commentary
- Accessible and proportionate
- Enable benchmarking with other areas

3. Alignment with national outcomes frameworks

The health and social care scorecard adopts relevant measures from the NHS, ASC and Public Health outcome frameworks where these align with local priorities. The core BCF measures also correlate with the outcome frameworks.

4. Commissioned services

Clear expectations for commissioned services and schemes from the start of the Better Care Fund in April 2015 will be set out in formal performance specifications as part of contract agreements (s75). Services / providers will be held to account for delivery of key performance measures and outcomes in relation to relevant schemes/services. Where appropriate and of benefit, these will link into the reporting process.

5. Suggested content and measures

The scorecard is attached in appendix 1.

The first four Schemes of the BCF relate to health and social care transformation and scaling up integration between health and social care. These are
BCF Scheme 1 - Prevention and Early Intervention
BCF Scheme 2 - Out of Hospital Community Integration
BCF Scheme 3 – Delivering Good Discharge
BCF Scheme 3 - Disabled Facilities Grant.

6. Proposed reporting structure and process

The proposed reporting process is set out in the table below.

The Council and the CCG are in the process of forming an “Integrated Data Users Forum”. The forum will be cross-organisational, potentially including representatives from any organisation that collects/uses data associated with the Thurrock Health and Social care system, and wider determinants of health. The forum will be formed alongside the planning and implementation of the integrated data set and will contribute to its successful implementation. The purpose of the forum is:

1) To ensure the successful implementation of the integrated data set
2) To facilitate the use of the above, ensuring that experts of specific data sets are aware of what the data is being used for, are consulted regarding data limitations and caveats, and analyses are conducted as robustly as possible
3) To share and support each other in use of data, analytics and statistics
4) To facilitate any further data sharing
5) To build relationships

Formal terms of reference will be developed. Although Public Health will initiate the forum, it is not envisaged that Public Health or any one organisation will have “ownership” and outputs will not be needed to be shared with any board or executive.

Reporting process

When	What	Where
Monthly	• BCF core measures scorecard • Key health, adult social care and public health measures • Monthly progress/highlights plus commentary on core measures	• Integrated Commissioning Executive (ICE)

Quarterly	• BCF core measures scorecard
	• Key health, adult social care and public health measures
	• Expanded report taking into account:
	  • Additional commentary and analysis
	  • Improvement actions e.g. scope for more detailed service input
	  • Supplementary information e.g. from commissioned services
		• Integrated Commissioning Executive (ICE)
		• ASC DMT
		• CCG Board
		• Health & Well-Being Board

Mid Year / Annual	• BCF core measures scorecard
	• Key health, adult social care and public health measures
	• Expanded report taking into account:
	  • Nationally available data
	  • Benchmarking and comparative analysis e.g. trends
	  • Additional commentary and analysis
	  • Improvement actions e.g. scope for more detailed service input
	  • Supplementary information e.g. from commissioned services
		• Integrated Commissioning Executive (ICE)
		• ASC DMT
		• CCG Board
		• Health & Well-Being Board

Better Care Fund Scorecard 2021/22

No	Indicator	19/20 Outturn	20/21 Outturn	Current National Avg.	22/22 Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD
5.1	Total non-elective admissions in to hospital, all age	**19,963**	**17,202**	**N/A**	**TBC**													
5.2	ASCOF 2A(2) – Social Care - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population *(number of admissions in brackets)*	**739.7 (178)**	**618.3 (149)**	**584.0**	**738.7 (178)**	**62.2 (15)**	**124.5 (30)**	**186.7 (45)**	**249.0 (60)**	**311.2 (75)**	**373.5 (90)**	**435.7 (105)**	**498.0 (120)**	**560.2 (135)**	**622.5 (150)**	**680.5 (164)**	**738.7 (178)**	**249.0 (60)**
5.3	ASCOF 2B – Social Care - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation	**87.4%**	**86.4%**	**82.0%**	**86.3%**													
5.4	Overall delayed transfers of care – Number of delayed days from hospital (per month) (average delayed days per day in brackets)	**1,623 (4.9)**	**N/A**	**N/A**	**TBC**	Indicator currently suspended by NHS England												
5.4 a	NHS delayed transfers of care – number of delayed days from hospital (per month) (average delayed days per day in brackets)	**1,041 (3.1)**	**N/A**	**N/A**	**N/A**	Indicator currently suspended by NHS England												
5.4 b	ASC delayed transfers of care – Number of delayed days from hospital (per month) (average delayed days per day in brackets)	**489 (1.5)**	**N/A**	**N/A**	**N/A**	Indicator currently suspended by NHS England												
5.4 c	Joint delayed transfers of care – Number of delayed days from hospital (per month) (average delayed days per day in brackets)	**93 (0.3)**	**N/A**	**N/A**	**N/A**	Indicator currently suspended by NHS England												
5.5	Number of beds occupied with long stay patients (21+ days)	**884**	**548**	**N/A**	**N/A**													
5.6	Number of A&E attendances for people aged 65+ (Thurrock patients attending any A&E)	**13,543**	**10,072**	**N/A**	**N/A**													

Part 6– BETTER CARE FUND PLAN

The Plan is available via the following link:

www.thurrock.gov.uk/how-care-is-changing/better-care-fund-plan

SCHEDULE 7 – INFORMATION GOVERNANCE PROTOCOL

The Parties will be inserting the Protocol as soon as possible after entering in to the Agreement.

Better Care Fund – Annual Governance Statement 2020-2021

1. Introduction

1.1 The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Thurrock pursuant to the Care Act 2014.

1.2 NHS Thurrock Clinical Commissioning Group has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Thurrock.

1.3 The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the national conditions and local objectives as set out within the Better Care Fund Plan. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

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

1.5 This Statement sets out how the Council and NHS Thurrock CCG (the CCG) are, through effective governance arrangements, complying with the responsibilities set out within the Better Care Fund Section 75 Agreement for Thurrock, and the extant Better Care Fund Operating Guidance[1].

2. Governance Arrangements

2.1 Governance of the Better Care Fund is through the Thurrock Integrated Care Partnership (TICP). Membership of the TICP includes:

NHS Thurrock Clinical Commissioning Group

- Accountable Officer
- Chief Finance Officer
- Director of Commissioning

Thurrock Council

- Corporate Director of Adults, Housing and Health
- Director of Finance and Information Technology

[1] https://www.england.nhs.uk/wp-content/uploads/2018/07/better-care-fund-operating-guidance-v1.pdf

- Strategic Lead for Commissioning and Procurement
- Director of Adult Social Care and Community Development

2.2 The TICP, and the BCF Delivery Group, meets monthly to:

- Provide strategic direction on the schemes contained within the BCF;
- Receive financial and activity information;
- Review the operation of the section 75 Agreement;
- Review risks monthly and agreed annually a risk assessment;
- Review and agree annually revised schedules as necessary; and
- Request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund.

2.3 The TICP is a sub-group of the Health and Wellbeing Board, and as such, minutes of its meeting are considered by the Board at each of its meetings.

2.4 Governance arrangements are reviewed on an annual basis as part of the development of, and approval arrangements for, the Better Care Fund Plan and Section 75 Agreement. This includes a review of the TICP Terms of Reference.

2.5 Terms of Reference for the TICP were updated following a review undertaken in January 2019.

3. Performance Arrangements

3.1 The TICP, assisted by the BCF Delivery Group, is accountable for a performance scorecard and report. The scorecard is the main performance monitoring tool for the Better Care Fund.

3.2 The scorecard is reported to the TICP, assisted by the BCF Delivery Group, on a monthly basis with a more detailed report considered on a quarterly basis. An expanded report is be considered at the end of the year and also mid-year.

3.3 Performance arrangements and the scorecard supporting the delivery of the Better Care Fund are reviewed on an annual basis.

4. Financial Arrangements

4.1 Financial monitoring takes place on a monthly basis with a report jointly prepared by the CCG's Head of and Thurrock Council's BCF finance lead.

4.2 Monthly monitoring arrangements allow for any underspends to be identified and for decisions to be made about how any underspends should be allocated.

4.3 Whilst the pooled fund is set at a defined amount, any risk of overspend in any area will require a remedial action plan to be produced and presented.

5. Risk Management Arrangements

5.1 The Better Care Fund Plan contains a risk register that identifies the top ten risks.

5.2 Risks are reviewed by the TICP, assisted by the BCF Delivery Group, on a monthly basis.

6. Review of Effectiveness

6.1 The robustness of the governance arrangements for the Better Care Fund, as set out within this document and as contained within the section 75 Agreement, are considered on an annual basis – with any necessary changes being made as they arise. The review of effectiveness is to be undertaken with specific reference to the 2020/21 Better Care Fund: Policy Framework and the associated Planning Guidance (as yet unpublished).

6.2 The review of the governance arrangements for the Better Care Fund 2020/21 is to be considered and agreed by the TICP, assisted by the BCF Delivery Group, as part of the process for formulating the Better Care Fund Plan 2021/22, and reported to the Health and Wellbeing Board for approval.

6.3 A review of the Better Care Fund and Section 75 Agreement was undertaken by Thurrock Council Internal Audit in May 2018. The specific recommendations made in the Internal Audit Report 2017/18, as well as agreed management actions to implement the recommendations, have been adopted and applied. At this time no further action is required.

7 Annual Review

7.1 The Section 75 Agreement contains a requirement for an annual review of the operation of the agreement, the Pooled Fund and the provision of Services, within 3 Months of the end of each financial year. The TICP can agree alternative arrangements, including alternative frequencies.

7.2 In December 2020 Health and Wellbeing Boards (HWBs) were advised [2]that BCF policy and planning requirements would not be published during the

[2] https://www.gov.uk/government/publications/better-care-fund-policy-statement-2020-to-2021/better-care-fund-policy-statement-2020-to-2021

initial response to the COVID-19 pandemic and that they should prioritise continuity of provision, social care capacity and system resilience and spend from ringfenced BCF pots based on local agreement in 2020 to 2021, pending further guidance. Given the ongoing pressures on systems, Departments and NHS England and NHS Improvement have agreed that formal BCF plans will not have to be submitted to NHS England and NHS Improvement for approval in 2020 to 2021.

7.3 When resumed, the planning process will encompass the review of operation of the agreement, the Pooled Fund and the provision of services. A Task and Finish Group has been constituted to undertake the review of performance of services and has developed a set of funding criteria for the Better Care Fund Plan which includes:

- Funding available for one-off investments;
- Deciding whether the funding of investments made in previous year(s) should continue;
- Helping to identify whether any further spend can be freed up for investing or using differently.

The outcome of the review of the provision of services, and the funding recommendations for the 2021/22 Plan, and subsequent years, will be presented to the Health and Well-Being Board.

7.4 In view of the available Guidance the Health and Well-Being Board is asked to approve the arrangements for the Better Care Fund and for the associated Section 75 Agreement to be executed.

8. Approved

Ian Wake
Corporate Director of Adults, Housing and Health
Thurrock Council

Mark Tebbs
Alliance Director for Thurrock
NHS Thurrock Clinical Commissioning Group

Date: