Appendix 4

Dated 31 October 2024

DUDLEY METROPOLITAN BOROUGH COUNCIL

and

NHS BLACK COUNTRY INTEGRATED CARE BOARD

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

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THIS AGREEMENT is made on the 31 October2023

PARTIES

(1) **DUDLEY METROPOLITAN BOROUGH COUNCIL of** the Council House, Priory Road, Dudley. DY1 1HF

(2) **the "Council")**

(3) **NHS BLACK COUNTRY INTERGRATED CARE BOARD** of Civic Centre, St Peter's Square, Wolverhampton WV1 1RG (the "**ICB"**)

BACKGROUND

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

(B) The ICB has the responsibility for commissioning health services pursuant to the 2006 Act in the Borough of Dudley.

(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 ICB 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 position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will be able to pool funds and align budgets as agreed between the Partners.

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

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

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

d) support the delivery of the overall vision for the social care and health economy for Dudley of one ambition, working as one for everyone.

(G) The Partners will jointly be carrying out consultations on the services affected by proposals in 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:

2018 Act means the Data Protection Act 2018.

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 23, 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 Metrics means the metrics specified in Part 1 to Schedule 9.

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

Better Care Pooled Fund means the Pooled Fund as specified in Schedule 2.

Better Care Fund Programme Director means the member of staff appointed by the Council or jointly appointed by the Council and the ICB who is the Pooled Fund Manager;

Care Act 2014 is the Act which places additional responsibilities upon Local Authorities to help to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

ICB Statutory Duties means the Duties of the ICB 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 xxx

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.

Demographic Growth means anticipated population changes including size, structure, and distribution

Financial Contributions means the financial contributions made by each Partner to the Better Care Pooled Fund for each Individual Scheme 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 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. This is subject to the exclusions listed in Regulation 6(a)(i) to
(vi) of the Regulations together with such exclusions and limitations as specified in the relevant Scheme Specification.

Host Partner means for the Better Care Pooled Fund, the Council.

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

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

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

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

Law means:

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

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

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

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

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

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

Local Performance Metrics means those metrics for each scheme specified in Part 2 of Schedule 9.

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 Loss 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 ICB as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Non-Recurrent Payments means funding provided by a Partner to the Better Care Pooled Fund in in respect of an Individual Scheme in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.4.

Overspend means any expenditure from the Better Care Pooled Fund in a Financial Year for any Individual Scheme which exceeds the Financial Contributions to the Better Care Pooled Fund for that Individual Scheme for that Financial Year save where such overspend results from Payment for Performance Fund payments not being available to the Better Care Pooled Fund.

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

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 3;

Pay for Performance Fund means the ring-fenced element of the Better Care Fund Pooled Fund as specified in Schedule 2, paragraph 3 and Schedule 4 which shall be used for the purposes set out in Schedule 2, paragraph 3 and Schedule 4.

Performance Measures means the Better Care Fund Metrics and the Local Performance Metrics.

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.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the Better Care Pooled Fund as is nominated by the Host Partner from time to time to manage the Better Care Pooled Fund in accordance with Clause 7.6.4.

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

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

Quarter means each of the following periods in

a Financial Year: 1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March“

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

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

Ring Fenced Capital Grants means one or more of the grants specified at Schedule 2.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement which shall, in all cases be agreed prior to any such scheme becoming operative.

Sensitive Personal Data means Sensitive Personal Data as defined in the 2018 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 individuals for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health and Social Care..

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 Partnership Board.

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 21.

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

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

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

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

3.2 The Partners agree to:

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

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

3.2.3 provide early information and notice about relevant problems.

3.3 The Partners enter into this Agreement in order to support the delivery of the overall shared vision for the Dudley health and social care economy of one ambition, working as one for everybody.

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

4 PARTNERSHIP FLEXIBILITIES

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

4.1.1 Integrated Commissioning;

4.1.2 Lead Commissioning; and

4.1.3 the establishment of a Pooled Fund.

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

4.2 The Council delegates to the ICB and the ICB 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 ICB delegates to the Council and the Council agrees to exercise on the ’ICB'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 as outlined in the Better Care Fund plan agreed on an Annual basis by the Health and Wellbeing Board.

5.3 Following the agreement of the Better Care Fund Plan, the Partnership Board will develop and agree Schemes for the delivery of functions in line with the Plan. The Specification for each Individual Scheme shall be in the form set out in Schedule 1.

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

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

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

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

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

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

6.4 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in respect of any Individual Scheme in the Better Care Pooled Fund.

6.5 The Partnership Board will report back to the Health and Wellbeing Board

as required by its Terms of Reference.

Appointment of a Lead Commissioner

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

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

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

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

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

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

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

6.6.7 undertake performance management and contract monitoring of all Service Contracts, reporting on performance by exception to the Partnership Board;

6.6.8 in consultation with the programme director, undertaking any enforcement action pursuant to any Services Contract;

6.6.9 make payment of all sums due to a Provider pursuant to the terms of any Services Contract;

6.6.10 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend for any Individual Scheme in the Better Care Pooled Fund.

6.6.11 notify the other Partners if it receives or serves:

(i) a Change in Control Notice.

(ii) a Notice of an Event of Force Majeure.

(iii) a Contract Query.

(iv) Exception

Reports and provide

copies of the same.

6.6.12 provide the other Partners with copies of any and all:

(i) CQUIN Performance Reports.

(ii) Monthly Activity Reports.

(iii) Review Records; and

(iv) Remedial Action Plans.

(v) JI Reports.

(vi) Service Quality Performance Report;

6.6.13 shall consult with the other Partners before attending:

(i) an Activity Management Meeting.

(ii) Contract Management Meeting.

(iii) Review Meeting.

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

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

6.6.15 shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

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

6.7 The Lead Commissioner shall not:

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

6.7.2 vary any Provider Plans (excluding Remedial Action Plans).

6.7.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan.

6.7.4 give any approvals under the Service Contract.

6.7.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices).

6.7.6 suspend all or part of the Services.

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

6.7.8 serve any notice.

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

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

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

6.8.1 resolve disputes pursuant to a Service Contract.

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

6.8.3 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.

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

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

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

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

7 ESTABLISHMENT OF A POOLED FUND

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

7.2 The Better Care 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 the Better Care 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 Better Care 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 Better Care Pooled Fund. The Host Partner shall be the Partner responsible for:

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

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

7.6.3 appointing the Pooled Fund Manager.

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

8 POOLED FUND MANAGEMENT

8.1 The Pooled Fund Manager in respect of the Better Care Pooled Fund shall have the following duties and responsibilities:

8.1.1 the day-to-day operation and management of the Better Care Pooled Fund;

8.1.2 ensuring that all expenditure from the Better Care Pooled Fund is in accordance with the provisions of this Agreement and the Scheme Specifications.

8.1.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Better Care Pooled Fund.

8.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the Better Care Pooled Fund.

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

8.1.6 ensuring action is taken to manage any projected under or overspends relating to any Individual Scheme within the Better Care Pooled Fund in accordance with this Agreement.

8.1.7 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Better Care Pooled Fund for all Individual Schemes and the Better Care Pooled Fund together with such other information

as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Better Care 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; and

8.1.8 preparing and submitting reports to the individual partners or the Health and Wellbeing Board as required by them.

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

8.3 Save where otherwise agreed by the Partnership Board, there shall be no vireing of funds between Individual Schemes within the Better Care Pooled Fund.

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the ICB and the Council to the Better Care Pooled Fund will be set out in the Better Care Fund Plan.

9.2 The Pooled Fund Manager will be responsible for making proposals to the Partnership Board future years' Better Care Fund Plan to determine the Financial Contribution of the ICB and the Council to the Better Care Pooled Fund.

9.3 Financial Contributions will be paid as set out in Schedule 2.

9.4 With the exception of Clause 12, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Better Care Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Partnership Board minutes and recorded in the budget statement as a separate item.

10 NON FINANCIAL CONTRIBUTIONS

10.1 The non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Better Care Pooled Fund) will be set out in a separate agreement between the ICB and the Council to support wider integration across the Health and Social Care economy in Dudley.

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 4, which provide for financial risks arising within the commissioning of services from the Better Care Pooled Fund.

Overspends in Pooled Fund

11.2 Subject to Clause 11.1, the relevant Partner for the Better Care Pooled Fund shall manage expenditure from the Better Care Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

11.3 The relevant Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from the Better Care Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 11.4.

11.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 4 shall apply.

Underspend

11.5 In the event that expenditure from the Better Care Pooled Fund for any Individual Scheme for which Financial Contributions within the Better Care Pooled Fund are made 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 and the terms of the Performance Payment Arrangement.

12 CAPITAL EXPENDITURE

12.1 The Better Care Pooled Fund shall not (subject to any Ring Fenced Capital Grant) 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.

13 VAT

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

13.2 Subject to Clause 13.1, Services commissioned by the Council will be subject to the VAT regime of the Council and Services commissioned by the ICB will be subject to the VAT regime of the National Health Service.

14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant 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.

14.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance

15 LIABILITIES AND INSURANCE AND INDEMNITY

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

15.2 Clause 15.1 shall 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 Partnership Board.

15.3 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 13.4 the Partner that may claim against the other indemnifying Partner will:

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

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

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

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

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

16 STANDARDS OF CONDUCT AND SERVICE

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

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

16.3 The ICB is subject to the ICB Statutory Duties and these incorporate both a duty to act effectively, efficiently and economically and 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 Better Care Pooled Fund is therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

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

17 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 5.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working across the health and social care economy is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established the Partnership Board to oversee the delivery of the Individual Schemes and Better Care Pooled Fund and their associated action plans and performance monitoring arrangements in accordance with the Better Care Fund Plan, this Agreement and any requirements of the Health and Wellbeing Board.

18.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have responsibility to make decisions in accordance with the Governance arrangements of each Partner which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 3.

18.4 The terms of reference of the Partnership Board shall be as set out in Schedule 3.

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

18.6 The Partnership Board shall be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

18.7 Each Scheme's Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Service is reported to the Partnership Board and Health and Wellbeing Board.

19 REVIEW

19.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement of the Better Care Pooled Fund or the Individual Schemes the subject of the Better Care Fund Plan and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 3.

19.3 The Partnership Board shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 19. A copy of this report shall be provided to both Partners and the Health and Wellbeing Board.

19.4 In the event that the Partners fail to meet either the requirements of the Better Care Fund Plan or any other relevant statutory requirement the Partners shall provide full co-operation with any regulatory bodies (including NHS England) to agree a recovery plan.

20 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.

21 TERMINATION & DEFAULT

21.1 Subject to the statutory requirements of the Better Care Fund, this Agreement may be terminated by either 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 which are operational at the date of such notice being given.

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

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

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and any terms of this Agreement that expressly or by implication survive termination of this Agreement.

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

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

21.5.2 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;

21.5.3 where either Partner has entered into a Service Contract such Partner shall use all 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 that Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Partner that has entered into such Service Contract shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.5.4 where a Service Contract held by either 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 Partner holding the Service Contract assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

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

21.5.6 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.

21.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.5 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

22.1 The Partnership Board shall, in the first instance, operate as the forum for discussion of issues relating to this Agreement. This shall be based on the outlined principles of openness and treating Partners with equal esteem to resolve, as far as possible, any issues in a collective, consensual manner.

22.2 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.

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

22.4 If the dispute remains after the meeting detailed in Clause 22.3 has taken place, the Partners' respective chief executive and accountable officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

22.5 If the dispute remains after the meeting detailed in Clause 22.4 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a

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

22.6 Nothing in the procedure set out in this Clause 22 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.

23 FORCE MAJEURE

23.1 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.

23.2 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.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than sixty (60) days, 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.

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**”) undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser’s prior written consent provided that:

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

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

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

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

24.2 Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

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

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; and

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

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

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

25.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

26 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.

27 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in Schedule 6, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 2018 Act**.**

28 NOTICES

28.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

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

28.1.3 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.

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

28.3 The address for service of notices as referred to in Clause 28 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the Director of Adult Services:

28.3.2

Tel: 01384 815805

E.Mail: Matt.Bowsher@dudley.gov.uk

and

28.3.3 if to the ICB, addressed to The Dudley Managing Director.

Tel: 01384 3219251.

E.Mail: neill.bucktin@nhs.net

29 VARIATION

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

29.2 The members of the Partnership Board shall have delegated authority from their respective organisations to agree the addition of schemes to the agreement following consideration of a detailed business case at a Partnership Board meeting.

29.3 Any other variation to the agreement, including any proposed variation following a review under the terms of Clause 19, will be subject to signed agreement from each of the Partners.

30 CHANGE IN LAW

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

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

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

31 WAIVER

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

32 SEVERANCE

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

33 ASSIGNMENT AND SUB CONTRACTING

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.

34 EXCLUSION OF PARTNERSHIP AND AGENCY

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

34.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither

Partner will have authority to, or hold itself out as having authority to:

34.2.1 act as an agent of the other;

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

34.2.3 bind the other in any way.

35 THIRD PARTY RIGHTS

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

36 ENTIRE AGREEMENT

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

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

37 COUNTERPARTS

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

38 GOVERNING LAW AND JURISDICTION

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

38.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may 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 and on behalf of **DUDLEY METROPOLITAN BOROUGH COUNCIL** by:

____

Authorised Officer

____

Name

____

Position

Signed for on behalf of **NHS BLACK COUNTRY INTEGRATED CARE BOARD** by:

____

Authorised Signatory

____

Name

____

Position

SCHEDULE 1 –SCHEME SPECIFICATIONS

The Schemes that are subject to this Agreement are as described in the Better Care Fund Plan as approved by the Dudley Health and Wellbeing Board.

The elements of the BCF Plan are set out below:-

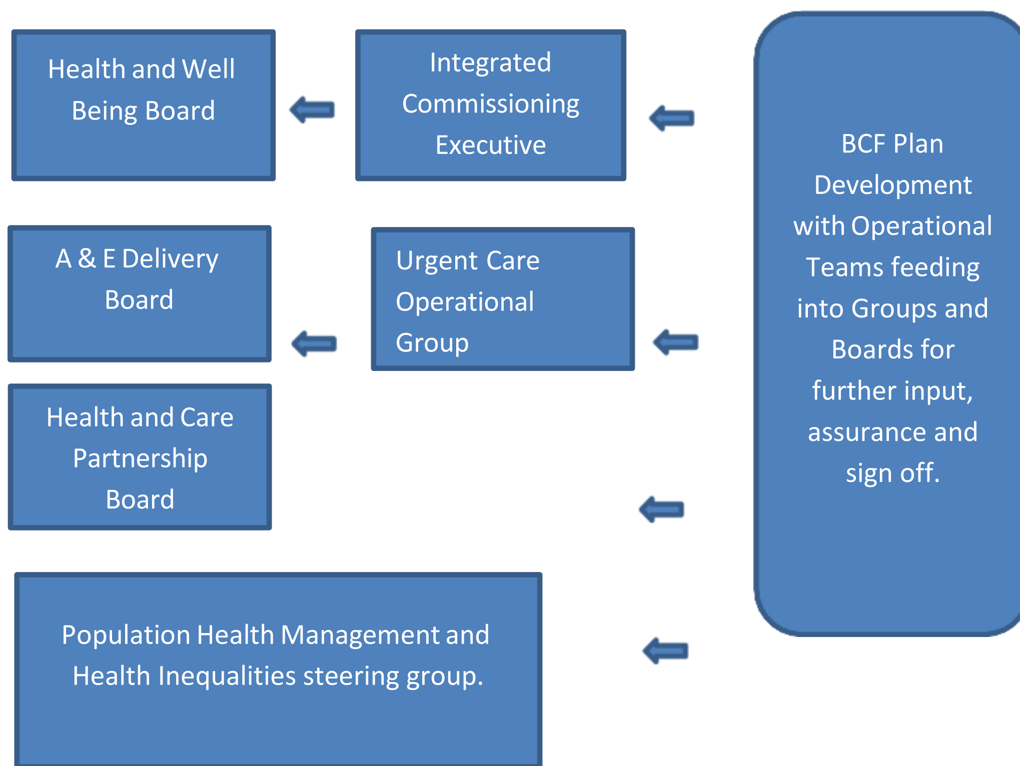
BCF Narrative Plan Template 23-25

Health and Wellbeing Board(s): Dudley

Governance

The assurance and decision-making process for the implementation and continuation of the BCF is the responsibility of the Integrated Commissioning Executive, established through a Section 75 Agreement between Black Country Integrated Care Board and Dudley Metropolitan Borough Council.

Consultation on the plan has been undertaken through an iterative process with Dudley A and E Delivery Board, the Urgent Care Operational Group, and Dudley Health and Care Partnership Board prior to approval by the Health and Well Being Board. A timeline of these meetings can be found in Appendix 1 (page 25). All stakeholders are represented on these boards, including Local authority, voluntary sector organisations, housing, mental health organisations. All partners have had an opportunity to comment and inform the plan. The plan has been collectively agreed with all partners through the process described. Diagrammatically this is shown below:



At the beginning of 2023, a programme commenced to review the existing lines of the BCF plan with all stakeholders to inform the 2023/25 programme. For 2023/25, there will be enhanced robust monitoring of the plan throughout the year with areas for further review identified. Evaluations and progress will be governed through the Integrated Commissioning Executive and shared with other stakeholder forums. The development of a revised joint reporting framework is underway which is due to be implemented in July 2023.

Executive summary

Our joint priorities for 2023/25 are: -

- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service
- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embedding the palliative care strategy and its recommendations,

alongside the development of a more integrated palliative care team.

- Further developing our Community Partnership Teams
- Exploring opportunities to merge pathways 2 and & 3 to create flexibility around resource and provision.
- Exploring further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in 2023.

Review of 2022/2023 programme

A light touch evaluation took place against the priorities within the 2022/23 plan. The outcome was that most of the investment areas were key in delivering the objectives laid down in the Better Care Fund Guidance, however it identified four areas of opportunity for efficiencies and transformation. An overarching review with comments against all schemes can be found in Appendix 2 (page 26). The review identified four areas for further transformation work to be undertaken during the next 2 years, as shown in Appendix 3: (page 31) -

- Transform palliative care services to ensure a truly integrated team across Health and Social care.
- Review of the existing Discharge to Assess Pathways to ensure that these are integrated and represent value for money, to provide D2A/reablement pathways that are the most cost effective and responsive to ensure flow through the urgent care system.
- Review medical cover within the plan for reablement services, particularly those whose function has changed post covid.
- Align rehabilitation investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.

As we progress through the identified areas of transformation, we intend to make appropriate changes to our existing BCF Plan. This is to ensure delivery of tangible impacts in line with the vision and objectives set out int the Policy Framework.

The ICB commissioned a review of Discharge to Assess pathways in 2022, and the outcomes from this review will also inform changes to the BCF Plan over the next 12 months. Further areas have also been aligned to the Better Care Fund Plan for 2023/25 where they meet the criteria, these are: -

- Dudley Clinical Hub: This provides an admission avoidance function.
- Handyman investment: To support quick and efficient discharge for those people. with housing issues where a simple intervention can reduce delays.
- Further investment into Discharge to Assess pathways bringing schemes together to ensure the most effective use of resources.

The Adult Social Care Discharge Fund for 2023/25 will continue to enhance current schemes within the existing BCF Plan, notably provision around Pathways 1, 2 and 3. All partners have agreed to the allocation of funding.

<u>Dudley Insights</u>

The information below provides an insight into the activity in the Dudley urgent and emergency care system. The data shows that there are significant peaks and troughs in activity and performance in Dudley and winter 2022/23 was particularly challenging.

Figure 1: ED attendances Type 1 at Dudley Group NHS Foundation Trust (DGFT).

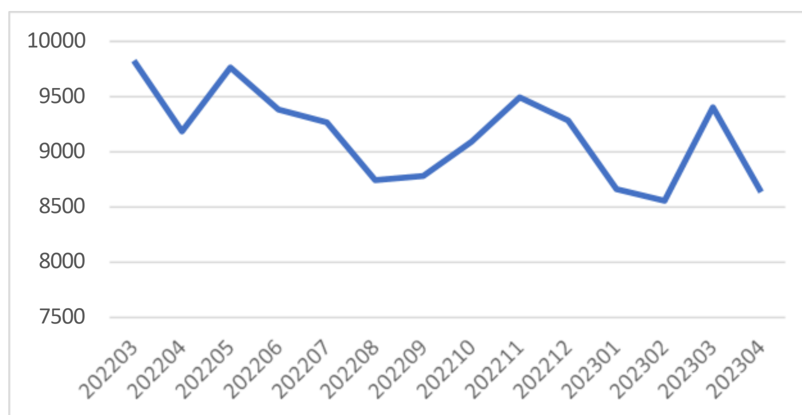


Figure 1 shows that over the last 12months we have seen a general reduction in the number of type 1 attendances at DGFT. We have not had a return to the peak in attendances we saw in March 2022.

Figure 2: Emergency admissions

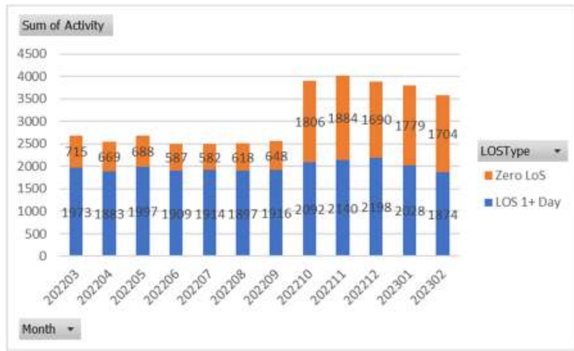
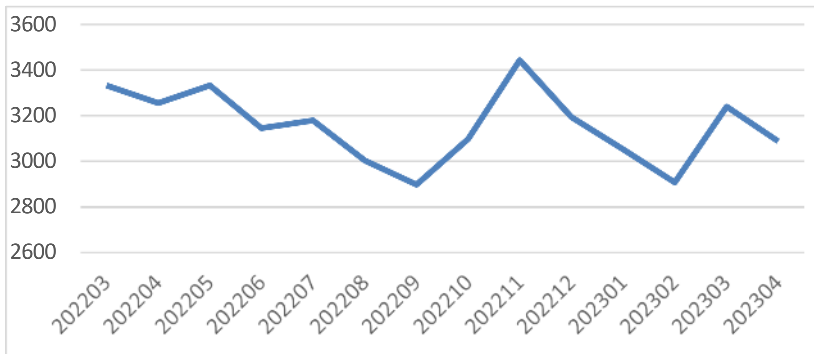


Figure 2 shows a change in activity around September/October of 2022. However, during this period DGFT changed the way Same Day Emergency Care (SDEC) activity was recorded and this is now coded as an emergency admission. The admissions have stayed relatively stable during this period.

Figure 3: Conveyances to DGFT



The admission avoidance activity has increased, and this may be why figure 3 shows a general reduction in ambulance conveyances during the previous 12 months despite the obvious peak during October – December 2022.

Figure 4: Care Home admissions:

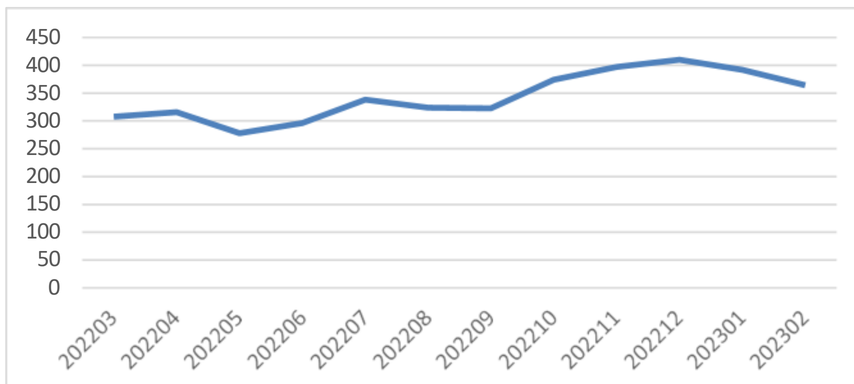
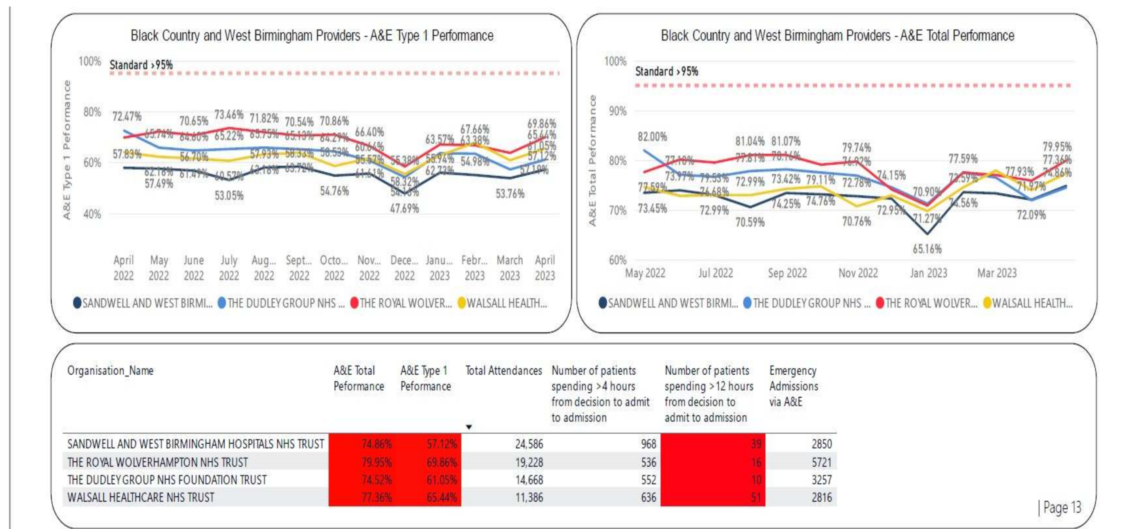


Figure 4 shows that despite an apparent reduction in the curve during recent months, care home admissions are still higher than they were in the same period last year. There is a focused piece of work with care homes working with staff on falls prevention and using appropriate admission avoidance interventions and we hope this will have a significant impact on care home admissions.

Figure 5: System wide A & E type 1 performance.



Organisation_Name	A&E Total Peformance	A&E Type 1 Peformance	Total Attendances	Number of patients spending >4 hours from decision to admit to admission	Number of patients spending >12 hours from decision to admit to admission	Emergency Admissions via A&E
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	74.86%	57.12%	24,586	968	39	2850
THE ROYAL WOLVERHAMPTON NHS TRUST	79.95%	69.86%	19,228	536	16	5721
THE DUDLEY GROUP NHS FOUNDATION TRUST	74.52%	61.05%	14,668	552	10	3257
WALSALL HEALTHCARE NHS TRUST	77.36%	65.44%	11,386	636	51	2816

Figure 5 shows that Dudley's activity is about average compared to neighbouring places and operates along the same trajectory of demand.

Our current challenges in Dudley are: -

- Too many community beds within Dudley place.
- People within a community bed having a length of stay beyond national guidance.
- Lack of specialist neuro-rehabilitation capacity
- Lack of Pathway 1 domiciliary care capacity.
- People being conveyed to hospital that could be managed through admission avoidance teams.
- Lack of pathway capacity to ensure consistent and smooth flow from an acute bed.

This BCF Plan is intended to respond to these challenges.

National Condition 1:

Overall BCF plan and approach to integration

This plan is designed to support the Dudley health and care system through: _

- Preventing inappropriate admission to hospital, residential or nursing care
- Supporting timely discharge from hospital
- Enabling people to live independent lives in supportive and resilient local communities.
- Reducing wider inequalities by enabling appropriate access to services and embedding preventative measures

Our approach to commissioning is led by the Integrated Commissioning Executive, established under the provisions of a Section 75 Agreement which governs the operation of the Better Care Fund. There is no set approach to joint commissioning, rather a set of approaches based upon what is required to address an issue – singular commissioning by either partner, aligned commissioning where each partner is responsible for their element, joint commissioning where resources are brought together to deliver a joint response.

During the period of our 2022/23 BCF Plan, a number of factors have informed our approach to the 2023/25 BCF Plan: -

- A review of our Discharge to Assess Pathways by an external organisation with a set of recommendations.
- The advent of the Adult Social Care Discharge Fund
- Lessons learned from the winter of 2022/23
- A review of existing BCF schemes

As a result of these specific changes and the challenges we have faced, our priorities for 2023/25 are as follows: -

- Further developing our Community Partnership Teams
- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service

- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embed the palliative care strategy and its recommendations, alongside development of a more integrated palliative care team.
- Explore opportunities to merge pathways 2 and 3 to create flexibility around resource and provision.
- Explore further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in the 2023.

The plan currently has both singular and aligned commissioned areas. Through the 23-25 planning term, we will be looking at opportunities to commission services through a joint commissioning approach, our priority area for 23-25 is palliative care.

National Condition 2: Meeting BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Detailed below are some of the main schemes in our approach in Dudley to 'Enabling people to stay well, safe and independent at home for longer.'

Community Partnership Teams

Our Community Partnership Teams are at the heart of our approach to support people at home within supportive local communities. They operate within our six PCNs and bring together clinical and operational staff across primary and community care to wrap higher quality care and services around patients nearer their homes. These teams bring together Community Nursing (District and Long-Term Condition Nurses), Social Care, Voluntary Sector Social Prescribers, Mental Health Nurses as well as the GP Practice and wider PCN workforce, to have a weekly focused discussion around our most complex and vulnerable patients in our community. In the last 10 months a transformation programme has further developed these teams which fundamentally underpin the Integrated Model of Care within Dudley. This has included standardised and dedicated leadership, development of clear metrics and outcomes and the embedding of care co-ordination across primary and secondary care. Currently these teams focus on people with complex comorbidities and frailty, as well as palliative care and complex mental health patients on a monthly basis. We are also expanding the model to have a focus on complex respiratory and diabetes cases. The plan will have strong links with the virtual ward programme as part of the step up/step down pathways of care for frailty, heart failure, respiratory palliative care and care home patients. The Intermediate Care/NHS Continuing Healthcare teams have been further embedded into these Community Partnership Teams to maximise support/rehabilitation to patients within their own home, facilitate timely discharge and support the wider MDTs.

Admission Avoidance

The Clinical Hub provides Dudley with its admission avoidance function through a single point of contact. This service provides the 2-hour community response service triage through to Same Day Emergency Care

(SDEC), hospital avoidance to both care homes and people in their own homes, care home educational service and the falls response service. They receive referrals from all stakeholders including primary care, care homes, GPs, social care, and ambulance service. The Urgent Community Response Service (UCR) operates seven days a week 8am-9pm, and the Care Home Educational Team operates 9am-5pm five days a week.Activity has significantly increased over the latter part of the period. All GP referrals for medical admissions where possible come though this service so that admission avoidance interventions can be put in place if safe to do so.

Figure 6: 2-hour Community Response Activity

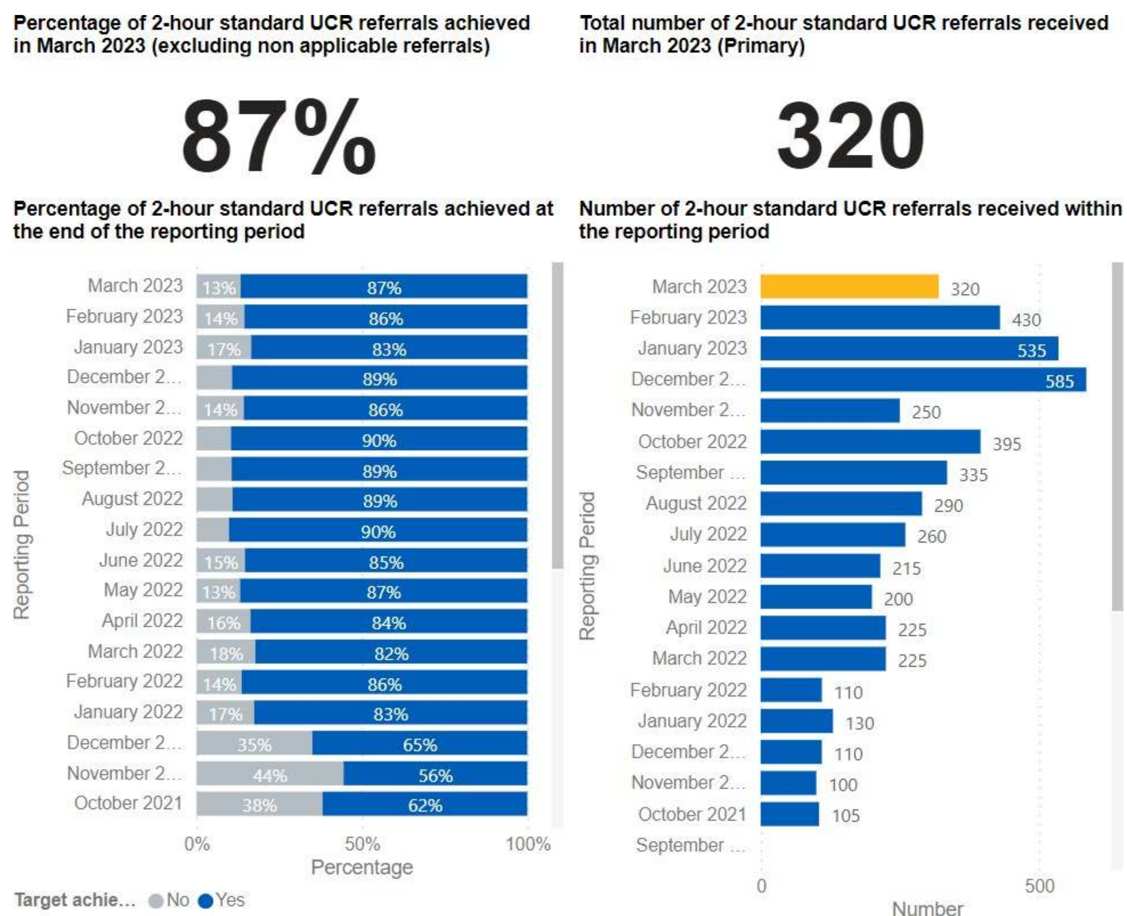


Figure 6 shows that the activity for 2 hour community response has increased over the last 12 months. We will contine to work with the Clinical Hub to ensure that the admisiosn avoidance function is maximised.

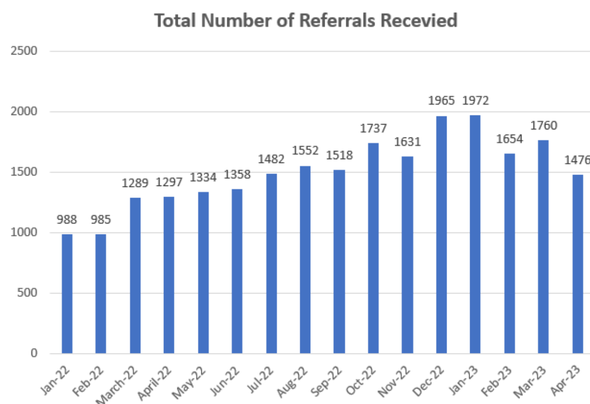
Education and oversight provision is provided for care homes by the Educational Care Home Team, focusing on 21 care homes identified as most in need. This supports care homes to ensure that a patient is not conveyed to

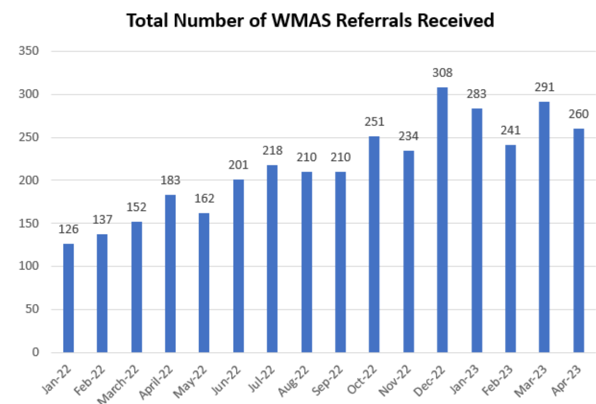
hospital unnecessarily and ensures that there is good quality of care delivered within care homes. The Clinical Hub also supports the ongoing Covid – 19 vaccination programme in care homes, and end of life provision. If necessary, the Clinical Hub, will provide carers over night to ensure that people can be cared for within their own environment rather than being admitted to hospital.

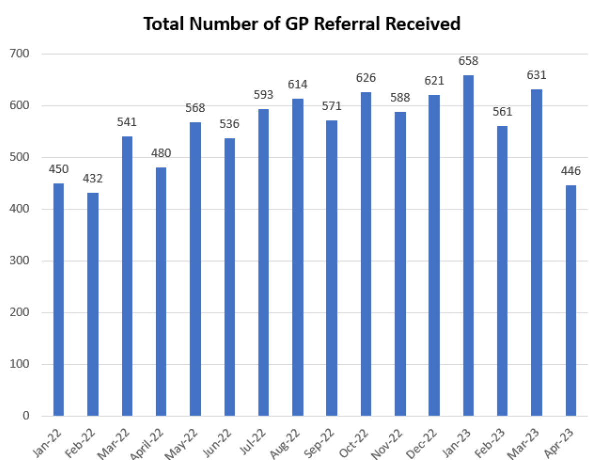
The Falls Service provides a same day response and is available to all care homes within Dudley. The teamwork with care homes and their residents to respond to the fall but also by providing interventions to prevent future falls. This team has only recently been set up but early data shows that they are reducing ED attendances for this cohort of people by 90%.

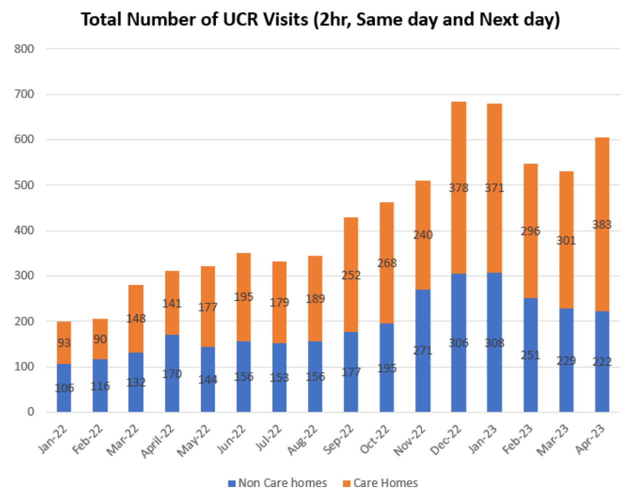
The Hub provides advice, guidance, and treatment around the 9 Core clinical pathways of the Enhanced Health and Care Home model, working in collaboration with the Care Home Education Team.

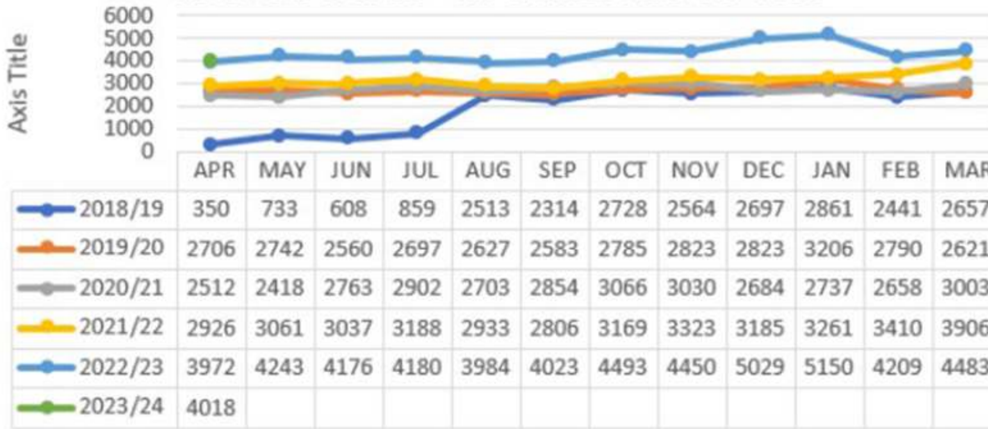
Figure 7 Clinical HUB activity from January 2022 – April 2023: again, showing the general increase in activity over the last 12 months.











	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2018/19	350	733	608	859	2513	2314	2728	2564	2697	2861	2441	2657
2019/20	2706	2742	2560	2697	2627	2583	2785	2823	2823	3206	2790	2621
2020/21	2512	2418	2763	2902	2703	2854	3066	3030	2684	2737	2658	3003
2021/22	2926	3061	3037	3188	2933	2806	3169	3323	3185	3261	3410	3906
2022/23	3972	4243	4176	4180	3984	4023	4493	4450	5029	5150	4209	4483
2023/24	4018											

Produced by: Community Informatics

Admission avoidance functions within the social care community teams offer either step-up facilities or emergency care within a person's own home. Health and social care teams work in collaboration to ensure the person can access the right care at the right time with wrap around support. Where a step-up bed is required, the teams provide the appropriate intervention and support to secure timely discharge back into the community. The hospital avoidance function provides preventative care in the community, signposting is given on direct payments, interventions for falls prevention, administering of personal budgets and health and wellbeing interventions. Reablement is provided by Therapy Services to maximise a person's potential and ensure that desired outcomes are achieved.

<u>Virtual Wards</u>

Dudley Group NHS Foundation Trust lead on the virtual ward programme providing eight virtual wards. The most successful programmes have been respiratory and paediatrics and there is further work required around frailty, and how this links in with the admission avoidance function. The priority so far has been in discharging people from an acute bed to a virtual ward programme, but during the next period the admission avoidance function will be enhanced, so people can be maintained at home, within a virtual ward without entering an acute hospital bed.

Single handed Care

During 2022/23 we piloted a programme of 'single handed care equipment'. This enabled a reduction in the number of carers required to keep people at home and prevent an admission but also facilitated discharge using fewer carers, hence ensuring the capacity of carers was greater. The programme involved training all staff in the use of single-handed equipment, both hospital staff and private providers, as well as a joint commitment to ensuring this is the default pathway for those people whose needs can be met using this system. Delivery of the equipment can be done at short notice and operates 7 days a week to support admission avoidance and hospital discharge.

Palliative Care Strategy

A palliative care strategy has recently been approved by the Health and Care Partnership Board which commits to developing a system wide approach so that citizens who are in the last stages of their life receive the care they need to preserve their integrity and wellbeing and are as comfortable as possible in the place of their choosing. Providing personalised care planning, shared records and involving the carer in all aspects of care when appropriate. The strategy will be embedded into all discharge plans to ensure that the ambitions of the plan are achieved. Palliative care will be an area we hope to transform within the plan to provide joint a joint commissioned approach as opposed to the current aligned approach through the delivery of a new palliative care service.

Housing Adaptions

The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering Disabled Facilities Grants (DFGs) funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team have strong links with both the Council's Adult Social Care team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre- vetted and approved contractors as part of a framework delivery. A handyman programme supports both admission avoidance and discharge, this can be something simple such as lock

changing, or furniture movement to something which requires a more substantial adaption or intervention.

We have positive relationships with our housing colleagues, and we are working together on homeless discharge pathways. We have regular meetings, with an upcoming focus on identifying patients with any housing issues at the point of admission and there is ongoing work on enhancing the transfer of care document to reflect those with specialist housing needs.

Demand and Capacity

Demand and capacity issues during the last term have been challenging due to several reasons including:

- Closure of 'block' units due to infection control issues
- Surges in referrals due to workforce issues in the local trust, such as reduced staff at weekends or due to staff sickness.
- Discharge planning issues within specialist units, such as specialist neurorehabilitation, which means length of stay is increased, which ultimately means more beds are utilised than actually needed if patients were discharged in a timely manner.
- Lack of capacity in pathways when surges occur.
- Service users having an increased length of stay in bed-based services due to lack of assessment capacity.

Some of the solutions include:

- Working with the local acute trust to have a consistent flow of referrals.
- Focused work with public health and quality teams around infection control issues and supporting homes due to infection control issues. Priority to re- opening facilities when safe to do so using a balanced approach to risk management.
- Focused work with specialist units to ensure discharge planning is proactive so no 'red' days (days without any action or progress).
- Utilisation of additional funding to procure additional social work assessment capacity in bed-based units.

More detailed information on some of the schemes is detailed below.

Pathway 2 (bedded rehabilitation) capacity and demand modelling has been embedded since the onset of the Covid pandemic and based on work completed through the National Audit for Intermediate Care. Learning from this analysis has highlighted demand trends and where increased capacity is required. Specifically, challenges arise when there are peaks in demand and where a community facility has beds closed due to, for example, infection control issues. Capacity has been used as flexibly as possible to ensure occupancy is maximised and an innovative project providing surge social work capacity funded through the Adult Social Care Discharge Fund (ASCDF) has significantly improved flow in all Discharge to Assess beds.

One area of potential unmet demand for 2023/24 is the gap in local service provision for patients requiring discharge to specialist Neuro-rehabilitation beds. To mitigate this, work is currently ongoing with system partners to develop referral pathways and improved responsiveness to decision making. A dedicated block commissioned specialist resource is being supported to ensure access and reduce delays.A further issue identified within the last 18 months activity data is the increased number of patients requiring 1:1 support from the acute setting into a Pathway 3 community bed.

Further work is being completed in this area to explore if this is a local assessment issue or a developing trend in the acuity of need. Comprehensive reviews of all patients referred with a 1:1 requirement is also being completed. The evidence and data from pathway 3 suggest a small proportion of patients once discharged from hospital and following a period of recouperation begin to improve and would benefit from rehabilitation. Linking pathway 2 and 3 units allows in this scenario rehabilitation to be delivered without moving the patients. Similarly having rehabilitation and therapy support across pathway 2 and 3 allows flexibility of the community bed base to meet surges in referrals to either pathway and deliver maintenance therapy support to those awaiting long term care assessments in pathway 3.

Pathway 1 capacity has improved during the later part of 2022/23 through ongoing work with the service providers. However, capacity does still not always meet demand. Again, this is challenging during ‘peaks,’ and capacity may be wasted when discharges are delayed due to reasons beyond Council control.

An implementation plan for a supported hospital discharge team will provide a home first approach to support patients with wrap around care and therapy support. There is ongoing work with DGFT to model the discharges that can be supported within the financial plan and ensure there are no wasted opportunities.

The demand and capacity analysis has highlighted the need to have at least between 3-5 Discharge to Assess Pathway 1 discharges every day. A priority for Pathway 1 teams in 2023/24 is to further develop links with bed-based intermediate care and community reablement/Own Bed Instead to ensure as many people can be supported in their own home as possible and improve flow through community beds.

Further work will be taking place during the next period to model a process where capacity is available to meet demand but also with partners to facilitate a system where there is a consistent flow of referrals rather than when resource is available within partner organisations.

The ongoing Discharge Funding allocated to ICBs, and Local authorities will be used to focus on the areas that have had the most demands through previous periods to ensure it has the greatest impact on delayed discharges. Plans for expenditure build on existing BCF plans and have been agreed with all partners.

National Condition 3: Meeting BCF objective2: Provide the right care in the right place at the right time.

We have described above our approach to admission avoidance and how our Community Partnership Teams function. This section will focus on how we deal with timely discharge and flow. Some of the areas previously discussed feature both within the admission avoidance and discharge flow plans, such as the single-handed equipment programme, the application of the palliative care strategy and housing adaptions.

In Dudley data shows that:

- There is on average about a 96% occupancy level of the acute beds.
- There are on average around 100 people at any one time who have been deemed medically fit for discharge, this includes those patients who are waiting for ward actions such as a therapy review.

- About 23% of discharges happen at weekends.
- The majority of those people on the list for meeting the criteria to be discharged are not discharged due to requiring therapy review, followed by a Pathway 1 provision and a small proportion on pathway 2.
- Those delayed on pathway 2 are mainly due to the availability of specialist neuro rehabilitation beds.

Discharge to Assess and Pathways 1,2 & 3.

The Discharge to Assess Policy is now embedded in operational teams with Home First always the starting point for conversations with patients, families, and carers around future destination. Own Bed Instead (OBI) dovetails into the discharge pathways with a commitment moving forward to integrate OBI into Pathway 1. Linking pathway 1 and 2 allows patients in community beds to be prioritised for discharge home earlier thereby improving flow in community bed capacity and ensuring people can return home as soon as possible. Where discharges do not happen and bed days are lost, we have a mechanism in place to record the reasons for this and themes and trends are used to develop a plan for improvement. For example, where one ward has a higher level of failed discharges then there is increased support to understand why, and further interventions are put in place.

There is a working group dedicated to the development of a robust Discharge to Assess programme, collaborating with all partners to ensure that bed days are used in the most effective way and that patients who are suitable enter the D2A programme.

During 2022/23, pathways 2 and 3 were used flexibly to allow for maximisation of capacity dependent on demand. This allowed flow to be maintained by changing the usage of beds in a fluid way dependent upon patient need.

Reablement programme

We have invested in a reablement programme across health and social care. This is a joint programme working across the teams to ensure that those entering pathway 1 on discharge have a robust reablement plan in place. This is a new programme and will be developed further over the coming year.

Home before Lunch

DGFT leads a ‘Home Before Lunch’ project with all partners supporting this principle. Many of the ‘failed’ discharges are due to losing daytime hours and therefore bringing even the most complex discharges out earlier in the day, allows time to facilitate smooth discharges. There is a KPI to ensure that 70% of discharges happen before lunch. On some wards this is being achieved and on other wards further work is required to improve their performance against this KPI.

System Developments

As a place we have bespoke schemes and programmes to meet the needs of our local population, however as Dudley is part of a wider Integrated Care System (ICS), we also look at opportunities to work at scale. For example, within the Black Country ICS the Adult Social Care Discharge Fund has been used to commission system wide schemes from Black Country Healthcare NHS Foundation Trust – the lead provider for mental health, learning disability and autism services. This includes providing housing support and a social prescribing service for mental health inpatients. During the next term, we will continue to look at opportunities to commission at scale where this makes sense.

Discharge HUB

There is currently a virtual Discharge HUB in Dudley with partners meeting several times during the day to discuss discharge pathways and the no criteria to reside lists, to ensure the maximum number of complex discharges are achieved. All teams use an integrated discharge database to manage discharges and ensure smooth lines of communicationwith all teams. Further work will take place during the next period to enhance how this database can accurately reflect discharge positions in real time.

In line with the NHSE targets for UEC discharge HUB developments we will continue to develop this team to ensure we are maximising its capability. A recently commissioned Integrated Brokerage Team, staffed through a collaborative model across organisations, delivers an integrated response to discharge into a bed-based service. This has functioned particularly well and allows people to naturally move from one pathway to another in a seamless manner if their needs change.

Handyman Programme

This was funded through the winter of 2022/23, and we will look to continue this programme during the next period. This was an excellent example of using a simple intervention to release acute bed days by using a personalised approach to discharge planning. For example, if a person had lost their keys, required house cleansing etc, the handyman programme was utilised to provide this personalised intervention to facilitate discharge.

High Impact Change Model

The High Impact Change Model has been reviewed for this financial year. A summary of the findings and opportunities for further development are detailed below. This table provides the key themes from the high impact assessment and identified key areas for development in the coming term. These areas focus on:

- Home for lunch.
- Development of the Integrated Discharge HUB.
- Better discharges to care homes.
- Improved BI system.
- Home First approach.

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	Some wards achieving KPI of home for lunch	Bring decision making to earlier in the day.	September 2023	Percentage increase of home for lunch

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 2: Monitoring and responding to system demand and capacity	Dudley place has a system for monitoring demand and capacity but does not align with system partners.	Further negotiation with system partners to align system and criteria for reporting.	July 2023	All criteria across the system for reporting demand and capacity is consistent.
Change 3: Multi-disciplinary working	Good MDT working although further work to develop the discharge HUB	Benchmark current practice against standards and develop a plan for improvement.	Benchmarking has begun, action plan will be developed by August 2023.	Meet the UEC standards for an integrated discharge hub
Change 4: Home first	Dependent on ward and area of discharge, depends on home first approach.	Work with acute colleagues on messaging and upskilling discharge conversations	September 2023	Default conversation for all discharges is 'Home first'
Change 5: Flexible working patterns	Flexible approach			
Change 6: Trusted assessment	In place			
Change 7: Engagement and choice	In place			
Change 8: Improved discharge to care homes	Performance is varied.	Work with acute colleagues and the care hone sector to agree what 'good' looks like. An existing work programme is in place to take this forward.	September 2023	No incidents reported from care homes for poor discharges.

Change 9: Housing and related services	Issues arise with complex discharges in housing related matters	Ensure housing and acute colleagues develop pathways and communication channels. This work has begun.	October 2023	For discharges that require housing interventions to be smooth and zero 'wasted' bed days.

How we support unpaid carers

BCF funding is used to fund the Carers Hub and Wellbeing Service. This is delivered by the Council's Carers Network Team and a commissioned provider, providing information, advice and support including peer support, welfare benefits advice and applications, young adult carers mentoring service (18 – 25), carers assessments and a preventative carer sitting service. Funding is used to ensure support is provided for the person receiving care at home. This includes support with social worker capacity to undertake Care Act compliant assessments.

The service operates from two HUBs, one in the south and one in the north of the borough.
•In 2022/23 the service engaged with approximately 3,500 carers.400 carers were referred for direct support to the Adult Carer Wellbeing Service They offer a range of services including: -
•

- Community-based delivery such as in local parks and libraries.
- Welfare benefits/allowance advice – supported new claims/appeals, raising
  £1,129,317.
- Peer Support – groups and activities
- Carers Rights and Awareness Sessions
- Young Adult Carer (18-25) Service.

The Hub delivered: -

- 244 Carers Assessments and 158 Carers Reviews.
- 113 Carers direct payments (via carers assessment) to support carers' health and wellbeing with a value £33,500.
- Provision of short-term preventative sitting service for carers. This service will be included as part of the commissioning of the

Adult Carers Wellbeing Service, to ensure it meets the current needs of carers.
- Support with 'cost of living' via Household Support Fund (HSF) payments to carers
- 1,200 carers aged 65 or above received a £150 voucher and 1,800 carers aged 18 – 64 received a £50 voucher.

Following its success, this service has extended a pilot digital carers service. The digital support targets the wider carer community who may not wish to access direct support from the Hub or need support outside of normal working hours. This includes information, advice, virtual chat, and peer group meetings.

Since the start of the pilot the service has achieved 19,751 hits to its website with 67% of this outside of normal working hours, ensuring support is available 24/7. In addition, it has engaged 2,306 carers and directly supported 641 carers.

Based on the success of the pilot, we plan to include a 'digital offer' within the next Carers Wellbeing Service tender. We are also continuing to work with ADASS Regional Carers to look at a possible regional digital offer for carers.

We are continuing to work with DGFT to establish a jointly funded Carers Information Hub within the hospital, to identify and support local carers. It is anticipated that this will open in summer 2023.
The Careers Strategy and Action Plan is currently being reviewed and refreshed, consultation and engagement with local carer organisations and groups has taken place with feedback now informing key priorities for the next strategy (2023 – 2026).

Following a review of the service and consultation with carers, the Adult and Young Carers Wellbeing Service will be recommissioned with services to commence from Autumn 2023.

Disabled Facilities Grant (DFG) and wider services

Dudley Council has a published its commitment to deliver DFGs for its residents. The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering DFGs funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team has strong links with both the Council's Adult Social Care Team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre-vetted and approved contractors.

There is a joint Housing, Communities and Social Care Action Plan, currently under review, to monitor and improve the service provided, with a particular focus on waiting times.
There is a current Council policy for DFGs, which provides for discretion in awarding grants, incorporated into the latest Housing Assistance and Guidance Policy.

A revised Housing Assistance and Guidance Policy has now been approved following the publication of the Disabled Facilities Grant (DFG): Guidance for Local Authorities in England to ensure that the Council continues the work that has already been undertaken to develop a service to ensure flexibility of grant delivery that enables people to stay well, safe, and independent at home for longer.

Flexible use of resource has already enabled a less bureaucratic means test of resources and assisted in providing minor adaptations, hoisting equipment, and helping people to re- locate to more adaptable homes. For example, we have invested:

- £695,000 towards additional Community Equipment Service equipment for prescribers across the health and care economy to support people to maximise their independence, including bathing equipment, specialist chairs, mobility aids and hoists.

- £47,000 towards the Handyman Service for the capital expenditure on key safes and ironmongery, safety, security, and small adaptations

In future, increasing the flexibility of the grant further will enable more heating and energy saving support to be provided, help for children living in joint residency, closer working with other housing providers and a contribution to other projects.

How is Dudley Tackling Health Inequalities?

The Black Country is the second most deprived ICS in the country. Nationally, 20% of the population lives in the most deprived quintile, and each of our areas in the Black Country are above the national average.

- Sandwell - 60%
- Walsall - 52%
- Wolverhampton - 52%
- Dudley – 28%

In Dudley we have a higher number of people than average, with disabilities (physical, mental health, learning disability, autism) and people from socially excluded groups (homeless, vulnerable migrants, Gypsies and Travellers, sex workers), as well as a higher- than-average older population.

Tackling inequalities in health and wellbeing is one of the overarching purposes of integration. Each new or existing service funded by the BCF or IBCF must have regard to the need to reduce inequalities in access to health and care and improve health and care outcomes.

Dudley's approach to health inequalities is based upon addressing the three pillars of access, prevention and the wider determinants of health and wellbeing. This forms the focus of activity for all partnership bodies led by the Health and Wellbeing Board's Joint Health, Wellbeing, and Inequalities Strategy.

The Health and Care Partnership Board has jointly agreed to an evidence-based Outcomes Framework that lies at the heart of our approach to Population Health Management. A Population Health Management and Inequalities Group reports to the Health and Wellbeing Board and co-

ordinates this work across partners.

The Health and Wellbeing Board has agreed its outcomes for patients, organisations and systems and this plan supports delivery of these outcomes by: -

Providing Care Closer to home with Improved
Outcomes Longer life Expectancy
Personalised care and Improved Patient Experience.
Increase in people attending community services, reducing pressures on hospitals, primary care, and social care.
Timely discharge from hospital
Sustainable health and care system.

The Health and Wellbeing Board's priorities are: -

Improving school readiness
Reducing Circulatory disease deaths
Improving breast cancer screening coverage

With a focus on those neighbourhoods with the greatest need.

This involves focusing on access to services preventing illness at a neighbourhood level through the work of our multi-disciplinary Community Partnership Teams, supporting those at risk with the most complex needs. These teams will utilise risk stratification and other population health management methodologies to enable access to the most appropriate support and prevent unnecessary admission to hospital or care homes.

There has been significant learning since the last plan around health inequalities, and how these impact on both health maintenance and prevention. Whilst the overall uptake rate is the highest in the Black Country, Covid vaccine take-up has been significantly lower in some population groups in Dudley, and these populations are at higher risk of hospital admission. This continues to be an area of focus and the lessons learned in understanding the reasons behind "vaccine hesitancy" have an impact on how we can ensure wider issues preventing access to services are addressed.

Part of our approach to addressing health inequalities is the creation of strong and resilient communities through our work with the voluntary and community sector. This has included investment in community led projects to address inequalities, including support for carers. These schemes will be reviewed in 2023/24 and the ICB will seek to fund sustainably if evaluations prove positive.

Dudley Council for Voluntary Service – the local umbrella body for voluntary and community sector organisations – is a key partner. As well as providing our local High Intensity User Service, their Integrated Plus workers are embedded within our Community Partnership Teams and work to support the discharge and admission avoidance processes, through the facilitation of effective social prescribing interventions to avoid the medicalisation of problems.

As a Dudley place we have a clear process for commissioning and re-commissioning services which includes ensuring our involvement and engagement team participate in all stages of commissioning, and we ensure this is driven through the findings in the Equality and Impact Assessments.

We ensure services are accessible and fair for every client. We provide person centred care in a non-judgmental manner; care plans are tailored to meet the person’s needs, including dislikes and beliefs, to ensure people can take part in whatever aspect of care they wish, whilst promoting their independence.

APPENDIX 1

Informal discussions with all stakeholders	Ongoing throughout the period
Integrated Commissioning Executive	3rd May 2023
Health and Care Partnership Board	18th May 2023
Integrated Commissioning Executive	7th June 2023
A & E Delivery Board	8th June 2023
Dudley Health and Well-Being Board	8th June 2023
Health and Care Partnership Board	15th May 2023

APPENDIX 2 Evaluation of Better Care Fund 2022 – 2023

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Tissue Viability Service - Assistive Technologies and Equipment	✓	✓	✓	✗	✓
Intermediate Care Team - District Nursing	✓	✓	✓	✗	✓
Step down - Occupational Therapy provided by DGFT		✓	✓	✗	✓
Step down - Physiotherapy provided by DGFT		✓	✓	💡	✓
LTC Nurses	✓	✓	✓	✗	✓
Own Bed Instead	✓	✓		✗	✓
Medical Cover into Intermediate Care Intermediate Care Support - Dr Plant		✓	✓	✗	✓

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Admission Avoidance Service – Beds Intermediate/ Stepdown Care - GP Respite	✓	✓	✓	✗	✓
Nursing Home Beds Intermediate/ Stepdown Care		✓	✓	✗	✓
Nursing Home Beds Pathway 3 Beds		✓	✓	✗	✓
Nursing Home Beds Intermediate/ Stepdown Care		✓	✓	✗	✓
Joint **Palliative Care** Support Team	✓	✓	✓	💡	✓

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Intermediate/ Stepdown Care - Physiotherapists		✓	✓	💡	✓
Medical Cover - Saltwells Stepdown Cover – DGFT		✓	✓	💡	✓
Highest Care Needs – coordinated palliative care community-based and inpatient care	✓	✓	✓	💡	✓
Reablement Highest Care Needs – coordinated community-based and inpatient care	✓	✓	✓	💡	✓

Note: 💡 This symbol denotes a line within the plan where further transformation work will be undertaken

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Enhanced neuro-rehabilitation capacity		✓	✓	✗
Additional Intermediate Care bed-based capacity		✓	✓	✗
Social work capacity		✓	✓	✗
Discharge to Assess – enhance model		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Therapy capacity for pathway 3 and spot purchase beds	✓	✓	✓	✗
Bridging beds		✓	✓	✗
Assessment capacity to review care packages in peoples own homes.	✓	✓	✓	✗
Therapy support in patents own homes	✓	✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional social work capacity for mental health and LD patients		✓	✓	✗
Additional equipment	✓	✓	✓	✗
Overtime for DOM care workers and social work staff	✓	✓	✓	✗
Additional Pathway 3 beds		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional Pathway 1		✓	✓	✗
Additional back-office support	✓	✓	✓	✗
Administration time for planning and co-ordination	✓	✓	✓	✗
Additional Intermediate Care Nurse capacity		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional discharge 2 Assess joint plan (townships)	✓	✓	✓	
Support for pathway 0		✓	✓	✗
Top slice for administration	✓	✓	✓	✗
Additional beds to support discharge for those patients testing positive for covid		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Voluntary sector support for mental health inpatients	✓	✓	✓	✗
Additional pathway 3 beds managed by health teams, patients with nursing needs		✓	✓	✗

APPENDIX 3 – BCF 23 – 24 Work Plan

4 areas for review	Q1	Q2	Q3	Q4
Transform **Palliative Care Services** to ensure a true integrated team across Health and Social care.	Set up Dudley Place Palliative Care Integration Working Group. Establish core members and develop TOR	Working group to explore opportunities and potential solutions for integration	Continue to collaborate to coproduce recommendations	Recommendations to be presented to the Integrated Care Executive
Review of the existing **Discharge to Assess Pathways**, ensuring integration, value for money and ensure patient flow.	D2A Steering Group established and in place. Need to determine action plan and timelines.	Continuation of D2A Steering Group and implementation of Action Plan.	Continue to collaborate to coproduce recommendations	Continue to collaborate to coproduce recommendations
Review **medical cover** within the plan for int care services, particularly those whose function has changed post covid.	Not a priority for Q1	Review current position and recommendations taken to Integrated Commissioning Executive.	Implementation of recommendations	Complete
Align rehabilitation **(Step down physiotherapy)** investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.	Not a priority for Q1	Discussion with existing provider to identify opportunities	Implementation	Complete

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1001	Whole Population Prevention / Population Health Management	Locality Based Prevention Hubs	Community Based Schemes	Charity / Voluntary Sector	Additional LA Contribution	Existing	£1,299,140	£1,299,140	14%
1001	Whole Population Prevention / Population Health Management	Locality Based Prevention Hubs - Carer support	Carers Services	Charity / Voluntary Sector	Additional LA Contribution	Existing	£434,900	£434,900	58%
1002	Whole Population Prevention / Population Health Management	Community Equipment Stores	Assistive Technologies and Equipment	Local Authority	Minimum NHS Contribution	Existing	£520,300	£527,100	20%
1002	Whole Population Prevention / Population Health Management	Community Equipment Stores	Assistive Technologies and Equipment	Local Authority	Additional LA Contribution	Existing	£616,300	£624,300	24%
1003	Whole Population Prevention / Population Health Management	Disabled Facilities Grant	DFG Related Schemes	Local Authority	DFG	Existing	£4,677,209	£4,677,209	41%
1003	Whole Population Prevention / Population Health Management	DFG - ASC Equipment Capital Costs	DFG Related Schemes	Local Authority	DFG	New	£695,000	£695,000	6%
1003	Whole Population Prevention / Population Health Management	DFG - Net Zero Neighbourhood Scheme	DFG Related Schemes	Local Authority	DFG	New	£500,000	£500,000	4%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1003	Whole Population Prevention / Population Health Management	DFG - Housing Assistance	DFG Related Schemes	Local Authority	DFG	New	£150,000	£150,000	1%
1003	Whole Population Prevention / Population Health Management	DFG - Minor Adaptations	DFG Related Schemes	Local Authority	DFG	New	£375,000	£375,000	3%
1003	Whole Population Prevention / Population Health Management	DFG - Handypersons Capital Costs	DFG Related Schemes	Local Authority	DFG	New	£47,000	£47,000	0%
1003	Whole Population Prevention / Population Health Management	DFG - Prior year carry forward	DFG Related Schemes	Local Authority	Additional LA Contribution	New	£5,024,000	£0	44%
1004	Whole Population Prevention / Population Health Management	Falls Service	Prevention / Early Intervention	Local Authority	Additional LA Contribution	Existing	£54,200	£58,400	4%
1005	Whole Population Prevention / Population Health Management	Careres Network Team	Carers Services	Local Authority	Minimum NHS Contribution	Existing	£219,400	£223,400	30%
2001	Urgent Care Needs – Integrated Access & Rapid Response	Out of Hours	Home-based intermediate care services	Local Authority	Minimum NHS Contribution	Existing	£200,400	£204,200	3%
2001	Urgent Care Needs – Integrated Access & Rapid Response	Out of Hours	Home-based intermediate care services	Local Authority	Additional LA Contribution	Existing	£34,200	£34,800	1%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
2002	Urgent Care Needs – Integrated Access & Rapid Response	Access - SPOA	Integrated Care Planning and Navigation	Local Authority	Additional LA Contribution	Existing	£1,691,900	£1,819,400	20%
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Private Sector	Minimum NHS Contribution	Existing	£7,083,923	£7,762,816	38%
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Private Sector	iBCF	Existing	£6,426,513	£6,426,513	33%
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Private Sector	Additional LA Contribution	Existing	£1,638,664	£1,638,664	8%
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Personalised Budgeting and Commissioning	Private Sector	Minimum NHS Contribution	Existing	£147,300	£155,600	4%
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Personalised Budgeting and Commissioning	Private Sector	Additional LA Contribution	Existing	£3,582,900	£3,582,900	96%
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Carers Services	Private Sector	Minimum NHS Contribution	Existing	£89,100	£89,100	12%
3004	Ongoing Care Needs - Enhanced Primary & Community Care	Urgent care assessment and therapy	High Impact Change Model for Managing Transfer of Care	Local Authority	Additional LA Contribution	Existing	£936,450	£965,150	27%
3004	Ongoing Care Needs - Enhanced Primary & Community Care	Urgent care assessment and therapy	Integrated Care Planning and Navigation	Local Authority	Additional LA Contribution	Existing	£936,450	£965,150	11%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
4001	Highest Care Needs – coordinated community-based and inpatient care	Living independentley Team - Community Reablement	Home-based intermediate care services	Local Authority	Minimum NHS Contribution	Existing	£724,400	£738,500	11%
4001	Highest Care Needs – coordinated community-based and inpatient care	Living independently Team - Community Reablement	Home-based intermediate care services	Local Authority	Additional LA Contribution	Existing	£790,300	£809,600	12%
4002	Highest Care Needs – coordinated community-based and inpatient care	Access & Prevention - Occupational Therapy	Prevention / Early Intervention	Local Authority	Minimum NHS Contribution	Existing	£228,100	£232,700	18%
4002	Highest Care Needs – coordinated community-based and inpatient care	Access & Prevention - Occupational Therapy	Prevention / Early Intervention	Local Authority	Additional LA Contribution	Existing	£1,002,400	£1,022,800	78%
4003	Highest Care Needs – coordinated community-based and inpatient care	Tiled House	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Local Authority	Minimum NHS Contribution	Existing	£2,983,600	£3,031,600	53%
4004	Highest Care Needs – coordinated community-based and inpatient care	External reablement - packages of care	Home-based intermediate care services	Private Sector	Minimum NHS Contribution	Existing	£2,235,600	£2,362,100	34%
4004	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care - Homecare assistants	Urgent Community Response	Local Authority	Minimum NHS Contribution	Existing	£536,900	£541,800	26%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
4004	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care - Homecare assistants	Urgent Community Response	Local Authority	Additional LA Contribution	Existing	£931,800	£956,300	45%
4005	Highest Care Needs – coordinated community-based and inpatient care	Palliative - front end	Personalised Care at Home	Local Authority	Minimum NHS Contribution	Existing	£272,000	£277,400	100%
4006	Highest Care Needs – coordinated community-based and inpatient care	Supported Living - MH	Home Care or Domiciliary Care	Private Sector	Minimum NHS Contribution	Existing	£246,100	£260,000	1%
4006	Highest Care Needs – coordinated community-based and inpatient care	Supported Living - MH	Home Care or Domiciliary Care	Private Sector	Additional LA Contribution	Existing	£1,610,789	£1,610,789	8%
4007	Highest Care Needs – coordinated community-based and inpatient care	Integrated Discharge Pathway	High Impact Change Model for Managing Transfer of Care	Private Sector	Minimum NHS Contribution	Existing	£1,063,600	£1,123,800	31%
4007	Highest Care Needs – coordinated community-based and inpatient care	Short Term beds	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Private Sector	Minimum NHS Contribution	Existing	£204,300	£215,900	4%
4007	Highest Care Needs – coordinated community-based and inpatient care	Short term beds	Bed based intermediate Care Services (Reablement, rehabilitation, wider	Private Sector	iBCF	Existing	£488,901	£488,901	9%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
			short-term services supporting recovery)						
4008	Highest Care Needs – coordinated community-based and inpatient care	Internal Day Care & Dementia Gateways	Community Based Schemes	Local Authority	Minimum NHS Contribution	Existing	£1,124,700	£1,145,700	12%
4009	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care enhanced offer	High Impact Change Model for Managing Transfer of Care	Local Authority	iBCF	Existing	£1,001,300	£1,001,300	28%
4010	Highest Care Needs – coordinated community-based and inpatient care	Enhanced therapy offer	Home-based intermediate care services	Local Authority	iBCF	Existing	£998,700	£998,700	15%
4011	Highest Care Needs – coordinated community-based and inpatient care	Enhanced review offer	Integrated Care Planning and Navigation	Local Authority	iBCF	Existing	£216,100	£216,100	2%
4012	Highest Care Needs – coordinated community-based and inpatient care	Bed based Packages	Integrated Care Planning and Navigation	Private Sector	iBCF	Existing	£5,934,569	£5,934,569	66%
4013	Highest Care Needs – coordinated community-based and inpatient care	DDS clients over 65	Home Care or Domiciliary Care	Private Sector	iBCF	Existing	£1,561,621	£1,561,621	8%
5001	Discharge to Assess	Enhance the discharge to Assess model and increase capacity	Home Care or Domiciliary Care	Private Sector	Local Authority Discharge Funding	Existing	£732,164	£732,164	4%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
5001	Discharge to Assess	Enhance the discharge to Assess model	Home-based intermediate care services	Local Authority	Local Authority Discharge Funding	New	£1,000,000	£2,538,578	26%
5002	Additional Pathway 3 beds	To support discharge to assess to ensure that patients are transferred from hospital to an appropriate setting to assess their long term needs. Additional 43 beds already in place.	Residential Placements	Private Sector	Local Authority Discharge Funding	Existing	£262,718	£262,718	8%
5003	Additional equipment	To reduce the number of resource for pathway 1 we require additional equipment for the single handed equipment initiative	Assistive Technologies and Equipment	Local Authority	Local Authority Discharge Funding	Existing	£200,000	£200,000	8%
5004	Additional social work capacity for mental health and LD colleagues	Dedicated SW support for this cohort, recruitment commenced for 2 WTE	Integrated Care Planning and Navigation	Local Authority	Local Authority Discharge Funding	Existing	£136,296	£136,296	2%
232501	Tissue Viability Service	Provision of equipment to enable discharge of patients to their own home, mattresses/beds etc. (Drive Devilbiss - equipment only)	Assistive Technologies and Equipment	NHS	Minimum NHS Contribution	Existing	£1,287,006	£1,296,015	48%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
232502	Clinical Hub - 2 Hour Response and Admission Avoidance	2 Hour Response and Admission Avoidance Service	Urgent Community Response	NHS	Additional NHS Contribution	Existing	£619,057	£623,390	29%
232503	PREVIOUSLY KNOWN AS Clinical Hub - Palliative and End of Life Care - dedicated Domiciliary Care Teams NEW SCHEME NAME Clinical Hub - Rapid Response Team	Dedicated Domiciliary Care providing end of life care to people in own homes NEW AMENDMENT Also provide end of life care to people in care homes.	Community Based Schemes	NHS	Minimum NHS Contribution	Existing	£1,962,619	£1,976,357	22%
232504	Clinical Hub - Own Bed Instead (OBI)	OBI is a rehab service to support people in their own homes	High Impact Change Model for Managing Transfer of Care	NHS	Minimum NHS Contribution	Existing	£487,055	£490,464	14%
232505	Clinical Hub - Long Term Conditions Nurses - Hospital Avoidance Team	Long Term Conditions Nurses (Hospital Avoidance Team)	Community Based Schemes	NHS	Minimum NHS Contribution	Existing	£252,944	£254,715	3%
232506	Pathway 2 Beds	Block Pathway 2 Capacity Intermediate/ Stepdown Care	Residential Placements	Private Sector	Minimum NHS Contribution	Existing	£2,063,159	£2,399,204	63%
232507	Additional Pathway 2 Beds capacity (ASCDF - Line 1 and 2)	Additional bed based capacity to support acute discharges and maintain patient flow	Residential Placements	Private Sector	ICB Discharge Funding	Existing	£280,000	£400,000	10%
232508	Pathway 3 Beds	Block Pathway 3 beds	Bed based intermediate Care Services	Private Sector	Minimum NHS Contribution	Existing	£1,093,476	£1,101,130	19%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
			(Reablement, rehabilitation, wider short-term services supporting recovery)						
232509	Pathway 2 Neuro Rehab Beds	Neuro-rehabilitation beds to aid discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Private Sector	Minimum NHS Contribution	Existing	£550,000	£755,250	13%
232510	Pathway 2 Neuro Rehab Beds ASCDF	Additional bed based capacity to support acute discharges and maintain patient flow (In addition to West Park)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Private Sector	ICB Discharge Funding	Existing	£100,000	£150,000	2%
232511	Intermediate Care Admision Avoidance Beds	Intermediate Care Admission Avoidance beds	Community Based Schemes	Private Sector	Minimum NHS Contribution	Existing	£1,632,835	£1,644,265	18%
232512	District Nursing support into Intermediate Care	District Nursing support into Intermediate Care based at Tiled House. (Provider - DGFT)	Community Based Schemes	NHS	Minimum NHS Contribution	Existing	£231,958	£233,582	3%
232513	Additional Social Work Capacity (ASCDF Line 3)	To underpin ongoing work and to support discharges from community beds	Community Based Schemes	NHS Community Provider	ICB Discharge Funding	New	£120,000	£150,000	2%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
232514	Extra Intermediate Care Nurse capacity to support Pathway 2 (Line 16 ASCDF)	To meet demand within the acute setting and to expedite discharge from P2 beds	Community Based Schemes	Private Sector	ICB Discharge Funding	New	£30,000	£40,000	0%
232515	Pathway support	Working with partners across the system to provide capacity across all pathways including mental health services.	Community Based Schemes	NHS	ICB Discharge Funding	New	£220,000	£250,000	3%
232516	Pathway 2 Medical Support - (Doctor cover) Summerhill	Doctor cover provision for patients in designated intermediate care homes. (Summerhill)	Other	NHS	Minimum NHS Contribution	Existing	£62,759	£63,198	100%
232517	Medical input into stepdown facilities - Saltwells	Medical input into stepdown facilities provided by DGFT (Included in the block - previously Saltwells)	Community Based Schemes	NHS	Minimum NHS Contribution	Existing	£89,271	£89,896	1%
232519	Pathway 2 Step Down Occupational Therapy	Pathway 2 Step down - Occupational Therapy Services based at Tiled House. (Provider - DGFT)	Community Based Schemes	NHS Acute Provider	Minimum NHS Contribution	Existing	£550,352	£554,204	6%
232520	Pathway 2 Step Down Physiotherapy	Step Down Physiotherapy Services provided within Local Acute Community Trust	Community Based Schemes	NHS	Minimum NHS Contribution	Existing	£211,948	£213,432	2%
232521	Pathway 2 Step Down Physiotherapy	Step Down Physiotherapy Services provided by private provider	Community Based Schemes	Private Sector	Minimum NHS Contribution	Existing	£69,045	£69,528	1%

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
232522	Support for discharge	To provide increased capacity in discharge pathways.	Community Based Schemes	Private Sector	ICB Discharge Funding	Existing	£739,628	£1,790,140	14%
232523	Pathway 2 beds	Block pathway 2 capacity Intermediate/Stepdown Care	Residential Placements	Private Sector	Additional NHS Contribution	Existing	£805,598	£489,634	20%

SCHEDULE 2– BETTER CARE POOLED FUND

The Better Care Pooled Fund is made up of contributions of the ICB and the Council as specified in the Better Care Fund Plan agreed by the Health and Wellbeing Board.

The Pooled Fund will include Ring Fenced Capital Grants which may only be paid out of the Better Care Pooled Fund for use by the Council in accordance with the conditions attached to those grants.

All monies in the Better Care Pooled Fund allocated to Individual Schemes may only be spent on those Individual Schemes and shall be accounted for and reported accordingly.

1. HOST PARTNER

1.1 The Host Partner for the Better Care Pooled Fund is the Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

2. FINANCIAL GOVERNANCE ARRANGEMENTS

2.1 As in the Agreement with the

following changes: <u>Management of the</u>

<u>Better Care Pooled Fund</u>

2.2 The other Partner shall make monthly payments to the Host Partners

2.3 Each month in monthly closedown estimates for over or under performance will be shared for accruals purposes in line with the following closedown timetable:-

2.3.1 The relevant Partner to submit pooled budget figures for each Individual Scheme to the Host Partner by the 8th Working Day of the month. The First reconciliation point will be at the end of Q2 (Month 6) to include any over/under performance to date but will not include assessment of performance payment

2.3.2 The Second reconciliation point will be the end of Q3 (Month 9) with potential to include assessment of performance payment preferred.

2.3.3 Over performance will be paid separately so as to keep a clear audit trail in line with Standard Financial Instructions and Standing Orders

2.3.4 Month 11 reporting will incorporate year end estimate on pooled budgets.

2.4 The year-end reporting will be shared in line with the following closedown timetable:-

2.4.1 The relevant Partner to submit draft figures for each Individual Scheme within the Better Care Pooled Fund to the Host Partner to enable the Host Partner to provide draft figures for the Better Care Pooled Fund by the 3rd Working Day following year end (to meet national accrual deadline)

2.4.2 The relevant Partner to submit budget information for each Individual Scheme within the Pooled Fund to the Host Partner to enable the Host Partner to submit budget information for inclusion in the annual accounts by the 10th Working Day following year end (to meet national deadline for submission of draft and audited accounts.)

2.5 The Host Partner financial system will be used for financial management purposes:

2.6 Budget holders will submit forecasts by the 10th Working Day of each month. These will then be reviewed by the appropriate Heads of Service and Service Directors by the 15th Working Day of the month.

2.7 A budget report will contain:

2.7.1 Financial codes and description of code

2.7.2 Original, revised and year to date budgets

2.7.3 Actual spend to date and commitments

2.7.4 Previous months and current forecasts

2.7.5 Comments

2.8 Budget Holders for each Individual Scheme will be detailed in each Scheme Specification and will be required to follow the established working rules and will be bound by the Host Partner's organisation's scheme of delegation.

2.9 Where budget holders are not employed by the Host Partner, they will need to sign an undertaking to abide by the established rules.

2.10 Training will be provided to budget holders and managers in the use of the Agresso financial system by the Host Partner.

2.11 Budget Holders for each Individual Scheme will be responsible for all financial transactions for their budget including raising invoices (sales notes) and authorising both pay and non-pay expenditure.

2.12 The fund will not include a contingency reserve; however this will be kept under review.

2.13 Means testing for any social care payments will be carried out by the Host Partner.

Changes to Contribution levels

2.14 The contribution levels to the Better Care Pooled Fund for each Individual Scheme have been agreed in principle as outlined above in Schedule 2.

2.15 Any changes to contribution levels will need to be agreed through the governance structure outlined in Schedule 3.

Audit Arrangements

2.16 The current Internal and External Auditors for both Partners will need to provide audit opinions on the operation of the pooled fund and sign off substantive audits.

2.17 Grant Thorntons have been appointed to manage the External Audit process for the Host Partner.

2.18 The Finance Department within the Host Partner will manage and act as the

point of liaison with the auditors.

2.19 The Audit arrangements for the Better Care Pooled Fund will comply with the external audit regimes of both parties.

3 REPORTING AND ASSURANCE ARRANGEMENTS

3.1 In line with the Better Care Fund Policy Framework the Host Partner in partnership with the relevant Partner shall provide quarterly and annual reports on the overall operation of the arrangements for the Better Care Pooled Fund.

3.2 The Quarterly and annual report shall include such information as will be specified in the Policy Framework and further guidance provided by NHS England and the Department of Health and Social Care to provide assurance to NHS England as to the appropriate use of the fund.

3.3 The Integrated Commissioning Committee, the arrangements for which are set out in Schedule 3, shall prepare the reports and (if required) submit them for approval to the Health and Wellbeing Board in order to meet the deadlines for the submission of the quarterly reports as set by NHS England and the Department of Health and Social Care.

SCHEDULE 3– GOVERNANCE

1. Partnership Board

1.1 The Dudley Integrated Commissioning Committee established by the Partners will act as the Partnership Board.

2. Role of Integrated Commissioning Committee

2.1 The Integrated Commissioning Committee shall:

2.1.1 provide strategic direction on the BCF Plan, based on advice and recommendations received from its Better Care Fund Executive. .

2.1.2 receive the financial and activity information, including the Quarterly reports of the Pooled Fund Manager for each Individual Scheme and ensure that such Individual Schemes are being developed to meet the requirements of the Better Care Fund Plan;.

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

2.1.4 agree such variations to this Agreement from time to time as it thinks fit, subject always to the governance arrangements of each Partner.

2.1.5 review and recommend annually a risk assessment and a Performance Payment protocol.

2.1.6 review and recommend annually revised Schedules as necessary.

2.1.7 request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Better Care Pooled Fund.

2.1.8 hold the Better Care Fund Programme Director to account for the delivery of the aims of the Agreement; and

2.1.9 provide regular reports to the Health and Well-Being Board on the operation of this Agreement.

3. Integrated Commissioning Committee Support

The Committee will be supported by officers from the Partners from time to

time. Administrative support will be provided by the ICB.

The Better Care Fund Executive will be responsible for the management of the Fund and will report to the Integrated Commissioning Committee.

4. Meetings

4.1 The arrangements for meetings of the Committee will be set out in its terms of reference. .

5. Delegated Authority

5.1 The Committee is authorised within the limits of the delegated authority given to either Partner, exercising by its members (which is received through their respective organisation's own financial scheme of delegation) to:

5.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to the Better Care Pooled Fund in respect of any Individual Scheme only where responsibility for that overrun has been determined under the procedures set out in Schedule 4 (but not further or otherwise); and

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

6. Information and Reports

Each Pooled Fund Manager shall supply to the Committee on a Quarterly basis the financial and activity information as required under the Agreement.

7. Post-termination

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

SCHEDULE 4– RISK SHARE AND OVERSPENDS

Pooled Fund Management

1. Variances on expenditure will be identified through monthly monitoring processes undertaken by Budget Managers in conjunction with the Host's Strategic Finance. Financial performance will be reported to the Integrated Commissioning Committee on a monthly basis

Overspend

2. The Partners agree that overspends shall be apportioned in accordance with this Schedule 4.

3. The Committee shall consider what action to take in respect of any actual or potential overspends

4. The Committee 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:

4.1 whether there is any action that can be taken in order to contain expenditure;

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

5. A cap will be set for each partner on the exposure to the other partners overspend in the pooled fund. This will be agreed by the Committee in line with the contributions from each partner agreed in the Better Care Fund Plan.

6. In the event that the overspend is below the total cap agreed, the overspend will be apportioned in accordance with their total revenue contribution to the pooled budget, taking into account specific arrangements for specific funding streams (for example Capital Grants) in the Better Care Fund Plan.

7. The Partners agree to co-operate fully to establish an agreed position in relation to any overspends.

8. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides.

SCHEDULE 5 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. Governance shall comply with the Nolan principles on public life, the relevant provisions of the Council's Code of Conduct for members and the ICB Code of Conduct for Governing Body Members and policies for managing conflicts of interest to the extent relevant.

2. No person may sit on the Integrated Commissioning Committee or otherwise be engaged in a decision with regard to the entering into of a Contract for Services where he / she has any personal / pecuniary interest, such as any financial or ownership interest in any body providing services in accordance with the definition of "Pecuniary Interest" within the constitution of the Council or the ICB's Policy for Declaring and Managing Interests.

3. Where it became apparent that an individual has such a personal or pecuniary interest, he / she will immediately disclose it to the Chair of the Integrated Commissioning Committee and take no further part in the discussions or determination of such item, except to the extent that this has been agreed by all other members of the Committee in attendance.

SCHEDULE 6 – INFORMATION GOVERNANCE PROTOCOL

1. The Information Governance arrangements for the agreement will follow the principles outlined in the Dudley Overarching Information Sharing Protocol to which both partners are signatories.

2. Information Sharing arrangements for individual schemes will be set out in the specification for each scheme and will include, as appropriate, information sharing agreements in line with the principles set out in the Overarching Information Sharing Protocol.