Board of Directors Meeting (Public)
will be held on Wednesday 30th March 2022 from 9.00am – 1.00pm
To Be Held at the Pavilions, Harrogate

AGENDA

Item No.	Item	Lead	Action	Paper	Time
SECTION 1: Opening Remarks and Matters Arising					
1.1	**Welcome and Apologies for Absence**	Chairman	Note	Verbal	9.00
1.2	**Patient Story**	Director of Nursing, Midwifery and AHPs	Note/ Discuss	Verbal	
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chairman	Note	**Attached**	
1.4	**Minutes of the Previous Board of Directors meeting held on 26th January 2022**	Chairman	**Approve**	**Attached**	
1.5	**Matters Arising and Action Log**	Chairman	Discuss/ Note/ Approve	**Attached**	
1.6	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal	9.20
1.7	**Remuneration Committee Update**	Chairman	Note	**Attached**	
SECTION 2: CEO Updates					
2.1	**Acting Chief Executive Report**	Acting Chief Executive	Discuss/ Note	**Attached**	9.30
2.2	**Corporate Risk Register**	Acting Chief Executive	Discuss/ Note	**Attached**	
SECTION 3: Strategy & Partnerships					
3.1	**Board Assurance Framework**	Chairman	Note	**Attached**	9.45
3.2	**Director of Strategy Report**	Director of Strategy	Note	**Attached**	
3.3	**Green Plan**	Acting Chief Executive	Approve	**Attached**	
3.4	**HARA Section 75**	Director of Strategy	Approve	**Attached**	
3.5	**HIF Shareholder Director**	Chairman	Approve	**Attached**	
SECTION 4: Patients and Service Uses (Quality and Safety)					
4.1	**Quality Committee Chair's Report – 28th March 2022**	Quality Committee Chair	Note	**Verbal** *(timing of meeting)*	10.20
4.2	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Executive Directors	Note/ Discuss	**Attached**	

Comfort Break (10.40 – 10.50)					
4.3a	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	10.50
4.3b	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Discuss / Note	**Attached**	11.10
4.3c	**Ockenden Review of Maternity Services**	Director of Nursing, Midwifery and AHPs	Discuss / Note	**Attached**	11.20
4.4a	**Medical Director Report**	Medical Director	Note	**Attached**	11.40
4.4b	**Learning from Deaths Quarterly Report**	Deputy Medical Director	Note	**Attached**	11.45
4.4c	**Covid 19 SI Report Summary**	Medical Director	Note	**Attached**	11.50
SECTION 5: Use of Resources and Operational Performance					
5.1	**Resource Committee Chair's Report – 28th March 2022**	Resource Committee Chair	Note/ Discuss	**Verbal** *(timing of meeting)*	12.00
5.2	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	Executive Directors	Note	**Attached**	
5.3	**Director of Finance Report**	Acting Finance Director	Discuss	**Attached**	
5.4	**Annual Planning 2022-23**	Acting Finance Director	Discuss	**Attached**	
5.5	**Chief Operating Officer's Report**	Deputy Chief Operating Officer	Discuss	**Attached**	
5.6	**Workforce Report**	Director of Workforce and Organisational Development	Discuss	**Attached**	
SECTION 6: People and Culture					
6.1	**People and Culture Committee Chair's Report – 14th March 2022**	Committee Chair	Note	**Attached**	12.15
6.2	**Integrated Board Report –** Indicators from Workforce Domains	Executive Directors	Note	**Attached**	12.20
6.3	**Organisational Development Report**	Director of Workforce and OD	Approve	**Attached**	12.25

SECTION 7: Governance Arrangements					
7.1	**Audit Committee Chair's Reports – 1st February 2022 and 8th March 2022**	Committee Chair	Note	**Attached**	
7.2	**Senior Management Team Report March 2022**	Acting Chief Executive	Note	**Attached**	
7.3	**2022 - 23 Board Workplan**	Chairman	Approve	**Attached**	
7.4	**Policy on Policies**	Medical Director	Approve	**Attached**	
7.5	**Aseptic Business Case**	Director of Strategy	Approve	**Attached**	
8.0	**Any Other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ Approve	Verbal	12.50
9.0	**Board Evaluation**	Chairman	Discuss	Verbal	12.55
10.0	**Date and Time of next meeting** Wednesday, 25th May 2022				
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*					

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interest
As at 30th March 2022

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	Date	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Member of the Yorkshire & Humber NHS Chairs' Network 4. Volunteer with Supporting Older People (charity). 5. Member of Humber Coast and Vale ICS Partnership
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing partner of Priory Medical Group, York
Sarah Armstrong	Non-executive Director	October 2018	Date	1. Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Company director for the flat management company of current residence 3. Chief Executive of the Ewing Foundation
Jonathan Coulter	Deputy Chief Executive/ Finance Director	November 2017	Date	(Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Mansfield Building Society 2. Chairman, Headrow Money Line Ltd (ended September 2021) 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman – Forget Me Not Children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member - Kirby Overblow Parish Council
Jill Foster	Chief Nurse	July 2020	April 2021	Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Tim Gold	Interim Chief Operating Officer	August 2020	March 2021	Seconded from Bradford Teaching Hospitals NHS Foundation Trust post of Director of Operations
Matt Graham	Director of Strategy	September 2021		Governor (Chair of Finance & Premises Committee) – Malton School
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)	No interests declared		
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)			1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.
Russell Nightingale	Chief Operating Officer	April 2021	Date	Director of ILS and IPS Pathology Joint Venture
Emma Nunez	Director of Nursing	April 2021	Date	No interests declared.
Andrew Papworth	Non-executive Director	March 2020	Date	Director of People Insight and Cost at Lloyds Banking Group
Laura Robson	Non-executive Director	September 2017	Date	Familial relationship with Alzheimer's Society

Board Member	Position	Relevant Dates From	To	Declaration Details
Steve Russell	Chief Executive	March 2020	Date	1. Chief Executive of NHS Nightingale Hospital Yorkshire and Humber (ended July 2021) 2. Member of NHS England and Improvement North East and Yorkshire Regional People Board 3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS 4. Co-Chair of WY&H Planned Care Alliance 5. Chair of Non-Surgical Oncology Steering Group 6. NHS Employers Policy Board Member (September 2020 and ongoing) 7. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 8. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)
Wallace Sampson OBE	Non-executive Director	March 2020	Date	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board 4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company.
Mrs Laura Angus	NExT Non-executive Director	January 2021	Date	1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG 2. Chair of York and Scarborough Medicines Commissioning Committee 3. Interim Chief Pharmacist at Humber, Coast and Vale ICS 4. MTech Associate; Council Member PrescQIPP 5. Chair of Governors at Kirby Hill Church of England Primary School
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care)	April 2017	Date	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018 January 2022 May 2018	Date January 2022	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Member of the Association of Directors of Children's Services 5. Member of Society of Local Authority Chief Executives 6. Local Government Information Unit Associate 7. Local Government Information Unit (Scotland) Associate 8. Fellow of the Royal Society of Arts 9. Member of the Corporation of the Heart of Yorkshire Education Group 10. Chair of the Corporation of Selby College
Maureen Taylor	Non-executive Director			No interests declared
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	Director of ILS and IPS Pathology Joint Venture

Deputy Directors and Others Attendees (providing advice and support to the Board)

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Jordan McKie	Deputy Director of Finance	No interests declared
Paul Nicholas	Deputy Director of Performance and Informatics	No interests declared
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Lynn Hughes	Interim Company Secretary (until June 2021)	Familial relationship with KLS Martin Ltd, a company providing services to the NHS
Kate Southgate	Company Secretary (from June 2021)	No interests declared

Board of Directors Meeting
Wednesday,26th January 2022 from 9.00am – 1.30pm
MS Teams

Present
Angela Schofield, Chairman
Sarah Armstrong, Non-executive Director
Jeremy Cross, Non-executive Director
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Wallace Sampson OBE, Non-executive Director (*In attendance from minute 12.0)*
Richard Stiff, Non-executive Director
Maureen Taylor, Non-executive Director
Steve Russell, Chief Executive
Jacqueline Andrews, Executive Medical Director
Jonathan Coulter, Finance Director/Deputy Chief Executive
Russell Nightingale, Chief Operating Officer
Emma Nunez, Executive Director of Nursing, Midwifery and Allied Health Professionals
Matthew Graham, Director of Strategy
Angela Wilkinson, Director of Workforce and Organisational Development (*In attendance from minute 6.5)*

In attendance
Laura Angus, NExT Non-Executive Director
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Natalie Lyth, Clinical Director for Community and Children's Directorate
Matt Shepherd, Deputy Chief Operating Officer/Clinical Director for Long Term and Unscheduled Care Directorate
Kate Southgate, Company Secretary

Matthew Milson, Guardian of Safe Working (*In attendance for BD/01/22/22)*
Charly Gill, Quality Matron / Freedom to Speak Up Guardian (*In attendance for BD/01/22/19)*

Observing
Tony Doveston, Governor
Darren Miller, Clinical Leadership Fellows
One member of the public

Item No.	Item
BD/01/22/1	**Welcome and Apologies for Absence**
1.1	The Chairman welcomed everyone to the meeting.
BD/01/22/2	**Patient Story**
2.1	Unfortunately the patient who was due to attend Board to discuss their story was unable to attend. It was hoped that he would be able to join the Board in March 2022.
BD/01/22/3	**Declarations of Interest and Register of Interests**
3.1	The register of interests was received and noted.
3.2	It was noted that Jonathan Coulter is Interim Chief Executive of HIF. Sarah Armstrong is a Director of Harrogate Integrated Facilities (HIF). Wallace Sampson is Chief Executive of Harrogate Borough Council, and Angela Wilkinson and Russell Nightingale are Directors of the ILS and IPS Pathology Joint Venture.

3.3	Richard Stiff noted that he would no longer be declaring his interest as Chair of Selby College but would be noted as a member of the Corporation of the Heart of Yorkshire Education Group
3.4	**Resolved:** the declarations were noted.
BD/01/22/4	**Minutes of the Previous Board of Directors meeting held on 24th November 2021**
4.1	The minutes of the previous meeting were confirmed with two amendments: • 19.10 – should read "time to hire" not "hirer" • 20.1- SG should read Safeguarding
4.2	**Resolved:** the minutes of the last meeting held on 24th November 2021 were agreed as an accurate record subject to the changes noted above.
BD/01/22/5	**Matters Arising and Action Log**
5.1	No matters arising not included on the agenda or action tracker were noted. The following updates on outstanding actions were noted: BoD/11/21/17.8 – Covid 19 Summary Report – Due March 2022 BoD/11/21/24.5 – Uplifting of the Living Wage – Completed BoD/7/21/16.9 – Management Restructure – Completed BoD/11/21/13.5 – Absconding Patient – Completed BoD/11/21/22.6 – Trust Strategy – Completed BoD/11/21/24.4 – Resource Committee Terms of Reference – Completed BoD/11/21/17.8 – Covid 19 Full SI Report - Completed
5.2	**Resolved:** sufficient assurance was received to update and / or close actions as detailed.
BD/01/22/6	**Overview by the Chairman**
6.1	A Happy New Year was expressed by the Chairman.
6.2	Services were noted as still under considerable pressure and the Board expressed their thanks to colleagues. The vaccination programme continued as does progress with Elective Recovery.
6.3	The Integrated Care Board implementation had been delayed in statute to the 1st July 2022.
6.4	It was highlighted that the footprint of HDFT had changed considerably in the last 5 years. It was noted that the HDFT constituencies still reflected the original make up. Therefore, a review of constituencies was ongoing. A proposal will be brought to the Council of Governors on the 7th March 2022. This would include Public and Staff constituencies. Elections will take place once the constituencies have been approved. *Angela Wilkinson joined the meeting.*

6.5	**Resolved:** The Chairman's report was noted.
BD/01/22/7	**Chief Executive Report**
7.1	The Chief Executive noted the contents of his report as read and highlighted a number of key points.
7.2	There were three areas of key focus noted. The first was on the implementation of the regulations that come into force on 1st April 2022 regarding vaccination as a condition of deployment. The second was on facilitating the discharge of patients, with work ongoing with heightened executive review and oversight. The third is on elective activity and the commitment for there to be no 104 weeks waits by the end of March 2022.
7.3	The Integrated Care Boards (ICB) are continuing to progress in shadow form, with statutory implementation delayed until July 2022. The Chief Executive updated on the governance arrangements in relation to the ICB.
7.4	Updates were provided regarding Covid infections in relation to patient numbers as well as staff absences. Significant work has taken place with regard to Vaccination as a Condition of Deployment (VCOD). The focus continues to be on supporting colleagues to take up the vaccine.
7.5	The risks in terms of the Children's Immunisation Programme were noted and work was ongoing at a regional and national level to assist in this. An engagement plan with Local Government has been developed.
7.6	Jeremy Cross queried what patients were waiting for in the community that was delaying discharge. It was confirmed that some delays were in relation to assessments for example occupational therapy and blood results.
7.7	Jeremy Cross queried reporting arrangements around Immunisation performance. The Chief Executive confirmed that the processes were being put in place to ensure oversight is built into the reporting framework.
7.8	Andy Papworth queried visiting arrangements. The Chief Executive confirmed that visiting arrangements continue to be reviewed on a regular basis. Given the recent national announcements, consideration would be given to all of the arrangements within HDFT and this would include visiting arrangements
7.9	Maureen Taylor noted that it was positive to see an increase in capacity in the mortuary. Laura Robson sought clarification about the developments in the mortuary. The Chief Operating Officer reported that further work was being undertaken to improve capacity. Once this was in place the mortuary assessment would be undertaken and would be reported to a future Board.
7.10	**Action:** The Mortuary Report would be brought back to a future Board meeting.
7.11	The Chairman noted the new risk on the Corporate Risk Register in relation to the Aseptic Unit. The Chief Executive confirmed that work was ongoing across the region and investment in facilities would be included in this. The remedial work that has been ongoing with the HDFT unit needed further work, hence the increased risk. Mitigation was in place and contingency arrangements were being put in place.
7.12	Following a query from the Chairman, The Director of Strategy updated on the Project Search Internship.
7.13	**Resolved:** The Chief Executive's Report was noted.

BD/01/22/8	**Corporate Risk Register**
8.1	The Chief Executive outlined the changes made to the Corporate Risk Register since the last meeting, including the mitigation of risks.
8.2	The Pharmacy Aseptic risk was noted as per above.
8.3	The Health and Safety risk was also noted, with further discussions taking place in Private Board.
8.4	Richard Stiff noted key updates. It was clarified that no further re-deployment of 0-19 staff would take place.
8.5	Andy Papworth noted the reduction in violence and aggression incidents. He queried the risk target for ED Performance reducing to a rating of 6 by March 2022. The Chief Executive confirmed that work was in progress to reduce the risk rating, however, internal and external constraints may limit the ability to achieve this by the date detailed.
8.6	The Chairman noted the support in relation to Staff Wellbeing. It was queried if the support was available to all staff, not just those in the Harrogate Hospital. The Chief Executive confirmed that a wide range of remote support was available, however, some parts of the support offer is more focused on the Hospital site. Further consideration would be given to this.
8.7	Andy Papworth noted the new style of report helped with assurance.
8.8	**Resolved:** the updates were noted.
BD/01/22/9	**Resource Committee Chair's Report**
9.1	Maureen Taylor as Chair of the Resource Committee presented her report on the December 2021 and January 2022 meetings as read and highlighted a number of key issues.
9.2	It was noted that performance, capacity and financial planning was discussed in detail at the December 2021 and the January 2022 meetings as detailed in the Chair's report.
9.3	The Chair of the Committee noted that there was slippage within the capital programme in 2021/22 which, without corrective action, would result in the loss of capital spending power (CDEL) of £3.4m. In addition to slippage, new capital approvals of £2.5m had been received which will need to be deferred to 2022/23. The two main schemes which will not go ahead as planned in 2021/22 are: • The upgrade of Wensleydale Ward • Refurbishment of the hospital entrance/foyer
9.4	These two schemes have been delayed due to programming and logistics issues (linking in with the Salix works throughout the hospital) and will now go ahead in 2022/23.
9.5	In total, CDEL slippage of £5.9m is expected against our original plans. Resources Committee have discussed the options available for maximising capital spending power through a combination of bringing forward to 2021/22 purchases of equipment originally planned for 2022/23 and also repaying existing loans early. Loan repayments will free up CDEL in future years for new capital spending.
9.6	The Resources Committee recommended to Board the following proposal: (a) Bring forward equipment purchases of £3.5m from 2022/23 made up of £2.5m medical equipment over 10 years old, £0.8m IT equipment and £0.2m within

	pathology for the Covid testing platform. This will release £3.5m CDEL in 2022/23 for new capital spending. (b) Repay in March 2022 two loans due to be repaid in 2022/23 releasing £0.54m CDEL in 2022/23: **Loan number RCD/FTFF/12/2012 £375,000** **Loan number RCD/FTFF/09/2013 £167,000** (c) Repay one loan in March 2022 with five years remaining, releasing £0.44m CDEL annually for the next five years: **Loan number ITFF/NCCIL/RCD/2016-08-02/A £2,201,000**
9.7	The Board of Directors was asked to approve the proposal outlined above.
9.8	It was noted that this was the last meeting that Maureen Taylor would be chairing with Jeremy Cross taking over the Chairmanship.
9.9	Richard Stiff queried the 5.6 indicator reference to MIUs and if this included Selby. It was confirmed that it was MIU and did not include Selby. Richard Stiff also queried if MIU could be included separately. The Chief Operating Officer confirmed that it could be included separately. Richard Stiff also noted 5.14 remained blank and the timeframe for this to be included. The Chief Operating Officer confirmed that increased visibility was needed. Work was ongoing and it was confirmed that this would be included in March 2022 reports.
9.10	Laura Robson congratulated the team on the reduction in the Glaucoma caseload, as it was noted this would be completed by March 2022.
9.11	Sarah Armstrong also noted the significant achievement regarded the glaucoma caseload. She also queried the requirements of the Wensleydale refurbishment. The Chief Operating Officer outlined the plan of refurbishment.
9.12	The Director of Finance provided further context to the capital programme. It was noted that the governance of the capital programme had been improved which would minimise the risk of slippage.
9.13	Andy Papworth queried if there was more risk of slippage. The Director of Finance confirmed that further mitigation and oversight was now in place.
9.14	**Resolved:** The Board confirmed approval of the proposal outlined by the Resource Committee.
BD/01/22/10	**Integrated Board Report**
10.1	The IBR Indicators linked to Resources and Operational Performance were noted.
10.2	**Resolved:** The Board noted the content of the report**.**
BD/01/22/11	**Director of Finance Report**
11.1	The Finance Director discussed with the Board the points raised in relation to the current financial position.
11.2	Agency spend was noted as a current area of risk and further work was ongoing with this area. In addition, discussions were held on the financial plan and allocation.
11.3	The Board were updated on the context of the 2022-23 plan. This included the allocation at ICS level with convergence to “fair” allocations, national growth of 3.6% (less convergence impact), provider inflation of 2.8% and assumed efficiency of 1.1%.

11.4	Covid funding would be reduced and local payment flows would be re-introduced with a move to simple blended tariffs, with a variable element for elective work. It was noted that there would be no national top-ups.
11.5	The final plan needs to be signed off internally at the end of March 2022, but it was noted that the system plans would be submitted at the end of April.
11.6	**Resolved:** the Director of Finance's report and updates against IBR were noted and assurance against progress was confirmed. *Wallace Sampson joined the meeting.*
BD/01/22/12	**Chief Operating Officer's Report**
12.1	The Chief Operating Officer highlighted key themes from the report and IBR indicators.
12.2	It was noted that December 2021 operationally had been challenging as detailed in the report. The report included updates on performance, discharge, capacity and Opel levels. It was noted that the ED dashboard was now live and on screens within the ED as well as other operational areas on the hospital sites. 12 hour breaches and ambulance handover breaches were noted in December 2021. 50% of the ED action plan has been delivered to date, but the overall action plan will now move from completion in March to April 2022.
12.3	A focus on diagnostics was highlighted. Waits beyond 6 weeks continue to decrease with a focus on maintaining the reduction of the backlog. RTT continues to be a focus with a trajectory of zero 104 week wait patients by the end of March 2022. Risks were noted in relation to a small number of community dental patients.
12.4	The Arches model has increased capacity to 32 active beds, just below the 35 planned. It was noted that the improved performance in two week wait for breast symptomatic referrals was continuing.
12.5	Sarah Armstrong noted the breadth of the indicators covered by the Chief Operating Officer. She noted that despite the challenges in December, there were positive areas of note such as the Arches model. Sarah Armstrong queried how patients are cared for when waiting in ED. The Chief Operating Officer, confirmed that patients are observed frequently.
12.6	The Chairman queried the circumstances where a patient had waited in ED over 24 hours. Andy Papworth also queried how these patients were investigated following the incident. The Chief Operating Officer confirmed that a root cause analysis (RCA) on every patient that waited over 12 hours had been undertaken. Key issues from the RCA were noted and no clinical harm was noted due to the length of time within the department.
12.7	Laura Robson sought clarification about the ED live board and the beds available across the organisation. The Chief Operating Officer noted that the dashboard was introduced in December 2021 and the team were learning about its functionality. In addition, Laura Robson felt that all 12 hour breaches were unacceptable. The Chief Operating Officer agreed. The Director of Nursing, Midwifery and AHPs also provided assurance about the level of care for patients who are in the ED for long periods of times. Quality indicators are being monitored such as complaints and incidents. It was confirmed that following the RCAs no additional harms had been caused.
12.8	Wallace Sampson noted the impacts on safeguarding and 0-19 services. The Chief Operating Officer confirmed that following discussions with the directorate at their

	performance meeting assurance had been received that the future state was improving and that mitigation was in place. The focus was on recruitment to staff vacancies.
12.9	Maureen Taylor noted some issues had been reported in the Guardian of Safe Working report regarding Same Day Emergency Care (SDEC). Kat Johnson confirmed that reviews have been undertaken, the number of admissions in general surgery is static, but the numbers seen in SDEC has increased. It is unclear at this time if this is due to a change in primary care practices or ED capacity. Further work is ongoing to review the staffing position within SDEC.
12.10	Jeremy Cross noted the difference in the numbers in the IBR and the Resource Committee packs in relation to Children's Services reporting. The Director of Finance noted that work was ongoing to increase visibility of certain indicators.
12.11	Andy Papworth noted antenatal visits around 28 weeks had been reducing and what the risk was associated with this. The Chief Operating Officer confirmed that this was an issue highlighted in Middlesbrough due to the staff challenges that will be remedied for the next reporting period.
12.12	The Chairman noted the current ED performance balanced against the range of actions and improvements being made. The Chief Operating Officer noted that there was significant learning around flow from the Perfect Week and the relevant changes would be made in due course.
12.13	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/01/22/13	**Workforce Report**
13.1	The Director of Workforce and Organisational Development presented the IBR indicators and escalation report. An update was provided on current workforce issues.
13.2	Vacancy and recruitment were noted as areas already discussed in other agenda items. A Mandatory vaccines update was also provided.
13.3	The Chairman noted the significant impact this issue was having on colleagues and thanks were expressed to all who were involved in the process.
13.4	Maureen Taylor queried the 144 colleagues who had not responded regarding vaccination status. It was also queried which key areas of the organisation that this would affect. The Director of Workforce and OD confirmed that work was ongoing with the members of staff to ascertain their vaccination status. The Directorates are receiving up to date numbers on a regular basis. Work was ongoing with colleagues in HIF as this was a potential area of risk.
13.5	Laura Robson queried pay protection arrangements. The Director of Workforce confirmed that pay protection would not be in place for those redeployed in these circumstances. It was confirmed that the regulations had received Parliamentary approval in January 2022.
13.6	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.

BD/01/22/14	**Quality Committee Chair's Report**
14.1	Laura Robson as Chair of the Quality Committee presented her report on the December 2021 meeting as read and highlighted a number of key issues. This included the discussion with Suzanne Lamb regarding the assurance regarding Safeguarding workload.
14.2	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/01/22/15	**Integrated Board Report**
15.1	The IBR Indicators linked to Quality were noted.
15.2	**Resolved:** The Board noted the content of the report**.**
BD/01/22/16	**Caring At Our Best**
16.1	The Executive Medical Director presented the report and highlighted a number of issues.
16.2	The project has been in place for just over a year. It was noted that a project manager was in post. There has been some short term slippage in milestones due to Covid. Meetings were taking place to review next steps.
16.3	It was confirmed that a stock take would now be taken with support from the Director of Strategy. This will include a review to ensure there is no duplication or lack of clear responsibility with regards to impacts from other corporate programmes.
16.4	The Director of Nursing, Midwifery and AHPs noted the actions from key SIs were in place and progressing with some short term slippage.
16.5	Laura Robson queried the ward manager review that was ongoing. The Director of Nursing, Midwifery and AHPs confirmed that the Matrons review had concluded and the Ward Manager review was commencing.
16.6	Jeremy Cross queried if there was duplication of actions with other work programmes. The Executive Medical Director noted that the stock take that would focus on what each of the workstreams was responsible for and reduce duplication.
16.7	**Action:** To include a workshop session on Caring At Our Best in February 2022 with a further report to March 2022 Board.
16.8	**Resolved:** The Board noted the content of the report.
BD/01/22/17	**Director of Nursing Report**
17.1	The Director of Nursing, Midwifery and Allied Health Professionals noted her report as read and highlighted the following issues in relation to the indicators in the IBR.
17.2	Nurse staffing fill rates have seen a decrease in December with Covid related absences and isolation. Falls and pressure ulcers safety huddles were in place and organisational safety huddles have been implemented. Work was underway in regarding to recruitment programmes.
17.3	The Director of Strategy commented that the Staff Strategy survey noted the importance of staff and patient feedback and ties in well with the work ongoing with patient experience.

17.4	Laura Robson queried if patients were moved at night. The Director of Nursing, Midwifery and AHPs noted that on occasion patients were moved at night. This number had not increased. There was not a metric that reported movement of patients after 11pm.
17.5	**Action:** To review the introduction of a metric for patients moved for non-clinical reasons after 11pm.
17.6	**Resolved:** The Board noted the content of the report**.**
BD/01/22/18	**Strengthening Maternity and Neonatal Safety**
18.1	The Executive Director of Nursing presented the report as read and noted the following.
18.2	Maternity had seen a similar pattern to others regarding staff absences and it was noted that this was beginning to improve. A continuity of care lead midwife has commenced in post. The maternity voices partnership has appointed a new chair and Andy Papworth, the Non-Executive Director Champion for maternity safety has met with them.
18.3	Laura Robson noted that no Level 3 Safeguarding training was available in December. The Director of Nursing, Midwifery and AHPS noted that it was in house training. A revised training package had commenced with 100% compliance planned for March 2022.
18.4	**Resolved:** The Board noted the content of the report.
BD/01/22/19	**Freedom to Speak Up Guardian Quarterly Report**
19.1	The Freedom to Speak Up Guardian provided an update on current situation as well as the project plan for the development of the initiative.
19.2	Freedom to Speak Up will be rebranded as Listening at Our Best and the plan and next steps were noted by the Board. An update was provided on the e-learning package and it was confirmed that the package would be available from the end of February 2022. Scope for an App was also being considered.
19.3	The numbers for concerns raised was relatively low. It was noted that there were other methods that colleagues used such as discussions with line managers.
19.4	Andy Papworth noted that other organisations will be in a similar position and learning from their methods could be valuable.
19.5	The Chairman confirmed that regular updates on high level issues were raised via the Guardian with the Chairman and the Chief Executive as appropriate.
19.6	**Resolved:** the report and updates were noted.
BD/01/22/20	**Embedding Service User Experience and Engagement**
20.1	The Director of Nursing, Midwifery and AHPs took the report as read.
20.2	This report highlighted how service users experience would be utilised across the organisation. Work was ongoing to complete an NHS England Self-Assessment.
20.3	**Resolved:** The Board noted the update.

BD/01/22/21	**Medical Director Report**
21.1	The Executive Medical Director introduced her report as read and highlighted the following.
21.2	Work regarding the Digital programme was ongoing and progressing well. A successful NHS Digital Bid for £250k was awarded for cyber security. In addition, £250k was awarded from NHS Unified Tech fund for a virtual exemplar ward patient call system.
21.3	Covid Medicine Delivery Units (CMDUs) are being set up for non-hospitalised high risk patients, there are challenges around geographical distances for patients and a review is ongoing to develop an HDFT model if required to do so.
21.4	Developments around policy management were ongoing.
21.5	A risk was highlighted in relation to a global cyber security alert for Log4j which is a software building block used in thousands of systems, applications and internet services. NHS Digital have commenced a national effort called Operation Sawmill to mitigate the risks.
21.6	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/01/22/22	**Guardian of Safe Working Quarterly Report**
22.1	The Guardian of Safe Working took the report as read. It was noted that 36 exception reports had been submitted in Quarter 3. This was a decrease from the previous quarter. Exception reporting remains in line with other Trusts across the region.
22.2	There had been 6 reported breaches of contract and as such £1136.80 fines had been levied. These breaches relate to working beyond the shift length within general surgery on SDEC. It was noted that this was the first time a fine had been levied from HDFT.
22.3	The Chairman queried what process was followed when escalating issues of themes and trends. The Guardian of Safe Working confirmed that he escalate issues to the relevant directorate leads.
22.4	The Executive Medical Director thanked the Guardian of Safe Working for his work. She also confirmed that the Guardian attended the monthly Medical Directorate Team to highlight key issues.
22.5	Kat Johnson confirmed that immediate actions had been put in place to mitigate issues for example a morning huddle has been created to ensure real time information to troubleshoot gaps promptly. She also noted that there were processes in place for Junior Doctors to escalate concerns during their shift.
22.6	Wallace Sampson queried attrition rate for Junior Doctors. The Executive Medical Director confirmed that information would be sought from the deanery.
22.7	**Action:** Attrition rate for Junior Doctors to be circulated.
22.8	Richard Stiff queried what the money from the fines would be used on. The Guardian of Safe Working was working with the Junior Doctors to determine how this could be spent that would help to improve their work life balance.
22.9	**Resolved:** The Board noted the update.

BD/01/22/23	**Paterson Inquiry Update**
23.1	The Executive Medical Director took the report as read. An overview of the Inquiry was provided which included the government's response.
23.2	The report included a gap analysis of the learning issued by the government in relation to the recommendations. Two matters were highlighted, firstly the work with the independent sector and secondly, patient engagement and communication.
23.3	Jeremy Cross noted there had be an SI where communication with a patient was not in terminology they understood which had led to issues. The Executive Medical Director confirmed that this would be considered.
23.4	**Resolved:** The Board noted the update.
BD/01/22/24	**People and Culture Committee Chair's Report**
24.1	Jeremy Cross, as Chair of the People and Culture Committee, highlighted key issues of his report.
24.2	It was noted that a presentation had been received at the meeting from the Emergency Department which had been well received.
24.3	Thrive discussions had been noted as low uptakes. The Director of Workforce reported that these are regularly promoted at line manager webinars.
24.4	**Resolved:** The Board noted the content of the report**.**
BD/01/22/25	**Integrated Board Report**
25.1	The IBR Indicators linked to People and Culture were noted.
25.2	**Resolved:** The Board noted the content of the report**.**
BD/01/22/26	**Organisational Development**
26.1	The Director of Workforce and OD noted the report as read. It was noted that national guidance had been issued regarding Reducing the Burden of Reporting and releasing capacity. It was confirmed that training was reviewed with this respect and it was noted that the risks for standing down training was greater than the benefit and therefore training remained in place.
26.2	An interim EDI lead has been appointed to support the growing programme of work. In addition a Colleague Wellbeing Programme Lead as well as a Mental Health Nurse have both been successfully appointed.
26.3	NHS Elect had been procured to provide OD support across a wide range of topics and across the geographical footprint. This is an arms-length NHS organisation hosted by Imperial College Healthcare NHS Trust.
26.4	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.

BD/01/22/27	**Board Assurance Framework**
27.1	The Chief Executive noted the changes to lead arrangements as well as the risk rating.
27.2	**Resolved:** The Board noted the update.
BD/01/22/28	**Director of Strategy Report**
28.1	The Director of Strategy noted his report as read and highlighted the following issues.
28.2	Strong engagement has been seen so far with over 500 responses to the staff survey, 100 colleagues had also attended the Clinical Strategy Workshops. The patient and public surveys were currently live.
28.3	The Business Case review and approval process has been revised to ensure greater structure and scrutiny.
28.4	The Programme Governance approach was being implemented to ensure greater visibility of progress, risks and mitigation against our programmes of work.
28.5	**Action:** The Trust Strategy will be an item of the February 2022 workshop.
BD/9/21/29	**Audit Committee Chair's Report**
29.1	Maureen Taylor had chaired the December 2021 meeting of the Audit Committee. Key updates on the Corporate Risk Register were noted. The Audit Committee Terms of Reference were approved.
29.2	The progress on the Internal Audit Programme was discussed with risks noted regarding delivery. This was escalated for review at the Executive Risk Management Group.
29.3	The Director of Finance updated on the situation with External Audit arrangements.
29.4	**Resolved:** The Board noted the content of the report
BD/01/22/30	**Senior Management Team Report**
30.1	The Chief Executive noted the contents of the two SMT reports for December 2021 and January 2022. They were taken as read and noted that all key issues had been discussed in other agenda items throughout the meeting.
30.2	**Resolved:** The Board noted the content of the report
BD/01/22/31	**Resource Committee Terms of Reference**
31.1	**Resolved:** The Board approved the Resource Committee Terms of Reference.
BD/01/22/32	**2021-22 Board Workplan**
32.1	**Resolved:** The content of the workplan was agreed.
BD/01/22/33	**Board Appointed Non-Executive Directors**
33.1	The Chairman update the Board on the requirements from the *Enhancing Board Oversight – a New Approach to Non-Executive Directors* from NHS England.
33.2	The Board noted that the retained Non-Executive Champions roles were as follows: • Maternity Safety – Andy Papworth • Wellbeing Guardian – Sarah Armstrong

	• Freedom to Speak Up – Laura Robson as role of Senior Independent Director • Doctors disciplinary champions – a Non-Executive director is assigned to each case.
33.3	Additional roles and governance arrangements were noted including Laura Robson as Children and Young People and EDI was Wallace Sampson.
33.4	It was noted that Procurement was reviewed at the Audit Committee and not Resource Committee.
33.5	**Action:** Cyber security to be included as a 6 month review on the Resource Committee
33.6	**Resolved:** The Chairman of the Audit Committee would be designated as the Non-Executive Champion for Security Management.
BD/01/22/34	**Non-Executive Directors Board Sub-Committee Membership**
34.1	The Chairman took the report as read in terms of the changes to the Non-Executive Director membership of sub-committees of the Board.
34.2	**Resolved:** The Board agreed the proposal.
BD/01/22/35	**Any Other Business**
35.1	There were no other areas of business raised.
BD/01/22/36	**Board Evaluation**
36.1	The Chairman posed the question about what had worked well and not as well with the meeting today.
36.2	It was noted that significant work had been covered during the meeting especially in relation to operational pressures and challenges. The support and challenge from the Non- Executive Team was welcomed.
36.3	A member of the public who had observed the meeting noted that as a former colleague thanks were expressed to the Trust and colleagues for the work that has been ongoing.
BD/01/22/37	**Date and Time of the Next Meeting**
37.1	The next meeting would be held on Wednesday, 30th March 2022.
BD/01/22/38	**Confidential Motion**
38.1	**Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Board of Directors (held in Public) Action Log
for March 2022 Board Meeting

Minute Number	**Date of Meeting**	Subject	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BoD/01/22/16.7	26 January 2022	Caring at our Best	To include a workshop session on Caring At Our Best in February 2022	Executive Medical Director/Director of Nursing, Midwifery & AHPs	30 March 2022	**Update March 2022** Inculded in the February 2022 Board "Workshop	Complete
BoD/01/22/17/5	26 January 2022	Director of Nursing Report	To review the introduction of a metric for patients moved for non-clinical reasons after 11pm.	Deputy Chief Operating Officer	30 March 2022	**Update March 2022** Standing Operating Procedure developed including montoring metrics	Complete
BoD/01/22/22.7	26 January 2022	Guardian of Safe Working Quarterly report	Attrition rate for Junior Doctors to be circulated	Executive Medical Director	01 March 2022	**Update March 2022** Circultaed following meeting	Complete
BoD/01/22/28.5	26 January 2022	Director of Strategy Report	The Trust Strategy will be an item of the February 2022 workshop.	Director of Strategy	23 February 2022	**Update March 2022** Included in the February Board Workshop	Complete
BoD/01/22/33.5	26 January 2022	Board Appointed Non-Executive Directors	Cyber security to be included as a 6 month review on the Resource Committee.	Director of Finance	30 March 2022	**Update March 2022** Added to Resources Committee Workplan, commencing July 2022	Complete
BoD/11/21/17.8	24 November 2021	Infection Prevention and Control Annual Report - Covid 19 SI Report	A summary of the Covid 19 SI Report to be submitted to Board once confirmed by the CCG.	Executive Medical Director	01 March 2022	**Update March 2022** On the agenda for March 2022 Public Trust Board	Complete
BoD/11/21/24.5	24 November 2021	Uplifting of the Living Wage	The Principal of uplifting the living wage each year to be brought to the Trust Board	Director of Workforce and OD	01 November 2022	**Update January 2022** Included on the work programme for November 2022	Closed at the January 2022 Board Meeting
BoD/7/21/16/16.9	28 July 2021	Management Restructure	For a Board Workshop to be held on the management restructure	Director of Workforce and OD	01 December 2021	**Update January 2022** Non-Executive Briefing was held in December 2021. Feedback from the Nonexecutives is being taken into account. A further Non-Executive briefing will be held in January / February 2022. In light of this the Board does not require a workshop and this action is recommended to be closed. **Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Closed at the January 2022 Board Meeting
BoD/11/21/13.5	24 November 2021	Safeguarding Annual Report - Absconding Patient	A case was noted in the Annual Report regarding an absconding patient. The Director of Nursing Midwifery and AHPs to provide further detail to Maureen Taylor (NED)	Director of Nursing, Midwifery and AHPs	26 January 2022	**Update January 2022** Information was provided and it is recommended that the action be closed.	Closed at the January 2022 Board Meeting
BoD/11/21/22.6	24 November 2021	Trust Strategy	The Trust Strategy would be included on the February Board Workshop	Company Secretary / Director of Strategy	26 January 2022	**Update for January Board Meeting** The Trust Strategy has been included on the Trust Board Workshop Work Programme. Recommended that the actions is closed.	Closed at the January 2022 Board Meeting
BoD/11/21/24.4	24 November 2021	Resource Committee Terms of Reference	Resource Committee Terms of Reference for approval	Company Secretary	26 January 2022	**Update for January Board Meeting** TOR included for approval on the 25th January 2022 Trust Board Agenda. Recommended that the action is closed.	Closed at the January 2022 Board Meeting

BoD/11/21/17.8	24 November 2021	Infection Prevention and Control Annual Report - Covid 19 SI Report	The complete Covid 19 SI Report to be submitted to Private Board once confirmed by the CCG	Executive Medical Director	01 March 2022	**Update January 2022** Due in March 2022	Closed at the January 2022 Board Meeting

Board of Directors (Public)
30th March 2022

Title:	**Remuneration Committee Update**
Responsible Director:	Chairman
Author:	Chairman

Purpose of the report and summary of key issues:	This report provides the Trust Board with the key updates relating to the secondment of the Chief Executive to NHS England, including the subsequent changes as a consequence of this secondment.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	None	
Recommendation:	The Board is asked to note this report.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

BOARD OF DIRECTORS

30 MARCH 2022

REPORT OF THE REMUNERATION COMMITTEE

1. Secondment of the Chief Executive to NHS England

The Chief Executive of Harrogate and District NHS Foundation Trust, Steve Russell, was approached by NHS England to express interest in the role of National Director for COVID19 and Flu Vaccination on a secondment basis. The Remuneration Committee of HDFT met on 3 February 2022 to consider this situation and the actions which would be required as a consequence. Remuneration Committee members were conscious of the pressures that this would entail, particularly for members of the Executive team. However, they were assured that some adjustments could be made to responsibilities to enable the secondment to be supported.

The Committee agreed that the Trust should support Steve Russell to take up this opportunity and to support NHSE in this important role. He would be seconded on his current salary and the Trust would be fully reimbursed for all employment and associated costs by NHS England. The secondment would be for between 6 and 12 months with 2 months notice (later amended to 3 months notice to comply with NHSE requirements), commencing 28 February 2022.

2. The consequences of the secondment of the Chief Executive

2.1 Appointment of Acting Chief Executive

The Remuneration Committee agreed that Jonathan Coulter, Deputy Chief Executive and Director of Finance should be appointed as Acting Chief Executive. The Committee expressed their thanks to him for taking on this role. The salary was agreed.

2.2 Harrogate Integrated Facilities

As Acting Chief Executive Jonathan Coulter would no longer be able to continue as Chief Executive of Harrogate Integrated Facilities or be HDFT's `nominated Non Executive Director to the HIF Board. Angie Gillett now has sufficient experience as Managing Director of HIF to continue without Jonathan Coulter's oversight.

2.3 Acting Director of Finance

The Remuneration Committee agreed that Jordan McKie, Deputy Director of Finance, should be appointed Acting Director of Finance. The Committee expressed their thanks to him for taking on this role. The salary was agreed.

2.4 Acting Deputy Chief Executive

The Remuneration Committee agreed that an Acting Deputy Chief Executive should be appointed. Jonathan Coulter would make this appointment following discussion with Executive Director Colleagues. As a result Emma Nunez, Director of Nursing, Midwifery and AHPs was asked to take on this role. The Remuneration Committee had agreed previously a formula for calculating the salary.

The Remuneration Committee expressed appreciation to all concerned for their support for Steve Russell's secondment to NHSE.

Angela Schofield
Chairman
March 2022

Board of Directors (Public)
30th March 2022

Title:	**Chief Executive's Report**
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held on 26th January 2022. The report highlights key challenges, activity and programmes currently impacting on the organisation.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
MARCH 2022

CHIEF EXECUTIVE'S REPORT

Introduction

1. Since the last Board meeting at the end of January, we have collectively been continuing to respond to the pressures of winter alongside the Omicron CoVid variant. This has put significant pressure on colleagues across the Trust who have been dealing with these issues in an environment of challenges in social care and material staff absences, which in some areas have averaged 10% or more at times.

2. These issues have combined to impact upon our services as can be seen through the barometer of urgent care delivery both locally and across the system which has been very challenging, and has meant that colleagues have struggled to deliver the standard of care that they would like to.

3. The current position in relation to CoVid patients is that as of this week we still have c30 patients in hospital who are CoVid positive. It should be noted though that none of these patients are in intensive care and the majority of patients are in for a different reason, but they happen to also have CoVid. This is an indication of the significant community prevalence of the infection still, but also the fact that for most people the impact is milder than before, largely as a result of the successful vaccination programme.

4. We continue to follow guidance in relation to the management of CoVid, and we are expecting to receive some revised Infection, Prevention, and Control Guidance very soon, which might change the way in which we can plan our elective admissions.

5. We have recently amended our visitor guidance to return to the position we were in before Xmas. This allows visitors back onto the wards in a controlled manner, which can only bring benefits for patients, families, and staff on our wards.

Vaccination as a Condition Of Deployment (VCOD)

6. The Board will be aware that regulations were due to be in force from 1st April that would have required colleagues to be fully vaccinated in order to continue to be deployed to provide CQC regulated activities.

7. Significant work was undertaken to engage with colleagues who were not fully vaccinated, in order to support them in their choice whilst recognising the impact of the regulations.

8. Following further national consideration and then national consultation, these regulations were withdrawn and therefore there is no longer a requirement for colleagues to be fully vaccinated. We will continue to encourage vaccination amongst colleagues, and it should be noted that over 98% of colleagues are vaccinated at present which is a positive position across the Trust.

Urgent and Emergency Care

9. February saw significant challenges with four-hour performance at 65%, thirty-seven 12-hour trolley waits, and fourteen 60-minute ambulance handover delays.

10. It should also be noted that the performance in March is equally challenging, and there have been occasions during the last few weeks when performance has been around 50%.

11. The performance in the ED is often a barometer of organisational and system-wide pressures, and it is fair to say that there are significant challenges internally in respect of flow and bed occupancy, and also externally, with other organisations under pressure also.

12. There are a number of improvement actions that we are seeking to implement, which will include a new clinical model. There are also some cultural developments that need to go alongside any new model so that we can embed and successfully deliver the change that is required to improve care for our patients. This is a significant priority for the organisation and was discussed at SMT in detail as we seek to introduce change whilst continuing to deliver the immediate service.

13. The Board should be aware though that our approach to ambulance handover is one of the best in the country with relatively few delays. This crucially allows the ambulance crews to get back out into the community to provide support where they are needed rather than being held up at Harrogate Hospital.

14. Positively, we are also providing support across the system to others who are struggling to deliver urgent care in a timely way. We continue to agree and accept ambulance diverts from other areas, despite our challenges, in recognition of the fact that it is often more difficult elsewhere. This does bring additional pressure to the HDH site, but is an appropriate system response to the need of patients.

15. Our 2 hour urgent response service is due to be rolled out in a phased way in line with recruitment over the next few months. This will have a positive impact on care delivery and support to patients in the community.

Planned care

16. The Trust continues to work in partnership with WYAAT and at the current time we are still targeting having no patients waiting over 104 weeks at the end of March. There is a risk in relation to a handful of patients who have had to be cancelled due to CoVid and for whom it is challenging to reschedule before the end of March. This will be a small number, and the teams have worked really well to deliver what will be a significant achievement. The number of over 52 week wait patients has also reduced in February which is positive.

17. As part of our planning for 22/23 and the next three years, we have submitted a proposal to develop additional theatre capacity on the hospital site that would effectively be managed as ‘green’ capacity. This proposal is a bid against the Targeted Investment Fund, and we are discussing with system partners and the Regional Office the next steps in developing this proposal. In addition, we are supporting investment proposals at Wharfedale Hospital that LTHT are undertaking, as we seek to collectively create appropriate capacity to enable elective care recovery. Clearly, these proposals will need an accompanying workforce strategy to ensure that any new facilities can be fully utilised, and we are also reflecting this in our clinical strategy development work.

18. As referenced at the last meeting, we have received the report reviewing the culture and colleague experience in theatres. A small group, including the Chair of the People & Culture Committee, are meeting to consider our response.

0-19 services

19. We continue to experience pressure across our 0-19 services, with OPEL levels in February being 2 or 3. The number of safeguarding strategies, which is a marker of complexity and demand, has continued at the previous levels and remains higher than in previous years.

20. As a result of the continued pressure, appropriate actions are being taken, including a more flexible approach to the timelines for mandated contacts in some areas. It should be noted though that the service continues to deliver the contacts as required in most of our geographic areas.

21. The 12-15 school based CoVid immunisation programme will be completed by 31st March. This has put pressure on our other vaccination and immunisation services and we continue to discuss this with our commissioners. We have also had two incidents in relation to our CoVid vaccination programme that we have reported and undertaken necessary changes to our processes.

22. There is a Northumberland 'Inequalities Summit' this week which I'm attending along with other colleagues from the Trust. This is multi-agency event that is to explore what we can collectively do to understand and respond to the inequalities in the area.

Quality and Safety

23. We continue to encourage curiosity and a culture of reporting of incidents. Positively, we have seen an increase in low and no harm reporting recently.

24. We are strengthening our quality governance team with appointments being made, and this will allow us to oversee, respond to, and manage quality concerns more robustly.

25. We are refining our SI process in the new year, and also seeking to create a greater pool of trained investigators.

26. We have had a number of never events recently, and thematic work is underway in response to these, which links to the cultural review undertaken within theatres recently.

Strategy & Partnerships

27. Within today's papers is the extension to the HARA Section 75 agreement. This has been approved by NYCC and is a commitment locally to continue the integration journey that we are on between health and social care. The intention is to use the extension period to consider our future ambition for how we will work together over a longer time period.

28. We are also working within HARA, alongside support from NHS Providers and Newton Europe Consulting, to explore what integration looks like and what support is required to enable integration to develop. A number of workshops will be happening over the coming months to explore these issues and assist NHS Providers in developing support offers for other systems that are not as advanced in the work that we are undertaking.

System Planning

29. As is reported within these papers, we continue to plan for 22/23 across the HCV system. Draft financial plans to date indicate significant financial challenges, which are replicated in a number of other systems/regions across the country.

30. Work is continuing with partners to prepare plans that deliver the necessary and desired level of elective care recovery whilst living with the allocations available.

Workforce and wellbeing

31. We have now received the staff survey outcome for the Trust. These are embargoed until the end of March, and we will discuss in detail during April.

32. Alongside this, we have the analysis of the latest internal Inpulse Survey, which provides rich information for local teams to explore and address concerns.

33. In relation to wellbeing, the comments from colleagues indicate strongly that the biggest impact on wellbeing is to have people present and in work, to have the tools to do the job and to work in a pleasant environment, and to be appreciated for the work that is undertaken.

34. This is a helpful reminder of what is important to colleagues, and we will continue to respond to these comments. We have an additional SMT session in April to share and discuss how teams have acted in response to Inpulse survey feedback.

35. We have responded to the fuel cost increase by temporarily increasing the mileage rate for colleagues who travel as part of undertaking their work. This 'cost of working' crisis has had a major impact on our community colleagues in particular, and whilst we await a national response we have taken some action to alleviate concerns of colleagues.

And finally….

36. I would like to place on record my personal thanks to our Chairman, Angela, who is retiring at the end of this month. Angela has been a fantastic Chairman and ambassador for HDFT over the last few years, and her support and wisdom in particularly challenging times has made a significant difference to the Trust. Thank you, Angela, for your contribution to HDFT, the local system and the wider NHS over a long career.

Jonathan Coulter
Acting Chief Executive
March 2022

Trust Board (Public)

Title:	**Corporate Risk Register**
Responsible Director:	Chief Executive
Author:	Company Secretary

Purpose of the report and summary of key issues:	The report provides the Board with key updates and actions since the previous meeting. All Corporate Risks have been reviewed via the Directorate Review Meetings, the Executive Risk Review Meeting and Senior Management Team meeting. Details of key indicators, mitigation, target risk ratings and current risk ratings are detailed in the report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings, Executive Risk Review Meeting and the Senior Management Team meeting.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
TRUST BOARD (PUBLIC)
MARCH 2022

CORPORATE RISK REGISTER

1.0 INTRODUCTION

The Corporate Risk Register consist of operational risk scoring 12 or above. It is reviewed monthly at the Directorate Performance Reviews and at the Executive Risk Management Group. This report provides a summary of the position in March 2022.

2.0 CORPORATE RISKS

2.1 CRR5 – Nursing Shortages

The current position regarding Registered Nurses is as follows:

Month	Vacancy WTE	Vacancy %
Feb 22	116.30	7.12%
Jan 22	122.23	7.51%
Dec 21	118.35	7.23%
Nov 21	94.36	5.86%
Oct 21	102.28	6.39%
Sep 21	98.93	6.62%
Aug 21	107.93	7.27%

The current position regarding Care Support Workers is as follows:

Month	Vacancy WTE	Vacancy %
Feb 22	110.63	20.5%
Jan 22	111.25	20.5%
Dec 21	100.66	19.0%
Nov 21	93.25	17.7%
Oct 21	56.80	11.4%
Sep 21	74.32	14.5%
Aug 21	63.78	12.5%

Of note is a successful bid (87k) to NHSE/I to recruit additional CSWs to bring to zero vacancy (inpatient units). Additional focused has been placed on the HCSW recruitment day 14th February resulted in 57 offers of posts to HCSWs – on boarding now taking place with a total of 54 new recruits remaining in the process

There has been a redefining of the CSW Development Programme to support new recruits and clarity of career progression from CSW to RN and points between. It has been agreed 'Home Trust' status with York St John University, have 100% clinical placement capacity at HDFT to support 'growing our own'

The Target Risk is 9 (3x3) – March 2023 (from March 2022).

The Current Risk is 12 (3x4) – March 2022. This is the same rating as November and December 2021 and January and February 2022.

2.2 CRR6 – Wellbeing of Staff

Work continues with the support and development programme to assist in colleagues wellbeing. Of note is that a Mental Health Nurse and a Colleague Wellbeing Programme Lead role have both been recruited to and are due to commence in Quarter 4 2021-22. Inpulse survey feedback being reviewed.

The following key actions have taken place:

- TIME OUT room in the Education Centre (Enterprise Room) with resources for any staff that would benefit from some time away. I'm aiming to be on site - previously a room at the back of Herriotts Restaurant was used for this purpose, but due to the refurbishment of Herriotts this has had to be relocated on 3rd floor, Strayside Wing.
- Refreshed Trust Wellbeing webpage & intranet with updated support offers & in-the-moment self-help
- Enhanced promotion around support offers with updated emails and poster circulation - please see poster in Appendix 2
- Re-tendering for EAP – subject to OH business case approval and funding.
- Mental Health Champions asked to enhance out-reach where they can & scheme re-promoted via Champion specific posters around site
- Thrive wellbeing conversations promoted & guidance provided
- A reminder sent via OMG about lessons learnt from Wave 1 and a reminder about End Well - checking out at the end of a shift as a process to support wellbeing –
- Psychology drop-in/easy book sessions to be offered on main site from 21/12/2021 (location & timings currently being confirmed).
- Wider psychology staffing pool being approached to see if additional support is feasible via other specialities/TEWV if needed.
- Wellbeing answerphone checked & responded to daily

The Target risk 8 (2x4) has been amended from July 2021 to September 2022.

Current risk is 12 (3x4) – March 2022 this is the same rating as November and December 2021 and January and February 2022.

2.3 CRR34 – Autism Assessment

The numbers on the waiting list is currently 509 (increase from 497 in January 2022). The longest wait is current 59 weeks (down from 64 weeks in January 2022). The Rolling 6 month average monthly referral rate is at 55 and is higher than baseline commissioned capacity of 47 assessments. Capacity is 63 with funded additional capacity until August 22.

Due to continuing higher referral numbers we are predicting it would require continuation of the WLI for 5 years to achieve a 3 month waiting list. Cost to continue to end of March 22 would be £157k.

Working with commissioners who have informed us they will be consulting with children and young people and their parents about the current model and proposals around a revised approach. Their intention is to have one model across North Yorkshire from April 23 and this may involve them giving notice and putting out to tender.

The Target Risk is 6 (3x2) – amended to March 2023 from March 2022, in line with the timetable for Commissioner review

The Current Risk is 12 (3x4) – March 2022. This is the same rating as November and December 2021, and January and February 2022.

2.4 CRR41 – RTT

Elective recovery work continues to be a major focus, and we continue to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery.

The current position is as follows:

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
No. of pathways 18-39 weeks	3,310	3,168	3,255	3,657	3,922	4,336	4,787	4,989	5,035	5,235
No. of pathways 40-49 weeks	521	666	644	735	748	820	743	748	925	950
No. of pathways 50-51 weeks	21	62	91	90	127	133	104	119	103	97
No. of pathways 52+ weeks	1,201	1,087	1,006	988	955	1,008	1,070	1,097	1,177	1,167
Total >18weeks	5,053	4,983	4,996	5,470	5,752	6,297	6,704	6,953	7,240	7,449
Total RTT List	18,182	19,746	20,631	21,785	22,168	22,648	22,423	22,714	23,464	23,833

To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered. There has been increased beds on the Elective Surgical Unit; these remain in place to help mitigate increased activity levels over the winter period. The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week.

Clinical prioritisation and review continues for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded

104+ week waiters

Through Quarter 3 and 4, the Trust have been working collectively with our partner Trusts across WYAAT to understand how each Trust could support pressures on waiting lists, redesigning pathways and agreeing governance for identifying capacity to support the treatment of long waiting patients and ensuring consistent communication.

As part of this process HDFT have supported both Bradford Trust and Leeds Teaching Hospitals Trust in the treatment of both ENT and Max Fax paediatric long waiting patients. The patients/carers were contacted and consented to transfer their care to Harrogate and will now receive their treatment before the end of March ’22. Capacity offered for the specialty areas has not had a detrimental impact on our ability to treat patients waiting for treatment in the same specialties. The support continues to be monitored carefully with the clinical and managerial teams.

Internally the Trust continue to review all patients on the Admitted pathway over 80 weeks and have initiated a weekly PTL meeting. With the service manager, admissions manager and 18-week lead, each patient is reviewed to ensure that there are clear plans in place.

The specialties of concern are currently Urology (33 patients waiting) due to increased demand and Gynaecology (32 patients waiting) are now all dated for treatment but very close to the end of March leaving little flexibility) due to capacity.

Additional theatre lists at a weekend

Significant progress has been made in engaging with clinicians to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric sessions, General Surgery and Urology. The first theatre lists went ahead on Saturday the 15th January, with another two subsequent lists post.

Staffing in theatres continues to be challenging with vacancies gaps and covid related sickness but there is now a greater up take for covering additional theatre lists in the evening and at weekends and there are currently 22 new starters in the workforce pipeline.

Clinical prioritisation and review continues for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded.

This risk is currently being reviewed in line with interim national targets. Whilst the current risk rating reflects not meeting constitutional standards, our trajectory is in line with planning guidance.

The Target Risk is 6 (3x2) – March 2023, amended from March 2021

The Current Risk is 12 (3x4) – March 2022. This is the same rating as November and December 2021 and January and February 2022.

2.5 CRR48 – Mental Health in the ED

The current performance against indicators is as follows:

- 28 total breaches for patients awaiting Mental Health review in January
- 13> 6 hour stays in ED awaiting mental health assessment/ admission (arrival to discharge)
- 2> 12 hour stays in ED awaiting mental health assessment/ admission (arrival to discharge)

There has been a reduction in- the number of mental health breaches noted in January with 2 >12 hours – both awaiting mental health act application and access to a mental health bed. Delays due to access to Approved Mental Health Practitioners (AMHP) who currently cover full NYCC footprint whilst on the duty rota and access to inpatient beds.

A review of the SLA with TEWV is currently underway.

The Target Risk is 9 (3 x 3) – May 2022, amended from March 2022

The Current Risk is 12 (3x4) – March 2022. This is the same rating as November and December 2021 and January and February 2022.

2.6 CRR61 – ED 4-hour Standard

A&E 4 hour standard remained below the 95% standard in February 2022.

In terms of further mitigation, a business case for a new walk in streaming model is in development. A full action plan developed from the kaizen event is in the process of being implemented although delays have been noted due to sickness and winter pressures.

The Target Risk is 10 (2x5) – May 2022. This is a change in target risk from 8 (4x2)

The Current Risk is 15 (3x5) – March 2022. This is the same rating as November and December 2021 and January and February 2022.

2.7 CRR63 – Violence and Aggression (ED)

The number of incidents relating to violence and aggression were:

- Datix incidents for aggression in the ED – 31 episodes through July
- Datix incidents for aggression in the ED – 28 episodes through August.
- Datix incidents for aggression in the ED – 12 episodes through September.
- Datix incidents for aggression in the ED – 8 episodes through October.
- Datix incidents for aggression in the ED – 11 episodes through November.
- Datix incidents for aggression in the ED – 9 episodes in December.
- Datix Incidents for aggression in the ED – 8 episodes through January 2022
- Datix Incidents for aggression in the ED – 11 episodes through February 2022

A review of security has taken place, and the following controls have been introduced – body cameras, CCTV, additional training for portering staff, the creation of a designated security responder, a structured 'threat response' standard operating procedure and a more structured approach to follow up with patients. The Trust has also engaged with the police to seek advice on the organisational approach. This should address the majority of the current gaps in control.

Staff body cams have been scheduled to be piloted in the ED January 2022 and the ED Manager is currently looking at an adapted SOP and will confirm the date to proceed supported by the LSMS Managers.

Emergency Security Response training (PMVA Level 2 equivalent) has now been completed for all Charge-hands and Deputy Charge-hands. A progressive roll out/refresher of Conflict resolution & De-escalation training is also continuing for both Healthcare Portering and HDFT colleagues.

With HIF colleagues, a further security review is being undertaken to assess further options.

The Target Risk is 8 (2x4) – May 2022 - target risk rating changed from September 2021

The Current Risk is 12 (3x4) – March 2022 this is the same as November and December 2021 and January and February 2022.

2.9 Health and Safety

Following discussions at the November 2021 Trust Board the Director of Finance and the Company Secretary agreed to undertake a gap analysis of the governance arrangements regarding Health and Safety. This was be submitted to the January 2022 Trust Board in Private. Initial recommendations,include a revised agenda for the Health and Safety Committee that includes discussions on RIDDOR, COSH, Risk Assessments and training compliance.

The Deputy Director of Estates is now in post on 10th January 2022. This will provide additional expertise to develop an action plan to reduce the levels of risk.

A Health and Safety consultant has been engaged and is working 3 days a week. The engagement is for 6 months and they will assist in recruiting a permanent H&S manager, advise on immediate actions needed, and produce an action plan by the end of March to cover what we need to undertake to be fully compliant.

The Target Risk is 8 (4x2) – May 2022 – revised from December 2021

The Current Risk is 12 (4x3) – March 2022, **this is an improved rating from 16 (4x4) in February 2022 due to increased mitigation.**

2.10 Pharmacy Aseptic

The Replacement of the Aseptic Unit is required to permanently reduce the risk. Replacing the unit will require it to close for approx 12 months. The impact of this will be mitigated by a combination of: ward based preparation of products, outsourcing products to LTHT and the private sector; HDFT aseptic staff working in the YSTHFT unit to increase its production capacity so it can supply products for HDFT.

Investment will be needed to build a new Aseptic Production Unit. A project is underway to develop the plans and a BC is planned for SMT in Mar 22 with construction of the new unit planned to start in Jun 22 (aligned with the replacement of the Air Handling Unit through the SALIX programme) subject to completion of the procurement process and availability of the chosen contractor to start the work.

Capital funding for 2022/23 has been agreed. A business case has been recommended for approval by BCRG, with request for some additional information. It will go to SMT, Resources Committee and Board in March.

There is a risk that the replacement will not be able to start immediately after the replacement of the AHU by Salix in Jun 22. This is because the procurement process needs to have been completed and the chosen contractor needs to be available to begin the work. If the work cannot start immediately it will extend the shutdown period which will increase the costs of the mitigation plans and increase the workforce risk because staff will be working at YTHFT for longer.

The Target Risk is 4 (1x4) – March 2023

The Current Risk is 12 (3x4) – March 2022, this is the same rating at January and February 2022.

3 RECOMMENDATIONS

It is recommended that the information is noted for assurance.

Kate Southgate
Associate Director of Quality and Corporate Affairs

March 2022

3.1

Board of Directors(Public)
30th March 2022

Title:	**Board Assurance Framework**
Responsible Director:	Chief Executive
Author:	Company Secretary

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting on 26th January 2022. Each Board Assurance Framework risk has been reviewed and assessed with the designated responsible Executive Director. The changes to the BAF made since the last meeting are detailed within the report	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Board Assurance Framework

1. STRATEGIC OBJECTIVE: TO BE AN OUTSTANDING PLACE TO WORK

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risks Linked to BAF	Positive Assurance			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	March 2022 Updates
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#1.1	To be an outstanding place to work	There is a risk HDFT's culture will be compromised due to an insufficient focus on the culture of the Trust and the health and wellbeing of staff.	3	4	12	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of Staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Mental Health Nurse – recruited Colleague Wellbeing Programme Lead – recruited Quiet room developed in the Education Centre Refreshed wellbeing intranet Mental Health Champions in place Thrive Wellbeing Conversations	Board of Directors Senior Management Team People and Culture Committee Sarah Armstrong – Non-Executive Director for Wellbeing Guardian	Staff Survey Action Plan	Cultural programmes in place and are being embedded. Data is being analysed by directorates and managers. Actions are being reviewed and implemented. Presentation was made by each directorate at November SMT. Analysis to assess the impacted on these and to determine how well embedded the cultural programmes are in HDFT and HIF remains outstanding.	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated..
BAF#1.2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that HDFT's culture may be compromised due to a lack of diversity.	4	5	20	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Becoming and Anti-Racist Work programme EDS2 Programme commissioned	Board of Directors SMT People and Culture Committee Wallace Sampson – Non-Executive Director for Inequality and Diversity	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated..

2. STRATEGIC OBJECTIVE: TO WORK WITH PARTNERS TO DELIVER INTEGRATED CARE																	
Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	March 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus which will impact on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	3	3	9	2x3=6	Apr-23		Medical Director attendance at LMC and HARA with focus on development of an aligned focus on health inequalities as a strategic priority Appointment of Director of Strategy has increased capacity to work with strategic partners	Medical Director Board Report Director of Strategy Board Report SMT	HARA Yorkshire Health Network LMC	This risk could be exasperated due to the potential local government and NHS (integrating care) reorganisation. Currently no strategic Harrogate Place Forum – discussions are ongoing to develop forum. Further work required on Harrogate as an anchor institution.	SMT	M Graham, Director of Strategy J Andrews, Executive Medical Director	With the appointment of Matt Graham, the Lead Executive has been updated to include the Director of Strategy. In addition, assurance controls and gaps have been updated to reflect the current position.
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	Risk that the population is not able to fully benefit from being part of an integrated care system because our acute services face towards West Yorkshire ICS and our place based population health activities sit within HCV ICS and there is insufficient executive capacity to participate in 2 ICSs.	3	3	9	3	3	9	2x3=6	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members	Appointment of Director of Strategy Executive Team are key members of strategic groups across the two ICSs.	ICS Groups eg the Provider Collaborative	The required input across the two local ICS may lead to a lack of clarity of funding arrangements. Requirement for HDFT to be members of two ICS means that Executive capacity needs to spread across two structures rather than one.	SMT	M Graham, Director of Strategy	With the appointment of Matt Graham, the Lead Executive has been updated to the Director of Strategy and not the Executive Medical Director. In addition, assurance controls and gaps have been updated to reflect the current position

3. STRATEGIC OBJECTIVE: TO DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	March 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding quality of care and patient experience due to insufficient focus on a culture of quality improvement.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place to strengthen the line of sight of quality of care and experience in our services. These include establishment of Quality Governance Management Group (QGMG) which includes 3 main fora – Patient Safety Forum, Clinical Effectiveness Forum and Making Experiences Count Forum. These groups will provide Executive level oversight of quality, identify risk and mitigations and triangulate learning and improvement. Governance structure has received a root and branch review and the creation of the three forums above will ensure greater control. Safe Staffing Review completed. Procured Perfect Ward with planned roll out in January and February 2022.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation Weekly Quality Summit and Learning Summit in place Complaints back log cleared	CQC Inspections Bi-monthly Assurance meetings with CCG Internal Audit Report – Board to Board reporting – significant assurance	Do not have consistent quality control in place Workforce challenges impacting	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated.
BAF#3.2	To provide a high quality service	Risk that a number of our clinical services are not operationally and financially sustainable because of the size of population we serve and associated financial income, the changing shape of the clinical workforce and preferences for ways of working and also our ability to deliver sub-specialty programmes of work	4	4	16	4	4	16	2x4 = 8	Apr-23	None	The appointment of the Director of Strategy has given renewed focus and increased resource on the development of the Clinical Strategy and a strategic governance programme is under development	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	Trust and Clinical Strategy under development however they are not yet in place.	Quality Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in assurance have been updated.
BAF#3.3	To provide high quality care to children and young people in adults community services	There is a risk that there is not sufficient visibility of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	'Hopes for Healthcare' sets out our organisational actions following engagement with children and young people on what they want from our services and each Directorate is working towards implementing these. Each Directorate is nominating a children's champion who will provide the Directorate link from the quarterly Children's Champions meeting back to the Directorate. This will be monitored via QGMG.	Adult and Young People Safeguarding Reports CQC Trust Wide Action Plan – now closed.	CQC Outstanding Report OFSTED Reports JTAI Reports	Metrics required to monitor the embedding of CQC Actions. Paediatric Emergency Department – workforce and environment	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated.
BAF#3.4	To provide outstanding care and outstanding patient experience	There is a risk that the Trust is unable to deliver treatment and care to the required national standards which may cause patient satisfaction to drop and harm to arise	3	4	12	4	3	12	2 x 3 = 6	Apr 23	CRR41 - RTT	Planned Care Recovery Programme in Place Weekly access meetings to track weekly progress against activity targets Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review Use of independent sector to increase inpatient, day case and diagnostic capacity Collaboration initiatives with other Acute Trusts Theatres utilisation workstream Elective Recovery progressing, ,Endoscopy Unit now fully operational	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review Operational Management Group	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	Current controls updated

BAF#3.5	To provide a high quality public health 0-19 service	There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors.	5	4	20	4	4	16	2x4=8	Apr-22	CRR5 – Nursing Shortage CRR57 – Safeguarding Demand	Recruitment & Retention Group set up & action plan in place and being progressed (includes skill mix work, setting up services on NHSP, rolling monthly recruitment in line with ward based nursing) Business case submitted to enhance Safeguarding resource which would support the specialist team and 0 -19 service pressures. Would support 'breaking the cycle' by freeing up 0 -19 capacity to undertake preventative work. Request made for support from wider Trust (needs to be nurses with experience of working with children and families) Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) Development of OPEL to increase visibility of pressure & actions taken Agile / Base & Home working - Developing offers with teams to support alternative ways of working • Work commenced on 0 -19 'Safer staffing' tool Services recommencing face to face contacts, however recognising that many community services have not returned to pre-pandemic arrangements.	SMT/ Quality Committee/ Resource Committee		The national mandate for roll out of Covid vaccinations for healthy 12-15 year olds is likely to impact on ongoing pressures Increased safeguarding activity referrals have continued into 2022 with an increase in workforce pressures. See CRR57 for activity information.		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

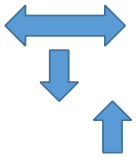
4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	March 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating					Internal	External				
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement	4	4	16	2	4	8	2x4=8	Mar-22	None	Current financial regime; national framework, ICS discussions; engagement in regional and local service transformation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT WYATT – creating financial framework to look at opportunities. The piece of work is being mirrored internally.	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation and the requirement to move to pre Covid levels of activity No new long-term productivity programme currently in place **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed.
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	2	4	8	2x4=8	Mar-23	None	Capital asset register and planning process; financial plan; current financial regime Strength of balance sheet Engaged with ICS Ongoing discussions with the ICS future allocation Site development group developing plan	Capital Oversight Group H2 efficiency programme	Ongoing discussions based on winter planning and national and regional allocations. H2 planning now in place with efficiency programme.	**Internal:** No efficiency programme	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Assurance controls and gaps in control update. Noted that the capital is available but potential risks as no long term site development plan currently in place.
BAF#4.3	To provide high quality care and to be a financially sustainable orgnisation	There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety	4	4	16	3	4	12	2x4=8	Apr-22	None	Digital Strategy Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme Working with digital aspirant programme to create strategic outline case for digital funding.	Capital Oversight Group Digital Strategy Group		Ongoing refresh of the Clinical Strategy and the Digital Strategy	Resource Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in control update.
#4.4	To be financially stable to provide outstanding quality of care	Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality	4	4	16	2	4	8	2x4=8	Apr 22	None	Quality governance arrangements; Contracts with commissioners Annual audit cycle PLACE Assessments 4. ICS and Place based networks Current financial regime	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities	Lack of system wide financial plan New financial allocations need to be agreed. Chief Executive/Finance Director has with ICS's and regulators Carnell Farrer Review	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Current risk rating updated to 8. Target risk met. Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed.

Risk Matrix

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost Certain
5. Extreme	5	10	15	20	25
4. Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2. Minor	2	4	6	8	10
1. Negligible	1	2	3	4	5

Changes in Ratings



No change in risk rating since from previous Assurance Framework

Risk rating has been downgraded from previous version

Risk rating has increased from previous version

Progress on Actons

1 Fully on plan across all actions
2 Actions defined - most progressing, where delays are occurring interventions are being taken
3 Actions defined - work started but behind plan
4 Actions defined - but largely behind plan
5 Actions not yet fully defined

Director of Strategy

Matters of concern & risks to escalate

- **Trust Strategy**: Timescales for refresh of Trust Strategy are achievable, but tight.
- **Clinical Strategy:** will require additional time to work with services to refine their service models and to develop a trust level clinical strategy.
- **NYY Community Diagnostic Centres**: ensure that HDFT is fully involved in decisions about community diagnostics for Harrogate & District and acute/community models work together.
- **Business Cases**: approval of BCs being requested at short notice and without awareness that case is under development. Ideally BCs should be identified during annual planning; in year BCs should be raised through Directorate Quality & Performance Reviews as early as possible. All potential BCs should be captured on the BC Tracker (attached in supporting papers)

Major actions commissioned & work underway

- **Trust Strategy**
  - Draft strategy reviewed by SMT & Board. Revised draft (with more ambition, tailored to HDFT) planned for end of March for review with staff, external stakeholders, SMT and Board; Board sign off planned for April 2022
  - Clinical Strategy: workinbg with services to refine models and combine into trust clinical strategy; meeting with YSTHFT
  - Corporate Teams Strategy Workshop, 4 April
- **Programme Governance**
  - First UEC and Planned Care Boards meetings held on 14/15 Mar
- **Anchor Institution**
  - Trust assessments vs HCV Anchor Institutions Framework completed; HCV system meeting on 8 April
  - Project SEARCH
  - Armed Forces: Re-accreditation of ERS Silver Award
- **NYY Community Diagnostic Centres**: working with Harrogate place partners to develop CDC proposal

Positive news & assurance

- **Trust Strategy**
  - Draft strategy positively reviewed by SMT and Board: covers the right areas and priorities
  - Vast majority of service model templates completed for clinical strategy.
  - Met YSTHFT about clinical strategy for services provided to HDFT
- **Project SEARCH**: Steering Group with NYCC and Harrogate College established; 9 teams have offered to provide rotations
- **Armed Forces**: AF covenant signed as a trust
- **March Business Cases** (BC Tracker in supporting papers):
  - Approved: Maternity EPR, Datix Cloud,
  - Recommended: C2 AI, Nurse Call, Aseptics
  - Further work: Employee Wellbeing & Occupational Health, Virtual Glaucoma Clinics, OP Booking Self Check-in, SALT capacity, Community Dentistry, ED Streaming, Wensleydale, Breast Unit

Decisions made & decisions required

- **Trust Strategy:** feedback from SMT/Board members on second draft of trust strategy

3.3

Board of Directors held in Public
30th March 2022

Title:	**Green Plan**
Responsible Director:	Executive Directors
Author:	Managing Director, HIF

Purpose of the report and summary of key issues:	The Trust Board is asked to note the information contained within this report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	Y
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	Y
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	Y
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	Y
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	Y
	BAF4.4 To be financially stable to provide outstanding quality of care	Y
Corporate Risks	None	
Report History:	The HIF Board of Directors considered the final draft Green Plan at its meeting in February 2022 and was subsequently discussed at the Trust SMT in March 2022. This final draft of the plan is now attached for consideration and approval by the Board of Directors. The Plan includes a detailed action plan and work will now be progressed to implement this plan. Initial actions include - ○ Establishing the Sustainability Group ○ Engaging with the Organisation and establishing our Green Champions	

	○ Agreeing Project leads for each of the work streams in the action Plan ○ Developing our Communications Strategy, including promoting the work in relation to the Salix Project ○ Providing regular updates to the Board of Directors within HIF and HDFT on progress against the agreed action plan ○ Engaging and working with other stakeholder organisations across the system to deliver the sustainability agenda The Green Plan will be an integral part of the Trust Strategy and clinical strategy work and this will also be reflected in the action plan.
Recommendation:	The Trust Board is asked to approve the Green Plan following agreement at the March SMT.

HIF HARROGATE INTEGRATED FACILITIES
Taking Pride in our Services

NHS
Harrogate and District
NHS Foundation Trust

3.3

Green Plan 2022-2025

Creating better, more sustainable healthcare for our community

teamHDFT
At our best

Contents

teamHDFT At our best | HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services | NHS Harrogate and District NHS Foundation Trust

1.0 **Foreword**

When people talk about the green agenda the focus is often on urban areas with large populations, significant carbon emissions, and increasing air pollution. Rural communities can often be forgotten, even though the issue is just as important there as anywhere else.

Left unabated climate change will have a detrimental effect on our healthcare service, with pollution contributing to an increase in major diseases such as cardiac problems, asthma and cancer. This is not just a concern for Trusts operating in our large cities and towns, it will also have a catastrophic effect on those operating in rural areas too - unless we address the issue now.

The National Health Service is determined to become the world's first healthcare system to reach net zero carbon emissions. It is an ideal that we as a Trust share and which has shaped our own Green Plan for the future.

Our Trust's footprint covers both geographies across North Yorkshire and the North East – from the historic towns of Harrogate, Ripon and Northallerton, and the cities of Sunderland and Gateshead, to the untouched natural beauty of the Yorkshire Dales and as far as Northumberland, so it is important that our Green Plan consider both.

Harrogate and District NHS Foundation Trust (HDFT), together with our subsidiary company Harrogate Integrated Facilities (HIF), take our environmental responsibilities extremely seriously and our Green Plan clearly demonstrates our aims for the future and how they will be achieved.

The plan has been developed to reflect our sustainability objectives, ensuring that they deliver improvements across the whole HDFT footprint, as well as contributing to the wider national sustainability agenda.

The plan sets out the key areas we need to focus on, for instance, to significantly reduce carbon emissions across our footprint by developing schemes that support walking and cycling, enhance green spaces, reduce pollutants and waste, improve energy efficiency, and increase recycling.

Such activity will not only help us to become a greener, more sustainable organisation, it will also lead to financial benefits. Delivering our green objectives will lead to reduced running costs, and the savings can be used to support improvements in patient care.

These are exciting times for teamHDFT. We are already progressing a number of environmental initiatives, and have a whole host of future activity planned, so that we can become a net zero organisation by 2040.

Of course, we will not be able to achieve our aims alone, and over the next three years we will need the help and support of our patients, staff and the wider community so that we can continue to implement the changes and become a greener NHS.

Our Trust's values of kindness, integrity, teamwork and equality are embedded in everything we do, including our plans for becoming a greener, more sustainable organisation. At teamHDFT we will work together to make changes that will benefit our future generations and ensure we can continue to provide a healthcare service of which we can all be proud.

Steve Russell
Chief Executive
Harrogate and District NHS Foundation Trust

Jonathan Coulter
Chief Executive
Harrogate Integrated Facilities

The plan sets out the key areas we need to focus on, for instance, to significantly reduce carbon emissions across our footprint by developing schemes that support walking and cycling, enhance green spaces, reduce pollutants and waste, improve energy efficiency, and increase recycling.

2.0 Introduction

2.1 Our Commitment to Sustainability

Our aim is to be a net-zero organisation by 2040, having reduced our carbon footprint by 80% by the end of this decade. We intend to deliver sustainable healthcare for the benefit of the population that we serve.

At Harrogate and District NHS Foundation Trust, we recognise the huge challenges that climate change, air pollution and waste present in the region in which we operate. As a major healthcare provider in North Yorkshire and the North East of England, it is essential that we reduce our contribution to climate change and embed sustainability throughout each aspect of our organisation to mitigate the risks to the health of our population. Harrogate Integrated Facilities Ltd (HIF), a wholly owned subsidiary of HDFT, we leading this work on behalf of the Trust, as we have the greater level of expertise in this area. This is an exciting joint venture between our respective organisations and we look forward to working together to implement the objectives set out in this plan. Our Green Plan sets out our strategic objectives for delivering sustainable healthcare across our communities.

Our Green Plan will build upon the successes of our Carbon Management Plan and set more ambitious targets for the future, in line with national and local objectives. The Plan will stand as an organisation-wide strategy, which will guide the implementation of a collection of actions to improve our sustainability credentials and meet NHS targets. The Green Plan will act as the core document pertaining to sustainable development at the Trust over the next three years and will act as a framework use to reduce our environmental impact and improve the health of our community.

2.2 Sustainability at a National Level

Climate change is considered the greatest environmental threat to global health in the 21st century by many organisations including, but not limited to, the World Health Organisation, British Medical Association, the Royal College of Physicians, and the Royal College of Nursing.

In line with the Climate Change Act 2008, the UK has set a legally binding target to reduce carbon emissions to net-zero by 2050. In its Net Zero Strategy, published in October 2020, the NHS set out a vision to become the world's first net zero carbon health service and respond to climate change, improving health now and for future generations. Every part of the NHS will need to act both in the short- and long-term to meet this ambition.

In 2020, NHS England announced the For a Greener NHS campaign. This campaign aims to provide top-level support for NHS Trusts to implement sustainable measures to minimise the NHS's contribution to climate change. As part of this campaign the NHS has commissioned a panel of experts who will assess how quickly net-zero emissions can be achieved in the NHS. The Trust will review the findings of the panel often and use any relevant findings to inform future updates of this Green Plan. To become a net-zero health service, reduce air pollution and reduce our waste the NHS will require the support of all Trusts, staff, and partner organisations.

2.3 Sustainability at a Local and Regional Level

The Trust commits to a partnership working approach.

We work closely with West Yorkshire and Harrogate ICS and Humber Coast and Vale ICS, and as such, we aim to align our Trust's ambitions with their commitments to climate change, sustainability, air pollution and waste management. These partnerships facilitate collaborative action between Clinical Commissioning Groups, local councils, care providers and third sector organisations from around the Yorkshire and Humber region.

The West Yorkshire and Harrogate ICS and Humber Coast and Vale ICS aspire to become global leaders in responding to the climate emergency. To achieve this, they plan to increase mitigation, invest in sustainable solutions, and encourage a culture change throughout the health and care system in our region. The partnerships will also work to increase preparedness to deal with the impact of climate change on public health.

The specific targets set by our partners, which we will adopt, are set out in Section 3 *Drivers and Targets*

2.4 Key Areas of Focus

This Green Plan will act as the framework for sustainability strategies across our Trust. The Plan will deliver the ambitions of the NHS Long Term Plan, ensure that the Trust is compliant with the latest legislation and enable the Trust to become a more sustainable organisation.

The Green Plan will be valid for three years and focus on nine main aspects:

- People and leadership
- Sustainable models of care
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Recruitment/induction/appraisal

2.5 Carbon Net-Zero

A key aim of national and local policy and a key driver of this Green Plan is to achieve net-zero carbon emissions.

Carbon net-zero, often referred to as Carbon Neutral, is defined as the state in which an organisation avoids emitting greenhouse gases (GHGs) though its generation and use of energy. To achieve this state the organisation must be powered by 100% renewable energy and not produce any carbon emissions.

Where carbon emissions cannot be reduced to zero, then carbon offsetting through investment into bio sequestration (e.g. planting trees) and technology-based carbon capture and storage can be sought to offset the residual emissions and achieve carbon neutrality.

2.6 Format of the Green Plan

3

Section 3
Drivers and Targets

Outlines the key policies, objectives and targets which drive sustainable development in the NHS, and which have been used to shape the targets and strategies established in this Green Plan.

4

Section 4
Our Carbon Footprint

Details how we have calculated our carbon baseline, which will be used as the year against which our emissions reductions are compared. This section also explains our progress in reducing our emissions so far, and the steps that have been taken to achieve these reductions.

5

Section 5
The Pathway to Net-Zero

Some of the national and local measures that will help us to achieve net-zero in addition to our internal actions are set out in Section 5 *The Pathway to Net-Zero.*

6

Section 6
Sustainable Action Plan

Finally, our *Sustainable Action Plan* is set out in Section 6. This section explains how our action plan was developed and provides a summary of the actions we plan to implement to achieve our targets.

3.0 Drivers and Targets

This section outlines the national legislation and health sector specific policies that will drive sustainable development within the UK over the next five years. It also outlines the targets and ambitions of our partner organisations and the targets and objectives we will adopt.

3.1 Sustainability Drivers

The UK Government has committed to achieving carbon net-zero emissions by 2050. This is a mandatory target as set by the Climate Change Act 2008. The NHS has acknowledged its significant contribution to UK carbon emissions and has therefore set a target to become carbon net-zero by 2040.

Substantial progress has already been made in improving sustainability within the NHS. A 62% reduction in the NHS carbon footprint was achieved between the years 1990 and 2020. This reduction was achieved by several measures to reduce carbon dioxide equivalent (CO_2e) and air pollution emissions and improve waste management.

The drivers for sustainable development in the NHS are set out in four key NHS specific documents:

- NHS Long Term Plan
- NHS Standard Service Contract 2021/22
- NHS Operational Planning and Contracting Guidance
- Delivering a Net-Zero National Health Service

The *NHS Long Term Plan* sets out how the NHS will develop and improve until 2030 and considers sustainability and new models of care developed will be aligned to the plan.

The *NHS Standard Service Contract* outlines several targets and objectives pertaining to sustainability. To assist the NHS in achieving the carbon reduction targets set by the government and to ensure the organisation is resilient in the future, the *NHS Operational Planning and Contracting Guidance* provides guidance on the actions required.

The Delivering a Net-Zero National Healthcare Service report establishes the actions the NHS will take to reduce emissions. This report explains the modelling and analytics that have been used to establish the NHS carbon footprint and future projections. Outlined in the report are the immediate actions the NHS is required to implement to meet the 2040 carbon net-zero target. This report will be continuously reviewed to ensure the NHS is on track to meet its long-term commitments and that the report provides the correct level of ambition.

The four documents just mentioned establish the following targets and objectives:

For carbon emissions controlled directly by the NHS (the NHS Carbon Footprint)

ACHIEVE net-zero by 2040

with an ambition to reach an

80% REDUCTION by 2028 to 2032

For carbon emissions the NHS can influence (the NHS Carbon Footprint Plus)

ACHIEVE net-zero by 2045

with an ambition to reach an

80% REDUCTION by 2036 to 2039

DELIVER A 4% REDUCTION

in carbon emissions by shifting to lower carbon inhalers

DELIVER A 2% REDUCTION

in carbon emissions by transforming anaesthetic practices and reduce the percentage of Desflurane used in surgeries

BY VOLUME TO 10%

ADOPT THE single use PLASTICS PLEDGE

PURCHASE 100% RENEWABLE ELECTRICITY

at all NHS organisations by April 2021

TRANSITION TO zero EMISSIONS

vehicles by 2032

3.2 Our Partnerships

Our local authority and local partnerships have committed to taking action on climate change. The Trust will aim to align our targets with the targets of our local partnerships and we will continue to work collaboratively to help achieve a reduction in environmental impacts throughout our region.

Local targets that have been established in our region have been outlined below:

West Yorkshire and Harrogate Health and Care Partnership:

- Achieve net-zero carbon emissions by 2038

Humber Coast and Vale Health and Care Partnership:

- Achieve net-zero carbon emissions by 2035

Harrogate Borough Council:

- Achieve net-zero carbon emissions in the council by 2038
- Promote and support activity within the region to help the Harrogate district as a whole to be net-zero by 2038

3.3 Our Commitment and Targets

In line with national and local drivers, the Trust will adopt the following targets:

3.3.1 Carbon Reduction

- We will achieve a 100% reduction of direct carbon dioxide equivalent (CO_2e) emissions by 2035. An 80% reduction will be achieved by 2030 at the latest.
- We will achieve a 100% reduction of indirect CO_2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest.

3.3.2 Air Pollution

- We will convert 90% of our fleet to low, ultra-low and zero-emission vehicles by 2028.
- We will cut air pollution emissions from business mileage and fleet by 20% by March 2024.
- We will work with Yorkshire Ambulance Service to understand the appropriate number of electric vehicle charging points we should install to accommodate their ambulances.

3.3.3 Waste

- We will send no waste to landfill
- We will increase our percentage of recycled waste to 25% by 2025

3.3.4 Procurement

- The Trust will work to adopt the West Yorkshire and Harrogate Sustainable Procurement practices
- The Trust will seek to reduce our indirect emissions through our supply chain
- The Trust will work to embed sustainability within our procurement decisions and practices

3.3.5 Clinical Services

- The Trust will work to reduce emissions through provision of our clinical services
- The Trust will work to embed sustainability within our clinical care models
- The Trust will work to eliminate unnecessary single use plastic items from our service delivery, where clinically appropriate

4.0 Our Carbon Footprint

To monitor the reduction in our carbon emissions we have created a Carbon Baseline against which we will compare our annual CO_2e emissions. This section details the methods used to establish the Carbon Baseline, the scope of our baseline and the changes in our emissions we have achieved so far across each aspect of our emissions.

4.1 Developing our Carbon Baseline

The Trust's Carbon Baseline is measured by reporting the annual emissions of carbon dioxide equivalent (CO_2e) emissions.

We have used 2013/14 as our baseline year, in line with NHS Sustainable Development Unit (SDU) guidance, this will be the year against which all subsequent annual CO_2e emissions will be compared.

To calculate our carbon emissions, we have multiplied our annual consumption data (e.g. kWh for gas consumption) by carbon conversion factors. Carbon conversion factors are produced annually by the Department for Business, Energy, and Industrial Strategy (BEIS) for greenhouse gas reporting. This gives us the annual CO_2e emissions for each aspect monitored.

4.1.1 Scope of the Carbon Baseline

The following key aspects of operating the Trust produce carbon emissions and are included in our carbon baseline:

- Electricity consumption
- Gas consumption
- Water consumption
- Waste arisings and disposal
- Business travel
- Anaesthetic gases

The Trust is made up of several sites within the footprint in which we operate, a number of which are leased by the Trust from external landlords which means they fall outside the scope of the Estates Returns Information Collection (ERIC) data which was used to create the baseline.

For the purposes of producing an accurate and meaningful baseline, the only sites included in the baseline are Harrogate District Hospital, Ripon Community Hospital and Lascelles Neurological Rehabilitation Unit. We will work to expand our carbon baseline in the future to ensure that we are monitoring the full scope of our emissions.

The Trust began monitoring the consumption of anaesthetic gases in 2016. For the purposes of this baseline the 2016 level of emissions from anaesthetic gases has been used as the baseline emission.

4.2 Our Overall Carbon Baseline

In 2013, the baseline year, we produced 8,553 tonnes of CO_2e (tCO_2e).

Energy consumption at the Trust was the largest contributor to emissions in the baseline year with 56% of CO_2e emissions from gas consumption and 27% from electricity consumption. The emissions from the use of anaesthetic gases contributed 10% of the Trust's total CO_2e emissions in 2013 followed by business travel which produced 6% of emissions. The emissions of oil, water and waste combined contributed to less than 2% of emissions.

Table 1 - Carbon Baseline for Harrogate and District NHS Foundation Trust based on 2013 data (tCO_2e)

Year	Electricity	Gas	Oil	Water	Waste Arisings and Disposal	Business Travel	Anaesthetic Gases	Total
2013-14	2,273	4,770	6	104	46	499	856	8,554

4.3 Progress against the Baseline

As shown in Figure 1, the Trust has reduced carbon emissions from the baseline.

In the six years since the baseline year a 14% reduction in CO_2e emissions has been achieved with annual emissions decreasing by 1,156 tCO_2e.

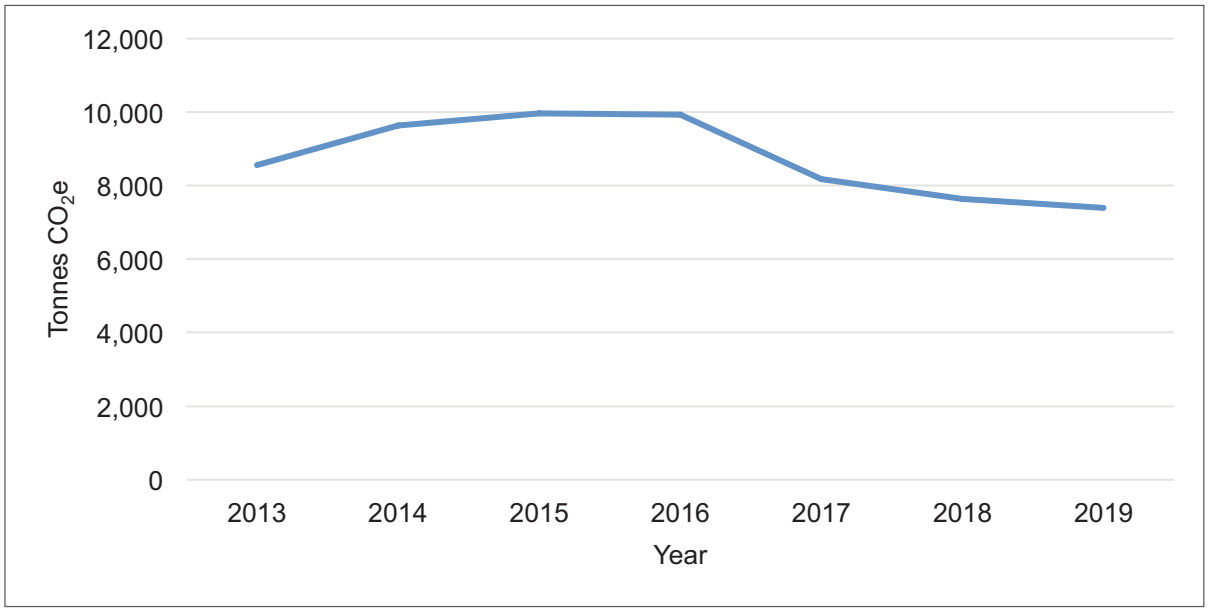


Figure 1 - Total annual CO_2e emissions from the Trust

This reduction falls short of the 2020 interim target set by the Climate Change Act 2008 which specified a 28% reduction in emissions from the 2013 baseline. The Trust will ensure that we meet the next interim target of an 80% reduction in emissions by 2032 which will require a further 5,686 tCO_2e reduction. We will then work to reduce our emissions to net-zero by 2035. Section 5 The Pathway to Net-Zero, details how we will achieve our next target and the trajectory we will follow to reach net-zero carbon emissions.

Table 2 - Comparison of CO_2e emissions in the baseline year and most recent year

Year	Electricity	Gas	Oil	Water	Waste Arisings and Disposal	Business Travel	Anaesthetic Gases	Total
Baseline	2,273	4,770	6	104	46	499	856	8,554
2019/20	926	5,039	23	105	16	669	619	7,397
Reduction	1,347	-270	-17	-1	29	-170	237	1,155

Emissions have been reduced from electricity consumption and waste arisings and disposal; this has resulted in a total reduction of 1,155 tCO_2e despite an increase in emissions from some aspects. The actions responsible for the changes in emissions for each aspect are detailed in section 4.2.

4.4 Key Aspects

4.4.1 Electricity

Electricity consumption is the second largest contributor to carbon emissions at the Trust, making up 27% of carbon emissions in the baseline year. The Trust has reduced carbon emissions from electricity by 59% since the baseline year a reduction of 1,347 tCO_2e, as shown in Figure 2.

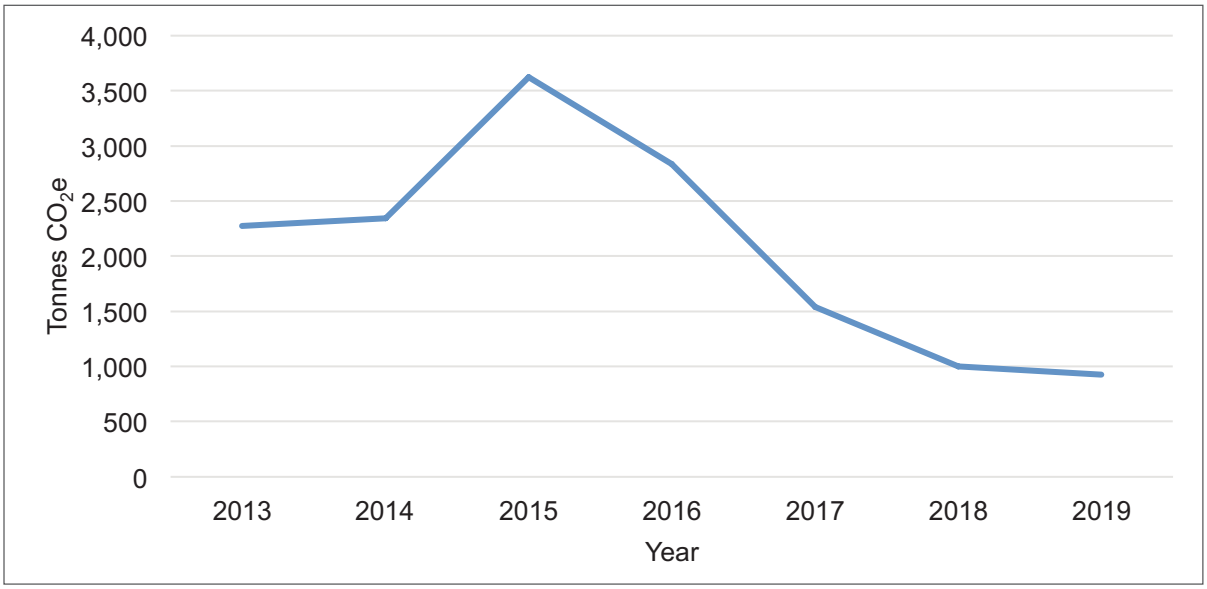


Figure 2 - tCO_2e from Trust electricity consumption from the grid

Consumption of electricity at the Trust has decreased by 35% since the baseline year, as shown in Figure 2. This reduction has been achieved through a series of measures implemented by the Trust since 2015. The Trust has upgraded its electrical infrastructure, with several items of electrical equipment being installed and commissioned. This included a new high-voltage power supply to the Strayside wing at Harrogate District Hospital, servicing a new substation and generator. The Trust also upgraded transformers, switchgear, and section boards. The Trust also upgraded the BMS to improve efficiency.

The Trust has also improved the energy efficiency of lighting. Since this project was implemented in 2016, 7,000 light fittings have been replaced with LED daylight lighting and are occupancy controlled. LEDs are being installed site-wide to replace inefficient lighting. It is estimated that this scheme has resulted in an annual saving of 154 tCO_2e.

In 2013, Microsoft Power Down was installed on all computers at the Trust. This ensures that computers are not left on when not in use, which reduces the amount of electricity wasted. This is estimated to have saved 144 tCO_2e annually.

The reduction in emissions has also partially been due to the reduction in carbon intensity of imported electricity since the baseline year, 2013. Electricity used in the National Grid is generated through a mix of sources including gas, coal, nuclear and renewable source such as wind. Every year, the proportion of renewable energy sources which contribute towards the UK's energy mix increases, which reduces the carbon intensity of the electricity supplied by the Grid. The reduction in carbon intensity to produce the UK's electricity results in a reduction in the associated emissions.

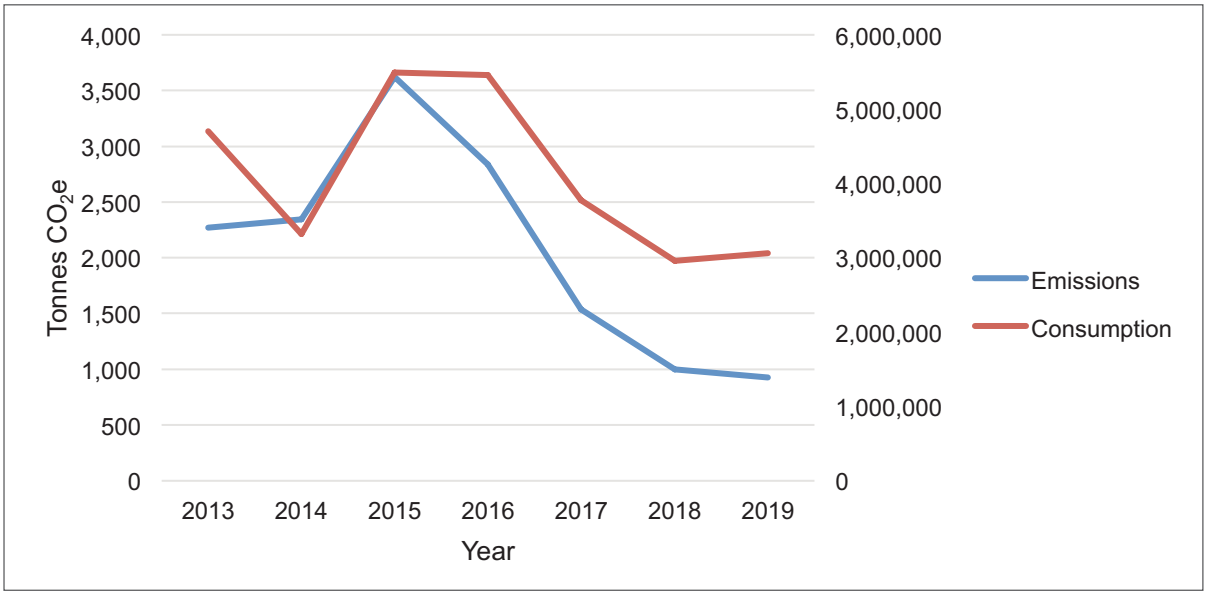


Figure 3 - Comparison between electricity consumption (kWh) and emissions (CO_2e)

The carbon intensity of electricity is calculated and published by the Department for Business, Energy, and Industrial Strategy (BEIS) each year. In the baseline year (2013), the carbon intensity was 0.48 kg CO_2e. This means that for every kWh of electricity consumed 0.48 kg of CO_2e was produced. By 2019-20 this carbon intensity had decreased by 42% to 0.28 kg CO_2e, resulting in lower annual emissions from electricity. This has enabled the Trust to achieve a 59% reduction in emissions with only a 35% reduction in consumption.

4.4.2 Gas

As shown in Figure 4, a decrease in emissions from gas consumption at the Trust has not been achieved. This is due to the use of the CHP (Combined Heat & Power) which uses gas to generate electricity onsite at Harrogate District Hospital. This has meant that there has been an increase in the gas consumed at the Trust and a decrease in the electricity imported from the National Grid.

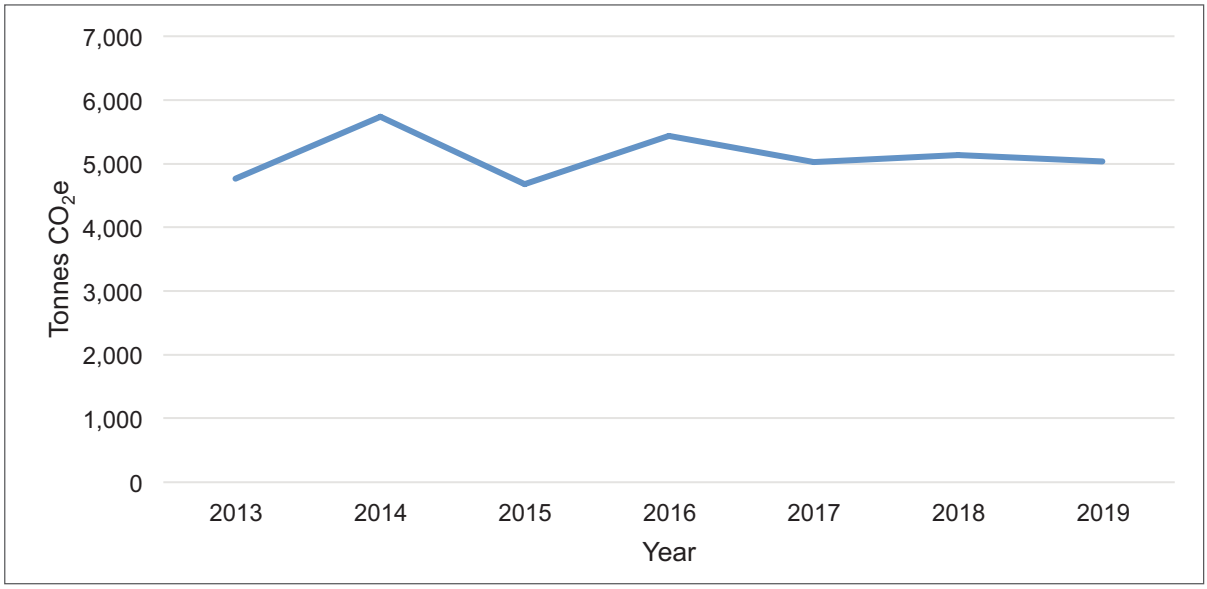


Figure 4 - tCO_2e from gas consumption at the Trust

At the Trust's main site, Harrogate District Hospital, a combined heat power (CHP) station is utilised to generate electricity and heat from natural gas. As part of the Trust's Carbon Management Plan published in 2014, it was recommended that the Trust improved the efficiency of the CHP and maximised a number of downstream energy management projects.

The CHP has now been optimised to act as the primary heat source for the Harrogate site. The heat from the CHP is used to reduce the consumption of gas in the heating boilers and serve as an absorption chiller. In the winter months, surplus heat it utilised onsite to keep the car park free of frost and snow.

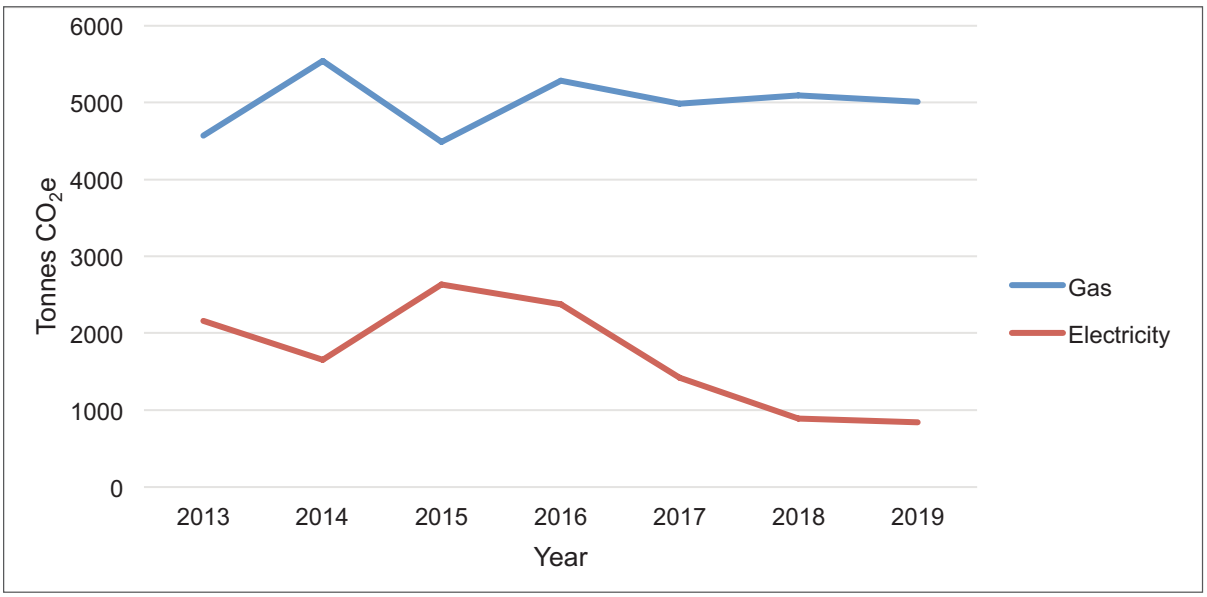


Figure 5 - CO_2e emissions from gas and electricity at Harrogate District Hospital

Measures have been implemented at the Trust to reduce the CO_2e emissions from gas, this has resulted in a significantly smaller increase in gas emissions (10%) than the decrease in electricity consumption from the grid (35%). This increase in gas emissions could also be attributed to the 7.5% increase in the total heated volume at Harrogate District Hospital.

The full-time operation of the CHP has required an increase in gas consumption at the Harrogate site, this has resulted in a 10% increase in CO_2e emissions from gas consumption at the Hospital, however the use of the CHP has also delivered a 59% reduction in CO_2e emissions from electricity.

Overall, at Harrogate District Hospital, 884 tCO_2e has been saved from gas and electricity consumption since the baseline year, a 13% reduction. In total, a 16% reduction in CO_2e emissions from gas and electricity has been achieved at the Trust, despite the increase in gas emissions.

4.4.3 Oil

As seen in Figure 6, oil consumption at the Trust has fluctuated significantly. This is because oil is not a primary energy source at the Trust, it is only used as a backup source in the event that either the electricity or gas supply is disrupted.

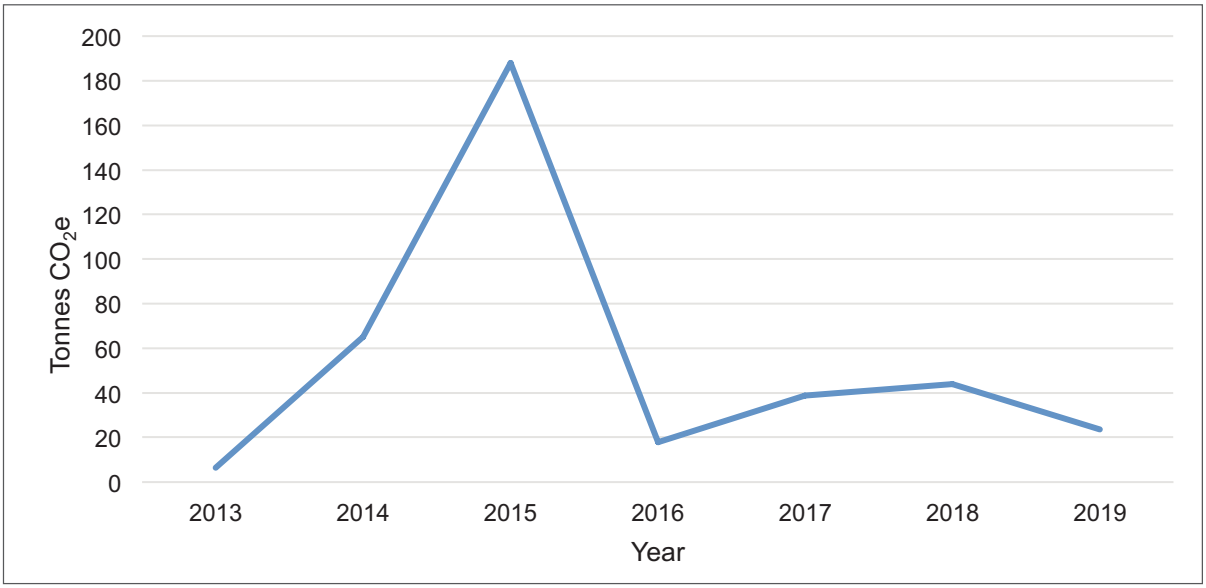


Figure 6 - tCO_2e emissions from oil consumption at the Trust

Having oil as a backup energy source is mandated by the Healthcare Technical Memoranda (HTM). The Trust chooses not to use oil as a primary energy source as it produces 1.4 times more CO_2e per kWh than natural gas. Oil is only used in the event of an emergency when gas or electricity supplies fail.

As shown in Table 1 - Carbon Baseline for Harrogate and District NHS Foundation Trust (page 14), based on 2013 data (tCO_2e), oil only contributes a small percentage of the total carbon baseline. To try to avoid the use of oil, the Trust aims to maintain our primary energy sources and equipment to reduce the risk of these events occurring.

4.4.4 Water

The emissions from water at the Trust have increased by approximately 1% since the baseline year. This is due to a sharp increase in water consumption in 2019 as shown in Figure 7.

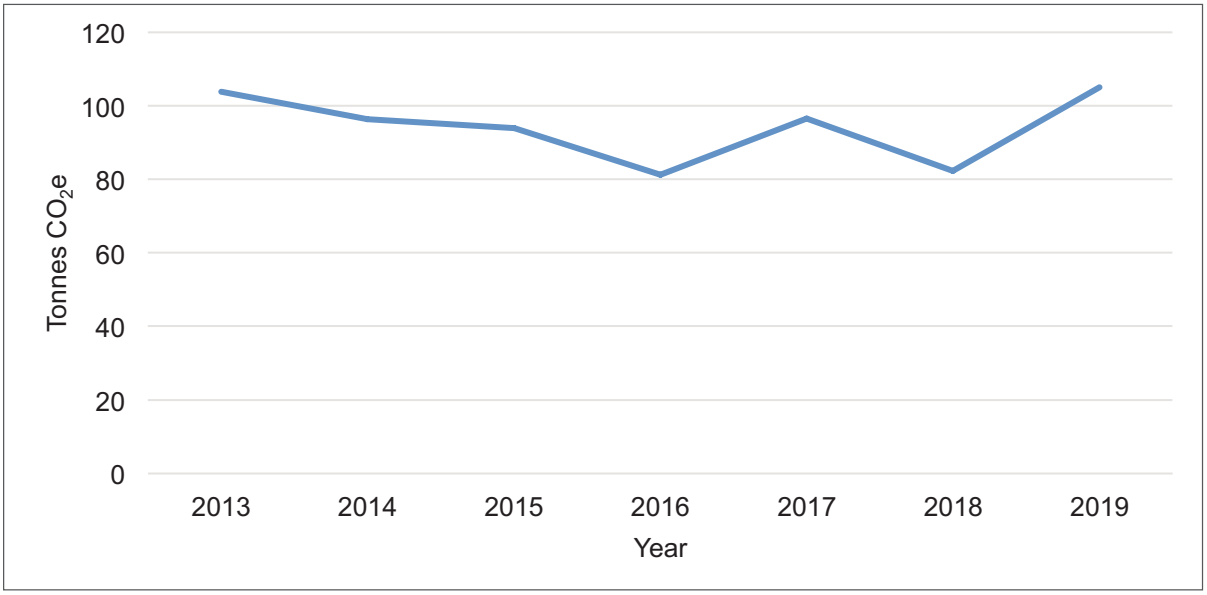


Figure 7 - CO_2e emissions from water consumption at the Trust.

In 2019 the Trust's sterile services underwent and extension, this resulted in an increase in water consumption during this year.

Although emissions from water consumption only make up a very small percentage of our carbon baseline (1.3%) it is important that we aim to use our resources efficiently to save water and reduce costs. We will work to improve the monitoring of water consumption at the Trust so that we can detect any leaks quickly to reduce unnecessary water loss. We will use the data we gather to identify strategic actions that can be implemented to reduce our water consumption.

4.4.5 Waste

Despite a spike in waste in 2017/18, the Trust has achieved a 65% reduction in the CO_2e emissions from waste disposal since the baseline year, as seen in Figure 8.

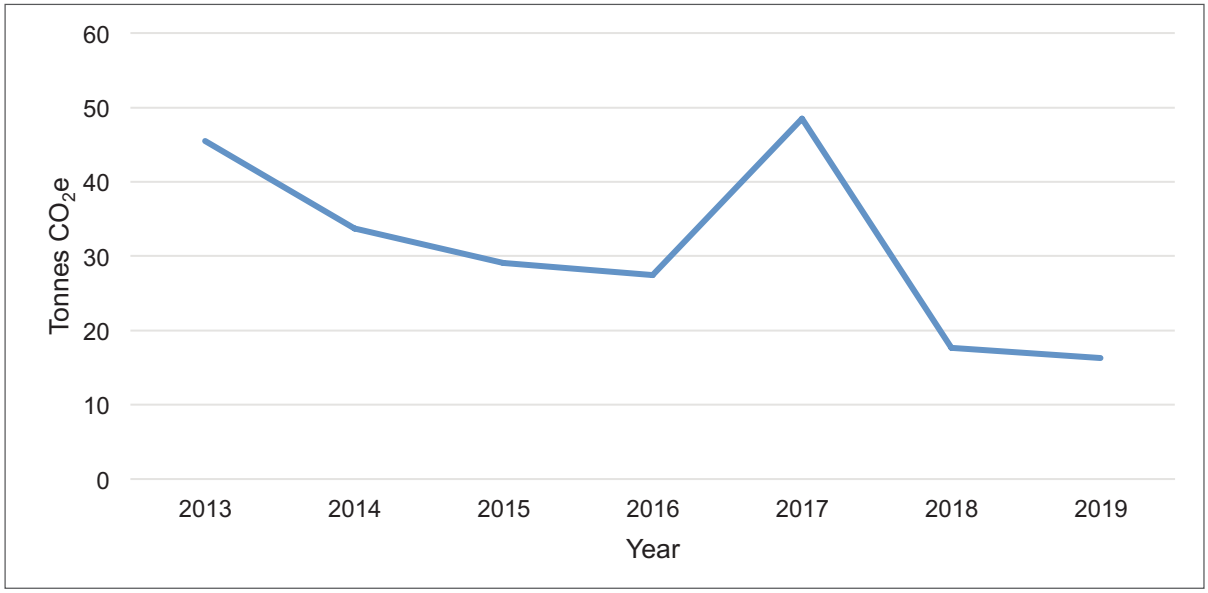


Figure 8 – CO_2e emissions from waste disposal at the Trust

This is a significant reduction, which has been achieved due to the Trust using the most efficient methods of disposal. The quantity of waste produced by the Trust has increased by 12% since the baseline year due to an increase in patient numbers.

In 2018, the Trust stopped sending waste to landfill, resulting in a large reduction in emissions. The Trust now use incineration, alternative treatment, and recycling to dispose of waste which have a lower carbon impact. The Trust also have a dedicated Waste Manager and use a waste reuse scheme to reduce the amount of waste requiring disposal.

To reduce these emissions further, the Trust will implement several actions guided by the waste hierarchy, which will look to reuse the creation of waste in the first instance, increase the amount of waste recycled or recovered, and then dispose of our remaining waste in the most efficient ways possible.

4.4.6 Anaesthetic Gases

Many medical procedures carried out at the Trust require the use of anaesthetic gases, most commonly the volatile agents Desflurane, Sevoflurane and Isoflurane.

Between the year 2016 and 2019 the Trust has reduced emissions from anaesthetic gases by 28%, a reduction of 237 tCO_2e as seen in Figure 9.

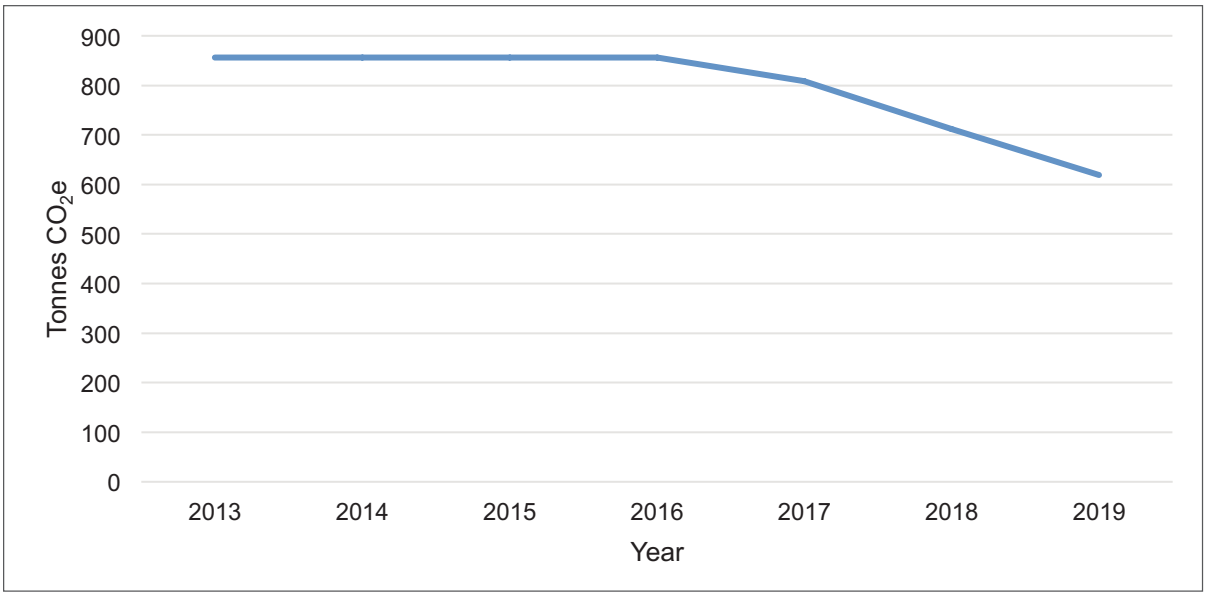


Figure 9 - CO_2e emissions from anaesthetic gases at the Trust

This reduction has been achieved by favouring the use of Sevoflurane over Desflurane. Desflurane has a Global Warming Potential (GWP) of 6,810, compared to Sevoflurane which has a GWP of only 440. Therefore, using Desflurane produces approximately 15 times more emissions than using Sevoflurane.

The use of anaesthetic gases is essential at the Trust so these emissions will not be reduced to zero. **The Trust has already removed Desflurane from its approved anaesthetic gases.**

4.4.7 Travel

Since the baseline year annual emissions from the Trust fleet have increased by 25% as shown in Figure 10. This is due to an increase in the mileage travelled since the baseline year.

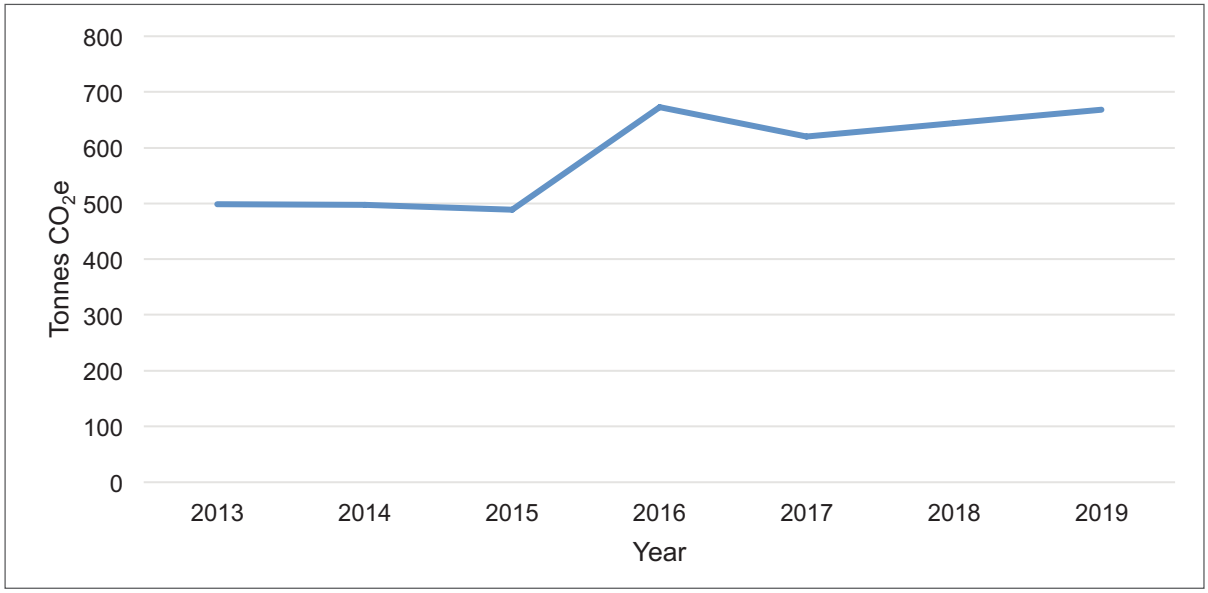


Figure 10 – CO_2e emissions from fleet travel at the Trust

In 2019/20 an additional 733,295 miles were travelled by the Trust than in the baseline year. As the Trust's fleet is comprised of petrol and diesel vehicles this has led to an increase in CO_2e emissions.

It is expected that emissions for 2020/21 will be significantly lower than in 2019/20. So far in 2020/21 there has been a 26% reduction in the average monthly mileage travelled compared to the baseline year. This is a 50% reduction from the previous year. If the amount of business travel continues at the current level, we predict that there will be a 35% reduction in CO_2e emissions from the baseline year by April 2021. This reduction has been achieved as a result of the restrictions due to the COVID-19 pandemic.

During the pandemic, staff who were not required to work at the Trust were able to work remotely from home. This reduced the need for commuting. Meetings were also conducted remotely which minimised business travel. To continue to provide services during the COVID-19 pandemic the Trust used Attend Anywhere, a secure web-based platform for patients to have video consultations. This platform enables the Trust to provide remote services and has therefore reduced the requirement for patients and staff to travel. Despite being introduced out of necessity, adopting the Attend Anywhere platform has enabled the Trust to reduce emissions and air pollution. Introducing this platform has also made our services more flexible and resilient.

The Trust intend to continue providing the option of remote consultations where appropriate, when face to face services resume, to enable patients to access our services from home and reduce the impacts of travel.

The Trust will continue to utilise technology to facilitate remote working and service provision following the pandemic to reduce travel. We will also implement a number of other measures to reduce the environmental impacts of our travel, such as transitioning to a low carbon fleet and encouraging active travel - such as walking or cycling.

5.0 A Pathway to Carbon Net-Zero

To date the Trust has achieved a reduction in total annual CO_2e emissions. However, achieving our ultimate target of reducing our emissions to net-zero will require a sustained effort.

This section will outline the trajectory the Trust will need to follow to become carbon net-zero by 2040. This section will also detail some of the national measures that are expected to be implemented that will assist the Trust in reducing residual emissions.

In addition to the 2040 net-zero carbon emissions target, the NHS have set an interim target for an 80% reduction in scope 1 emissions by 2028 to 2032. These targets are given in Section 3 Drivers and Targets.

These targets are not legally binding but have been set as a national commitment by NHS England to ensure that the NHS achieves net-zero emissions as soon as possible and achieves the mandatory national 2050 net-zero target.

The level of emissions the Trust will need to achieve to meet these targets are set out in Table 3 below. The Trust will monitor our emissions against these targets and publish our emissions annually.

Table 3 - NHS carbon emissions targets in percentage terms and tCO_2e

Year	Baseline	2020	2032	2040
Target Emission Reduction (%)	n/a	28	80	100
Target Emissions (tCO_2e)	8,553	6,843	1,711	0

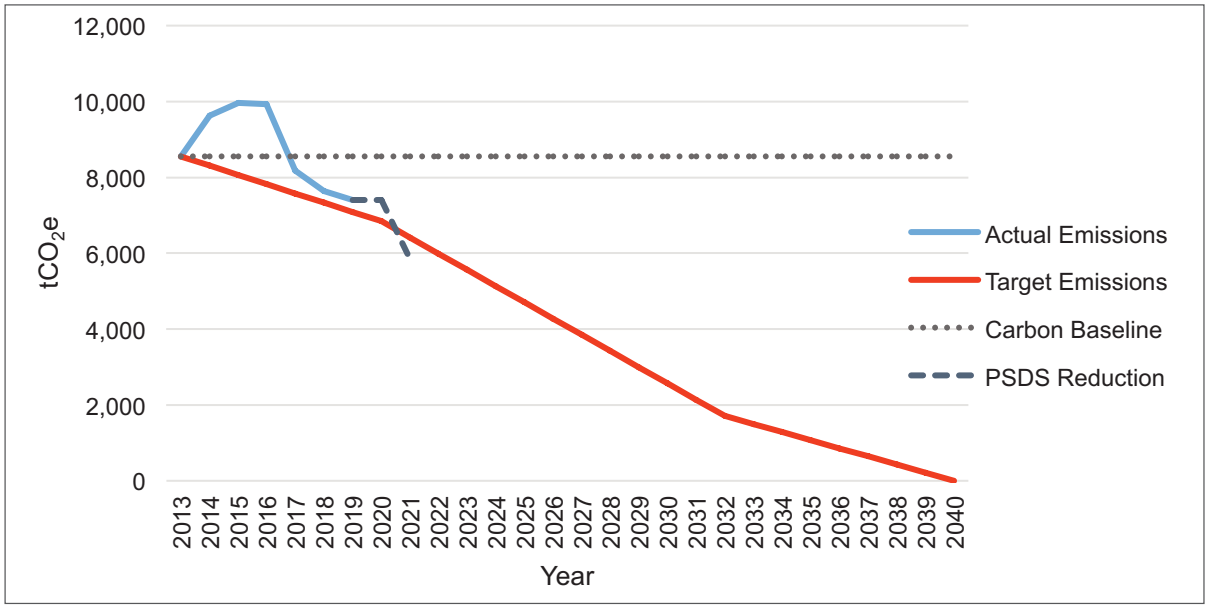


Figure 11 – Trust emissions against the NHS CO_2e emissions targets

Figure 11 shows the Trust's carbon footprint since 2013 baseline against the NHS's CO_2e target reductions. As shown, the Trust did not meet the 2020 reduction target of 28%, but have achieved an annual reduction in carbon emissions since 2015.

Reducing our residual 7,397 tCO_2e of emissions to net-zero will require actions to be taken across all aspects of the Trust to improve efficiency. Our Sustainable Action Plan, outlined in Section 6, will be used as a framework to monitor the implementation and effectiveness of the actions we will take over the next five years to reduce carbon emissions, air pollution and waste. When the Trust has successfully implemented all practicable actions and achieved the maximum reduction in emissions, we will then rely on national schemes to help reduce our residual emissions in the long-term.

5.1 Public Sector Decarbonisation Grant

The Public Sector Decarbonisation Scheme (PSDS) was set up as part of the government's 'Plan for Jobs 2020' to provide grants to public sector organisations to fund heat decarbonisation and energy efficiency projects. The scheme supports the UK's carbon net-zero ambition by encouraging the public sector to transition from fossil fuel heating systems to greener energy.

£1 billion was available as part of the scheme, and the Trust has been granted £14.1million of funding to support a range of decarbonisation schemes.

The Trust will implement a number of upgrades to the Harrogate District Hospital site to decarbonise heating and electricity and improve the efficiency of the estate. The planned interventions and the carbon reductions they will deliver are outlined in Table 4. As shown in Figure 11, the interventions and upgrades implemented as part of this scheme will bring the Trust ahead of the 2040 net-zero trajectory by reducing emissions to approximately 5,850 tCO_2e annually. These measures will also provide the Trust with a £192,390 annual financial saving.

Table 4 - Public Sector Decarbonisation Scheme interventions at Harrogate District Hospital

Baseline	2020	2032	2040
Heating	Air-source heat pump - Gas	£76,809	£549.10
	Air-source heat pump - Electricity	£77,403	£56.09
	Ground-source heat pump - Gas	£21,823	£176.93
	Ground-source heat pump - Electric	£22,641	£14.50
	Desteaming	£25,603	£183.03
Cooling	Air conditioning units	£11,095	£8.04
Insulation building fabric	Window replacement	£10,461	£76.07
	Roof insulation	£2,866	£20.49
Renewable energy	Photovoltaics	£12,381	£8.97
Ventilation	AHU ventilation	£60,571	£433.01
Motor controls	Pumping	£25,543	£18.51
Metering	BMS upgrades	-	-
	Total	**£347,196**	**£1,544.74**

To reduce reliance on gas for heating, the Trust will install a 300-kW air source heat pump to preheat the domestic water system and provide electricity. In Phase 2 of the project, we will also install a ground-source heat pump and reduce the Trust's gas and electricity emissions. We will also replace the steam calorifier with a plate heat exchanger. The heating projects implemented will save approximately 980 tCO_2e annually at the Trust and generate an annual financial saving of £69,473.

To produce renewable energy onsite and reduce our reliance on electricity from the national grid we will install solar photovoltaics. This will save 140,125 kWh of electricity annually and avoid the emission of approximately 9 tCO_2e. The Trust will also update cooling systems which will be remote controlled and will prevent excessive heating or cooling and maintain comfort levels in rooms.

To improve efficiency across our estate we will improve the insulation of our building fabric. We have identified flat roofs on our site which will be updated with increased insulation to improve the thermal performance of the building and reduce the escape of heat. We will also replace single glazed windows at the Harrogate site and repair any failed seals or hinges on the newer double glazing to reduce heat loss. These improvements will save the Trust 96.6 tCO_2e a year.

We will upgrade our Buildings Management Systems (BMS) to allow detailed metering across the site. The upgrade will enable remote monitoring and logging to optimise the operation of all current equipment at the site. Although we are unable to quantify the direct carbon reduction that will result from this project, introducing additional sub metering will enable the Trust to identify carbon hotspots across the estate. By identifying carbon hotspots, we can target future measures to ensure that we achieve carbon net-zero by 2040.

This project will also strive to procure equipment, materials, and labour from local and regional sources. This is to support local businesses, many of which will have been negatively impacted by the COVID-19 pandemic. As part of project, we will provide 102 manufacturing jobs and 98 installation jobs which support SMEs and local businesses.

5.2 National Considerations

The UK Government considers achieving carbon net-zero a national priority.

The Trust will implement actions to reduce our carbon emissions, air pollution and waste as much as possible, and will utilise national schemes to reduce the residual emissions to net-zero. This section will outline some of the key national schemes that are planned to reduce emissions and air pollution over the next 30 years which should help the Trust achieve net-zero by 2040.

To act as a framework to guide the UK's transition to a net-zero economy, the Government have set out their Ten Point Plan. The Plan will be supported by £5 billion in funding to kickstart the Green Industrial Revolution in the UK. The Government aims to create 250,000 new jobs by 2030 in green energy and zero-carbon technologies including offshore wind farms, nuclear plants, hydrogen power technologies and carbon capture to support a green recovery from the COVID-19 pandemic.

5.2.1 Renewable Energy

As outlined in section 5, the percentage of UK electricity generated from renewable sources increases each year, which reduces the carbon intensity of electricity in the UK. To enable the UK to achieve net-zero by 2050 and decarbonise electricity, the Government plans to increase the amount of renewable energy generated. 40 GW of energy is expected to be generated through offshore wind farms which will be coupled with carbon capture technologies and battery storage so this energy can meet demands. This is enough energy to power every home in the UK. There will also be an increase in low-carbon nuclear energy.

The increase in renewable electricity will make a significant difference to our carbon emissions from electricity. **The Trust currently procures 100% renewable electricity at our main site Harrogate District Hospital,** the increase in renewables would make the greatest difference in areas of the estate which are managed by NHS Property Services.

5.2.2 Emerging Technologies and Opportunities

The Ten Point Plan outlines the government's plans to drive the growth of low-carbon hydrogen to decarbonise heating. The transition to hydrogen technologies will be supported by the Net Zero Hydrogen Fund which will provide £240 million of capital co-investment by 2024/25.

The use of hydrogen for heating, would provide an alternative to fossil fuels such as natural gas and oil. Converting the gas grid to hydrogen could reduce UK carbon emissions by an estimated 73%. The Government intend to create 5GW of low-carbon hydrogen production capacity by 2030.

The government intends for large village heating trials to be carried out by 2025 with a potential Hydrogen Town by 2030. This is in addition to privately funded schemes, such as the H21 City Gate Project, which seeks to begin converting the gas grid to hydrogen within this decade.

The Government will consult on the role of 'hydrogen ready appliances' in 2022 in preparation for any future conversion of the gas grid. Subject to testing and successful trials, the Government will also work the Health and Safety Executive to enable up to 20% hydrogen blending in the gas grid by 2023.

Carbon capture will be utilised to ensure that hydrogen heating can be implemented across the UK and can be delivered at costs that can rival natural gas heating. If the UK can successfully transition to hydrogen heating, it would significantly reduce the Trust's carbon emissions from gas in the long term. This would dramatically reduce our overall carbon footprint, as gas is our largest contributor to emissions.

Viable new technologies are constantly emerging. The Trust has 15 years to reduce carbon emissions to net-zero. It is crucial that the Trust remains up to date with emerging technologies to ensure that we are using the best possible methods to decarbonise our Trust by 2035.

5.2.3 Transport

As part of the Ten Point Plan, the Government will encourage the use of public transport and active travel to continue to achieve a reduction in air pollution, as was observed during the COVID-19 pandemic.

The Government have promised funding to improve rail and bus networks across the UK. To upgrade and renew these networks more rail lines will be electrified, and bus and rail networks will be integrated, with the introduction of smart ticketing to make travelling by bus and rail more convenient.

To accompany this plan, a National Bus Strategy will be published. This strategy will detail plans to create more zero emissions buses and super buses which will provide a cheaper, more frequent bus service. It is expected that these schemes will facilitate easier travel by public transport and will therefore reduce the number of people who are reliant on cars.

Schemes are also planned to encourage active travel. To enable more people to cycle safely, the Government plans to build thousands of miles of segregated cycle lanes across England. To monitor the implementation of active travel schemes, an Active Travel body has been set up. This body will be responsible for assessing the active travel performance of local authorities and distribute funding accordingly. Encouraging active travel across England will not only help to reduce the Trust's emissions from staff and patient travel, it will also improve air quality and improve the health and wellbeing of the local population.

The Ten Point Plan also addresses emissions from private vehicles. From 2030 the sale of new petrol and diesel vehicles will be banned, followed by a ban on hybrid models by 2035. This ban has been brought forward by 10 years to accelerate the transition to electric vehicles. To support this, the Government will develop 'Gigafactories' to produce batteries to accommodate the expected increase in electric vehicle manufacturing. Electric vehicle charging points will also become more readily available.

Together these schemes will assist the Trust in reducing Scope 3 emissions. Scope 3 emissions are the most difficult to quantity and reduce as they outside of the Trust's direct control. The shift towards public and active travel will help to reduce our emissions from staff and patient travel and the transition to electric vehicles will reduce both travel and procurement emissions.

6.0 **Our Sustainable Action Plan**

As an organisation we are committing to the following:

We will achieve a 100% reduction of direct carbon dioxide equivalent (CO_2e) emissions by 2035. An 80% reduction will be achieved by 2030 at the latest.

We will achieve a 100% reduction of indirect CO_2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest.

6.1 Action and Objectives - Year 1

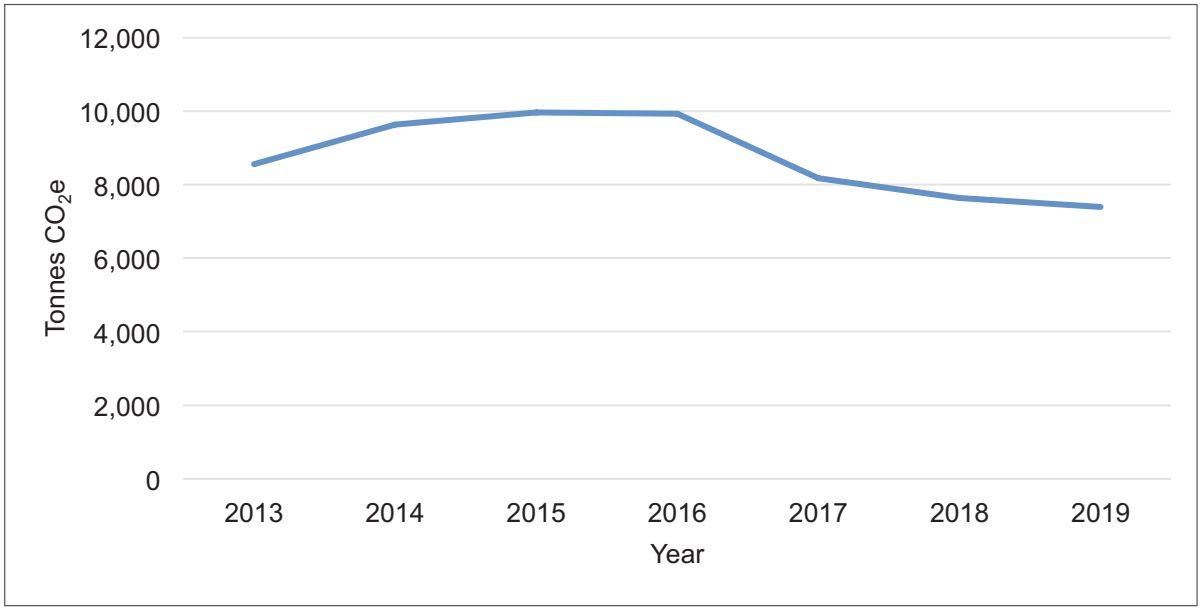
We know the scale of the challenge:

The Journey So Far

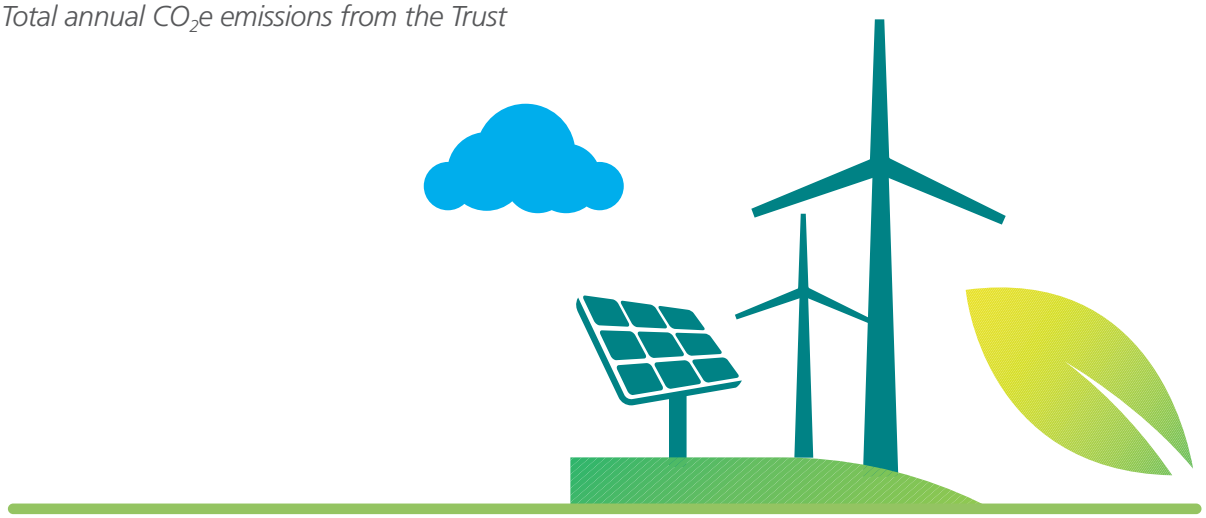
The Trust has reduced carbon emissions from the baseline in 2013. In the six years since then, a 14% reduction in CO_2e emissions has been achieved with annual emissions decreasing by 1,156 tCO_2e.

Year	Electricity	Gas	Oil	Water	Waste Arisings and Disposal	Business Travel	Anaesthetic Gases	Total
2013-14	2,273	4,770	6	104	46	499	856	8,554

Carbon Baseline for Harrogate and District Foundation Trust based on 2013 data (tCO_2e)



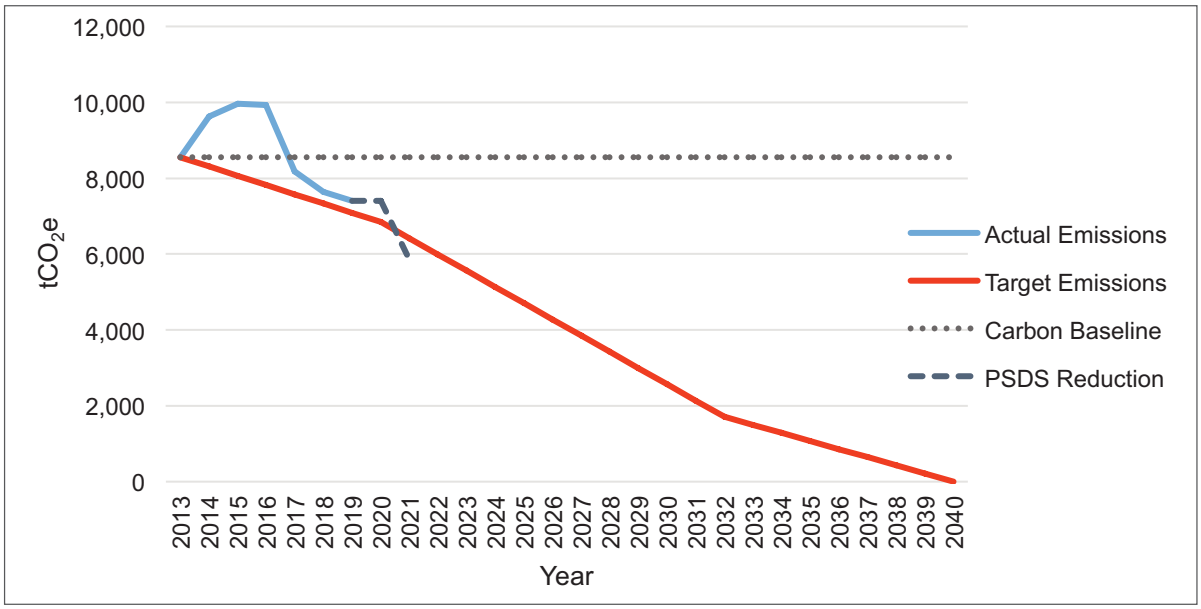
Total annual CO_2e emissions from the Trust



The Future Challenge

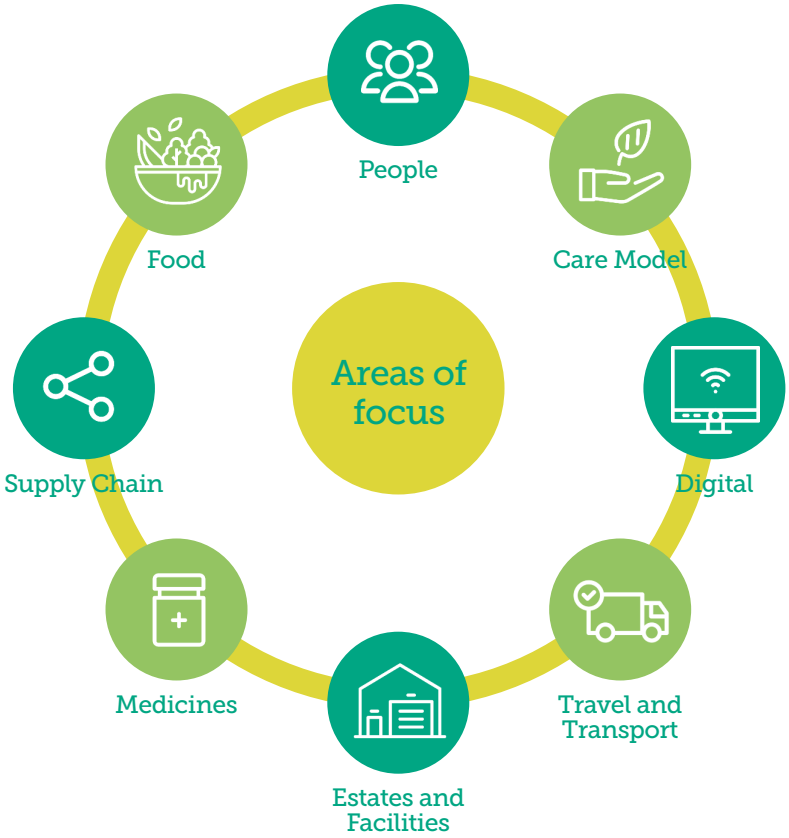
	Baseline	2020	2032	2040
Target Emission Reduction (%)	n/a	28	80	100
Target Emissions (tCO_2e)	8,553	6,843	1,711	0

NHS carbon emissions targets in percentage terms and tCO_2e



Trust emissions against the NHS CO_2e emissions targets

To meet this challenge we are focusing on the following:



6.1.1 People and Leadership

Create the governance infrastructure and engage with our colleagues and partners to deliver our green objectives. We will develop a communication plan which we will rollout and support the engagement with all our partners. We recognise the key role our 'green champions' will play in delivering our plan acting as role models for the rest of our organisations.

The support of our respective Board of Directors will be essential. Each Board will identify a Non Executive Director who will have a role/interest in supporting the green agenda.

6.1.2 Sustainable Models of Care

Embedding net-zero principles across all clinical services, considering carbon reduction opportunities in the way care is delivered.

6.1.3 Digital Transformation

Harness digital technology and systems to streamline service delivery and supporting functions.

6.1.4 Travel and Transport

To reduce the carbon emissions arising from the travel and transport associated with our Trust. Develop a travel plan and engage with partner organisations to explore schemes in relation to walking, cycling and public transport.

6.1.5 Estates and Facilities

Focus on reducing the carbon emissions arising from our buildings and infrastructure. Explore opportunities for reducing waste. Develop an energy strategy to support the future infrastructure on the site.

6.1.6 Medicines

Consider how we can reduce the carbon emissions related to our prescribing and use of medicines and medical products.

6.1.7 Recruitment/ Induction/Appraisal

Include discussions with staff as part of the recruitment/ induction and appraisal process on how they can contribute to delivering our green plan.

6.1.8 Supply Chain and Procurement

Consider how we may use individual or collective purchasing power and decisions to reduce carbon embedded in their supply chains.

6.1.9 Food and Nutrition

Consider ways to reduce the carbon emissions from the food made, processed or served within the organisation.

6.1.10 Governance

How we plan to ensure sustainability is embedded in our programmes and reporting structure.

Our Green Plan covers a three year period but will be reviewed and updated annually. With this in mind the following sets out our planned actions for the first year.

6.2 First Year Activity

The following outlines our focus over the next 12 months.

Area of work	Action	Date for Completion
People and Leadership	• Sustainability board created	• April 2022'
	• Green working group to deliver the programme of work	• April 2022
	• Green 'colleague panel' to engage and generate ideas	• May 2022
	• Carbon Literacy training for key colleagues	• July 2022'
	• Develop a communications strategy and work with partners to develop a strong and cohesive narrative to include: • Development of a sustainability charter • 10 top initiatives	• April 2022
	• Explore inclusion of sustainability initiatives as part of mandatory training across the organisation	• December 2022
Sustainable Models of Care	• Understand the opportunities to deliver care in a more sustainable way	• Scope over next 6 months
	• Connect the development of new models of OP care to reduction in carbon	• Scope over next 6 months
	• Include carbon reduction as a criteria within service change decisions	• Include within Business Case process – June 22
Digital Transformation	• Support delivery of virtual / telephone clinics	• Link to development of Digital Strategy work and agree timeline
	• Paper-free outpatients in line with digital strategy	
	• Test digital roadmap against carbon usage and include carbon reduction within investment decisions	
Travel and Transport	• Engage travel consultant to advise on a new Travel Plan	• April 2022
	• Develop travel plan for roll out	• May 2022
	• Work with partners to introduce incentives to utilise public transport	• June 2022
	• Any lease cars will be ultra-low / zero emission only	• June 2022
	• Install electric charging points on the hospital site, subject to the development of a plan for additional infrastructure for the Harrogate District Hospital site	• Mid 2023
	• Liaise with landlords of properties to develop charging point options	• Mid 2023

Area of work	Action	Date for Completion
Estates and Facilities	• Deliver the Salix programme and reduce energy usage • Ensure all building designs / refurbishments are environmentally considerate	• December 2022
Medicines	• Link the Scan 4 Safety project and Omnicell roll out to reduction of waste • Explore opportunities to reduce use of high use inhalers • Ensure continued compliance with agreed anaesthetic gas formulary	• Autumn 2022 • Autumn 2022 • Autumn 2022
Supply Chain and Procurement	• All contracts with suppliers to include carbon reduction clause • Understand best practice and develop a procurement plan as part of WYAAT, using collaborative procurement to drive change	• June 2022 • Autumn 2022
Food	• Ensure food is locally sourced • Undertake review of provisions to reduce food waste • Contribute to the revised food and drink strategy	• June 2022 • June 2022 • End 2022

This action plan will be reviewed and updated regularly through the Sustainability Board. The Board will also be responsible for identifying executive sponsors to take forward the detailed work associated with each of the areas in the action plan.

A series of measurements will also need to be developed which can be monitored by both organisations through their respective Integrated Board Reports. A review of the progress against the agreed action plan will be undertaken in 18 months with a view to further initiatives being further explored to support the delivery of our sustainability agenda.

We will underpin this work by:

Embedding the Sustainability Board within our governance structure

Report routinely to SMT / Boards

Include green KPIs within the IBR

Ensure carbon reduction is a consideration within key reports and decision-making processes

Review of our arrangements within future Internal Audit programme

Produce an Annual Report

Summary

Sustainability is a key issue for everyone and we have set out a number of initiatives we will take forward over the next three years which support our commitment to delivering change.

In summary we will:

USE **less energy**

and the energy we do use we will aim to deliver in more efficient ways

USE **local suppliers**

to provide our food, materials and resources

Recycle where possible

Ask everyone how they can help to **deliver change**

and 'do their bit' no matter how small as all actions can make a difference

Encourage everyone **to be involved**

and help them to understand the importance of this work, BUT don't force the agenda

RECOGNISE THAT **small changes**

can support major change

We recognise there are some challenges around the agenda but everyone can support the contribution in our 6 key actions we have developed.

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3.4

Board of Directors (Public)
30th March 2022

Title:	Section 75 Update
Responsible Director:	Chief Operating Officer
Author:	Deputy Chief Operating Officer Alliance Director, Harrogate and Rural Alliance

Purpose of the report and summary of key issues:	*To update the Trust Board on the section 75 position and seek support for a one year extension with the intention to use the 12 months to work towards greater integration.*	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	✓
	BAF3.5 To provide high quality public health 0-19 services	✓
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks		
Report History:	This report was presented to Senior Management Team on 23rd march 2022.	
Recommendation:	It is recommended that the Trust Board note the items contained within this report and support the 12 month extension to the Section 75 agreement.	

Harrogate & District NHS Foundation Trust

Trust Board Update

23 March 2022

Harrogate and Rural Alliance (HARA): Extension to Section 75 Agreements

1.0 Purpose Of Report

The purpose of this report is to update and seek agreement from board colleagues on the extension of the existing Section 75 County Council/NHS provider agreement for the integrated community health and social care services in the Harrogate district.

It will also form the basis for a future report about the next stages of the service's development, alongside potential revisions to the Section 75s and any public consultation requirements.

2.0 Background

In Autumn 2019 the HDFT Board approved a provider Section 75s covering Harrogate and District NHS Foundations Trust involvement in the Harrogate & Rural Alliance (HARA). This was one of two Section 75's (one provider and one commissioner) to establish the agreements to govern and manage shared planning and commissioning and delivery of integrated services, supported by an indicative set of core and aligned budgets in the geography of Harrogate and Rural District.

The service went "live" from 30 September 2019, bringing together 400 frontline community health and social care staff and managers, employed by Harrogate and District NHS Foundation Trust (HDFT) and North Yorkshire County Council (NYCC), and led by an integrated management team reporting to an Alliance Director who, in turn, is accountable to an NYCC Adult Social Care Assistant Director and the HDFT Operational Director for Community & Children. The aligned spend of the service started at £50m.

HARA is a partnership involving the NHS (North Yorkshire Clinical Commissioning Group, HDFT, Tees Esk and Wear Valleys NHS Foundation Trust and Yorkshire Health Network GP Federation and the 4 Primary Care Networks in the Harrogate district) and the vision for the programme is that it will: "Deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Services will be aligned to defined primary care networks to create an enhanced local offer that delivers benefit for the population through maximising the local resource and assets".

The HARA Partners have a shared vision of a timely transformation towards an integrated approach to commissioning and provision of health care, public health and social care services in Harrogate and Rural District. The parties believe that co-ordinating and integrating their planning, commissioning and delivery activities will help facilitate the best use of resources to support the local resident and patient population.

The continued ambition for the HARA service is that it has:

- Prevention as the starting point.
- Care anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource.
- Care delivered at home wherever possible
- A focus on population health as opposed to organisations.
- Where possible, a Primary Care Practice Centred Model (currently it operated a hybrid model between practices and geography).
- Primary care involvement and commitment (ideally daily)
- Active involvement from people who use services and carers.

The purpose of the two Section 75s, agreed in 2019, was to put in place the agreements to govern and manage shared planning and commissioning and delivery of integrated services, supported by an indicative set of core and aligned budgets in the geography of Harrogate and Rural District. The Harrogate and Rural Alliance Board (HARAB) was established as the vehicle through which all parties will discharge their shared responsibilities in respect of working together within the defined financial schedules. The Agreements apply to the defined health, public health and social care services supplied to the residents of North Yorkshire County Council and to patients registered with the GP Practices within the former Harrogate and Rural District CCG.

Annex 1 contains a copy of the current commissioner Section 75 and Annex 2 a copy of the current provider agreement.

3.0 Issues for consideration

Extension of the Two Section 75s

The purpose of the extension is to allow HARA to continue to operate for a further year whilst work is undertaken on the future scope of HARA. Over the last two years, despite the focus on the COVID-19 response, much foundational work has been undertaken. This includes:

- Maturing of relationships between senior leaders
- Establishment of an integrated management structure, with an Alliance Director
- Implementation of Integrated Daily Huddles in the four HARA localities
- Establishment of a framework for monthly Multidisciplinary Team Meetings in each of the four Primary Care Networks
- Development of new services including an Acute Response and Rehabilitation in the Community, Home and Hospital (ARCH) service.

The context in which HARA operates will be changing over the next twelve months and it will need to respond to these changes. There are a number of key factors affecting the context. These include:

- White Paper "Health and social care integration: joining up care for people, places and populations
- Local Government Review implementation
- White Paper "People at the Heart of Care: adult social care reform"
- The Health and Care Bill's changes in the Governance and Structure of the NHS with Integrated Care Systems becoming statutory bodies and the abolition of CCGs.

Given this context, this report proposes a simple extension of the Section 75s for one year, which will allow HARA to continue to operate within its current governance framework for a further year to 31 March 2023. During this period work will be completed on the future scope of HARA, taking into account changes in Local Government, Social Care and the NHS noted above.

The requirements for consultation

A formal consultation was undertaken as part of the process for the approval of the Section 75s in 2019, which included the options to extend with the Section 75s.

Some amendments may be required as NHS statutory bodies change, in the coming months, and to take account of other organisational changes. If needed the variation process outlined in the Section 75 Agreements will be followed. Whether a consultation is required at this stage may depend on how fundamental the changes are.

4.0 Performance Implications

None as it is an extension of current arrangements which are subject to regular service monitoring by Elected Members and officers within the County Council and, also, by NHS counterparts.

5.0 Financial Implications

There are no new financial implications as this is an extension of the current arrangements. Whilst the Section 75 contains the powers to establish pooled funds, to date these powers have not been exercised. At the end of quarter 3 in 2021/22 the HARA budget was in total £49.8m with an NYCC Budget of £43.1m and an NHS budget of £6.7m. The parties to these Agreements are not sharing financial risk.

6.0 Legal Implications and Governance compliance

As a recap, Section 75 of the 2006 NHS Act gives powers to local authorities and the NHS 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; to establish integrated commissioning arrangements and to establish integrated management functions in relation to health and social care services.

The proposal is to extend an existing provider S75 and commissioner S75 for 12 months which is permitted in the terms of the S75 Agreements.

Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 ("Regulations") enable NHS bodies to exercise prescribed local authority health-related functions in conjunction with their own NHS functions (provider S75 Agreement) and to establish integrated commissioning arrangements (commissioner S75 agreement).

In relation to the Provider S75 Agreement, under the Public Contracts Regulations 2015 (PCRs) two contracting authorities can enter into a collaboration agreement (co-operation) subject to meeting the tests of Regulation 12 (7) PCRs (known as Hamburg) without the need to undertake a procurement exercise.

7.0 Equalities Implications

The Equality Impact Assessments will be reviewed as part of the extension arrangements, including revised proposals to be presented within the period 2022/23.

8.0 Recommendations

- That the Board of Directors approves a twelve month extension to the Provider HARA Section 75 Agreements. NYCCG and NYCC will be reviewing and signing off the extension to the commissioner section 75.

- That further proposals for future development of the service and any revisions to the Section 75 Agreements are brought back for consideration within the extension period, to enable any decisions and public consultation to take place with respect to longer-term arrangements being agreed beyond 2022/23.

Chris Watson, Alliance Director, Harrogate and Rural Alliance
15th March 2022

Annex 1

DATED 3rd October 2019

NHS Harrogate and Rural District Clinical Commissioning Group (1)

and

North Yorkshire County Council (2)

SECTION 75 PARTNERSHIP AGREEMENT

For the creation of shared planning and commissioning arrangements for Health Care, Public Health and Adult Social Care Service in the geography of Harrogate and Rural District

These arrangements include the use of Section 75 powers to establish core and aligned budgets to support delivery of integrated services to the Harrogate and Rural District population

NHS Harrogate and Rural District Clinical Commissioning Group

North Yorkshire County Council

On behalf of NHS Harrogate and Rural District Clinical Commissioning Group
Amanda Bloor, Accountable Officer, North Yorkshire Clinical Commissioning Groups

On behalf of North Yorkshire County Council
Richard Flinton, Chief Executive Officer

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1. The Parties:

1) **NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP (CCG)** of 1 Grimbald Crag Court, St James Business Park, Knaresborough, HG5 8QB ("the CCG");

2) **NORTH YORKSHIRE COUNTY COUNCIL** of County Hall, Northallerton, DL7 8AD ("the Council")

2. Background

2.1 The Council has responsibility for commissioning and/or providing public health and social care services on behalf of the resident population of the borough of Harrogate.

2.2 The CCG has the responsibility for commissioning health services pursuant to the National Health Service Act 2006 for the population of people resident in the Harrogate and Rural District CCG area and patients registered to GP practices within same area.

2.3 Section 75 of the 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; to establish integrated commissioning arrangements and to establish integrated management functions in relation to health and social care services.

2.4 The purpose of the Agreement is to put in place the arrangements required to govern and manage shared planning and commissioning of integrated services, supported by a Pooled Fund in the geography of Harrogate and Rural District. The Harrogate and Rural Alliance Board (HARAB) will be established as the vehicle through which all parties will discharge their shared responsibilities in respect of working together within the defined financial schedules. This Agreement applies to the defined health, public health and social care services provided to the residents of the North Yorkshire County Council and to patients registered with the GP Practices within the Harrogate and Rural District CCG area and whose medical services contracts are managed by the CCG.

2.5 All partner organisations within the geographical scope of the Agreement face significant financial challenges despite delivering cost saving programmes over recent years. The health and social care system overall is challenged in terms of continuing to deliver high quality care within reduced financial envelopes and within the context of austerity.

2.6 The Parties will remain sovereign in line with their statutory duties and responsibilities.

2.7 These Partnership Arrangements have been established pursuant to Section 75 of the Act and pursuant to the Regulations.

3 Joint vision

3.1 The vision for the programme is that it will:

"Deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Services will be aligned to defined primary care networks to create an enhanced local offer that delivers benefit for the population through maximising the local resource and assets"

3.2 The Parties have a shared vision of a timely transformation towards an integrated approach to commissioning and provision of health care, public health and social care services in Harrogate and Rural District. The parties believe that co-ordinating and integrating their planning, commissioning and delivery activities will help facilitate the best use of resources to support the local resident and patient population.

3.3 The ambition for the programme is that the new integrated service will:

- Have prevention as the starting point.
- Develop a new model, anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource.
- Provide care at home wherever possible.
- Focus on population health as opposed to organisations.
- Where possible, be a GP practice centred model (hybrid model between practices and geography).
- Include GP daily involvement and commitment
- Have active involvement from people who use services and carers.

3.4 The value of working together as commissioners and providers locally to bring about change in a meaningful way is recognised. There is a clear desire to build on the strength of the provider and commissioner relationships in the Harrogate and Rural area to deliver affordable and sustainable health and care. Therefore, the programme aims to develop and create a new integrated service model. This Agreement reflects the Parties' commitment to the integration of services to be delivered against agreed measures of effectiveness and financial outcomes.

3.5 A Partnership Framework has been put in place to support the formal and legal arrangements between partner organisations. The objective of the Partnership Framework is to improve the outcomes for health and social care users from commissioned services through closer working between the National Health Service and Local Government to the extent (from time to time and subject to the terms of this Agreement) that it is lawful to do so and consistent with the obligations of the Parties to co-operate with each other in the planning and commissioning of services.

3.6 The Agreement is grounded in the following Principles which have been agreed by the Partners:

Principles to be applied to the integrated care delivery model	
1	Demonstrates an integrated approach to prevention and care to include physical and mental health integrated with social care.
2	Focuses on self-care and prevention to promote independence and reduce pressures on the health and social care system.
3	Clear access points for people to receive modern health and social care services from co- located teams.
4	Ensures people have access to high quality services when needed within a simplified system.
5	Works closely with the community and the voluntary sector.
6	Evidence of Alliance Agreement/partnership to facilitate whole system approach, which is about more than a document or a contract and refer to an alliance style of working, based on constructive, productive relationships.
7	Has effective governance arrangements.
8	Plans to vary the flow of money and resources are identified and agreed underpinned by risk/gain share agreements.
9	Uses whole population budgets and is not based on paying for single events (e.g. “procedures”, “admissions”, “attendances”, “contacts”).
10	Describes how outcomes will be achieved within available resources and timeframe.
11	Any shift in activity between providers within the system needs to be balanced by demonstrable shift in resource where required.
12	The change management plan supports staff through change, identifies and introduces any required new skills and promotes innovation.
13	A clear estates strategy that supports delivery of a modern health and care estate.
14	Has a strategic leadership role for General practice which recognises and develops the full spectrum of primary care service delivery
15	Enables strong clinical and practitioner operational leadership, including the GP as the expert generalist with the person.
16	To improve the quality and efficiency of services enables the sharing of records, data and information including integrating information management and technology.
17	Enables innovation in service provision using technology.
18	Seeks continuous and effective involvement with public, patient and colleague involvement. Where service changes are proposed, ensure consultation in line with legislation and best practice.

4. Section 75 commissioning document purpose

4.1 The Parties believe that the commissioning arrangements proposed by this Agreement fulfil the objectives set out by: the North Yorkshire Health and Wellbeing Board within the Joint Health and Wellbeing Strategy; the NHS Constitution; the key plans of the NHS locally and nationally; of North Yorkshire County Council and guidance in so far as it relates to local,

regional and national requirements, the Council Plan and the Council's relevant strategic directorate business plans.

4.2 The purpose of this Section 75 Agreement is to:

4.2.2 Record the intentions of the Parties to work together in planning and commissioning health, public health and adult social care services.

4.2.3 Allow for the Pooled Fund arrangements, including provision for services set out in Schedule Two. These arrangements will be reviewed throughout the mobilisation phase (March 2019 to September 2019) to allow adjustment in line with the objectives of the Programme. Any change to the services after 1 October 2019 will be enacted in line with Clause 35 of the Agreement.

4.2.4 Describe the role of the Harrogate and Rural Alliance Board within the Partnership Framework and to make formal arrangements for its procedures and actions.

4.2.5 Describe the health, public health and social care services, as set out in Schedule Two, to be covered by the Partnership Framework.

4.2.6 Make the necessary delegation, governance, audit and regulatory arrangements to facilitate the purposes listed above as agreed by each organisation within this Agreement. Each organisation will remain sovereign for decision making through its own internal procedures.

5. Definitions and interpretation

5.1 In this Agreement, unless the context otherwise requires, Schedule One pertains.

6. Joint planning and commissioning

6.1 The arrangements set out in this Agreement shall be how the Parties work in partnership to secure the services described in Schedule Two.

6.2 During the period of this Agreement the Parties will co-operate with a view to introducing integrated commissioning where appropriate and with the agreement of both Parties. Where this is not appropriate the Parties will co-operate to ensure that planning and commissioning by all Parties is done in a co-ordinated and joined up manner.

7. Joint planning and commissioning objectives

7.1 The Parties shall seek to achieve the following objectives through the planning and commissioning arrangements set out in this Agreement:

7.1.1 Improved quality of care through integrated service planning and delivery arrangements.

7.1.2 Ensure better investment and spend of public monies to meet the statutory requirements of each agency and to deliver the service and financial imperatives of both parties.

7.1.3 Improved service delivery efficiencies (cashable or non-cashable) through joint planning and commissioning arrangements.

7.1.4 Exploration of increased integration of service planning and commissioning arrangements.

7.1.5 Progression of any steps required to develop a future procurement strategy for the better integration of services.

8. Planning and commissioning arrangements covered by this Agreement

8.1 The Parties propose to plan and commission the services described in Schedule Two of this Agreement subject to the governance arrangements set out in Schedule Four of this Agreement. Under the Agreement the Parties retain independence in their commissioning arrangements relating to the specified services and will determine what services will be integrated and how they will achieve this.

8.2 To facilitate these arrangements, the Responsible Officers will establish a formal quarterly Commissioner Review meeting as set out in Schedule Six Part Two of this Agreement.

8.3 The Commissioner Review meeting will be a forum for the Responsible Officers to enact this Agreement as follows:

8.3.1 To determine any actions necessary to support the objectives of the integrated delivery model; to act upon and/or communicate these through the Partnership Framework in line with the principles set out in Clause 3.7 of this Agreement.

8.3.3 To formally receive and record reports submitted to the Parties as set out in this Agreement.

8.3.3 To consider variation, extension or termination of this Agreement at 31 March 2021 subject to Clause 35.1 of this Agreement.

8.3.4 To agree to, and oversee, the use of HSCA 2012 flexibilities for establishing and then operating the Pooled Fund and joint planning and commissioning between the Parties under the terms of this Agreement.

8.3.5 To approve the overall Pooled Fund, the component Pooled Service Budgets and the required Party contributions to the Pooled Fund.

8.3.6 To monitor the Pooled Fund in accordance with NHS England guidance and the requirements of the Council, making use of recommended best practice templates and to report to the Responsible Officers for sign off and in relation to any specific required annual returns relevant to the Parties' statutory duties and responsibilities in so far as they relate to this Agreement.

8.3.7 To receive reports from the Finance Lead(s) who will form part of the membership of the Commissioner Review meeting as set out in Schedule Six Part Two and will, in particular report on: the forecast financial position compared to the planned financial position; operational and strategic cost pressures of each Party that may impact on this Agreement; any cumulative risk factors that may impact on this Agreement.

8.3.8 To receive proposals from the Finance Lead(s) for managing the financial aspects of the Pooled Fund for consideration by both Parties, including the initial separate management of the Parties contributions and then, following any pooling of the aligned resources, the risk management arrangements associated with this.

8.3.9 To receive (as a minimum) quarterly reports from the Alliance Director subject to Clause 16.1.7, in a form to be agreed, to fulfil the Parties' performance management requirements and to agree appropriate action resulting from the above reports were necessary.

8.3.10 To review the role and effectiveness of the joint planning and commissioning arrangements through achievement of shared objectives and targets, ultimately demonstrating improved outcomes for service users and making recommendations to the Council and CCG as to any amendment to its functions.

8.3.11 To report to the sovereign organisations, on an appropriate basis, on the joint planning and commissioning arrangements to ensure appropriate reporting and accountability in line with each Party's internal governance arrangements.

8.3.12 Any other purposes as may be deemed appropriate by the Parties and agreed as set out in this Agreement.

8.4 Where there is agreement on integrated commissioning, the commissioning contracts will initially be between the Party with responsibility for commissioning of that service and the provider selected by the commissioning party and subject to the integrated service delivery arrangements agreed.

8.5 Following the establishment of integrated commissioning arrangements through the Pooled Fund, the contracting role may be undertaken by either Party or as otherwise provided for under this Agreement as long as both Parties agree as set out in a written agreement between the Parties

.

8.6 Provider performance will be considered as part of the quarterly Commissioner Review meeting set out in Clause 16.1.7.

9. Delegations

9.1 Under the arrangements the Parties retain independence and sovereignty in their commissioning arrangements relating to the specified services. Where it is deemed by the Parties that the objectives of this Agreement can be met through integrated commissioning arrangements, the Parties will work together, and with other members of the Partnership Framework, in partnership (but not so as to create the legal relationship of partnership between them), to implement the shared planning and delivery arrangements set out in this Agreement. To support commissioning for the services to be provided under Schedule Two the Parties agree that:

9.1.1 In the event that any delegation of powers by any of the Parties provided for under this Agreement shall require obtaining the consent or approval of any Minister of the Crown, Government Department or any other body formally constituted for that (and other) purposes then the Party required to seek such consent or approval shall use its best endeavours to do so and in a timely fashion, efficiently and without unreasonable delay.

9.1.2 The Parties shall only delegate such powers to each other as are required to implement the terms of this Agreement and through consent and specifically reserve all other statutory powers and functions to themselves.

10. Partial or incomplete delegations

10.1 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant service as set out in Schedule Two. The Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with those statutory constraints subject to 9.1.1 and 9.1.2.

11. Parties mutual responsibilities

11.1 The Parties agree that, where appropriate and in relation to this Agreement, they shall work together for the purposes of undertaking shared planning and commissioning arrangements to achieve the objectives described in Clause 7 and shall:

11.1.1 Co-operate with each other in the conduct of all activities relating to the objectives.

11.1.2 Undertake the necessary governance processes to support Clauses 9.1.1 and 9.1.2, including any formal arrangements to give all necessary third-party consents or notifications.

11.1.3 Make all and any agreed contributions into the Pooled Fund as set out in Schedule Three promptly and without deductions for the purposes of providing the services.

11.1.4 Make any necessary arrangements to make payments from the Pooled Fund as agreed by the Parties to provide the services that have been commissioned under this Agreement.

11.1.5 Operate all their related activities and services in a manner that is compatible with the objectives set out in Clause 7 so far as they are not inconsistent with their other legal obligations or formal planning and commissioning arrangements.

11.1.6 Operate the joint planning and commissioning arrangements set out in Clause 8 and fulfilling all responsibilities relating to them as agreed in this Agreement.

11.1.7 Both Parties shall work in co-operation and shall endeavour to ensure that the services specified in Schedule Two are commissioned with all due skill, care and attention through the Partnership Arrangements and in the spirit of the Partnership Framework.

11.1.8 Exercise candour in their dealings with each other and conduct themselves transparently in any negotiations, including disclosing any reasonable prospect that there shall be a conflict of interest between them.

11.1.9 Unless otherwise specifically agreed in writing, overspends in relation to this Agreement are the responsibility of the relevant commissioning organisation.

12. Legacy contracts, transitional commissioning arrangements

12.1 All Parties agree that any contracts for the full or partial delivery of the services specified in Schedule Two that are continuing at the date of this Agreement and which are between the Parties and other providers (legacy contracts) will be unaffected by this Agreement.

13. Role of the Harrogate and Rural Alliance Board

13.1 The main aim of the HARAB is to deliver care wrapped around primary care networks of c. 30-50,000 population to support strategic delivery of an integrated health and social care model which optimises the Parties' resources to improve health and care outcomes for the defined population.

13.2 The HARAB will provide strategic direction on issues of operational delivery for the services described in Schedule Two of this Agreement. The HARAB will operate within a defined Terms of Reference as set out in Schedule Six of this Agreement.

13.3 Implementation of the decisions taken by the HARAB shall be under the overall direction of the Alliance Director as the lead operational manager, as reflected in the Partnership Framework.

13.4 The Parties may, at their discretion, either make their own commissioning arrangements or instruct the HARAB, through the Alliance Director, to make such arrangements as may be required in relation to the services, subject to sovereign governance processes.

13.5 The Parties reserve the right to escalate HARAB issues to the Commissioner Review Meeting as defined in Schedule Six of this Agreement.

14. Monitoring and review of the Harrogate and Rural Alliance Board

14.1 The Responsible Officers of the Parties shall from time to time agree joint arrangements to monitor and review the way the HARAB exercises its functions as set out in this Agreement to ensure that they are exercised in compliance with the law and with the terms of this Agreement and that the way they are exercised is both effective and appropriate.

14.2 The HARAB will make any necessary reports to the Health and Wellbeing Board outside the terms of this Agreement as may be required under the HSCA 2012.

15. Financial accountability and risk sharing

15.1 Each party will maintain its existing financial accountability and internal and external audit arrangements and shall bear its own risks in relation to the arrangements set out in this Agreement. By way of clarification this means that the Council will follow its Financial Procedure rules and the CCG will follow its own Standing Financial Instructions and Standing orders as last approved by the CCG Governing Body.

15.2 The approach to bearing risks will remain under continuous review by all Parties in line with the objectives of the Agreement relating to shared planning and commissioning and the management of the Pooled Fund.

15.3 The Alliance Director shall present an annual report (unless alternative arrangements are agreed in writing by both Parties) to the HARAB, which shall include income and expenditure received by or incurred from the Pooled Fund.

16. The Pooled Fund

16.1 The Parties agree as follows:

16.1.1 Responsibility for accounting, audit and the financial reporting of the overall Pooled Fund will be the Finance Lead(s) nominated by each party.

16.1.2 The Finance Lead(s) will create a clear identifiable accounting structure within their financial systems to enable effective monitoring and reporting of the Pooled Fund and the budgets of the Individual Pooled Services.

16.1.3 The Finance Lead(s) will be responsible for maintaining an overall accounting structure for the Pooled Fund to be deployed by the Alliance Director.

16.1.4 The Parties will determine delegation of financial responsibility to the Alliance Director who will work through the HARAB to deliver the services set out in Schedule Two of the Agreement on behalf of the Parties and the HARAB.

16.1.5 The level of financial delegation pertinent to the Alliance Director will be set out in a specific Scheme of Delegation to reflect permissions in line with his employing organisation and any associated honorary contract arrangements.

16.1.6 The Parties will, through the auspices of the Finance Lead(s) provide the Alliance Director and the Individual Pooled Service Budget Managers with the necessary financial advice and support to enable the effective and efficient management of the Pooled Fund and any Individual Pooled Service Budget.

16.1.7 The Alliance Director will provide information as is deemed necessary by the Parties to this Agreement to enable effective performance management of the Services provided under this Agreement. As a minimum, this information will include budget monitoring, service performance and workforce analysis in accordance with Clauses 8.3.9 and 15.3.

17. Operation of the Pooled Fund

17.1 The Parties will agree their contribution to the Pooled Fund as set out in Schedule Three for each Financial Year in accordance with this Clause 17.1. The contributions for the Financial Year 2019/20 and indicatively for 2020/21 are as set out in Schedule Three and will be used as a basis for agreeing any future Financial Year contributions from the Parties. Such annual contributions will be evidenced in writing by insertion into the said Schedule Three as an agreed amendment.

17.2 The Parties agree that the annual Pooled Fund will be confirmed by 31 March for the following Financial Year, subject to budget setting processes, and approval by NHS England in relation to the CCG's contribution. HARAB will receive notice of planned contributions within a reasonable timescale and no later than one week after the Parties have formally approved said contributions in line with sovereign organisational budget setting processes.

17.3 The Alliance Director shall ensure that Value for Money is always actively secured in making payments from the Pooled Fund to deliver the services set out in Schedule Two.

17.4 Any monies specifically allocated by the government for particular client groups, services or specific projects shall be considered and put into the relevant Pooled Service Budget subject to such discretions that funding allocations allow to the Parties. The Responsible Officers, or their nominated deputies, shall approve the expenditure plans for such grants and report appropriately for such purposes. The appropriate Individual Pooled Service Budget manager will ensure that the conditions of the grant are met. Where grants are put into relevant Pooled Service Budgets any underspends in the grant will be carried over to the next Financial Year unless this is not allowed by the conditions of the grant.

17.5 For the avoidance of doubt, all funding between the organisations supplied under this Agreement is included in each party's annual contribution to the Pooled Fund.

18. Contributions to the Pooled Fund

18.1 The annual Pooled Fund will normally be calculated as the initial Pooled Fund for the previous year. Annual contributions to the Pooled Fund will be agreed between the Parties and may consider, but not limited to, the following: recurrently rolled forward Funds from previous year

18.1.1 plus, or minus agreed in-year changes where recurrent (overspends or underspends)
18.1.2 plus, or minus agreed inflationary uplift
18.1.3 plus, or minus planned and agreed changes, and
18.1.4 minus planned and agreed efficiency requirements

18.2 The Parties agree that these changes must not have a detrimental financial impact on either Party unless specifically agreed with the Party adversely affected and approved by the Responsible Officers, or their nominated deputies.

18.3 Contributions agreed by Parties will be formally budgeted for prior to the start of the new Financial Year.

18.4 The Parties may not normally vary their annual contributions to the Pooled Fund during the course of the Financial Year to which the annual contribution applies. Any variations to the Parties' annual contributions must be agreed in writing by the Responsible Officers following consideration of information prepared by the Parties' respective Finance Leads.

18.5 The contribution by the Council to the Pooled Fund shall be made upon the gross figure prior to deductions for charges levied on Service Users, or any associated or expenses or as alternatively agreed.

18.6 The services set out in Schedule Two and the relevant budgets in Schedule Three shall set out any non-financial contributions (and the service or services to which they relate) of each Party including staff (Alliance Director),

premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

18.7 Both Parties may contribute additional resource which supports management and delivery of the integrated service model which is not detailed in Schedule Three. Such contributions will be the responsibility of each individual Party unless a variation to the Agreement is considered appropriate, subject to Clause 35.

18.8 Changes forecast to the total level of agreed Pooled Fund expenditure for the year shall be reported to the HARAB in the first instance through the Alliance Director.

18.9 The Pooled Fund shall only be used for the provision of services as set out at Schedule Two to this Agreement.

18.10 The Parties recognise that there may be scope to develop the Partnership Framework and to bring other budgets and services in addition to those specified in Schedule Two into the Pooled Fund or aligned arrangements from time to time and any such changes will be treated as variations to this Agreement and will be evidenced in writing and scheduled to this Agreement.

18.11 This Agreement does not remove the responsibility from the commissioner for any service contracts entered into for the provision of services as set out in Schedule 2. Where a contractual agreement is directly impacted by this Agreement it will be the responsibility of the relevant Party to manage any contract change accordingly, subject to Clause 8.

19. Pooled Fund: Underspends and Overspends

19.1 The Parties have agreed that as a general principle the Pooled Fund is a defined budget for each Party as set out in Schedule 3.

19.2 In the context of this Agreement, any underspends or overspends will be the responsibility of the relevant party and not shared.

20. Division of Pooled Fund into Individual Pooled Service Budgets (PSB's):

20.1 The HARAB shall establish suitable arrangements for the purposes of creating pooled service budgets for the individual services to be provided under this Agreement to be operated in accordance with the financial governance arrangements set out in this Agreement and the budgets set out in Schedule Three.

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

21. Capital expenditure

21.1 No part of the Pooled Fund shall 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 the Council. The Trust does not hold capital budgets but accesses capital funding through bids to NHS England. If a need for capital expenditure is identified the source of capital funding and the revenue impact must be agreed by both Parties.

22. Relationship between the Parties and over-arching principle of financial probity within the Partnership Framework

22.1 All Parties shall promote a culture of financial probity and sound financial discipline and control in relation to the arrangements set out in this Agreement.

22.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access by them to any document, information or explanation they require from any employee, member of the Parties 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. This must be agreed in writing by the relevant Responsible Officer, or their nominated deputies.

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

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

22.5 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties 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.

23. Data and information sharing

23.1 Information shall be shared between the Parties save that no commercially sensitive information shall be communicated between the Parties in the course of the operation of this Agreement without the express agreement of the Responsible Officer for either Party.

23.2 Any and all agreements between the Parties shall be subject to their duties under the Data Protection Act (the 2018 Act), the Freedom of Information Act (the 2000 Act) and the Environmental Protection Regulations 2004 (the 2004 Act).

23.3 The Parties agree that they will each co-operate with each other to enable any Party receiving a request for information under the 2000 Act, the 2004 Act or the 2018 Act to respond to a request promptly and within the statutory timescales. This co-operation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Parties as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

23.4 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act, the 2004 Act or the 2018 Act. No Party shall be in breach of Clause 23 if it makes disclosures of information in accordance with any of the Acts set out in Clause 23.

23.5 Any processing of data that is undertaken by the Parties, their servants, employees, agents or subcontractors in the course of this Agreement shall comply with the Fair Data Processing principles set out in the 2018 Act. Provisions for Data Processing, Personal Data and Data Subject are shown on Schedule 4A.

24 Confidentiality

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

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

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25. Managing conflicts of interest

25.1 The Parties shall comply with the agreed principles for identifying and managing conflicts of interest via adherence to their own policies ensuring they meet the NHS England Managing Conflicts of Interest Statutory Guidance.

25.2 Where a dispute between the parties occurs this shall be subject to Clause 26 of the Agreement.

26. Resolution of commissioning disputes between parties by mediation

26.1 In the event of a dispute between the Parties arising out of this Agreement, either Party may serve written notice of the dispute on the other Party, setting out full details of the dispute.

26.2 The Responsible Officers, or their nominated deputy, shall meet in good faith as soon as possible and in any event within seven 7 days' notice of the dispute being served pursuant to Clause 25 at a meeting convened for the purpose of resolving the dispute.

26.3 If the dispute remains after the meeting detailed in Clause 26.2 has taken place, then the Parties will escalate the issue to the Chief Officers who shall meet in good faith as soon as possible and, in any event, within 7 days' notice of the escalation by one of the Parties.

26.4 If the dispute remains after the meeting detailed in Clause 26.3 has taken place, then the Parties will mutually agree further action to resolve the issue. If either Party does not agree to any such proposed further action, the Parties will attempt to settle such dispute by formal mediation in accordance with an independent mediation procedure as agreed by the Parties. To initiate mediation, either Party may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to the Centre for Effective Dispute Resolution (CEDR) or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Party 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, Clause 14 of the Model Mediation Procedure will apply (or the equivalent Clause of any other model mediation procedure agreed by the Parties). The Parties 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.

26.4 Nothing in the procedure set out in this Clause 26 shall in any way affect either Party's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

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27. Liabilities, Insurance and Indemnity

27.1 Subject to Clause 9, if a Party ("First Party") incurs a Loss arising out of or in connection with this Agreement or in relation to the Services to be jointly commissioned under the terms of this Agreement as a consequence of any act or omission of another Party ("Other Party") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the contract under which the Services are to be provided then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

27.2 Clause 27.1 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Party acting in accordance with the instructions or requests of the First Party.

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

27.3.1 As soon as reasonably practicable give written notice of that matter to the Other Party specifying in reasonable detail the nature of the relevant claim.

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

27.3.3 Give the other Party 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 Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purposes of assessing the metis of and if necessary, defending the relevant claim.

27.4 Each Party 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 legal liabilities arising in tort from this Agreement.

27.5 Each Party 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.

28. Conduct of Claims

28.1 In respect of the indemnities given in this Clause 28:

28.1.1 the indemnified Party shall give written notice to the indemnifying Party as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

28.1.2 the indemnifying Party shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Party, the indemnifying Party shall consult with the indemnified Party about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Party informed of all material matters.

28.1.3 the indemnifying and indemnified Party shall each give to the other all such co-operation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

29. Term of the Agreement

29.1 This Agreement will commence on 1 October 2019 and expire at 31 March 2022. Thereafter it can be extended on a year to year basis at the Parties' discretion and agreement for a maximum period of ten years subject to Clause 35.

29.2 Unless otherwise stated, the duration of the arrangements for each element of service shall be as set out in Schedule Two.

30. Continued co-operation between parties after end of the Agreement

30.1 The Parties shall continue to co-operate with each other or their statutory successors following the termination of this agreement (for any reason) with a view to ensuring the continuity of delivery of the services, the continuation, renewal or re-procurement of the services, any commissioning arrangements relating to them and the continued provision of health and social care to the served populations

31. Continuing contracts and liabilities arising from termination of the Agreement

31.1 In the event that this Agreement is ended then any contracts made under it will be deemed to continue as between the parties to that Agreement and the Parties will seek to co-operate under Clause 12 in relation to the arrangements made under such contracts.

32. Third party rights and contracts

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

33. Governing and applicable law

33.1 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.

33.2 Subject to Clause 26, the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

33.3 Ombudsman - 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.

34. Complaints procedures

34.1 During the term of the Agreement, complaints can be made to any Party to this Agreement and will be dealt with through that Party's usual complaints process in line with the statutory complaints procedure of that Party but where the complaint relates to all Parties, they will work together to provide a joint response.

34.2 Where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Responsible Officers, or their nominated deputies will set up a complaints subgroup to examine the complaint and recommend remedies.

35. Review and variation

35.1 The Parties shall formally review the Section 75 arrangements no later than 12 months prior (31 March 2021) to expiry of the Term (31 March 2022) with a view to varying the Agreement for the period 1 April 2021 to 31 March 2022 subject to Clause 35.5, or termination of the Agreement subject to Clause 46.

35.2 Formal review as set out in Clause 35.1 will be as directed by the Responsible Officers of the Parties and shall comprise:

35.2.1 the delivery of the Functions and any related Functions

35.2.2 the extent to which the objectives of the joint planning and commissioning arrangements are met

35.2.3 compliance with and fulfilment of national and local policies

35.2.4 financial arrangements and continuous improvement in quality of care as determined by the outcomes and benefits agreed by the Parties.

35.3 The review and variation provisions in this Clause 35 shall apply as a means of developing and refining the parties' respective functions in relation to the services and fulfilling the objectives of this Agreement.

35.4 If at any time during the term of this Agreement either Party (First Party) wishes to vary this Agreement, they must set this out in writing and submit a Variation Notice to the Other Party (Second Party) for consideration. The Second Party must confirm their agreement or disagreement in writing fourteen (14) days after the necessary internal governance processes have been undertaken.

35.5 In the event of mutual agreement to the Variation Notice then a Memorandum of Agreement shall be prepared and executed by the Parties and thereafter the variation shall be binding.

35.6 If the Second Party does not agree to the request to vary the agreement, then the variation shall not take place.

35.7 The Parties may determine to renew the Agreement at the end of the Term subject to this Clause 35.

36. Appointment of Legal Advisors

36.1 The parties shall in all circumstances where it is practicable to do so, and where both parties are in agreement, take a single advisor approach to seeking legal advice in relation to the implementation of this Agreement, any dispute arising from it or any proposed change to or modification of its terms.

36.2 Agreement to a single advisor approach should be confirmed in writing between the parties and is at the discretion of the Responsible Officers, or their nominated deputies.

36.3 Where there is potential for a conflict of interest to arise, Parties may obtain separate independent legal advice at their own expense.

37. Appointment of Financial and Audit Advisors

37.1 At all times the Parties shall retain their own financial and audit advisors for their financial and governance arrangements but may make arrangements for a single advisor in relation to specific matters where it is practicable to do so, and where both parties are in agreement.

37.2 Agreement to a single advisor approach should be confirmed in writing between the parties and is at the discretion of the Responsible Officers, or their nominated deputies.

38. Responsibility for public statements, press releases and social media

38.1 The Parties shall co-operate when issuing any public statement, press release or social media communication relating to the terms of this Agreement or any activity undertaken under it or discretion exercised by reference to it to the intent that both Parties agree such statement or release which should represent the agreed position of all parties in relation to such matters.

39. Entire Agreement

39.1 The terms herein contained together with the contents of the schedules constitute the complete Agreement between the Parties with respect to planning and commissioning of services as set out in Schedule 2 and supersede all previous communications, representations, understandings and agreement and any representation, promise or condition not incorporated herein shall not be binding on any Party.

40. No Partnership or Agency

40.1 Nothing in this Agreement shall create or be deemed to create a legal partnership or the relationship of employer and employee or agent and principal between the Parties.

41. Invalidity and severability

41.1 If any Clause or part of this Agreement is found by any court tribunal administrative body or authority of competent jurisdiction to be illegal invalid or unenforceable then that provision will to the extent required be severed from this Agreement and will be ineffective without as far as is possible modifying any other Clause or part of this Agreement and this will not affect any other provisions of this Agreement which will remain in full force and effect.

42. Counterparts

42.1 This Agreement may be executed in any number of counterparts or duplicates, each of which shall be an original, and such counterparts or duplicates shall together constitute one and the same agreement.

43. Notice

43.1 All formal Notices relating to this Agreement shall be given by hand, pre-paid first class post (or in accordance with the Postal Services Act 2000 if applicable) or facsimile transmission confirmed by pre-paid letter to the addressee at the address given below or such other address as the addressee shall have for the time being notified to the other Party giving notice and such notice shall be deemed to have been delivered either upon delivery if by hand or if by letter at the expiration of forty eight (48) hours after posting or if by facsimile, upon receipt.

44. Addresses

44.1 For the purposes of this Agreement, the address of each Party shall be:

(1) NHS Harrogate & Rural District Clinical Commissioning Group:
1 Grimbald Crag Court
St James Business Park
Knaresborough
North Yorkshire
HG5 8QB

(2) North Yorkshire County Council:
County Hall
Northallerton
North Yorkshire
DL7 8AD

45. Force Majeure

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

45.2 On the occurrence of a Force Majeure Event, the affected Party shall notify the other Party 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 Party and any action proposed to mitigate its effect.

45.3 As soon as practicable, following notification as detailed in Clause 45.2, the Parties 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 45.4, facilitate the continued performance of the Agreement.

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

46. Termination

46.1 This Agreement shall terminate upon the effluxion of time except where Clause 35 applies, or the Agreement is otherwise renewed on review by the Parties.

46.2 In the event of dispute or disagreement relating to the terms and conditions of this Agreement, which cannot be resolved under this Agreement, then either Party may, by service of 3 months' notice in writing upon the other Party, terminate this Agreement.

46.3 In the event that the Agreement terminates, responsibility for the CCG's Functions exercised under the Agreement will be returned to the CCG and responsibility for the Council's Functions exercised under the Agreement will be returned to the Council.

46.5 Either Party may terminate the Agreement at any time with immediate effect in the event that:

46.5.1 There is a change in law that materially affects the Partnership Arrangements made pursuant to this Agreement under the Regulations or renders performance of any Party's obligations (or the obligations of any other party towards that Party) ultra vires.

46.5.2 One of the Parties is in material breach of its obligations under this Agreement, provided that where the breach is remediable, the non-defaulting Party shall require the defaulting Party to remedy the breach and if the defaulting Party so remedies the breach within one month, such breach shall not give rise to a right to terminate the agreement.

46.6 In the event of immediate termination of this Agreement the Pooled Funds, including underspends and overspends shall be returned to the Parties based on proportions of contributions to the Pool. In the event of assets being purchased from the pool, the Parties will provide proposals to the Responsible Officers, or their nominated deputies, on how these will be dealt with prior to the termination of the agreement. If these proposals cannot be agreed that Parties will refer to the dispute procedure at Clause 26.

46.7 Termination of the Agreement shall be without prejudice to the rights, duties and liabilities of the Parties or any of them that have accrued prior to termination.

47. Transferability of the Agreement

47.1 In the event that any individual role or statutory function of any Party that is a fundamental requirement for the effectiveness of this Agreement shall be transferred to another organisation then:

47.1.1 The remaining Parties shall first seek to negotiate a continuation of this agreement with that organisation and if that shall not prove possible within a reasonable period (to be agreed between the Parties) then this Agreement will be deemed to have ended due to supervening impossibility of performance.

47.2 Should either Party cease to exist or cease to be responsible for the defined functions then, subject to any applicable ministerial direction or delegated legislation, this Agreement shall be deemed to continue with any other organisation that takes over substantially all its role or statutory function with the Harrogate and Rural District boundaries.

47.3 The Parties shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the Other Party, 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 Party's statutory functions.

Schedule One: Definitions and Interpretations of this Agreement

Definition	Means
Agreement	this Section 75 document including its Schedules and Appendices jointly agreed by the Parties for the purposes of providing the Services pursuant to the Regulations and Section 75 of the Act.
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.
Alliance Agreement	the separate multi-agency partnership agreement entered into by the organisations that comprise the Harrogate and Rural Alliance Board set within the Partnership Framework
Alliance Director	the nominated officer responsible for operational delivery of the Harrogate and Rural Alliance Board's integrated care operating model and who will be accountable to the HARAB for the management of the Pooled Fund in accordance with the Pooled Fund arrangements.
CCG	the NHS Harrogate and Rural District Clinical Commissioning Group.
CCG functions	means such of those NHS Harrogate and Rural District Clinical Commissioning Group functions as may be necessary to provide the Services.
Chief Officers	means the Chief Officer of the Clinical Commissioning Group and the Chief Executive Officer of the Council.
Commencement Date	1 October 2019.
Commissioner Review meeting	a meeting jointly chaired by the Responsible Officers to review the arrangements set out in this Agreement to (a) determine any actions necessary to support the objectives of the integrated delivery model (b) formally receive and record reports to the Parties as set out in this Agreement (c) consider variation, extension or termination of this Agreement at 31 March 2021 (as a minimum)
Confidential Information	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 Service User 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
Council's Functions	means such functions of the Council as may be necessary to provide the Services specified in Schedule Two.
Finance Lead(s)	the Section 151 Officer of the Council and the Chief Finance Officer of the CCG, or their nominated deputies.

Definition	Means
Financial Year	a twelve-month period commencing on 1 April and terminating on the following 31 March.
Gender and persons	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
Harrogate and Rural Alliance Board (HARAB)	shall mean the strategic forum established by the Parties to oversee the co-ordination and delivery of the integrated services.
Harrogate and Rural District CCG area	Harrogate and Rural District CCG area within the Boundary of North Yorkshire. It includes areas in which GPs listed by the CCG are practicing and for which commissioning responsibilities exist for the registered population.
Health-Related Functions	the public health functions of the Council under the HSCA 2012 and any other functions that may be exercised by the Council in its commissioning of the Services specified in Schedule Two.
In the event of a conflict	the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
Indirect Losses	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 Pooled Service Budget Managers	being officers with delegated responsibility (for budgets and the provision of services) within an individual pooled service.
Individual Pooled Service Budgets	the budgets agreed between the Parties within the Harrogate and Rural Alliance Board to provide the services specified in Schedule Two of this Agreement from the Pooled Fund as set out in Schedule Three of this Agreement.
Integrated Commissioning	a mechanism by which the Parties jointly commission a Service. For the avoidance of doubt, an integrated commissioning arrangement does not involve the delegation of any functions outside of this Agreement.
Joint planning and commissioning	the shared intention and supporting arrangements captured within this Agreement in relation to the commissioning of services. For the avoidance of doubt, joint planning and commissioning arrangements do not involve the delegation of any functions outside of this Agreement.
Losses	any and all direct losses, costs, claims, proceedings, damages, liabilities and any reasonably incurred expenses, including legal fees and disbursements whether arising under statute, contract or at common law but excluding indirect losses.
Mode of formal communication	subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Parties shall be in writing.
Money	unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but if pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall

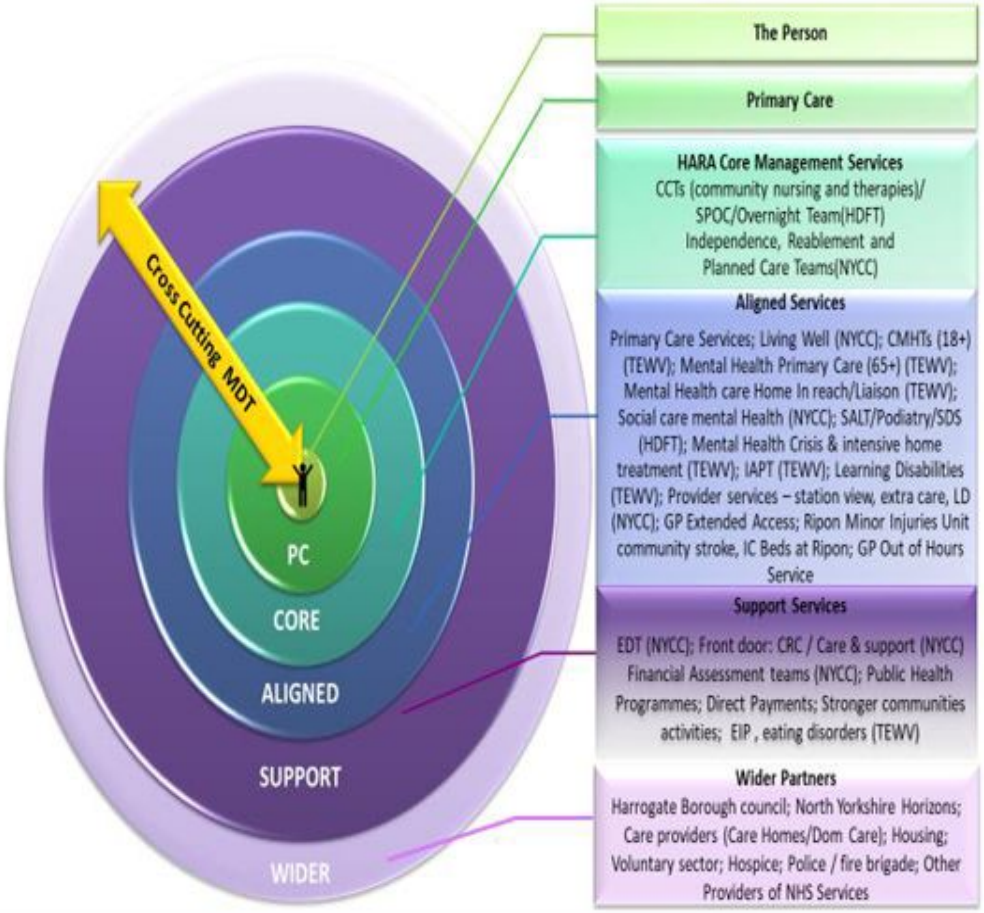
Definition	Means
	be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.
Non-exhaustive lists	Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.
Parties	together Harrogate and Rural District CCG and North Yorkshire County Council (commissioner responsibilities).
Partners	the organisations that comprise the HARA Board
Partnership Arrangements	the arrangements jointly agreed by the Parties for the purposes of providing the services pursuant to the Regulations and Section 75 of the Act.
Partnership Framework	this Section 75 document (commissioners); a Section 75 document (providers) and associated Harrogate and Rural Alliance Agreement (members of the HARA Board).
Pool Host	The service provider that has responsibility for delivery of the services aligned to an Individual Pooled Service.
Pooled Fund	such fund or funds of monies received from separate contributions by the Parties for the purposes of providing the specified services to be delivered through the HARAB and which are set out in Schedule Two of this Agreement.
Pooled Fund Arrangements	means the arrangements agreed by the Parties for establishing and maintaining the Pooled Fund.
Reference to the Parties	shall include their respective statutory successors, employees and agents subject to the provision of Clause 30.1.
References to this Agreement	within its text include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.
Responsible Officers	the named individual as nominated by each Party with responsibility for overseeing this Agreement, as specified in Schedule Four of this Agreement.
Service contract	an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the services in accordance with the relevant service.
Singularity	words importing the singular only shall include the plural and vice versa.
SOSH	the Secretary of State for Health.
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.
The Act	means the National Health Service Act 2006.
The Council	means the North Yorkshire County Council.
The Functions	means the NHS and health related functions and the Council's Functions in so far as they relate to the Agreement.
The headings in this Agreement	are inserted for convenience only and shall not affect its construction and a reference to any Schedule or clause is to a Schedule or clause of this Agreement.
The HSCA 2012	means the Health and Social Care Act 2012.
The NHS Functions	those NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the services and which may be further described in Schedule Two.

Definition	Means
The Regulations	the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No. 617 and any amendments and subsequent re-enactments.
The Service User	an individual in receipt of services commissioned under the Agreement.
The Services	the services planned, commissioned and delivered under this Agreement.
Third Party Costs	all such third-party costs (including legal and other professional fees) in respect of each service as a Party reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Responsible Officers of this Agreement.
Words importing the singular number	shall include the plural and vice versa and words importing the masculine shall include the feminine and vice versa.
Working Day	means the normal service times for each service provider within the Alliance.

Schedule Two: Scope of services relating to this Section 75 Agreement

For clarity, the services covered by the commissioner section 75 agreement are those described as 'Core' and 'Aligned' within Figure 1. Other services may, at the discretion of the Parties and in agreement with the Partners, be brought into this Agreement subject to the conditions set out in this Entire Agreement.
In terms of this specific Agreement, it is designed to bring together the provider elements of current services described as 'Core', giving the Alliance Director delegated authority through a clear governance structure, as well as enabling the Alliance Director to manage operations of these health and social care services described. This complements the responsibilities of the Alliance Director described in the commissioner agreement.
The Alliance Director and their immediate Alliance Management Team (comprising of two NYCC Service Managers and two HDFT Service Managers) will have the direct responsibility for the 'Core' services. They will also influence the 'Aligned' services through the daily coordination of huddles and the wider Alliance Leadership Team which includes representatives from the 'Aligned' service areas.

Figure 1: Target Operating Model showing service delivery arrangements[1]



[1] Target Operating Model (13/8/19 from subgroup)

Schedule Three: Financial budgets relating to this Section 75 Agreement[2]

For the period 1 October 2019 to 31 March 2020 and indicative budgets for 2020-2021

	Annual budget £	Oct 2019 to Mar 2020 £	Indicative budget 2020-2021 £
	North Yorkshire County Council		
Reablement Teams	1,629,400	814,700	1,661,988
Independence Teams	888,900	444,450	906,678
Planned Care Teams			
Pay & Other non-pay	1,909,300	954,650	1,847,486
Care Packages	40,063,800	20,031,900	40,565,076
Direct Payments	3,987,700	1,993,850	3,767,454
Total Core Services	**48,479,100**	**24,239,550**	**48,748,682**
Carers	109,400	54,700	111,588
Equipment	1,385,000	692,500	1,412,700
Senior Management Team	1,047,700	523,850	1,068,654
Living Well	275,000	137,500	280,500
Social Care Mental Health	1,772,300	886,150	1,807,746
Provider Services	2,203,300	1,101,650	2,247,366
Total Non Core / Aligned Services	**6,792,700**	**3,396,350**	**6,928,554**
Total Budget NYCC	**55,271,800**	**27,635,900**	**55,677,236**
	Harrogate and Rural District CCG		
	Annual budget £	Oct 2019 to Mar 2020 £	Indicative budget 2020-2021 £
Integrated Community Care Team	5,104,000	2,552,000	5,206,080
Total Core Services	**5,104,000**	**2,552,000**	**5,206,080**
CHC - Joint/Fully/PHB *	14,508,000	7,254,000	14,798,160
FNC *	4,105,000	2,052,500	4,187,100
GP Extended Access *	891,000	445,500	908,820
GP Care Homes Scheme *	73,000	36,500	74,460
Ripon Community Hospital	1,103,000	551,500	1,125,060
Community Equipment *	480,000	240,000	489,600
Community Medical Devices	94,000	47,000	95,880
Community Stroke	154,000	77,000	157,079
Total Non Core / Aligned Services	**21,408,000**	**10,704,000**	**21,836,159**
Total Budget CCG	**26,512,000**	**13,256,000**	**27,042,239**
Total	**81,783,800**	**40,891,900**	**82,719,475**

* Note that these services are not provided by HDFT and therefore do not factor in the provider Section 75.

[2] Schedule 3 – Version 7 (13/8/19 from finance subgroup)

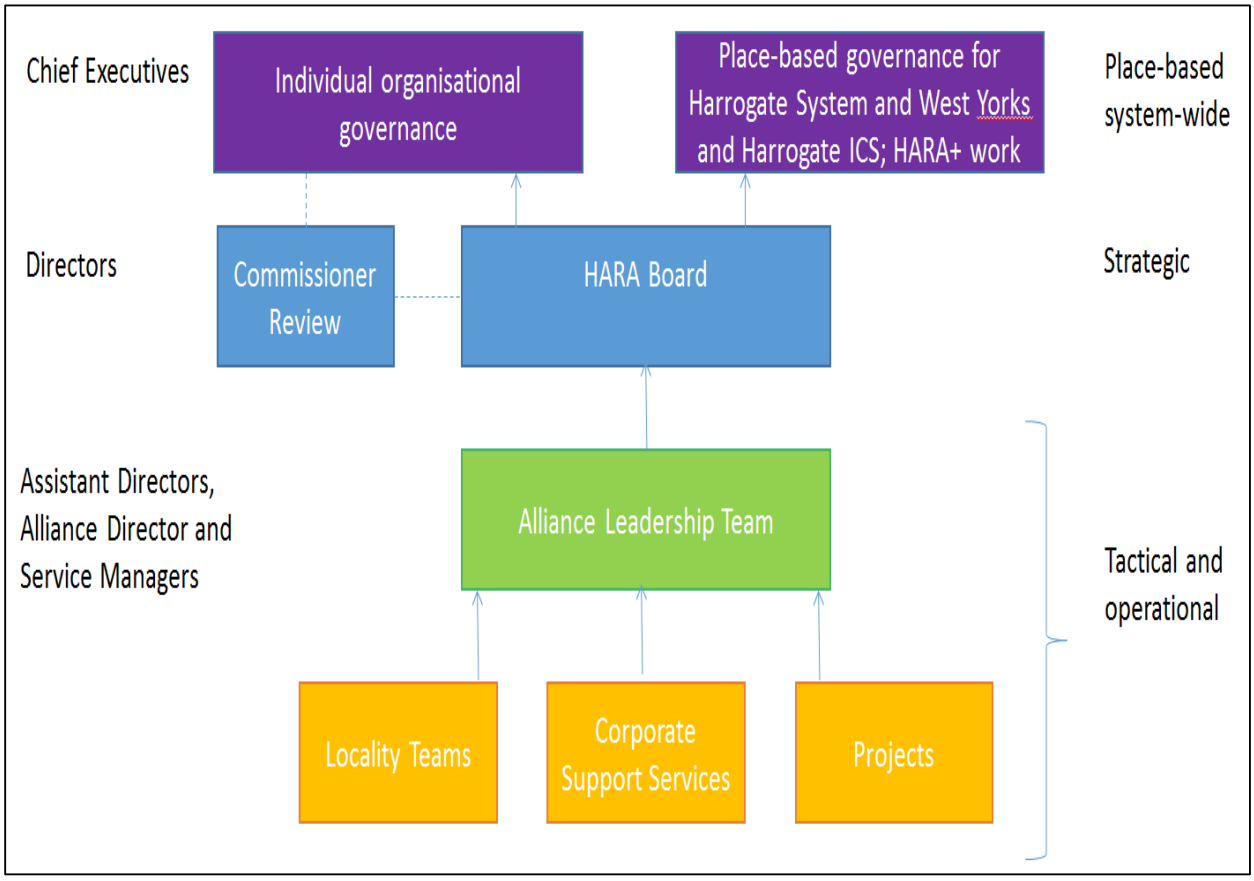
3.4

Schedule Four: Governance arrangements relating to this Section 75 Agreement (set within the wider arrangements comprising the Partnership Framework)

(1) The CCG's Responsible Officer:
Wendy Balmain, Director of Transformation and Delivery

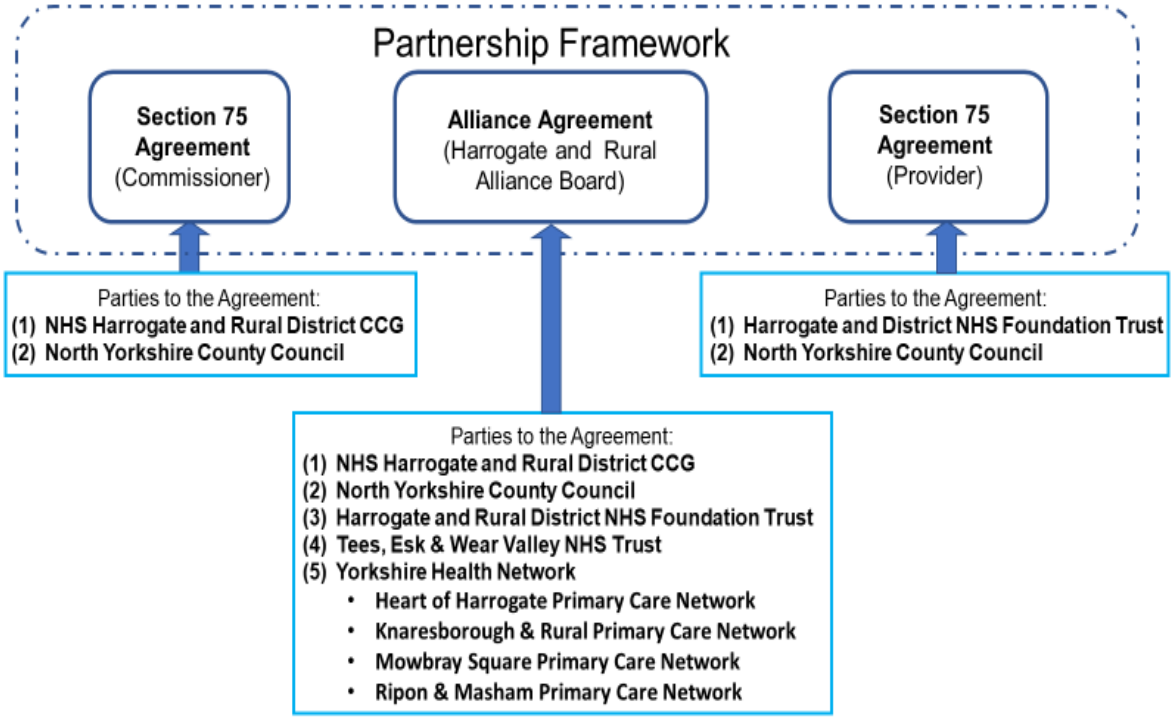
(2) The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

Figure 1: Governance diagram for Harrogate and Rural Alliance arrangements[3]



[3] Governance diagram as at 16/8/19

Figure 2: Relationship between this Section 75 Agreement and the wider Partnership Framework[4]



[4] Partnership Framework as at 16/8/19

SCHEDULE FOUR A - DATA PROCESSING, PERSONAL DATA AND DATA SUBJECT

1. The Provider shall comply with any further written instructions with respect to processing by the Purchaser.

2. Any such further instructions shall be incorporated into this Schedule 3.

Description	Details
Subject matter of the processing	**Single Point of Access Overflow Service** To provide a continuous single point of access service for HDFT by redirecting calls that would receive an engaged call to the overflow service at NYCC whereby the referral detail are taken and referred to the Admin staff at HDFT. The provider will be the Data Controller and North Yorkshire County Council will be the Data Processor. **Multi Disciplinary Teams (MDT's)** A weekly MDT of 60-90 minutes will be held within the four Primary Care Networks across the Harrogate and Rural District footprint. The purpose of the MDT's are to bring Primary Care colleagues together with Community Teams. To have a space to discuss complex cases, to share intelligence across Primary Care and Community Teams and take a preventative approach to supporting people in the community. To try and ensure health and care is more joined up and coordinated around the person and prevent that person being unnecessarily admitted to hospital Each Provider is a Data Controller in their own right. **Huddles** The Operational Huddles will be led in each of the 4 areas by the relevant Team Managers from each HDFT and NYCC team. Each Organisation will access their own organisation's systems, to support understanding of capacity and resilience, as well as to share any relevant case updates where a specific person is brought to the Operational Huddle for discussion. Where cases are brought to the Operational Huddle discussion, the aim will be to use the professional expertise across the integrated disciplines to support better outcomes for the person in relation to their health and care needs. Each Provider is a Data Controller in their own right. **Performance Reporting**

	Anonymous summary performance data for each of the HARA partners to enable monitoring and decision making. Each Provider is a Data Controller in their own right. **Workforce Skills Audit** An audit of the skills of each workforce. Each Provider is a Data Controller in their own right. **Population Health Management** Data sharing between HARA Organisations to provide data insights to improve health and wellbeing of the populace within Harrogate and the surrounding areas over the coming decades. Each Provider is a Data Controller in their own right.
Duration of the processing	As per Clause 29 of the Section 75 Partnership Agreement. **29. Term of Agreement** 29.1 This Agreement will commence on 1 October 2019 and expire at 31 March 2022. Thereafter it can be extended on a year to year basis at the Parties' discretion and agreement for a maximum period of ten years subject to Clause 35. 29.2 Unless otherwise stated, the duration of the arrangements for each element of service shall be as set out in Schedule Two.
Nature and purposes of the processing	**Single Point of Access Overflow Service** The current process will for the most part remain unchanged, but for the exception where the HDFT SPOA main number is engaged then the caller will be re-routed to a different data controller (an NYCC Social Care Advisor in the customer service centre.) On receipt of the call, the Social Care Advisor will complete the required information on a word document (see below) and on completion email this to a secure HDFT SPOA email inbox. The provider will be the Data Controller and North Yorkshire County Council will be the Data Processor. **Multi Disciplinary Teams (MDT's)** A weekly MDT of 60-90 minutes will be held within the four Primary Care Networks across the Harrogate and Rural District footprint to bring Primary Care colleagues together with Community Teams to ensure

	health and care is more joined up and coordinated around the person by sharing intelligence across Primary Care and Community Teams to enable a preventative approach to supporting people in the community Each Provider is a Data Controller in their own right. **Huddles** The Operational Huddles will be led in each of the 4 areas by the relevant Team Managers from each HDFT and NYCC team. Each Organisation will access their own organisation's systems, to support understanding of capacity and resilience, as well as to share any relevant case updates where a specific person is brought to the Operational Huddle for discussion. Each Provider is a Data Controller in their own right. **Performance Reporting** Sharing of summarised performance information relating to the activities of work within the Harrogate and Rural Alliance with partners, which includes, Harrogate District Foundation Trust – (HDFT) and Yorkshire Health Network (YHN) and Tees, Esk and wear Valley Trust (TEWV). Each Provider is a Data Controller in their own right. **Workforce Skills Audit** Information will need to be gathered about resource / capacity, skill-sets, qualifications, recruitment and retention challenges. The intention is to amalgamate data sets to create a combined view of the workforce profile across the health and social care system, which can be mapped against a view of the activity/ demand in each of the four geographic areas/ networks. The data will need to be reviewed in relation to the strategic priorities and service development objectives identified by Alliance Management Team and the HARA Programme Board for Year 2, to inform the areas for the workforce model to address by developing the skills profile. Each Provider is a Data Controller in their own right.

Type of Personal Data	**<u>Personal data</u>:** General personal information: name, address, identification number, UPN, ULN, date of birth, gender, telephone number (home, mobile), NHS number Family information: parent/carer name, siblings, other family members Resource profile (turnover, vacancies, specific recruitment challenges) GP details In relation to Staff: Capacity (roles & FTE) Skills (qualifications, professional registrations, specialist skills, baseline assessment of common skills areas – to be defined e.g. mental health, motivational interviewing, digital skills); degree of competence (e.g. Basic, Confident, Expert, Can teach others) **<u>Special category data</u>:** Full history of Social Care episodes Full history of Health and Medical episodes Post looked after information Ethnic code
Type of Personal Data	**<u>Population Health Management</u>** Data sharing between HARA Organisations to provide data insights to improve health and wellbeing of the populace within Harrogate and the surrounding areas over the coming decades. This activity will likely develop over a number of phases as data sharing practices are developed and introduced. Each Provider is a Data Controller in their own right.
Categories of Data Subject	Clients, Family Members, plus providers, providers' staff, Local Authority officers, GP's, Other Professionals where applicable.
Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data	In line with the provider's own retention and disposal schedule.

Schedule Five: Benefit Framework and Metrics

This schedule comprises:

- Figure X: Strategic framework of benefits, metrics and commissioning priorities for HARA and the wider system
- Figure Y: Operational HARA metrics for core services – day 1
- Figure Z: Harrogate and Rural Alliance Benefits Framework

Figure X: Strategic framework of benefits, metrics and commissioning priorities for HARA and the wider system

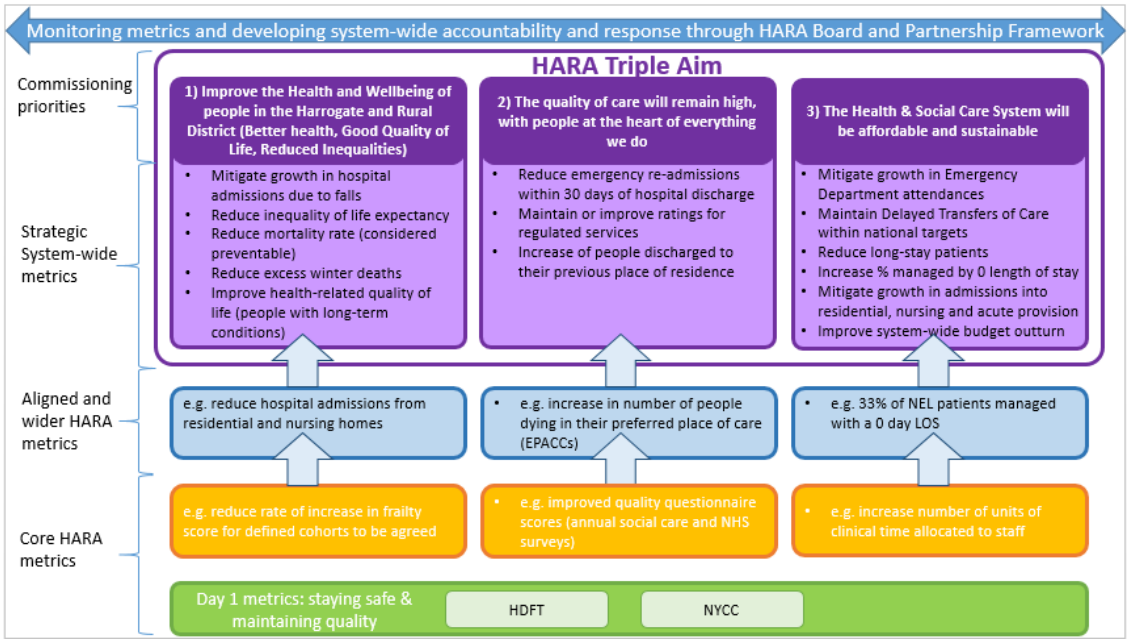


Figure Y: Operational HARA metrics for core services – day 1

HARA Quarterly Performance Report - Harrogate District and Foundation Trust ICCT Teams

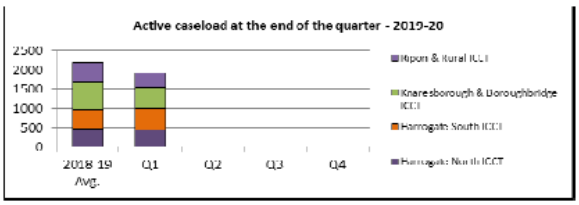
Patient Contacts

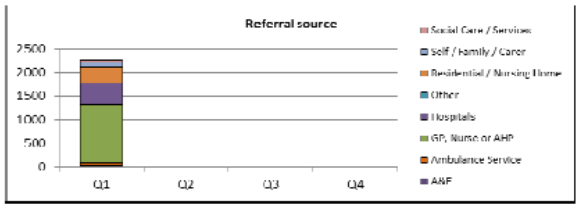
KPI	Avg. 2018-19	Q1 2019/20
No. Face to Face Contacts with Patient	32466	35052
Activity - clinical contact	29913	33742
Activity - clinical contact - unplanned	257	235
Activity - performing care plan	2296	1075
No. Telephone Contacts with Patient	665	524

Top 10 Care Plans

Category	YTD 2019/20	% of F2F Contacts
Medication administration	9594	27.4%
Wound Care	9406	26.8%
Pressure Ulcer Prevention / Management	6288	17.9%
Contact Assessment	1633	4.7%
Continence	1162	3.3%
End of Life Care	695	2.0%
Leg Ulcer	492	1.4%
Phlebotomy	453	1.3%
Diabetes management	369	1.1%
Advice and Support	348	1.0%
		86.8%

Referrals and Discharges





KPI	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
No. Referrals received	2272			
No Discharges	2229			
2019/20: Avg. length of time between Ref and Dis	110 Days			

System-wide Measures

	Apr-19	May-19	Jun-19
No. of patients 7+ days LOS in month	133	134	111
No. of patients 21+ days LOS in month	52	57	48
% Readmissions in month	13.4%	13.5%	13.8%
% Delayed Transfers of Care in month	1.0%	0.8%	1.2%

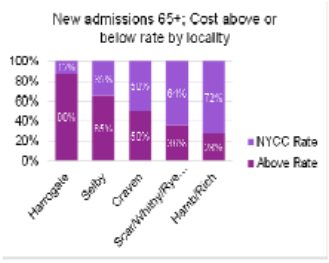
HARA Quarterly Performance Report - Adult Social Care

Current Reporting Period

KPI	Q4 2018/19	Q Trend
No. of referrals into Harrogate teams.	215	▲
% of assessments resulting in service provision.	12	▲
Rate of admissions per pop. to permanent placements.	10.2	▲
% permanent OP placements above NYCC approved rates.	76.6	▲
Volume of safeguarding concerns.	100	▲
% of safeguarding enquiries progressing to enquiry.	20	▲
% of reablement clients not returning within 90 days.	84.2	▼
% of people assessed for reablement who received reablement.	52	▲
Rate of Total DTOC bed days per head of pop.	0.6	▼
Rate of adult social care DTOC bed days per head of pop.	0.1	◀▶

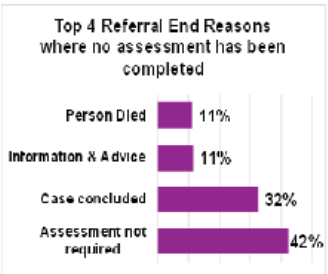
Performance Exceptions

% permanent OP placements above NYCC approved rates



Harrogate has the highest proportion of new admissions being placed at costs above the NYCC rates with 88%. This is up from 79% in December. The average number of new admissions above rate across the county is 53%.
Harrogate has the highest average costs for admissions for those aged 65+ in both residential (£801) and nursing care (£1008). These averages are up 3% and 6% respectively on December's average costs.

% of assessments resulting in service provision.



- 31% of all referrals allocated to planned care teams are closed without an assessment
- The highest proportion are closed in Harrogate (34%)
- 44% of assessments lead no service, the main assessment outcomes for these are; 12% receive advice & info, 12% have no services offered, 4.5% are self-funding, 1.3% are referred for preventative support.

Figure Z: Harrogate and Rural Alliance Benefits Framework

Harrogate and Rural Alliance
Health and Social care working together with you

Monitoring metrics and developing system-wide accountability and response through HARA Board and Partnership Framework

HARA Triple Aim	1) Improve the Health and Wellbeing of people in Harrogate and Rural District (Better health, Good Quality of Life, Reduced Inequalities)	2) The quality of care will remain high, with people at the heart of everything we do	3) The Health & Social Care System will be affordable and sustainable
Strategic system-wide metrics	• Mitigate growth in hospital admissions due to falls • Reduce inequality of life expectancy • Reduce mortality rate (considered preventable) • Reduce excess winter deaths • Improve health-related quality of life (people with long-term conditions)	• Reduce emergency re-admissions within 30 days of hospital discharge • Maintain or improve ratings for regulated services • Increase of people discharged to their previous place of residence	• Mitigate growth in Emergency Department attendances • Maintain Delayed Transfers of Care within national targets • Reduce long-stay patients • Increase % managed by 0 length of stay • Mitigate growth in admissions into residential, nursing and acute provision • Improve system-wide budget outturn
Aligned and wider HARA metrics	• Reduction in hospital admissions from residential and nursing homes. • Increase in PAM 'activation' score - Patients who are 'activated' are likely to self-care and improve their own risks. Patients who are less activated should be targeted more. • Population Health Management measures to be identified - as approach is developed	• Skills audit work to define training and skills data/metrics • Increase in number of people dying in their preferred place of care (EPACCs)	• Reduction in the number of Stranded/ Super Stranded Patients - patients who have been in hospital more than 21 days (HDFT target is 42% based on April 18 baseline, which HARA will support) • Reduction in Length of Stay for Non-elective admissions for targeted cohorts (over 18s) - beginning with the frailty cohort?

	• Increase referrals to diabetes prevention programme. [consider as PCNs develop] • Mitigate increase in prevalence of diabetes, cardio-vascular disease, respiratory conditions, sepsis [consider as PCNs develop] • Mental health metrics - further consideration needed as TEWV become more involved in HARA • Loneliness / isolation metrics [for future consideration in partnership with the voluntary sector as loneliness strategy is developed] • Reduce smoking prevalence to 15% or lower by 2021. • % of patients on repeat medications who have had a medication review in the last 12 months [consider as PCNs develop] • Cases by location and specific need group (eg LD, travellers and homeless population) • Increase service utilisation by different channels including online • Increase number of community contacts in rural areas or identified areas of deprivation		• 33% of NEL patients managed with a 0 day LOS (link to Acute Frailty Approach and improve same day facilities) • Mitigate growth in cost of care including CHC (D2A Pathway 3) following discharge [Consider as a development opportunity in future years] • Measures of demand on GP services/extended access offer - to consider development with PCNs
Core HARA metrics	• Reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population. • Reduction in re-attendances at GP within 90 days for people on the HARA caseload [work with PCNs to develop baseline]	• Reduce number of complaints and increase number of commendations received (in relation to the number of people in receipt of a service) • Improved quality questionnaire scores (annual social care and NHS surveys) - Friends and Family test % of responses indicating Extremely Likely or Likely to	• Reduced budget out-turn / overspend for commissioning organisations (NYCC, CCG) • Reduction in the number of non-elective admissions for patients in target population cohorts (beginning with frailty cohort, further cohorts to be agreed)

	• Reduce rate of increase in frailty score (moderately and severely frail) for defined cohorts to be agreed • Reduction in number of urgent and scheduled visits (HDFT) for those on HARA caseload / target cohorts to be identified • Reduction in number of NYCC open planned care cases • Increase the % of people assessed for reablement who go on to receive a reablement service • Mitigate growth in A&E attendances for targeted cohorts (over 18s - to be defined after PHM work) [cross-reference to affordable and sustainable system] • NYCC - reduction in assessment completion timescale • Reduction in waiting time for therapy services (NYCC and HDFT) • Maintain and improve on 4hr response to urgent clinical need • Decreased % No Further Action and proportion of contacts diverted at the front door (SPOC or CRC) (NYCC) [data and service development of SPOA required to measure this for HDFT patients]	recommend service; social care questions to be identified • Case file audits demonstrating improved quality of practice against CQC and professional standards • Increase the proportion of carers/patient groups/representatives who report that they have been included or consulted in discussions - beginning with Therapy Outcome Measure metrics (reablement) • Increase the reporting of low and no harm incidents, evidencing increased awareness and opportunities for shared learning • Reduction in staff sickness • Increase response rate and increase overall staff satisfaction for surveys: annual social work health check; NYCC staff survey; HDFT annual staff survey: questions from all to be identified. • Number of staff in the alliance (FTE) • % of huddles (daily) and MDTs (weekly) held • % MDTs attended by GPs • Increase in remote log-ons for HARA workforce • Progress reporting against agreed milestones for integrated working • Maintaining or improving CQC inspection outcomes for Adult Community Services, Reablement Delivery and NYCC in-house provision (Station View)	• Increase proportion of patients discharged to their usual place of residence. • Maintain the average total monthly delayed transfers of care (attributable to either NHS, Social Care or both) per 100,000 below NHSE targets • Maintain proportion of beds occupied by a reportable delay within target (target is no more than 3.5% of beds) • Reduction in budget out-turn / overspend for provider organisations (HDFT, NYCC) • Improve OPEL levels for HARA services • Increase in number of cases and % of whole caseload aligned to delivery through single co-ordinator (metric to be developed) • Increase in remote log-ons for HARA workforce • Increase in skype and video-conferencing usage for HARA workforce - increase in #minutes per staff member used • Reduction in ratio of desk space to colleague headcount for HARA workforce • Reduced rescheduling of appointments • Staff time efficiency - increase number of units of clinical time allocated to staff (HDFT); NYCC metric to be developed.

Schedule Six (Part 1): Terms of Reference for Harrogate and Rural Alliance Board[5]

1 Purpose

1.1 The Harrogate and Rural Alliance Board (HARAB) has been established to provide strategic direction to the alliance, to provide governance and oversight of risk and to hold to account the Alliance Leadership Team (ALT) for the performance of the alliance such that it achieves the objectives set for it.

2 Status and authority

2.1 The Alliance is established by the Participants, who remain sovereign organisations, to provide a financial and governance framework for the delivery of the Services. The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

2.2 The Agreement establishes the HARAB to lead the Alliance on behalf of the Participants. As a result of the status of the Alliance the HARAB is unable in law to bind any Participant so it will function as a forum for discussion of issues with the aim of reaching consensus among the Participants.

2.3 The HARAB will function through engagement between its members so that each Participant makes a decision in respect of, and expresses its views about, each matter considered by the HARAB. The decisions of the HARAB will, therefore, be the decisions of the Participants, the mechanism for which shall be authority delegated by the Participants to their representatives on the HARAB.

2.4 Each Participant shall delegate to its representative on the HARAB such authority as is agreed to be necessary in order for the HARAB to function effectively in discharging the duties within these Terms of Reference. The Participants shall ensure that each of their representatives has equivalent delegated authority. Authority delegated by the Participants shall be defined in writing and agreed by the Participants and shall be recognised to the extent necessary in the Participants' own schemes of delegation (or similar).

2.5 The Participants shall ensure that the HARAB members understand the status of the HARAB and the limits of the authority delegated to them.

2.6 The HARAB operates within a Partnership Framework as set out in Figure 2 of this Terms of Reference.

[5] Harroate and Rural Alliance Board (HARAB) Terms of Reference as at 16/8/19

3 Responsibilities

3.1 The HARAB will:

a) support alignment of service delivery in line with the Harrogate and Rural Alliance vision and objectives;
b) promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;
c) formulate, agree and ensure implementation of strategies for achieving the Alliance Objectives and the management of the Alliance;
d) discuss strategic issues and resolve challenges including those escalated by the Alliance Leadership Team such that the Alliance Objectives can be achieved;
e) respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;
f) agree performance outcomes/targets for the Alliance such that it achieves the Alliance Objectives;
g) review the performance of the Alliance, holding the Alliance Director and Leadership Team to account, and determine strategies to improve performance or rectify poor performance of the Alliance;
h) ensure that the Alliance Director and Leadership Team identify and manage the risks associated with the Alliance, integrating where necessary with the Participants' own risk management arrangements;
i) generally, ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders as set out in Figure 1 of this Terms of Reference (Stakeholder diagram);
j) contribute to the requirements of relevant regulators in respect of the services in the scope of the Alliance and other stakeholders through appropriate means, as determined by the Participants
k) oversee the implementation of, and ensure the Participants' compliance with this Agreement and ensure that Alliance activities do not jeopardise any of the individual Participants' contractual requirements;
l) review the governance arrangements for the Alliance at least annually.

4 Accountability

4.1 The HARAB is accountable to the Participants through the representatives delegated as members on behalf of the Participants.

4.2 The minutes shall be accompanied by a report on any matters which the Chair considers to be material. It shall also address any minimum content for such reports agreed by the Participants.

4.3 The minutes of the HARAB meetings will be sent to the Participants (usually via the HARAB membership) in advance of the next meeting.

5 Membership and Quorum

5.1 The HARAB will comprise:

- 5.1.1 Harrogate and District NHS Foundation Trust: Chief Operating Officer
- 5.1.2 North Yorkshire County Council: Corporate Director, Health and Adult Services
- 5.1.3 NHS Harrogate and Rural District Clinical Commissioning Group: Director of Strategy and Integration
- 5.1.4 Tees, Esk and Wear Valleys NHS Foundation Trust: Director of Operations for North Yorkshire and York
- 5.1.5 Yorkshire Health Network: Chair of the Network

5.2 The following persons should attend meetings of the HARAB as observers but will not participate in decisions:

- 5.2.1 Harrogate and Rural Alliance Director
- 5.2.2 Harrogate and District NHS Foundation Trust: Operational Director, Long Term and Unscheduled Care
- 5.2.3 North Yorkshire County Council: Assistant Director, Care and Support
- 5.2.4 Primary Care Networks: A Clinical Director
- 5.2.5 Yorkshire Health Network: Chief Operating Officer

5.3 Others may attend on an as required basis to contribute to items.

5.4 The HARAB will be quorate if:

(a) two thirds of its members are present, of which;
(b) at least one commissioner participant, one provider participant and one primary care provider participant.

5.5 Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Named deputies must be able to contribute and make decisions on behalf of the Participant that they are representing in accordance with individual Participant Schemes of Delegation. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

5.6 Subject to the members present being able to represent the views and decisions of the Participants who are not present at any meeting. Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Named deputies must be able to contribute and make decisions on behalf of the Participant that they are representing in accordance with individual Participant Schemes of Delegation. Deputising arrangements must be agreed with the Chair

prior to the relevant meeting.

5.7 The HARAB will be chaired by a member of the Board based on a majority vote of the HARAB members on an annual basis.

5.8 The Chair will be held by the nominated member for a period of no more than two consecutive years.

6 Conduct of Business

6.1 Meetings will be held monthly initially and from time to time as an extraordinary meeting as required by the needs of the Alliance.

6.2 The agenda will be developed in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place one week before the meeting is scheduled to take place. In the event members wish to add an item to the agenda they need to notify the Chair's nominated representative who will confirm this with the Chair accordingly.

6.3 At the discretion of the Chair business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

6.4 At the discretion of the Chair a decision may be made on any matter within these Terms of Reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

6.5 The HARAB shall receive reports from the ALT at least quarterly.

6.6 In accordance with Clause 18.4 of the Alliance Agreement, a Rectification Notice may be issued by any organisations within the Harrogate and Rural Alliance. The Chair shall be responsible for overseeing the subsequent Rectification Meeting(s) as set out in the Alliance Agreement. In a situation where the Chair is conflicted, the non-conflicted members of the HARAB shall nominate an alternative representative to oversee this process.

7 Decision Making and Voting

7.1 Each member of the HARAB shall have one vote in any decisions and motions will be carried on a majority basis.

7.2 Majority decisions can only be carried if the voting majority include at least one of the Commissioner Participants.

7.3 Decision made subject Clause 7.1 and 7.2 shall be binding all Participants.

8 Conflicts of Interests

8.1 The members of the HARAB must refrain from actions that are likely to create any actual or perceived conflicts of interests.

8.2 The HARAB shall manage Conflicts of Interests in line with the Board's approved protocol for addressing actual or potential conflicts of interests among its members (and those of the ALT).

9 Confidentiality

9.1 Information obtained during the business of the HARAB must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

9.2 Members of the HARAB are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Alliance. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

10 Support

10.1 Secretariat support to the HARAB will be agreed by the partners.

11 Review

11.1 The HARAB Terms of Reference will be formally reviewed at least annually.

11.2 Terms of Reference Approved Date 29th August 2019

11.3 Terms of Reference Review Date 29th August 2020

Figure 1: Stakeholder diagram[6] - See Schedule 4 (Governance) of this Agreement
Figure 2: Partnership Framework[7] - See Schedule 4 (Governance) of this Agreement

[6] Stakeholder diagram as at 16/8/19
[7] Partnership Framework as at 16/8/19

Schedule Six (Part 2): Terms of Reference for Commissioner Review Meeting[8]

HARROGATE AND RURAL ALLIANCE (HARA)
COMMISSIONER REVIEW MEETING
TERMS OF REFERENCE

1 Purpose of the Commissioner Review Meeting

To establish a Commissioner Review meeting that aligns the commissioning intentions and plans of North Yorkshire County Council (NYCC) and Harrogate and Rural District Clinical Commissioning Group (HARDCCG) to realise the vision of the Harrogate and Rural Alliance to:

"Deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Services will be aligned to defined primary care networks to create an enhanced local offer that delivers benefit for the population through maximising the local resource and assets"

2 The Aims and Objectives

2.1 To explore further integration of service planning and commissioning arrangements in relation to HARA.

2.2 To formally review operational and financial performance and discuss by exception where performance is not acceptable or has an impact on safety and quality, agreeing service performance actions and timescales to mitigate and recover the position to acceptable levels. It will provide committee members with greater clarity on the underlying performance (in terms of cost, activity, quality and safety) on commissioned services.

2.3 To ensure better investment and spend of public monies to meet the statutory requirements of each agency and to deliver the service and financial imperatives of both NYCC and HaRD CCG in relation to HARA.

2.4 To improve service delivery efficiencies (cashable or non-cashable) of HARA through joint planning and commissioning arrangements.

2.5 To determine any actions necessary to support the objectives of the integrated delivery model; to act upon and/or communicate these through the Partnership Framework in line with the principles set out in Clause 3.7 of the Commissioner Section 75 Agreement.

2.6 To maintain an effective dialogue with the HARA Leadership Team to ensure that market intelligence informs strategic commissioning decisions.

[8] Commissioner Review meeting Terms of Reference as at 15/8/19

2.7 To support service development and commissioning through a collective approach which can share evidence, intelligence, good practice, and progress to build a sustainable HARA that has people who use services at the centre of design.

3 Reporting Requirements

3.1 To regularly monitor performance to provide feedback to HARAB and assurance to the sovereign organisations in relation to implementation of the HARA integrated service model.

3.2 To receive (as a minimum) quarterly reports from the HARA Alliance Director, in a form to be agreed, to fulfil NYCC and HaRD CCG performance management requirements and to agree appropriate action resulting from the above reports were necessary.

3.3 The Finance Lead(s) will meet formally on a quarterly basis as part of the Commissioner Review meetings to facilitate Clause 8.3.8 of the Section 75 Agreement and, in particular consider: the forecast financial position compared to the planned financial position; strategic cost pressures of each Party that may impact on the Agreement; any cumulative risk factors that may impact on this Agreement.

4 Membership, frequency and quoracy

4.1 The Commissioner Review meeting will be held quarterly in the Harrogate and Rural District.

4.2 Membership of the Commissioner Forum to include:

- 4.2.1 Corporate Director Health and Adult Services and a senior Commissioning Officer, NYCC
- 4.2.2 Director of Strategy and Integration and Senior Commissioning Officer HaRD CCG.
- 4.2.3 Director of Finance, NYCC
- 4.2.4 Chief Finance Officer, HaRD CCG

4.3 The Commissioner Forum will be quorate when all 4 members are present. A nominated deputy may be agreed for this purpose.

5 Conflicts of Interest

5.1 Where a member has, or becomes aware of, an interest in relation to a matter subject to action or decision of the committee, the interest must be considered as a potential conflict.

5.2 The member must declare the interest as early as possible and shall not participate in the discussions.

5.3 The Chair will take the decision to request that member to withdraw until the Committee's consideration has been completed. Because of matters of quoracy, arrangements should be made in advance to enable the alternate member to be present.

5.4 If the Chair is conflicted, then arrangements must be made in advance of the meeting for one of the other Forum members to Chair and for the alternate to also be present.

6 Chair arrangements

6.1 The Chair of the Commissioner Review Meeting to be either the Corporate Director Health and Adult Services, NYCC or the Director of Strategy and Integration, HaRD CCG. The Chair position to be held for a period of 12 months and then rotate.

6.2 The secretariat for the Commissioner Review Meeting will be provided by the employing organisation of the Chair.

7 Accountability

7.1 The Commissioner Forum is accountable to their sovereign organisations.

8 Governance

8.1 Figure 1[9] illustrates how the Commissioner Review meeting relates to other elements of the HARA Governance framework.

9 Review

11.2 The Commissioner Review meeting Terms of reference will be formally reviewed at least annually.

11.2 Terms of Reference Approved Date 29th August 2019

11.3 Terms of Reference Review Date 29th August 2020.

[9] See Schedule 4 (Governance) Figure 1 for the Stakeholder diagram

Annex 2

DATED 3rd October 2019

Harrogate Rural NHS Foundation Trust (1)

And

North Yorkshire County Council (2)

SECTION 75 PARTNERSHIP AGREEMENT

For the creation of shared service delivery arrangements for Health Care, Public Health and Adult Social Care Service in the geography of Harrogate and Rural District

These arrangements include the use of Section 75 powers to establish core and aligned budgets to support delivery of integrated services to the Harrogate and Rural District population

Harrogate and District NHS Foundation Trust

North Yorkshire County Council

On behalf of Harrogate and District NHS Foundation Trust
Steve Russell, Chief Executive Officer

The Trust's Responsible Officer:
Robert Harrison, Chief Operating Officer

On behalf of North Yorkshire County Council
Richard Flinton, Chief Executive Officer

The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

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2. The Parties:

3) **HARROGATE AND DISTRICT NHS FOUNDATION TRUST** of Lancaster Park Road, Harrogate, HG2 7SX ("the Trust");

4) **NORTH YORKSHIRE COUNTY COUNCIL** of County Hall, Northallerton, DL7 8AD ("the Council")

2. Background

2.1 The Council has responsibility for commissioning and/or providing public health and social care services on behalf of the resident population of the borough of Harrogate.

2.2 The Trust has responsibility for delivering health services commissioned by NHS Harrogate and Rural District Commissioning Group ("the CCG") pursuant to the 2006 Act for the population of people resident in the Harrogate and Rural District CCG area and patients registered to GP practices within same area.

2.3 Section 75 of the 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; to establish integrated commissioning arrangements and to establish integrated management functions in relation to health and social care services.

2.4 The purpose of the Agreement is to put in place the arrangements required to govern and manage delivery of integrated services, supported by a Pooled Fund in the geography of Harrogate and Rural District. The Harrogate and Rural Alliance Board (HARAB) will be established as the vehicle through which all parties will discharge their shared responsibilities in respect of working together within the defined financial schedules. This Agreement applies to the defined health, public health and social care services provided to the residents of the North Yorkshire County Council and to patients registered with the GP Practices within the Harrogate and Rural District CCG area and whose medical services contracts are managed by the CCG.

2.5 All partner organisations within the geographical scope of the Agreement face significant financial challenges despite delivering cost saving programmes over recent years. The health and social care system overall is challenged in terms of continuing to deliver high quality care within reduced financial envelopes and within the context of austerity.

2.6 The Parties will remain sovereign in line with their statutory duties and responsibilities.

2.7 These Partnership Arrangements have been established pursuant to Section 75 of the Act and pursuant to the Regulations.

3 Joint vision

3.1 The vision for the programme is that it will:

"Deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Services will be aligned to defined primary care networks to create an enhanced local offer that delivers benefit for the population through maximising the local resource and assets"

3.2 The Parties have a shared vision of a timely transformation towards an integrated approach to commissioning and provision of health care, public health and social care services in Harrogate and Rural District. The parties believe that co-ordinating and integrating their planning, commissioning and delivery activities will help facilitate the best use of resources to support the local resident and patient population.

3.3 The ambition for the programme is that the new integrated service will:

- Have prevention as the starting point.
- Develop a new model, anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource.
- Provide care at home wherever possible.
- Focus on population health as opposed to organisations.
- Where possible, be a Primary care practice centred model (hybrid model between practices and geography).
- Include primary care daily involvement and commitment
- Have active involvement from people who use services and carers.

3.4 The value of working together as commissioners and providers locally to bring about change in a meaningful way is recognised. There is a clear desire to build on the strength of the provider and commissioner relationships in the Harrogate and Rural area to deliver affordable and sustainable health and care. Therefore, the programme aims to develop and create a new integrated service model. This Agreement reflects the Parties' commitment to the integration of services to be delivered against agreed measures of effectiveness and financial outcomes.

3.5 A Partnership Framework has been put in place to support the formal and legal arrangements between partner organisations. The objective of the Partnership Framework is to improve the outcomes for health and social care users from commissioned services through closer working between the National Health Service and Local Government to the extent (from time to time and subject to the terms of this Agreement) that it is lawful to do so and consistent with the obligations of the Parties to co-operate with each other in the planning, commissioning and delivery of services.

3.6 The Agreement is grounded in the following Principles which have been agreed by the Partners:

Principles to be applied to the integrated care delivery model	
1	Demonstrates an integrated approach to prevention and care to include physical and mental health integrated with social care.
2	Focuses on self-care and prevention to promote independence and reduce pressures on the health and social care system.
3	Clear access points for people to receive modern health and social care services from co- located teams.
4	Ensures people have access to high quality services when needed within a simplified system.
5	Works closely with the community and the voluntary sector.
6	Evidence of Alliance Agreement/partnership to facilitate whole system approach, which is about more than a document or a contract and refer to an alliance style of working, based on constructive, productive relationships.
7	Has effective governance arrangements.
8	Plans to vary the flow of money and resources are identified and agreed underpinned by risk/gain share agreements.
9	Uses whole population budgets and is not based on paying for single events (e.g. “procedures”, “admissions”, “attendances”, “contacts”).
10	Describes how outcomes will be achieved within available resources and timeframe.
11	Any shift in activity between providers within the system needs to be balanced by demonstrable shift in resource where required.
12	The change management plan supports staff through change, identifies and introduces any required new skills and promotes innovation.
13	A clear estates strategy that supports delivery of a modern health and care estate.
14	Has a strategic leadership role for General practice which recognises and develops the full spectrum of primary care service delivery.
15	Enables strong clinical and practitioner operational leadership, including the GP as the expert generalist with the person.
16	To improve the quality and efficiency of services enables the sharing of records, data and information including integrating information management and technology.
17	Enables innovation in service provision using technology.
18	Seeks continuous and effective involvement with public, patient and colleague involvement. Where service changes are proposed, ensure consultation in line with legislation and best practice.

4. Section 75 provider document purpose

4.1 The Parties believe that the integrated delivery arrangements proposed by this Agreement fulfil the objectives set out by: the North Yorkshire Health and Wellbeing Board within the Joint Health and Wellbeing Strategy; the NHS Constitution; the key plans of the NHS locally and nationally; of North Yorkshire County Council and guidance in so far as it relates to local, regional

and national requirements, the Council Plan and the Council's relevant strategic directorate business plans.

4.2 The purpose of this Section 75 Agreement is to:

4.2.2 Record the intentions of the Parties to work together in delivering health, public health and adult social care services.

4.2.3 Allow for the establishment of integrated management arrangements as set out in Schedule Four. These arrangements will be reviewed throughout the mobilisation phase (March 2019 to September 2019) to allow adjustment in line with the objectives of the Programme. Any change to the services after 1 October 2019 will be enacted in line with Clause 35 of this Agreement.

4.2.4 Describe the role of the Harrogate and Rural Alliance Board within the Partnership Framework and to make formal arrangements for its procedures and actions.

4.2.5 Describe the health, public health and social care services, as set out in Schedule Two, to be covered by the Partnership Framework.

4.2.6 Make the necessary delegation, governance, audit and regulatory arrangements to facilitate the purposes listed above as agreed by each organisation within this Agreement. Each organisation will remain sovereign for decision making through its own internal procedures.

5. Definitions and interpretation

5.1 In this Agreement, unless the context otherwise requires, Schedule One pertains.

6. Integrated service delivery

6.1 The arrangements set out in this Agreement shall be how the Parties work in partnership to deliver the services described in Schedule Two.

6.2 During the period of this Agreement the Parties will co-operate with a view to introduce integrated service delivery where appropriate and with the agreement of both Parties. Where this is not appropriate the Parties will co-operate to ensure that service delivery by all Parties is done in a co-ordinated and joined up manner.

8. Integrated service delivery objectives

7.1 The Parties shall seek to achieve the following objectives through the integrated service delivery arrangements set out in this Agreement:

7.1.1 Improved quality of care through integrated service planning and delivery arrangements.

7.1.2 Ensure better investment and spend of public monies to meet the statutory requirements of each agency and to deliver the service and financial imperatives of both parties.

7.1.3 Improved service delivery efficiencies (cashable or non-cashable) through joint planning and delivery arrangements.

7.1.4 Exploration of increased integration of service planning and delivery arrangements.

7.1.5 Progression of any steps required to develop a future procurement strategy for the better integration of services.

8. Integrated service arrangements covered by this Agreement

8.1 The Parties propose to deliver the services described in Schedule Two of this Agreement subject to the governance arrangements set out in Schedule Five of this Agreement.

8.2 The HARA service management structure, as set out in Schedule Four, will facilitate the following:

8.2.1 To oversee the use of HSCA 2012 flexibilities for establishing and then operating a Pooled Fund to support integrated service delivery between the Parties under the terms of this Agreement.

8.2.2 To manage services within the overall Pooled Fund, the component individual service elements and the required Party contributions to the Pooled Fund.

8.2.3 To monitor the Pooled Fund in accordance with NHS England guidance, making use of recommended best practice templates and to report to the Responsible Officers for sign off and in relation to any specific required annual returns relevant to the Parties' statutory duties and responsibilities in so far as they relate to this Agreement.

8.2.4 To receive proposals from the Finance Lead(s) for managing the financial aspects of the Pooled Funds for consideration by both Parties, including the initial separate management of the Parties contributions and then, following any pooling of the aligned resources, the risk management arrangements associated with this.

8.2.5 To inform (as a minimum) HARA performance reports, to include both service and financial information, in a form to be agreed, to fulfil the Parties' performance management requirements and to agree appropriate action resulting from the above reports were necessary.

8.2.6 To effectively deliver integrated service objectives and targets, ultimately demonstrating improved outcomes for service users

and making recommendations to the HARA Board as to any amendment to its functions.

8.2.7 To report to the sovereign organisations, on an appropriate basis, on the integrated service delivery arrangements to ensure appropriate reporting and accountability in line with each Party's internal governance arrangements.

8.2.8 Any other purposes as may be deemed appropriate by the Parties and agreed as set out in this Agreement.

8.3 Where there is agreement on joint service delivery, the service contract(s) will initially be between the Party with responsibility for delivery of that service and the commissioner of the service.

8.4 Following the establishment of integrated service delivery arrangements through the Pooled Fund, service provision may be undertaken by either Party or as otherwise provided for under this Agreement as long as both Parties agree as set out in a written agreement between the Parties.

8.5 Services may be flexed to maximise the opportunities for integrated service delivery where this meets the principles agreed by the Partners subject to Clause 3.7 and/or the integrated service delivery objectives set out in Clause 7 of this Agreement.

8.6 Subject to Clause 8.5, the Alliance Director will be responsible for issuing a revised Schedule Two and/or Schedule Four as a formal amendment to this Agreement.

8.7 The Finance Lead(s) will meet formally on a quarterly basis to facilitate this Agreement and, in particular consider: the forecast financial position compared to the planned financial position; operational and strategic cost pressures of each Party that may impact on this Agreement; any cumulative risk factors that may impact on this Agreement.

9. Delegations

9.1 Under the arrangements the Parties retain individual sovereignty for the specified services. Where it is deemed by the Parties that the objectives of this Agreement can be met through shared service delivery arrangements, the Parties will work together, and with other members of the Partnership Framework, in partnership (but not so as to create the legal relationship of partnership between them), to implement the shared planning and delivery arrangements set out in this Agreement. To support delivery for the services to be provided under Schedule Two the Parties agree that:

9.1.1 In the event that any delegation of powers by any of the Parties provided for under this Agreement shall require obtaining the consent or approval of any Minister of the Crown, Government Department or any other body formally constituted for that (and other) purposes then the Party required to seek such consent or

approval shall use its best endeavours to do so and in a timely fashion, efficiently and without unreasonable delay.

9.1.2 The Parties shall only delegate such powers to each other as are required to implement the terms of this Agreement and through consent and specifically reserve all other statutory powers and functions to themselves.

10. Partial or incomplete delegations

10.1 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant service as set out in Schedule Two. The Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with those statutory constraints subject to 9.1.1 and 9.1.2.

11. Parties mutual responsibilities

11.1 The Parties agree that that, where appropriate and in relation to this Agreement, they shall work together for the purposes of undertaking shared planning and delivery arrangements to achieve the objectives described in Clause 7 and shall:

11.1.1 Co-operate with each other in the conduct of all activities relating to the objectives.

11.1.2 Make the necessary delegations as set out in Clauses 9.1.1 and 9.1.2 including any formal arrangements to give all necessary third-party consents or notifications.

11.1.3 Make all and any agreed contributions into the Pooled Fund as set out in Schedule Three promptly and without deductions for the purposes of providing the services.

11.1.4 Make any necessary arrangements to make payments from the Pooled Fund as agreed by the Parties to provide the services that have been commissioned under this Agreement.

11.1.5 Operate all their related activities and services in a manner that is compatible with the objectives set out in Clause 7 so far as they are not inconsistent with their other legal obligations or formal service delivery arrangements.

11.1.6 Operate the integrated service delivery arrangements set out in Clause 8 and fulfilling all responsibilities relating to them as agreed in this Agreement.

11.1.7 Both Parties shall work in co-operation and shall endeavour to ensure that the services specified in Schedule Two are delivered with all due skill, care and attention through the Partnership Arrangements and in the spirit of the Partnership Framework.

11.1.8 Exercise candour in their dealings with each other and conduct themselves transparently in any negotiations, including

disclosing any reasonable prospect that there shall be a conflict of interest between them.

11.1.9 Unless otherwise specifically agreed in writing, overspends in relation to this Agreement are the responsibility of the relevant provider organisation.

12. Legacy contracts, transitional service arrangements

12.1 All Parties agree that any contracts for the full or partial delivery of the services specified in Schedule Two that are continuing at the date of this Agreement and which are between the Parties and other commissioners/providers (legacy contracts) will be unaffected by this Agreement.

13. Role of the Harrogate and Rural Alliance Board

13.1 The main aim of the HARAB is to deliver care wrapped around primary care networks of c. 30-50,000 population to support strategic delivery of an integrated health and social care model which optimises the Parties' resources to improve health and care outcomes for the defined population.

13.2 The HARAB will provide strategic direction on issues of operational delivery for the services described in Schedule Two of this Agreement. The HARAB will operate within a defined Terms of Reference as set out in Schedule Six of this Agreement.

13.3 Implementation of the decisions taken by the HARAB shall be under the overall direction of the Alliance Director as the lead operational manager, as reflected in the Partnership Framework.

14. Monitoring and review of the Harrogate and Rural Alliance Board

14.1 The Responsible Officers of the Parties shall from time to time agree joint arrangements to monitor and review the way the HARAB exercises it's functions as set out in this Agreement to ensure that they are exercised in compliance with the law and with the terms of this Agreement and that the way they are exercised is both effective and appropriate.

14.2 The HARAB will make any necessary reports to the Health and Wellbeing Board outside the terms of this Agreement as may be required under the HSCA 2012.

15. Financial accountability and risk sharing

15.1 Each party will maintain its existing financial accountability and internal and external audit arrangements and shall bear its own risks in relation to the integrated service delivery arrangements. By way of clarification this means that the Council will follow its Financial Procedure rules and the Trust will

follow its own Standing Financial Instructions and Standing orders as last approved by the Trust Board.

15.2 The approach to bearing risks will remain under continuous review by all Parties in line with the objectives of the Agreement relating to integrated service delivery and the management of the Pooled Fund. The default position (unless otherwise agreed by both Parties in writing) will be that the relevant provider Party who has responsibility for the service in question will be liable for the overspend subject to Clause 19.

15.3 The Alliance Director shall present an annual report to the HARAB which shall include income and expenditure received by or incurred from the Pooled Fund.

16. Pooled Fund

16.1 The Parties agree as follows:

16.1.1 Responsibility for accounting, audit and the financial reporting of the overall Pooled Fund will be the Finance Lead(s) nominated by each party.

16.1.2 The Finance Lead(s) will create a clear identifiable accounting structure within their financial systems to enable effective monitoring and reporting of the Pooled Fund and the budgets of the Individual Pooled Services.

16.1.3 The Finance Lead(s) will be responsible for maintaining an overall accounting structure for the Pooled Fund to be deployed by the Alliance Director.

16.1.4 The Parties will determine delegation of financial responsibility to the Alliance Director who will work through the HARAB to deliver the services set out in Schedule Two of the Agreement on behalf of the Parties and the HARAB.

16.1.5 The level of financial delegation pertinent to the Alliance Director will be set out in a specific Scheme of Delegation to reflect permissions in line with his employing organisation and any associated honorary contract arrangements.

16.1.6 Parties will, through the auspices of the Finance Lead(s) provide the Alliance Director and the Individual Pooled Service Budget Managers with the necessary financial advice and support to enable the effective and efficient management of the Pooled Fund and any Individual Pooled Service Budget.

16.1.7 The Alliance Director will provide information as is deemed necessary by the Parties to enable effective performance management of the Services provided under this Agreement. As a minimum, this information will include budget monitoring, service performance and workforce analysis in accordance with 15.3.

17. Operation of the Pooled Fund

17.1 The Parties will agree the Pooled Fund as set out in Schedule Three for each Financial Year in accordance with this Clause 17.1. The contributions for the Financial Year 2019/20 and indicatively for 2020/21 are as set out in Schedule Three and will be used as a basis for agreeing any future Financial Year contributions from the Parties. Such annual contributions will be evidenced in writing by insertion into the said Schedule Three as an agreed amendment.

17.2 The Parties agree that the annual Pooled Fund will be confirmed by 31 March for the following Financial Year, subject to budget setting processes. HARAB will receive notice of planned contributions within a reasonable timescale and no later than one week after the Parties have formally approved said contributions in line with sovereign organisational budget setting processes.

17.3 The Alliance Director shall ensure that Value for Money is always actively secured in making payments from the Pooled Fund to deliver the services set out in Schedule Two.

17.4 Any monies specifically allocated by the government for particular client groups, services or specific projects shall be considered and put into the relevant Pooled Service Budget subject to such discretions that funding allocations allow to the Parties. The Responsible Officers, or their nominated deputies, shall approve the expenditure plans for such grants and report appropriately for such purposes. The appropriate Individual Pooled Service Budget manager will ensure that the conditions of the grant are met. Where grants are put into relevant Pooled Service Budgets any underspends in the grant will be carried over to the next Financial Year unless this is not allowed by the conditions of the grant.

17.5 For the avoidance of doubt, all funding between the organisations supplied under this Agreement is included in each party's annual contribution to the Pooled Fund.

17.6 Where a change to the Pooled Fund is made to the extent that it is reflected in Schedule Three this should be reported to the HARAB at the earliest opportunity by the Alliance Director.

18. Contributions to the Pooled Fund

18.1 The annual Pooled Fund will normally be calculated as the initial Pooled Fund for the previous year. Annual contributions to the Pooled Fund will be agreed between the Parties and may consider, but not limited to, the following: recurrently rolled forward Funds from previous year

18.1.1 plus, or minus agreed in-year changes where recurrent (overspends or underspends)

18.1.2 plus, or minus agreed inflationary uplift

18.1.3 plus, or minus planned and agreed changes, and

18.1.4 minus planned and agreed efficiency requirements

18.2 The Parties agree that these changes must not have a detrimental financial impact on either Party unless specifically agreed with the Party adversely affected and approved by the Responsible Officers, or their nominated deputies.

18.3 Contributions agreed by Parties will be formally budgeted for prior to the start of the new Financial Year.

18.4 The Parties may not normally vary their annual contributions to the Pooled Fund during the course of the Financial Year to which the annual contribution applies. Any variations to the Parties' annual contributions must be agreed in writing by the Responsible Officers following consideration of information prepared by the Parties' respective Finance Leads.

18.5 The contribution by the Council to the Pooled Fund shall be made upon the gross figure prior to deductions for charges levied on Service Users, or any associated or expenses or as alternatively agreed.

18.6 The services set out in Schedule Two and the relevant budgets in Schedule Three shall set out any non-financial contributions (and the service or services to which they relate) of each Party including staff (Alliance Director), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

18.7 Both Parties may contribute additional resource which supports management and delivery of the integrated service model which is not detailed in Schedule Three. Such contributions will be the responsibility of each individual Party unless a variation to the Agreement is considered appropriate, subject to Clause 35.

18.8 Changes forecast to the total level of agreed Pooled Fund expenditure for the year shall be reported to the HARAB in the first instance through the Alliance Director.

18.9 The Pooled Fund shall only be used for the provision of services as set out at Schedule Two to this Agreement.

18.10 The Parties recognise that there may be scope to develop the Partnership Framework and to bring other budgets and services in addition to those specified in Schedule Two into the Pooled Fund or aligned arrangements from time to time and any such changes will be treated as variations to this Agreement and will be evidenced in writing and scheduled to this Agreement subject to Clauses 8.6 (schedule variation), Clause 35 (formal review and variation to the Agreement).

19. Pooled Fund: Underspends and overspends

19.1 The Parties have agreed that as a general principle the Pooled Fund is a defined budget for each Party as set out in Schedule 3.

19.2 In the context of this Agreement, any underspends or overspends will be the responsibility of the relevant party and not shared.

20. Division of Pooled Fund into Individual Pooled Service Budgets (PSB's):

20.1 The HARAB shall establish suitable arrangements for the purposes of creating pooled service budgets for the individual services to be provided under this Agreement to be operated in accordance with the financial governance arrangements set out in this Agreement and the budgets set out in Schedule Three.

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

21. Capital expenditure

21.1 No part of the Pooled Fund shall 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 the Council. While the Trust generates a resource for capital through depreciation, this has a minor impact on the services described. There are no capital budgets within the Trust linked to this Agreement. If a need for capital expenditure is identified this must be agreed by the Parties.

22. Relationship between parties and HARAB, over-arching principle of financial probity

22.1 All Parties shall promote a culture of financial probity and sound financial discipline and control in relation to the arrangements set out in this Agreement.

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

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

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

22.5 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties 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.

23. Data and information sharing

23.1 Information shall be shared between the Parties save that no commercially sensitive information shall be communicated between the Parties in the course of the operation of this Agreement without the express agreement of the Responsible Officer for either Party.

23.2 Any and all agreements between the Parties shall be subject to their duties under the Data Protection Act (the 2018 Act), the Freedom of Information Act (the 2000 Act) and the Environmental Protection Regulations 2004 (the 2004 Act).

23.3 The Parties agree that they will each co-operate with each other to enable any Party receiving a request for information under the 2000 Act, the 2004 Act or the 2018 Act to respond to a request promptly and within the statutory timescales. This co-operation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Parties as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

23.4 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act, the 2004 Act or the 2018 Act. No Party shall be in breach of Clause 23 if it makes disclosures of information in accordance with any of the Acts set out in Clause 23.

23.5 Any processing of data that is undertaken by the Parties, their servants, employees, agents or subcontractors in the course of this Agreement shall comply with the Fair Data Processing principles set out in the 2018 Act. Provisions for Data Processing, Personal Data and Data Subject are shown on Schedule 5A.

24 Confidentiality

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

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

(d) 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 Party:

24.3.1 may only disclose Confidential Information to its employees (this includes individuals with Honorary Contract status) and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25. Managing conflicts of interest

25.1 The Parties shall comply with the agreed principles for identifying and managing conflicts of interest via adherence to their own policies ensuring they meet the NHS England Managing Conflicts of Interest Statutory Guidance.

25.2 Where a dispute between the parties occurs this shall be subject to Clause 26 of the Agreement.

26. Resolution of service delivery disputes between parties by mediation

26.1 In the event of a dispute between the Parties arising out of this Agreement, either Party may serve written notice of the dispute on the other Party, setting out full details of the dispute.

26.2 The Responsible Officers, or their nominated deputy, shall meet in good faith as soon as possible and, in any event, within seven 7 days' notice of the dispute being served pursuant to Clause 25 at a meeting convened for the purpose of resolving the dispute.

26.3 If the dispute remains after the meeting detailed in Clause 26.2 has taken place, then the Parties will escalate the issue to the Chief Officers who shall meet in good faith as soon as possible and, in any event, within 7 days' notice of the escalation by one of the Parties.

26.4 If the dispute remains after the meeting detailed in Clause 26.3 has taken place, then the Parties will mutually agree further action to resolve the issue. If either Party does not agree to any such proposed further action, the Parties will attempt to settle such dispute by formal mediation in accordance with an independent mediation procedure as agreed by the Parties. To initiate mediation, either Party may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to the Centre for Effective Dispute Resolution (CEDR) or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Party 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, Clause 14 of the Model Mediation Procedure will apply (or the equivalent Clause of any other model mediation procedure agreed by the Parties). The Parties 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.

27. Liabilities, insurance and indemnity

27.1 Subject to Clause 9, if a Party ("First Party") incurs a Loss arising out of or in connection with this Agreement or in relation to the Services to be jointly commissioned under the terms of this agreement as a consequence of any act or omission of another Party ("Other Party") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the contract under which the Services are to be provided then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

27.2 Clause 27.1 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Party acting in accordance with the instructions or requests of the First Party or the HARAB.

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

27.3.1 As soon as reasonably practicable give written notice of that matter to the Other Party specifying in reasonable detail the nature of the relevant claim.

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

27.3.3 Give the other Party 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 Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purposes of assessing the metis of and if necessary, defending the relevant claim.

27.4 Each Party 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 legal liabilities arising in tort from this Agreement.

27.5 Each Party 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.

28. Conduct of claims

28.1 In respect of the indemnities given in this Clause 28:

28.1.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

28.1.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters.

28.1.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

29. Term of Agreement

29.1 This Agreement will commence on 1 October 2019 and expire at 31 March 2022. Thereafter it can be extended on a year to year basis at the Parties' discretion and agreement for a maximum period of ten years subject to Clause 35.

29.2 Unless otherwise stated, the duration of the arrangements for each element of service shall be as set out in Schedule Two.

30. Continued co-operation between parties after end of the Agreement

30.1 The Parties shall continue to co-operate with each other or their statutory successors following the termination of this agreement (for any reason) with a view to ensuring the continuity of delivery of the services relating to them and the continued provision of health and social care to the served populations, subject to the requisite contractual arrangements for services.

31. Continuing contracts and liabilities arising from termination of the Agreement

31.1 In the event that this Agreement is ended then any contracts made under it will be deemed to continue as between the parties to that Agreement and the Parties will seek to co-operate under Clause 12 in relation to the arrangements made under such contracts.

32. Third party rights and contracts

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

33. Governing and applicable law

33.1 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.

33.2 Subject to Clause 26, the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

33.3 Ombudsman - The Parties 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.

34. Complaints procedures

34.1 During the term of the Agreement, complaints can be made to any Party to this Agreement and will be dealt with through that Party's usual complaints process in line with the statutory complaints procedure of that Party but where the complaint relates to all Parties, they will work together to provide a joint response.

34.2 Where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Responsible Officers, or their nominated deputies will set up a complaints subgroup to examine the complaint and recommend remedies.

35. Review and variation

35.1 The Parties shall formally review the Section 75 arrangements no later than 12 months (31 March 2021) prior to expiry of the Term (31 March 2022) with a view to varying the Agreement for the period 1 April 2021 to 31 March 2022 subject to Clause 35.1 or termination of the Agreement subject to Clause 46.

35.2 Formal review as set out in Clause 35.1 will be as directed by the Responsible Officers of the Parties and shall comprise:

35.2.1 the delivery of the Functions and any related Functions

35.2.2 the extent to which the objectives of the joint service delivery arrangements are met

35.2.3 compliance with and fulfilment of national and local policies

35.2.4 financial arrangements and continuous improvement in quality of care as determined by the outcomes and benefits agreed by the Parties.

35.3 The review and variation provisions in this Clause 35 shall apply as a means of developing and refining the parties' respective functions in relation to the services and fulfilling the objectives of this Agreement.

35.4 If at any time during the term of this Agreement either Party (First Party) wishes to vary this Agreement, they must set this out in writing and submit a Variation Notice to the Other Party (Second Party) for consideration. The Second Party must confirm their agreement or disagreement in writing fourteen (14) days after the necessary internal governance processes have been undertaken.

35.5 In the event of mutual agreement to the Variation Notice then a Memorandum of Agreement shall be prepared and executed by the Parties and thereafter the variation shall be binding.

35.6 If the Second Party does not agree to the request to vary the agreement, then the variation shall not take place.

35.7 The Parties may determine to renew the Agreement at the end of the Term subject to this Clause 35.

36. Appointment of Legal Advisors

36.1 The Parties shall in all circumstances where it is practicable to do so, and where both Parties are in agreement, take a single advisor approach to seeking legal advice in relation to the implementation of this Agreement, any dispute arising from it or any proposed change to or modification of its terms.

36.2 Agreement to a single advisor approach should be confirmed in writing between the Parties and is at the discretion of the Responsible Officers, or their nominated deputies.

36.3 Where there is potential for a conflict of interest to arise, Parties may obtain separate independent legal advice at their own expense.

37. Appointment of Financial and Audit Advisors

37.1 At all times the Parties shall retain their own financial and audit advisors for their financial and governance arrangements but may make arrangements for a single advisor in relation to specific matters where it is practicable to do so, and where both parties are in agreement.

37.2 Agreement to a single advisor approach should be confirmed in writing between the parties and is at the discretion of the Responsible Officers, or their nominated deputies.

38. Responsibility for public statements, press releases and social media

38.1 The Parties shall co-operate when issuing any public statement, press release or social media communication relating to the terms of this Agreement or any activity undertaken under it or discretion exercised by reference to it to the intent that both Parties agree such statement or release which should represent the agreed position of all parties in relation to such matters.

39. Entire Agreement

39.1 The terms herein contained together with the contents of the schedules constitute the complete Agreement between the Parties with respect to planning and delivery of services as set out in Schedule Two and supersede all previous communications, representations, understandings and agreement and any representation, promise or condition not incorporated herein shall not be binding on any Party.

40. No Partnership or Agency

40.1 Nothing in this Agreement shall create or be deemed to create a legal partnership or the relationship of employer and employee or agent and principal between the Parties.

41. Invalidity and severability

41.1 If any Clause or part of this Agreement is found by any court tribunal administrative body or authority of competent jurisdiction to be illegal invalid or unenforceable then that provision will to the extent required be severed from this Agreement and will be ineffective without as far as is possible modifying any other Clause or part of this Agreement and this will not affect any other provisions of this Agreement which will remain in full force and effect.

42. Counterparts

42.1 This Agreement may be executed in any number of counterparts or duplicates, each of which shall be an original, and such counterparts or duplicates shall together constitute one and the same agreement.

43. Notice

43.1 All formal Notices relating to this Agreement shall be given by hand, pre-paid first class post (or in accordance with the Postal Services Act 2000 if applicable) or facsimile transmission confirmed by pre-paid letter to the addressee at the address given below or such other address as the addressee shall have for the time being notified to the other Party giving notice and such notice shall be deemed to have been delivered either upon delivery if by hand or if by letter at the expiration of forty eight (48) hours after posting or if by facsimile, upon receipt.

44. Addresses

44.1 For the purposes of this Agreement, the address of each Party shall be:

(1) Harrogate and District NHS Foundation Trust:
Harrogate District Hospital
Lancaster Park Road
Harrogate
North Yorkshire
HG2 7SX

(2) North Yorkshire County Council:
County Hall
Northallerton
North Yorkshire
DL7 8AD

45. Force Majeure

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

45.2 On the occurrence of a Force Majeure Event, the affected Party shall notify the other Party 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 Party and any action proposed to mitigate its effect.

45.3 As soon as practicable, following notification as detailed in Clause 45.2, the Parties 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 45.4, facilitate the continued performance of the Agreement.

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

46. Termination

46.1 This Agreement shall terminate upon the effluxion of time except where Clause 35 applies, or the Agreement is otherwise renewed on review by the Parties.

46.2 In the event of dispute or disagreement relating to the terms and conditions of this Agreement, which cannot be resolved under this Agreement, then either Party may, by service of 3 months' notice in writing upon the other Party, terminate this Agreement.

46.3 In the event that the Agreement terminates, responsibility for the Trust's Functions exercised under the Agreement will be returned to the Trust and responsibility for the Council's Functions exercised under the Agreement will be returned to the Council.

46.5 Either Party may terminate the Agreement at any time with immediate effect in the event that:

46.5.1 There is a change in law that materially affects the Partnership Arrangements made pursuant to this Agreement under the Regulations or renders performance of any Party's obligations (or the obligations of any other party towards that Party) ultra vires.

46.5.2 One of the Parties is in material breach of its obligations under this Agreement, provided that where the breach is remediable, the non-defaulting Party shall require the defaulting Party to remedy the breach and if the defaulting Party so remedies the breach within one month, such breach shall not give rise to a right to terminate the agreement.

46.6 In the event of immediate termination of this Agreement the Pooled Funds, including underspends and overspends shall be returned to the Parties based on proportions of contributions to the Pool. In the event of assets being purchased from the pool, the Parties will provide proposals to the Responsible Officers, or their nominated deputies, on how these will be dealt with prior to the termination of the agreement. If these proposals cannot be agreed that Parties will refer to the dispute procedure at Clause 26.

46.7 Termination of the Agreement shall be without prejudice to the rights, duties and liabilities of the Parties or any of them that have accrued prior to termination.

47. Transferability of the Agreement

47.1 In the event that any individual role or statutory function of any Party that is a fundamental requirement for the effectiveness of this Agreement shall be transferred to another organisation then:

47.1.1 The remaining Parties shall first seek to negotiate a continuation of this agreement with that organisation and if that shall not prove possible within a reasonable period (to be agreed between the Parties) then this Agreement will be deemed to have ended due to supervening impossibility of performance.

47.2 Should either Party cease to exist or cease to be responsible for the defined functions then, subject to any applicable ministerial direction or delegated legislation, this Agreement shall be deemed to continue with any other organisation that takes over substantially all its role or statutory function with the Harrogate and Rural District boundaries.

47.3 The Parties shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the Other Party, 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 Party's statutory functions.

Schedule One: Definitions and Interpretations of this Agreement

Definition	Means
Agreement	this Section 75 document including its Schedules and Appendices jointly agreed by the Parties for the purposes of providing the Services pursuant to the Regulations and Section 75 of the Act.
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.
Alliance Agreement	the separate multi-agency partnership agreement entered into by the organisations that comprise the Harrogate and Rural Alliance Board set within the Partnership Framework
Alliance Director	the nominated officer responsible for operational delivery of the Harrogate and Rural Alliance Board's integrated care operating model and who will be accountable to the HARAB for the management of the Pooled Fund in accordance with the Pooled Fund arrangements.
CCG	the NHS Harrogate and Rural District Clinical Commissioning Group.
Trust functions	means such of those Harrogate and District NHS Foundation Trust functions as may be necessary to provide the Services.
Chief Officers	means the Chief Executive Officer of the Trust and the Chief Executive Officer of the Council.
Commencement Date	1 October 2019.
Confidential Information	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 Service User 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
Council's Functions	means such functions of the Council as may be necessary to provide the Services specified in Schedule Two.
Finance Lead(s)	the Section 151 Officer of the Council and the Finance Director of the Trust, or their nominated deputies.
Financial Year	a twelve-month period commencing on 1 April and terminating on the following 31 March.
Gender and persons	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

Definition	Means
Harrogate and Rural Alliance (HARA)	the collective name for the services comprising the integrated service delivery model for the population covered by this Agreement.
Harrogate and Rural Alliance Board (HARAB)	the strategic forum established by the Parties and other members of the Alliance to oversee the co-ordination and delivery of the integrated services.
Harrogate and Rural District CCG area	Harrogate and Rural District CCG area within the Boundary of North Yorkshire. It includes areas in which GPs listed by the CCG are practicing and for which commissioning responsibilities exist for the registered population.
Health-Related Functions	the public health functions of the Council under the HSCA 2012 and any other functions that may be exercised by the Council in its delivery of the Services specified in Schedule Two.
In the event of a conflict	the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
Indirect Losses	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 Pooled Service Budget Managers	being officers with delegated responsibility (for budgets and the provision of services) within an individual pooled service.
Individual Pooled Service Budgets	the budgets agreed between the Parties within the Harrogate and Rural Alliance Board to provide the services specified in Schedule Two of this Agreement from the Pooled Fund as set out in Schedule Three of this Agreement.
Integrated service delivery	a mechanism by which the Parties jointly operationally deliver a Service. For the avoidance of doubt, an integrated service delivery arrangement does not involve the delegation of any functions outside of this Agreement.
Losses	any and all direct losses, costs, claims, proceedings, damages, liabilities and any reasonably incurred expenses, including legal fees and disbursements whether arising under statute, contract or at common law but excluding indirect losses.
Mode of formal communication	subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Parties shall be in writing.
Money	unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but if 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.
Non-exhaustive lists	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.
Parties	together Harrogate and District NHS Foundation Trust and North Yorkshire County Council (provider responsibilities).
Partners	the organisations that comprise the HARA Board

Definition	Means
Partnership Arrangements	the arrangements jointly agreed by the Parties for the purposes of providing the services pursuant to the Regulations and Section 75 of the Act.
Partnership Framework	this Section 75 document (providers); a Section 75 document (commissioners) and associated Harrogate and Rural Alliance Agreement (members of the HARA Board).
Pool Host	The service provider that has responsibility for delivery of the services aligned to an Individual Pooled Service.
Pooled Fund	such fund or funds of monies received from separate contributions by the Parties for the purposes of providing the specified services to be delivered through the HARAB and which are set out in Schedule Two of this Agreement.
Pooled Fund Arrangements	means the arrangements agreed by the Parties for establishing and maintaining the Pooled Fund.
Reference to the Parties	shall include their respective statutory successors, employees and agents subject to the provision of Clause 30.1.
References to this Agreement	within its text include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.
Responsible Officers	the named individual as nominated by each Party with responsibility for overseeing this Agreement, as specified in Schedule Four of this Agreement.
Service contract	an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the services in accordance with the relevant service.
Singularity	words importing the singular only shall include the plural and vice versa.
SOSH	the Secretary of State for Health.
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.
The Act	means the National Health Service Act 2006.
The Council	means the North Yorkshire County Council.
The Functions	means the NHS and health related functions and the Council's Functions in so far as they relate to the Agreement.
The headings in this Agreement	are inserted for convenience only and shall not affect its construction and a reference to any Schedule or clause is to a Schedule or clause of this Agreement.
The HSCA 2012	means the Health and Social Care Act 2012.
The NHS Functions	those NHS functions listed in Regulation 5 of the Regulations as are exercisable by the Trust as are relevant to the provision of the services and which may be further described in Schedule Two.
The Regulations	the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No. 617 and any amendments and subsequent re-enactments.
The Service User	an individual in receipt of services commissioned under the Agreement.
The Services	the services planned, commissioned and delivered under this Agreement.
Third Party Costs	all such third-party costs (including legal and other professional fees) in respect of each service as a Party reasonably and properly incurs in the

Definition	Means
	proper performance of its obligations under this Agreement and as agreed by the Responsible Officers of this Agreement.
Words importing the singular number	shall include the plural and vice versa and words importing the masculine shall include the feminine and vice versa.
Working Day	means the normal service times for each service provider within the Alliance.

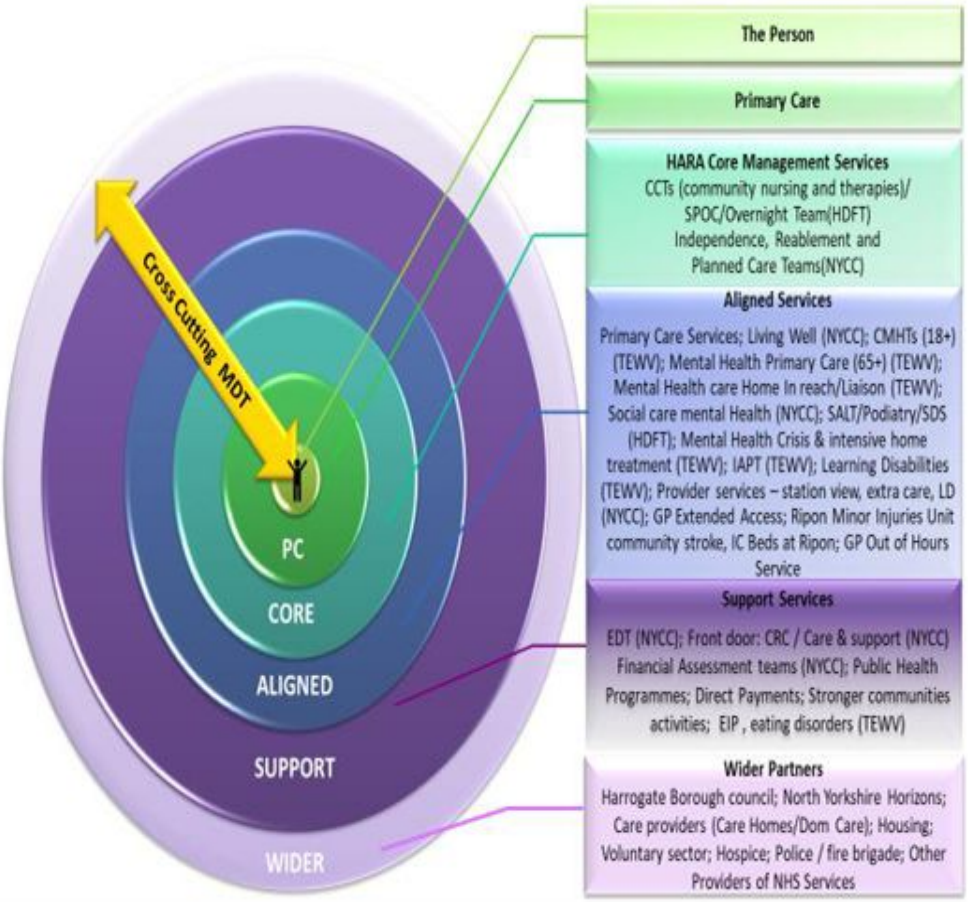
Schedule Two: Scope of services relating to this Section 75 Agreement

For clarity, the services covered by the commissioner section 75 agreement are those described as 'Core' and 'Aligned' within Figure 1. Other services may, at the discretion of the Parties and in agreement with the Partners, be brought into this Agreement subject to the conditions set out in this Entire Agreement.

In terms of this specific Agreement, it is designed to bring together the provider elements of current services described as 'Core', giving the Alliance Director delegated authority through a clear governance structure, as well as enabling the Alliance Director to manage operations of these health and social care services described. This complements the responsibilities of the Alliance Director described in the commissioner agreement.

The Alliance Director and their immediate Alliance Management Team (comprising of two NYCC Service Managers and two HDFT Service Managers) will have the direct responsibility for the 'Core' services. They will also influence the 'Aligned' services through the daily coordination of huddles and the wider Alliance Leadership Team which includes representatives from the 'Aligned' service areas.

Figure 1: Target Operating Model showing service delivery arrangements[10]



[10] Target Operating Model (13/8/19 from subgroup)

Schedule Three: Financial budgets relating to this Section 75 Agreement[11]

For the period 1 October 2019 to 31 March 2020 and indicative budgets for 2020-2021

	North Yorkshire County Council		
	Annual budget £	Oct 2019 to Mar 2020 £	Indicative budget 2020-2021 £
Reablement Teams	1,629,400	814,700	1,661,988
Independence Teams	888,900	444,450	906,678
Planned Care Teams			
Pay & Other non-pay	1,909,300	954,650	1,847,486
Care Packages	40,063,800	20,031,900	40,565,076
Direct Payments	3,987,700	1,993,850	3,767,454
Total Core Services	**48,479,100**	**24,239,550**	**48,748,682**
Carers	109,400	54,700	111,588
Equipment	1,385,000	692,500	1,412,700
Senior Management Team	1,047,700	523,850	1,068,654
Living Well	275,000	137,500	280,500
Social Care Mental Health	1,772,300	886,150	1,807,746
Provider Services	2,203,300	1,101,650	2,247,366
Total Non Core / Aligned Services	**6,792,700**	**3,396,350**	**6,928,554**
Total Budget NYCC	**55,271,800**	**27,635,900**	**55,677,236**

	Harrogate and District Foundation Trust		
	Annual budget £	Oct 2019 to Mar 2020 £	Indicative budget 2020-2021 £
Community Care Teams	5,104,000	2,552,000	5,206,080
			-
Total Core Services	**5,104,000**	**2,552,000**	**5,206,080**
Community Stroke	154,000	77,000	157,080
Community Medical Devices	94,000	47,000	95,880
Ripon Community Hospital	1,103,000	551,500	1,125,059
Total Non Core / Aligned Services	**1,351,000**	**675,500**	**1,378,019**
Total Budget HDFT	**6,455,000**	**3,227,500**	**6,584,099**
Total	**61,726,800**	**30,863,400**	**62,261,335**

[11] Schedule 3 – Version 7 (13/8/19 from finance subgroup)

Schedule Four: HARA management structure relating to this Section 75 Agreement

From 1 October 2019-31 March 2021, the following arrangements will be implemented to facilitate this Agreement:

1. A senior manager, the Alliance Director appointed to manage the service and be accountable to relevant partners, as well as the HARAB. The Alliance Director will be responsible for four service managers who manage both community health services and NYCC Adult Social Care Services, with a view to developing a fully integrated management structures across the Harrogate and Rural Alliance from Year 2 onwards.

2. Tactical and operational management will be done through the current organisational leads of each of the Parties to the Agreement. For clarity these are:

    a. Harrogate and District NHS Foundation Trust: Operational Director, Long Term and Unscheduled Care

    b. North Yorkshire County Council: Assistant Director, Care and Support

3. The core services will continue to be managed by their current organisational manager in the first year of service delivery, but this may change from year two onwards. All staff will be employed by their existing employers. However, these managers will have designated locality responsibility as well.

4. The governance arrangements which operate across the HARA structure, and the context of this Agreement in the wider Partnership Framework, are set out in Schedule Five.

5. There will be clinical/practice leadership (not necessarily line management) and decision making based around the operational teams within each of the localities for the population covered by this Agreement.

6. It is the responsibility of the employing organisation to ensure that all colleagues have the required qualification, up to date professional registration (where required), statutory and mandatory training, recruitment checks and clearances (i.e. Identity, Right to Work and DBS checks).

7. Colleagues will be responsible for their own individual practice and must work within their scope of competence, experience and professional code of conduct (as applicable).

8. Clinical liability (including any subsequent claim) and responsibility for the actions of any colleague lie with the employing organisation.

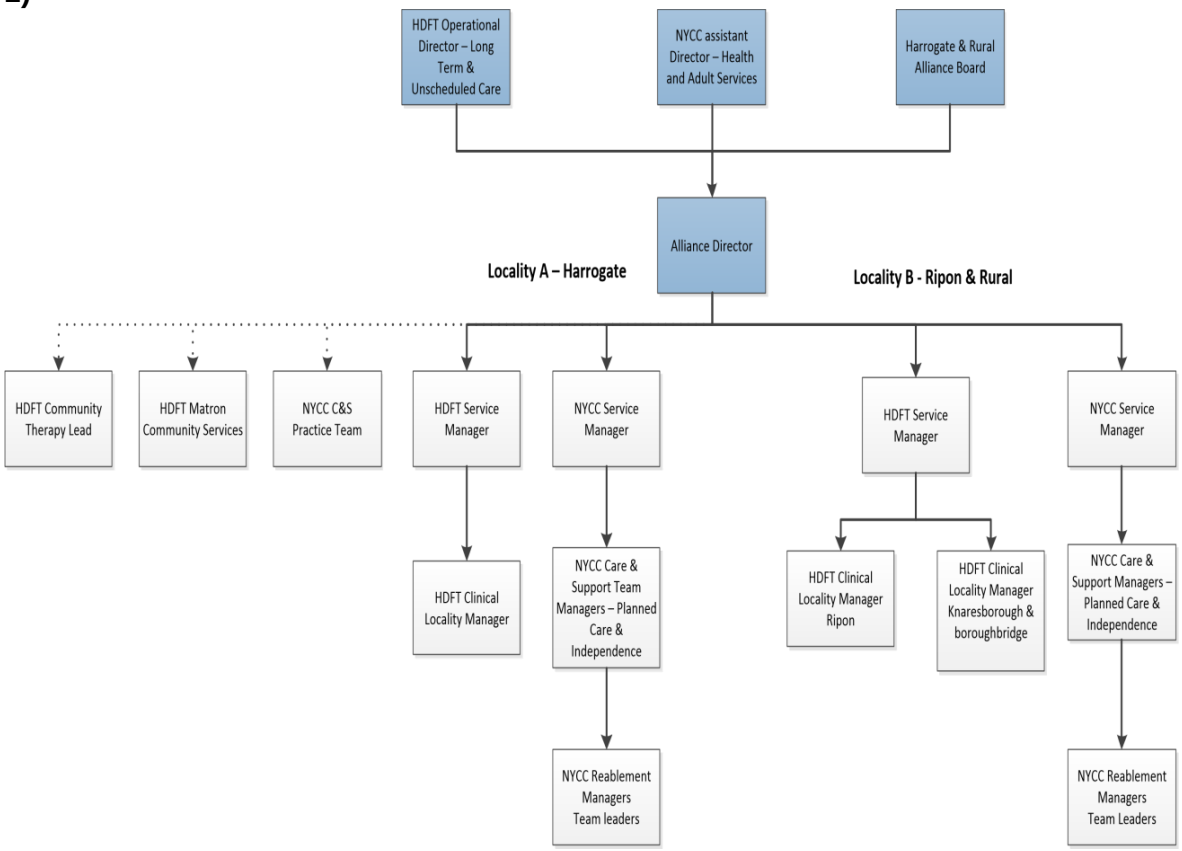
9. Where roles have joint accountabilities, e.g. as part of the integrated management structure, the Parties agree to the exchange of information regarding recruitment checks and clearances (Identity, Right to Work and Disclosure Barring Service), with the

consent of individual colleagues, to support the set-up of honorary contract arrangements, and service delivery as set out in Schedule Two of the Agreement.

10. It will be the responsibility of the employing organisation to investigate any concerns in accordance with their policies and procedures. The policies and procedures of the employing organisation of the colleague to whom the concern relates will have primacy. Where concerns relate to multiple colleagues across different employing organisations, the Parties agree to give consideration to the policies and procedures of the other Party and share relevant information in line with the Alliance Information Sharing Agreements. The Parties will adopt an approach, on a case by case basis, which supports the Alliance objectives and principles.

11. This Schedule will be updated in accordance with revisions to the HARA management structure (see Figure 2 in this Schedule) in line with changes to the service operating model, at the discretion of the Alliance Director and in liaison with the Responsible Officers, subject to Clause 8.5 and 8.6 of this Agreement.

Figure 2: Harrogate & Rural Alliance Integrated Management Structure (Year 1)[12]



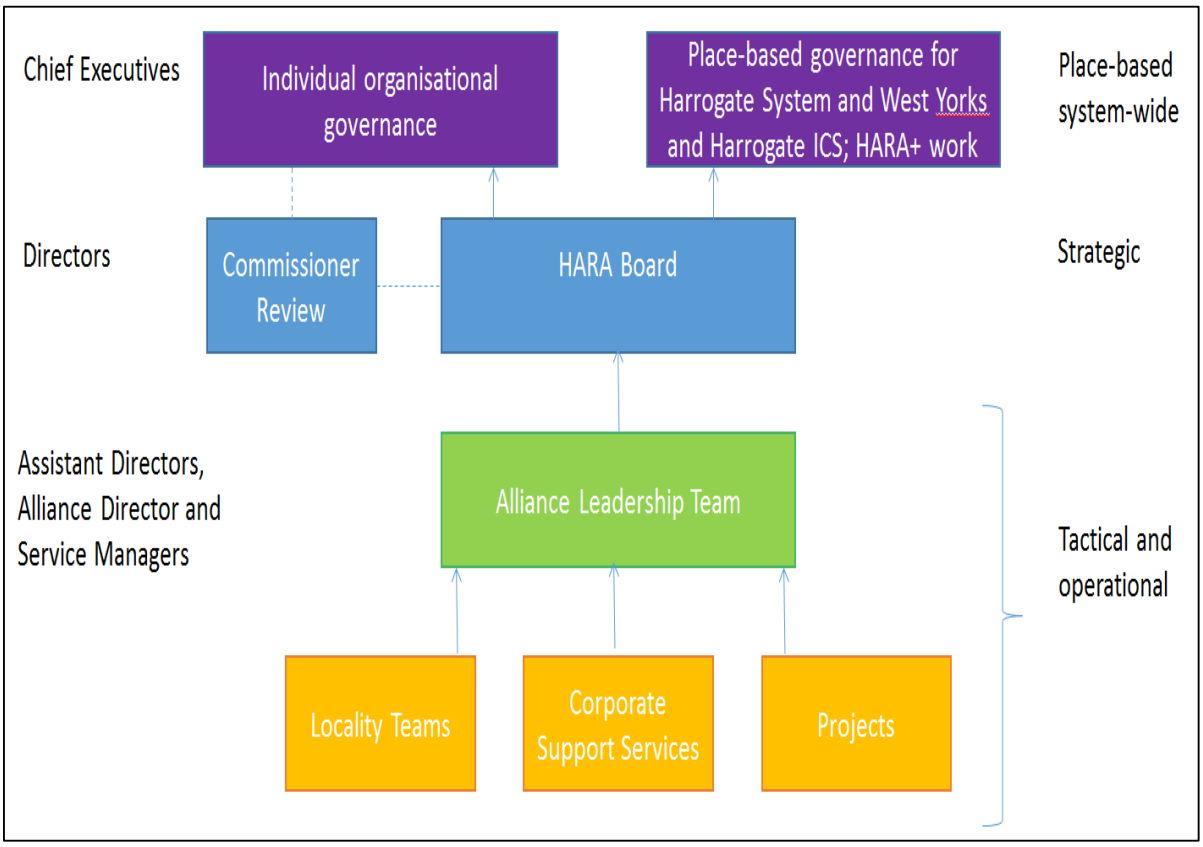
[12] HARA Management structure V4 (13/8/19)

Schedule Five: Governance arrangements relating to this Section 75 Agreement (set within the wider arrangements comprising the Partnership Framework)

(1) The Trust's Responsible Officer:
Rob Harrison, Chief Operating Officer

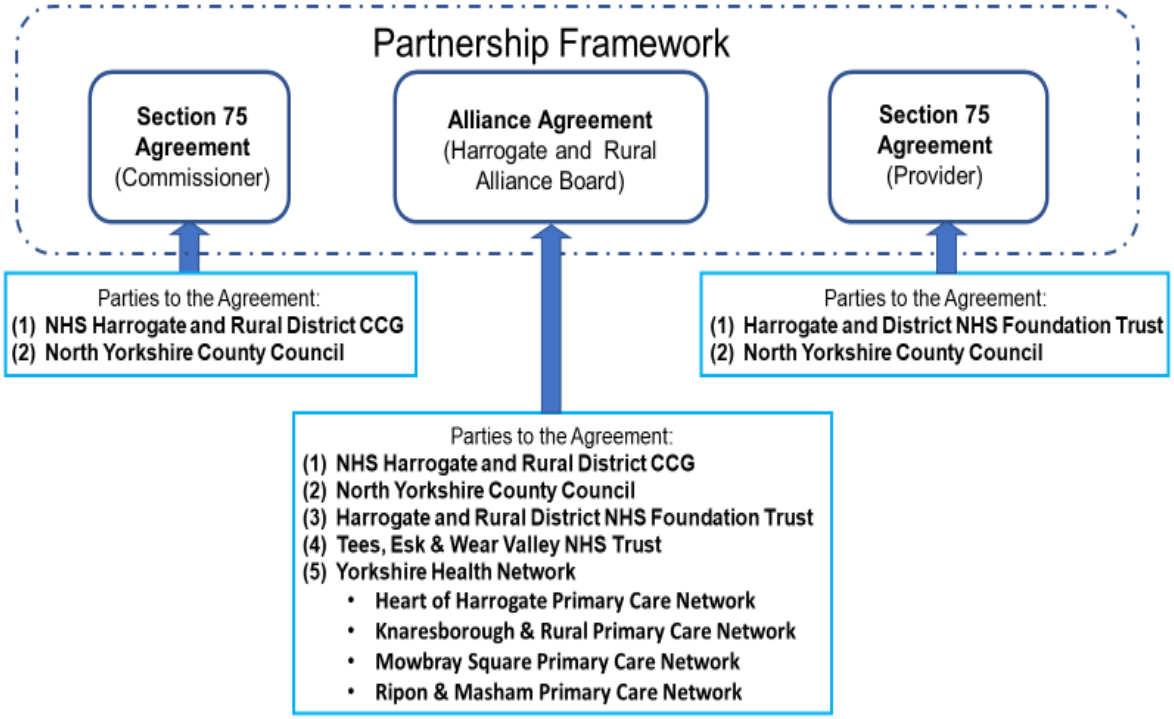
(2) The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

Figure 1: Governance diagram for Harrogate and Rural Alliance arrangements[13]



[13] Governance diagram as at 16/8/19

Figure 2: Relationship between this Section 75 Agreement and the wider Partnership Framework[14]



[14] Partnership Framework as at 16/8/19

SCHEDULE FIVE A DATA PROCESSING, PERSONAL DATA AND DATA SUBJECT

3. The Provider shall comply with any further written instructions with respect to processing by the Purchaser.

4. Any such further instructions shall be incorporated into this Schedule 3.

Description	Details
Subject matter of the processing	**<u>Single Point of Access Overflow Service</u>** To provide a continuous single point of access service for HDFT by redirecting calls that would receive an engaged call to the overflow service at NYCC whereby the referral detail are taken and referred to the Admin staff at HDFT. The provider will be the Data Controller and North Yorkshire County Council will be the Data Processor. **<u>Multi Disciplinary Teams (MDT's)</u>** A weekly MDT of 60-90 minutes will be held within the four Primary Care Networks across the Harrogate and Rural District footprint. The purpose of the MDT's are to bring Primary Care colleagues together with Community Teams. To have a space to discuss complex cases, to share intelligence across Primary Care and Community Teams and take a preventative approach to supporting people in the community. To try and ensure health and care is more joined up and coordinated around the person and prevent that person being unnecessarily admitted to hospital Each Provider is a Data Controller in their own right. **<u>Huddles</u>** The Operational Huddles will be led in each of the 4 areas by the relevant Team Managers from each HDFT and NYCC team. Each Organisation will access their own organisation's systems, to support understanding of capacity and resilience, as well as to share any relevant case updates where a specific person is brought to the Operational Huddle for discussion. Where cases are brought to the Operational Huddle discussion, the aim will be to use the professional expertise across the integrated disciplines to support better outcomes for the person in relation to their health and care needs. Each Provider is a Data Controller in their own right.

	Performance Reporting Anonymous summary performance data for each of the HARA partners to enable monitoring and decision making. Each Provider is a Data Controller in their own right. **Workforce Skills Audit** An audit of the skills of each workforce. Each Provider is a Data Controller in their own right. **Population Health Management** Data sharing between HARA Organisations to provide data insights to improve health and wellbeing of the populace within Harrogate and the surrounding areas over the coming decades. Each Provider is a Data Controller in their own right.
Duration of the processing	As per Clause 29 of the Section 75 Partnership Agreement. **29. Term of Agreement** 29.1 This Agreement will commence on 1 October 2019 and expire at 31 March 2022. Thereafter it can be extended on a year to year basis at the Parties' discretion and agreement for a maximum period of ten years subject to Clause 35. 29.2 Unless otherwise stated, the duration of the arrangements for each element of service shall be as set out in Schedule Two.
Nature and purposes of the processing	**Single Point of Access Overflow Service** The current process will for the most part remain unchanged, but for the exception where the HDFT SPOA main number is engaged then the caller will be re-routed to a different data controller (an NYCC Social Care Advisor in the customer service centre.) On receipt of the call, the Social Care Advisor will complete the required information on a word document (see below) and on completion email this to a secure HDFT SPOA email inbox. The provider will be the Data Controller and North Yorkshire County Council will be the Data Processor. **Multi Disciplinary Teams (MDT's)** A weekly MDT of 60-90 minutes will be held within the four Primary Care Networks across the Harrogate and Rural District footprint to bring Primary Care colleagues together with Community Teams to ensure

	health and care is more joined up and coordinated around the person by sharing intelligence across Primary Care and Community Teams to enable a preventative approach to supporting people in the community Each Provider is a Data Controller in their own right. **Huddles** The Operational Huddles will be led in each of the 4 areas by the relevant Team Managers from each HDFT and NYCC team. Each Organisation will access their own organisation's systems, to support understanding of capacity and resilience, as well as to share any relevant case updates where a specific person is brought to the Operational Huddle for discussion. Each Provider is a Data Controller in their own right. **Performance Reporting** Sharing of summarised performance information relating to the activities of work within the Harrogate and Rural Alliance with partners, which includes, Harrogate District Foundation Trust – (HDFT) and Yorkshire Health Network (YHN) and Tees, Esk and wear Valley Trust (TEWV). Each Provider is a Data Controller in their own right. **Workforce Skills Audit** Information will need to be gathered about resource / capacity, skill-sets, qualifications, recruitment and retention challenges. The intention is to amalgamate data sets to create a combined view of the workforce profile across the health and social care system, which can be mapped against a view of the activity/ demand in each of the four geographic areas/ networks. The data will need to be reviewed in relation to the strategic priorities and service development objectives identified by Alliance Management Team and the HARA Programme Board for Year 2, to inform the areas for the workforce model to address by developing the skills profile. Each Provider is a Data Controller in their own right.

Type of Personal Data	**<u>Personal data</u>:** General personal information: name, address, identification number, UPN, ULN, date of birth, gender, telephone number (home, mobile), NHS number Family information: parent/carer name, siblings, other family members Resource profile (turnover, vacancies, specific recruitment challenges) GP details In relation to Staff: Capacity (roles & FTE) Skills (qualifications, professional registrations, specialist skills, baseline assessment of common skills areas – to be defined e.g. mental health, motivational interviewing, digital skills); degree of competence (e.g. Basic, Confident, Expert, Can teach others) **<u>Special category data</u>:** Full history of Social Care episodes Full history of Health and Medical episodes Post looked after information Ethnic code
Type of Personal Data	**<u>Population Health Management</u>** Data sharing between HARA Organisations to provide data insights to improve health and wellbeing of the populace within Harrogate and the surrounding areas over the coming decades. This activity will likely develop over a number of phases as data sharing practices are developed and introduced. Each Provider is a Data Controller in their own right.
Categories of Data Subject	Clients, Family Members, plus providers, providers' staff, Local Authority officers, GP's, Other Professionals where applicable.
Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data	In line with the provider's own retention and disposal schedule.

Schedule Six: Benefit Framework and Metrics

This schedule comprises:

- Figure X: Strategic framework of benefits, metrics and commissioning priorities for HARA and the wider system
- Figure Y: Operational HARA metrics for core services – day 1
- Figure Z: Harrogate and Rural Alliance Benefits Framework

Figure X: Strategic framework of benefits, metrics and commissioning priorities for HARA and the wider system

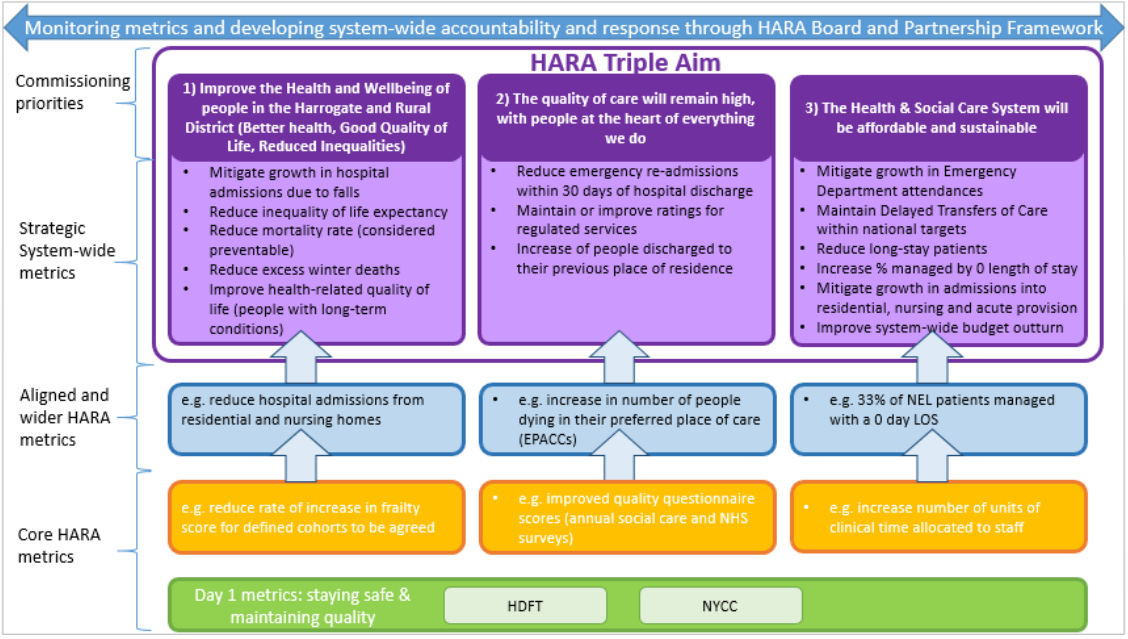


Figure Y: Operational HARA metrics for core services – day 1

HARA Quarterly Performance Report - Harrogate District and Foundation Trust ICCT Teams

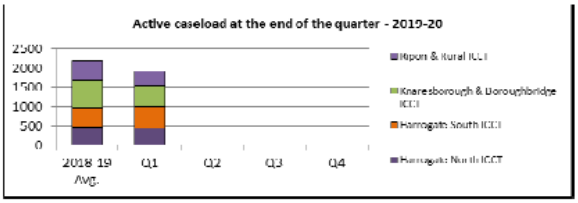
Patient Contacts

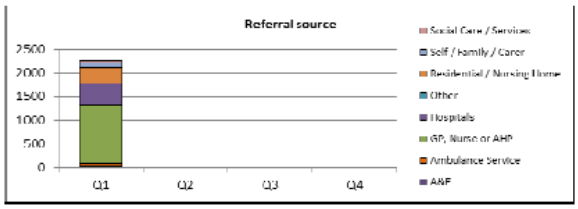
KPI	Avg. 2018-19	Q1 2019/20
No. Face to Face Contacts with Patient	32466	35052
Activity - clinical contact	29913	33742
Activity - clinical contact - unplanned	257	235
Activity - performing care plan	2296	1075
No. Telephone Contacts with Patient	665	524

Top 10 Care Plans

Category	YTD 2019/20	% of F2F Contacts
Medication administration	9594	27.4%
Wound Care	9406	26.8%
Pressure Ulcer Prevention / Management	6288	17.9%
Contact Assessment	1633	4.7%
Continence	1162	3.3%
End of Life Care	695	2.0%
Leg Ulcer	492	1.4%
Phlebotomy	453	1.3%
Diabetes management	369	1.1%
Advice and Support	348	1.0%
		86.8%

Referrals and Discharges





KPI	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
No. Referrals received	2272			
No Discharges	2229			
2019/20: Avg. length of time between Ref and Dis	110 Days			

System-wide Measures

	Apr-19	May-19	Jun-19
No. of patients 7+ days LOS in month	133	134	111
No. of patients 21+ days LOS in month	52	57	48
% Readmissions in month	13.4%	13.5%	13.8%
% Delayed Transfers of Care in month	1.0%	0.8%	1.2%

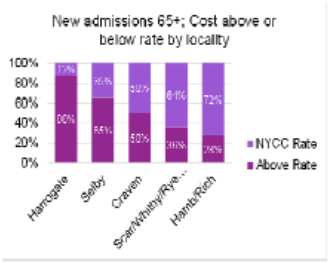
HARA Quarterly Performance Report - Adult Social Care

Current Reporting Period

KPI	Q4 2018/19	Q Trend
No. of referrals into Harrogate teams.	215	▲
% of assessments resulting in service provision.	12	▲
Rate of admissions per pop. to permanent placements.	10.2	▲
% permanent OP placements above NYCC approved rates.	76.6	▲
Volume of safeguarding concerns.	100	▲
% of safeguarding enquiries progressing to enquiry.	20	▲
% of reablement clients not returning within 90 days.	84.2	▼
% of people assessed for reablement who received reablement.	52	▲
Rate of Total DTOC bed days per head of pop.	0.6	▼
Rate of adult social care DTOC bed days per head of pop.	0.1	◀▶

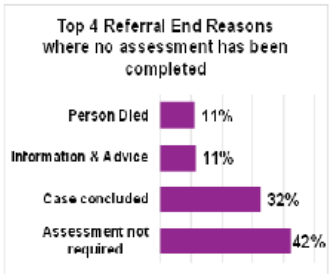
Performance Exceptions

% permanent OP placements above NYCC approved rates



Harrogate has the highest proportion of new admissions being placed at costs above the NYCC rates with 88%. This is up from 79% in December. The average number of new admissions above rate across the county is 53%.
Harrogate has the highest average costs for admissions for those aged 65+ in both residential (£801) and nursing care (£1008). These averages are up 3% and 6% respectively on December's average costs.

% of assessments resulting in service provision.



- 31% of all referrals allocated to planned care teams are closed without an assessment
- The highest proportion are closed in Harrogate (34%)
- 44% of assessments lead no service, the main assessment outcomes for these are; 12% receive advice & info, 12% have no services offered, 4.5% are self-funding, 1.3% are referred for preventative support.

Figure Z: Harrogate and Rural Alliance Benefits Framework

Harrogate and Rural Alliance
Health and Social care working together with you

Monitoring metrics and developing system-wide accountability and response through HARA Board and Partnership Framework

HARA Triple Aim	1) Improve the Health and Wellbeing of people in Harrogate and Rural District (Better health, Good Quality of Life, Reduced Inequalities)	2) The quality of care will remain high, with people at the heart of everything we do	3) The Health & Social Care System will be affordable and sustainable
Strategic system-wide metrics	• Mitigate growth in hospital admissions due to falls • Reduce inequality of life expectancy • Reduce mortality rate (considered preventable) • Reduce excess winter deaths • Improve health-related quality of life (people with long-term conditions)	• Reduce emergency re-admissions within 30 days of hospital discharge • Maintain or improve ratings for regulated services • Increase of people discharged to their previous place of residence	• Mitigate growth in Emergency Department attendances • Maintain Delayed Transfers of Care within national targets • Reduce long-stay patients • Increase % managed by 0 length of stay • Mitigate growth in admissions into residential, nursing and acute provision • Improve system-wide budget outturn
Aligned and wider HARA metrics	• Reduction in hospital admissions from residential and nursing homes. • Increase in PAM 'activation' score - Patients who are 'activated' are likely to self-care and improve their own risks. Patients who are less activated should be targeted more. • Population Health Management measures to be identified - as approach is developed • Increase referrals to diabetes prevention programme. [consider as PCNs develop]	• Skills audit work to define training and skills data/metrics • Increase in number of people dying in their preferred place of care (EPACCs)	• Reduction in the number of Stranded/ Super Stranded Patients - patients who have been in hospital more than 21 days (HDFT target is 42% based on April 18 baseline, which HARA will support) • Reduction in Length of Stay for Non-elective admissions for targeted cohorts (over 18s) - beginning with the frailty cohort? • 33% of NEL patients managed with a 0 day LOS (link to Acute Frailty Approach and improve same day facilities)

	• Mitigate increase in prevalence of diabetes, cardio-vascular disease, respiratory conditions, sepsis [consider as PCNs develop] • Mental health metrics - further consideration needed as TEWV become more involved in HARA • Loneliness / isolation metrics [for future consideration in partnership with the voluntary sector as loneliness strategy is developed] • Reduce smoking prevalence to 15% or lower by 2021. • % of patients on repeat medications who have had a medication review in the last 12 months [consider as PCNs develop] • Cases by location and specific need group (eg LD, travellers and homeless population) • Increase service utilisation by different channels including online • Increase number of community contacts in rural areas or identified areas of deprivation		• Mitigate growth in cost of care including CHC (D2A Pathway 3) following discharge [Consider as a development opportunity in future years] • Measures of demand on GP services/extended access offer - to consider development with PCNs
Core HARA metrics	• Reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population. • Reduction in re-attendances at GP within 90 days for people on the HARA caseload [work with PCNs to develop baseline] • Reduce rate of increase in frailty score (moderately and severely frail) for defined cohorts to be agreed • Reduction in number of urgent and scheduled visits (HDFT) for those	• Reduce number of complaints and increase number of commendations received (in relation to the number of people in receipt of a service) • Improved quality questionnaire scores (annual social care and NHS surveys) - Friends and Family test % of responses indicating Extremely Likely or Likely to recommend service; social care questions to be identified • Case file audits demonstrating improved quality of practice against CQC and professional standards	• Reduced budget out-turn / overspend for commissioning organisations (NYCC, CCG) • Reduction in the number of non-elective admissions for patients in target population cohorts (beginning with frailty cohort, further cohorts to be agreed) • Increase proportion of patients discharged to their usual place of residence. • Maintain the average total monthly delayed transfers of care (attributable

	on HARA caseload / target cohorts to be identified • Reduction in number of NYCC open planned care cases • Increase the % of people assessed for reablement who go on to receive a reablement service • Mitigate growth in A&E attendances for targeted cohorts (over 18s - to be defined after PHM work) [cross-reference to affordable and sustainable system] • NYCC - reduction in assessment completion timescale • Reduction in waiting time for therapy services (NYCC and HDFT) • Maintain and improve on 4hr response to urgent clinical need • Decreased % No Further Action and proportion of contacts diverted at the front door (SPOC or CRC) (NYCC) [data and service development of SPOA required to measure this for HDFT patients]	• Increase the proportion of carers/patient groups/representatives who report that they have been included or consulted in discussions - beginning with Therapy Outcome Measure metrics (reablement) • Increase the reporting of low and no harm incidents, evidencing increased awareness and opportunities for shared learning • Reduction in staff sickness • Increase response rate and increase overall staff satisfaction for surveys: annual social work health check; NYCC staff survey; HDFT annual staff survey: questions from all to be identified. • Number of staff in the alliance (FTE) • % of huddles (daily) and MDTs (weekly) held • % MDTs attended by GPs • Increase in remote log-ons for HARA workforce • Progress reporting against agreed milestones for integrated working • Maintaining or improving CQC inspection outcomes for Adult Community Services, Reablement Delivery and NYCC in-house provision (Station View)	to either NHS, Social Care or both) per 100,000 below NHSE targets • Maintain proportion of beds occupied by a reportable delay within target (target is no more than 3.5% of beds) • Reduction in budget out-turn / overspend for provider organisations (HDFT, NYCC) • Improve OPEL levels for HARA services • Increase in number of cases and % of whole caseload aligned to delivery through single co-ordinator (metric to be developed) • Increase in remote log-ons for HARA workforce • Increase in skype and video-conferencing usage for HARA workforce - increase in #minutes per staff member used • Reduction in ratio of desk space to colleague headcount for HARA workforce • Reduced rescheduling of appointments • Staff time efficiency - increase number of units of clinical time allocated to staff (HDFT); NYCC metric to be developed.

Schedule Seven: Terms of Reference for HARAB[15]

12 Purpose

12.1 The Harrogate and Rural Alliance Board (HARAB) has been established to provide strategic direction to the alliance, to provide governance and oversight of risk and to hold to account the Alliance Leadership Team (ALT) for the performance of the alliance such that it achieves the objectives set for it.

13 Status and authority

13.1 The Alliance is established by the Participants, who remain sovereign organisations, to provide a financial and governance framework for the delivery of the Services. The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

13.2 The Agreement establishes the HARAB to lead the Alliance on behalf of the Participants. As a result of the status of the Alliance the HARAB is unable in law to bind any Participant so it will function as a forum for discussion of issues with the aim of reaching consensus among the Participants.

13.3 The HARAB will function through engagement between its members so that each Participant makes a decision in respect of, and expresses its views about, each matter considered by the HARAB. The decisions of the HARAB will, therefore, be the decisions of the Participants, the mechanism for which shall be authority delegated by the Participants to their representatives on the HARAB.

13.4 Each Participant shall delegate to its representative on the HARAB such authority as is agreed to be necessary in order for the HARAB to function effectively in discharging the duties within these Terms of Reference. The Participants shall ensure that each of their representatives has equivalent delegated authority. Authority delegated by the Participants shall be defined in writing and agreed by the Participants and shall be recognised to the extent necessary in the Participants' own schemes of delegation (or similar).

13.5 The Participants shall ensure that the HARAB members understand the status of the HARAB and the limits of the authority delegated to them.

13.6 The HARAB operates within a Partnership Framework as set out in Figure 2 of this Terms of Reference.

14 Responsibilities

[15] Harrogate and Rural Alliance Board (HARAB) Terms of Reference as at 16/8/19

14.1 The HARAB will:

m) support alignment of service delivery in line with the Harrogate and Rural Alliance vision and objectives;
n) promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;
o) formulate, agree and ensure implementation of strategies for achieving the Alliance Objectives and the management of the Alliance;
p) discuss strategic issues and resolve challenges including those escalated by the Alliance Leadership Team such that the Alliance Objectives can be achieved;
q) respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;
r) agree performance outcomes/targets for the Alliance such that it achieves the Alliance Objectives;
s) review the performance of the Alliance, holding the Alliance Director and Leadership Team to account, and determine strategies to improve performance or rectify poor performance of the Alliance;
t) ensure that the Alliance Director and Leadership Team identify and manage the risks associated with the Alliance, integrating where necessary with the Participants' own risk management arrangements;
u) generally, ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders as set out in Figure 1 of this Terms of Reference (Stakeholder diagram);
v) contribute to the requirements of relevant regulators in respect of the services in the scope of the Alliance and other stakeholders through appropriate means, as determined by the Participants
w) oversee the implementation of, and ensure the Participants' compliance with this Agreement and ensure that Alliance activities do not jeopardise any of the individual Participants' contractual requirements;
x) review the governance arrangements for the Alliance at least annually.

15 Accountability

15.1 The HARAB is accountable to the Participants through the representatives delegated as members on behalf of the Participants.

15.2 The minutes shall be accompanied by a report on any matters which the Chair considers to be material. It shall also address any minimum content for such reports agreed by the Participants.

15.3 The minutes of the HARAB meetings will be sent to the Participants (usually via the HARAB membership) in advance of the next meeting.

16 Membership and Quorum

16.1 The HARAB will comprise:

5.1.1 Harrogate and District NHS Foundation Trust: Chief Operating Officer
5.1.2 North Yorkshire County Council: Corporate Director, Health and Adult Services
5.1.3 NHS Harrogate and Rural District Clinical Commissioning Group: Director of Strategy and Integration
5.1.4 Tees, Esk and Wear Valleys NHS Foundation Trust: Director of Operations for North Yorkshire and York
5.1.5 Yorkshire Health Network: Chair of the Network

16.2 The following persons should attend meetings of the HARAB as observers but will not participate in decisions:

5.2.1 Harrogate and Rural Alliance Director
5.2.2 Harrogate and District NHS Foundation Trust: Operational Director, Long Term and Unscheduled Care
5.2.3 North Yorkshire County Council: Assistant Director, Care and Support
5.2.4 Primary Care Networks: A Clinical Director
5.2.5 Yorkshire Health Network: Chief Operating Officer

16.3 Others may attend on an as required basis to contribute to items.

16.4 The HARAB will be quorate if:

(a) two thirds of its members are present, of which;

(b) at least one commissioner participant, one provider participant and one primary care provider participant.

5.5 Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Named deputies must be able to contribute and make decisions on behalf of the Participant that they are representing in accordance with individual Participant Schemes of Delegation. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

5.6 Subject to the members present being able to represent the views and decisions of the Participants who are not present at any meeting. Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Named deputies must be able to contribute and make decisions on behalf of the Participant that they are representing in accordance with individual Participant Schemes of Delegation. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

5.7 The HARAB will be chaired by a member of the Board based on a majority vote of the HARAB members on an annual basis.

5.8 The Chair will be held by the nominated member for a period of no more than

two consecutive years.

17 Conduct of Business

17.1 Meetings will be held monthly initially and from time to time as an extraordinary meeting as required by the needs of the Alliance.

17.2 The agenda will be developed in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place before the meeting is scheduled to take place. In the event members wish to add an item to the agenda they need to notify the Chair's nominated representative who will confirm this with the Chair accordingly.

17.3 At the discretion of the Chair business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

17.4 At the discretion of the Chair a decision may be made on any matter within these Terms of Reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

17.5 The HARAB shall receive reports from the ALT at least quarterly.

17.6 In accordance with Clause 18.4 of the Alliance Agreement, a Rectification Notice may be issued by any organisations within the Harrogate and Rural Alliance. The Chair shall be responsible for overseeing the subsequent Rectification Meeting(s) as set out in the Alliance Agreement. In a situation where the Chair is conflicted, the non-conflicted members of the HARAB shall nominate an alternative representative to oversee this process.

18 Decision Making and Voting

18.1 Each member of the HARAB shall have one vote in any decisions and motions will be carried on a majority basis.

18.2 Majority decisions can only be carried if the voting majority include at least one of the Commissioner Participants.

18.3 Decision made subject Clause 7.1 and 7.2 shall be binding all Participants.

19 Conflicts of Interests

19.1 The members of the HARAB must refrain from actions that are likely to create any actual or perceived conflicts of interests.

19.2 The HARAB shall manage Conflicts of Interests in line with the Board's approved protocol for addressing actual or potential conflicts of interests among its members (and those of the ALT).

20 Confidentiality

20.1 Information obtained during the business of the HARAB must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

20.2 Members of the HARAB are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Alliance. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

21 Support

10.1 Secretariat support to the HARAB will be provided by the employing organisation of the Chair.

22 Review

22.1 The HARAB terms of reference will be formally reviewed at least annually.

11.2 Terms of Reference Approved Date 29th August 2019

11.3 Terms of Reference Review Date 29th August 2020

Figure 1: Stakeholder diagram[16] - See Schedule 5 (Governance) of this Agreement

Figure 2: Partnership Framework[17] - See Schedule 5 (Governance) of this Agreement

[16] Stakeholder diagram as at 16/8/19
[17] Partnership Framework as at 16/8/19

Board of Directors (Public)

Title:	**HIF Shareholder Director**
Responsible Director:	Chief Executive
Author:	Company Secretary

Purpose of the report and summary of key issues:	The report requests review of the proposal that revised Shareholder Directors are appointed to the HIF Board.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	None	
Recommendation:	The Board is asked to approve the nomination of the Director of Strategy as Shareholder Director to the HIF Board and note the proposal regarding the Non-Executive Director appointment.	

Harrogate and District NHS Foundation Trust
Trust Board

HIF Shareholder Director

1.0 INTRODUCTION

HIF is a wholly-owned subsidiary of Harrogate & District NHS Foundation Trust, but operates at 'Arm's Length'. When created in November 2017 it was agreed that the Trust would two Shareholder Directors onto the HIF Board who were members of the Trust Board as set out in the Articles of Association.

2.0 SHAREHOLDER DIRECTOR

2.1 Articles of Association

The Articles of Association state the following:-

20 APPOINTMENT OF DIRECTORS

20.1 Subject to Article 20.2, the Shareholder may at any time and from time to time by notice in writing signed on behalf of it appoint any person to be a Shareholder Director.

20.2 The Board of the Shareholder will approve all proposed appointments of Shareholder Directors in writing prior to their appointment, otherwise any appointment made without this approval is not a valid appointment of a Director.

20.3 Non-Shareholder Directors shall be appointed by the Board of Directors of the Company from time to time.

2.2 Current Board Membership

The HIF Board currently has two shareholder directors from HDFT:- an Executive Director and Non-Executive Director of the HDFT Board. This is Jonathan Coulter, Director of Finance and Deputy Chief Executive and Sarah Armstrong, Non-Executive Director of HDFT.

2.3 Appointment of Shareholder Directors

Jonathan Coulter, as of 28th February 2022 is Acting Chief Executive of HDFT and on the 1st April 2022, Sarah Armstrong will become the Chair of HDFT.

Therefore, a proposal for two new Shareholder Director for HIF is required. This is a Board level decision.

Following consideration by the Trust, the Director of Strategy has been proposed due to the range of skills and experience he brings to the role as the Executive Director appointment.

HDFT is currently undertaking a recruitment campaign for Non-Executive Directors, once this has been completed there will be a process to appoint to the HIF Board as a Shareholder Director.

3.0 RECOMMENDATIONS

It is recommended that:-

- Matt Graham, Director of Strategy is appointed as the Shareholder Director to the HIF Board and,
- Following an HDFT Non-Executive Director recruitment process, a proposal will be made on appointment to the HIF Board of a HDFT Non-Executive Director.

Kate Southgate
Associate Director of Quality and Corporate Affairs

March 2022

Board of Directors held in Public
30th March 2022

4.2

Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

Purpose of the report and summary of key issues:	The Trust Board is asked to note the items contained within this report. This month's report presents data for the set of indicators proposed for the new style Integrated Board Report. This month's report includes charts and narrative for each indicator as previously agreed with Trust Board.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	Y
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	Y
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	Y
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	Y
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	Y
	BAF3.2 To provide a high quality service	Y
	BAF3.3 To provide high quality care to children and young people in adults community services	Y
	BAF3.5 To provide high quality public health 0-19 services	Y
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	Y
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	Y
	BAF4.4 To be financially stable to provide outstanding quality of care	Y
Corporate Risks	None	
Report History:	A draft version of this report was presented to Senior Management Team earlier this month.	
Recommendation:	The Trust Board is asked to note the items contained within this report.	

Integrated Board Report - February 2022

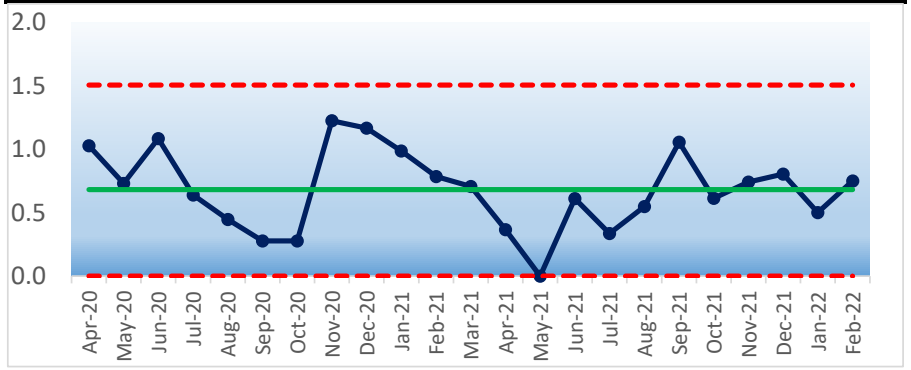
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	0.75

Indicator description

The number of hospital acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 bed days.

SPC chart



Narrative

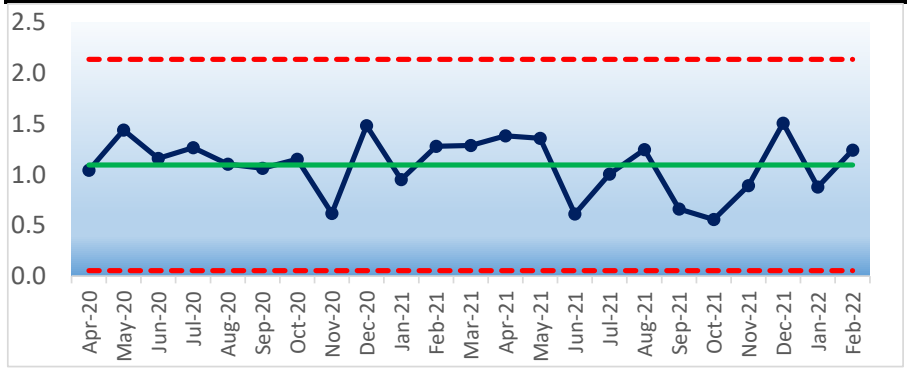
Increase in hospital acquired PU's likely due to the high acuity and general frailty of patients. There were significant staffing challenges throughout February which is likely to have resulted in repositioning regimes not being met 100% of the time. TVN team are providing enhanced support to wards where there has been an increase; this includes bedside reviews, ward based training and validation of the reported incidents. Visibility of pressure ulcer information is now displayed in ward areas on the quality boards and the Tendable audit programme is being built with the Tissue Viability Team to continue to support quality improvements in this area. Planning for pressure ulcer prevention training to revert to face to face is underway and virtual training sessions continue.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	1.24

Indicator description

The number of community acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 community patient contacts.

SPC chart



Narrative

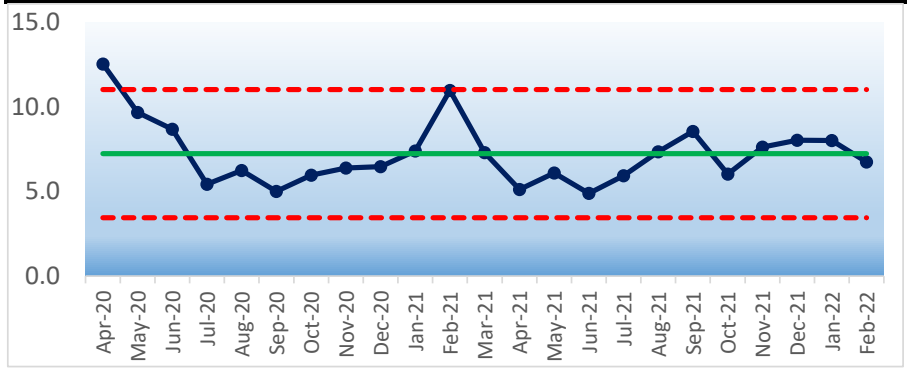
Increase in community acquired cat 3 and above pressure ulcers is likely due to the increased acuity and frailty of patients on the DN caseload, as well as in Care Homes. Adult community services have been at OPEL 3 and had significant staffing challenges most days, therefore some regular reviews of patients will have been postponed; although not definitive, this is thought to have had impact. The TVN team are providing additional training opportunities for staff in relation to pressure ulcer prevention and the appropriate selection of equipment. The impact of lack of social care to provide adequate packages of care also impacts on the repositioning needs of patients in their own homes reliant on carers.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	6.74

Indicator description

The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm.

SPC chart



Narrative

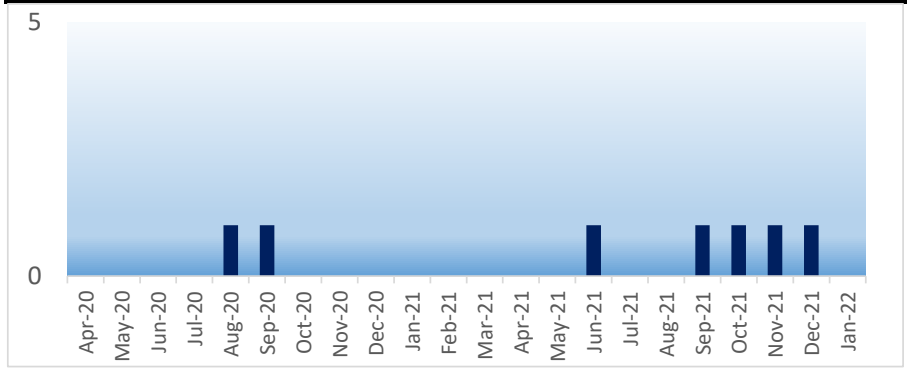
A slight reduction and downward trend with inpatient falls. Safety huddles are being refreshed on wards and within the ED which is supporting the communication between and across teams and likely to be impacting on the reduction. February also saw less "multiple fallers" which will be impacting on the improvement. A falls improvement plan is being developed.

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	0

Indicator description

The number of hospital acquired C.difficile cases where root cause analysis has identified a lapse in care. HDFT's C. difficile trajectory for 2021/22 is 19 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

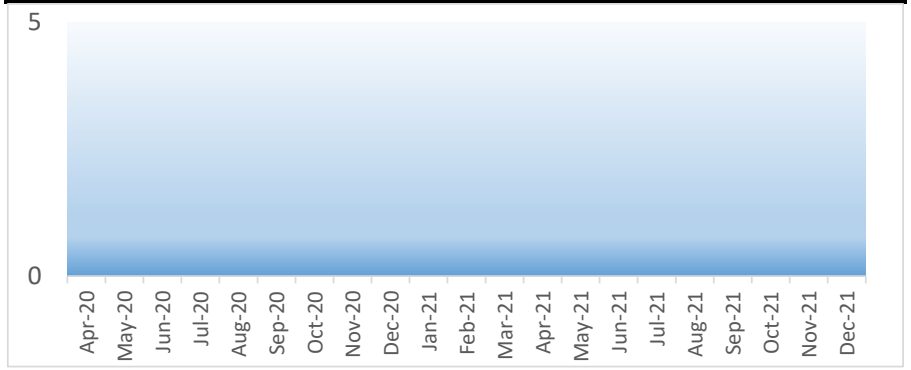
Note - although no avoidable hospital acquired cases were reported in February, this indicator is flagging as red due to the total of 34 hopsital acquired case reported year to date against a maximiun trajectory of 29 for 2021/22.

Indicator	**1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	0

Indicator description

The number of hospital acquired MRSA cases where root cause analysis has identified a lapse in care. HDFT's MRSA trajectory for 2021/22 is 0 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

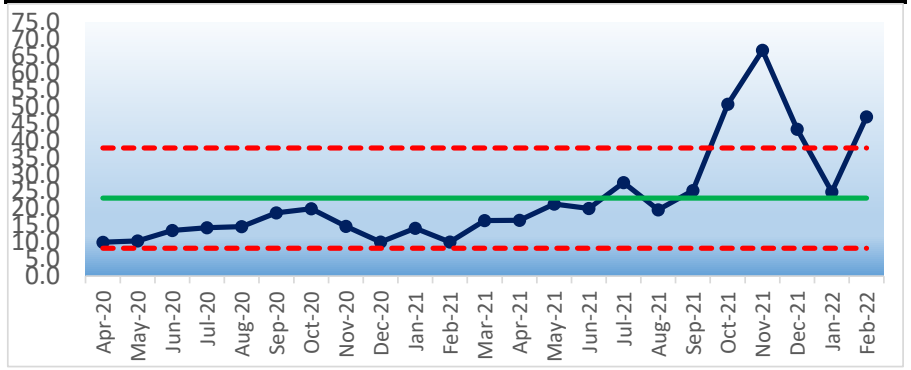
No hospital acquired MRSA cases where lapses in care identified for February.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	47.1

Indicator description

The number of incidents reported within the Trust each month. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture.

SPC chart



Narrative

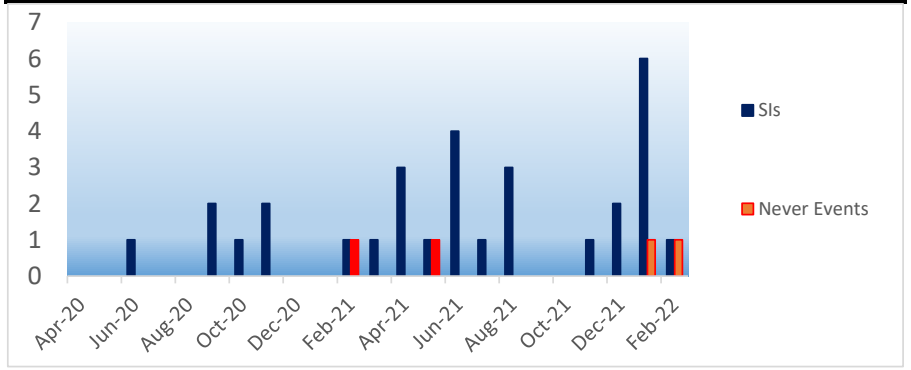
February saw a rise in the reporting of low harm incidents that took the numbers to above the upper control limit of the SPC chart. It is pleasing to observe the increase in reporting in February following the significant dip in January. Prior to the impact of Omicron in December and January, the Trust was reporting a gradual and consistent increase in the numbers of low harm incidents reported. The data reported in February shows a return to improving trajectory for the number of low harm incidents reported.

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	1 (SI), 1 (Never Events)

Indicator description

The number of Serious Incidents (SI) and Never Events reported. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the pressure ulcer / falls indicators above.

Trend chart



Narrative

The Never Event was reported within the community dental service. A serious incident was reported relating to a patient who died in ED following a delay in treatment.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	80.8%

Indicator description

The chart shows the overall fill rate at HDFT for registered nurses/midwives (RN) and care support workers (CSW) for day and night shifts on inpatient wards. The fill rate is calculated by comparing planned staffing with actual levels achieved.

SPC chart

Narrative

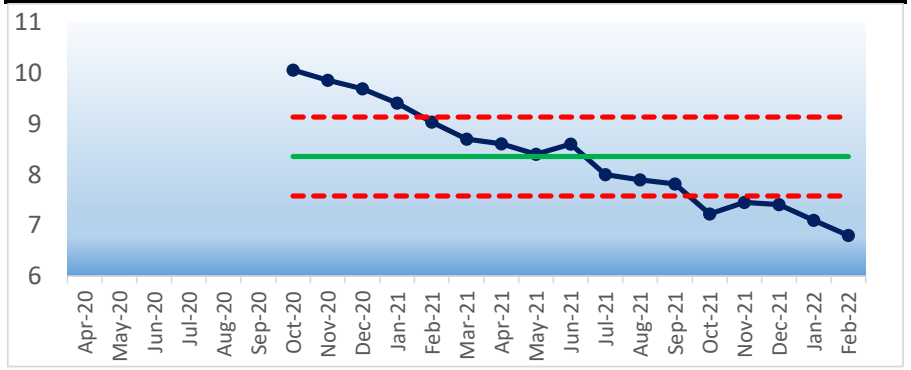
Staffing fill rate decreased further in the month of February by 1.2%. February staffing was challenging as we continue to see the impact of Covid absences as well as planned annual leave. Bed occupancy remained high during this month and escalation beds remained open, exacerbating the staffing position. Those wards with staffing below 80% fill rates include Bolton, Byland, ESU, Farndale, Granby, Harlow, Maternity, Nidderdale, Oakdale, Rowan, Wensleydale and Woodlands. CHPPPD impact ranges from +0.3hrs to -1.3hrs in those areas which is further described in 1.8.2. Harlow is our escalation ward which has proved challenging. The staff to the agreed bed base of 15 (and at peak escalation went to 25 beds) which has resulted in the need to move RNs and CSWs from elsewhere to support and manage the collective risk. ESU occupany has been reduced, meaning the reduced fill rate has been professionally judged and agreed as part of our ongoing daily risk assessment and management of staffing.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	6.8

Indicator description

The chart shows the care hours per patient per day (CHPPPD). This is caclulated by comparing the total hours worked by reigstered and unregistered nurses and midwives and comparing these to the number of patients on the wards during the month.

SPC chart



Narrative

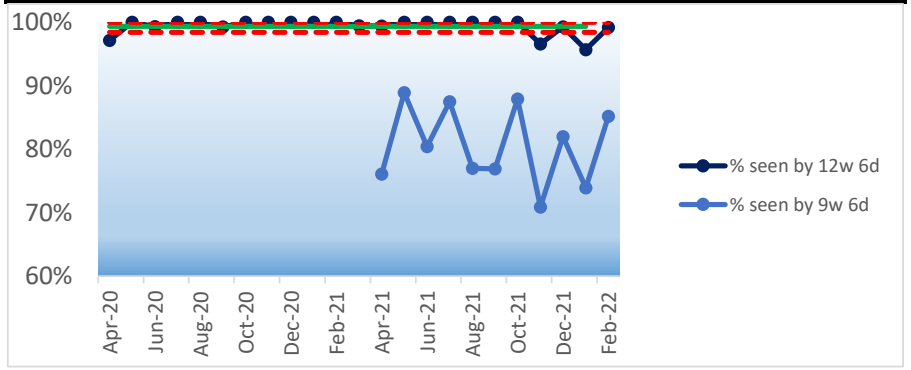
CHPPPD has continued to fall for the month of February due to the continued reduction in the number of registered and unregistered nursing staff available to deliver care due to an increase in Covid absences. Acuity of patients continued to be consistently high and this has been reflected in the rise of enhanced care requests made, particularly across our elderly and complex care wards. The individual ward impact of the reduction in CHPPPD is as follows: Bolton: 0.5hrs, Byland: 0.5hrs, ESU: 0.5hrs, Farndale: 0.2hrs, Granby: 0.1hrs, Harlow: 0.7hrs, ITU: 0.5hrs, Jervaux: 0.1hrs, Rowan: 0.2hrs, Littondale: 0.3hrs, Nidderdale: 0.2hrs, Oakdale: 0.1hrs, Trinity: 0.3hrs, Wensleydale: 0.3hrs, Woodlands: 1.3hrs. Wensleydale, despite the reduction in CSW day fill rates and RN night fill rates, increased their CHPPD by 0.3hrs. The lowest CHPPPD was on Littondale Ward (5.0hrs) and the highest was ITU (28.9hrs). As sickness absence decreases and onboarding of CSWs is fully implemented following the successful recruitment event, fill rates and CHPPPD are expected to increase. This will also require bed occupancy to remain at less than 100%.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	99.2%

Indicator description

The % of pregnant women seen by a midwife (or healthcare professional) by 12 weeks 6 days gestation.

SPC chart



Narrative

We have seen an increase in the number of women seen by a midwife (or healthcare professional) by 12 weeks and 6 days gestation and are almost at 100% for February.

Indicator	**1.10 - Maternity - % women with Continuity of Care pathway**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

We continue to submit 0% compliance with this model, as we are providing continuity during the antenatal and postnatal periods but not intrapartum care to women. This is due to reduced midwifery staffing levels and the need to maintain safe staffing levels across the unit.

A new CofC project lead midwife has now started in post in November and we plan to implement one integrated team in March 2022 who will aim to provide continuity for the whole patient journey. This team will consist of existing CofC midwives who are able to work in all areas of the department.

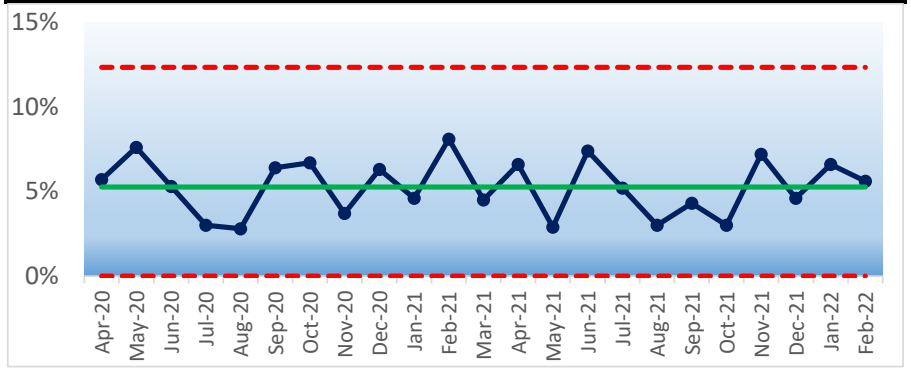
The department are having weekly CofC meetings and implementing a plan for CofC to be the default model of care for all women by March 2023 providing safe staffing levels allow this.

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	5.6%

Indicator description

The % of pregnant women smoking at the time of delivery.

SPC chart



Narrative

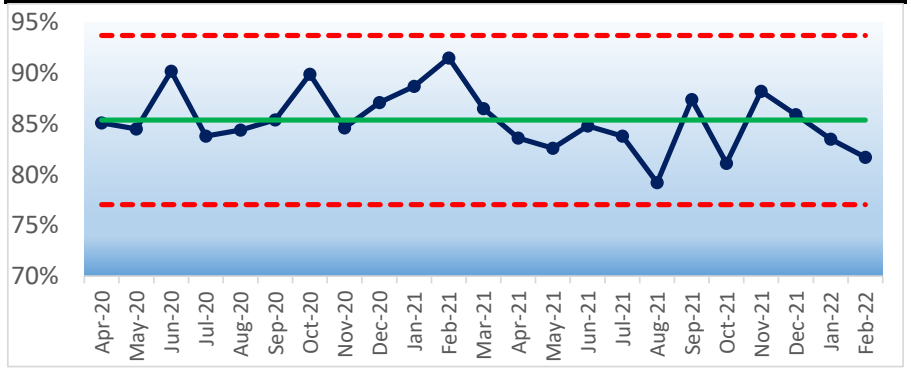
HDFT continue to see low levels of pregnant women smoking at the time of delivery.

Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	81.7%

Indicator description

The % of women initiating breastfeeding

SPC chart



Narrative

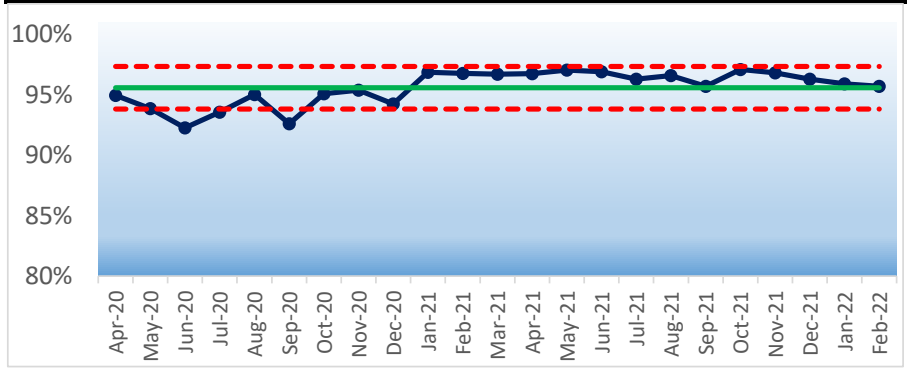
We have seen a slight decrease in the number of women initiating breastfeeding in February. This may be linked to the staffing challenges and activity over February impacting on the availability of midwives and CSWs to support and encourage breastfeeding initiation. We will continue to monitor next month.

Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	95.7%

Indicator description

The percentage of eligible adult inpatients who received a VTE risk assessment.

SPC chart



Narrative

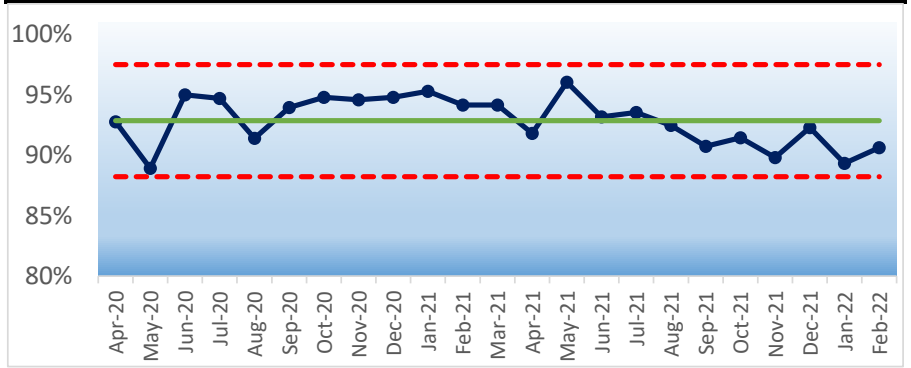
VTE risk assessment compliance remains above the 95% standard.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	90.6%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

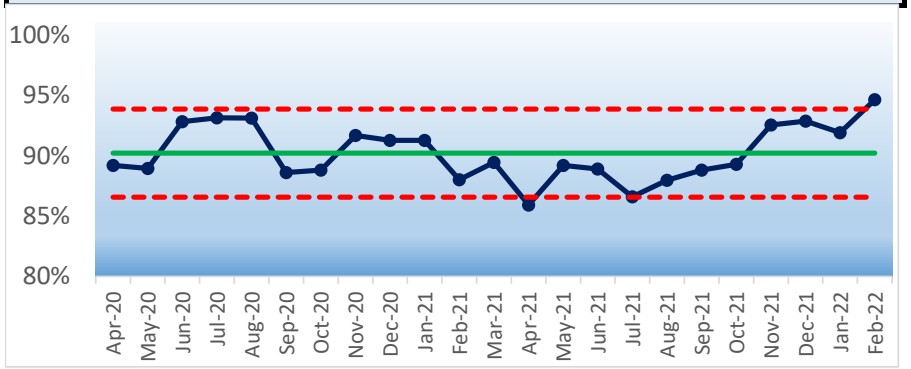
Improvement with sepsis screening noted, emphasis from ward managers and matrons to improve compliance.

Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	94.6%

Indicator description

The percentage of eligible Emergency Department attendances who were screened for sepsis.

SPC chart



Narrative

Significant improvement with ED Sepsis Screen compliance due to the recent quality improvement initiative in this area.

Integrated Board Report - February 2022

Domain 2 - Caring

Indicator	**2.1.1 - Friends & Family Test (FFT) - Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	92.0%

Indicator description

The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment.

SPC chart

Narrative

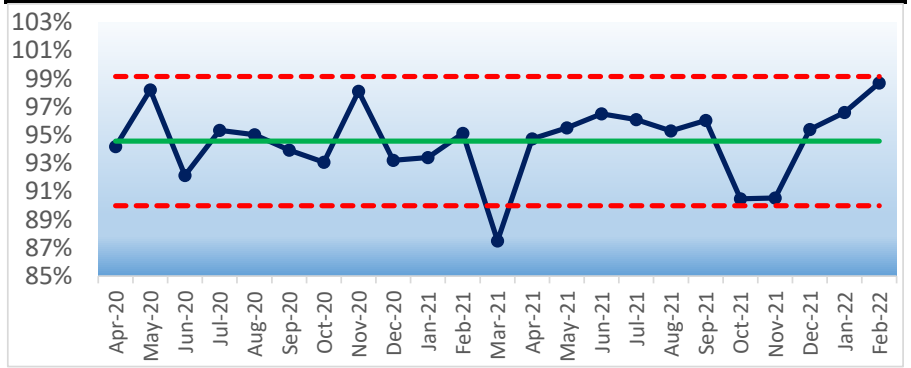
Reduction in the overall FFT position this month which is a variation in the previous trend. There is ongoing work to understand the driver for the reduction and whether this correlates with complaints regarding communication and visitor restrictions.

Indicator	**2.1.2 - Friends & Family Test (FFT) - Adult Community Services**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	98.7%

Indicator description

The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment.

SPC chart



Narrative

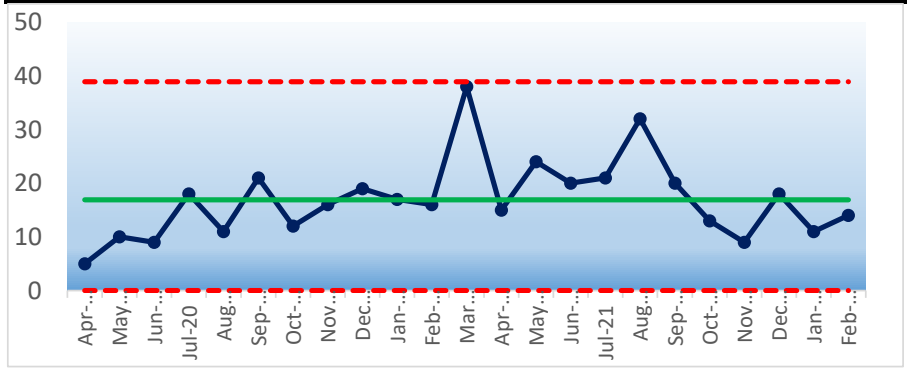
Positive performance during February.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	14

Indicator description

The number of complaints received by the Trust, shown by month of receipt of complaint. The data includes complaints relating to both hospital and community services.

SPC chart



Narrative

14 complaints were received in the month of February. The main themes were communication with relatives during period of visitor restrictions.

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	55%

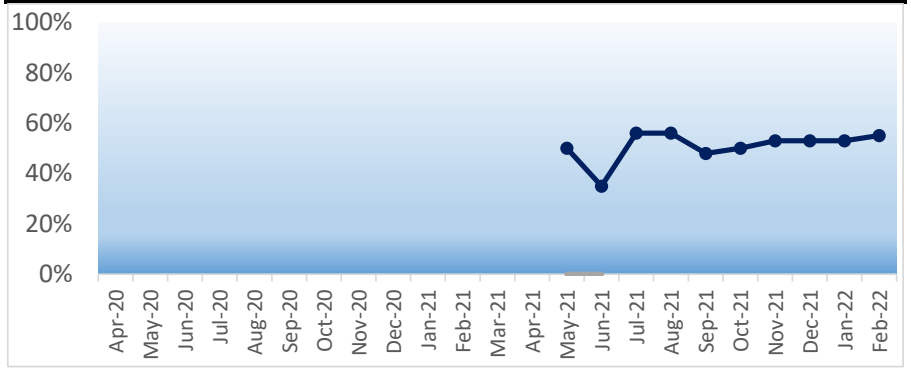
Indicator description

The number of complaints responded to within 25 days, shown as the year to date position. The Trust's improvement trajectory for 2021/22 is to respond to 95% of non-multi-agency complaints on time by December 2021.

Narrative

The month end performance for the number of complaints responded to within the 25 day standard was 100%. The IBR measures the rolling annual response rate rather than in month.

Trend chart



Integrated Board Report - February 2022

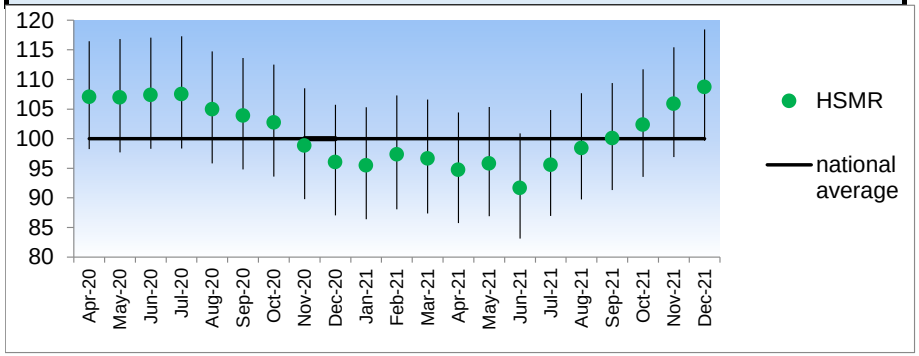
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Dec-21
Value / RAG rating	108.72

Indicator description

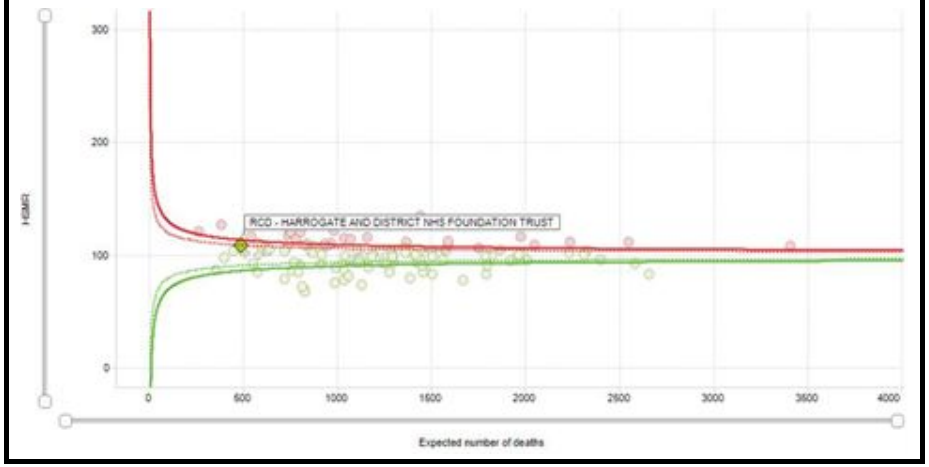
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.

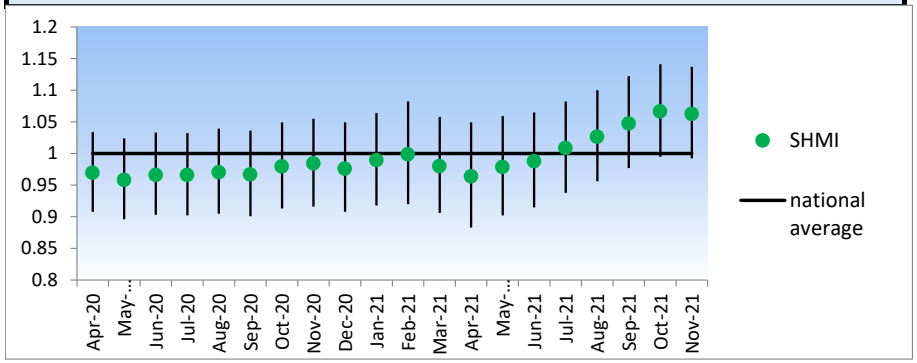


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Nov-21
Value / RAG rating	1.06

Indicator description

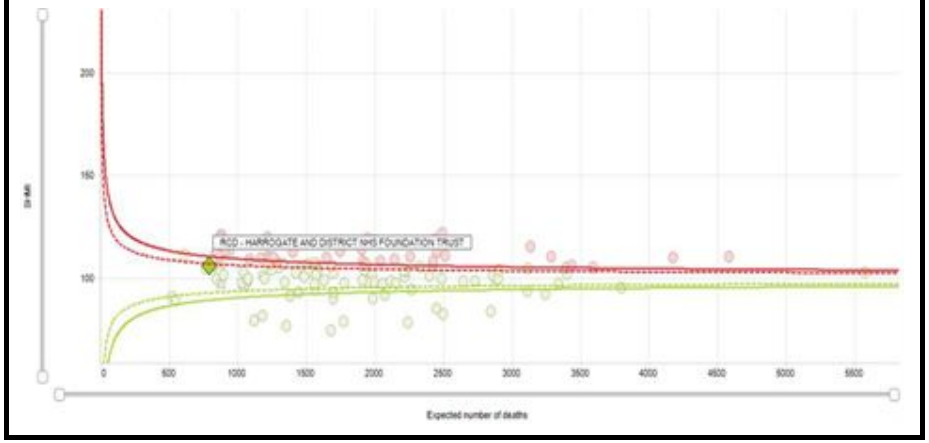
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

National average is 1. HDFT remains within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.



Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jan-22
Value / RAG rating	1.5%

Indicator description

The percentage of patients readmitted to the same specialty as an emergency within 30 days of discharge of an elective admission. This data is reported a month behind so that any recent readmissions are captured in the data.

SPC chart

Narrative

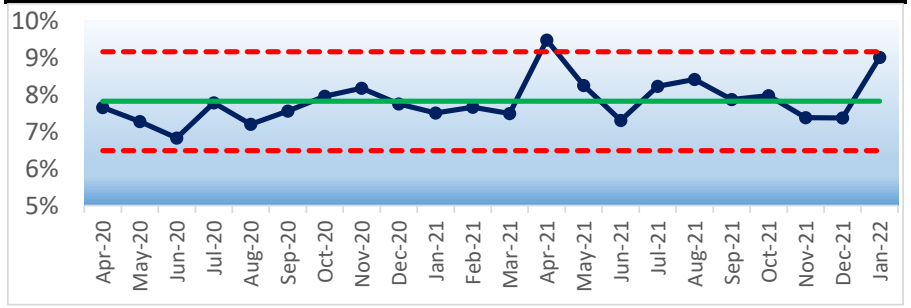
Readmissions following an elective admission remained at 1.5% in January. This remains within control limits and less than national average.

Indicator	**3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jan-22
Value / RAG rating	9.0%

Indicator description

The number patients readmitted to the same specialty as an emergency within 30 days of discharge of an emergency admission. This data is reported a month behind so that any recent readmissions are captured in the data.

SPC chart



Narrative

Readmissions following a non-elective admission rose to 9.0% in January.

Indicator	**3.4 - Returns to theatre**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

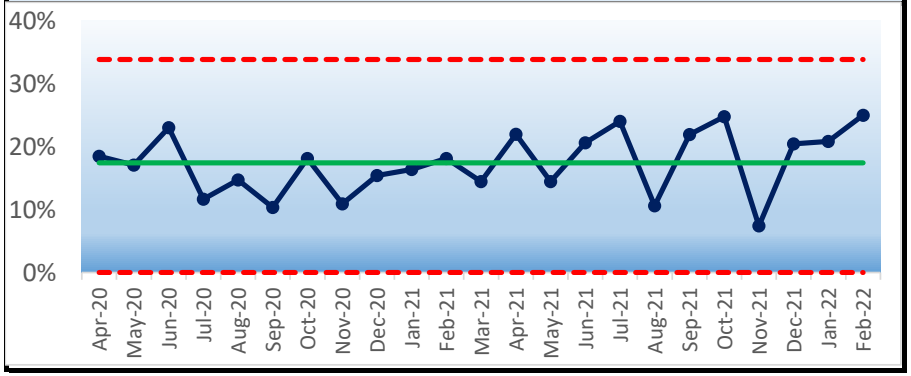
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	25.0%

Indicator description

The percentage of inpatients not meeting the criteria to reside as reported on the daily discharges sitrep.

SPC chart



Narrative

Delayed transfer of care increased in February. The Trust have now purchased a system using funding from NHSE that will allow the ward teams to electronically capture the criteria to reside of every patient. Roll out and training commenced in February 2022.

This will enable real time viewing of delayed patients, however the major blockage with hospital outflow currently is the social care crisis. 20% of MFFD (medically fit for discharge) patients are waiting for PoC or Care home placements. The reduction reflects higher acuity of patients thus more meeting criteria to reside rather than a significant change in 'delays'. This reflects the 40-50 patients consistently awaiting PoC , residential or nursing home placement. (COVID impacting providers of these)

Trust Board Report March 2022
Report: Executive Director of Nursing, Midwifery and AHPs
Author: Emma Nunez

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Nurse Staffing – (*IBR 1.8.1 & 1.8.2*) Staffing Fill Rates have seen a decrease in February due to continued Covid related absences as well as planned annual leave. Care Hours Per Patient Day has fallen slightly in March in line with the reduced fill rates and increased bed occupancy/open escalation beds.
- Pressure Ulcers – (*IBR 1.1 & 1.2*) have seen an increase across inpatient and community services. Correlates with reduced fill rates and CHPPD for inpatient areas, increased acuity and dependency of patients and also reduced home care packages in the community.
- Serious Incidents and Never Events (*IBR 1.7)* delays in the publication/launch of national revised Patient Safety Incident Response Framework (PSIRF). Revised date May/June. Internal plans remain in place for implementation.

Major actions commissioned & work underway

- Ward Manager Roles and Responsibility Review in line with the Matrons Review
- Full scale review of SI Process and Gap Analysis of PSIRF commenced
- Full scale review of NHS Patient Safety Strategy and Gap Analysis commenced, including organisational training requirements
- Re-introduction of Quality Assurance/Peer Reviews against CQC framework
- Project delivery team formed for the implementation of Datix Cloud

Positive news & assurance

- Appointment of Deputy Director of Nursing
- Appointment of Head of Nursing for Long Term and Unscheduled Care
- Appointment of Patient Safety Manager, Patient Experience Manager and Compliance Manager for newly formed Quality and Safety Team
- Associate Director of Midwifery recruitment underway
- Positive engagement and feedback regarding reinvigorated Making Experience Count Forum and associated work plan

Decisions made & decisions required of Board

Harrogate and District NHS Foundation Trust

4.3

Strengthening Maternity and Neonatal Safety Report

Board of Directors (Public)
30th March 2022

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Alison Pedlingham (HOM), Andy Brown (Risk management Midwife), Danielle Bhanvra (Matron, Maternity), Kat Johnson (Clinical Director), Julie Walker (Matron Paediatrics)

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update on the board level safety measures for the month of November as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Maternity Services Forum Maternity Safety Champions meeting Senior Management Team 23/3/22	
Recommendation:	Board is asked to note the updated information provided in the report, and for further discussion. The report was discussed at SMT on 23/3/22.	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of February as set out in the Perinatal Quality Surveillance model.

1.0 Introduction

The new quality surveillance model seeks to provide consistent and methodical oversight of all services, including maternity. Strengthening trust-level oversight for quality and safety includes a focus on leadership, strong governance processes and pathways for information and escalation from floor to Board. The model includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. To aid implementation there are local, regional and national elements of this model.

At local level, the model includes a monthly review of maternity and neonatal safety and quality reported to the Trust board.

2.0 Proposal

2.1 The report covers the provider Board level measures required as part of the perinatal surveillance model. The report now includes additional neonatal measures.

2.2 SMT is asked to note the information provided in the report which provides a local update on progress.

3.0 Quality Implications and Clinical Input

3.1 The report provides a narrative on the key measures set out in the Perinatal Quality Surveillance model and has been analysed and presented by members of the maternity midwifery, neonatal and obstetric teams.

4.0 Equality Analysis

5.1 An equality analysis has not been undertaken

5.0 Risks and Mitigating Actions

6.1 The middle grade staffing remains a concern however there are plans in place, explained below in the obstetric cover on delivery suite, gaps in rota section of the report. The staffing position remains challenging and is also impacted by annual leave and compassionate leave. This is stabilised by resilience from consistent use of agency.

6.2 Midwifery staffing levels have continued to be a challenge in January but due to the impact of Covid (staff Covid positive and requirement to isolate due to family contacts) not because of the midwifery numbers. We have successfully recruited new staff who are starting to work in the department.

7.0 Recommendation

7.1 The Board is asked to note the updated information provided in the report and for further discussion.


Insert Grid Title
Matters of concern & risks to escalate
• Number of middle grade doctors remain an issue
• Multi-disciplinary training – low attendance of obstetric and anaesthetic staff due to staffing levels
• Estates and hubs remain a significant risk with lack of community provision – approaches to local leisure centres, libraries, NYCC and Harrogate Council with no success
• Continued impact of Covid on midwifery staffing levels in February
Major actions commissioned & work underway
• Ockenden review of maternity services – one year on report completed for Trust Board (public) in March
• Awaitng Ockenden part 2 – due in March 22nd however delayed due to parliamentary processes
• Awaiting revised timescales for Maternity Incentive Scheme year 4
Positive news & assurance
• Improved midwifery compliance with safeguarding children's level 3. Further sessions to be arranged
• New named midwife for safeguarding started in post
• Plans continue for the 1st CofC team
• Local MVP group restarted – work streams agreed with real local interest and engagement with this group
Decisions made & decisions required of the Board

Narrative in support of the Provider Board Level Measures – February 2022 data

Introduction
The revised perinatal surveillance model sets out six requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include

- A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
- All maternity Serious Incidents (SIs) are shared with Trust Boards (in addition to reporting as required to HSIB) and
- To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

Obstetric cover on the delivery suite, gaps in rotas

No change to obstetric cover information from last month. We reported in January on a concerning situation with a locum specialty doctor leaving for a post elsewhere and a specialty trainee relocating for family reasons. A recruitment process has resulted in two appointments at specialty doctor level. Both appointees have significant experience outside the UK but require a period of induction to work at 'middle grade' level in the UK. They will start in March and May and the department are constructing an induction period where they can progress from direct consultant supervision to working out of hours with the consultant off site.

At the doctor in training level, there is a doctor in their third year of training in obstetrics and gynaecology who does not yet have the clinical skills or experience to be on call without a consultant present and again needs a consultant on site. This therefore is impacting on the ability to cover nights and weekend on call because there is no resident consultant. They are undertaking long days on labour ward, meaning the consultant is on site until 20:00h when they then return home and are available as required. In addition a further doctor in training is currently on sick leave and will require a phased return to work when they return (the return work has not yet been planned). The successful recruitment process described above has yielded a further acceptance of a doctor to a six month locum post to cover these gaps. Again this doctor has significant experience outside the UK and will require an appropriate induction period before working with a consultant off site.

The staffing position in February remains challenging and is also impacted by annual leave and compassionate leave. This is stabilised by resilience from consistent use of agency. There is a well understood contingency plan for ensuring that the provision of a three tier on call is maintained which ultimately results in the consultant becoming resident. However, these events have an inevitable effect on the ability of the consultant body to undertake elective work as they take compensatory rest after resident on site duties. In addition, the middle grade and consultant work force are at risk of fatigue with the additional pressure.

To assure the board, with mitigations as described above, the maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below.

The maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below. There is no change to obstetric staffing since the last report in October.

Staffing Gaps and Contingencies			
Grade of doctor	**Staffing gaps**	**Contingency**	**Risks**
First on call rota FY2/ GPVTS/ ST1/2	None	Internal cover for short term sickness as required	None identified

Second on call rota ST3-7/ specialty doctor	Two staffing vacancies for February (new appointees to start in March and May) One doctor on long term sick One doctor working on the middle grade rota unable to work without on-site senior supervision.	Internal cover prioritising labour ward cover Internal cover for short term sickness as required Consultants covering shortfall Urgent recruitment to the vacant post required (due to start in March and May)	Risk of fatigue in doctors on second on call tier Risk of cancelling elective activity to protect Delivery Suite cover Added to risk register March 2021
Consultant	No gaps		

Midwifery safe staffing, vacancies and recruitment update

Midwifery minimum safe staffing planned cover versus actual prospectively.

Average fill rate

Average fill rate	Midwives	MSW's
Delivery Suite	92.8%	82.6%
Pannal ward	93.6%	74.2%

Sickness

Delivery Suite

Midwives

Long term Sickness (more than 28 days)	0 midwives
Short Term Sickness	4 midwives (total 122 hours) (11.5 hour D&V, 15 hours COVID-19, 15 hours phased return, 69 hours work related stress)
Maternity Leave	2 midwives (1.4 WTE)
Paid Absence/Unpaid Absence	1 midwives (7.5 hours carers leave)
Non patient facing	0 midwives
Medical Isolation (Covid)	1 midwife (15 hours- COVID positive)
Common Sickness Themes	None

MSW's

Long term Sickness (more than 28 days)	None
Short Term Sickness	3 MSW's (total 79 hours) (30 hours COVID-19, 15 hours ENT, 11.5hours muscular, 11.5 gynae issues, 11.5 cold/flu)
Maternity Leave	1 MSW (0.5 WTE)
Paid Absence/Unpaid Absence	7.5 hours unpaid absence
Non patient facing	None
Medical Isolation Covid	1MSW (30 hours tested positive)

Pannal ward

Midwives

Long term Sickness (more than 28 days)	0 midwives
Short Term Sickness	3 episodes – 1 Covid pos (23 hours), 1 gastro (23 hours) and 1 MSK injury.(11.5 hours)
Maternity Leave	4 midwives totalling 480 hours
Paid Absence	1 x carer's leave 11.5 hours
Non patient facing	None

Unpaid absence	None
Household isolation	None
Common sickness themes	MSK injury

MSW's

Long term Sickness (more than 28 days)	No members of staff on long term sick.
Short Term Sickness	3 episode 2 stress and anxiety (46 hours) 1x migraine (23 hours)
Maternity Leave	1 maternity support worker (135 hours)
Paid Absence	None
Non patient facing	None
Unpaid absence	None
Household isolation	1 episode (11.5 hours)
Common sickness themes	Stress

Staffing and vacancies

Midwives			
Bands	Staff in post (WTE)	Staff recruited awaiting start date (WTE)	Vacancies out to advert (WTE)
Band 8	2.00	0	0
Band 7	16.12	0	1.7
Band 6	43.48	6.5	.60
Band 5	7.32	1.60	0.08
Band 3	6.25	1.80	0
Band 2	8.40	1.00	1.00

Vacancies, retirements and resignations – in the month of February

Two x band 6 midwives have handed in their notice

- One due to work related stress (this midwife has been invited to meet with team leader and HR to try and support her to remain at HDFT)
- One due to moving back to her old trust (midwife returned from overseas and there was no job at her old trust. This has since changed and due to travel times will be returning there)

Use of NHSP and agency for February

Delivery Suite

Midwifery

- From 1st- 28th February 2022, a total of 2576 hours were required to safely staff Delivery Suite. During this period, 7.6% of hours were covered by NHSP (198 hours). 119 hours (4.6%) were left uncovered meaning that 87.8% of the midwifery hours were covered by contractual hours.

MSW's

- Between 1st- 28th February 2022, 644 maternity support worker hours were required for the unit to be fully staffed. During this period, 53 hours (8%) were covered by NHSP and 193 hours were left uncovered (30%).

Pannal

Midwifery

- Day shifts. During January there were 168 shifts (1260 hours) to cover including both Early and Lates. 91% of shifts were covered by contracted hours and 9% (11 shifts = 82.5 hours) were covered by NHSP.
- Night Shifts- During January there were 56 night shifts (644 hours) requiring staffing. 3 (34.5 hours) of these remained uncovered. 94% of shifts were covered. 87.5% of shifts were covered with contracted hours and 12.5% (80.5 hours) covered by NHSP.

MSW's

- For the same period, there were 84 (742 hours) maternity support worker shifts to cover. 82% of these shifts were covered by contractual hours. 12% (75 hours) were covered by NHSP. 18% of shifts remained uncovered.

Staffing summary

As a unit we are still seeing the effects of COVID-19 isolation. Our overall staffing numbers have improved and we will be recruiting further band 2, 5 and 6 posts.
Two midwives have returned from maternity leave.
One midwife has started her contract in February and there are four more are awaiting start dates.
No elective caesarean sections were performed on Delivery Suite during February which greatly reduced workload. Only one patient attended for bereavement care compared to six in the previous month. We need to aim to increase uptake of MSW shifts on NHSP.

In February, some members of the senior midwifery management team worked clinically to support the unit, this was not documented on Birth rate +:

- Risk management midwife assisted with NIPE examinations to aid early discharge home
- Delivery suite manager worked clinically twice on management day due to reduced staffing levels
- Practice development midwife assisted on MAC in periods of high activity
- Digital midwife assisted with break cover and staffing

Number of times the maternity unit was closed to further admissions/women diverted and action

Number of times the unit closed to further admissions and women diverted to other maternity units in the region October 21 – February 22:

	October	November	December	January 2022	February
No. of times maternity unit closed to admissions	5	6	1	5	3
Reason					
Increased activity	3	4	1	4	3
Staffing below minimum levels	4	2	1	4	0

No. of women diverted to other maternity units	7	10	0	5	5

The changes to the maternity escalation guideline are now in place including Opel criteria level and discussion with and final decision made to close/divert with the Director on call.

Of the five women diverted to other maternity units in February, four women delivered elsewhere and one woman returned back to Harrogate to deliver. All women were contacted by telephone and a follow-up letter sent by the HOM. As in previous months all women understood the reason for diversion and appreciative of the contact and offer of additional explanation, all declined this offer.

February data – BR+ acuity tool

124 women delivered, 126 babies born (1 BBA)
1:1 care in labour - 99.1% 1 to 1 care for women birthed (100% for those born within unit at HDFT)

Labour ward coordinator supernumerary - 98.5%

Midwife: birth ratio - 27.76% (gold standard 1:26)
Percentage of specialist midwives in post - 7.2 WTE

Red Flag events (Birthrate +)

Delivery Suite

There was one red flag identified from the Birth Rate Plus Data.

- Midwife unable to provide 1:1 high dependency care for antenatal or postnatal patient.

Pannal Ward

There were two occasions where red flags were identified from the Birth Rate Plus Data which were:

- Delay between admission for induction and beginning of process.

Neonatal services
Safer staffing

1.0WTE recruited, newly qualified nurse who is very interested in BFI but will not start until September.
Vacancy at present 0.69 wte band 5.
2.6% of our workforce in February covered by agency, this was due to vacancy.

Sickness

SCBU	Nurses	Nursery Nurse
Short Term	Sickness - None	
Long Term	None	LTS (4 weeks), now has fit note to return (46 hrs in Feb)
Maternity leave	None	None
Medical Isolation	Isolation – 11.5hrs B5	None

Qualified in Speciality (QIS) – 82% (87% - January) (aim for above 70%)

Staff sickness

1 x LTS of Band 4. COVID isolation improved in February

Essential training compliance for all staff groups related to the core competency framework and wider job essential training – (maternity and neonatal)

Training compliance in February

Prompt emergency face-to-face training recommenced in October.

Prompt emergency skills training

	Medical staff (including anaesthetists)	Midwives
December 2021	31%	37%
January 2022	31%	37%
February 2022	47%	48%

Numbers of staff attended face to face Prompt training since October 2021

Midwives	48.2% (40 / 83)
MSW's	5.8% (1/17)
Obstetric staff	47.4% 9/19 (1 consultant)
Anaesthetic staff	33.3% (7/21)

Fetal surveillance training (K2 online training package)

	Obstetric staff	Midwives
December 2021	9%	18%
January 2022	9%	18%
February 2022	1/11 – 9%	11/61 18%

Percentages are higher in previous reports as previous figures included online training which is not applicable for this year as the online training now requires updating.

Neonatal resuscitation training (midwives)

	Midwives
December 2021 (Jan report)	83 % 63/76
January 2022 (Feb report)	92% 70/76
February 2022 (March report)	84% 70/83 (note increase in staff numbers)

Safeguarding children level 3 training:

- Midwives have watched two 45 minute episodes of '24 hours in Police Custody' (a recent case from Cambridge of an 11 week old baby and another of domestic abuse) and reflect on three questions followed by attendance at a reflective discussion meeting about the case both virtual and face-to-face.
- Compliance levels will continue to be monitored closely over the next couple of months

- We have agreed with the safeguarding team and HOM that these reflective sessions can also be counted as a clinical supervision session due to the nature of the discussions generated
- A total of 27 midwives have attended these sessions, further sessions to be arranged
- The new safeguarding lead midwife started in post 28th February
- Completion of e-workbooks – overall 42% compliant

SCBU

Training
We have secured a place on each Neonatal Advanced Life Support course this year. There is one Registered Nurse out of date however all others currently in date.

We have secured a place on each NALS course this year, we have 1 x RN out of date however all others currently in date.

Overall, learning lab training compliance for SCBU staff is 85.5%

Risk and Safety

Risk register summary

The Risk Register was last reviewed with PSC Quality Assurance Lead on 23rd Nov 2021. The Risk Register was transferred to Datix. Currently nine open risks.

- **Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 12).** Gaps in Middle Grade rota. Vacancies advertised and two new staff appointed. Anticipate reduction in risk score following commencement in post.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 12).** Additional staff recruited and attempts to fill gaps with extras, agency staff and financial incentives. Staff being moved between areas according to need.
- **Risk to compliance with national strategy, MSDS, and patient safety due to lack of end-end electronic record system (Score 12).** Contract signed. Plan ongoing and anticipated full implementation by end 2022. For downgrade once in place.
- **Delay in review of clinical guidelines (Score 10).** Risk relating to out-of-date clinical guidelines. Work ongoing to undertake routine reviews but delayed due to clinical demands and lack of capacity. Current guidelines remain in place but risk that not up to date with best evidence.
- **Risk to patient safety and experience from GP surgeries removing support for midwifery clinics (Score 10).** Situation continues to be challenging. Previously escalated to CCG and PCN Link GP. Communications sent out locally to elicit offers of possible alternative locations for community clinics/hubs.
- **Failure to meet national targets in relation to Continuity of Carer (Score 10).** Remain unable to meet specified targets. Local plan to relaunch team in April.
- **Lack of local frenulotomy service leading to delays in treatment of neonatal tongue-tie (Score 8).** Infant Feeding Coordinator undergone training and competency training completed. Commissioning of service remains under investigation.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Level 3 updates for existing staff implemented with Safeguarding Team, through video observations and reflective sessions. Compliance rates improving.

Postnatal care plans not being filed within hospital notes in timely manner when discharged from midwifery care (Score 6). Persisting issue. Planned use of agency staff.

The number of incidents logged graded as moderate or above and what actions are being taken

In February 2022 there were 51 total incidents reported through Datix. Of these, there was one incident recorded as Moderate Harm. This incident was a fourth degree perineal tear sustained during forceps delivery. Statement from staff present indicate that forceps were applied but the mother pushed unexpectedly and without traction on the forceps, the baby's head was born suddenly. A 48h report was completed and reviewed at PSC quality and safety huddle and no further action required.

There was also birth of a 29-week baby on Delivery suite. The mother was admitted with severe pre-eclampsia and abnormal CTG and the appropriate decision was made to deliver by emergency caesarean section. The baby was transferred out to tertiary unit for ongoing care.

SCBU Incidents

No moderate harm. 1 x discharge paperwork not sent to community midwife resulting in missed postnatal visit. 3 x ATAIN (information below).

Risk Register

There are no new risks to the risk register in February.

Cot occupancy (Cots available on the unit = 7).

Remain open with 7 cots, 6 babies at present. With 9 admissions in February

ATAIN
In February three babies fitted this criteria:

- Baby born by C Section, thick meconium at delivery, no antenatal steroids. Cold baby.
- home birth, meconium, low sats, needed O2
- Low BM and raised lactate.

Babies transferred out.

- 29+3/40 gestation transferred due to prematurity.
- 42 weeks transferred due to birth asphyxiation multiple problems, full resuscitation.
- Term baby transferred out, due to home delivery of breech baby, baby in extremely poor condition at birth required full resuscitation and stabilisation prior to transfer to James Cook hospital. This baby is being cared for in Harrogate SCBU.

<u>Findings of review of all perinatal deaths using the real time data-monitoring tool</u>

Perinatal Monitoring Review Tool Report:

There are four new cases which qualify for review using the PMRT.

- 36 weeks Intra Uterine Death discovered at scan appointment in Dec 2021 – a complex requiring further discussion after initial review was held at PAP. Extra antenatal care with diabetic, obstetric and safeguarding teams. Due to the complexities, the named consultant asked for the opinion of a colleague to enable a chronology prior PMRT discussion

- Neonatal death of premature twin born at 28/40 by Emergency caesarean at Harrogate – both babies transferred to Leeds where one twin sadly died.

- Neonatal death of a baby with known fetal abnormalities not expected to survive. Parents opted to continue with the pregnancy, planned palliative care at delivery. This baby lived for just under an hour and died peacefully

- Stillbirth at 38+3. Low risk pregnancy which resulted in an ante partum haemorrhage after spontaneous rupture of membranes. Sadly, no fetal heart rate was detected on admission to Maternity Assessment Centre. Case qualified for HSIB investigation – parents have declined this. An RCA is currently underway, after discussion at PAP there were no concerns about care or advice highlighted

Service User feedback

Maternity Voice Partnership group – a new MVP chair has now started in post, Jen Baldry. This is a paid role by North Yorkshire CCG. The first meetings of the MVP group have taken place with the following projects agreed – parent and baby safety, reducing mortality, continuity of carer, personalised care and support plan, equity and equality.

CQC Maternity Survey 2021 - we received the local results for the CQC Maternity Survey 2021. These results have been shared with the staff and the local MVP. The HOM presented the survey results at the Making Experiences Count forum in early March. An action plan will be developed, progress will be monitored via Maternity Services Forum.

20220112 MAT21 RCD V6.pdf

CQC Maternity Survey 2021 (1).pptx

Complaints / concerns to PET / compliments

FFT - 21 responses have been received for Friends and Family (FFT) in February 2022. Of the 21 responses inputted for February 2022 100% responses were reported as good or very good. Early discussions have taken place to transfer from paper to electronic.

Regular positive feedback is received on a daily basis through the Social Media Facebook pages and shared (with permission) to the public and maternity team.

During February, we had no concern(s) that has been responded to and two formal complaints, responses in progress

Parents feedback received by SCBU

November 2021 to January 2022, 15 families gave feedback.
We asked:
Did you feel involved in your baby's care? **100% - yes definitely**

Were there any times you were prevented from being with your baby? **100% said no**

Could we have done anything else to make you feel more at home? **100% said no**

Comments

Absolutely fabulous team of doctors and nurses. We cannot thank you enough for everything, including the care for our babies and the support you have given us as parents. We leave with a lot of love for you all, feeling confident about our babies future, thanks to you all.

We could not praise SCBU highly enough. The team has given us the support, skills and confidence we needed to look after our little girl.

Wonderful team, providing invaluable help in every way. Fully confident to take baby home after being provided with so much information on how to care & feed. Cannot thank you enough.

I can't thank the staff on SCBU enough, they went above and beyond at all times. We wouldn't be where we are today if it wasn't for all the nurses on SCBU. When I had bad days there was always someone around to pick me up. I can't reiterate enough how thankful me and my partner are for everybody on SCBU.

12 out of 10 service, 100% satisfaction. Very impressed. Can't thank all at SCBU enough

Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received in February 2022.

Request for action from external bodies – NHS Resolution, HSIB

In February 2022:

One new case notified in this period. Family have declined HSIB investigation so returned to Trust for decision about investigation. Discussed at PSC Q&S Summit and also brought to WY&H LMS SI Panel. Agreement not for discussion as SI as no lapse in care. Will be reviewed routinely through Perinatal Mortality review (PMRT) and agreement to write up as Level 1 concise RCA for completeness.

This case relates to a patient contact to MAC with vaginal bleeding at 38+3 weeks, following rupture of membranes a few hours earlier. Asked to come in, and on arrival the was no fetal heartbeat. Antenatal care had been appropriate and fetal movements were normal prior to contacting.

The case notified to HSIB in the last period relating to breech birth and severe HIE Grade 3 has been declined, due to lack of parental consent. Discussed at PSC Q&S Summit. There was not considered to be any lapse in care, and not considered to be need for further investigation. However, in view of the circumstances and significant impact upon the baby it was agreed to bring together findings as a Level 1 concise RCA for completeness.

Action plans from previous cases are being progressed with monitoring of the action plans through MRMG.

Maternity incentive scheme – year 4 (NHS Resolution)

We are waiting to hear from NHS Resolution of revised timeframes due to the ‘pause’ for three months from December 24th

Key staff in the maternity department continue to work towards compliance with the ten maternity safety actions for year 4 of the scheme.

National priorities

Midwifery Continuity of carer (MCofC) update

Although we continue to report 0% women booked onto a pathway planning for roll out of our first team is well underway. Anticipated to commence April 2022 and once fully established will provide MCofC to 20% of eligible women.

Safe staffing remaining community provision as midwives move into MCofC teams has become a challenge with further movement of staff both out of the trust and into inpatient areas.

Estates and hubs remain a significant risk with a lack of community-based provision. Approaches to leisure centres, libraries, NYCC and HTC have been unable to secure appropriate accommodation. Plans for Leon Smallwood Unit awaiting response from NHSPS regarding leasing.

Engagement with Band 7 delivery suite coordinators staff has helped raised the profile of the continuity model within the inpatient areas.

Ockenden report *(December, 2020)*

Update on Ockenden action plan

Regular updates of the local action plan are completed and has recently been shared with the regional chief midwife and deputy and with the WY&H LMS.

The updated action plan is attached below:

Ockenden Action Plan June 2021 (Revi

Outstanding actions from the action plan:

- The completion of an audit schedule to address ongoing, regular audit of planned place of birth, ongoing audit of risk assessment throughout pregnancy, named consultant for women with complex pregnancy and personalised care plans – the clinical audit & effectiveness role has now been appointed (to start in post early April).
- A named obstetric fetal monitoring lead has been identified but requires designated time to perform the role (additional PA) – agreement with the clinical lead and PSC Directorate is required
- Multi-disciplinary training – staff who work together must train together. Multi-disciplinary training has not been possible between October – February due to reduced middle grade doctors and subsequent impact on the consultant obstetrician & Gynaecologists. A plan has been agreed and close monitoring will continue over the next 3-6 months.
- We are compliant with all aspects of Saving Babies Lives care bundle (V2) but need standard operating procedures to support the five criteria – currently in progress.

Progress

- A clinical audit & effectiveness role (maternity specific) to support the ongoing audits recommended in the Ockenden report has now been appointed and starts in post early April
- A plan is now in place to review and update patient information leaflets (maternity specific) – approval by the MVP group

- The patient information leaflet for maternal choice for caesarean section has been ratified and uploaded, in use and available to women via staff in the ANC and community midwifery/continuity of carer teams
- We are now working closely with the new chair of the local MVP group to ensure the voices of services users are heard via this forum and the first meeting of this year, occurred 28th February. The MVP chair has met with key staff within and outside the organisation.

Following significant financial investment into maternity services across England, NHSE/I have requested a local update on progress with implementation of the seven Immediate and Essential Actions (IEA's) recommended in the Ockenden report (2020) and an update on maternity services workforce plans. The Assurance Assessment tool completed in February 2021 also included recommendations from a previous maternity investigation report at Morecambe Bay (Kirkup report, 2015).

The local report has been completed for discussion and review at Trust Board 30th March.

The second part of the Ockenden report expected in March 2022 has been delayed due to parliamentary processes.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

Regional data received for Quarter 3 shown below. No new update.

In summary for Quarter 3:

- *Bookings less than 10 weeks are 74.0%, an improvement from Q2 (72.5%), and amongst the highest in the region (range 45.7-80.7%). No Y&H Trust has met the 90% target.*
- *1:1 care in labour was 98.3%. This compares very well against other Trusts (regional average 94.7%).*
- *Normal delivery rate was 55.6% (an improvement over Q2 [52.2%]), against a regional average of 57.3%.*
- *Total Caesarean section rate was 30.3% (compared with the regional average of 32.0%). There were 16.9% elective Caesarean sections (compared with 13.2% regional average), and is the highest in the region.*
- *Induction rate (32.1%) was lower than the Y&H average (35.3%), with the highest induction rate in the region being 50.9%.*
- *Significant PPH rate was again lower in this quarter (3.8%), and is now similar to the regional average (3.6%).*
- *There were 2 stillbirths at HDFT in Q3. Rolling annual antenatal stillbirth rate is currently 3 per 1000 births compared with the Y&H average of 4.2 per 1000.*
- *Breastfeeding initiation rates remain very high at 85.4% compared with the regional average of 67.2%, and remains the highest in the region.*
- *Smoking rates at booking and time of birth are the lowest in the region (4.1% and 5.1% respectively), compared with Y&H average of 13.8% and 11.5% respectively.*

Local data capture for carbon monoxide testing at booking and 36 weeks remains a challenge, but consider needs significant improvement.

Local HDFT dashboard information

For the month of February:

- 124 mothers delivered (and 126 babies born)
- Elective Caesarean section rate 9.5% (decrease since Jan, 15.9%).

- 11.1% emergency Caesarean section (decrease since Jan, 15.9%)
- 64.3% normal delivery rate (significant increase from Jan, 54.3%)
- 33.3% induction rate (increase from Jan, 30.4%)
- 3.2% significant PPH ≥1500ml rate (increase compared to Jan [1.4%]; 4 patients)
- One 3rd/4th degree tear [at instrumental delivery, 4th]
- 81.7% breastfeeding initiation rate
- 5.6% smoking rate at time of delivery [6.6% in Jan]
- One stillbirth at 38+3 weeks.

OASI2 Project

We are currently in the implementation period of the trial where we are trying to raise awareness and train staff. Data collection has now commenced from mid-February. The midwifery team are attending PROMPT and Dr's meetings to ensure they are reaching as many people as possible to raise awareness of the project and to train all staff. A date will be decided to start assessing outcomes.

Conclusion and recommendation

Please see the grid attached for concerns/risks to escalate and positive news and assurance.

Appendix - Supporting information – (applicable to some sections of the report)

This section provides additional information around individual sections in the report.

Obstetric cover on the delivery suite, gaps in rotas

The obstetric cover for delivery suite runs 24 hours a day, 7 days a week. There is always an onsite first on call doctor and second on call doctor. The consultant is on site Monday – Friday 08:00h – 16:30h and on call thereafter within 30 minutes of the hospital.

The second on call rota is staffed by permanent specialty doctors (establishment 4 WTE), and doctors in training in obstetrics and gynaecology (establishment 3 WTE). At specialty doctor level one of the permanent posts is filled by a locum appointment because of difficulties in recruitment. Due to clinical skills and experience required a consultant is required to be present on site.

The department is working towards consultant on site cover 08:00h – 20:00h seven days per week in line with the recommendations form the Ockenden Report. This would alleviate some of the issues around on site supervision of doctors in training.

Birthrate + acuity tool

The Birthrate Plus acuity tool is currently the only midwifery specific, national tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services. It provides a valuable resource that can routinely support operational and strategic decision making in maternity services. The tool is a prospective “real time” tool that assesses the numbers of midwives and support staff required to safely operate intrapartum and ward services.
Birthrate Plus can calculate an individual ratio of clinical midwives to births for maternity services by reviewing activity, case mix, local demographics and skill mix.
Using NICE guidance and available evidence and best practice, Birthrate Plus calculates how many midwives would be required to meet the needs of women across the whole service.

Birthrate Plus makes a distinction between midwives who provide direct clinical care and those employed in management, development and governance roles, essential to the safe running of the service but not directly involved in clinical care of women. Birthrate Plus recognises that not all of the clinical work in maternity needs to be undertaken by midwives and that by enriching skill mix to include maternity support workers (MSWs) and nursery nurses, midwifery time and expertise can be better focused and targeted. Individual units will make their own judgement about the proportion of midwifery time that can safely be replaced by other roles.

- The suggested skill mix adjustment is 90:10 for clinical support staff who replace midwifery hours.
- Support staff who assist midwives but do not provide direct care e.g. clerical staff and housekeepers should not be included in this ratio.

Safer staffing – neonatal services (SCBU)

- Each shift has 2 registered nurses on duty one being Qualified in Speciality (QIS) meeting BAPM Professional guidance regarding optimal nurse staffing as described in the BAPM Service Standards for Hospitals providing Neonatal Care (2010)
- The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care.

Qualified in speciality

In the last five years the response to the National Audit Office report (NAO, 2007) into neonatal care delivered in the UK has resulted in the publication of government and professional standards (DH, 2009; BAPM, 2010, NICE, 2011). Within all these frameworks for care, clear recommendations are made for the role of the QIS nurse as a central member of the nursing workforce. QIS nurses provide a pivotal role in workforce strategy, not only in providing direct clinical care to babies and families. Once qualified they are able to develop further into more specialised clinical practice areas (e.g. stabilisation and transport, breast feeding advisor, outreach nurse), or enhance their practice skills/knowledge (eg intubation, cannulation, surgical nursing), and undertake development to advanced practice
level. They are also vital for supporting the foundation learning of novice nurses in neonatal areas.

National drivers for nursing include standardisation of levels of competence (DH, 2008). Competence in practice relies on the assessment of knowledge and understanding, and in skills performance. At QIS level the expectation is for the neonatal nurse to be able to apply knowledge to practice in terms of rationalising judgements, problem solving and making clinical decisions in order to optimise infant outcomes.

Maternity escalation guideline

The maternity escalation guideline was updated in January 2022 in line with the Y&H regional maternity escalation guideline to ensure consistency in systems/processes and terminology used. The level of escalation, based on activity, acuity and staffing levels now uses **Opel level criteria** and not the traffic light system (previously used).

OPEL 1 - Green
OPEL 2 - Amber
OPEL 3 - Red
OPEL 4 - Black

The decision to divert or close the maternity unit is the responsibility of the Executive Director on-call in close communication with key senior staff within the maternity unit. An SBAR form has been introduced to enable clear and accurate communication between the maternity unit, the clinical site manager on duty and the Director on call. The form includes staffing levels, activity, acuity of women and babies and the Opel level to aid in the decision-making.

CQC Maternity Survey 2021

The 2021 maternity survey involved 122 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1st and 28nd February 2021 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2021. Responses were received from more than 23,000 women, an adjusted overall response rate of 52%.

The CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used to support CQC inspections.

Perinatal Mortality Review Tool (PMRT)

Commissioned in 2016, the national Perinatal Mortality Review Tool places at its core the fundamental aim of supporting objective, robust and standardised review to provide answers

for bereaved parents about why their baby died. A further aim of the tool is to ensure local and national learning to improve care and ultimately prevent future baby deaths.

The national PMRT was developed with clinicians and bereaved parents in 2017 and was launched in England, Wales and Scotland in early 2018. Unlike other review or investigation processes, the PMRT makes it possible to review every baby death, after 22 weeks' gestation, and not just a subset of deaths. For 92% of parents the PMRT process will likely be the only review of their baby's death they will receive.

Further refinement and development of the PMRT continued through 2019 and 2020. In addition, the tool was adapted in mid-2020 to enable the impact of SARS-CoV-2 on service delivery be reflected in reviews.

It remains the case that the PMRT is only a tool, and will therefore, only be as good as the information that is inputted into it and the way it is used. If it is to achieve the original vision set out by the Task and Finish Group in 2012, it is up to Trusts and Health Boards to improve the way this process is supported and implemented.

ATAIN

ATAIN (Avoiding Term Admission into Neonatal unit) is a national programme designed to reduce avoidable admissions of Term gestation babies, and reduce the harm caused by separation of mothers and their babies. The work focuses on quality improvement work in four main areas:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

To aid this, all Term admissions to SCBU are reviewed against a standardised proforma through a monthly multidisciplinary panel (midwifery, obstetric and paediatric/neonatal) to determine whether the admission could have been avoided and whether there is any learning or practice changes that could be embedded.

Data for Term admissions is captured through an ATAIN dashboard, submitted through the WY&H LMS, together with an action plan of learning points.

Coroner Reg 28 made directly to Trust

A Coroner has the power to make a report to prevent future deaths, provided under Regulation 28 of Coroner (Investigations) Regulations 2013.

Maternity Voice Partnership (MVP)

A Maternity Voice Partnership (MVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. It includes a team of service users, midwives, doctors and commissioners, working together to review and contribute to the development of local maternity services.

A successful MVP needs:

- Structure
- Membership
- Role Descriptions
- Terms of Reference
- Funding
- Women's feedback

The Harrogate MVP launched in November 2018, before this date there was no equivalent group at local level. Since the end of 2018, we have been on an extensive journey.

A chair was nominated at the beginning of this process on a voluntary basis to help set up, develop the group and to chair the meetings. The chair successfully recruited a small number of local women to take part. Apart from close communication with the WY&H LMS senior Midwife, we have had little guidance and support in developing this group. From the beginning, the chair of the group did not request payment for performing this important role. At the time, none of us appreciated the amount of work that would be required and the necessary commitment to the role at both local and regional level.

Since the start of the group in late 2018, we have achieved the following:

- Had quarterly meetings of the main group with sub-meetings arranged for members of the committee and local women in-between
- Before Covid-19, the meetings were held face to face in a local children's centre with attendance by a small number of women, the CCG, the chair, HOM, Matron, the parent education midwife
- The chair is invited to the bi-monthly Maternity Services Forum (MSF) and receives minutes of this meeting if unable to attend
- Agreed TOR for the group
- Before Covid – 19, members of the MVP group completed 15 steps challenge in all areas of the maternity department, walk the patch and worked with the maternity service to survey women's experiences of maternity services during Covid-19. There is an action plan in place monitored by the MVP group and MSF

Healthcare Safety Investigation Branch (HSIB)

HSIB conduct independent investigations of patient safety concerns in NHS-funded care across England. The maternity investigation programme is part of a national action plan to make maternity care safer. The organisation is in a unique position as a national and independent investigating body to:

- Use a standardised approach to maternity investigations without attributing blame or liability.
- Work with families to make sure we understand from their perspective what has happened when an incident has occurred.
- Work with NHS staff and support local trust teams to improve maternity safety investigations.
- Bring together the findings of our reports to identify themes and influence change across the national maternity healthcare system.

All NHS trusts with maternity services in England refer incidents to the teams at HSIB.

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. HSIB investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. The recommendations made aim to improve healthcare systems and processes in order to reduce risk and improve safety. HSIB, as an organisation values independence, transparency, objectivity, expertise and learning for improvement. Work closely with patients, families and healthcare staff affected by patient safety incidents, they never attribute blame or liability to individuals. HSIB is funded by the Department of Health & Social Care and hosted by NHS England and NHS Improvement.

During the investigations, all clinical and medical aspects of the incident are reviewed, as well as aspects of the workplace environment and culture surrounding the incident.

Criteria for inclusion:

- All incidents that meet the Each baby Counts criteria or defined criteria for maternal deaths
- Eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour, who have one of the below outcomes
- Where the baby was thought to be alive at the start of labour but was born with no signs of life
- When the baby died within the first week of life (0-6 days) of any cause

Potential severe brain injury diagnosed in the first 7 days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) - brain injury caused by the baby's brain not getting enough oxygen.
- Was therapeutically cooled (active cooling only) - when the baby's body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
- Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

Maternity incentive scheme – year 3 (update)

Following submission of an FOI from Baby Lifeline, all trusts were asked to reconfirm whether on further review, the Trust had met the minimum evidential requirements in year three of the maternity incentive scheme for safety standards 6 & 8 surrounding training compliance. There were discrepancies identified in the information some trusts had submitted for the FOI request and what had been submitted to NHS Resolution. Harrogate did submit the FOI request and re-confirmation was completed in the timeframe requested. We are waiting for confirmation from NHS Resolution of these actions for safety actions 6 and 8 of the scheme and therefore reconfirmation of compliance with all 10 maternity safety standards.

Maternity Incentive Scheme (NHS Resolution) – Year 4

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year three, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions. Trusts that can demonstrate full compliance with all of the requirements in the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated fund. The ten maternity safety actions include:

1. Can you demonstrate the use of the national PMRT to review perinatal deaths to the required standard?
2. Can you demonstrate submission of data to the Maternity Services Data set to the required standard?
3. Can you demonstrate transitional care services to support the ATAIN programme?
4. Can you demonstrate an effective system of medical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of Saving Babies Lives care bundle?
7. Can you demonstrate patient feedback mechanism for maternity services and that you regularly act on feedback?
8. Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training

programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence at least 90% of each maternity unit staff group have attended an 'in-house' one day multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and Newborn life support, starting from the launch of MIS year 4?

9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme for 2021/22?

Update from NHS Resolution (24th December)

In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) **10 safety actions are paused with immediate effect for a minimum of 3 months**. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples include:

- Continuing to undertake midwifery workforce reviews
- Continuing to ensure that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continues
- Continuing to use available on line training resources where applicable
- To continue to report to MBRRACE-UK and report eligible cases to the Health Safety Investigation Branch (HSIB)
- Every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital.

The reporting period for MIS year 4 will be kept under review and may potentially be extended by the MIS Collaborative Advisory Group (CAG) who will reconvene in February 2022.

Continuity of Carer

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth (Better Births 2017).

The Cochrane Review by Sandall showed that there are significant improvements to the outcomes of mothers and babies when a Continuity of Carer (CofC) model is used (Sandall et al 2017). This model of care (if implemented correctly) provides a mechanism whereby midwives can gain a holistic understanding of women's needs and as such be the vehicle that drives improvements in many aspects of maternity care.

The value placed on continuity of carer is highlighted in key national documents such as the NHS Long Term plan, 'Saving Babies Lives Vs2' (NHS, 2016), and most recently the Maternity Incentive Scheme and the workforce review section of the Ockenden report. There are also indications that CofC will be linked to CQC and maternity tariff requirements. It is therefore essential that as a trust this element of maternity transformation is prioritised.

HDFT maternity has been on an unprecedented journey to achieve the national ambition since late 2018. We have faced a number of achievements as well as challenges along the way. Our workforce understands the national direction of travel and through working closely with Human Resources: we have been able to provide opportunities for staff to share their views and create fair processes to support staff through the change. In early 2019 we started

with our willing volunteers, which resulted in the launch of two consecutive continuity teams; Ivy and Willow during 2019, taking us to 24% of women booking onto a pathway. For a period of time these teams worked well and were evaluated positively by women and many of the midwives.

Currently 3 teams of midwives are providing antenatal and postnatal care in the community. Providing intrapartum care is not currently possible due to staffing and skill mix issues within the community and in-patient areas. Whilst we have needed to take a step back, the end goal has remained our focus. In light of COVID-19 and the impact on our local midwifery staffing, our continuity of carer plans were revised and a new rollout plan was proposed, agreed and launched in January 2021. Due to the nature of facilitating a large scale change through a global pandemic it has been essential that the project management takes an agile approach to implementation. The journey we have been on so far demonstrates how essential it is to have a transformation strategy that will allow us to continually adapt to the unpredictable nature of the current climate, whilst continuing to move towards the national goal. Since the revised rollout was launched in January 2021 the national ambition has been updated again to stipulate that all eligible women must be in receipt of continuity of carer by March 2023.

Our revised plan has meant that the percentage of women in receipt of continuity of care has fallen back to 0% from May 2021 and will sit at this level for some time. However, this will not undo the progress we have made so far. The midwives will continue to work together in the 3 geographical mixed risk teams and will over time increase the number of midwives able to provide the full spectrum of maternity care as we recruit and continue to upskill our existing workforce.

Our continuity strategy will focus on the below key areas, which will provide the building blocks to maintain safe care and drive effective and sustainable change.

The key building blocks:

Workforce planning – ensuring we have the right number of midwives in the right places at the right time.

Positive Culture – develop a strategy for positive workforce engagement centred on the trust values of kindness, integrity, teamwork and equality.

Hubs – community hubs will provide an environment that fosters effective teamwork and the enhancement of relational care

'Follow the data' - An action plan for the evaluation of our models and integrating continuity of carer into our new electronic system.

The Health and Social Care Committee provided clear support in its July report for the importance of Midwifery CofC, and the strength of its evidence base. It highlighted longstanding challenges in local implementation, and the need for sufficient resources and support to deliver it. The NHS Operational Planning Guidance for 2021/22 requires that MCoC is established as the default model of midwifery care and to be offered to all women by March 2023.

Ockenden Report (2020)

This independent maternity review focuses on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at Shrewsbury & Telford NHS Trust. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

This first report was published in December 2020, the review panel, led by Donna Ockenden identified important themes which were shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make early recommendations for the wider NHS Immediate and Essential Actions.

The families who contributed to the Ockenden Review wanted answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They were concerned by the perception that clinical teams had failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future. After reviewing 250 cases and listening to many more families, this first report identified themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

Immediate and essential actions

1) Enhanced safety

- Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

2) Listening to women and families

- Essential action - Maternity services must ensure that women and their families are listened to with their voices heard.

3) Staff training and working together

- Essential action - Staff who work together must train together.

4) Managing complex pregnancy

- Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

5) Risk assessment throughout pregnancy

- Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway,

6) Monitoring fetal wellbeing

- Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

7) Informed consent

- Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

Ockenden part 2 is expected mid-end March 2022.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

Comparative summary data from Trusts within with Yorkshire & Humber region is produced on a quarterly basis.

OASI2 Project

An obstetric anal sphincter injury (OASI), is the combined term for a third- or fourth-degree perineal tear, a severe complication of vaginal childbirth. Long-term outcomes of OASI include chronic pain, sexual dysfunction, and urinary and/or anal incontinence. OASI rates are increasing in many countries. In the UK, OASI rates tripled among primiparous women over a 10-year period. The rise in OASI rates was linked to improved recognition of tears, changes in the characteristics of women giving birth as well as to changes in practice. These include an increased use of a 'hands-poised/hands-off' approach, opposed to a 'hands-on' approach to protect the perineum during childbirth, a reluctance to perform an episiotomy, and gaps in the training of midwives and obstetricians.

In response to rising OASI rates, a multidisciplinary team of national experts, supported by the RCM and the RCOG, developed The OASI Care Bundle. The OASI Care Bundle has four elements: antenatal education of women, manual protection of the perineum during delivery, consent for episiotomy if required and rectal examination following delivery.

Through OASI1, the OASI Care Bundle proved to be acceptable, appropriate, and feasible for clinicians and women and is clinically effective in reducing OASI rates. In this follow-on project – OASI2, the focus is on studying and optimising the implementation of the care bundle for eventual national scale-up in the UK, with the primary focus shifting from clinical to implementation effectiveness.

The OASI2 project was launched in Harrogate on 13th December 2021, facilitated by Andrea Stephenson, Rachael Fawcett (DS team leaders), Louise Wills (research midwife) and supported by Mr. Justin and Mr. Altanis (Consultant Obstetricians & Gynaecologists). We have previously implemented some of the aspects of the OASI care bundle and these elements have become embedded in clinical practice however we have not succeeded in reducing our OASI rate. As a multi-disciplinary team, we have identified that we would benefit from the additional support and training offered within this project.

Ockenden Review of Maternity Services

Board of Directors (Public)
30th March 2022

Title:	**Ockenden Review of Maternity Services**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Alison Pedlingham (HOM), Danielle Bhanvra (Matron, Maternity)

Purpose of the report and summary of key issues:	The purpose of this report is to provide an update on progress made, one year on, on the immediate and essential actions in maternity services for Trusts as set out in the Ockenden Report. The update was discussed at SMT on 23rd March 2022.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Maternity Services Forum Maternity Safety Champions meeting Senior Management Team meeting 23/3/22	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

4.3

Ockenden review of maternity services – one year on

Progress report for Harrogate & District NHS Foundation Trust

Alison Pedlingham, HOM and Danielle Bhanvra, Matron

Ockenden review of maternity services – one year on
March 2022

Introduction

Following significant financial investment into maternity services across England, NHSE/I have requested a local update on progress with implementation of the seven Immediate and Essential Actions (IEA's) recommended in the Ockenden report (2020) and an update on maternity services workforce plans. The Assurance Assessment tool completed in February 2021 also included recommendations from a previous maternity investigation report at Morecambe Bay (Kirkup report, 2015).

The information within this report shows progress at Harrogate against the seven IEA's and plans to address any outstanding risks, most are within our control but a small number are the responsibility of the West Yorkshire & Harrogate Local Maternity System (WY&H LMS).

The action plan attached below details the plan to ensure full compliance against all recommendations within the report.

Ockenden Action Plan June 2021 (Revi

Background

The Ockenden review was ordered in 2017 by the health secretary, who instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. This happened after the families of two babies, who died under the trust's care, raised concerns about their cases and 21 others.

The independent maternity review by Donna Ockenden focused on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at the Trust. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

The emerging findings and recommendations from the independent Review of Maternity Services was published in December 2020. The review panel identified important themes to be shared with all units and implemented across all maternity services as a matter of urgency to improve the safety of maternity services. The panel formed seven Local Immediate and Essential Actions (IEA's) for Learning and made early recommendations for the wider NHS.

The 7 x IEA's identified include:

1. Enhanced safety
2. Listening to Women and Families
3. Staffing working and training together
4. Managing complex pregnancy
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed consent.

Ockenden review of maternity services – one year on
March 2022

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- *Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.*

Progress

Harrogate is part of the West Yorkshire & Harrogate Local Maternity System (WY&H LMS) and works very closely as a system with the other five organisations within this LMS.

The LMS agreed that sharing information be included in a quarterly quality and safety report (includes safety, personalisation and public health). Data is collected from all six organisations within the WY&H LMS in a dashboard, which is presented at LMS Board on a quarterly basis. This report has recently been added to the agenda for Maternity Risk Management Group (MRMG) agenda.

Risks

No risks identified for this section of IEA 1.

- *External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.*

Progress

A WY&H LMS Serious Incident (SI) process was agreed and a panel established that has multi-disciplinary representation, the first meeting was held in August 2021. Trusts had backdated the Serious Incidents (SIs) submitted to April 2021. A regional SOP for this SI process and sharing/external review of investigations was agreed and shared via internal organisational governance processes.

Two senior midwives and one obstetrician from Harrogate attended a five-day SI training course by Baby Lifeline in November 2021. This training was organised and paid for by the LMS with places allocated to a number of key staff. There is regular local attendance at the monthly LMS SI review panel.

We continue to submit eligible cases to HSIB and to work closely with HSIB to improve safety and supporting families and staff throughout the investigation process to ensure learning from incidents occurs.

Risks

No risks identified for this section of IEA 1.

- *All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months*

Progress

There have been no local SI's declared since June 2021, all SI's within the organisation are submitted to the Trust Board via local and organisational governance processes and the WY&H LMS to ensure scrutiny, oversight and transparency.

Risks

No risks identified for this section of IEA 1.

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- *Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards*
- *The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome*.

Progress

There is no available information from the national maternity team on the independent senior advocate role, we can see the benefit of such and independent role and would be interested to pursue this in the future when further information is available.

At a local level, women and their families are involved in any complaint responses, investigations and SI's and will always be asked for questions as part of our internal governance processes. A Family Liaison Officer is allocated to support a family throughout any local SI process. For SI's, a Professional Midwifery Advocate (PMA) is allocated to support staff throughout the process. Action plans are developed following complaints and investigations, progress is monitored via the Maternity Risk Management Group.

Risk

An independent senior advocate role would be beneficial both to the organisation and to local families but no further information is available from the national team.

Please see information above.

- *Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.*

Progress

Andy Papworth was appointed as the non-executive director for maternity services and has oversight of the service by regularly attending Maternity Services Forum (MSF), Maternity Risk Management Group (MRMG) and the Maternity Safety Champions meetings, also attended regularly by the Executive Director for Nursing, Midwifery and AHP's who is the executive maternity safety champion. Andy has also made initial links with the new chair of the local Maternity Voice Partnership (MVP) group. Regular meetings are planned between the non-executive safety champion and the new MVP chair to ensure that the views and experiences of local patients are heard.

Ockenden review of maternity services – one year on
March 2022

A new MVP chair was appointed in December 2021; remuneration for the role of the chair was agreed with North Yorkshire CCG. The group have been very active over the last couple of months (main areas for focus are parent & baby focus, reducing mortality, continuity of carer, personalised care and support plan and equity and equality) . The maternity team are looking forward to working in partnership with this group to co-produce services together with regular meetings planned for 2022.

It was agreed at the Maternity Safety Champions meeting that there would be a variety of different ways for both staff and service users to be able to provide feedback or to escalate any safety concerns. These include a designated safety champions email address with an internal form on the intranet that goes directly to the email address, the maternity safety champion has had an occasional walkabouts in different areas of maternity however, due to the impact of Covid and visiting restrictions there have been no regular walkabouts, from the non-executive director as Andy Papworth. As Covid restrictions are lifted, there are plans for face-to-face visits in the future. However, his role is firmly embedded in the organisation and within the department.

The role of the non-executive Maternity Safety champion is supportive towards the maternity department and brings appropriate challenge if required and escalation of any safety issues to Trust Board.

There was no MVP chair in Harrogate between mid to late 2021 and therefore this local group has not had the opportunity to work together with maternity services over the last 6 months of 2021. The new chair has planned meetings with the midwifery MVP lead and has planned committee meetings for 2022.

Risks

No risks identified for this section of IEA 2.

Immediate and essential action 3: Staff Training and Working Together -

Staff who work together must train together

- *Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year*

Progress

The department has a good history of working and training together; a Training Needs Analysis is available and the content is reviewed on an annual basis. Any safety concerns highlighted because of clinical incidents, complaints or investigations may prompt an earlier review.

Due to Covid-19 restrictions, face-to-face training was suspended and replaced by Prompt online training in February 2021 and therefore not multi-disciplinary in approach. Face to face training was re-introduced in October 2021 with six training days delivered since then.

Live ‘hot debriefs’ take place after any difficult case, these include the full MDT and provides the team with an opportunity to walk through these cases and a focus on learning.

Risk

- Due to significant gaps in medical staffing (Middle grade level), senior medical staff attendance at the face to face Prompt sessions has not been achievable between

October 2021 to February 2022. With the recent appointment of three middle grade doctors, attendance will improve in the future. Close monitoring will continue for the remainder of the year.

- Anaesthetic attendance at the MDT training has been poor due to staffing levels.
- Midwifery staff have been attending study days in their own time and being paid from the maternity budgets to do so and monies not taken from the Ockenden monies. Action will be undertaken by ward/departmental team leaders: to draw monies down from the rosters.

- *Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.*

A multi-disciplinary daily huddle on delivery suite was introduced in October 2021. The huddle includes staff representation from Delivery Suite, Pannal ward, anaesthetics, theatre and SCBU. The focus of the daily huddles is to discuss activity and acuity in all inpatient areas. This gives the whole team the opportunity to raise any concerns regarding patients, safety issues, high-risk cases and any acute staffing issues.

Following receipt of the Ockenden report, our local guidance was updated to ensure the department can meet the guidance for twice-daily ward rounds in obstetrics. A standard operating procedure was developed and agreed in June 2021.

The multidisciplinary consultant led ward round occurs on a twice daily basis. These should occur following the 0800 handover and the consultant on call for the 1630 – 0800 night shift should conduct a ward round following handover at 1630. This should encompasses high risk labouring women, antenatal and postnatal patients requiring a medical review and agreed plans of care. Completion of the ward round is documented on the labour ward handover sheet. Sign in is now embedded in the daily routine. Initial audits of compliance were undertaken in February, March and April 2021 followed by the implementation of the SOP in June.

Risk

Currently attendance by the ODP and scrub nurse is poor at both the morning and evening ward rounds. Timing for the obstetric consultant at the evening ward round is also a current risk as the consultant currently performs the ward round and handover at 16.30 – 17.00 rather than 20.00 as the day consultant hours are until 17.00. There are discussions in the department and directorate in place to extend the daytime consultant session until 20.00

- *Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only*

Progress

Apart from the receipt of the Ockenden monies to support training, fetal monitoring lead roles and additional midwives, no monies have been received into the organisation.

Immediate and essential action 4: Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies

- *Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.*

Progress

Good progress has been made within the region with the development of a Maternal Medicine Centre. The Yorkshire & Humber (Y&H) region has come together to form a Maternal Medicine Network; this includes three LMSs (Humber, Coast and Vale, South Yorkshire and Bassetlaw, and West Yorkshire and Harrogate) working with commissioners, providers, clinicians, the Y&H Maternity Clinical Network, service users via MVPs and has the support of the ICSs.

The aim is to provide equitable and expert support for women with pre-existing or pregnancy-induced significant medical issues, to ensure sustainability of that care wherever in Yorkshire & Humber region they may live, and additionally, to provide perinatal mental health support or other onward referral as required.

The Y&H Maternity Clinical Network has supported the development of the Maternity Medicine centre with Lead commissioning arrangements agreed. Leeds CCG are managing financial flows with a collaborative approach to other elements of the commissioning across Y&H and Lead provider arrangement with Leeds Teaching Hospitals NHS FT agreed for the next 2 years, with a review at 1 year from network commencement. Activity will be delivered across Y&H by a single team at locations throughout Y&H based on predicted activity volume with supporting telephone and virtual advice also available

A project plan has been developed and maintained, along with action and risk logging. The current pathways for referral from the region are being collated. The three LMS Boards and the NEY Regional Maternity Transformation Programme Board approved the proposed workforce model. A stakeholder and communication plan is in place.

Harrogate have good existing links with Leeds fetal medicine centre and robust clinical pathways are already in place.

- *Women with complex pregnancies must have a named consultant lead*

Pregnant women self-refer to maternity services by completion of an online risk assessment through the pregnancy self-referral portal. This enables rapid triage and referral to early pregnancy booking appointments. Full risk assessment is undertaken at a subsequent booking appointment with reference to any risk factors. Women with risk factors are referred to a consultant-led clinic for review and initiation of an individualised management plan.

Women assigned to Consultant led care will attend antenatal appointments at Harrogate and Ripon antenatal clinics (ANC). At any stage, development of risks during pregnancy would result in a transfer to Consultant care.

Progress

In order to provide assurance that appropriate and safe local processes are in place as described within the Ockenden report and assess compliance two snapshot audits were

completed in 2021. The aim of the audits was to determine how many maternity patients booking with a complex pregnancy had a named Consultant listed on iCS and an audit of paper records whether this is effectively transcribed to patient handheld and hospital notes.

Whilst the allocation of women with complex pregnancy to a named consultant on iCS system at booking is very high, in the hospital maternity environment, it is necessary that clinical documentation is recorded by handwritten duplication in both handheld and hospital records so that appropriate information is available to both hospital and community staff. Consequently, there are significant issues experienced by staff being required to maintain duplicate entries in both records, and iCS, SystmOne (used by community midwives), ensuring that all necessary fields are completed comprehensively.

There was an improvement between the first and second audit from 56.2% to 73.3% named consultant on the hand held notes, stickers were then introduced for named Consultant.

The midwifery team identified that a clinical audit and effectiveness role was required due to the number of audits required in the Ockenden report to support and complete these recommendations and to ensure that a maternity audit schedule is in place. This role has recently been appointed and the post holder is due to start in post early April. All ongoing audits to assess compliance of the requirements of Ockenden and other maternity work streams will be completed as part of this audit schedule.

Risk

- Regular, ongoing audit of named consultant for complex pregnancy has not been possible due to the impact of Covid-19 and reduced midwifery numbers. The audit will form part of the maternity audit schedule from April 2022.
- The two snapshot audits were time consuming due to a computer system (iCS) that is not routinely used throughout the antenatal period and a paper-based system (women carry their own hand held antenatal notes). Maternity staff complete written documentation in the hospital notes and community staff use SystmOne. A maternity electronic system has been procured and agreed, it is expected to be fully in place by the end of 2022 early 2023. Until full implementation of this system this risk will remain.

- *Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team*

Progress

Harrogate has maintained effective links with Leeds fetal medicine and early specialist involvement occurs because of this. There is a newly created SOP for referrals to Leeds with all patients monitored through the screening team database remaining live on the system until discharge.

The purchase of a maternity electronic system will ensure more efficient and timely communication and sharing of information with other departments within and outside the organisation and enable women to have access to their own records allowing more involvement in their management plans.

Risk

From a local point of view, we have achieved full compliance with this IEA however we could strengthen further development of links with the tertiary level Maternal Medicine Centre and the management of women locally by recruitment of an obstetrician with a special interest in fetal/maternal medicine.

Until full implementation of a maternity electronic system, early specialist involvement and agreed management plan will rely on written documentation on a case-by-case basis.

Immediate and essential action 5: Risk Assessment throughout Pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- *All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional*

A risk assessment forms an essential part of any antenatal check, whether this is in antenatal clinic (hospital and community), and attendance at Maternity Assessment Centre (MAC), Delivery Suite or Pannal ward. The risk assessment occurs at the booking appointment and captured on iCS however iCS is not updated or used until labour/delivery. Being able to provide evidence this occurs is more difficult due to a paper-based system and the need for staff to duplicate this information in several different places.

At each subsequent appointment after the initial booking appointment, clinical care should include an assessment of the ongoing risk status of the patient, and if any new clinical conditions have developed requiring a revised management plan. It is a specification in the Antenatal Pathway that the PCP Management Plan should be reviewed at each contact and that any changes in risk factors should be documented. Within the handheld patient records there are two checkboxes to evidence that the PCP Management Plan has been reviewed and updated, if required.

Progress

Two snapshot audits were undertaken in January and May 2021. Both audits showed good compliance of commencement of the management plan at the booking appointment but ongoing review of risk assessment was mixed. The issues identified were very similar to named Consultant (IEA 4).

The maternity team identified the need for a clinical audit & effectiveness role due to the need for ongoing audits as part of the Ockenden report. The Planned & Surgical Directorate agreed the role, a JD was completed and finance for the role finally agreed. We have successfully recruited to this post and the member of staff is due to start in post mid/end March. The member of staff works in the organisation, is familiar with maternity and systems and will undertake an audit schedule to agree a process for on-going audit.

Risk

The implementation of a maternity electronic system will make the process for formal risk assessment at every antenatal contact easier for staff as no need to duplicate the same information in different systems and records.

- *Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.*

Choice of planned place of birth is discussed and documented in the hospital paper records and the handheld notes. The suitability for low risk homebirth should be re-evaluated at each contact and re-visited formally at 34-36 weeks, when final decisions about place of birth are completed, in accordance with the pathway.

Risk (risk assessment throughout pregnancy, planned place of birth)

- Regular, ongoing audit of risk assessment throughout pregnancy and planned place of birth has not been possible due to the impact of Covid-19 and reduced midwifery numbers. The audit will form part of the maternity audit schedule from April 2022.
- The two snapshot audits were time consuming due to a computer system (iCS) that is not routinely used throughout the antenatal period and a paper-based system (women carry their own hand held antenatal notes, maternity staff complete written documentation in the hospital notes and community staff use SystmOne). A maternity electronic system has been procured and agreed, is expected to be fully in place by the end of 2022/2023. Until full implementation of this system this risk will remain.

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:-

- *Improving the practice of monitoring fetal wellbeing –*
- *Consolidating existing knowledge of monitoring fetal wellbeing*
- *Keeping abreast of developments in the field –*
- *Raising the profile of fetal wellbeing monitoring –*
- *Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –*
- *Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.*
- *The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.*
- *They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.*
- *The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.*

Progress

A dedicated Lead Midwife has been in place since April 2021 and an obstetric lead for a short period until June 2021 (left the Trust). The fetal monitoring lead midwife role is firmly embedded in practice with designated time (15 hours) to perform the role within the department and to attend regional events. The lead midwife has introduced the following:

- Face to face updates for all clinicians who care for women in any birth setting (intermittent auscultation and electronic fetal monitoring,
- Interactive online courses to support learning & development and provide evidence of competency,
- Delivery of regular weekly MDT fetal monitoring case discussions,
- From January 2021 PROMPT on-line will include a chapter on Intrapartum fetal surveillance and Human Factors.
- Improving the practice of monitoring fetal wellbeing – by being visible in the clinical areas 2 days and accessible as a proponent of best practice.
- Consolidating existing knowledge of monitoring fetal wellbeing – by providing training consistent with current best practice both at face to face training and by encouraging staff to retain their knowledge and skills by accessing the K2 online training.
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – by being accessible personally for advise and by ensuring the Delivery Suite Co-ordinators have the most up to date knowledge and skills related to FM.
- The lead midwife and obstetricians attend the professional advisory panel to review cases with adverse outcome involving poor FHR interpretation and practice. Any training needs identified are actioned with individuals and cases used in training.

If face-to-face training is not possible due to Covid restrictions then training is delivered virtually.

Risk

- Due to reduced numbers of middle grade doctors, a dedicated obstetric fetal monitoring lead has no PA to undertake this role. The role has been undertaken on an ad hoc basis supporting the lead midwife when able to do so. Discussions are underway to agree the PA required with support from the senior obstetric team and the PSC Directorate
- Staff are able to attend and share in regional fetal monitoring case meetings every week and / or take part in small in house group face to face discussions. Seven of these have taken place in the past quarter however attendance has not been Multi-disciplinary with only 2 sessions attended by an Obstetrician. No Obstetric Middle Grade doctors have been able to attend. This should improve when the Obstetric fetal monitoring lead has protected time to perform the role. The recruitment of two middle grade doctors (start dates March and May) will enable improved attendance.

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- *All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care*

Progress

All patient information leaflets are available on the trust website; women are signposted to specific leaflets depending on individual requirements. The MVP group are now involved in

the approval process of these leaflets and once agreed these are uploaded to the trust intranet and the external website.

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care with women's choices respected following a shared and informed decision making process. There is currently a midwife led birth choices clinic for all women who are requesting an elective caesarean section. This clinic enables the midwife to provide risks and benefits to the woman and her partner on both and elective section and a vaginal birth.

Risks

The patient information leaflets are reviewed as part of an on-going process and are not all up to date at the same time.

Section 2

Maternity Workforce Planning

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard.

This information will be provided at a later date.

Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Progress

The maternity department has used the Birth rate + acuity tool on Delivery Suite and Pannal ward since 2018. Birthrate + is currently the only midwifery specific, national tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services. It is a valuable resource that can routinely support operational and strategic decision making in maternity services. The tool is a prospective “real time” tool that assesses the numbers of midwives and support staff required to safely operate intrapartum and ward services. Birthrate Plus can calculate an individual ratio of clinical midwives to births for maternity services by reviewing activity, case mix, local demographics and skill mix.

A Birthrate Plus review was undertaken, data collection completed in February and March 2021 with the report available in May. The review highlighted the need for 9.0WTE additional midwives however, the review included continuity of carer (CofC). This model was not included in the allocation of Ockenden monies and therefore monies were allocated for an additional 5.0WTE midwives to the midwifery establishment.

Current Staffing and vacancies

Midwives			
Bands	Staff in post (WTE)	Staff recruited awaiting start date (WTE)	Vacancies out to advert (WTE)
Band 8	2.00	0	0
Band 7	16.12	0	1.7
Band 6	43.48	6.5	0.60
Band 5	7.32	1.60	0.1
Band 3	6.25	1.80	0
Band 2	8.40	1.00	1.00

The maternity department has seen a significant change to the workforce in the last 12 months with increased numbers of staff on maternity leave, staff leavers due to retirement and promotion to other roles and a number of staff choosing to leave the midwifery profession.

Once all new staff start in post we will be very close to achieving full establishment.

The department has worked hard to support maternity workforce plans and also worked closely with the WY&H LMS with central recruitment of band 5 midwives and sharing examples of good practice to support and strengthen the role of the MSW.

Staffing summary

The staffing levels have improved over the past six months however; there has been an increase in sickness, isolation due to Covid and advice for pregnant staff be non-patient facing from the third trimester. We continue to recruit band 2, 3, 5 and 6 posts within the trust. Over the next 3 months, we have 6.5 WTE band 6 midwives and 1.60 WTE band 5 midwives joining the department and a further three midwives returning to work after maternity leave. We have also successfully recruited one band 2 MSW and four band 3 MSW's.

The WY&H LMS undertook central recruitment for band 5 midwives in 2021 and following evaluation this work will continue for a second year.

International recruitment

HDFT have agreed to support two international midwives in 2022 and a further two in 2023. Harrogate has joined York Hospital in the recruitment process with the plan to interview in the next two months. Additional funding to support the international recruitment campaign was secured through NHSEi.

Clinical Practice Support & Retention Midwife (monies from NHSEi) - just appointed.

The focus of this role will be to work alongside newly qualified midwives, internationally recruited midwives, midwives new to the organisation and Maternity Support workers (MSW's). To support and nurture junior midwives to ensure they build on the knowledge and skills acquired during their training to develop into confident and competent midwives. The post holder will create a learning environment conducive to all staff gaining the required knowledge and skills within their role to meet the needs of women and their families.

The post holder will also provide pastoral care and be the point of contact for newly qualified midwives, internationally recruited midwives and MSW's working as part of a collaborative working network with other specialist midwives and members of the senior midwifery management team. To support the retention of midwives, to work alongside all new starters in clinical practice, to enhance confidence, competence and the acquisition of new skills.

To support the delivery of a high quality, safe, personalised and compassionate care, the post-holder is expected to act as a role model to others in all aspects of their work and consistently demonstrate the values of HDFT; kindness, integrity, teamwork and equality.

Risks

The current Head of Midwifery retires in March 2022; the replacement role will be Associate Director of Midwifery in line with strengthening midwifery leadership: a manifesto for better maternity care (RCM, 2019). This post has not been advertised and will therefore leave a significant gap in the senior midwifery leadership team.

There is an acknowledgement that there is a lack of midwifery specialist roles to support the perinatal mental health agenda and the plan is to include this role within the continuity teams and have a specialist midwife in each team.

Work is being undertaken within the LMS on the role of the maternity support worker (MSW) and the correct banding for this role. Through the maternity support worker framework it was identified that any patient facing maternity support worker should be banded as a band 3 and not a band 2. A regional training needs analysis was developed by the LMS on how the existing workforce can be upskilled and Heads/Directors of Midwifery have been approached

to confirm their support. This increased banding will cause financial implications for the maternity department as well as the wider organisation.

It has been identified that the current midwifery leadership structure does not fully support the national agendas and the required recommendations for consideration. Once the new Associate Director of Midwifery has been appointed there will be a full review of the midwifery leadership structure and specialist midwifery roles.

A business case has been written to support the role of the band 4 nursery nurse on Pannal ward to care for transitional care babies, there is a financial impact of this model and it has yet to go through the Planned and Surgical directorate and resource committee for agreement and approval.

The current ward clerk establishment on Pannal and delivery suite covers part weeks in both areas however; the lack of dull time clerk cover creates additional pressure for midwives and support workers who have to perform admin roles to support the service. 2.1 WTE additional ward clerks would ensure the department had 7-day cover 8-4.

Due to the national issues surrounding the number of midwives at all levels the maternity department is planning a full workforce review with a potential increase in non-qualified roles to enable midwives to perform their roles more effectively.

Summary

Immediate & essential action	Compliance	Action
IEA 1 (Enhanced safety)	Compliant	
IEA 2 (Listening to women and families)	Compliant	
IEA 3 (staff working and training together)	Partial compliance	Plan made to ensure medical staff attendance at MDT training (obstetric and anaesthetic). Continue to monitor closely
IEA 4 (Managing complex pregnancy)	Partial compliance	Complete audit schedule to include on-going audit. Clinical audit & effectiveness role starts 29/3/22. Maternity electronic system will ensure more timely receipt of data
IEA 5 (Risk assessment throughout pregnancy)	Partial compliance	Complete audit schedule to include on-going audit. Clinical audit & effectiveness role starts 29/3/22. Maternity electronic system will ensure more timely receipt of data
IEA 6 (Monitoring fetal wellbeing)	Partial compliance	Directorate discussion on PA for obstetric fetal monitoring role
IEA 7 (Informed consent)	Partial compliance	Process in place for updating of PIL's, explore ways of providing information in other languages
Effective system of medical workforce planning		Information to be provided at a later date
Effective system of midwifery workforce planning	Partial compliance	See gap analysis

Good progress has been made at local level in the last 12 months. Clear plans are in place to address the outstanding risks:

- Plan to ensure attendance of obstetric and anaesthetic staff at Prompt face to face training

- Successful recruitment of a clinical audit and effectiveness advisor who will complete the ongoing audits for named consultant for complex pregnancy, ongoing risk assessment throughout pregnancy and planned place of birth
- The introduction of a maternity electronic system to enable more accurate and timely data collection
- Directorate discussion on the PA required for the obstetric fetal monitoring lead
- Once the new Associate Director of Midwifery is appointed, a review of the gap analysis for midwifery workforce planning.

Local gap analysis of 'Strengthening midwifery leadership: a manifesto for better maternity care' (RCM, 2019)

Gap analysis midwifery leadershi

Ockenden review of maternity services – one year on
March 2022

Board of Directors (Public)
30th March 2022

4.4

Title:	**Medical Director Update**
Responsible Director:	Medical Director
Author:	Medical Director

Purpose of the report and summary of key issues:	For noting and information	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	none	
Report History:	none	
Recommendation:	The Board are asked to note and approve the information contained in this report	

Medical Director Report
Date: March 2022 Public Board

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
• HDFT CMDU (COVID Medicines Delivery Unit) commissioned however financial model not yet clarified by CCG/ICS causing a risk to sustainability • Capacity of clinical effectiveness and compliance teams to undertake commissioned work around policy management and compliance with national clinical standards- new positions out to advert with good response	• Assessment of current compliance with NICE and other national clinical standards data underway, Clinical Effectiveness Team supporting Clinical Directorates with their action plans working towards compliance • Commissioned working party to address standards and guidance gaps in relation to Transitioning from Paediatric to Adult services. • Draft Policy for polices and procedures approved by QGMG • Policy re-writes commissioned for Clinical Guidelines policy, NICE policy, External Standards Policy, Clinical Audit Policy, Research and Innovation Policy • National digital strategy moving towards EHR convergence at ICS level- HDFT working with system partners to perform soft market testing with a range of EHR vendors • Good medical engagement with ongoing clinical strategy work, work to scope principles for medical job planning underway
Positive news & assurance	**Decisions made & decisions required of Board**
• Caring At Our Best (HDFT Quality Programme) milestones on track, monthly learning summit now established with linkage to Learning Lab and Trust-wide communication strategy agreed • Priority Clinical Audit Programme for 2022/23 approved by QGMG and Quality committee • External Standards quarterly report for assurance on position of compliance with external recommendations now complete • HDFT Pharmacy Aseptic Services – Assurance Report now being received monthly by QGMG- no IPC risks to escalate currently • Claims masterclass and ongoing training agreed to maximise triangulation and learning opportunities • A number of medical and medical associated professional (MAP) engagement events confirmed (Junior Doctor and trainee MAP celebration event 8th June) • Chief Registrar leading work to address junior doctor rota issues in LTUC – Kaizen event successfully completed	

4.4

Board Meeting Held in Public
March 30th 2022

Title:	Learning from Deaths Quarterly Report 3: October-December 2021
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust. Trust mortality is in line with expected values. Details are provided in the report for areas where any concerns have been identified.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	No prior scrutiny before Board. Paper is also discussed at Patient Safety Forum	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Board Meeting Held in Public

30th March 2022

Learning from Deaths Quarterly Report 3

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to track the national trends.

Standardised mortality rates continue to be within the expected range, although a slight upward trend is noted.

10 structured judgement reviews have been undertaken since the last report. Median score for overall care were classed as “good” with no episodes of poor care identified.

There continues to be a significant level of Covid-19 mortality.

A review into a rise compared to expected Mortality in Critical Care in Q4 2020-2021 has concluded this was likely due to Covid-19 and which patients are treated in Critical Care in HDFT compared to other units.

A CUSUM-HSMR Alert was received relating to excess deaths with a coding of “Septicaemia (except in Labour)”. This related to a spike in October 2021. 8 cases were reviewed and only 2 were identified with true septicaemia. In addition, 7 cases of sepsis underwent SJR with no lapses in care identified.

The HDFT Medical Examiner team continues to perform well when benchmarked against regional data.

2.0 Introduction

Mortality data in Q3 continues in a similar manner to Q2, with a return to more normal levels than that seen during previous Covid waves. The time period covered in this report includes the final stages of the Delta-variant wave and early Omnicron emergence.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality rates. In total, 198 deaths were recorded in Q3, up from 170 in Q2. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years.

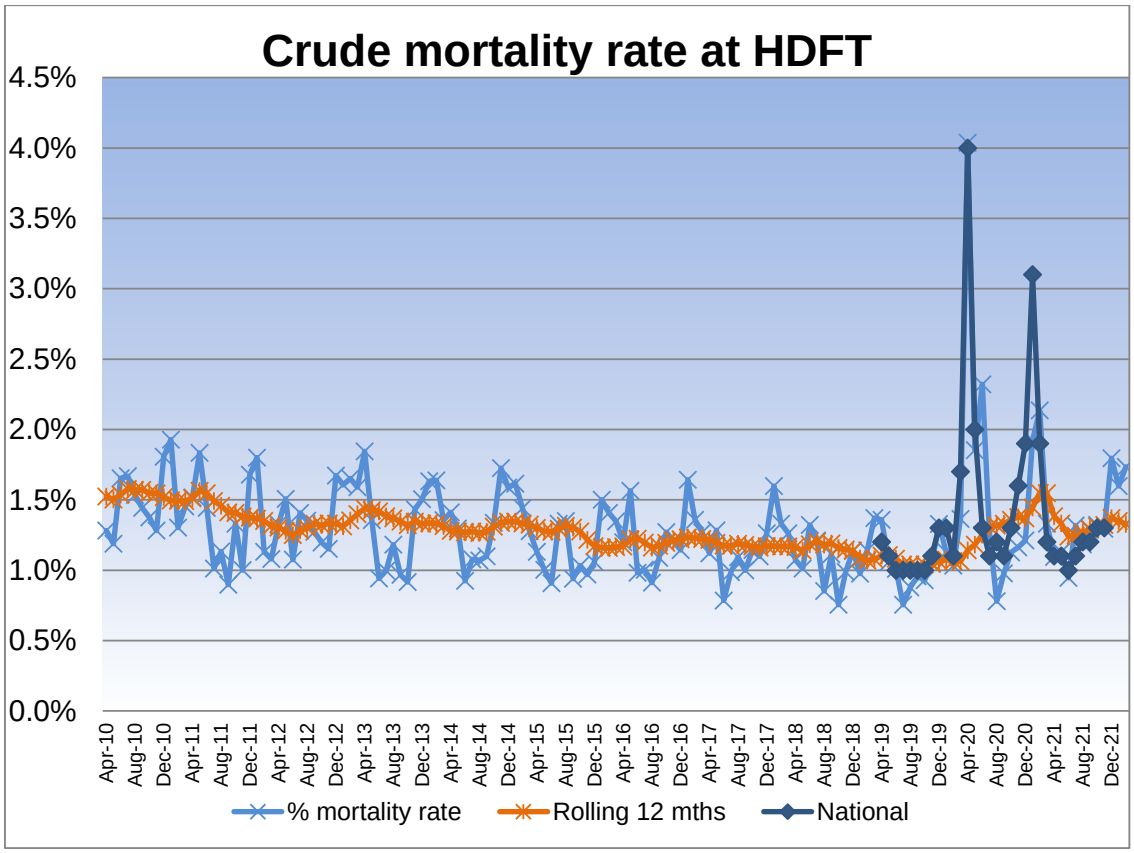


Figure 1: Crude mortality rates over the last 11 years (%deaths per qualifying admission activity)

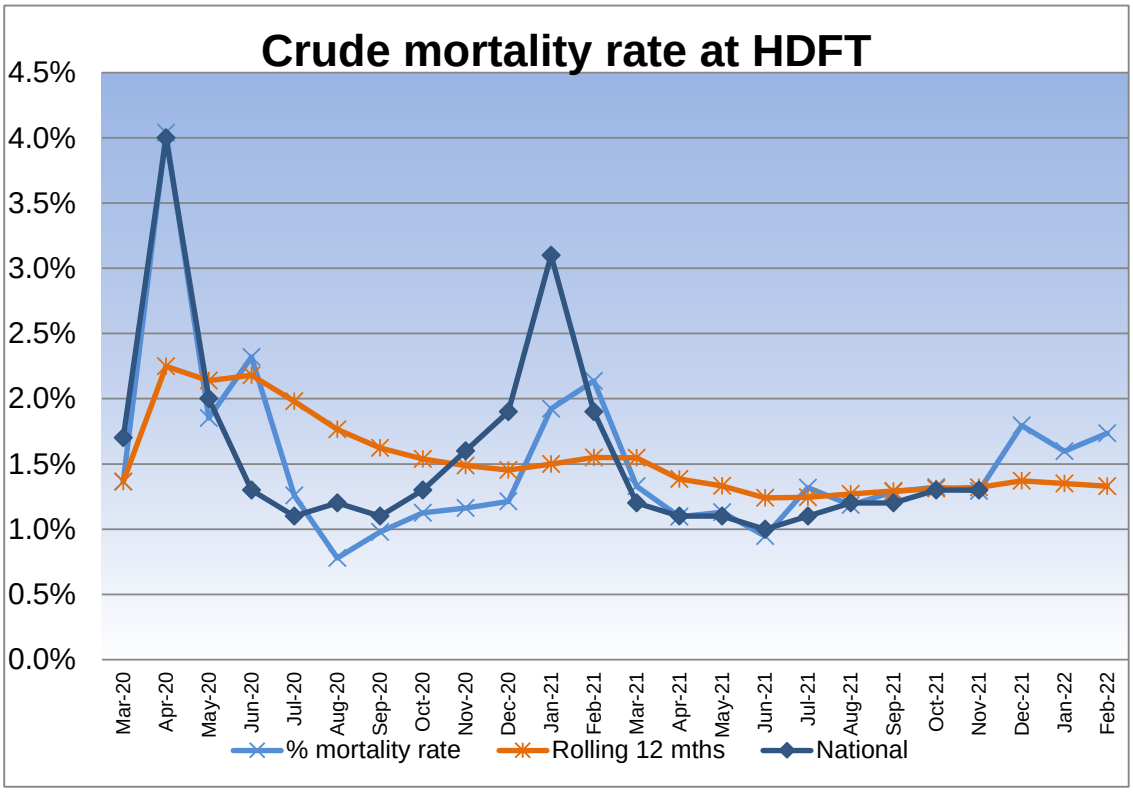


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital admission)

3.2 Standardised Mortality Rates (HSMR and SHMI)

Figures 3-8 show the most recent data available for HSMR and SHMI. Overall, our results from both indices are within expected ranges. Please note that Figures 3 and 6 show the 12 month rolling data. Both indices have shown a steady rise over recent months. No specific areas responsible for the rise have been identified, and we still lie in expected levels for both.

3.2.1 HSMR

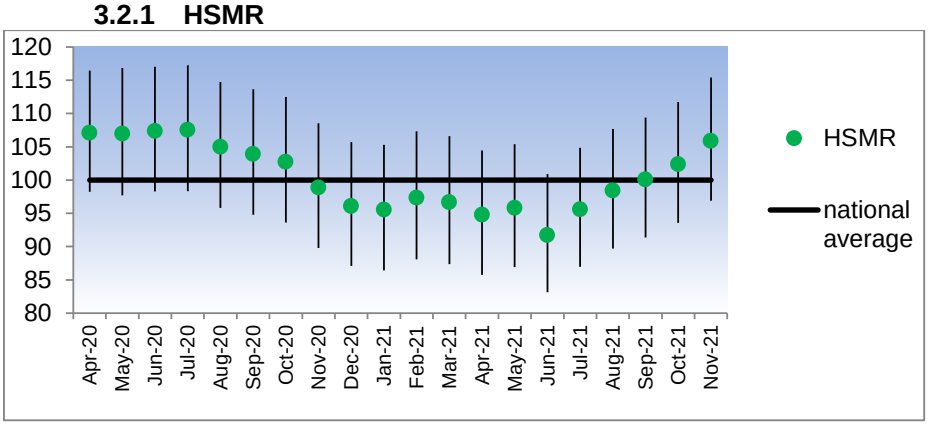


Figure 3: HSMR. Dots show the recorded values with error bars showing possible range of true values.

Figures 4 and 5 below shows our most recent HSMR data in comparison to national and regional peers. HDFT results are shown as a black diamond.

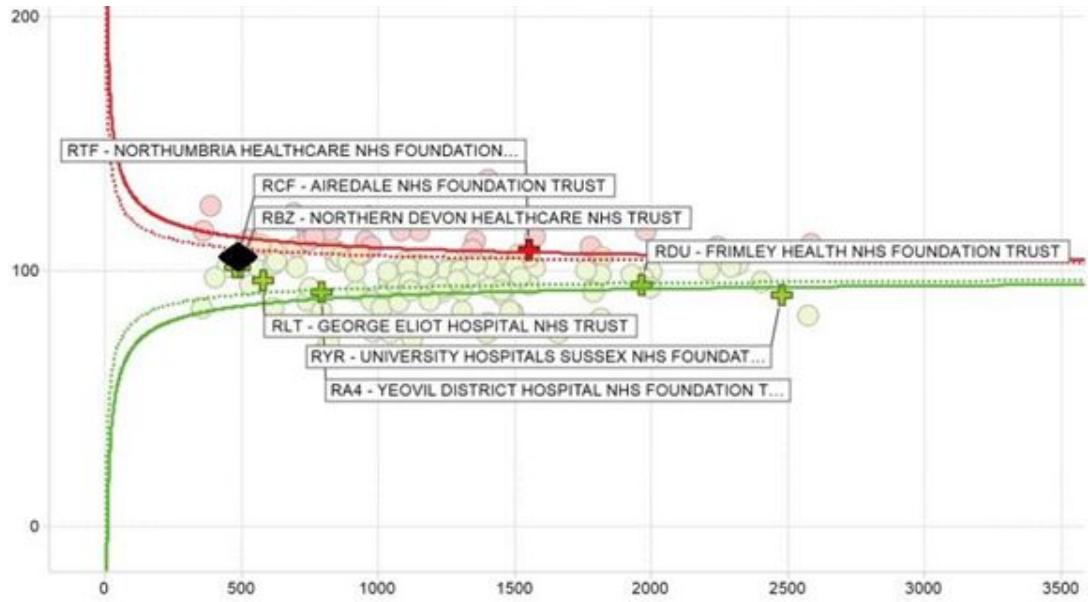


Figure 4: HMSR data for peer organisations

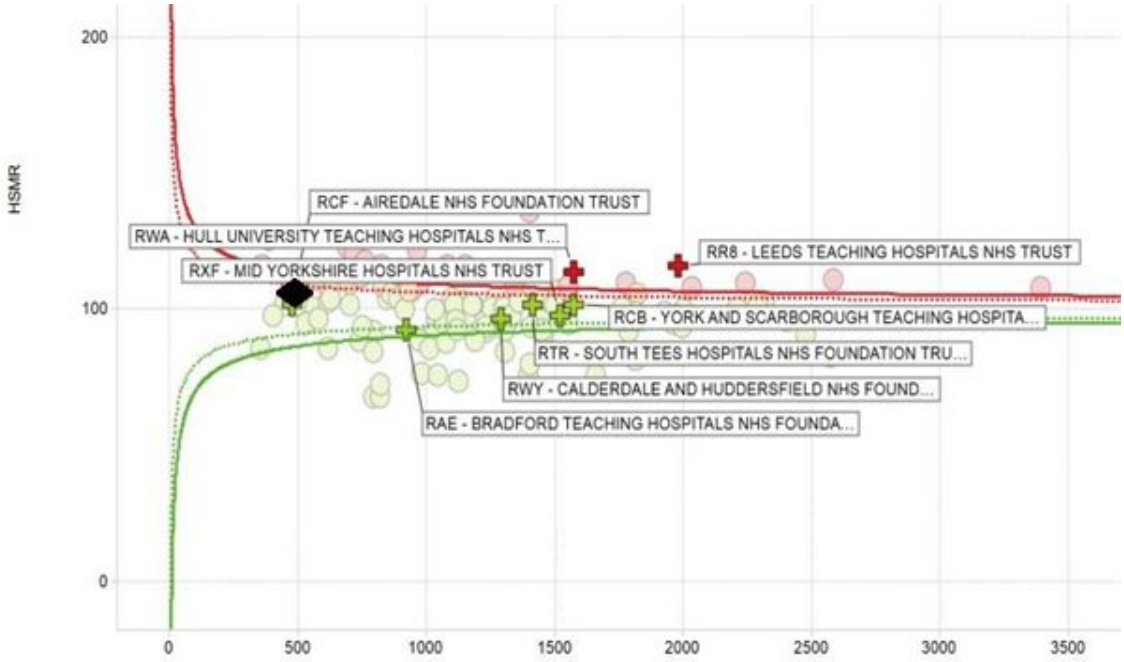


Figure 5: HMSR data for regional organisations

3.2.2 SHMI

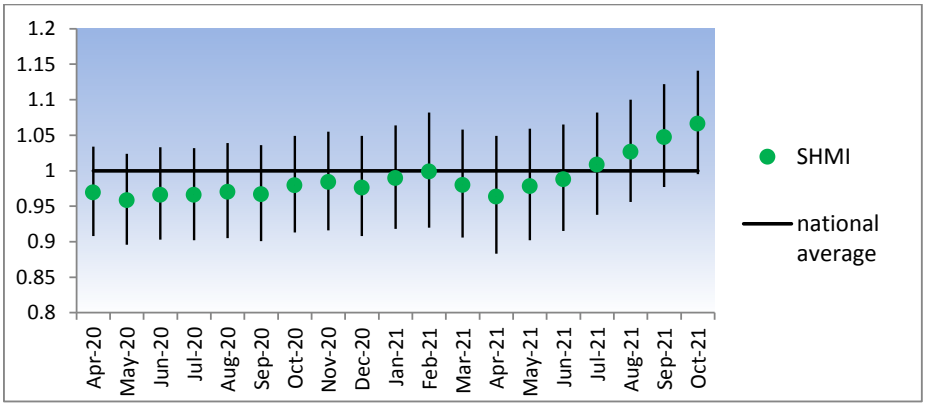


Figure 6: SHMI Dots show the recorded values with error bars showing possible range of true values.

Figures 7 -8 demonstrate our SHMI against that of peer and regional trusts. Again, HDFT is marked as a black diamond.

Figure 7: SHMI data for peer organisations

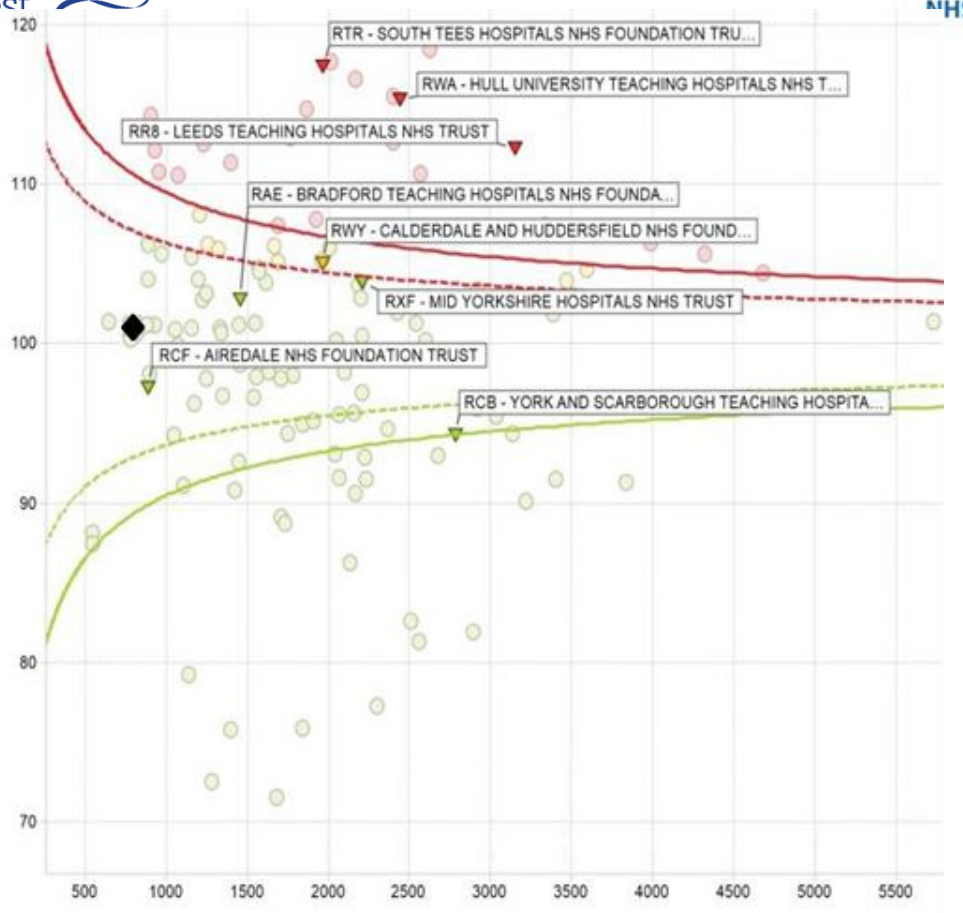


Figure 8: SHMI data for regional organisations

3.3 Structured judgement reviews (SJR)

10 cases have been reviewed in this quarter, with 5 relating to deaths in this quarter, 4 from late Q1 and 1 from 2020. This latter case related to a patient with Learning Disabilities whose notes were misplaced and only recently located. 7 of the cases had a diagnosis of sepsis (as identified by a Medical Examiner) and were chosen to provide assurance on delivery of sepsis care. 1 case has been declared a Serious Incident (SI), relating to an ED attendance the day before admission to the hospital.

The overall assessment of standard of care of all cases is shown in Table 1:

Case ID	Admission Date	Learning Disability	Serious Mental Health Issue	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Sept 21	No	No	4	4	4	**4**	5
2	Oct 21	No	No	4	-	-	**4**	3
3	Oct 21	No	No	4	4	4	**4**	4
4	Dec 21	No	No	4	4	4	**4**	4
5	Sept 21	No	No	5	4	4	**4**	4
6	Sept 21	No	No	4	4	4	**4**	4
7	Nov 21	Yes	No	4	4	5	**4**	-
8	Oct 21	No	No	4	-	-	**4**	3
9	Jan 20	Yes	No	4	4	4	**4**	4
10	Sept 21	No	No	4	3	3	**3**	3
Median Score				4	4	4	**4**	4

Table 1: Structured Judgemental Reviews (SJR) conducted in Q3 2021-2022

No recurrent themes have been identified in these reviews. 2 cases died soon after admission, so ongoing care beyond 24 hours was not available. In both these cases, there was insufficient evidence for the reviewer to comment on the quality of End of Life care. One case is missing an assessment of the quality of note-keeping due to an error by the reviewer to score this field.

1 case was identified as having Learning Disabilities. This will be subject to an external review as part of the LeDeR process, and feedback from that will be provided in a future report.

Since the start of the Covid pandemic, approved training to undertake SJRs has been unavailable. In addition, the funded Royal College of Physicians' platform to upload and analyse data has ceased. I am pleased to report that the Improvement Academy has just started a program of SJR Training events, and 7 HDFT staff have already completed their training. In addition, we have secured funding for the SJR Module within the Datix iCloud system. These 2 significant advances will enable an expansion of cases reviewed in the coming months, as we aim to review approximately 15% of all deaths.

3.4 Covid-19 Deaths

Table 2 shows the hospital's Covid-19 mortality for Q2 and Q3 2021/22. Please note that this data uses the current NHS definition of a positive Covid-19 diagnosis and does not include data where Covid-19 is included on a death certificate based on clinical suspicion. The data in the 1st column titled "Total" represents all inpatients with a positive PCR test. The 2nd column "Death within 28 days" refers to deaths that occurred after hospital discharge and is therefore in addition to the in-hospital deaths shown in column 3. We are increasingly seeing patients with other acute conditions testing positive for Covid-19, and in a number of these the impact of Covid on their outcome is not as clear as in previous waves.

Confirmed Covid-19 inpatient discharges (Jul-Sep 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	11	0	0	0.0%	0.0%
6-17	10	0	0	0.0%	0.0%
18-24	4	0	0	0.0%	0.0%
25-34	17	0	0	0.0%	0.0%
35-44	24	0	0	0.0%	0.0%
45-54	15	0	0	0.0%	0.0%
55-64	26	0	2	0.0%	7.7%
65-74	17	0	2	0.0%	11.8%
75-84	15	1	2	6.7%	13.3%
85+	16	0	5	0.0%	31.3%
Total	**155**	**1**	**11**	**0.6%**	**7.1%**

Confirmed Covid-19 inpatient discharges (Oct-Dec 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	11	0	0	0.0%	0.0%
6-17	14	0	0	0.0%	0.0%
18-24	4	0	0	0.0%	0.0%
25-34	3	0	0	0.0%	0.0%
35-44	19	0	1	0.0%	5.3%
45-54	16	0	1	0.0%	6.3%
55-64	32	0	3	0.0%	9.4%
65-74	38	0	8	0.0%	21.1%
75-84	37	1	6	2.7%	16.2%
85+	38	0	6	0.0%	15.8%
Total	**212**	**1**	**25**	**0.5%**	**11.8%**

Table 2: Covid19 deaths for admissions in Q2 and Q3 either whilst still an inpatient or after discharge but within 28 days of positive test. Note that "Confirmed Covid-19" relates to patients with a positive PCR test and excludes any patient with negative PCR results whose imaging and clinical impression was of suspected Covid-19.

3.5 Mortality after Critical Care Admission

In the Q1 Learning from Death report, an increase over predicted mortality of Critical Care admissions was demonstrated from January-March 2021. Dr Martin Huntley, Clinical Lead for Critical Care, has investigated this in detail with input from the national ICNARC team. In that period, 55% of the deaths were Covid-19 related. 50% had their treatment limited to CPAP due to comorbidities (56% were over 65 years old). Such patients were not admitted to Critical Care in many other hospitals as CPAP could be delivered on a ward environment, and therefore were not entered into the ICNARC dataset for comparison.

In summary, Dr Huntley believes that we admitted a relatively high proportion of patients over the age of 65 with Covid-19, and that this caused a shift in our survival pattern compared to units which did not admit this high-risk group.

3.6 Excess Death in Patients with a Diagnosis of Septicaemia (except in Labour)

In October 2021 we received a CUSUM-HSMR alert relating to a significantly higher than expected number of deaths with the diagnosis code of "Septicaemia (except in Labour)". As can be seen in Figure 9, this related to a sudden spike in cases in October. All 8 cases from October have been examined, and only 2 cases had confirmed septicaemia (the presence of bacteria in the bloodstream). We will continue to monitor this area and investigate further should a further rise in cases occur.

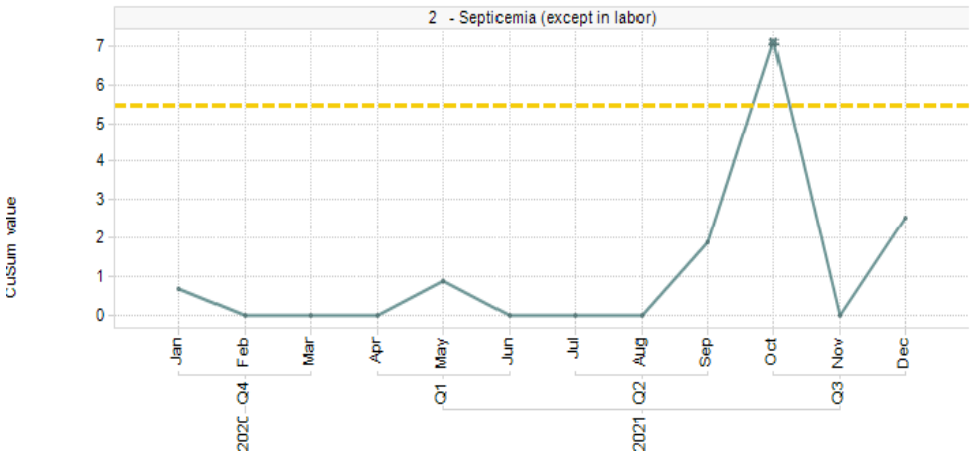


Figure 9: CUSUM-HMSR for "Septicaemia (except in Labour)

3.7 Medical Examiner Service

We have now been able to obtain data from all Medical Examiner Offices in the North of England. Table 3 shows the performance of HDFT's Medical Examiner team benchmarked against our regional colleagues. This confirms that we are performing well above the regional average in 3 of the most significant metrics. We were unable to issue an MCCD within 72 hours in 17 cases. This reflects the difficulty of a 4-day Bank Holiday followed by another 3-day holiday weekend. As Registrar Offices were also closed in these periods, we are unaware on any impact or concern raised by the bereaved in this period.

In addition to the metrics below, in Q3 the Medical Examiner team highlighted 7 cases for an SJR and 1 with significant concerns about the quality of care (since declared an SI).

	Q1		Q2		Q3	
	Regional	HDFT	Regional	HDFT	Regional	HDFT
Deaths Scrutinised	**5205/7915 (66%)**	**147/147 (100%)**	**6772/9527 (71%)**	**179/179 (100%)**	**8355/10932 (76%)**	**213/213 (100%)**
Death certificate takes longer than 3 days	**663 (13%)**	**6 (4%)**	**650 (10%)**	**2 (1%)**	**1048 (13%)**	**17 (8%)**
Death certificate rejected by Registrar	**27 (0.7%)**	**0**	**34 (0.7%)**	**0**	**44 (0.5%)**	**0**

Table 3: Performance of HDFT Medical Examiner team compared to the Regional Average

4.0 Recommendation

The Board is asked to note the contents of this report and the processes for ensuring learning from death

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Board of Directors

30th March 2022

4.4

Title:	Serious Investigation Report in to 10 COVID -19 ward outbreaks and 2 isolated cases of hospital acquired COVID -19 infection
Responsible Director:	Dr Jackie Andrews – Medical Director
Author:	Dr Lauren Heath – Consultant Microbiologist

Purpose of the report and summary of key issues:	This serious incident report is provided to the board to describe the process undertaken to investigate the 10 coronavirus (COVID-19) ward outbreaks and 2 non-outbreak linked hospital-onset COVID-19 infection (HOCI) deaths at Harrogate District Hospital. The outbreaks involved 133 patients and 47 members of staff. The first outbreak was declared on 23/05/2020 and the final outbreak was closed on 03/04/2021. 28 patients who were associated with the outbreaks died within 28 days of testing positive for COVID-19. A further 2 deaths within 28 days of diagnosis occurred in non-outbreak associated patients.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	There are no corporate risks highlighted within this report.	

Harrogate and District NHS Foundation Trust

4.4

Report History:	This report was submitted to the CCG within the 60 day allocated timescale, it was also shared internally within HDFT in the following fora; IPCC Meeting Quality Summit It was distributed to HDFT staff as listed below; Executive Director of Nursing, Midwifery and AHPs. Executive Medical Director Clinical Directors Heads of Nursing Matrons Directorate Quality Assurance Leads Operational Directors Consultants Chief Executive. The report was also discussed at the Senior Management Team meeting, held on 23rd March 2022.
Recommendation:	This report is submitted to the Board to provide assurance that a Serious Incident investigation was undertaken for the cluster of COVID -19 cases that occurred in HDFT between 03/05/2020 – 01/07/2021. The report should be read in conjunction with the attached action plan that provides assurance with regards to the actions taken following the outbreak.

Harrogate and District NHS Foundation Trust

4.4

Serious Incident Investigation Report

Brief Incident Description	10 COVID-19 Ward Outbreaks & 2 isolated cases of Hospital Acquired COVID-19 infection
Incident date	03/05/2020 – 01/07/2021
Directorate	Harrogate and District NHS Foundation Trust
Location where incident occurred	Wards: Jervaulx, Byland, Oakdale, Littondale, Rowan, Trinity, Granby
STEIS Reference	2021/12504
Datix ID	DW54905, DW55741, DW56238, DW59645, DW62073, DW62383, DW62393, DW62446, DW62843, DW64478, DW64479, DW66504
Authors & Job Titles	Dr Lauren Heath – Consultant Microbiologist and Infection Control Doctor Dr Clare Sobala – FY2 doctor

Report approved by	Steve Russell, Chief Executive
Date report approved	15/09/2021

Contents

Summary of Incident

This report describes the 10 coronavirus (COVID-19) ward outbreaks and 2 non-outbreak linked hospital-onset COVID-19 infection (HOCI) deaths at Harrogate District Hospital.

The outbreaks involved 133 patients and 47 members of staff. The first outbreak was declared on 23/05/2020 and the final outbreak was closed on 03/04/2021.

A total of 28 patients who were associated with the outbreaks died within 28 days of testing positive for COVID-19. A further 2 deaths within 28 days of diagnosis occurred in non-outbreak associated patients.

Public Health England provides nationally agreed epidemiological definitions for COVID-19 outbreaks and clusters in particular settings. The definitions are to inform local alerts and action and to provide consistency. The definitions for Healthcare-associated COVID-19 (for example an inpatient setting) are as follows:

Outbreak criteria
Two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital.

End of outbreak
No test-confirmed cases with illness onset dates in the last 28 days in that setting.

Chronology of Events

When?	Where?	Specialty	No. of patients (COVID-19 positive via a PCR test)[1]:	No. of staff (COVID-19 positive via a PCR test):
03/05/2020	Wensleydale Ward (Isolated case)	General Medicine	1	0
23/05/2020	Jervaulx Ward	Elderly Medicine	24	11
26/06/2020	Byland Ward	Elderly Medicine	2	0
20/11/2020	*Introduction of Day 3 repeat screening (in addition to Day 5)*			
24/11/2020	Oakdale Ward	Adult Medicine	11	5
01/12/2020	*Introduction of twice-weekly lateral flow testing for staff*			
18/12/2020	*Introduction of minimum window opening requirement to 10 minutes per hour.*			
11/01/2021	*Introduction of plastic barrier curtains between beds in bays*			
21/01/2021	Jervaulx Ward	Elderly Medicine	29	4
25/01/2021	Oakdale Ward	Adult Medicine	16	7
	Introduction of proactive PCR contact testing (every 72h for 14 days)			
30/01/2021	Rowan Ward	Rehabilitation Medicine	13	5
	Littondale Ward	General Surgery	4	0
01/02/2021	Byland Ward	Cardiology Medicine	21	8
	Introduction of single trust-wide Outbreak Control Group (OCG) to manage all COVID-19 outbreaks, rather than each ward outbreak having a separate OCG.			
04/02/2021	*Eye protection to be worn within 2m of people, irrespective of duration of contact*			
10/02/2021	*Drive to encourage inpatients to wear surgical masks*			
11/02/2021	Trinity Ward (Ripon)	Elderly and Rehabilitation Medicine	10	6
17/02/2021	*Provision of funding to support an additional cleaning rota specifically to target high touch point areas (enhanced cleaning team)*			
	COVID snapshot audit (see detail below)			
22/02/2021	*Infection Prevention & Control (IPC) Team completing Quality Audit Tool during February & March*			
03/03/2021	Granby Ward	Respiratory Medicine	3	1
08/03/2021	*Once weekly screening for all inpatients introduced.*			
29/03/2021	*Screening stepped back down to admission, day 3 and day 5*			
01/07/2021	Littondale Ward (Isolated case)	General Surgery	1	0

COVID snapshot audit

This was an audit carried out by the IPC team as an unannounced visit to check compliance with 5 key measures:

[1] Please note this includes both people who have symptoms of COVID-19 and those who are asymptomatic. It does not include people who are recovered from COVID-19 (PCR tests can remain positive for some time) as you are excluded from PCR testing for 90 days following your first positive test.

1. Were patients wearing masks (where appropriate)?
2. Were the plastic barrier curtains being used appropriately?
3. Were the windows open (or evidence they had been open in the last hour)?
4. Were staff wearing eye protection?
5. Were the doors to the bays and side rooms closed?

This audit was done several times per week, on all inpatient wards during the second wave.

Immediate actions taken

Appropriate actions were taken based on national guidance alongside our evolving understanding of the virus throughout the period in question. In addition to those actions listed in italics in the chronology above, the following actions were taken:

- IT tool developed to facilitate contact tracing
- Bed moves reduced to an absolute minimum
- Staff rotation minimised to reduce risk of them acting as vectors of transmission
- IPC surveillance team daily review of swabs due & telephoned wards every morning
- ePMA set up to prescribe Day 3 and Day 5 swabs
- Daily safety huddles utilised to track repeat swabs required
- Fleece blankets purchased by hospital charity to enable keeping windows open
- Strict visitor policy implemented
- Only essential staff allowed on wards
- Maximised remote working wherever possible
- "Clinell Clean Time" introduced to ensure staff workstations / computers / telephones regularly decontaminated

Risk Assessment

		Severity of Harm				
Likelihood of recurrence		No Harm	Minor	Moderate	Major	Death
	Almost certain (monthly)	5	10	15	20	25
	Likely (2-11x yearly)	4	8	12	16	20
	Possible (1x yearly)	3	6	9	12	15
	Unlikely (1x 3 years)	2	4	6	8	10
	Rare - Not expected again	1	2	3	4	5

Likelihood: Likely

Severity of Harm: Death

Pre-investigation risk score: 20

Likelihood: Possible
Severity of Harm: Death
Post-investigation risk score: 15

Terms of Reference

The purpose of the serious incident investigation is to examine the circumstances that led to the incidents occurring in order to:

- establish the root cause(s)
- review the related systems and processes that are in place, including Trust policy, procedure, guidelines and identify whether any changes may be required
- identify problems relating to care and service delivery and the contributory factors
- identify the lessons to be learned
- highlight areas of good practice to be shared from the investigation
- make recommendations and identify actions to mitigate risks to reduce the risk of recurrence
- Identify pre and post investigation risk scores

The Investigator(s) will gather evidence to support the investigation, including, but not limited to:

- Medical records
- Current policy/procedure
- Relevant literature/national and local guidance
- Outbreak reports and minutes

The following factors will be considered in the investigation:

- Where the incidents occurred, who was involved, how they occurred, and why
- The extent to which care corresponded with relevant internal/external guidance and local operational policies/procedures

The investigation and report will be completed and submitted to commissioners within 60 working days of the date of initial reporting, in line with the revised national guidance published by NHS England in March 2015.

Target dates for completion: **25/08/2021 for Quality Summit**
08/09/2021 for CCG and families (Extended to 15/09/21 to enable executive sign off)

Duty of Candour

Ward managers and matrons were encouraged to comply with the Duty of Candour for any cases of hospital acquired COVID-19 where it was identified moderate harm had occurred to the patient as quickly as possible. This was usually via a conversation with the patient by the ward manager when they were alerted to a positive test by the IPC team.

For the 30 patients who sadly died within 28 days of a positive COVID-19 test, phone calls have been made to the Next of Kin wherever possible and this has been followed up with a letter from the Deputy Director of Nursing. Contact has been made with 27 of the 30 affected families. Unfortunately in 3 cases, we have been unable to obtain current contact details to enable us to have the duty of candour discussion or to write with our apologies and condolences.

Details of the Investigation

A Root Cause Analysis methodology has been utilised in accordance with the Trust's Serious Incident investigations procedure.

Background & Context

All new admissions to Harrogate District Hospital who required admission to an inpatient bed were allocated a bed in a side room on the admission wards (Farndale/Harlow) whilst the result of their COVID-19 PCR test was awaited. Once the PCR result was available, if positive the patient was transferred to a bed on a 'Red' (COVID-19) ward. If the result was negative, following a clinical review the patient would be transferred to a bed on a 'Yellow' (non COVID-19) ward.

Patients with a COVID-19 PCR test which was negative but who were "contacts" of a known COVID-19 case (for example a household member who was COVID-19 positive) were nursed in a side room rather than in a bay until their self-isolation time was completed.

This admission protocol ensured that no positive patients or patients who were known contacts could be placed in bays on our 'Yellow' wards.

Following admission, all inpatients who tested negative on admission would have a repeat COVID test at days 3 and 5. The purpose of this testing was to detect patients who were asymptomatic but had been incubating the virus on admission to hospital.

The Trust attempted to maintain a physical distance of 2m between patients in all areas at all times. Two beds were initially removed from the bays on some of our 'Yellow' wards, however the demand for inpatient beds meant that these beds had to be returned.

Care/Service Delivery Problems & Contributory Factors

Care/Service Delivery Problem:
Lack of Social Distancing
Contributory Factors:

- Physical space available in ward areas is limited. Patients cannot socially distance by 2 metres when there are 6 beds per bay, even when adopting the bed/chair/locker layout. The number of beds in a bay could not be reduced to 4, because of the demand for inpatient beds - the Escalation Ward (Swaledale) had already been opened. This in combination with other key factors such as poor ventilation and lack of mask wearing by patients, resulted in high transmission rates within a bay (up to 100%).
- Workstation areas for clinical staff in wards are small which made it challenging for staff to physically distance from one another at all times. Staff rest areas are also often small rooms. Staggering of breaks was implemented to counteract this but the lack of space would not have facilitated staff being able to socially distance from one another. Plastic barrier curtains could not always be pulled around every patient in elderly care wards where they could present a hazard to confused mobile patients. Patients at high risk of having falls cannot always be isolated in side rooms (however this did not result in COVID-19 positive patients (or symptomatic patients) being left in bays on yellow wards).
- Confused patients who wander are not able to comply with social distancing measures.
- Frail elderly patients often cannot tolerate wearing of surgical masks for long periods of time – if at all.

Care/Service Delivery Problem:
Multiple Contacts & Contact Tracing

Contributory Factors:

- Frequent bed moves, some being for only short periods of time, increases the number of people that patients are exposed to and makes contract tracing difficult, increasing the risk of missing significant contacts.
- Staff are not “ring-fenced” to work in one ward area, increasing the risk of staff acting as vectors of transmission between ward areas. This also makes it difficult to definitively link staff to specific outbreaks.
- It is difficult to reduce staff movements for Doctors and Allied Health Professionals.

This all results in high footfall to wards.

Care/Service Delivery Problem:
System processes around PCR and lateral flow testing

Contributory Factors:

- Patients who test negative for COVID-19 on admission may still be incubating the virus
- System processes needed to prompt compliance with repeat swabbing at day 3 and 5.
- Detecting positive patients (outside of the routing re-screening points) is not possible when patients do not display any symptoms of the infection therefore testing is vital.
- Staff lateral flow testing was required twice weekly, however limited monitoring for this was in place.

Care/Service Delivery Problem:

Limits on Ventilation

Contributory Factors:

- Majority of ward areas do not have mechanical ventilation.
- Estates were contacted to ask if the settings of the mechanical ventilation could be altered to increase the fresh air supply, but unfortunately this wasn't possible (a limitation of a ventilation system which is 30 years old).Opening windows (the method employed to increase ventilation) was challenging during the cold winter months, particularly on wards with frail elderly patients.

Care/Service Delivery Problem:
Surface cleaning

Contributory Factors:

- Although not the major route of transmission, transmission of the virus from inanimate objects is possible and more likely to occur from frequently touched surfaces.
- It took time to procure additional resource for cleaning these areas.

Good Practice

1. No lapses in care identified, i.e. no acute admission was placed in a bay on a yellow (medium risk) ward until they had:
    - at least 1 negative PCR test
    - a clinical review to assess symptoms (likelihood of a false negative result) and contact history (increased risk of incubating the virus).
2. COVID-19 positive inpatients were all promptly transferred to dedicated COVID-19 wards.
3. There was good multi-disciplinary engagement at the Trust OCG meetings
4. All outbreaks were reported to the national outbreak database with weekly updates.
5. Visual references for staff were provided and updated frequently to communicate the "correct" PPE for the area.
6. COVID-19 notice boards in wards provided for staff, to try and disseminate rapidly changing information as quickly as possible.
7. An IT tool to facilitate contact tracing was developed by IT services.
8. ePMA was set up to "prescribe" day 3 and day 5 swabs.
9. All patients with hospital acquired COVID-19 were subject to a Root Cause Analysis (RCA)

Root Cause

These incidents occurred in the context of the COVID-19 global pandemic when there was high community prevalence in an unvaccinated population.

Safeguarding

Have safeguarding and wilful neglect been considered in conjunction with the Mental Capacity Act/ Care Act, and appropriate action taken?
Considered and not deemed applicable to this case as the Trust was not felt to be neglectful.

Lessons Learned

1. Early ward closure appears to be key. It became apparent from the first outbreaks that this infection was difficult to manage just by closing affected bays. Early closure of the entire ward proved a more effective way of containing the outbreak.
2. A unique outbreak identification number is required. Outbreaks were named as per the ward, but some wards had more than one outbreak – leading to confusion. A system of giving each outbreak a unique identification number would improve communication moving forward.
3. An outbreak prevention bundle was needed to prevent COVID-19 transmission, rather than a singular measure. This included:
    a. Physical distancing between patients and staff
    b. Physical barriers where distancing of 2m not possible
    c. PPE for staff – correctly donned and doffed
    d. PPE for patients where clinically appropriate
    e. Optimising ventilation
    f. Hand hygiene for patients and staff
    g. Cleaning of the environment, especially high touch surfaces
    h. Case detection – testing on admission, day 3 and day 5
    i. Contact tracing – identification, isolation and proactive testing of contacts
    j. Reducing opportunities for contact – essential staff only; reducing the number of bed and staff moves; visitors only in exceptional circumstances.

Sharing Learning

1. Report to be discussed at IPCC meeting.
2. For discussion at Quality Summit.
3. Distributed to HDFT staff as per distribution list below.

Distribution List:

Executive Director of Nursing, Midwifery & AHPs
Executive Medical Director
Quality Summit
Clinical Directors
Head of Nursing
Matrons
Directorate Quality Assurance Leads
Chief Executive
Operational Directors
Consultants

Recommendations

Recommendations and actions were identified and implemented whilst managing the outbreaks as explained in the 'lessons learned' and 'immediate actions taken' sections above.

1. Future outbreaks to be given a unique reference number to aid correct identification
2. To use all of the cumulative learning gained from managing these outbreaks if future outbreaks occur

Glossary of Abbreviations

DSU	Day Surgery Unit
ESU	Elective Surgical Unit
ICU	Intensive Care Unit
IPC	Infection Prevention & Control
PPE	Personal Protective Equipment
PCR	Polymerase Chain Reaction – the test performed to detect genetic material from a specific organism, such as a virus. The test detects the presence of a virus if you are infected at the time of the test. The test could also detect fragments of virus even after you are no longer infected.

Action plan: Comprehensive SI 2021/12504 - COVID-19 outbreaks
Date: September 2021
Action plan owner: Dr Heath, Infection Control Doctor
Monitoring group / committee: Infection Prevention & Control Committee

ID no.	Care/Service Delivery Problem	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	ID no.	Risk at review (H/M/L or complete)	Progress made	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	New target date if original passed
1	System processes around PCR and lateral flow testing	High	Introduction of Day 3 repeat screening (in addition to Day 5)	IPC team and Ward Managers	Lauren Heath IPC Doctor	20/11/2020		Complete					
2			Introduction of twice-weekly lateral flow testing for staff	Matt Shepherd Acting deputy COO	Tim Gold Interim COO	01/12/2020		Complete					
3			Introduction of once weekly screening for all inpatients.	IPC team and Ward Managers	Lauren Heath IPC Doctor	08/03/2021		Complete					
4			ePMA set up to prescribe Day 3 and Day 5 swabs	Sonya Ashworth, IPC Matron	Kate Woodrow, Chief Pharmacist	31/01/2021		Complete					
5			Introduction of proactive PCR contact testing (every 72h for 14 days)	IPC team	Lauren Heath IPC Doctor	25/01/2021		Complete					
6			IPC surveillance team daily review of swabs due & telephoned wards every morning	IPC team	Sonya Ashworth, IPC Matron	31/01/2021		Complete					
7			Daily safety huddles utilised to track repeat swabs required	Ward Managers	Sonya Ashworth, IPC Matron	31/01/2021		Complete					
8	Limits on ventilation	High	Introduction of minimum window opening requirement to 10 minutes per hour.	IPC team	Lauren Heath IPC Doctor	18/12/2020		Complete					
9			Fleece blankets purchased by hospital charity to enable keeping windows open	Ward Managers	Sammy Lambert, Business Development, Charity and Volunteer Manager	31/01/2021		Complete					
10			Gap analysis of current HDH ventilation system with HTM 03-01	Stephen Worwood, Chair of Ventilation Safety Group	Angie Gillet, Interim Director of HIF	31/10/2021		High					
11	Lack of social distancing	High	Introduction of plastic barrier curtains between beds in bays	IPC team	Lauren Heath IPC Doctor	11/01/2021		Complete					
12			Eye protection to be worn within 2m of people, irrespective of duration of contact	IPC team	Sonya Ashworth, IPC Matron	04/02/2021		Complete					
13			Drive to encourage inpatients to wear surgical masks	Ward Managers	Lauren Heath ICD	10/02/2021		Complete					
14	Surface cleaning	Medium	Provision of funding to support an additional cleaning rota specifically to target high touch point areas (enhanced cleaning team)	Adrian Kopycinski Senior Domestic Supervisor	Dean Harker Head of Facilities Management	17/02/2021		Complete					
15			"Clinell Clean Time" introduced to ensure staff workstations / computers / telephones regularly decontaminated	IPC team and Ward Managers	Sonya Ashworth, IPC Matron	31/01/2021		Complete					
16	Multiple contacts and contact tracing	High	IT tool developed to facilitate contact tracing	Joe Ingle Head of Information Systems Development	Lauren Heath IPC Doctor	31/03/2021		Complete					
17			Bed moves reduced to an absolute minimum	Ward managers	Clinical Site Managers	11/01/2021		Complete					
18			Staff rotation minimised to reduce risk of them acting as vectors of transmission	Rota-Coordinators	Directorate Managers	11/01/2021		Complete					

Action plan progress

19			Only essential staff allowed on wards	Ward Managers	Matrons	11/01/2021			Complete					
20			Strict visitor policy implemented	IPC team, Matrons and Ward Managers	Jackie Andrews interim DIPC	11/01/2021			Complete					
21			Maximised remote working wherever possible	Line Managers	Clinical Directorate Managers	11/01/2021			Complete					
22	Multiple outbreaks to manage	Medium	Introduction of single trust-wide Outbreak Control Group (OCG) to manage all COVID-19 outbreaks, rather than each ward outbreak having a separate OCG.	Sonya Ashworth, IPC Matron	Dr Lauren Heath, IPC Doctor	01/02/2021			Complete					
23	Outbreaks were named as per the ward, but some wards had more than one outbreak – leading to confusion.	Medium	Future outbreaks to be given a unique reference number to aid correct identification	Lauren Heath IPC Doctor	Dr Jackie Andrews, Executive Medical Director and interim DIPC	31/12/2021 (subject to future outbreaks)			Medium					
24	Arrangements for shared learning	High	To use all of the cumulative learning gained from managing these outbreaks if future outbreaks occur	Dr Lauren Heath, IPC Doctor	Dr Jackie Andrews, Executive Medical Director	31/12/2021 (subject to future outbreaks)			High					
25	Unable to contact some families	Medium	Contact relevant GPs to see if they can provide alternative contact details for Next of Kin	Risk Management Team	Andrea Leng, Head of Risk Management	31/10/2021			Medium					
26	Ensuring improvement and learning is embedded	High	COVID snapshot audit during second wave	Sonya Ashworth, IPC Matron	Dr Lauren Heath, IPC Doctor	31/05/2021			Complete					
27			Infection Prevention & Control (IPC) Team to complete Quality Audit Tool during February & March 2021	Sonya Ashworth, IPC Matron	Dr Lauren Heath, IPC Doctor	22/02/2021			Complete					
28			Review and implement recommendations as per updated national guidance regarding the management of COVID-19 in healthcare settings	IPC team	Emma Nunez (DIPC)	Subject to new guidance being published			High					
29			Audit to assess learning as a result of the actions above to be added to the Serious Incident action plan audit log	Rebecca Wixey, Patient Safety Manager	Andrea Leng, Head of Risk Management	28/09/2021			Complete					

Audit requirements to ensure learning is embedded - COVID snapshot audit
This was an audit carried out by the IPC team as an unannounced visit to check compliance with 5 key measures:
1. Were patients wearing masks (where appropriate)?
2. Were the plastic barrier curtains being used appropriately?
3. Were the windows open (or evidence they had been open in the last hour)?
4. Were staff wearing eye protection?
5. Were the doors to the bays and side rooms closed?

This audit was done several times per week, on all inpatient wards during the second wave. Should there be a further wave, this snapshot audit will be reinstated.

Integrated Board Report - February 2022

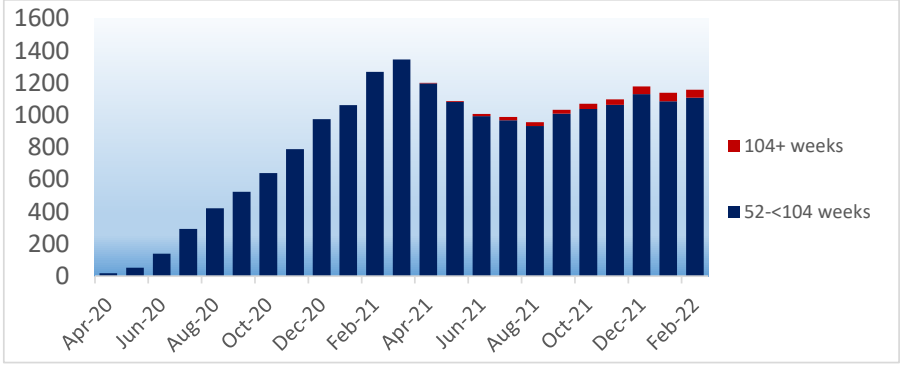
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	1157

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

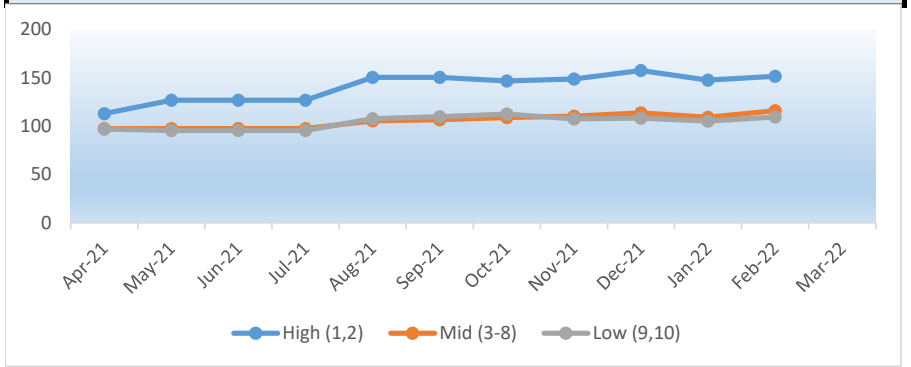
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Current end of financial year target is to reduce this figure to below 950 patients. Plans in place to reduce this number to 500 by March 2023. The 104 week waiters position continues to improve - due to COVID cancellations (patients and/or staff being ill), circa 10 patients will remain to be treated at end of March.

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

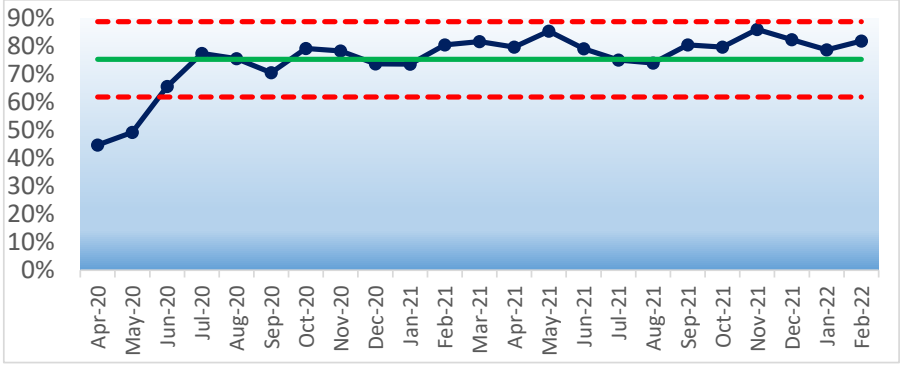
The Trust has carried out an analysis of waiting times by ethnicity, by deprivation and for patients with learning disabilities. There does not appear to be any inequity in waiting times by ethnicity or for patients with learning disabilities but these will continue to be tracked on a monthly basis. There does appear to be a difference in waiting times by deprivation with patients from the most deprived postcodes waiting longer. A further analysis of this is being carried out looking at the data by clinical priority and by specialty.

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	81.9%

Indicator description

Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%.

SPC chart



Narrative

82% of patients were waiting less than 6 weeks for a diagnostic test at end February against a 99% target.

There were 839 waiting over 6 weeks (881 last month) – comprising 453 Dexa, 133 audiology, 68 MRI, 60 ultrasound and 125 other. The bone density scanner has arrived and installation works underway in the Briary Wing due to be finished early March. Dual running of two machines to start once installed. Additional staffing absence driven by Covid has slowed the activity recovery in MRI and Ultrasound but this should return to the previous trajectory over the next 2 weeks.

Indicator	**5.4 - Outpatients lost to follow-up - number of follow up patients past due date**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

A data quality exercise is underway to review the follow up outpatient waiting list data and to understand the full scope of this problem and determine how many patients still require a follow up appointment. This work includes reviewing the way that we store and retain information from our follow up waiting lists to enable easier reporting of historical data. It is likely that we will refine the metric for reporting in this report as part of this work.

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	92.9%

Indicator description

The number of inpatients with a valid ethnic group recorded on the Trust's PAS system.

SPC chart

Narrative

The Trust remains below the required standard of 97%. A revised focus on ethnicity data collection is underway, this measure is monitored at Trust weekly access meetings.

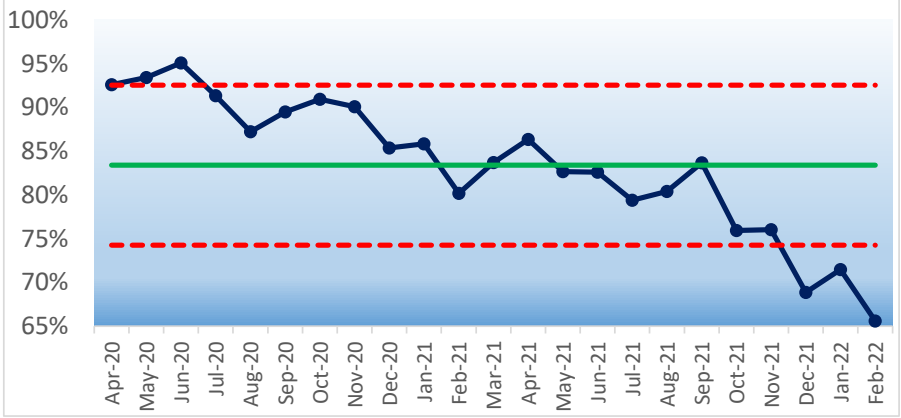
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions that we will join once details shared
- Reminded staff of the process regarding the collection of this data including reception staff aware that they should be collecting ethnic category, if not already there, as part of the demographic check.
- Progress of new Kiosks – previously electronic check in kiosks included a step to complete / update ethnic category. Removed as a result of COVID, awaiting new kiosks to re-introduce process.
- Exploring option of sending electronic forms to patients for completion and return.

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	65.6%

Indicator description

Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The data includes all A&E Departments, including Minor Injury Units (MIUs). The operational standard is 95%.

SPC chart



Narrative

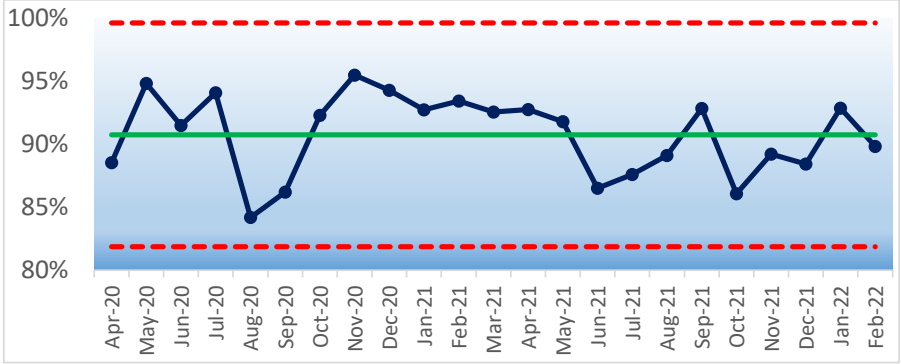
Performance against the A&E 4-hour standard remains well below the 95% standard.
Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses. We continue to support the HCV(York & Scarborough) system which is significantly pressured (OPEL4) with regular diverts of ambulance patients to Harrogate - this negatively impacts on our 4 hour performance and length of stay.
Current work underway to improve this position includes:
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising SDEC opportunities;
- educating other specialties to avoid using ED as their triage and assessment service;
- increased GP Out of Hours provision to avoid Primary Care attendance;
- revision of infection control procedures as soon as national guidance changes to allow more rapid flow;
- implementing a 'fit to sit' area to improve flow when cubicle capactiy becomes an issue;
- external independent operational review of ED and hospital flow processes commissioned for March.

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	89.8%

Indicator description

The percentage of ambulance patients who were handed over to Emergency Department staff within 15 mins.

SPC chart



Narrative

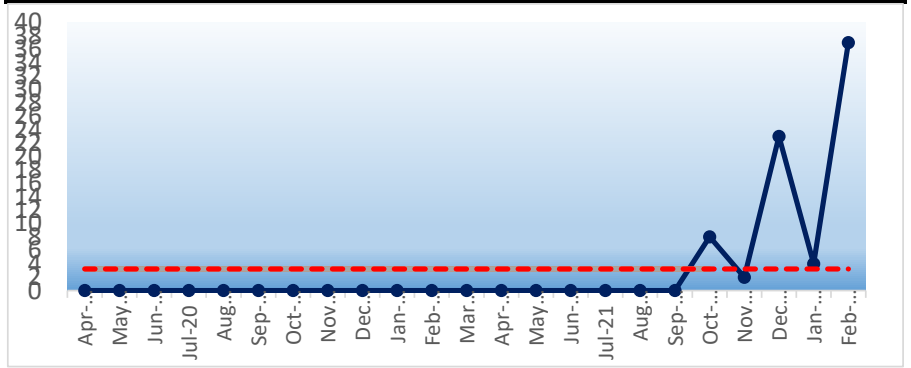
Just under 90% of ambulance handovers took place within 15 minutes in February. There were 17 over 30-minute handover breaches including 3 over 60-minute breaches in January. Prevention of ambulance handover delays continues to be a focus with our operational processes being shared across the region by NHSE/I. Depsite the high bed occupancy, acuity and activity, the lost hours to handover in Harrogate remains very low.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	37

Indicator description

The number of patients spending more than 12 hours in the Emergency Department between a decision to admit and being admitted.

SPC chart



Narrative

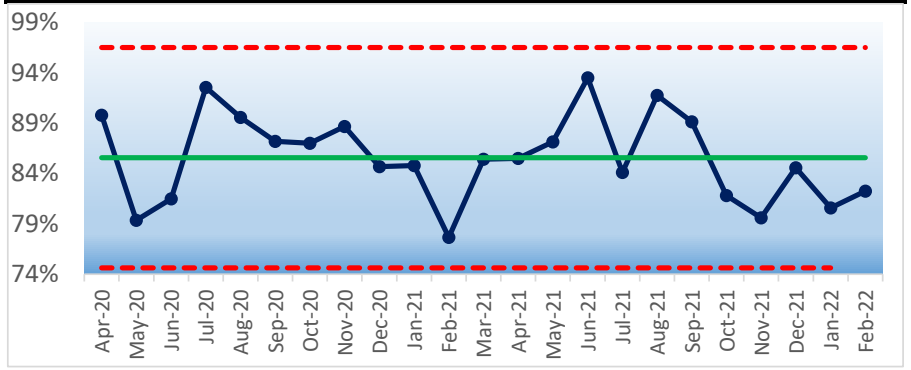
37 over 12 hour trolley waits were reported in February, the majority of these occurred over the course of the final weekend in the month. RCAs have been completed and reviewed at internal quality and performance meetings. The long waiting patients are exclusively linked to times when there are no available beds in the hospital (despite maximal escalation capacity being open).

Indicator	**5.9.1 - Cancer - 62 day wait for first treatment from urgent GP referral to treatment**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	82.2%

Indicator description

Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%.

SPC chart



Narrative

Provisional data indicates that the 62 day standard was not delivered in February for the fifth consecutive month (82.2%). There were 53.5 accountable treatments (59 patients) in February with 9.5 treated outside 62 days. Of the 10 tumour sites treated in February, performance was below 85% for 6 (Breast, Gynaecology, Haematology, Colorectal, Upper GI, Urology). All pathway delays will be reviewed by the breach panel at the end of March.

Delivery of the 62 day standard continues to be affected by challenges with Colorectal theatre capacity and delays to appointments for urology patients.

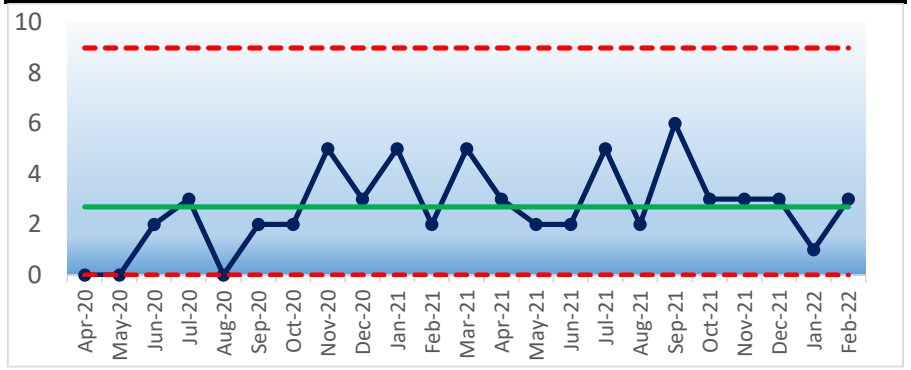
Provisional data indicates that 45.5% (5/11) of patients treated at tertiary centres in February were transferred for treatment by day 38, which is a deterioration on last month (53.3%).

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	3

Indicator description

The number of cancer patients waiting 104 days or more since urgent GP referral.

SPC chart



Narrative

3 patients waited 104+ days for treatment in February (1 x Harrogate colorectl; 1 x Leeds renal; 1 x Leeds Gynaecology).

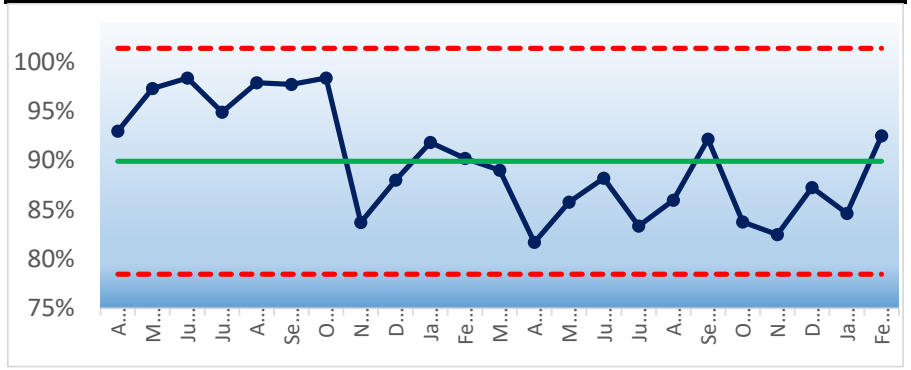
The 2 Leeds patients were both transferred after day 38 - the primary reason for the Gynae patient delay was due to diagnostic complexity, and treatment for the Renal patient was delayed due to patient and holiday and capacity at Leeds. The Harrogate patient required a period of input from the AAC team before proceeding with surgical treatmnet. All patients have now received treatment and their pathways will be reviewed by the breach panel at the end of March.

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	92.5%

Indicator description

Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.

SPC chart



Narrative

879 patients attended their first appointment for suspected cancer in Febuary - 66 patients were seen after day 14 (compared to 121 last month), and of these 30 were Lower GI referrals and 16 were Upper GI referrals. Of 114 Breast attendances 9 were seen after 14 days (92.2%) which is a deterioration on last month (97.7%).

Issues continue for appointments in Lower GI and Urology - the service is looking at addressing the capacity issues in urology with potentially an additional clinic per week. In Lower GI, there is some long-term sickness and we haven't been able to recruit to a locum post.

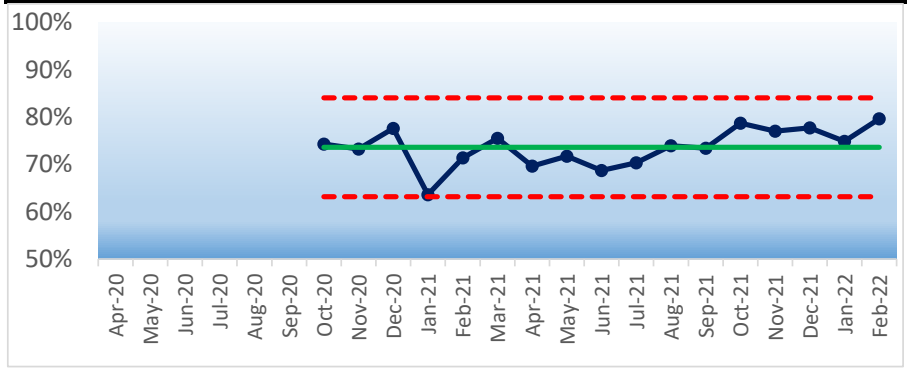
The breast 2WW standard has deteriorated in February with performance below the operational standard (85.9%). Additional capacity is being provided and appointments are now being booked within 14 days.

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	79.6%

Indicator description

From October 2021, Trusts are required to deliver the new 28 days faster diagnosis standard for all suspected cancer referrals. The proposed operational standard is 75%.

SPC chart



Narrative

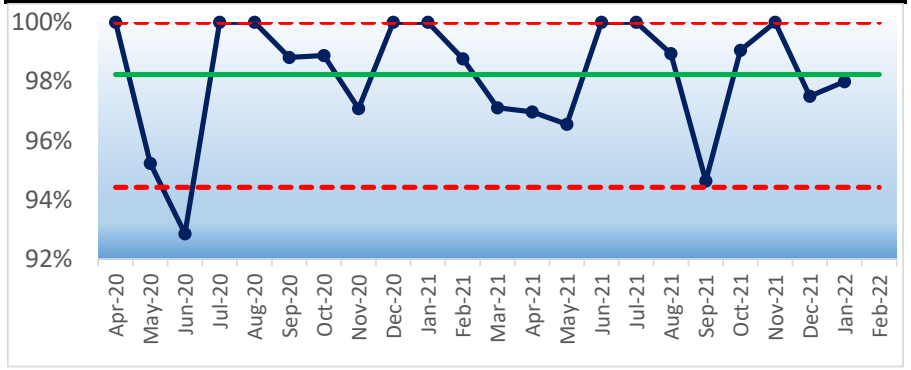
Provisional data indicates that in February combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) has remained above the proposed operational standard of 75%.

Indicator	**5.12 - Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	99.0%

Indicator description

Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%.

SPC chart



Narrative

Provisional data indicate that 100 patients received First Definitive Treatment for cancer at HDFT in February.

1 Breast patient was treated outside 31 days of decision to treat - surgery was initially booked within the expected timeframe but this was cancelled and rescheduled for 2 weeks later as the patient tested positive for Covid-19.

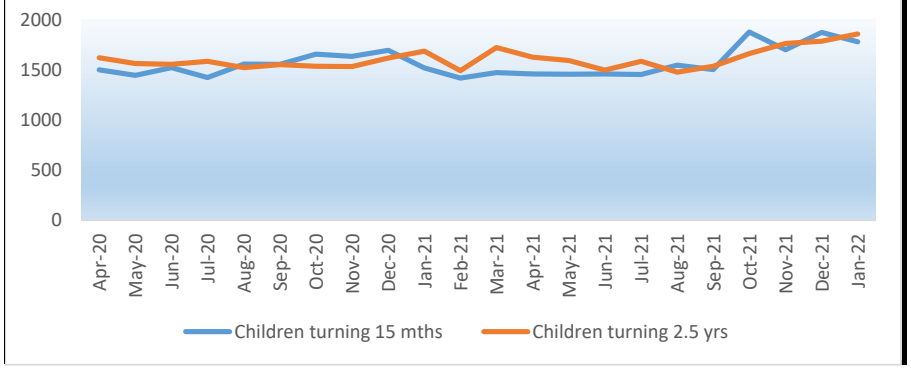
Overall peformance was above the expected standard of 96%.

Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

The chart shows the number of children turning 15 mths and 2.5 yrs across the full footprint of HDFT's 0-19 Services.

SPC chart



Narrative

Northumberland data is included from Oct-21.

Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	980

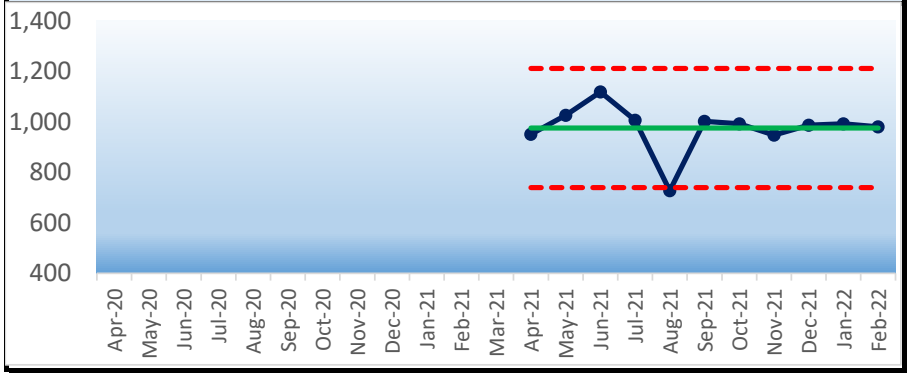
Indicator description

The chart shows the number of Child Protection strategies as an estimate for Safeguarding caseload.

Narrative

The chart shows the number of Child Protection strategies as an estimate for Safeguarding caseload.

SPC chart

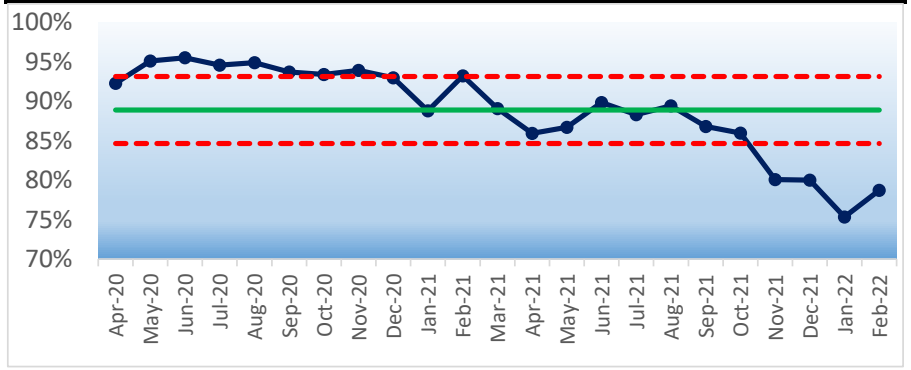


Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	78.7%

Indicator description

The number of mothers receiving a first face to face antenatal contact at 28 weeks or above before birth.

SPC chart



Narrative

79% of eligible pregnant women received an initial antenatal visit in February. The deterioration in performance in recent months is due to the Middlesbrough provision and a fall from 90% performance to 33%. Staff isolation, sickness and vacancies contributed to this decline. Remedial actions in place to return to previous activity levels.

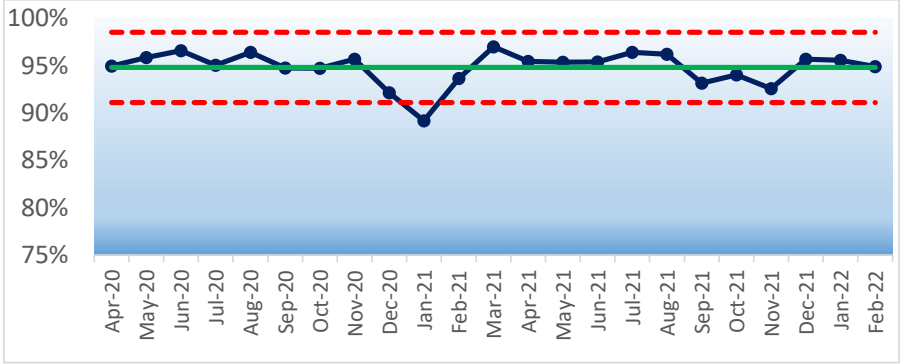
Data for Northumberland is now included from Oct-21 onwards.

Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	94.9%

Indicator description

The number of eligible infants who received a face-to-face Health Visitor new birth visit undertaken within 14 days from birth.

SPC chart



Narrative

95% of infants received a new birth visit within 10-14 days of birth during February.

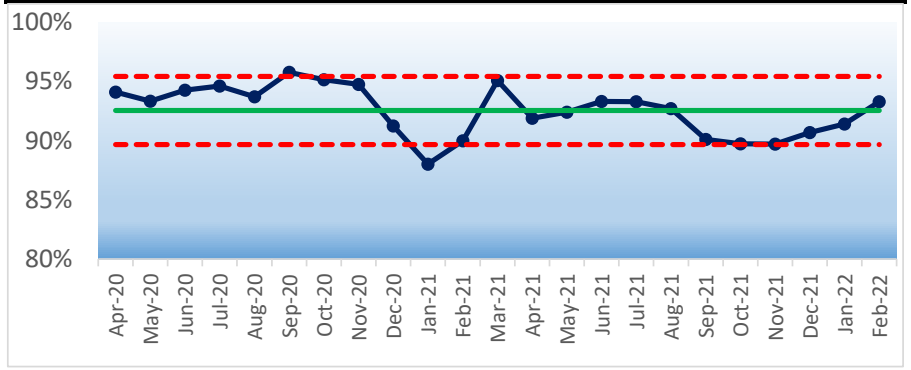
Data for Northumberland is now included from Oct-21 onwards.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	93.3%

Indicator description

The number eligible infants who received 6-8 week review by 8 weeks of age.

SPC chart



Narrative

93% of infants received a 6-8 week visit by 8 weeks of age during February.

Data for Northumberland is now included from Oct-21 onwards.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	93.7%

Indicator description

The number of children that received a 12 month review by 15 months of age.

SPC chart

Narrative

94% of eligible children received a 12 month review by 15 months of age during February.

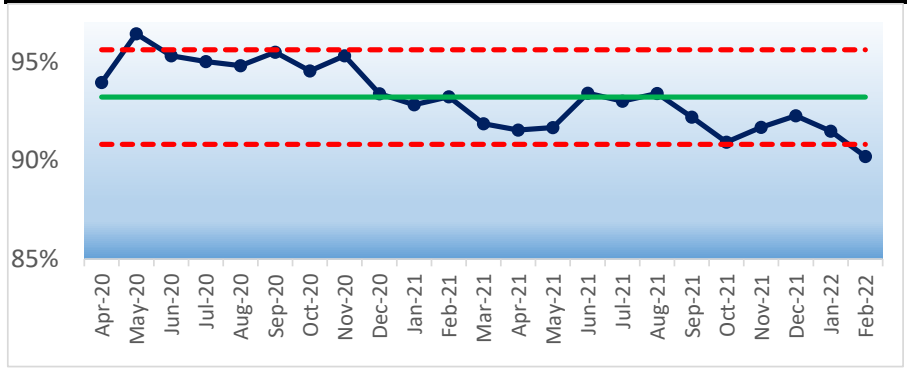
Data for Northumberland is now included from Oct-21 onwards.

Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	90.2%

Indicator description

The number of eligible children receiving a 2-2.5 year review by the time they were 2.5 years.

SPC chart



Narrative

90% of eligible children received a 2-2.5 year review by 2.5 years of age during February.

Data for Northumberland is now included from Oct-21 onwards.

Indicator	**5.20 - Children's Services - % children with all 5 mandated contacts**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

A one-off audit was carried out on North Yorkshire data in 2021 which looked at children born in 2017/18 and how many mandated contacts they had received. This showed that 62% of children had received all mandated contacts. 0.4% of children were recording as not having had any mandated contacts. A list of these children was shared with service managers to follow up.

The intention is to repeat this audit annually and extend to include all localities covered by HDFT's Children's Services.

Indicator	**5.21 - Children's Services - Delivery of Immunisation trajectory**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.22 - Children's Services - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

CC Directorate have started to discuss and record OPEL levels for 0-19 Services at their Safety and Governance huddles. The position for February was:
Sunderland 3
Gateshead 3
Darlington 2
Durham 3
Stockton 3
Middlesbrough 3
North Yorkshire 2
Northumberland 2
Safeguarding 3
Acute Paediatrics 1

Indicator	**5.23 - Community Care Adult Teams - performance against new timeliness standards**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

The NHS Operational Planning and Contracting Guidance 2021/22 set out the first stage for implementing the community two-hour crisis response standard in England by March 2022. All integrated care systems (ICSs) in England must ensure that crisis response care is available to all people within their homes or usual place of residence, including care homes, within two hours.

The Trust is currently preparing to be able to report this data from March 2022 onwards.

Indicator	**5.20 - Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.25 - Community Care Adult Teams - Number of cancelled routine visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.26 - Community Care Adult Teams - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

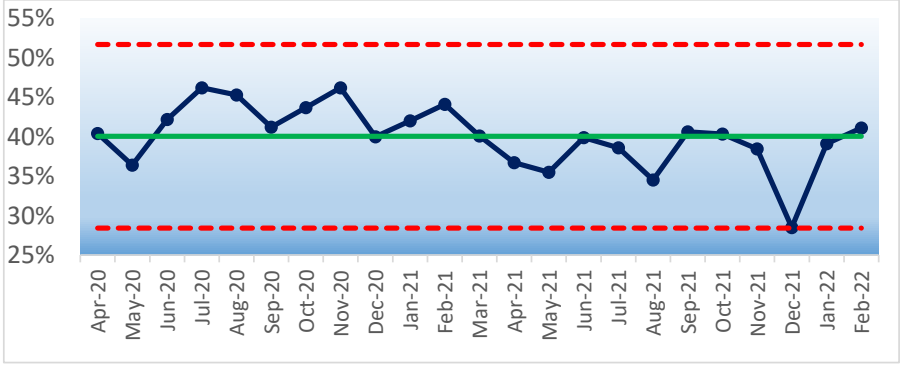
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for February remained at level 3.

Indicator	**5.27 - GPOOH - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	41.1%

Indicator description

The percentage of telephone clinical assessment for URGENT cases carried out within 20 minutes of call prioritisation.

SPC chart



Narrative

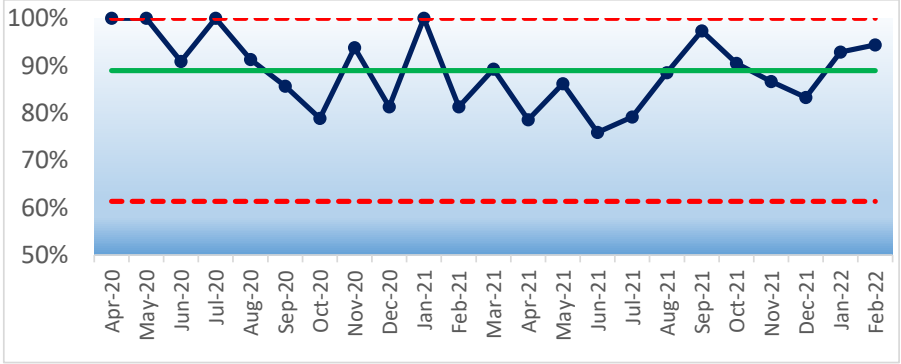
In February, 41% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation, remaining below the 95% target.

Indicator	**5.28 - GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	94.4%

Indicator description

The percentage of home visit face to face consultations started for URGENT cases within 2 hrs.

SPC chart



Narrative

In February, 94% of urgent GPOOH cases received a home visit face to face consultation within 2 hours. There has been an increase in the number of face to face consultations requested as the country moves out of the most recent Covid wave and demand and capacity planning is underway looking to see if the 95% target is achievable with the increase.

Integrated Board Report - February 2022

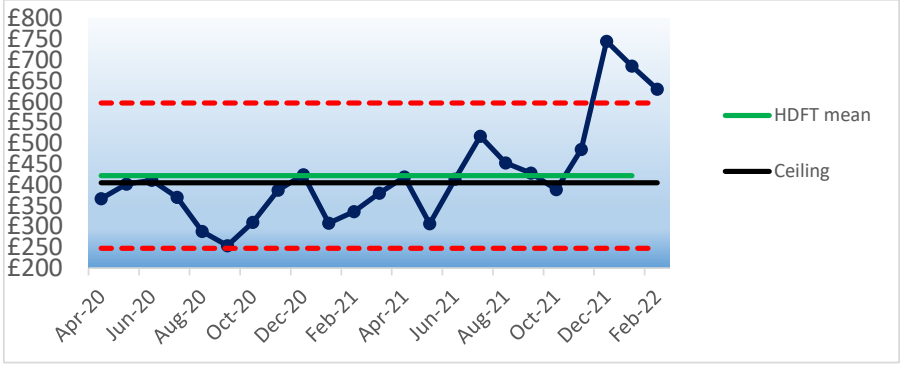
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	£630

Indicator description

Expenditure in relation to Agency staff (£'000s). The Trust aims to have less than 3% of the total pay bill on agency staff.

SPC chart



Narrative

Agency continues to be used for vacancies and sickness cover, with spend continuing to be monitored closely.

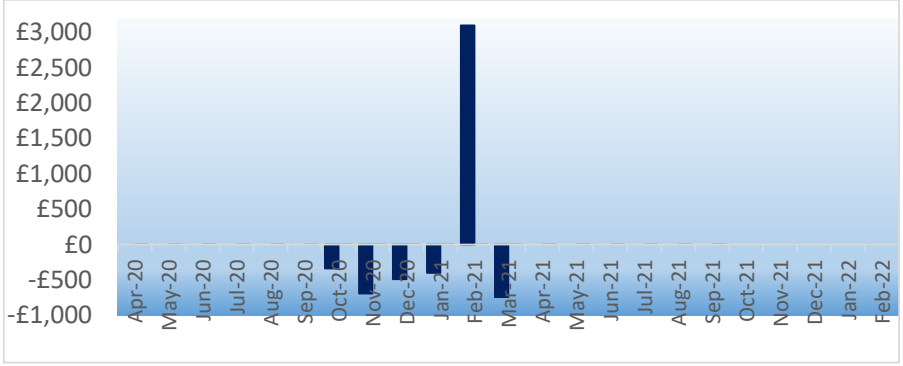
Further information has been shared at Resource Committee.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	£0

Indicator description

Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.

Trend chart



Narrative

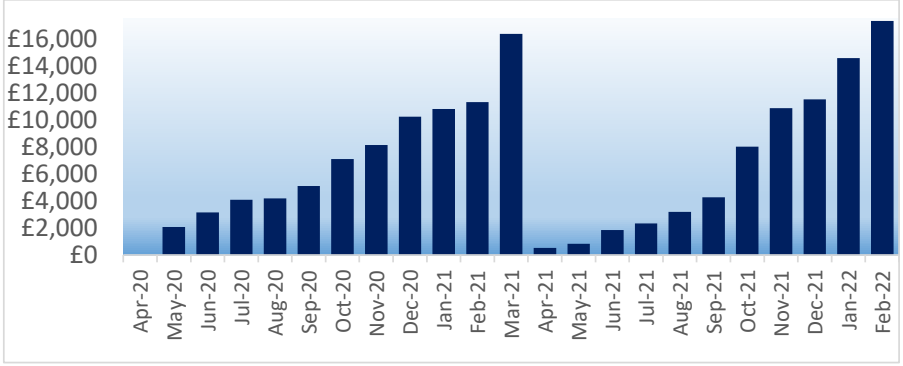
As outlined within the Finance report, the Trust is reporting a balanced position following adjustments for Salix and other, non-control total items.

Indicator	**6.3 - Capital spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	£17,301

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

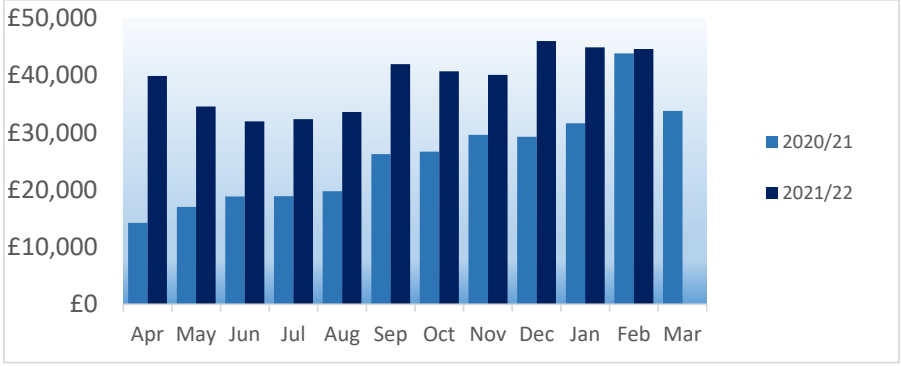
Capital Expenditure is significant in 2021/22, with expenditure already exceeding 2020/21 totals. The key scheme within capital is performance against the Salix programme. The Trust remains on course to spend its CDEL allocation for this financial year.

Indicator	**6.4 Cash balance**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	£44,615

Indicator description

The Trust's cash balance by month (£'000s)

Trend chart



Narrative

The cash balance continues to be strong, however, there will be a significant level of capital expenditure in month 12 that will reduce the overall balance.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	177

Indicator description

The average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart

Narrative

The number of long stay patients (> 7 days) increased to 177 in February. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	86

Indicator description

The average number of patients that were in the hospital with a length of stay of over 21 days (previously defined as super-stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart

Narrative

The number of long stay patients (> 21 days) increased to 86 in February.This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	57.8

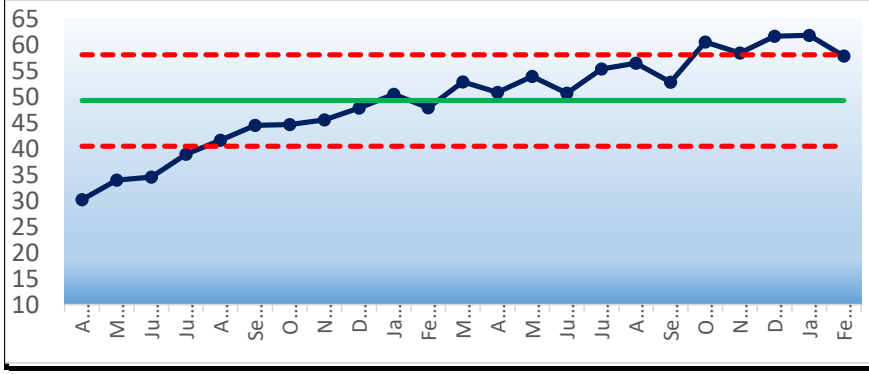
Indicator description

The number of occupied bed days expressed per 1,000 population, using the mid-2020 population estimate for Harrogate.

Narrative

Occupied bed days reduced in February but have generally seen a steady increase since the start of the pandemic period. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, in line with the current level.

SPC chart

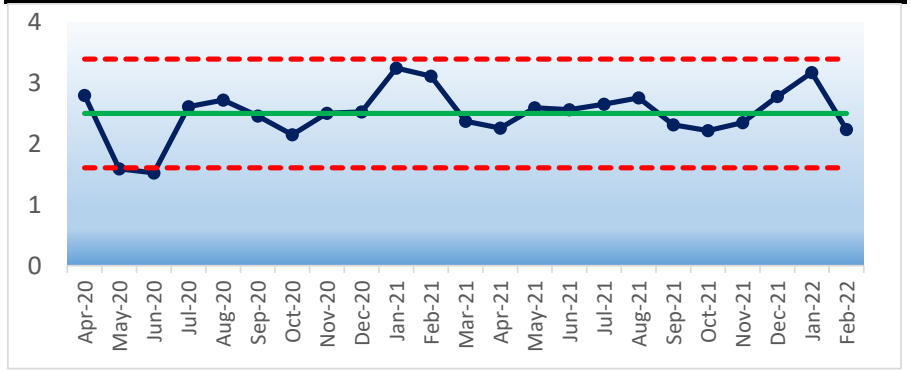


Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	2.2

Indicator description

Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.

SPC chart



Narrative

Elective length of stay decreased in February and is now below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	5.8

Indicator description

Average length of stay in days for non-elective (emergency) patients.

SPC chart

Narrative

Non-Elective length of stay increased in February and remains above our local stretch target.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jan-22
Value / RAG rating	213

Indicator description

The number of avoidable emergency admissions as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission.

SPC chart

Narrative

There were 213 avoidable admissions in January, a reduction on the previous month. The most common diagnoses remain as urinary tract infections and pneumonia. Excluding children and admissions via CAT/SDEC, the figure was 137.

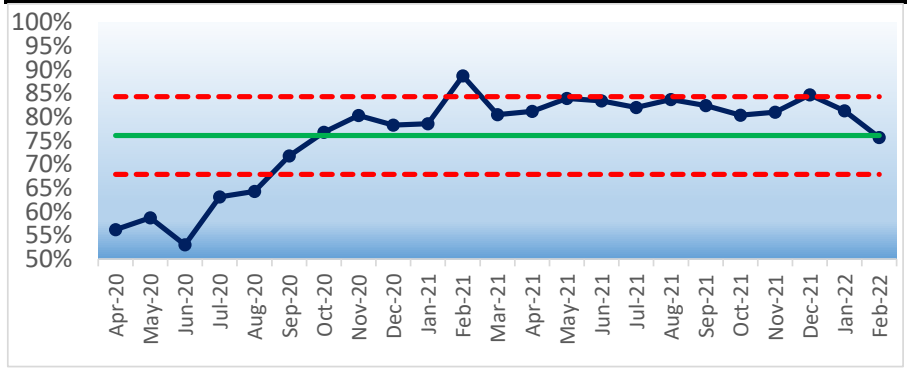
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	75.7%

Indicator description

The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions.

SPC chart



Narrative

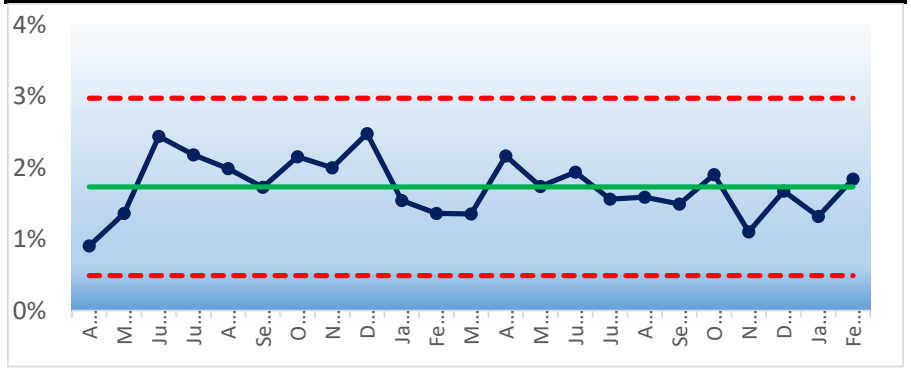
Theatre utilisation remains below the local intermediate target of 90%.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	1.8%

Indicator description

The percentage of intended elective day case admissions that ended up staying overnight or longer.

SPC chart



Narrative

1.8% (39 patients) of intended day cases stayed overnight or longer in February.

Integrated Board Report - February 2022

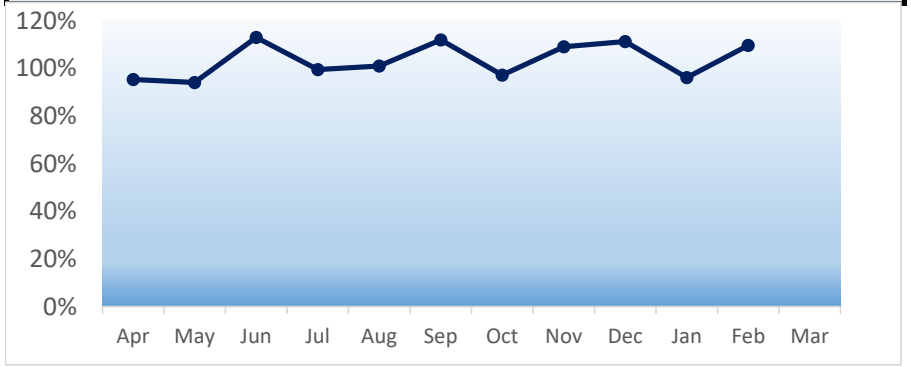
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	109.7%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

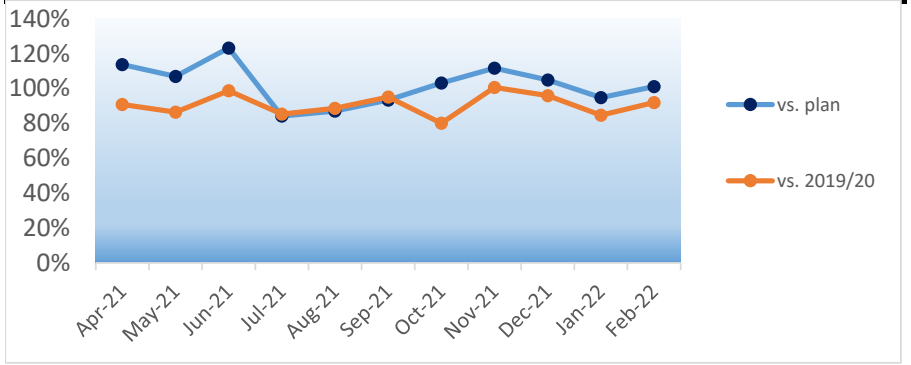
In February, GP referrals were 10% above the equivalent month in 2019/20. On a year to date basis, GP referrals are 13% above 2019/20 levels.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	101.1%

Indicator description

Outpatient activity (consultant led) against plan and 2019/20 baseline. The data includes new and follow up attendances.

Trend chart



Narrative

Outpatient activity was 1% above plan in February.

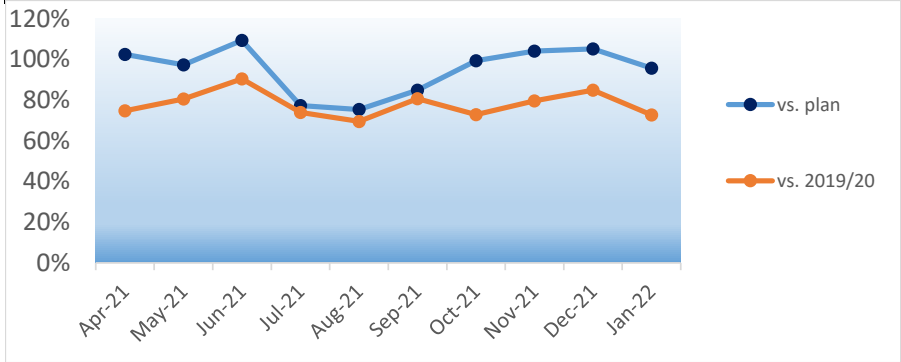
Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	88.6%

Indicator description

Elective activity against plan and 2019/20 baseline. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

Elective admissions were 11% below plan in February.

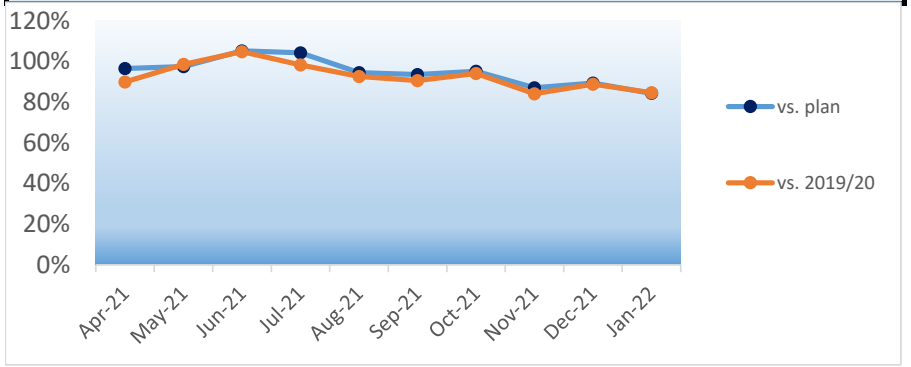
Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	85.4%

Indicator description

Non-elective activity against plan and 2019/20 baseline.

Trend chart



Narrative

Non-elective activity was 15% below plan in February.

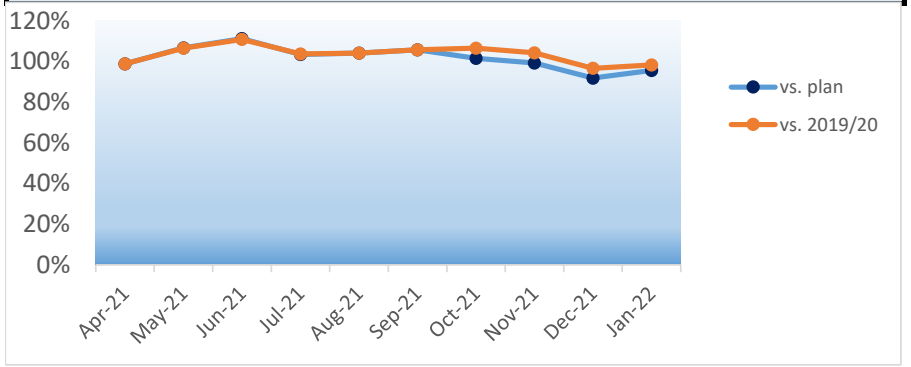
Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-22
Value / RAG rating	94.95%

Indicator description

Emergency Department attendances against plan and 2019/20 baseline.

Trend chart



Narrative

Emergency Department attendances were 5% below plan in February.

Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Finance Report
Board of Directors – 30/03/2022

Matters of concern & risks to escalate

- There continues to be areas of pressure across the Trust, offset by underspends on activity and 0-19 services.
- Agency spend continues to be high in a number of areas
- Planning for 2022/23 continues to highlight a significantly more challenging position anticipated
- The wider Humber, Coast and Vale ICS plan is further challenged, meaning greater asks on system resources

Major actions commissioned & work underway

- Continued focus on delivering capital programme in 2021/22
- Working with Nursing, Medical and HR teams to refresh process for use of temporary and agency staffing
- Finalising planning for 2022/23, following process outlined in previous meetings
- Working with ICS to ensure resources available to support this plan
- Implementation of Qubix (Budget/forecasting solution)

Positive news & assurance

- Continue to deliver financial plan for H2, as well as meet efficiency ask for H2
- Cash position remains positive
- Significant capital programme addressing a number of issues, as well as step change in energy infrastructure as a result of Salix programme
- 3 self nominated Health and Wellbeing champions working alongside Future Focused Finance.

Decisions made & decisions required of the Board

- Approve operational budgets for 2022/23
- Approve audit committee recommendation that the Trust accounts are prepared on a going concern basis

Board of Directors (Public)
30th March 2022

Title:	Finance Position February 2022
Responsible Director:	Finance Director
Author:	Finance Director Deputy Director of Finance

5.3

Purpose of the report and summary of key issues:	The report has been developed to give information and assurance on the financial position as reported as at the end of February 22. The position includes information on Revenue, CIP and 22/23 planning. The Board is asked to note the contents of the paper.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	No change	
Report History:	Information within the report is supported by Directorate Board discussions, and the monthly Resource Review sessions.	
Recommendation:	The board is asked to note the contents of the paper.	

Harrogate and District NHS Foundation Trust

Board of Directors
Financial Position – February 2022

1. Purpose of the report

This paper has been developed to update the Board of Directors on progress against the annual Financial Plan. The Board is asked to note the contents of the report.

As described below, the Trust Revenue position is aligned to plan. There are specific issues described in relation to the Capital Programme and Better Payment Practice Code (BPPC) performance.

2. Introduction

The paper is an update on the Trust Financial Position, and continues the monthly updates received by the Board. The paper aims to provide assurance on the financial position, as well as provide opportunity to discuss the key financial issues across the organisation.

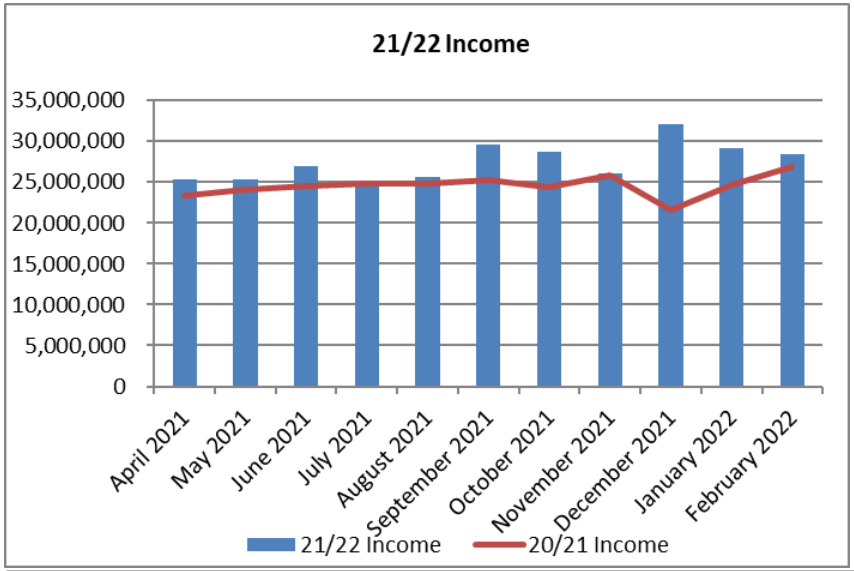
Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.

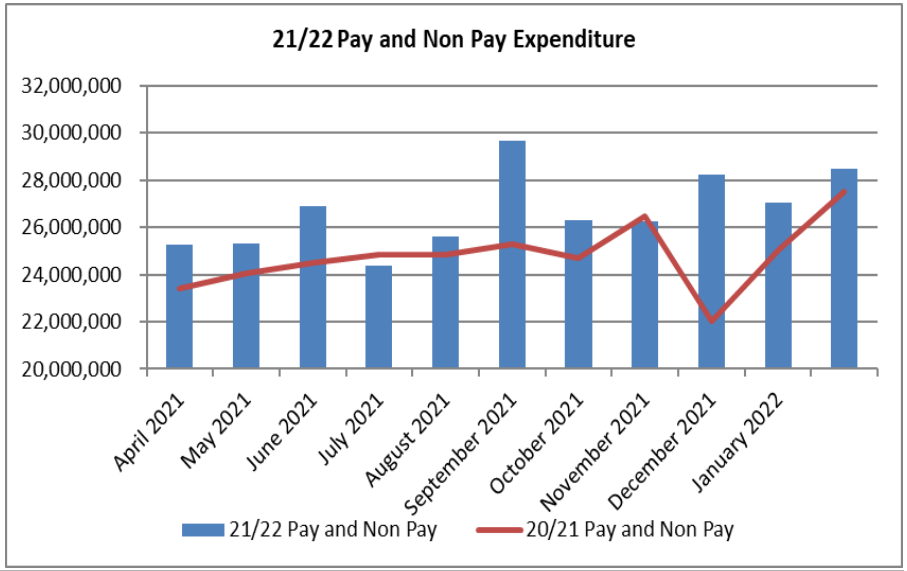
3. Financial Position

High Level Analysis	Mth Budget £000's	Mth Actual £000's	Variance £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's
Commissioner Income	**23,559**	**22,777**	**-783**	**248,601**	**251,946**	**3,345**
Directorate Income	**3,610**	**5,582**	**1,972**	**39,616**	**49,835**	**10,220**
Pay Costs	-17,781	-17,947	-166	-188,521	-187,161	1,360
Non Pay Costs	-8,666	-10,526	-1,861	-100,176	-106,254	-6,078
Expenditure	**-26,447**	**-28,474**	**-2,027**	**-288,697**	**-293,415**	**-4,718**
Surplus / (Deficit)	**722**	**-115**	**-837**	**-481**	**8,366**	**8,847**

Notes *Salix Income of £8.8m included in the position less adjustment depreciation on donated assets.

3.1 Revenue





The position above of a £8.3m surplus is a positive position for the second half of 2021/22. (Includes an adjustment made for depreciation on donated assets of £0.4m)

The position includes income associated with the Salix grant £8.8m Adjusting for this results in a breakeven position, in line with the plan and expectations set by NHS England and NHS Improvement (NHSEI).

The year end forecast remains a breakeven position.

The Income position reflects additional payments received from HEE £2m which was expected.

Directorate spend remains similar to previous months continued pressure within Medical Staffing, Wards and Private Patient income. A new pressure emerging is relation to energy costs.

Premium spend continues across the Trust either via incentive payments/agreed rates outside of A4C or Agency.

Community &Childrens	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**1,690**	**1,670**	**-20**
Pay Costs	-57,368	-55,103	2,265
Non Pay Costs	-5,983	-5,024	959
Expenditure	**-63,351**	**-60,127**	**3,224**
Total	**-61,661**	**-58,457**	**3,204**

LTUC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**6,181**	**6,447**	**266**
Pay Costs	-54,679	-56,252	-1,572
Non Pay Costs	-19,937	-21,203	-1,266
Expenditure	**-74,616**	**-77,455**	**-2,839**
Total	**-68,435**	**-71,007**	**-2,572**

PSC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**742**	**822**	**79**
Pay Costs	-50,542	-50,509	33
Non Pay Costs	-19,441	-18,580	860
Expenditure	**-69,983**	**-69,090**	**893**
Total	**-69,240**	**-68,268**	**972**

Corporate	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**8,805**	**17,064**	**8,260**
Pay Costs	-16,502	-16,017	485
Non Pay Costs	-35,113	-34,053	1,060
Expenditure	**-51,615**	**-50,070**	**1,545**
Total	**-42,810**	**-33,006**	**9,805**

HIF	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**18,413**	**18,141**	**-272**
Pay Costs	-8,852	-8,319	532
Non Pay Costs	-9,377	-9,765	-387
Expenditure	**-18,229**	**-18,084**	**145**
Total	**183**	**56**	**-127**

There is a clear importance in managing directorate budgets to ensure the Trust financial plan is achieved.

Directorate performance is outlined to the side.

Within the Directorate positions are some common areas of risk.

These include –

- Ward pay expenditure position – £6k overspend in month, £788k overspend YTD. This position includes additional budget for winter. £10k reduction from previous month.
- Medical Staffing pressures – Agency continues to be used to cover substantive gaps.
- Significant underspends within Children's Services and Adult Community Services.
- Third party costs for addressing activity backlog
- General risk of covering staff in Acute area's from Covid sickness/Isolation
- Utility pressures now emerging.

These areas will continually monitored.

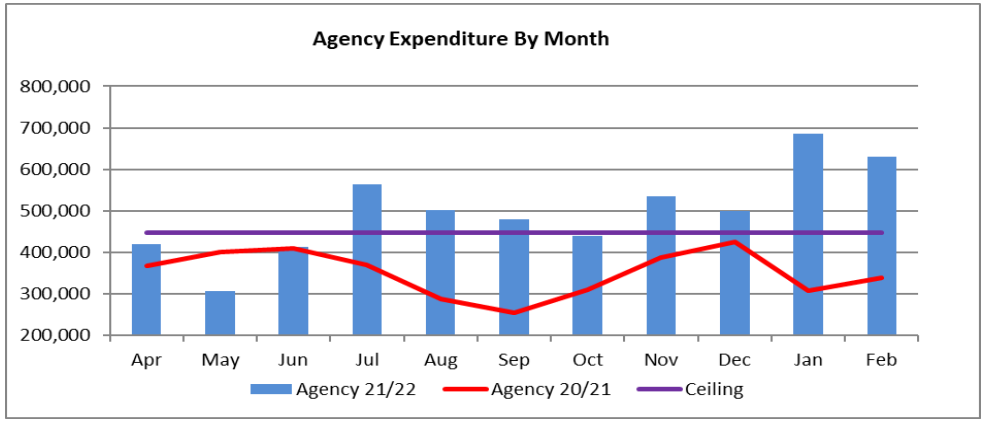
HR and Finance colleagues continue to reconcile vacancies across the directorates.

3.2 Agency

Month 11 expenditure on Agency is £630k

HIF agency costs have doubled from a run rate of £20k to £44k in the past two months covering vacancies and sickness.
CC increase in agency costs is in relation to the 12-15yrs vaccination programme, £29k in month.
LTUC agency use remains fairly consistent (£200k Med Staff, £70k Wards) ED nursing agency use has doubled from £10k to £20k a month as TFS Healthcare is now being used which is an increase of £13 per hr in comparison to Pulse. Medical Staffing agency continues to cover substantive vacancies.
PSC Theatre Ophthalmology agency costs are included in the Agency spend, £70k in month.

	Actual											
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	YTD
Total Agency	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medical	-216	-169	-264	-334	-306	-231	-216	-253	-201	-330	-267	-2,787
Nursing	-123	-100	-110	-146	-113	-157	-124	-178	-197	-226	-318	-1,792
Other Clinical	-17	5	-9	-13	-10	-13	-15	-12	-8	-5	106	9
Non Clinical	-63	-42	-30	-69	-75	-78	-84	-91	-95	-124	-151	-903
Total Agency	**-419**	**-307**	**-414**	**-563**	**-503**	**-479**	**-439**	**-535**	**-500**	**-685**	**-630**	**-5,473**
Agency Ceiling	-448	-448	-448	-448	-448	-448	-448	-448	-448	-448	-448	**-4,928**
Variance	**-29**	**-141**	**-34**	**115**	**55**	**31**	**-9**	**87**	**52**	**237**	**545**	**545**

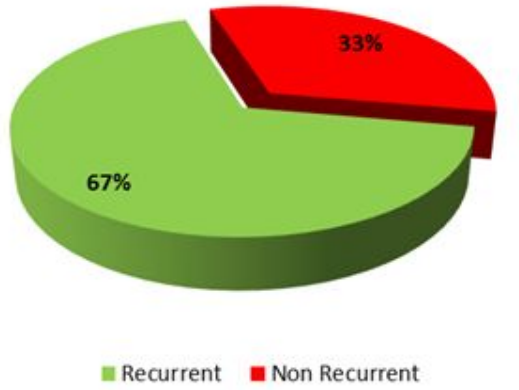


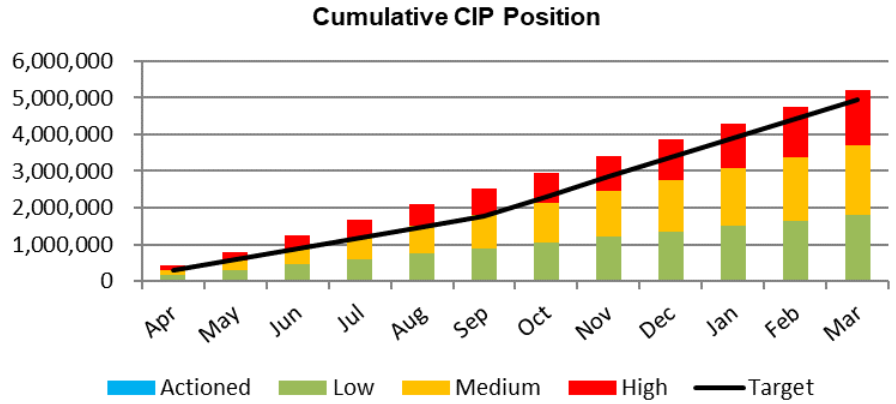
3.3 CIP

Directorates have been actively working on CIP plans for 22/23 and a summary of the current status is summarised below. Positively there has been an increased focus on recurrent schemes.

22/23 target includes non recurrent carry forward and a 2% efficiency target for 22/23.

Target	Actioned	Low	Medium	High	Unidentified	Total	Total %age	Risk Adjusted Plans	Risk adjusted shortfall	Risk Adj %age
6,861,600	0	1,800,836	1,899,250	1,494,200	1,667,314	5,194,286	76%	3,529,034	3,332,566	51%
% of target	0%	26%	28%	22%	24%					





3.4 Capital

Capital spend YTD £17.3m, this is an increase of £2.8m in comparison to the previous month which was not in relation to the Salix scheme.

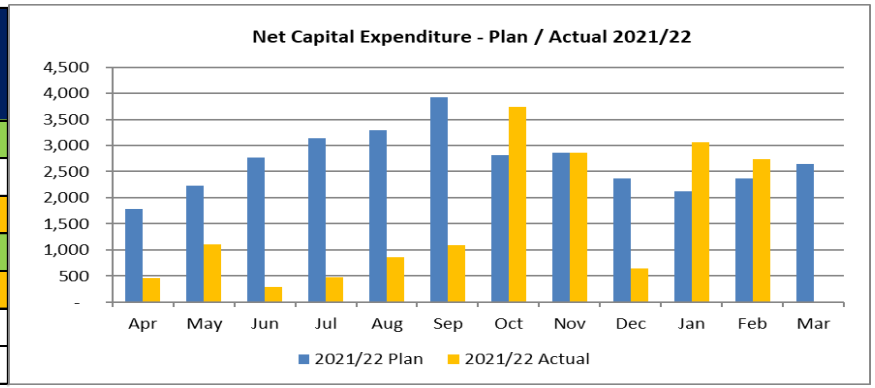
Salix continues to be on target to spend the grant allocated, £9m spend YTD, there are further invoices awaiting to be processed.

Early settlement of three loans occurred in February.

The programme continues to be monitored on a weekly basis to assess progress, with added pressure to spend as a result of a number of PDC backed schemes being awarded but not progressed. Work is under away to try and spend the allocation this financial year but no slippage has been included in 22/23 planning.

22/23 planning is being finalised with the team working through timings of major schemes and the impact on CDEL.

Scheme	Plan	Spend YTD	Forecast Spend	Total Spend 21/22	Risk Rating
Salix	**14,180,000**	9,012,869	5,360,984	14,373,853	
PDC	**4,726,477**	1,253,695	3,022,583	4,276,278	
PDC but part of CDEL	**1,164,000**		606,600	606,600	
CDEL	**12,440,000**	6,886,023	5,971,006	12,857,029	
Total	**32,510,477**	**17,152,587**	**14,961,173**	**32,113,760**	



3.5 Better Payment Practice

The Trust is required to adhere to the Better Payment Practice Code, which targets the payment of 95% of invoices within 30 days.

There has been great progress with achieving the BPPC.

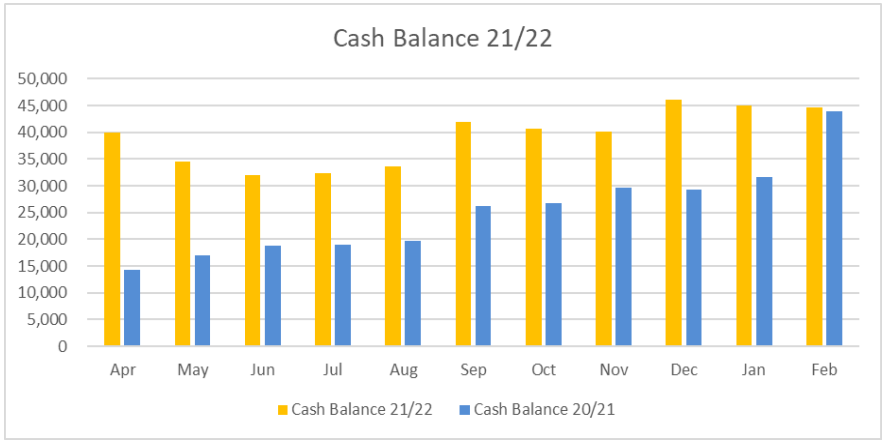
Payments and Procurement are now actively promoting the use of purchase orders with the future aim of no PO no payment.

	In Month		YTD	
	Number	£000's	Number	£000's
Total Invoices paid in Period	3,470	7,864	38,103	78,248
Total Invoices paid within target	3,223	7,202	35,833	71,390
% Paid within target	93%	92%	94%	91%

3.6 Cash Balance

The Trust cash balance continues to remains positive as at the end of February.

The cash balance is anticipated to reduce as some large capital items are paid for.



4. Financial Implication/Risk assessment

As described within the report. The Trust continues to balance the overall position, however, there remains pressures in some areas, with underspending issues as much an issue as those areas overspending.

5. Risks

There are currently no issues of risk to be updated on the Corporate risk register related to this report. Risks are being managed within local risk registers, and will be escalated when appropriate.

6. Recommendation

The Board of Directors is asked to note and discuss the content of this report.

Jordan Mckie Finance Director

Board of Directors (Public)
30th March 2022

Title:	Annual Planning 2022/23
Responsible Director:	Acting Director of Finance
Author:	Acting Director of Finance Deputy Director of Finance

Purpose of the report and summary of key issues:	This report is a brief summary of the planning position. It outlines the overall draft position for the Trust, with more detail discussed at Senior Management Team and Resource Committee. The Board will be further updated when discussions on the points raised are addressed.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	No change	
Report History:	Continuation of annual planning process.	
Recommendation:	The board is asked to note the contents of the paper and approve the recommendation from Senior Management Team that the Budgets underpinning this position are approved.	

Financial Planning 2022/23
Board of Directors
March 2022

Following discussion over the last 6 months, the following financial plan has been developed as a draft –

Summary Income and Expenditure Account		
	Outturn 2021/22 £'000	Plan 2022/23 £'000
Operating income from patient care activities	274,766	263,178
Other operating income	37,669	19,636
Employee expenses	-203,938	-199,149
Operating expenses excluding employee expenses	-91,551	-88,416
OPERATING SURPLUS/(DEFICIT)	**16,946**	**-4,751**
Non Operating Expenditure	-3,290	-3,313
Surplus /(Deficit) for the period/year	**13,656**	**-8,064**
Operating surplus/(deficit)	**16,946**	**-4,751**
Add back depreciation and amortisation	8,282	10,008
Add back all I&E impairments/(reversals)	0	0
Less donations of physical assets and peppercorn leases (non-cash)	0	0
Less cash donations / grants for the purchase of capital assets	-14,137	-700
EBITDA	**11,091**	**4,557**
Income relating to EBITDA	**298,298**	**282,114**
EBITDA percentage	**3.72%**	**1.62%**

There remain three key areas of further work –

1. Further System discussions on the planned System distribution of Elective Recovery Funding.

2. Closure of the current planning gap in relation to efficiency savings (programme of £8.3m, risk adjusted planning gap of £3.3m).

3. There remains further work on prioritisation of the developments put forward by directorates. Currently £2m is allocated in the planning model for this.

The above has been discussed in further detail at Senior Management Team and Resource Committee. It is expected that the conclusion of the above discussions will move the Trust to a break even position, in line with regulatory requirements. There does remain a level of risk related to this that will be articulated in Risk Registers, alongside the risks of not proceeding with some of the developments put forward by directorates.

The Board of Directors is asked to note and discuss the above. The Board of Directors is also asked to approve the operational budgets that underpin the above financial plan.

Board of Directors (Public)
30th March 2022

Title:	Operational Performance Update
Responsible Director:	Chief Operating Officer
Author:	Chief Operating Officer Deputy Director of Performance and Informatics

5.5

Purpose of the report and summary of key issues:	*To inform the Trust Board of the month 11 position regarding operational performance*	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	✓
	BAF3.5 To provide high quality public health 0-19 services	✓
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	CRR44- ED 4 hour Standard, CRR41- RTT	
Report History:	*None*	
Recommendation:	It is recommended that the Trust Board note the items contained within this report.	

Trust Board - Operational Update

March 2022

Matt Shepherd
Deputy Chief Operating Officer

Operational Update March 2022 (February Performance)

Matters of concern & risks to escalate

- COVID admissions continued throughout February with inpatient numbers remaining at a consistent level (mid twenties).
- Cancer 62-day performance improved in February but remained below the standard at 81.6%, with longer waiting patients receiving treatment
- Non-Elective demand remains a challenge and the Trust continues at full capacity (100%+ bed occupancy)
- Demand for new outpatient ECHO test has increased by 40% based on 2019 demand *(5.3)*
- 4-hour ED performance – February performance reduced to 65.6%, significant bed pressures impacting on flow, continued increase in presentations, 10% above 2019/20 levels. *(5.6)*
- 37 x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)
- 14 x 60-minute ambulance handover breaches in February

Major actions commissioned & work underway

- New working agreement with the Duchy, c.800 cases agreed to IPT in 2022/23
- Duchy pathways to support diagnostics under exploration
- ED Business case has been presented and work is progressing
- External independent operational review of ED processes taken place

Positive news & assurance

- Two week wait cancer performance – improved position and just below the standard, 92.5% against the 93% standard *(5.1)*
- Cancer 31-day wait target achieved at 99% *(5.1.2)*
- Cancer 28 days faster diagnosis 79.5%, above the 75% standard (5.*11)*
- Continuing to support LTHT and YTH with Endoscopy demand c.175 patients per month
- PIFU identification mechanism implemented
- Continued to support York District Hospital with acute patient diverts when required and able to support
- NHSE/I meeting regarding ambulance handover – Harrogate process to minimise delays praised and continued low ambulance delays recognised.

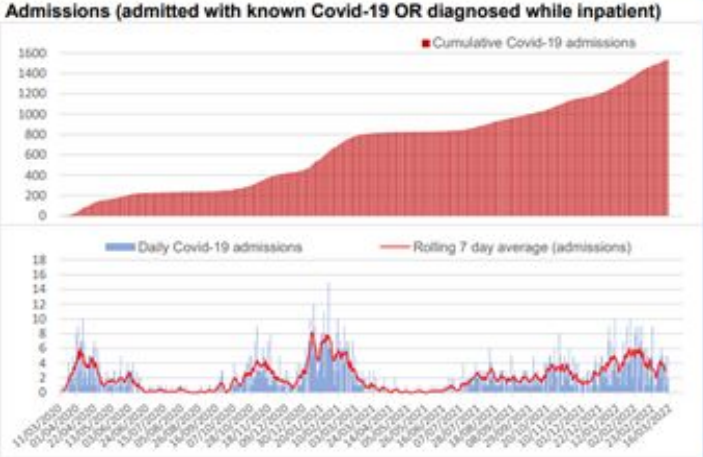
Decisions made & decisions required of the Board

- Orthopaedic LLP Trial agreed (50 cases)
- Activity plans submitted for 22/23 – would attract between £7-8m extra revenue on fair share allocation, includes 8% efficacy growth on 2019 figures.
- TIF2 submission complete for new theatre build (£14.9m)

COVID-19 Management Report

Inpatients with confirmed Covid-19 (NHSE Daily Sit Rep)

Admissions (admitted with known Covid-19 OR diagnosed while inpatient)



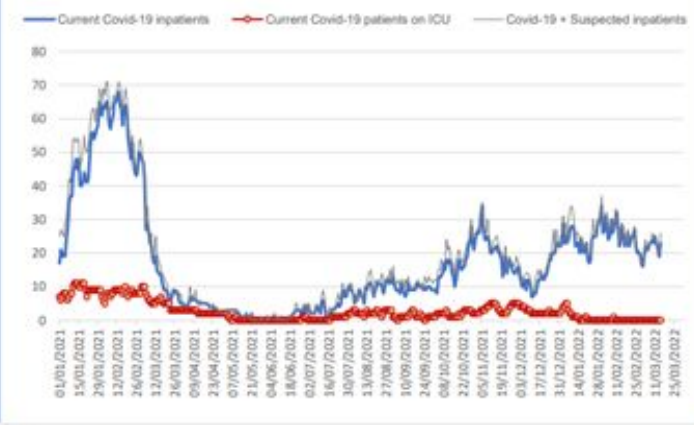
Yesterday **5**

To date **1541**

Last 7 days **21**

8-14 days ago **29**

Current Covid-19 inpatients



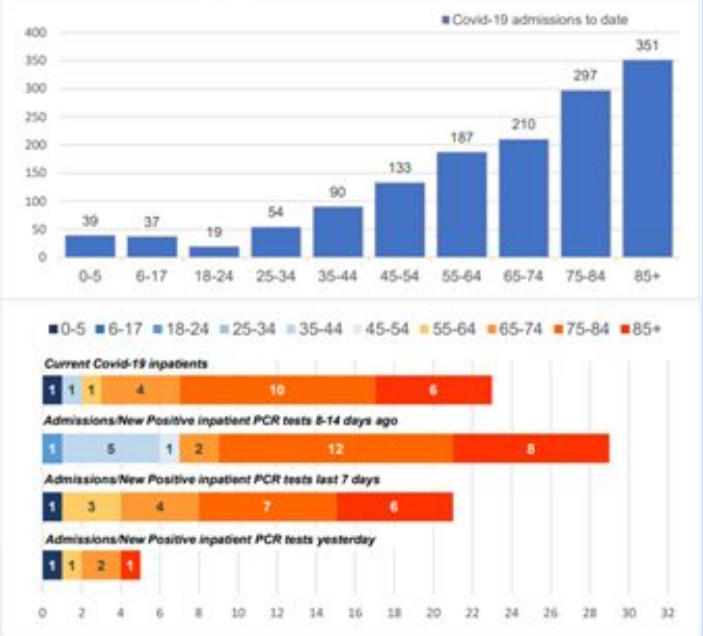
Today **23**

Yesterday **19**

7 days ago **23**

14 days ago **17**

Covid-19 admissions by age

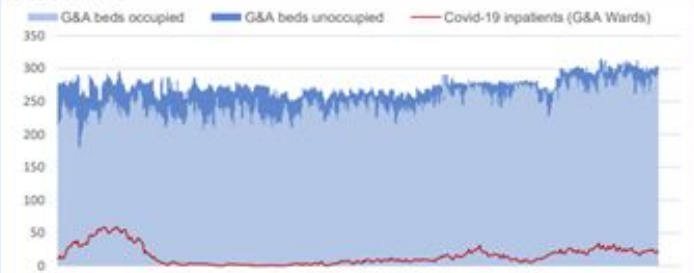


Today

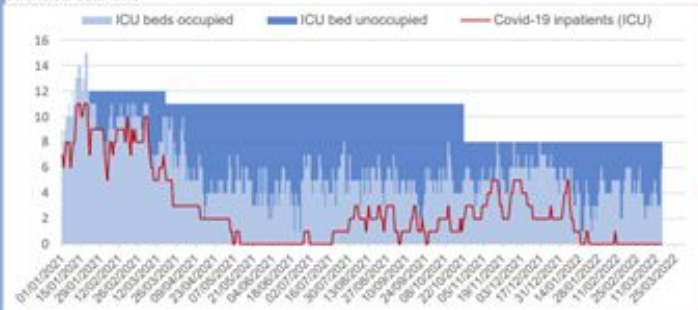
0-5	1
6-17	0
18-24	0
25-34	0
35-44	1
45-54	0
55-64	1
65-74	4
75-84	10
85+	6

Bed occupancy

Adult G&A wards



Intensive Care Unit



G&A (Adult)
% occupied
96.0%
% Covid-19
7.9%

ICU
% occupied
75.0%
% Covid-19
0.0%

% Covid
(Adult G&A + ICU)
7.7%

Planned Care Recovery – H2 Plan

H2 Activity Plan - HDFT

Outpatients

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) Plan	10	10	214	214	214	290
Actual	10	10	389	404	299	
Consultant-led first outpatient attendances (Spec acute) Plan	4,435	4,653	4,189	4,809	4,285	4,185
Consultant-led first outpatient attendances (Spec acute) Actual	4,434	5,214	4,176	4,343	4,360	
Consultant-led follow-up outpatient attendances (Spec acute) Plan	8,747	9,242	8,131	9,780	8,375	9,702
Consultant-led follow-up outpatient attendances (Spec acute) Actual	9,101	10,042	8,637	9,297	8,851	

Elective Admissions

Total number of Specific Acute elective spells in the period Plan	2,513	2,561	2,292	2,529	2,516	2,605
Total number of Specific Acute elective spells in the period Actual	2,498	2,659	2,401	2,418	2,233	
Total number of Specific Acute elective day case spells in the period Plan	2,332	2,345	2,094	2,318	2,310	2,388
Total number of Specific Acute elective day case spells in the period Actual	2,317	2,497	2,227	2,244	2,081	
Total number of Specific Acute elective ordinary spells in the period Plan	181	216	198	211	206	217
Total number of Specific Acute elective ordinary spells in the period Actual	181	162	174	174	152	

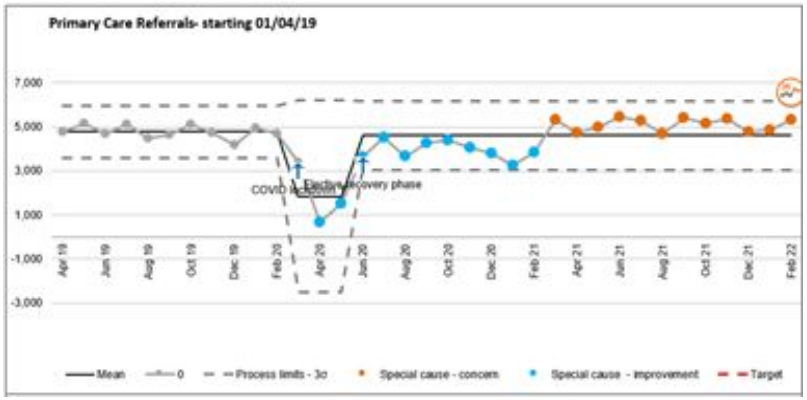
RTT

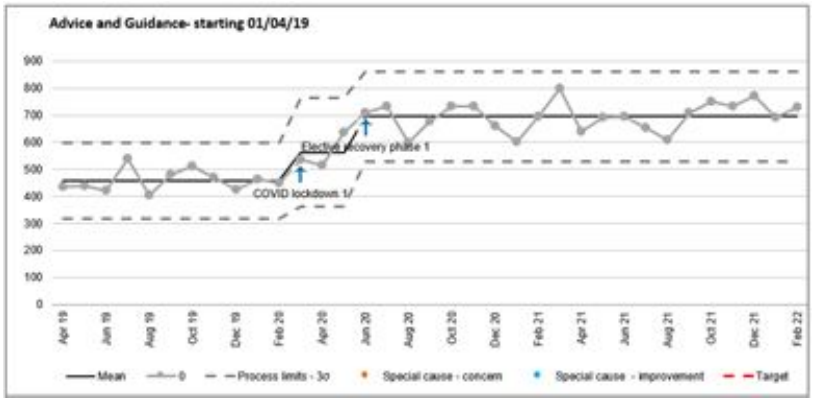
Number of Completed Admitted RTT Pathways Plan	866	972	871	961	956	989
Number of Completed Admitted RTT Pathways Actual	970	1,029	838	930	831	
Number of Completed Non-Admitted RTT Pathways Plan	3,930	4,020	3,563	4,221	3,661	3,822
Number of Completed Non-Admitted RTT Pathways Actual	4,591	5,064	3,818	4,317	3,928	
Number of New RTT Pathways (Clockstarts) Plan	7,466	7,334	5,855	7,023	6,122	6,302
Number of New RTT Pathways (Clockstarts) Actual	7,142	7,718	6,626	6,715	6,913	
The number of incomplete RTT pathways waiting 52+weeks Plan	1,089	1,069	1,049	1,029	1,009	978
The number of incomplete RTT pathways waiting 52+weeks Actual	1,070	1,097	1,177	1,138	1,157	
The number of incomplete RTT pathways waiting 104+weeks Plan	33	33	30	27	14	0
The number of incomplete RTT pathways waiting 104+weeks Actual	33	34	47	52	50	
Incomplete RTT pathways that will breach 104+ wks 31 Mar 22		231	199	132	67	56
Incomplete RTT pathways that will breach 104+ wks 31 Mar 22 with TCI		76	119	72	33	32
The total number of incomplete RTT pathways Plan	22,900	22,500	22,350	22,200	22,050	21,900
The total number of incomplete RTT pathways Actual	22,423	22,714	23,464	23,323	23,900	

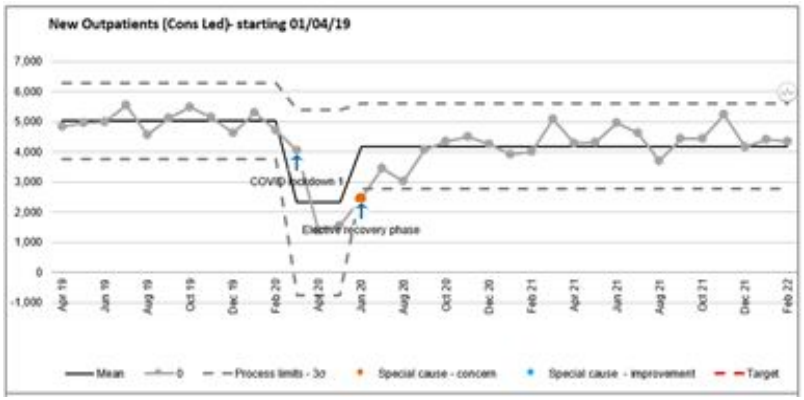
Cancer

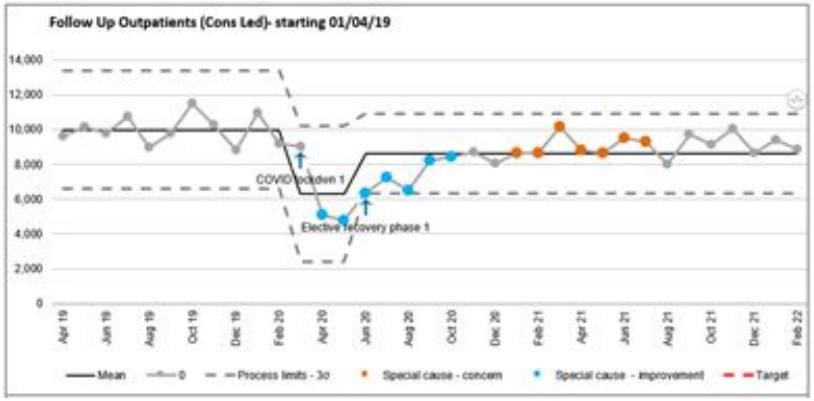
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Plan	46	46	46	46	35	27
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Actual	41	36	29	47	46	

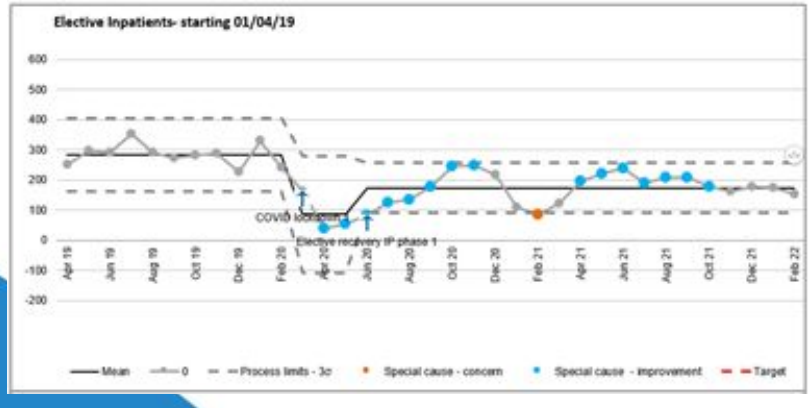
Elective Recovery

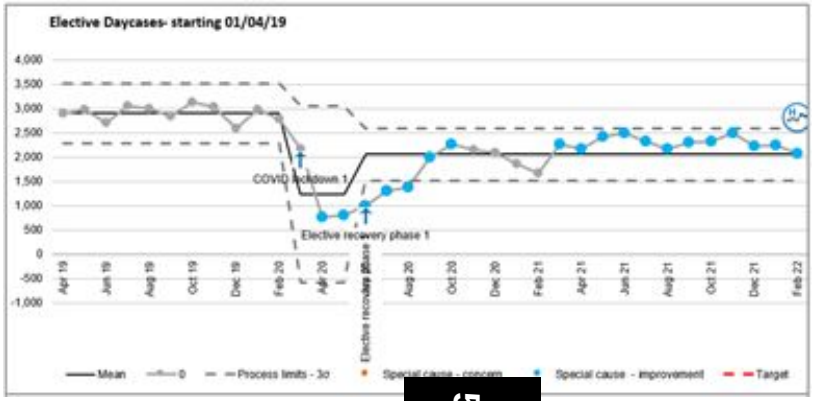




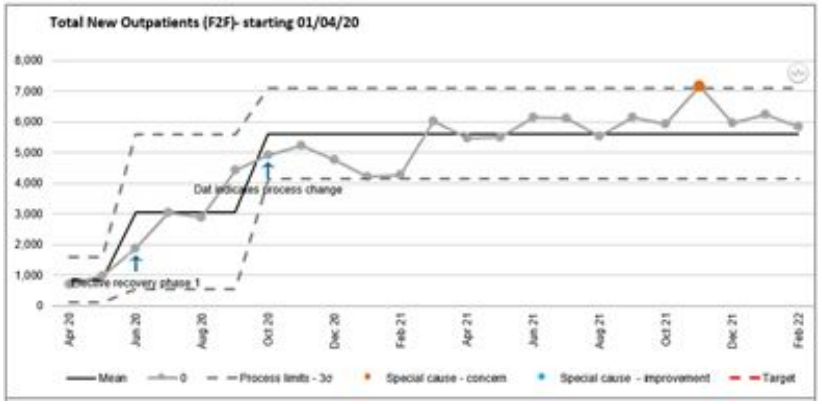


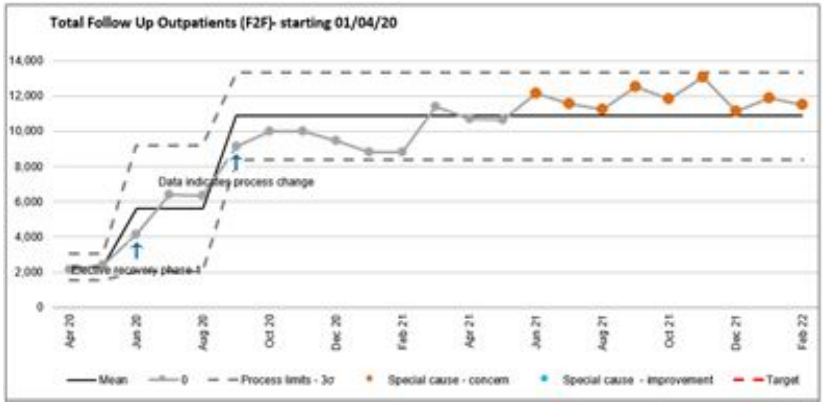


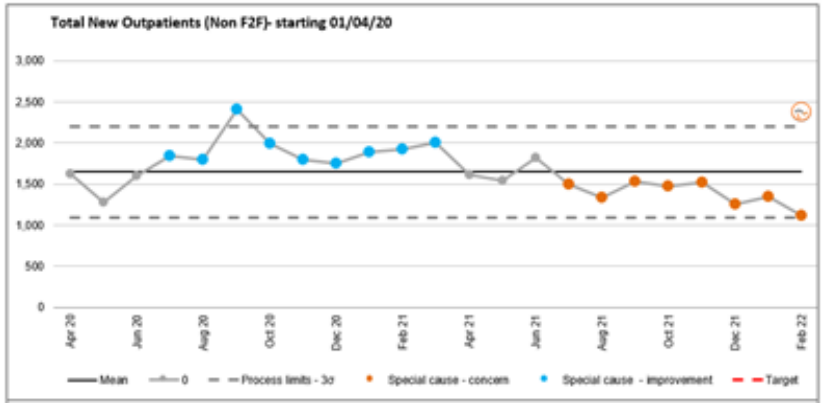


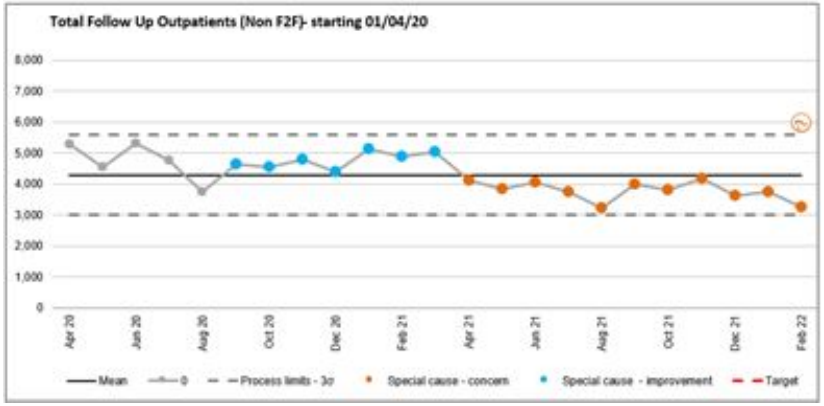


Elective Recovery





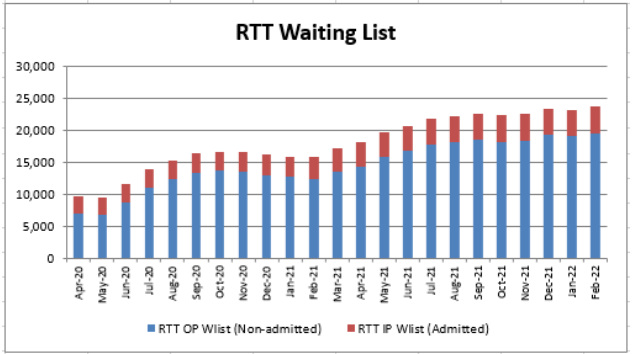


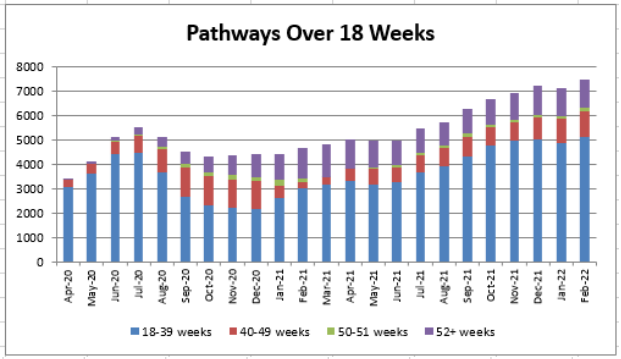


- Elective demand continues to be a challenge with Primary Care Referrals and Advice and Guidance requests both remaining above 19/20 levels.
- Total New and Follow up outpatient attendances in February remained at similar levels to the previous month, however remain above the average. The Trust continues to deliver 90% of 2019/20 attendance levels.
- Elective inpatients and day cases both reduced slightly in February and remain in line with the average.
- Non face to face first and follow up outpatient contacts have remained below the average since the start of the year, an element of reduction was expected following the change in national guidelines in July 2020. Increasing non face to face contacts remains a focus and is part of the outpatient transformation programme that is working closely with services to increase where appropriate.
- Elective theatres staffing remains a significant challenge as a result of vacancies, sickness and self isolation.
- Focus remains on stepping levels of activity back up to 2019/20 levels.

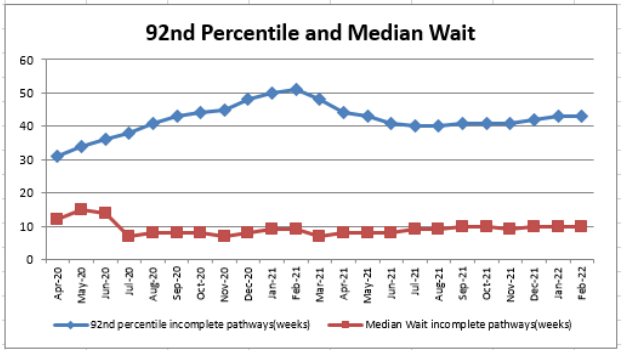
Referral to Treatment (RTT)

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
No. of pathways 18-39 weeks	3,310	3,168	3,255	3,657	3,922	4,336	4,787	4,989	5,035	4,900	5,140
No. of pathways 40-49 weeks	521	666	644	735	748	820	743	748	925	978	1,041
No. of pathways 50-51 weeks	21	62	91	90	127	133	104	119	103	127	135
No. of pathways 52+ weeks	1,201	1,087	1,006	988	955	1,008	1,070	1,097	1,177	1,138	1,157
Total >18weeks	5,053	4,983	4,996	5,470	5,752	6,297	6,704	6,953	7,240	7,143	7,473
Total RTT List	18,182	19,746	20,631	21,785	22,168	22,648	22,423	22,714	23,464	23,323	23,900



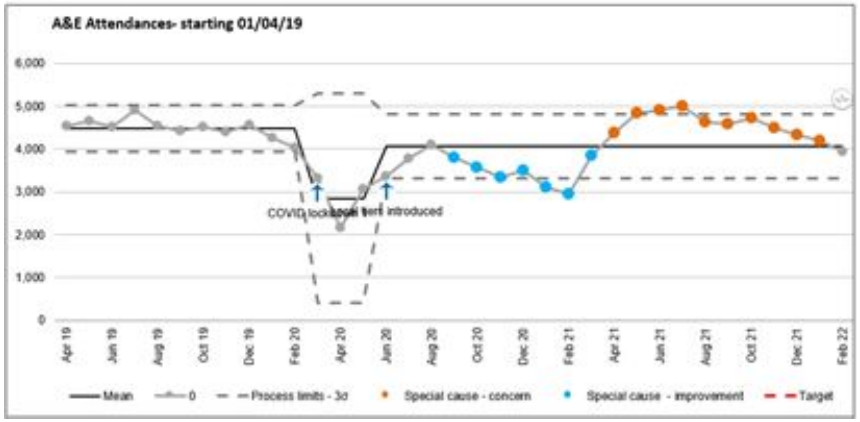


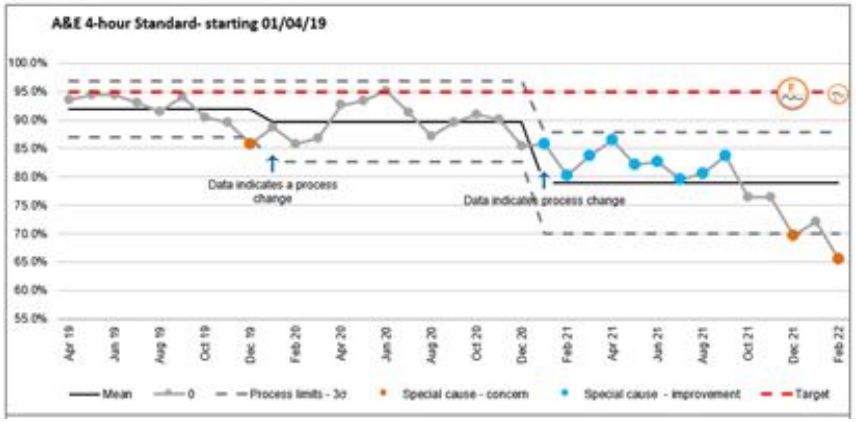
Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	57	0	1	301	304	220	0	19	**902**
3-4	7	0	0	47	148	159	0	5	**366**
5-6	3	0	0	20	95	178	0	6	**302**
7-8	1	0	0	14	65	184	0	4	**268**
9-10	1	0	0	6	43	89	0	2	**141**
11-12	0	0	0	8	25	126	0	4	**163**
13-14	1	0	0	5	38	154	0	2	**200**
15+	6	0	0	5	383	2,152	0	30	**2,576**
Total	**76**	**0**	**1**	**406**	**1,101**	**3,262**	**0**	**72**	**4,918**

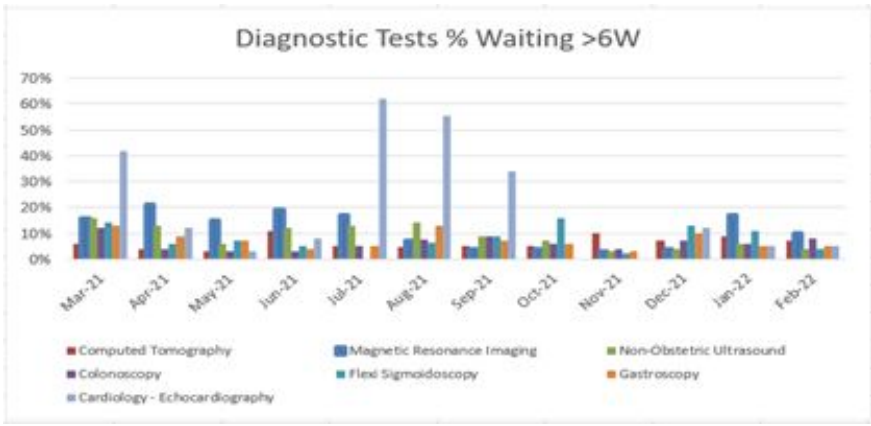


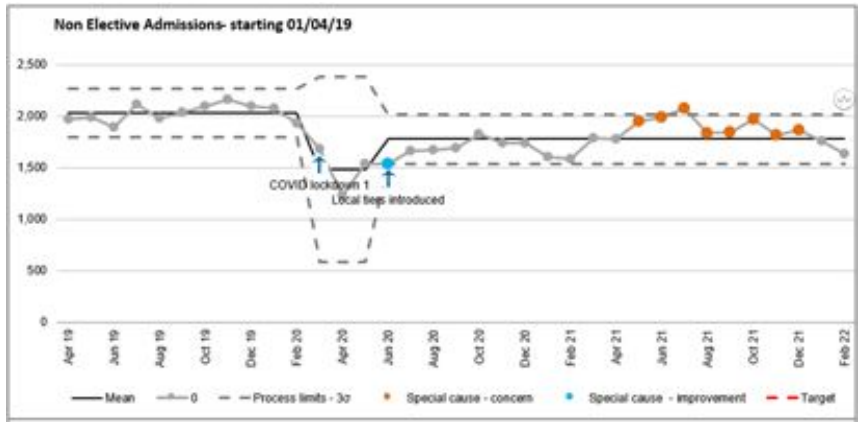
RTT - The Trust had 23,900 patients waiting at the end of January, this is an increase of 577 patients on the January position.
There are 1,157 patients waiting over 52 weeks, this is a **1.6% reduction** on the January position.
The 92nd centile remains at 43-weeks in February and the median wait remains at **10 weeks.**
Of the 4,918 patients waiting for a procedure, 39% are Orthopaedics, 17% General Surgery and 12% Ophthalmology.
Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 98.5% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (57/76) have been waiting <=2 weeks and work continues to ensure these are rapidly coded. 86% of P2 patients have been waiting less than 28-days and there is still a large element of patient choice owing to Covid-19. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

Urgent Care and Diagnostics









- Performance against the A&E 4-hour standard remained below 95% in February at 65.6%. The 95th percentile wait was 10-hours 38-minutes.
- There were thirty-seven 12-hour breaches in February.
- There were 14 x 30-minute handover breaches and 3 x 60-minute ambulance handover breaches in February.
- ED attendances continue to remain above 2019/20 levels, this combined with the high occupancy levels in the hospital makes flow through the department a significant challenge.
- A UEC and ED Performance meeting dashboard enables monitoring of ED flow and performance to increase visibility and is now published to ED teams.
- A live ED dashboard is now in place with screens visible in a number of hospital operational areas.
- Diagnostic waits beyond 6-weeks continue to decrease with focus maintained on reducing the backlog, echocardiography continues to experience staffing challenges, countered with a short term increase in IS support.

A&E Performance - Comparison

Title: A&E Attendances & Emergency Admission monthly statistics, NHS and independent sector organisations in England

Summa A&E attendances, performance and emergency admissions

Period: February 2022

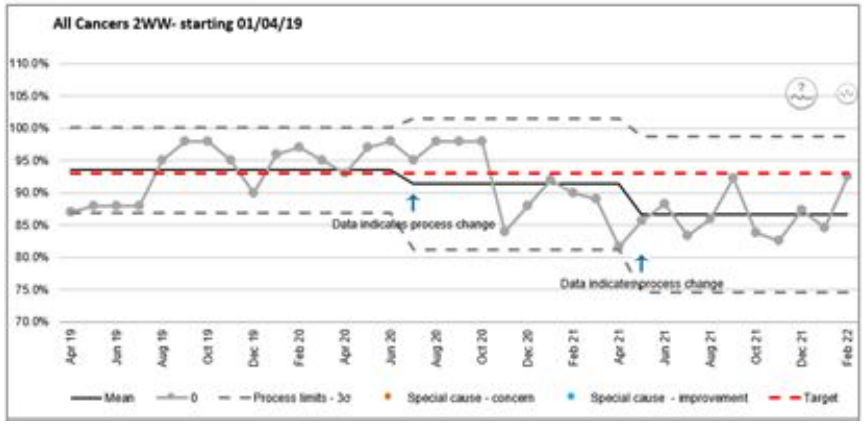
Source: SDCS data collection - MSitAE
Basis: Provider
Publish 10th March 2022
Revised:
Status: Published
Contact Chris Evison - England.nhsdata@nhs.net

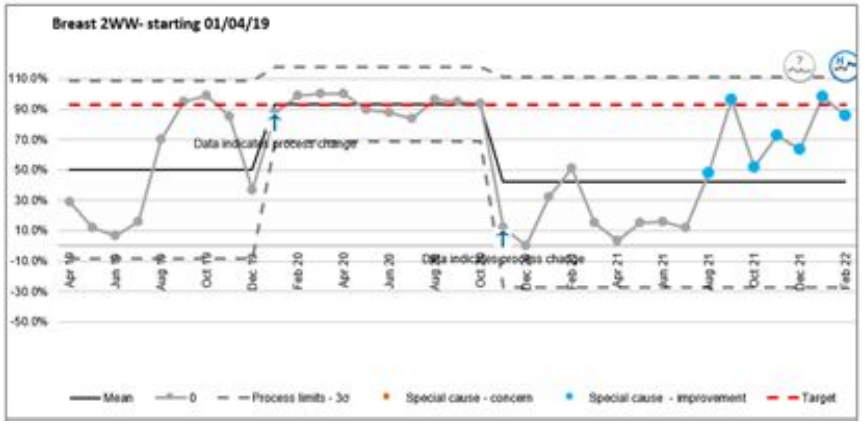
Provider Level Data

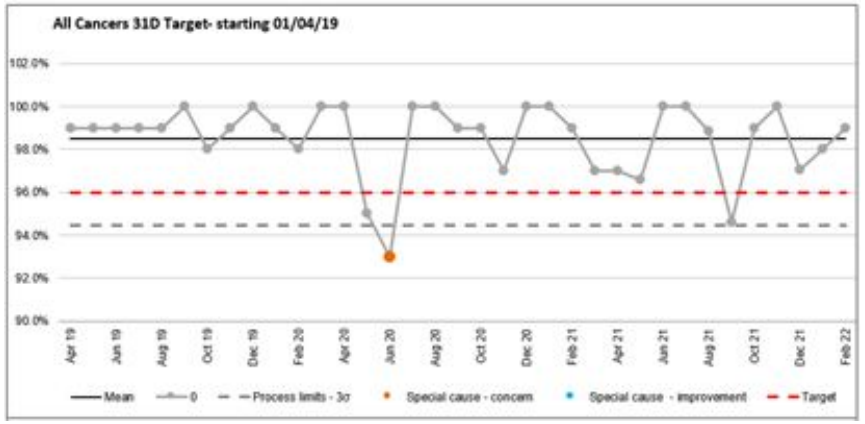
			A&E attendances	Percentage of attendances within 4 hours			Emergency Admissions
Code	Region	Name	Total attendances	Percentage in 4 hours or less (all)	Percentage in 4 hours or less (type 1)	Percentage in 4 hours or less (type 3)	Number of patients spending >12 hours from decision to admit to admission
-	-	England	1,825,362	73.3%	60.8%	96.2%	16,404
RCF	NHS England North East And Yorkshire	Airedale NHS Foundation Trust	5,502	62.4%	60.5%	-	2
RAE	NHS England North East And Yorkshire	Bradford Teaching Hospitals NHS Foundation Trust	10,700	75.5%	73.3%	99.1%	2
RWY	NHS England North East And Yorkshire	Calderdale And Huddersfield NHS Foundation Trust	12,705	73.9%	73.9%	-	1
RCD	NHS England North East And Yorkshire	Harrogate And District NHS Foundation Trust	4,595	65.4%	60.2%	100.0%	37
RWA	NHS England North East And Yorkshire	Hull University Teaching Hospitals NHS Trust	8,683	50.5%	50.5%	-	51
RR8	NHS England North East And Yorkshire	Leeds Teaching Hospitals NHS Trust	24,470	72.2%	56.9%	100.0%	140
RXF	NHS England North East And Yorkshire	Mid Yorkshire Hospitals NHS Trust	19,572	-	-	-	0
RJL	NHS England North East And Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	11,265	64.4%	64.4%	-	307
RCB	NHS England North East And Yorkshire	York And Scarborough Teaching Hospitals NHS Foundation Tru	16,086	71.9%	48.7%	96.8%	583

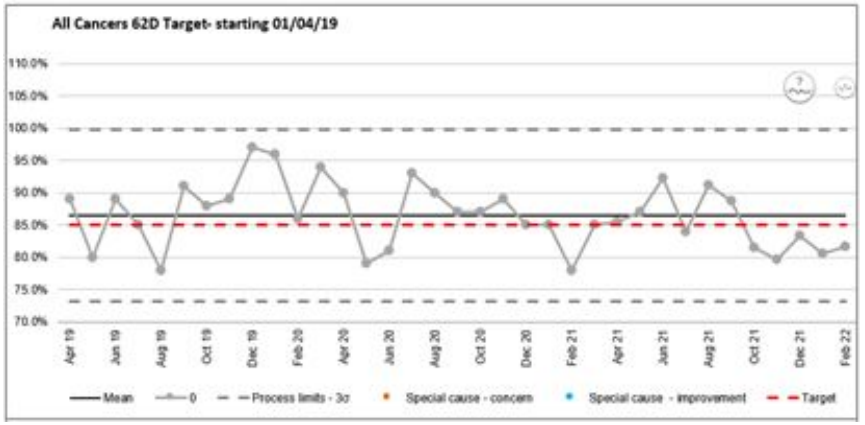
- The table to the left shows the February A&E performance data for HDFT and other Acute Providers in WY&H and HCV ICS'.
- The national performance for the 4-hour standard in February was 73.3% and 60.8% for type 1 -Acute sites.
- HDFT was the second highest performing provider in HCV and fourth highest in WY&H ICS.
- Selby performance is still included in York figures

Cancer Performance









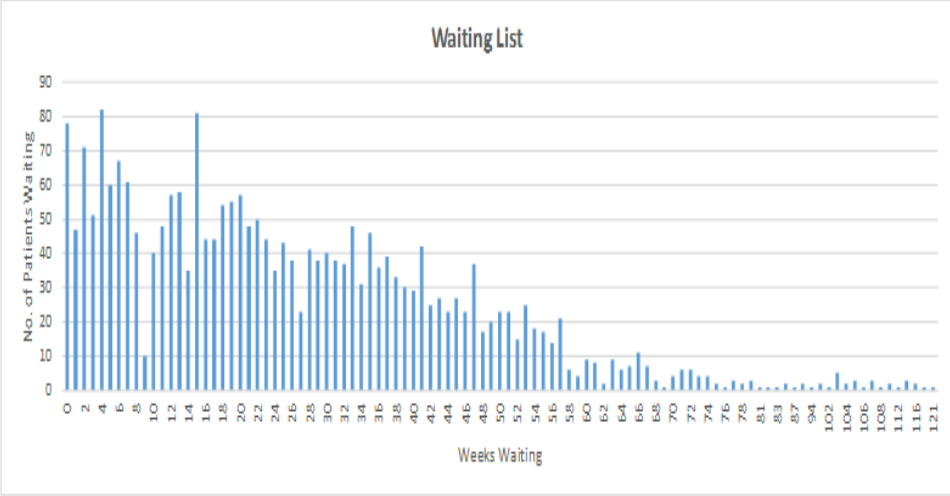
- The 62-day standard was not met in February with a performance of 81.6%
- The 31-day standard was met in February with a performance of 99%
- The 2-week wait standard improved in February, however remained just below the standard with a performance at 93%
- The 2-week wait breast symptomatic standard was met in February with a performance of 85.9%
- At the end of February 46 patients remain on an open cancer pathway over 62 days and 13 patients over 104 days. This remains a key focus, it is also one of the smallest PTL backlogs nationally when adjusted for size. The main tumour site breaching is colorectal; demand and capacity analysis has been completed and actions being taken to address the shortfall. The colorectal pathway has now resumed 'straight to test'.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work to improve the position is now underway including outsourcing work to a private service provider with additional clinics in place.

Children's and Community

Community Dental Services

Number of Patients Waiting	Number Over 104 Weeks
2459	20

Number Over 52 Weeks
255



Community 0-19 Services

Performance Indicator Description	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	92.6%	90.3%	92.3%	**91.7%**	94.0%	92.5%	89.1%	**91.9%**	91.6%	81.6%	93.5%	**88.9%**	92.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.1%	96.0%	96.3%	**96.1%**	97.6%	96.3%	94.3%	**96.1%**	97.0%	95.0%	95.9%	**96.0%**	95.1%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	91.1%	97.6%	97.2%	**95.3%**	93.8%	98.9%	96.2%	**96.3%**	96.2%	97.4%	95.3%	**96.3%**	100.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	96.4%	97.4%	92.7%	**95.5%**	95.8%	94.3%	92.4%	**94.2%**	86.7%	96.6%	94.8%	**92.7%**	92.6%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	89.4%	89.7%	92.4%	**90.5%**	93.3%	90.5%	86.4%	**90.1%**	93.1%	89.4%	94.2%	**92.2%**	88.5%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	96.5%	96.2%	97.9%	**96.9%**	98.8%	99.3%	98.7%	**98.9%**	92.5%	96.4%	98.8%	**95.9%**	98.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Sunderland**	98.9%	99.6%	98.3%	**98.9%**	96.2%	99.6%	99.5%	**98.4%**	98.6%	99.6%	100.0%	**99.4%**	98.3%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Northumberland**									91.7%	93.1%	92.4%	**92.4%**	91.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	82.6%	85.6%	91.9%	**86.7%**	90.9%	90.1%	90.2%	**90.4%**	84.2%	88.3%	92.0%	**88.2%**	87.0%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.1%	87.6%	90.4%	**89.4%**	89.8%	90.0%	87.8%	**89.2%**	89.5%	89.9%	88.1%	**89.2%**	88.0%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.9%	98.8%	**98.5%**	94.9%	97.7%	98.8%	**97.1%**	97.3%	95.1%	95.3%	**95.9%**	95.2%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	97.3%	94.9%	94.1%	**95.4%**	94.2%	96.8%	98.2%	**96.4%**	97.3%	93.8%	95.3%	**95.5%**	96.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	92.9%	94.4%	91.8%	**93.0%**	90.5%	91.9%	93.1%	**91.8%**	87.5%	94.2%	89.1%	**90.3%**	87.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	95.0%	97.1%	97.2%	**96.4%**	95.5%	98.6%	97.2%	**97.1%**	95.4%	95.5%	93.2%	**94.7%**	95.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	97.8%	97.7%	94.5%	**96.7%**	95.9%	97.5%	92.4%	**95.3%**	94.4%	95.9%	94.6%	**95.0%**	96.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Northumberland**									90.6%	87.6%	90.7%	**89.6%**	89.8%

February OPEL Level – 3

Adult Community

Service continues to be very pressured due to increased complexity of caseloads and high vacancy rate, sickness and COVID challenges

Task and finish group established to progress skill mix review, updated recruitment campaign.

Virtual recruitment event took place on the 22 Jan and work progressing on skill mix review, with new Senior Community Nurse job description developed to support pressures in District Nursing and retention of Band 5 community Nurses. Recruitment for these new roles have commenced.

0-19 Service

In line with OPEL 2/3 level the following actions are being taken:

- Non urgent activity paused, cancelled or re-arranged.
- Flexible approach to timelines for mandated contacts introduced.
- Face to face or virtual contacts based on COVID risk assessment, family health needs assessment and cumulative risk.
- Support required from outside of contract area.

Safeguarding

Staff absence from work within the safeguarding specialist team is impacting on capacity within the team.

Demand for safeguarding remains high within 0-19 and specialist safeguarding teams.

Statutory responsibilities still being delivered

Community Dental

Plans in place to link with clinical teams across HCV to embed best practise and teams have scheduled WLI sessions to target long waiters to ensure all dated before end of March 22. All day Saturday lists have commenced. Key risk are those patients that require GA and external anaesthetic support has been commissioned to support additional sessions.

WORKFORCE MATTERS

Matters of concern & risks to escalate

- Demand and capacity imbalance continued during February due to difficulties in recruiting to vacant posts. This impacted upon Recruitment campaigns, occupational health, EDI, HR operations and ER Casework.

Sickness Absence

- Sickness rates still remain high at 5.74%, however sickness levels have decreased in comparison to January's sickness, which was 6.67%.
- Excluding Covid related sickness, the Trust's sickness rate is 3.91% which is just above the Trust's threshold of 3.90%.
- 5.74% is the highest rate of sickness recorded for the month of February compared to previous years, however Covid is a key factor in this figure.

Turnover

- Turnover has increased in February to 14.75% from 14.28% last month.
- Turnover had begun to see a decrease in November 2021, however has risen again in the new year and this month sees the highest level recorded by the Trust in recent years.
- Acute Paediatrics and Theatres are the services with the highest levels of turnover, with turnover rates of 28.54% and 25.64% respectively.

Appraisals

- Appraisals have seen an increase this month to 63.04%, from 56.32% last month.
- The Trust's appraisal rate has not seen this level of compliance since the beginning of the Covid Pandemic and has average 56% over the last 12 months.

Major actions commissioned & work underway

- Theatres Investigation ongoing – draft report shared with PSC Directorate team to develop action plan.
- Terms of Reference being developed for Cultural Review in ED.
- Mandatory Vaccines - The government have confirmed that the revocation of the Mandatory Vaccination requirement for both care homes and the wider health and social care sector will take effect on 15 March 2022. Arrangements are underway to notify staff.

e-Rostering

The project continues with the following aspects to be implemented:

- NHSP Interface – additional training being provided to a wider staff base and rollout continuing April 2022
- ESRgo – Interface with ESR that allows daily system updates – Project commences 23 April with an anticipated 4 month roll out
- Allocate Loop – A new App recently launched that staff can download to their phone, and provides easy access to their rosters and enables them to book leave. This is being demonstrated shortly and a decision made in respect of configuration and implementation timescales

ESR MSS

- The first phase of the ESR Manager Self Service rollout is now complete, with all departments on a non-complex roster who were on RosterPro now implemented on the system. The second phase of the implementation will begin in May 2022 and will see the system rolled out to the remaining departments in the Trust.

Annual Workforce Planning submission

- Work is currently being undertaken within Directorates to identify any changes to workforce requirements for 2022/23. This will be fed into the Workforce Plan submission alongside trends to account for staff movement, including any know recruitment due to commence. The deadline for the first draft of the submission is 17th March 2022.

Positive news & assurance	Decisions made & decisions required of the Board
e-Rostering update The roll out of HealthRoster to areas of the Trust designated to use the system is now virtually complete. The final payroll has been run from RosterPro on Friday 4th March after which the system will be decommissioned. .	

NHS
Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Andy Papworth
Date of meeting:	14th March 2022
Date of Board meeting this report is to be presented	30th March 2022

6.1

Summary of key issues

- Jeremy Cross was thanked for his role in chairing this committee since its inception. With Jeremy moving to Chair the Resources Committee, Andy Papworth was welcomed as the new People and Culture Committee Chair.

- The importance of colleague wellbeing and culture had been referenced strongly in the recent Board workshop.

- The committee received a comprehensive update on the People Plan, which included a summary of the latest staff survey results:
  - Response rate of 39% (1651 colleagues), albeit below median benchmark of 46%.
  - Positive impact from the work on culture: line managers listening to concerns, colleagues treating each other with kindness and respect, and colleagues feeling valued / part of a team.
  - Areas to focus on: feeling that there is sufficient staffing and resources, time to do the job well, support to develop and progress and overall morale (the lowest score).
  - A full communication and action plan will be progressed. We should think about how to involve members of the colleague panel in this work.

- We covered elements of the People Plan, which show good progress.
  - Ongoing recruitment of roles to support occupational health and wellbeing.
  - Progress to 'root out racism'.
  - NHS Rainbow accreditation.
  - Menopause accreditation and a new network.
  - Roll out of Health Roster, which we will consider for community teams.
  - Leadership development – 2 weeks of protected time on a programme for all managers which will include 'leading at our best', supporting wellbeing through Thrive, and equality, diversity and inclusion training.

- We were informed that the legislation to make vaccination a condition of deployment has been revoked.

- The Committee reviewed the latest People Metrics:
  - Sickness levels are still relatively high, albeit reducing. The importance of supporting colleagues to return to work was discussed.
  - Turnover also remains high, and a recruitment and retention working group will review the actions around this.
  - The reported completion rate for Thrive conversations remains very low at 4%. There is a strong belief that Thrive conversations are a main gateway to supporting colleague wellbeing and we discussed actions to address the low take up, including senior leader role-modelling and making sure the reporting is accurate.
  - Non Execs queried a target of 7% for disability disclosure and this will be looked at.

- There was a useful discussion on violence and aggression within the Emergency Department. Incidents (based on Datix) have reduced since last summer (31 in July 21 vs 8 in Dec 21), however, other feedback obtained suggests, despite the comprehensive action plan, some colleagues still don't feel safe. A review of the action plan will be undertaken and brought back to our next meeting.

- The Committee reviewed progress against the Culture plan, again with good progress across the range of actions.

- The Committee received updates from some of the colleague networks:
  - Lisa McCabe is stepping down as Chair of the BAME Network but will continue as an active member. Lisa was thanked for her fantastic work and contribution. Lisa and Shirley described the arrangements that are being made to support colleagues observing Ramadan and to celebrate Eid.
  - Robyn Precious is stepping down as Chair of the LGBT+ Network. Again Robyn was thanked and will continue as an active member.

- Due to apologies of attendance, we were unable to receive updates this time from the Disability and Long Term Conditions Network, and the FTSU Guardian. These will be picked up in our next meeting.

- Jane Tasker joined the meeting to talk about current experience as a colleague in the 0-19 service. Jane described how busy colleagues are, with some long hours being worked due to demand on the service and covering (e.g. where there are vacancies or for sickness including Covid). Jane also described huge pride in the teams' work and fantastic support from the locality management, which meant colleagues feel valued. In addition, there was a culture of openness, kindness and listening to colleague suggestions for making improvements. One suggestion from Jane was to review the mileage rate given current fuel prices. Jane felt able to raise any concerns with local and directorate management. Committee members commented on the

importance of good line management, team work and communication, and thanked Jane for her positive feedback.

- Finally, we received and discussed the results from the second Inpulse survey, which focused on kindness. In summary:
  - Response rate of 20% (1026 colleagues vs 668 last time) with aim to improve this going forward.
  - Engagement of 65% (versus 53% last time).
  - Interestingly, the most engaged colleagues on average are those who have been with the organisation <2 years (73%) or more than 30 years (70%).
  - Some measurable positives for culture: colleagues being themselves at work at 77% (vs 66% last time), positive emotions at 44% (vs 36%) and 98% of colleagues saying we take opportunities to display kindness. Also, recommending HDFT as a place to work 56% (vs 47%), happy with standard of care 70% (vs 60%), making improvement suggestions 72% (vs 65%), and looking forward to going to work 51% (vs 41%)
  - 50 teams are able to see their team level data (vs 29 last time) - this is important as the power of Inpulse is in the teams having their own data and taking any necessary action.
  - Areas for improvement triangulated with the National staff survey and discussion earlier in our meeting, namely: 1. frustrations about workload and long hours; 2. resources (technical, physical and people); and 3. line manager support. There is a strong sense that more is needed around health and wellbeing support with only 50% saying the support provided is sufficient and this being the biggest negative (21%) in the feedback.
  - Individual teams will own their actions, and People and Culture Committee will continue to monitor themes and progress. Non Execs commented on the particular usefulness of this more real time data and that colleagues should be encouraged to share best practice where things are working well, so that learning can be applied to help departments where there is scope for improvement. The next survey will focus on Integrity.

Any significant risks for noting by Board? (list if appropriate)

- No new risks or items for escalation to the Board were identified. Ian Barlow, our Governor observer commented on a positive meeting, with good detail and discussion.

Any matters of escalation to Board for decision or noting (list if appropriate)

- As well as the follow up actions, at our next meeting we will take a deep dive review of the Employee Assistance Programme (EAP) offering.

Integrated Board Report - February 2022

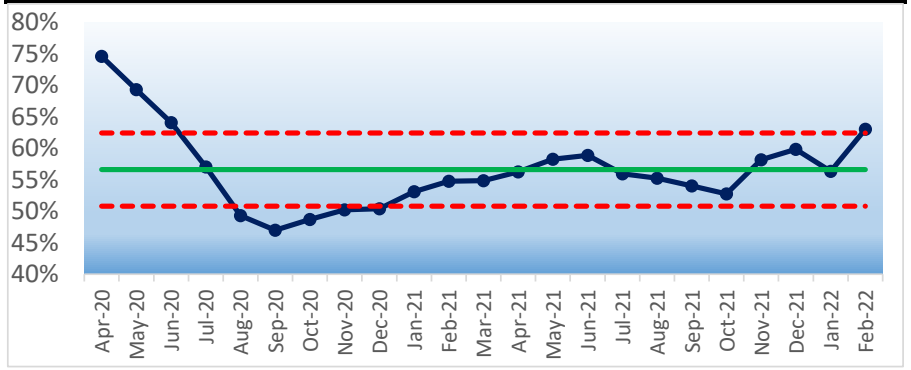
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-22
Value / RAG rating	63.0%

Indicator description

The number of staff who had an appraisal within the last 12 months. The Trust aims to have 90% of staff appraised.

SPC chart



Narrative

The appraisal rate in February is 63.0%, which is an increase from January (56.3%). This is this Trust's highest level of compliance for appraisals seen since the beginning of the Covid Pandemic, which has averaged 56% over the last 12 months.

- Non-Medical appraisal % = 62.8% (previous month 55.2%)
- Medical appraisal % = 66.0% (previous month 68.0%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-22
Value / RAG rating	85.0%

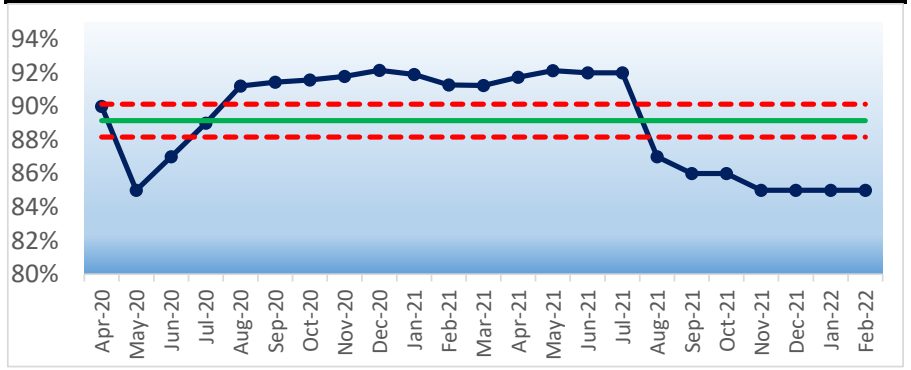
Indicator description

Latest position on the % of substantive staff trained for each mandatory training requirement

Narrative

The data shown is for the end of February. The overall training rate for mandatory elements for substantive staff is 86% and has increased by 1% since the previous month.

SPC chart



Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-22
Value / RAG rating	5.7%

Indicator description

Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%.

SPC chart

Narrative

Sickness rates still remain high at 5.7%, however sickness levels have decreased in comparison to January's sickness, which was 6.7%. Excluding Covid related sickness, the Trust's sickness rate is 3.9%, in line with the Trust's threshold.

Both long term and short term sickness has seen a decrease in February. "S15 Chest & respiratory problems" is the top reason for sickness in February and this reason equates to 34% of the overall sickness in the month. This is the sickness reason used for recording Covid related sickness.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-22
Value / RAG rating	14.8%

Indicator description

The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%.

SPC chart

Narrative

The Trust has seen an increase in turnover this month from 14.3% to 14.8%. This remains below the Trust threshold of 15%. The breakdown of turnover in January is 3.3% due to involuntary terminations and 11.5% due to voluntary terminations.

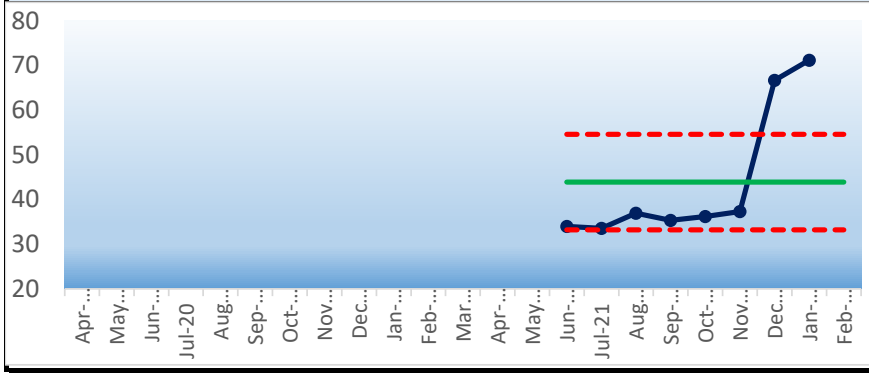
All Directorates have seen an increase to turnover in February. The 'Additional Clinical Services' staff group has seen a further increase to turnover this month and remains the staff group with the highest turnover rate, which is 17.4% in February.

Indicator	**4.5 - Children's Services - 0-19 Services - vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jan-21
Value / RAG rating	71.17

Indicator description

The chart shows the total number of vacancies across all localities of the Trust's 0-19 Children's Services. This data is provided a month in arrears.

SPC chart



Narrative

Vacancies of Health Visitors and School Nurses within the 0-19 Children's service have increased further in January to 71.17 wte. The 0-19 Children's service is holding monthly workforce meetings and has an action plan in place to reduce the number of vacancies and ensure they do not rise. Recruitment Events to continue to mitigate vacancies. The next event will take place in March.

Indicator	**4.6 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**4.7 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

OD MATTERS

Matters of concern & risks to escalate

Thrive wellbeing conversations
The compliance rate for Thrive wellbeing conversations is 4.8%. Work is underway to raise the profile of compliance levels within Directorates and to deliver a promotional campaign around the benefits of Thrive, how to hold a conversation and how to record these.

Medicines Management Mandatory Training
Compliance levels with Medicines Management Mandatory training have fallen below 50%. A recovery plan has been developed, but is taking longer than envisaged to enact. This includes moving the delivery of training to a digital platform rather than face to face. Due to the lack of urgent reaction this has now been placed on the HR Risk Register.

Gap in EAP provision due to length of process for sign-off of OH business case
Due to the lengthy process for the sign-off the OH Business Case to enable the continuation of resources that were provisioned through COVID funding, there will be no EAP provision for a period of time, as our existing contract ends in March, and no further funding has yet been agreed. This provides a risk to colleague wellbeing, and guidance will be provided to ensure that alternative routes of support are known about and accessed.

Rising petrol/diesel costs and impact on colleague wellbeing
We are currently gathering soft intelligence to assess the impact of rising fuel costs on colleagues, and will be working with our partnering Trusts and ICS and Trade Union colleagues to lobby government increase the mileage allowance. CC Directorate colleagues are mainly affected, and the leadership team are aware and in discussion with colleagues about their concerns.

Major actions commissioned & work underway

Staff Support Networks
- Work is underway to develop a guide to setting up and running a staff support network. This will help with developing the maturity of our networks. 2 of our network chairs – LGBT+ and BAME have taken the decision to step down, and we will shortly begin the internal recruitment process for new chairs.

Preparations underway to provide support to colleagues who observe Ramadan – 1st or 2nd April
- Planning is taking place to put arrangements in place to support colleagues who observe Ramadan. This will include the provision of snacks out of normal catering hours for when breaking fast, washing facilities, prayer facilities and a special menu to celebrate Eid. An email is to be sent to all line managers reminding them of the requirements of colleagues observing Ramadan and the responsibilities we have as an employer to support this.

National Staff Survey results
The national staff survey results have been released, however these are under strict embargo until 30 March 2022. A communication plan has been developed to enable the sharing of these results and initiation of action planning and implementation of changes to address the outcomes of the survey. These results are to be triangulated with the quarterly Inpulse survey results to enable us to measure progress and improvement. The communication plan is included in the Board pack.

OD MATTERS

Matters of concern & risks to escalate

Major actions commissioned & work underway

Leadership Journey

- The proposal for colleagues with line manager responsibilities is to be given 2 weeks of protected time over the 12 months to complete the Leading At Our Best is detailed below:

Following the induction process listed above (excluding being at our best), managing colleagues will complete:

1-3 months

- Pathway to management training
- Wellbeing/mental health awareness training
- Setting expectations and objectives
- All At our best e-learning modules

3-6 months

- Quality Improvement – Silver level training
- Equality, Diversity and Inclusion Training

6-12 months

- First Line Leaders (to be renamed) sessions 1-6, session 7 3-6month after reflection session
- Peer to Peer Action Learning Sets
- Re-visit expectations and objectives

Ongoing development of colleagues and managers after first year on the leadership journey

Ongoing leadership development pathway

Continued Peer to Peer support

Ongoing Peer to Peer Action Learning Sets

Access to NHS Elect e-learning and webinar packages

OD MATTERS

Matters of concern & risks to escalate	Major actions commissioned & work underway
	• **Tender process for new EAP (funding dependent)** We are currently running a process to interview 3 EAP providers as alternatives to our existing provider, as we believe that there are better providers in the market. Providers being seen are: Vivup • Financial wellbeing information on Living at our Best We are reviewing the provision information on how to get support for managing finances, and building relationships with a credit union, money advice service, running savings challenges. Our procurement of the EAP will include this as part of the criteria. • Menopause accreditation We are progressing towards achieving our menopause accredited status. • Rainbow badge accreditation Work is progressing with our assessment against the rainbow badge standard. • RPIW – Mandatory Training An RPIW has been commissioned to provide a review of mandatory training, which will commence in April 2022. This to review the elements of training that are mandatory. • RPIW – HR workflow and internal KPI This is at the early stages of planning to develop improved processes around managing workload management, standardisation and performance management of HR Processes.

OD MATTERS

Positive news & assurance

Recruitment to Clinical Lead for Schwartz Rounds
Helen Law has stepped down as Clinical Lead for Schwartz Rounds due to her pending retirement. I am delighted to announce that Lisa McCabe has been successful in securing the role and will take over from 1 April.

Launch of Menopause Staff Network
In line with our Menopause Accreditation programme we have launched our Menopause Support Staff Network. Lorraine Dyson has agreed to be the Chair of the network, and Shirley Silvester is the Executive Sponsor.

Celebration of International Women's Day – 8 March
The theme of this day was 'breaking the bias' We marked this day on TeamTalk on Monday 7 March, with a fabulous video from Charlie Talbot around supporting women in medicine and the launch of our menopause support staff network.

Decisions made & decisions required of the Board

EDS2 Project proposal

- Diverse Mckenzie are to present their approach to making an assessment of the Trust against the EDS2 standard to an additional SMT workshop

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Richard Stiff
Date of meeting:	1st February and 8th March 2022
Date of Board meeting this report is to be presented	30th March 2022

Summary of key issues

The Committee met on both occasions via Microsoft Teams and was well attended. The February meeting welcomed Helen Higgs to her first meeting in her new role as MD of Audit Yorkshire and HDFT Head of Internal Audit following Helen Kemp-Taylor's retirement. Steve Treece observed the 1st February meeting on behalf of the Council of Governors. At the 8th March meeting Tom Watson was thanked for his service as Internal Audit Manager at the Trust on his departure for a new role away from Audit Yorkshire. Mr Watson's successor at Audit Yorkshire is Mrs Kim Betts who will start with the Trust on 1 April.

1st February 2022

Matters considered included –

- **The Corporate Risk Register & Risk Review Meetings -** The Committee received an update on the management of corporate risks together with recent minutes of the Risk Review Group. It was noted that a number of risks have had the dates for the achievement of target ratings extended. It was reported that the Executive Risk Group is to consider adding corporate risks regarding in relation to data quality and themes and issues emerging from SI investigations and reports.

- **Quality Committee Minutes -** The chair of the Quality Committee spoke to the minutes of the November meeting. The meeting had discussed moderate harm incidents and 12-hour ED waits.

- **Gifts and Hospitality -** a report on the Trust's register of gifts and hospitality was received. It was not clear as to whether the register presented a complete picture across the Trust. Although it was confirmed that nil returns are requested the items recorded seemed relatively few given the scale of the Trust's workforce. Further clarification was requested as to whether

declarations were recording payment received or the notional cost of an event attended.

- **Accounting Policies and Plans for the Annual Report and Accounts –** A brief verbal update was received as the delivery of the anticipated papers had been delayed by Covid absences in the Finance team. The item was deferred to the March meeting.

- **Internal Audit Reports –** The Committee received a report setting out progress on the completion of the 2021/22 audit plans for HDFT and HIF. The plan for HDFT has slipped further due to sickness absence in the audit team and amongst service staff. "Must do" audits are being prioritised as is 2021 with major reviews expected to be completed. Completion of the 2021/22 programme by the end of Q1 in 2022/23 was suggested giving rise to some concerns about the delivery of the 2022/23 programme being impacted. Two IA reports were received, Corporate Governance: providing significant assurance and Research Governance providing only limited assurance. It was noted that all recommendations had been accepted by management and action plans were in place to address all recommendations.

- **Implementation of outstanding Audit Recommendations** - The number of incomplete audit report recommendations continued to be a cause for concern although at a lower level than previously.

- **Appointment of External Auditors -** The committee received an update on the procurement of external audit services. It was anticipated that an update on this procurement would be provided to the Council of Governors meeting in March.

8th March 2022

The meeting began with the regular private meeting with the Head of Internal Audit and Audit Manager. Jordan McKie was welcomed to his first meeting as Acting Finance Director. Matters considered in the meeting proper included –

- **The Corporate Risk Register & Risk Review Meetings –** There was discussion of the reduced risk rating allocated to safeguarding pressures and its removal from the Corporate Risk Register, risks related to violence and aggression and pressures in 0-19 services were also discussed.

- **Quality Committee Minutes -** The chair of the Quality Committee spoke to the minutes of the November meeting. There had been a good presentation and discussion on safeguarding pressures at the last meeting.

- **Fitness to Register with the CQC –** The position of the Acting CEO as registered officer for this purpose was noted. "Fitness" would be considered

by the Quality Committee with the September Audit Committee assessing assurance around the decision making process.

- **Gifts and Hospitality –** The Committee received an update on the development of the software used by staff to declare/approve declarations. Information was provided on the issues raised at the February meeting. A further update was requested for the May meeting.

- **Year End Financial Processes –** The Committee noted the proposed timetable for the preparation of year end statements. There were no material changes in accounting policies to consider. The Committee received a report setting out "significant issues" likely to feature in the accounts including continuing uncertainty associated with the so called "Flowers case" relating to leave entitlements, annual leave accruals arising from Covid working arrangements and the current revaluation of the Trust's estates.

- **Quarterly Procurement Report –** The Committee received and considered a quarterly procurement report. An estimated saving in excess of £460k had been achieved through collaboration on procurement in the year to date. The Committee noted the withdrawal of all other WYATT members from the North of England Procurement Collaborative – a more extensive northern purchasing consortium - but was assured that HDFT's continued membership of the organisation would continue to provide benefits to the Trust.

- **Counter Fraud Plan 2022-23 –** The Committee considered and approved the Counter Fraud plan for the year ahead. It was noted that an additional 5 days would be funded by the Trust to support work need to ensure compliance with new national standards introduced in 2021. The plan included proposals for an "awareness review", better connection with Freedom to Speak Up arrangements and additional work on cyber security in partnership with the IT team. New approaches to gathering feedback from staff would also be developed.

- **Internal Audit 3 Year Strategy and Operational Plan for 2022-23 –** The Committee received and approved both the 3-year strategy and the audit plan for the year ahead. The annual plan included mandated audits linked to regulatory requirements and/or the preparation of the annual Head of Internal Audit Opinion as well as those requested by Executive management, arising from previous Audit outcomes or from the Committee's work. It was noted that the developing risk management approach had contributed significantly to the development of the annual plan. The Committee asked for data quality considerations to form a specific element of work planned on key indicators such as RTT, A&E waits etc.

- **Internal Audit Progress Report –** The Committee received and noted the latest IA update report. Three reports providing significant assurance were received – Procurement, Clinical Waste Follow-up and Timely Notification of

Deaths. Remaining audits were scheduled to completed by the end of May 2022. Committee members expressed concern about the possible impact on the 2022-23 programme of late work on 2021-22 audits spilling over into the new audit year. The Head of Internal Audit indicated that it was unlikely that her formal opinion would be negatively impacted by failure to deliver outstanding IA work.

- **IA Recommendations –** The Committee had been paying close attention to overdue IA recommendations for some time. The latest report showed that there had been significant progress in addressing this issue, although a number of seemingly "stuck" recommendations remained.
- **HIF IA Progress Report –** No reports were made available to the Committee at this meeting. Staffing issues in the HIF management team and some ill-health absence in the IA team had contributed to this. The IA Manager and HIF management were collaborating to address the backlog of audit work and progress was expected.
- **External Audit –** The Committee received a verbal update on the procurement of an external audit provider.
- **Post Project Evaluations –** A report was received and noted. The PPE process was beginning to function at an appropriate level following a hiatus at the peak of the pandemic.
- **Single Tender Actions –** No reports were provided at the meeting.

The Committee will meet next on 25th April 2022. Additional informal meetings related to the year end process will be called as required.

Any significant risks for noting by Board? (list if appropriate)

Matters related to the appointment of an external audit services provider.
The continuing and growing threat to all NHS organisations from cybercrime.

Any matters of escalation to Board for decision or noting (list if appropriate)

None.

Report to the Board of Directors from SMT meeting

Name:	SMT
Chair of committee:	Jonathan Coulter
Date of last meeting:	23rd March 2022
Date of Board meeting for which this report is prepared	30th March 2022

Summary of key issues:

1. System update provided, and update in respect of planning across HCV discussed.
2. Key issues highlighted including UEC position in particular
3. The Inpulse survey feedback in respect of wellbeing was highlighted
4. Discussion initiated in respect of decision-making and where and how decisions should be taken
5. Each Directorate provided an update of key risks and issues, as well as highlighting positive news.
6. Brief updates were received in respect of quality & safety, the financial position, workforce, strategy development and operation performance.
7. Key areas within the updates included our ED performance and actions required, how to encourage wellbeing conversations that support colleagues but are not seen as being a performance indicator in any way, Ockendon and maternity services risks, and delivery of our Vaccination & Immunisation service
8. Four significant topics covered in more depth at the meeting
    - Annual planning and agreement of our financial plan
    - Green plan and approval
    - Extension to the HARA section75 agreement
    - Pharmacy aseptics business case

Are there any significant risks for noting by Board? (list if appropriate)

1. Contained within the Corporate Risk Register.

Any matters of escalation to Board for decision or noting (list if appropriate)

1. Approval of Green Plan
2. Approval of budgets that underpin the financial plan
3. Approval of the aseptics business case
4. Approval of the extension to the HARA section75 agreement

			2022						2023	
Element	**Item**	**Frequency**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**
Opening Items	Patient Story	All	x	x	x	x	x	x	x	x
	Declarations	All	x	x	x	x	x	x	x	x
	Minutes	All	x	x	x	x	x	x	x	x
	Action Tracker	All	x	x	x	x	x	x	x	x
	Chairman Report	All	x	x	x	x	x	x	x	x
Chief Executive	Chief Executive Report	All	x	x	x	x	x	x	x	x
	Corporate Risk Register	All	x	x	x	x	x	x	x	x
Quality & Safety	Quality Committee Chair Report	All	x	x	x	x	x	x	x	x
	IBR Metrics	All	x	x	x	x	x	x	x	x
	Director of Nursing, Midwifery and AHPs	All	x	x	x	x	x	x	x	x
	Freedom to Speak Up	Quarterly	X	x	x		x	x		x
	Strengthening Maternity and Neonatal Safety	All	X	x	x	x	x	x	x	x
	Medical Director Report	All	X	x	x	x	x	x	x	x
	Guardian of Safe Working	Quarterly	X	x	x		x	x		x
	Learning from Deaths	Quarterly		x	x		x	x		x
	Statement – Eliminating Mixed Sex Accommodation	Annually			x					
	Quality Accounts	Annually			x					
	National Patient Survey	Annually				x				x
	Safeguarding Annual Report	Annually				x				
	Health and Safety Annual Report	Annually			x					
	IPC Annual Report	Annually			x					
	7 Day Working Framework	As required								
	Paterson Inquiry	As required	X							
People & Culture	People & Culture Chairs Report	All	X	x	x	x	x	x	x	x
	IBT Metrics	All	X	x	x	x	x	x	x	x
	Workforce Report	All	X	x	x	x	x	x	x	x
	Workforce Race Equality Standards	Annually			x					
	Workforce Disability Equality Standards	Annually			x					
	Public Sector Equality Duty	Annually			x					
	Gender Pay Gap	Annually			x					
	Medical Revalidation	Annually			x					
	Modern Slavery	Annually			x					
	National Staff Survey	Annually			x			x		
Strategy & Partnerships	Director of Partnership Report	All	X	x	x	x	x	x	x	x
	Trust Strategy	As required				x				
Resources and Finance	Resource Committee Chairs Report	All	X	X	x	x	x	x	x	x
	IBR Metrics	All	X	X	x	x	x	x	x	x
	Director of Finance report	All	X	X	x	x	x	x	x	x
	Chief Operating Officer Report	All	X	X	x	x	x	x	x	x

			2022						2023	
Element	**Item**	**Frequency**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**
	Organisational Development Report	All	X	X	x	x	x	x	x	x
Governance	Audit Committee Chairs Report	All	X	X	x	x	x	x	x	X
	SMT Chairs Report	All	X	X	x	x	x	x	x	X
	Board Assurance Framework	All	X	X	x	x	x	x	x	X
	Board Reporting Framework	All	X	X	x	x	x	x	x	x
	Annual Accounts	Annually			x					
	Going Concern Review	Annually			x					
	Audit Letter	Annually			x					
	Annual Report	Annually			x					
	Emergency Preparedness Statement	Annually			x					
	Self certification and statement	Annually			X					
	Fit and Proper Person	Annually			x					
	Standing Orders	As Required								
	Use of Trust Seal	As required								
	Board Effectiveness Review	Annually				x				
	Certification on training for governors	Annually			X					
	Board Appointed Non Executive Roles	Annually	X							
	Constitution Review	Annually			X					
	Section 75 Arrangements	As required		x						

Board of Directors (Public)
30th March 2022

Title:	Draft Policy for the Development and Management of Trust-wide Policies and Procedures
Responsible Director:	Medical Director
Author:	Quality Governance Advisor

Purpose of the report and summary of key issues:	This Draft Policy is presented for support for its submission for formal approval by the Board. It is presented together with its review/approval checklist (attached).
Report History:	The Policy for the Development and Management of Trust-wide Policies and Procedures has been written to replace the previous Policy Development Manual. It clarifies the requirements relating to Trust-wide policies and procedures, embedding their review/approval, and monitoring of implementation, in the new governance framework. Work is underway to develop a parallel process for review and approval of trust-wide clinical guidelines and protocols It has been reviewed and supported by the Quality Governance Management Group, Policy Advisory Group and Partnership Forum.
Recommendation:	The Senior Management Team is asked to support the Policy for the Development and Management of Trust-wide Policies and Procedures, for presentation to the Trust Board for formal approval.

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

(To be completed and attached to the Policy or Procedure when submitted to Approval body for consideration and approval.)

	Policy for the Development and Management of Policies and Procedures	Yes/No/ Unsure	Comments
1.	**Format and Content**		
	Is it in the correct format?	Yes	
	Are the intended outcomes clearly described? (the Policy/Procedure Effect)	Yes	
	Is there a Definitions section giving an explanation of key terms used?	Yes	
	Is there an Equality Impact Assessment?	Yes	Stage 1 EIA undergone for previous manual; full stage 2 EIA. Not required
2.	**Consultation and Review**		
	Has there been appropriate consultation with stakeholders and users?	Yes	All directorates via the Executive Directors Group Communications Manager
	Has an appropriate Governance Group reviewed and supported the document prior to submission for formal approval?	Yes	QGMG
	For HR Policies only, has the Policy Advisory Group approved the document, and it been reviewed by the Partnership Forum?	Yes	Patient Advisory Group & Partnership Forum 16.3.22
3.	**Dissemination and Implementation**		
	Is it clear how it will be communicated?	Yes	Via teamHDFTcolleague App and Team Talk or the Weekly Update and highlighted by email to Governance Leads.
4.	**Process to Monitor Compliance and Effectiveness**		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)	Yes	
5.	**Review Date**		
	Is the review date in 2 years? If not is there a justified reason?	Yes	April 2024

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Harrogate and District NHS Foundation Trust

DRAFT

Template for Trust Policies

TITLE OF POLICY

Version	Date	Purpose of Issue/Description of Change	Review Date
		Include details of the version that is being replaced.	

Status		
Publication Scheme		
FOI Classification		
Document Type	Policy	
Key Words		
Executive Lead		
Policy Lead		
Author (if different from above)		
Governance Group (that *will oversee effectiveness of implementation)*		
Approval Body		**Date/s**
Review Date (Usually 2 years from approval date)		

Contents

In Office 2010 use “References” – “Table of Contents” and select first list and it will automatically insert contents from headings and page numbers. This can be updated when work is complete by right clicking in the TOC and selecting “Update Field”.

1 PURPOSE

A short paragraph outlining the purpose of the Policy.

It is important for Policy authors to be able to state clearly in one or two short sentences the purpose of the Policy and what it does. The main document is an opportunity to elaborate but this short section in bold text is a key feature that makes a Policy more accessible for users.

2 BACKGROUND/CONTEXT

This section can be used to explain any relevant background information or context for the Policy. It should be kept as short as possible.

3 DEFINITIONS

Any key terms used within the document should be defined.

4 POLICY EFFECT

One or more sections outlining the processes covered by the Policy, and what these processes aim to achieve.

These sections should lead into the “Roles and Responsibilities” in section 5 by showing how the responsibilities outlined in that section fit together into a process/processes.

Wherever possible, the process(es) should be clarified in a flow chart.

It should go into sufficient detail for someone unfamiliar within the process to understand it.

5 ROLES AND RESPONSIBILITIES

This section should set out responsibilities within the Trust: it must state clearly the requirements of staff in terms of their roles, responsibilities, and expected standards of behaviour. It must also set out who is responsible for implementing all aspects of the Policy. Where it is appropriate, acceptable levels of delegation should also be stated.

It should include the responsibilities of relevant committees/groups.

Roles relating to multidisciplinary teams should be taken into account and clearly specified in this section.

It should go into sufficient details for anyone at any level of the organisation to understand their responsibilities.

6 EQUALITY ANALYSIS

All Policies should contain a brief summary of the Equality Impact Assessment (EIA) that has been undertaken e.g.

- This Policy has undergone stage 1 EIA.
- This Policy does / does not require a full stage 2 EIA.

- The results of the full stage 2 EIA have been published on the Trust website.

Information about Equality, Diversity and Inclusion and EIA forms and resources are available on the intranet.

7 CONSULTATION, REVIEW AND COMMUNICATION

This section should describe the nature of the consultation process undertaken. The way in which the finalised Policy will be communicated back to those involved in consultation will be included in the consultation plan in Annex 1**.**

For all Policies, the approving body will normally expect to see evidence of relevant staff involvement and consultation. There may be exceptions to this principle, e.g. where Policy is determined by a legal or regulatory requirement, or where the Policy is substantially determined by specialist professional advice. Under such circumstances, Trust staff may expect to be consulted on how to implement the Policy, though not in the substantial provisions of the Policy.

Prior to seeking approval from Senior Management Team:

- All new or revised Policies will be reviewed by the appropriate Governance Group
- All staff related Policies will be signed off by PAG and reviewed at the Partnership Forum

The Policy should include a brief summary of how it will be communicated.

8 STANDARDS/KEY PERFORMANCE INDICATORS

This section must specify any relevant standards and KPIs which will be used to measure the impact/effectiveness of the Policy e.g. how will we know if the Policy is in place and being effective. Standards/indicators should only be referred to if they are measurable and there are plans referred to in Section 9 for monitoring them.

9. MONITORING COMPLIANCE AND EFFECTIVENESS

This section, using the template below, must include details of how compliance and effectiveness of implementation of the Policy will be monitored. This will include monitoring for any adverse impact on different groups. This should include the role of the Policy Lead and overseeing Governance Group in reviewing assurance.

Where an audit is required in order to measure compliance or effectiveness, the audit should be included in the Trust Annual Clinical Audit Programme and an audit tool should be made available.

Appendix A

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Include a separate row below for each element required by Policy and any other aspects required by the Trust.	*How will we know if the Policy is being implemented effectively?*					

10. REFERENCES/ASSOCIATED DOCUMENTATION

A list of any source documents referred to within the Policy.

Policy Template Appendix A

To be included as required for the individual Policy

Other appendices may be added

Policy Template Annex 1

1.1. Consultation Summary

	List Groups and/or Individuals Consulted
Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	

Harrogate and District NHS Foundation Trust

DRAFT

Template for Trust Procedure

TITLE OF PROCEDURE

Version	Date	Purpose of Issue/Description of Change	Review Date
		Include details of the version that is being replaced.	

Status	
Publication Scheme	
FOI Classification	
Document Type	Procedure
Key Words	
Executive Lead	
Procedure Lead	
Author (if different from above)	
Governance Group (that *will oversee effectiveness of implementation)*	
Approval Body	**Date/s**
Review Date (Usually 2 years from approval date)	

Contents

In Office 2010 use “References” – “Table of Contents” and select first list and it will automatically insert contents from headings and page numbers. This can be updated when work is complete by right clicking in the TOC and selecting “Update Field”.

1 PURPOSE

A short paragraph outlining the purpose of the Procedure.

It is important for Procedure authors to be able to state clearly in one or two short sentences the purpose of the Procedure and what it does. The main document is an opportunity to elaborate but this short section in bold text is a key feature that makes a Procedure more accessible for users.

2 BACKGROUND/CONTEXT

This section can be used to explain any relevant background information or context for the Procedure. It should be kept as short as possible.

3 DEFINITIONS

Any key terms used within the document should be defined.

4 PROCEDURE

One or more sections outlining the processes covered by the Procedure, and what these processes aim to achieve.

These sections should lead into the “Roles and Responsibilities” in section 5 by showing how the responsibilities outlined in that section fit together into a process/processes.

Wherever possible, the process(es) should be clarified in a flow chart.

It should go into sufficient detail for someone unfamiliar within the process to understand it.

5 ROLES AND RESPONSIBILITIES

This section should set out responsibilities within the Trust: it must state clearly the requirements of staff in terms of their roles, responsibilities, and expected standards of behaviour. It must also set out who is responsible for implementing all aspects of the Procedure. Where it is appropriate, acceptable levels of delegation should also be stated.

It should include the responsibilities of relevant committees/groups.

Roles relating to multidisciplinary teams should be taken into account and clearly specified in this section.

It should go into sufficient details for anyone at any level of the organisation to understand their responsibilities.

6 CONSULTATION AND REVIEW PROCESS

This section should describe the nature of the consultation process undertaken. The way in which the finalised Procedure will be communicated back to those involved in consultation will be included in the consultation plan in Annex 1.

"A consultation plan should be attached (as annex 1) for all new staff related Procedures."

For all Procedures, the approving body will normally expect to see evidence of relevant staff involvement and consultation. There may be exceptions to this principle, e.g. where Procedure is determined by a legal or regulatory requirement, or where the Procedure is substantially determined by specialist professional advice. Under such circumstances, Trust staff may expect to be consulted on how to implement the Procedure, though not in the substantial provisions of the Procedure

Prior to seeking approval from the Executive Director:

- All new or revised Procedures will be reviewed by the appropriate Governance Group
- All staff related Procedures will be signed off by PAG.

The Policy or Procedure should include a brief summary of how it will be communicated.

7 STANDARDS/KEY PERFORMANCE INDICATORS

This section must specify any relevant standards and KPIs which will be used to measure the impact/effectiveness of the Procedure e.g. how will we know if the Procedure is in place and being effective. Standards/indicators should only be referred to if they are measurable and there are plans referred to in Section 9 for monitoring them.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

This section, using the template below, must include details of how compliance and effectiveness of implementation of the Procedure will be monitored. This will include monitoring for any adverse impact on different groups. This should include the role of the Procedure Lead and overseeing Governance Group in reviewing assurance.

Where an audit is required in order to measure compliance or effectiveness, the audit should be included in the Trust Annual Clinical Audit Programme and an audit tool should be made available.

Appendix A

Procedure element to be monitored	Standards/ Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Include a separate row below for each element required by Procedure and any other aspects required by the Trust.	*How will we know if the Procedure is being implemented effectively?*					

9. REFERENCES/ASSOCIATED DOCUMENTATION

A list of any source documents referred to within the Procedure.

Procedure Template Appendix A

To be included as required for the individual Procedure

Other appendices may be added

Procedure Template Annex 1

1.1. Consultation Summary

Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	**List Groups and/or Individuals Consulted**

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

To be completed and attached to the Policy or Procedure when submitted to Approval body for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Format and Content**		
	Is it in the correct format?		
	Are the intended outcomes clearly described? (the Policy/Procedure Effect)		
	Is there a Definitions section giving an explanation of key terms used?		
	Is there an Equality Impact Assessment?		
2.	**Consultation and Review**		
	Has there been appropriate consultation with stakeholders and users?		
	Has an appropriate Governance Group reviewed and supported the document prior to submission for formal approval?		
	For HR Policies only, has the Policy Advisory Group approved the document, and it been reviewed by the Partnership Forum?		
3.	**Dissemination and Implementation**		
	Is it clear how it will be communicated?		
4.	**Process to Monitor Compliance and Effectiveness**		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)		
5.	**Review Date**		
	Is the review date in 2 years? If not is there a justified reason?		

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Senior Management Team
Insert Date

Title:	Insert Title of Policy
Responsible Director:	Insert Title
Author:	Insert

Purpose of the report and summary of key issues:	This revised Policy is presented for formal approval, together with a completed review checklist or presented for extension of the revision date.
Report History:	The xxx Policy has been reviewed and updated as part of the routine review of Trust Policies. The key changes to the document are as follows; Please bullet point It has been reviewed and supported by xxx Governance Group xxx Date
Recommendation:	The Senior Management Team is asked to approve the updated xxx (or approve an extension of the revision date to xxx).

Harrogate and District NHS Foundation Trust

Final Draft

Policy for the Development and Management of Trust-wide Policies and Procedures
'Policy on Policies'

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	March 2022	Major Revision and Renaming of the Policy Development Manual	April 2024

Status	**Open**	
Publication Scheme	**Our Policies and Procedures**	
FOI Classification	**Release without reference to author**	
Document Type	**Policy**	
Key Words	**Strategy, Protocol, Procedure, Format, Template**	
Executive Lead	**Medical Director**	
Policy Lead	**Company Secretary**	
Author (if different from above)	**Quality Governance Advisor**	
Governance Group (that *will oversee effectiveness of implementation)*	**Clinical Effectiveness Forum and Audit Committee**	
Approval Body	**Senior Management Team**	Date/s
Review Date (Usually 2 years from approval date)	April 2024	

7.4

CONTENTS

Staff Summary

This Policy is relevant to all those in the Trust who are responsible for developing, reviewing and implementing Trust-wide Policies or Non-Clinical Procedures. It is not of particular relevance to other staff.

All Trust-wide Policies, and Non-Clinical Procedures, will be developed and approved in accordance with this Policy and the associated templates.

Definitions of the documents covered by this Policy can be seen in Section 1.3.

There will be a **Lead Executive Director** with overall responsibility for each new and existing Policy and Non-Clinical Procedure. The Director will nominate an individual (the Policy or Procedure Lead) to develop and review the document. The lead is also responsible for communicating and monitoring implementation of the Policy or Procedure.

A Policy, within HDFT is considered to be a binding statement on all employees which specifies what the Trust requires employees to do and/or how they are expected to act.

Policies will be written using a consistent style and format as set out in the Policy Template and Appendix C. The process to follow when creating and approving a Policy is set out in Figure 1 in Section 2.1.

The key requirements of a Policy will be captured in the Policy effect section. Appendices will be used for detailed Policy requirements. Annexes will be used for checklists that Policy users would not need to access. Guidance, toolkits and supporting procedural documents can be referenced from the Policy and should be held in a separate document to support the Policy.

All Trust Policies, and any revisions, will be approved by the Senior Management Team. Each Policy will be overseen by a Governance Group which will receive routine reports on compliance with the Policy.

All Trust-wide **Non-Clinical Procedures** will be developed using the format in the Procedure Template. The flowchart to be followed when creating and approving Non-Clinical Procedures is set out in Figure 2 in Section 2.1. They will be approved by the Lead Executive Director. A Governance Group will also oversee their implementation and effectiveness.

The flowchart for **monitoring and review of Policies, and Non-Clinical Procedures** is set out in Figure 3 in Section 2.1.

Clinical Guidelines and Protocols must follow the relevant processes set out in the Procedure for the Development and Approval of Clinical Guidelines/Protocols in HDFT.

Local Non-Clinical Procedures/SOPs specific to an individual specialty/service will be governed by the local governance arrangements.

1. INTRODUCTION

Harrogate and District NHS Foundation Trust (HDFT), referred to hereafter as 'the Trust', provides a range of services that are guided by statutory duty and legislative requirements. These services are delivered within a framework of Policy, Procedure and practice to ensure compliance with these requirements.

1.1. Purpose

This Policy and associated templates outline the process for development and approval of all Clinical and Non-Clinical Policies, and Non-Clinical Procedures. This will ensure that a consistent approach is adopted and that consultation takes place with relevant parties.

This document also seeks to ensure that all Trust-wide Policies and Procedures are written in a consistent style that is accessible to all staff.

This Policy should be read in conjunction with the Procedure for the Development and Approval of Clinical Guidelines/Protocols where the document is in relation to Clinical activity.

1.2. Scope

The contents of this document will apply to all Policies and Procedures produced within the Trust, wherever the Trust carries out its responsibilities and to all staff employed by the Trust.

1.3. Definitions

Policy - a binding statement on all employees that specifies what the Trust requires employees to do and/or how they are expected to act. All Policies will be Trust-wide documents. These may be supported by Procedures and/or by guidance and toolkits which support staff in the implementation of a Policy.

Procedure – a **Trust Procedure** sets out a standardised series of actions to be taken, with clear responsibilities, to achieve a task so that everyone undertakes it in an agreed and consistent manner to achieve a safe and effective outcome. When used as part of a Policy, Procedures will provide the means to fulfil the objectives of the Policy.

Clinical Guidelines and Protocols fall under the remit of the Procedure for Development and Approval of Clinical Guidelines/Protocols. Definitions can be seen in Appendix A.

2. POLICY EFFECT

A summary table of governance arrangements for all Trust Policies/ Procedures/Guidelines whether local or Trust-wide can be seen in Appendix B.

This Policy covers Trust-wide Policies and Non-Clinical Procedures, as set out below.

2.1. Creating and Approving a Policy or Procedure

The process to be followed when creating and approving a Policy or Procedure are set out in Figures 1 and 2 below.

The flowchart for review of Policies and Non-Clinical Procedures is set out in Figure 3 below.

Figure 1. Flowchart for Creation and Approval of a Policy

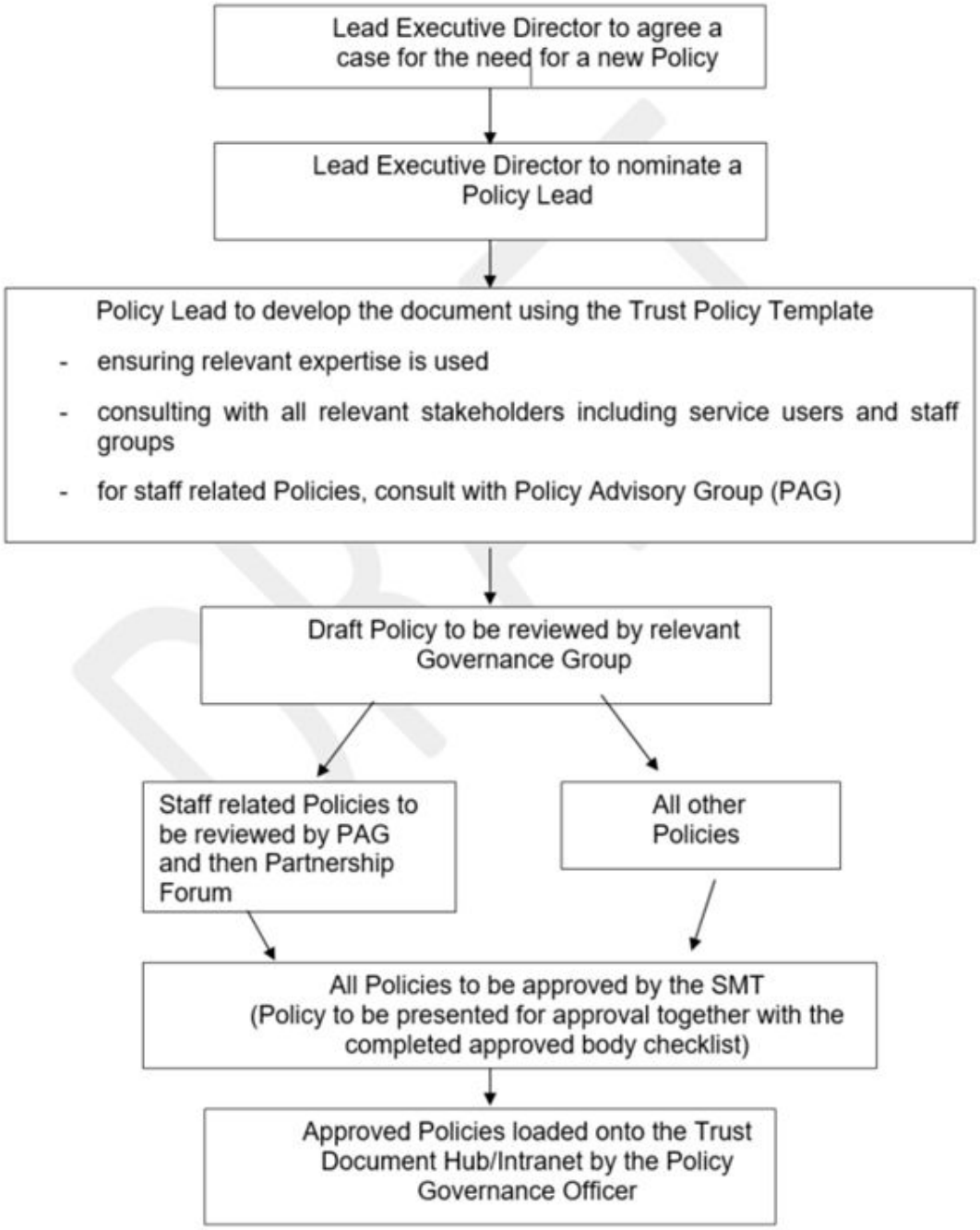


Figure 2. Flowchart for Creation and Approval of a Trust-wide Non-Clinical Procedure

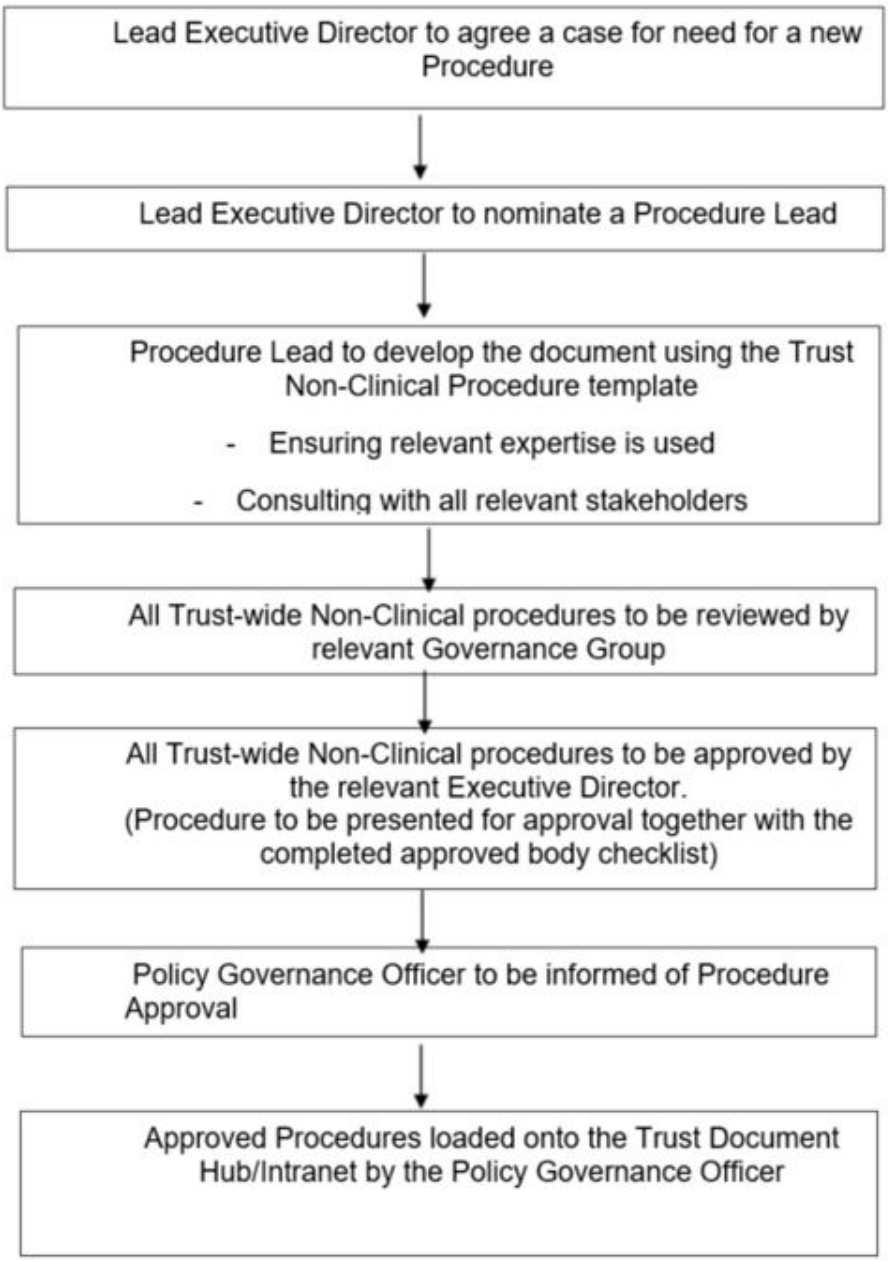
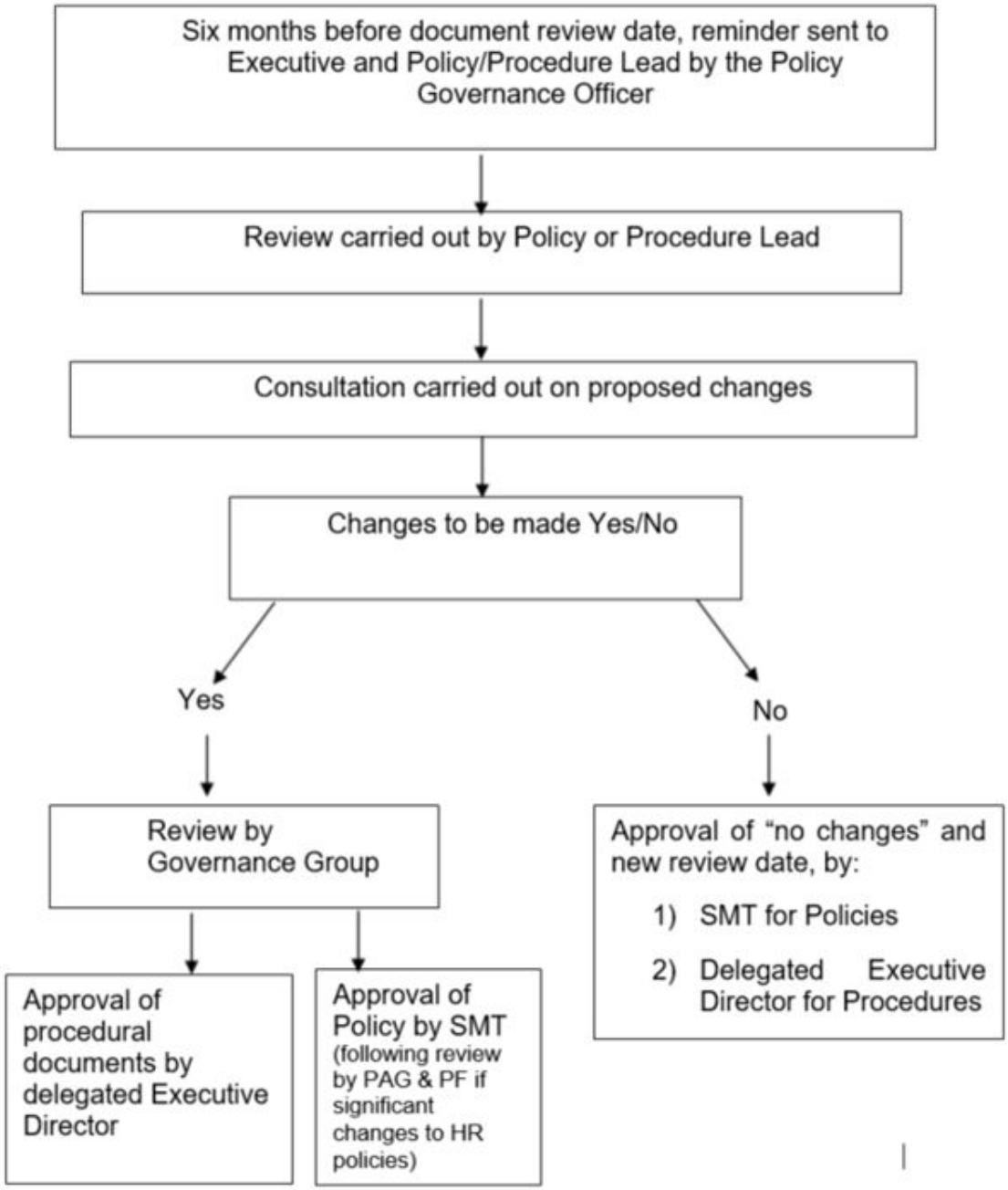


Figure 3. Review of Policies and Non-Clinical Procedures



2.2. Style, Format and Structure of Policies

All Policies will be written using a consistent style as set out in the Appendix C and using the format in the Trust Policy Template.

All Non-Clinical Procedures will use the format set out in the Non-Clinical Procedure template.

All Policies and Procedures will include a 'definitions' section giving an explanation of any key terms used.

All Policies should be succinct, clearly set out in plain language, and identify the points that people need to know in order to implement them safely. In most situations, a simple flow chart or process map can helpfully summarise and provide an overview of the process.

Appendices will be used for detailed Policy requirements. Annexes will be used for checklists that Policy users do not need to access. Guidance, toolkits and supporting procedural documents can be referenced from the Policy and should be held on the Document Hub/Intranet and linked to the Policy.

A table of contents can be created automatically from the formatted headings in the Policy template using Word Table of Contents.

2.3. Development Process

The process to be followed when developing or reviewing a Policy or Non-Clinical Procedure is set out below. The following sections (2.4 - 2.13) provide more detail on the process.

For any new Policies, the Lead Executive Director will:

- establish a clear justification for developing the new Policy
- establish how it links with service priorities
- ensure that it is not duplicating other work.

For each document under development, the Lead Executive Director will identify a Policy Lead who has responsibility for ensuring this Policy is followed. In addition to this Policy/Procedure Lead, a steering group may also be established.

2.4. Identification of Stakeholders

The Trust will seek the involvement of stakeholders in the development of new Policies and Procedures and any major review of existing documents. On occasion, this may include relevant staff representatives and service users. Key stakeholders outside the organisation will be informed during development or when the document has been approved, prior to implementation, at the discretion of the Lead Executive Director.

2.5. Equality Impact Assessment

The Trust is committed to creating a culture that fully respects equality and diversity and aims to ensure that all its services are accessible, appropriate and sensitive to the needs of the whole

community. It believes in fairness, equity and above all values diversity in all its dealings, both as a provider of health services and as an employer.

All Policies should be developed to deliver the highest standards of equality and diversity in all our services.

An Equality Impact Assessment (EIA) is a way of systematically and thoroughly assessing and consulting on the effects that a Policy is likely to have. The EIA helps to identify any possibility that a Policy could disadvantage some groups on the grounds of race, disability, age, gender, sexuality, faith or language. To undertake this means involving appropriate users and/or groups in the design, review and development of a Policy. The publication of the EIA, including consultations and action plans is a statutory duty for the Trust.

All Policies should contain a brief summary of the EIA that has been undertaken e.g.

- This Policy has undergone stage 1 EIA screening
- This Policy does / does not require a full stage 2 EIA
- The results of the full stage 2 EIA have been published on the Trust website.

Information about Equality, Diversity and Inclusion and EIA forms and resources are available on the Intranet.

2.6. Consultation Process

All Policy/Procedural Documents

Relevant staff should be involved or consulted on the development of all Policies and Procedures. Where a Policy or Procedure is determined by a legal or regulatory requirement, Trust staff may expect to be consulted on how to implement it, rather than on the substantial requirements.

- Relevant practitioners must be involved in the development and review of Clinical Policies
- Where relevant, the views of people from different ethnic minority groups, of different gender, disabled people, and other groups should be sought (in accordance with the Trust's Equality and Diversity Policy)
- For Policies that directly affect patients and service users, it will generally be appropriate to involve some patients, carers and public at the outset as well as consulting more widely on the drafts
- There is a statutory duty to consult with staff on all Health and Safety related Policies
- Any major actions taken as result of involvement/consultation feedback should be documented on the version control sheet retained as an Annex to the Policy.

Consideration should also be given to any additional training required, or if existing training needs to be amended. Training requirements should be discussed with the Learning and Development Team in Workforce Development hdft.learninganddevelopment1@nhs.net

Staff Related Policies

Policies which fall into one of the categories listed below should go to the Trust Policy Advisory Group (PAG) for consultation

- Policies which affect terms and conditions of employment
- Policies which are authored by the HR Services
- Policies which affect (contractual and non-contractual) employee benefits
- Policies which could potentially affect all Trust employees, regardless of the job role which they are employed to do.

The involvement/consultation process, and major actions resulting from it, must be documented in an annex to the Policy documentation (see Appendix D) or in appendix 1 of the Policy template.

2.7. Approval and Ratification Process

All new or revised Policies will be approved by the Senior Management Team (SMT).

Prior to seeking approval from the Senior Management Team, all new or revised Policies will be reviewed by the appropriate Governance Group and forwarded to the SMT together with the completed checklist for review and approval.

Staff Related Policies (as defined in Section 2.6) will normally be agreed by the PAG. However, where it is not possible to reach agreement, the Trust reserves the right to refer a Policy to the Senior Management Team for approval.
Where a Policy has been agreed by the PAG, the HR Service will be responsible for retaining a copy of the Policy signed by both the Director of HR and Staff Side Chair of the committee.

All new or revised Non-Clinical Procedures will be reviewed by the appropriate Governance Group prior to approval by the delegated Executive Director. They will then be forwarded to the Policy Governance Office for posting onto the Document Hub/Intranet.

2.8. Process for Reviewing a Policy or Procedure

Policies and Procedures will normally require a review date to be set two years from the approval date. The review date may be extended to three years if the Policy requirements are unlikely to change significantly during this period. Review dates may also be brought forward if there are significant changes required, for example due to new national guidance or legislative changes. Policy/Procedure Leads must ensure they have arrangements in place to review the document at that time.

All reviews and revisions to Policies and Procedures must be approved by Executive Directors according to the process flow charts included in this Policy. Substantial changes would normally require a similar consultation process to the original Policy. Changes to supporting guidance and toolkits can be made with approval from the relevant management or Governance Group.

Where no changes are required to a Policy following review, this will be approved by Senior Management Team. A new review date will be agreed by SMT.

Where no changes are required to a Non-Clinical Procedure following review, this will be approved by the appropriate Executive Director, and a new review date will be agreed by the Director.

Please do not send Policies and Procedures directly to the Senior Management Team for their approval, please send via the Policies and Procedure email address (Policy Governance Officer) to ensure appropriate governance arrangements are followed.

2.9. Version Control

Each new 'final' version should be identified separately and distinctly with appropriate numbering on the cover sheet. Version 1 is the first published version of any Policy, minor amendments may be numbered 1.1, 1.2 etc and major revisions/reviews should then become Version 2.

All Trust Policy/procedural documents should contain a footer incorporating the title and approval date.

2.10. Communication, Dissemination and Implementation

All policies will include roles and responsibilities for ensuring staff are aware of the requirements of the policy.

All policies and procedure authors must consider the appropriate level of communication needed, and whether to engage with the Communications and Marketing Team for support in developing a Communications plan.

Effective communication of policies is vital to ensure that the correct teams and individuals are aware of policies and changes to policies.

All new policies and non-clinical procedural documents, and substantial revisions, can be communicated via the teamHDFTcolleague App, and/or if appropriate via Team Talk or the Weekly Update.

2.11. Document Control including Archiving Arrangements

Register/Library of Policies and Procedures

The Trust has a central register of Policies and Non-Clinical Procedures held by the Policy Governance Officer. The documents themselves are held on the Document Hub/Intranet. To support this development, **all** Policies and Trust-wide Non-Clinical Procedures must be notified to the Policy Governance Officer who will ensure they are made available on the Hub/Intranet site.

The centrally-held version of the Policy/Procedure must be the only one actually published. If the Policy/Procedure is referred to within another local site on the Trust Intranet it must be hyper-linked to the centrally held version.

It is recognised that there will be valid operational or training reasons for managers and staff to have hard copies of Policies as working documents. However copies of Trust documents should not be printed unless it is absolutely necessary as there is a risk that out of date copies may be in circulation. It is the responsibility of the copyholder to ensure that any Policy document in circulation is current. All non-current Policies are invalid.

It should be made clear that requests for Policies in an alternative language or format (such as Braille, audiotape, large print etc.) will be considered and obtained whenever possible.

Archiving Arrangements

The Trust will maintain a web-based archive, which will include:

- reviewed or updated Policy/Procedural documents
- those no longer in place, including the dates where the archived versions were extant.

Archived versions of Policies and Procedures must be retained in accordance with the national guidance on records management and the Trust records retention schedules. There is guidance for staff in the HDFT Corporate Records Management Policy.

Staff will be prevented from using obsolete documents as only the latest published version will be available to staff, with those with administrative access to the document Hub/Intranet able to retrieve older versions on request.

2.12. Monitoring Compliance and Effectiveness

All Policies and Non-Clinical Procedures will contain a description of any relevant standards or key performance indicators and details of how compliance and effectiveness will be monitored including:

- Which Governance Group will oversee its implementation in conjunction with the Policy/Procedure Lead
- What monitoring arrangements for compliance and effectiveness will be adopted, e.g. audit, self-assessment, peer review, survey, or other research/evaluation
- Which specific group or named individual will have responsibility for conducting the monitoring/audit
- Reporting arrangements.

Internal auditors will be asked regularly to assess awareness and compliance with Trust Policies, including this Policy.

2.13. Reference Documents

An evidence base for Policy/Procedure documents will be provided with up to date references. All references should be cited in full.

2.14. Associated Documentation

Any local organisational supporting documents will be referred to, in conjunction with the document being developed.

2.15. Appendices

Any appendices will be listed, including as a minimum the consultation summary and the monitoring, audit and feedback summary.

3. ROLES AND RESPONSIBILITIES

3.1. Trust Board

The Trust Board has overall responsibility for Trust Policy. The Chief Executive will delegate responsibility for development of Policy/Procedure to nominated Executive Directors. The Trust Board has delegated its responsibility for approval of Policies to the Senior Management Team.

3.2. Senior Management Team

The Senior Management Team will:

Approve all Trust Policies, and delegate approval of Trust Procedures to the appropriate Executive Director.

3.3. Governance Committees, Groups, and Sub-Groups

The Committees, Groups, Fora, and Sub-Groups will be responsible for:

- Receiving and reviewing minutes and assurance reports from Governance Groups
- Referring risks upwards to a Board Committee where appropriate.

Acting as the nominated Governance Group for Policies and Procedures for which they provide the first line of oversight.

3.4. Audit Committee

The Audit Committee will be responsible for reviewing the effectiveness of this Policy on an annual basis.

3.5. Nominated Governance Groups

The nominated Governance Group will:

- review new or revised Policies/Procedures prior to presentation to SMT or Executive Director, for approval
- receive routine assurance reports as required by each Policy/Procedure
- commission actions required to improve assurance or compliance.

3.6. Lead Executive Directors

Lead Executive Directors have overall responsibility for specific new and revised Policies and Procedures. This includes:

- Nominating a Policy/Procedure Lead
- Nominating the appropriate Governance Group for the Policy/Procedure
- Establishing a steering group, if required, to steer the development of a Policy, and submission for approval
- Ensuring the document is reviewed prior to its review date
- Ensuring appropriate levels and methods of patient, carer and public involvement
- Ensuring key stakeholders outside the organisation are involved or informed during Policy development or when a Policy has been approved, prior to implementation
- Confirming that implementation is achievable within the resources of the service/organisation

- Ensuring the document has an appropriate review date, normally two years from the approval date
- Reviewing all Policies/Procedures before being submitted for approval
- Ensuring that arrangements are put in place to monitor implementation of the Policy/Procedure, and report on compliance.

3.7. Policy/Procedure Lead

The Lead will be responsible for:

- Coordinating the development of the document
- Leading the development of a communication and implementation plan
- Carrying out consultation
- Proposing how the implementation will be monitored
- Ensuring the Policy/Procedure is written in plain English, is jargon-free, and in the correct format
- Ensuring the Policy has been assessed for relevance to the statutory equality duties
- Ensuring the correct review and approval process is followed
- Notifying the Policy Governance Officer when the final document has been agreed and providing the approved version for posting on the document Hub/Intranet
- Ensure arrangements are in place to review the document at the appointed time
- Noting when significant changes have occurred which impact on the Policy/Procedure and contacting the Lead Executive Director to trigger an immediate review, if necessary
- For any Policy being considered by the PAG, the Policy Lead is responsible for providing PAG with progress reports of the work and achievements against any agreed consultation plan
- Ensuring that the agreed monitoring and reporting arrangements are put in place.

3.8. Consultees

When draft copies of a Policy/Procedure are circulated and comments invited, respondents should make their comments by the date given. Failure to respond to the invitation to comment by the given date will be taken to be consent to their approval.

3.9. Compliance Manager

The Compliance Manager will be responsible for:

- Managing the Policy Governance Officer post and ensuring deputising arrangements are in place in their absence
- Maintaining the Register of Trust Policies and Non-Clinical Procedures

- Proving quarterly assurance reports on the implementation of this Policy to the Clinical Effectiveness Forum.

3.10. All Staff

Failure to follow a Trust Policy could result in the instigation of disciplinary Procedures, in accordance with the Trust Conduct and Discipline Policy.

4. POLICY DEVELOPMENT AND EQUALITY

The previous Policy Development Manual has undergone stage 1 Equality Impact Assessment (EIA) screening. This Policy does not require a full stage 2 EIA.

5. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

The consultation process in relation to the current version of this Policy is listed in Appendix D.
The Policy for the Development and Management of Trust-wide Policies and Procedures Development Manual is a Policy with Trust-wide significance. Changes will require ratification by Senior Management Team.

6. DOCUMENT CONTROL

This Policy will be published on the Trust Intranet after ratification in order that all Trust staff can access it. It will replace the previous version, which will be archived on the Intranet.

This document should not be printed unless it is absolutely necessary, as there is a risk that out of date copies may be in circulation. It is the responsibility of the copyholder to ensure that any paper copy in circulation is current. All non-current Policies are invalid.

7. DISSEMINATION AND IMPLEMENTATION

The publication of a new version of this Policy on the Intranet, and key messages will be communicated via the teamHDFTcolleague App and/or if appropriate via Team Talk or the Weekly Update and highlighted by email to Governance Lead.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

The key performance indicators are:

- All New Trust Policies and Procedures will be in the required style and format
- All Trust Policies and Procedures will have been subject to consultation with identified stakeholders
- All Trust Policies and Procedures will have due regard to Equality and Diversity requirements
- All Trust Policies and Procedures will have identified a Lead Director and a Policy/ Procedure Lead responsible for development and monitoring implementation and review
- All Trust Policies and Procedures will be ratified by the appropriate Governance Group prior to approval
- All Trust Policies and Procedures will be approved by the Executive team or delegated Board Director prior to being uploaded onto the Policy and Procedure Hub/Intranet
- All Trust Policies and Procedures will be accessible on the Hub/Intranet and reviewed in accordance with the agreed review date
- All superceded versions of Policies and Procedures will be archived.

The monitoring, audit and feedback process is summarised in Appendix E.

9. REFERENCE DOCUMENTS

The documents that informed the development of this Policy were:

NHSLA Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care.

An Organisation-wide Document for the Development and Management of Procedural Documents; NHSLA Risk Management Template.

10. ASSOCIATED DOCUMENTATION

The following HDFT documents should be referred to in conjunction with this Policy:

- Trustwide Policy Template
- Trustwide Procedure Template
- Checklist for Review & Approval Proforma
- Policy Cover Paper for SMT
- Procedure on Development and Approval of Clinical Guidelines/Protocols

11. APPENDICES

11.1. Appendix A: Document Definitions

11.2. Appendix B: Policy/Procedure/Guidelines Governance Table

11.3. Appendix C: Style Guide

11.4. Appendix D: Consultation summary

11.5. Appendix E: Monitoring, audit and feedback summary

Appendix A: Document Definitions Used in HDFT

The definitions of the different documents used in the Trust can be seen below.

A Policy is a binding statement on all employees that specifies what the Trust requires employees to do and/or how they are expected to act.

Policies apply to all relevant staff as a 'must do' requirement, and a breach of Policy may have contractual consequences for the employee. Policy is a statement of the standard to be achieved rather than how to implement the standard. Policies often arise from legislation, national Policy or Trust strategy.

> A **Clinical Policy** is a Trust-wide Policy, as described above, which relates to a particular Clinical or patient care related issue. (A Clinical Policy will often have associated Clinical Guidelines, Protocols or Procedures - or possibly all three).

Procedural Documents

A Trust Procedure is a standardised series of actions to be taken to achieve a task so that everyone undertakes it in an agreed and consistent manner to achieve a safe and effective outcome. (When a Procedure is part of an approved Policy it provides the means to fulfil the objectives of the Policy and to show how the Policy statement is to be achieved).

Clinical Documents - These give guidance on direction regarding diagnosis, management and/or treatment in specific Clinical areas.

A **Clinical Standard Operating Procedure (SOP**) is a step by step description of how to do something at a practical level. An example of a Clinical Procedure (SOP) is a Procedure for insertion of peripheral venous cannula

A **Clinical Protocol** is a mandatory course of action that a clinician must take when they decide that the conditions of 'specific Clinical circumstances' are met. A Protocol may contain Procedures within it. An example of a Protocol could be an Immunisation Protocol for a Neonatal Unit. Clinical Protocols can be seen as more specific than Guidelines and defined in greater detail. Protocols provide "a comprehensive set of rigid criteria outlining the management steps for a single Clinical condition or aspects of organisation"

Clinical Guideline - A systematically developed, evidence based document that assists employees, including healthcare professionals, to make decisions concerning the appropriate course of action to take or care for specific Clinical conditions.

A Clinical Guideline will often contain embedded Protocols and/or Procedures.

A Clinical Guideline does not override the individual responsibility of health professionals to make Clinical decisions appropriate to the circumstances of individual patients in consultation with the patient and/or their guardian or carer. If such a decision means that a Clinical Guideline is not followed for an individual patient, the reasons must be fully recorded in the patients' medical records.

Local Procedures/SOPs

Local Clinical Procedures/SOPs specific to one specialty or service area (to be managed through local governance arrangements).

Appendix B: Summary Table of Governance Arrangements

	Policies	Trust-wide Procedures		Trust-wide Clinical Guidelines	Local Clinical Guidelines	Local Procedures/SOPs	
		Non-Clinical	Clinical			Clinical	Non-Clinical
Formal Approval	Senior management Team	Delegated Executive Director	Delegated Executive Director	Clinical Guidelines Group*	Clinical Guidelines Group*	Directorate Governance Group or delegated specialty group	Directorate Governance Group or delegated specialty group
Reviewed By	Relevant Governance Group, prior to formal approval	Relevant Governance Group, prior to formal approval	Relevant Governance Group, prior to formal approval	Peer review determined by the author/specialty.		Local peer review process	
Held on	Document Hub (Intranet)	Document Hub (Intranet)	Document Hub (Intranet)	Document Hub (Intranet)	Document Hub (Intranet)	On specialty specific shared drive or on Document Hub (Intranet)	
Monitored By	Through Trust-wide mechanisms including Audit Programmes, Staff and Patient Surveys. Reported into governance structure as set out in Policy/Procedure Monitoring Tables			As set out in their audit section	Through specialty Audit Programme		

* Guidelines/Protocols/Procedures relating specifically to:

- Drugs will be approved by the Drug and Therapeutics Group. Antimicrobials by the Antimicrobial Safety Group.
- Safeguarding Adults & Children can approve their Clinical Guidelines/Protocols and Procedures through their own governance processes.
- Protocols or SOPs that are specialty specific may be approved through their own Directorate governance forum.

Appendix C: Guidance on the style and format of Policy documents

Style and Format of Policy Documents

For those involved in the preparation of Policy/Procedure documents, the official, approved Trust branding and template must be used for the Policy. The updated branding can be found here: http://nww.hdft.nhs.uk/corporate/communications-and-marketing/hdft-branding/

The required style and format are automatically created in the approved templates. See Policy template and Procedure template.

Paper size	A4, Portrait for body text
Body Text Font	Arial, 12
Heading 1	Arial, 14, Upper Case, Bold
Heading 2	Arial, 12, Lower Case, Bold
Heading 3	Arial, 12, Lower Case, Underline
Justification	Set Full
Line Spacing	Single
Paragraph Spacing	One line between paragraphs
Logo and banner	Title page only Logo - Set top and align right Banner – Set top and align left
Margins	Left 2.54cm Right 2.54cm Top 2.54cm Bottom 2.54cm
Headers/Footers	Arial, 10pt
Appendices	Numbered and referenced within the text

Title Page

The title page of the Policy template will contain the following information:

- Trust logo
- Title of Policy
- Version control details
  - Version number
  - Date – date version published
  - Purpose of issue / description of change
  - Review date
- Status e.g. Open / Restricted. If protective marking is required, this should be included in the header of every page in bold red print
- Publication Scheme (see Intranet training documents Freedom of Information (FOI) Classification (see Intranet training documents).
- FOI Classification
- Document Type e.g. Policy
- Key Words
- Executive Lead
- Policy Lead
- Author (If different from above)
- Governance Group (that will oversee effectiveness of implementation)

- Approval Body
- Review Date (Usually 2 years from approval date)

Header
The Trust logo will appear, aligned right, in the header of the first page. Protective marking e.g. NHS Confidential, NHS Protect will appear at the centre header of **all** pages in bold red print. Draft can be indicated in the header or using the draft watermark.

Footer
The title of the Policy, and version number, aligned left, will appear in the footer of every page, page number (expressed as 'n of xx', where n equals the page number and xx the total number of pages in the document) aligned right, except the title page.

Contents Page
A contents page must be included for documents where the main body of the document is over 3 pages long. The contents page must be created using Microsoft Word's automatic table of contents and will contain the list of content headings and page numbers.

Appendix D: Consultation Summary

	List Groups and/or Individuals Consulted
Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Executive Directors Group
	Communications Manager
	Policy Advisory Group

Appendix E: PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Style and format	All Trust Polices and Non-Clinical Procedures will be in the required style and format.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Terms used	All Trust Policies and Non-Clinical Procedures will include a Definitions sections, explaining frequently used terms.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Associated Documents and supporting references	All Trust Policies and Non-Clinical Procedures will reference key associated documents. All Trust Policies and Non-Clinical Procedures will include clear references to its drivers and evidence base.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Consultation	All Trust Polices and Non-Clinical procedures will have been subject to consultation with stakeholders.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Ownership and governance of Polices	All Trust Policies and Non-Clinical Procedures will have an identified Lead Executive Director, a Policy/Procedure Lead, and an identified Governance Group to oversee ongoing implementation and review.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Approval of Policies	All Trust Policies to be reviewed and supported by appropriate Governance Group prior to SMT approval.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Approval of Procedures/Protocols	All Trust Non-Clinical Procedures to be reviewed and supported by appropriate Governance Group prior to Executive Director approval.	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee
Review of Polices	All Trust Policies and Non-Clinical Procedures to be on Trust's Document Hub/Intranet and reviewed in accordance with agreed review date.	Quarterly Review by Compliance Manager Annual Internal Audit Review	Compliance Manager Internal Audit	Quarterly Annual	Company Secretary	Quarterly report to Clinical Effectiveness Forum Annual report to Audit Committee
Archiving of Polices	All superseded versions of Policies and Procedures will be archived	Annual Internal Audit Review	Internal Audit	Annual	Company Secretary	Annual report to Audit Committee

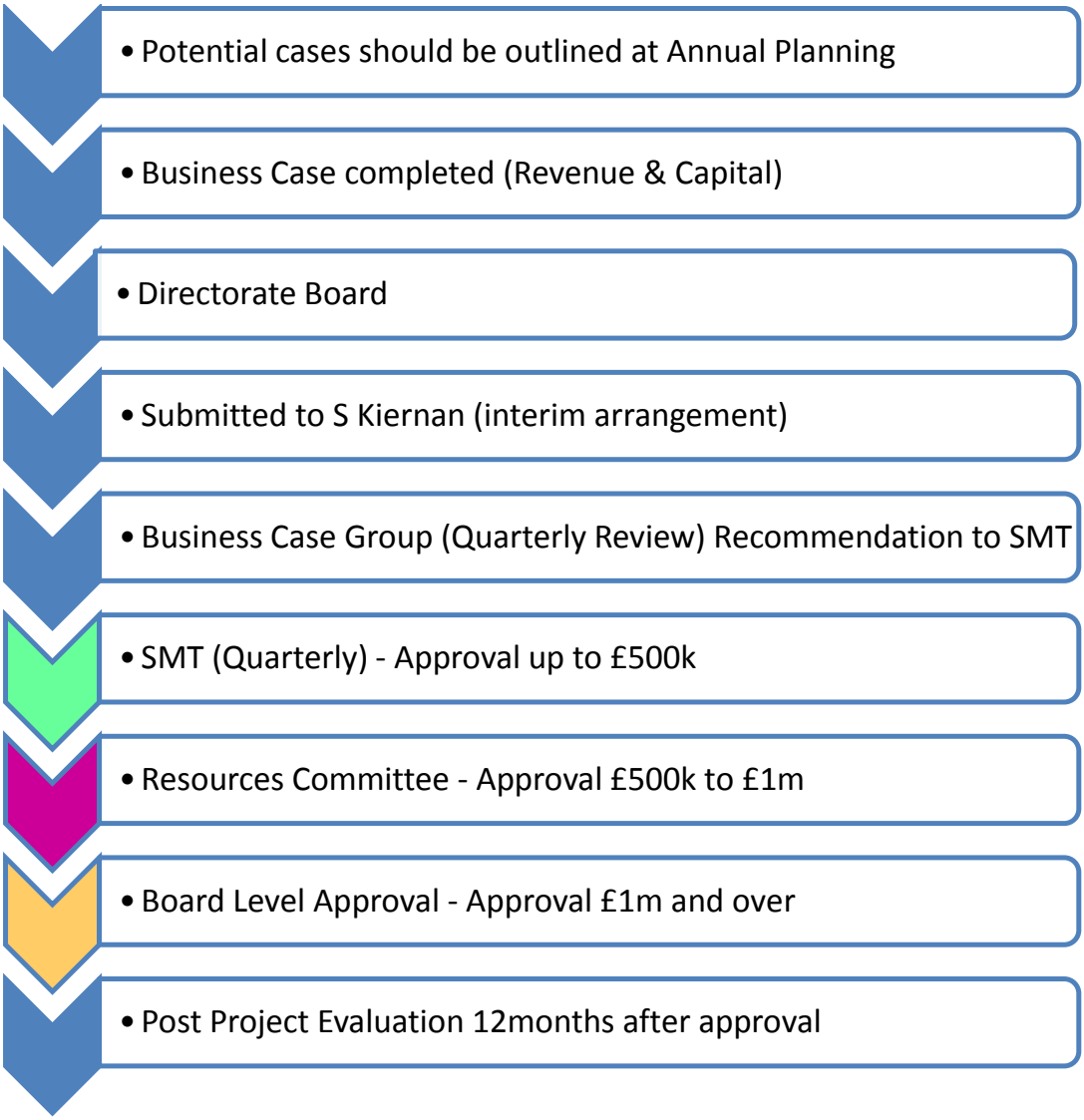
Board of Directors (Public)
30th March 2022

Title:	Pharmacy Aseptics Business Case
Responsible Director:	Director of Strategy
Author:	Chief Pharmacist Director of Strategy

Purpose of the report and summary of key issues:	To note the proposal to undertake a full aseptics unit replacement programme, following an audit of HDFT Pharmacy aseptic facilities.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	✓
	BAF3.5 To provide high quality public health 0-19 services	✓
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	✓
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks		
Report History:	This report was presented to Senior Management Team on 23rd march 2022.	
Recommendation:	It is recommended that the Trust Board note and approve the business case for the Pharmacy Aseptics unit replacement.	

7.5

Business Case Process



The Business Case Review group will ensure Business Cases are accurate, address the necessary issues and will make a recommendation to SMT

1. **Proposed Scheme/Project**	**Pharmacy Aseptics Unit Replacement**
2. **Date of Request**	17th January 2022
3. **Lead Director (sponsor)**	Matt Graham, Director of Strategy
4. **Directorate**	LTUC
5. **Directorate Board Approval**	28th February 2022
6. **Scheme/Project Lead**	Kate Woodrow, Chief Pharmacist

7. Summary (What is the case demonstrating?)

This business case describes the proposal to undertake a full aseptic unit replacement programme including facilities, equipment (including all isolators) and air handling unit (completed as part of the SALIX grant) to achieve compliance with EL(97)52 audit standards Quality Assurance of Aseptic Preparation Services: Standards (QAAPS 5).

Since 2017/18, Cancer Services activity has increased by 28%, there has been a corresponding increase in Pharmacy aseptics activity with activity in 2021/22 above pre-pandemic levels. Alongside meeting the growth of core systemic anti-cancer therapy and parenteral nutrition (PN), there is a need to plan for future demand such as growth in clinical trials of intravenous medicines, significant growth in monoclonal antibodies (MAbs) and potential to address the sizeable burden on nursing staff (the unmet need) making up injectable medicines on wards.

Horizon scanning shows that there is significant growth in immunotherapy treatments and also new combined chemotherapy/immunotherapy products with the vast majority being injectables that require aseptic preparation. In terms of disease progression and drug development we anticipate there will be continued growth in this area with more complex and novel treatments being developed that can only be handled in an aseptic environment.

This business case has been developed following an audit of HDFT Pharmacy aseptic facilities against EL(97)52 audit standards Quality Assurance of Aseptic Preparation Services: Standards (QAAPS 5). The outcome of this audit is that HDFT aseptics facilities are classed as “significant” risk to patient safety.

This business case has been developed to mitigate the risk of:

- Risk to service delivery that the trust is not able to provide some cancer and other treatments because we have to close (or external regulators direct us to close) the Aseptic Production Unit at short notice because we are unable to maintain QA standards because the transfer hatches and air handling unit do not meet the required standards. Due to capacity constraints in NHS and private sector aseptic production units, it is unlikely that we would be able to source all products externally.
- Risk to service delivery that the trust is not able to provide support to clinical trials for investigational medicinal products (CTIMPs) requiring aseptic manufacture.
- Risk to patient safety because QA standards for the aseptic production of medicines may not be met because the transfer hatches and air handling unit do not meet the required standards.
- Risk to staff safety due to exposure to substances harmful to health because the transfer hatches and air handling unit do not meet the required standards.

- Financial risk if the unit has to close because we would have to seek external provision of medicines which is likely to be at increased cost.

This case aligns with the following Board Assurance Frameworks (BAF) BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience; BAF3.2 To provide a high quality service and BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation.

This case aligns with the WYAAT regional aseptic collaboration which supports BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care and BAF2.2 To be an active partner in population health and the transformation of health inequalities.

In summary, this paper describes a case that will:

- Achieve compliance with EL(97)52 audit standards Quality Assurance of Aseptic Preparation Services: Standards (QAAPS 5)
- Provide a safe and effective aseptically prepared medicines supply service (systemic anti-cancer therapy, parenteral nutrition (PN), clinical trials of intravenous medicines, monoclonal antibodies (MAbs) and other high risk injectables) to meet the current and predicted forecast increase in demand.
- Support the WYAAT regional aseptic collaboration and proposal for a "hub and spoke" model for aseptic medicine supply by ensuring that the HDFT "spoke" is able to meet medicines supply which cannot be met through the "hub" model.

Resources Committee and Trust Board are recommended to approve:

- Replacement of the trust's pharmacy aseptic unit in order to mitigate the quality and service delivery risks set out in this case.
- Indicative costs for the project of up to £1.5m capital and £50k revenue
- Initiation of the procurement process to appoint the suppliers and obtain final costs for the project

8. Proposal (Is the proposal needed? Future aims and objectives?)

This paper outlines a proposal to undertake a full Pharmacy aseptic unit replacement project to enable safe and effective continuation of aseptically prepared medicines supply services to the acute trust including Adult Parenteral Nutrition (PN), Cytotoxic Chemotherapy/Monoclonal antibodies and a Centralised Intravenous Additive Service (CIVA) Service. All preparation is carried out under Section 10 exemption from the Medicines Act.

The Aseptic Production Unit provides aseptically prepared injectables to approximately 300 Cancer Services and 100 non-Cancer Services patients each month. This represents 50% of all Cancer services patient activity (based on 600 patient attendees at SROMC each month); the remaining 50% of patients receive oral treatments available from Lloyds outsourced outpatient pharmacy. There has been a 28% increase in Cancer Services activity since 2017/18, in the last year 2021/22 there has been a 40% increase with activity now exceeding pre-pandemic levels. Pre-pandemic in 2019/20 the Aseptic Production Unit provided aseptically prepared Clinical Trial Investigational Medicinal Products (CTIMPs) to just over 100 patients per year. The Trust Research and Innovation department wish to increase clinical trial activity; the ability to support research and innovation is attractive for future employees, especially clinical researchers. The vast

majority of clinical trials involving CTIMPs are for injectable medicines which must be prepared under aseptic conditions. Whilst there are some MaBs that do not currently necessitate manufacture under aseptic conditions, a national review is underway to determine the safety of this practice and whether these products should be prepared under aseptic conditions both for the protection of the aseptic operator and the integrity of the product.

The current aseptic facilities are classed as "Significant risk" to patient safety following an EL(97)52 audit of HDFT Pharmacy aseptic facilities.

The Carter Report into NHS aseptic services in England, instigated by NHS England (NHSE) and NHS Improvement (NHSI), concluded current services are unsustainable. This case dovetails with the WYAAT regional aseptic collaboration and plans to develop a hub and spoke model for Pharmacy aseptic services. The benefits of the WYAAT model are to generate new aseptic production capacity, deliver efficiencies and improve resilience on a regional service footprint to ultimately improve patient care through the use of more ready-to-administer products, reduced time to first dose and releasing nursing time to care. This model is dependent on spoke facilities such as those at HDFT to continue to provide aseptic pharmacy services for those products that will not be supplied by hubs including bespoke patient specific dosing, short expiry dated products and medicines as part of clinical trials. The hub model will focus on high volume dose banded medicines / ready to administer injectables, which in turn will release capacity for spoke sites to increase in-house manufacture of other high risk injectable that are currently prepared at ward level.

The aims of the replacement programme are to:

- Achieve compliance with EL(97)52 audit standards Quality Assurance of Aseptic Preparation Services: Standards (QAAPS 5)
- Provide a safe and effective aseptically prepared medicines supply service (systemic anti-cancer therapy, parenteral nutrition (PN), clinical trials of intravenous medicines, monoclonal antibodies (MAbs) and other high risk injectables) to meet the current and predicted forecast increase in demand.
- Support the WYAAT regional aseptic collaboration and proposal for a "hub and spoke" model for aseptic medicine supply by ensuring that the HDFT "spoke" is able to meet medicines supply which cannot be met through the "hub" model.

9. Options Appraisal (Range of options considered considering cost/benefits/risk)

Option 1 – Do Nothing

This is the least preferred option. This option does not mitigate any of the risks relating to the ability to provide a safe and effective aseptically prepared medicines supply service.

This option describes a situation where the integrity of the facilities are left to further decline leading to closure of the aseptic unit and the inability to deliver any aseptic pharmacy services on site.

The closure of the aseptic unit may arise from:

a) A planned decision to cease manufacture due to QA metrics exceeding safe limits

b) An unplanned decision to cease manufacture due to a patient safety incident which wasn't previously detected through monitoring of QA standards
c) A forced closure imposed upon the Trust by an External regulator

Benefits
No requirement for capital funding

Risks
There is a risk to service delivery that the trust is not able to provide some cancer and other treatments because we have to close (or external regulators direct us to close) the Aseptic Production Unit at short notice because we are unable to maintain QA standards because the transfer hatches and air handling unit do not meet the required standards. The impact of this is potentially 300 Cancer patients per month (50% of all Cancer services patients) whom we would have to source aseptically prepared medicines via an alternative route or the Trust would no longer be able to offer treatment for these Cancer patients.
There is a risk to service delivery because the demand for outsourced aseptically prepared products exceeds available capacity and exceeds available product range in alternative commercial and NHS providers. - Closure of the unit would lead to a service model that is dependent on 100% outsourcing; the current capacity of the commercial and other NHS providers meets 40% of our requirements. The impact of this is that the Trust would be unable to source aseptically prepared medicines for 240 patients per month. - If the commercial and other NHS providers *could* meet increased outsourcing demand, there are still 25% aseptically prepared products which are unsuitable for outsourcing due to expiry dates less than 24 hours. The impact of this is that the Trust would be unable to source aseptically prepared medicines for 100 patients per month; 66% of these patients are in Cancer services and the remaining 33% are non-Cancer services.
There is a risk to service delivery that the trust is not able to provide support to clinical trials for investigational medicinal products (CTIMPs) requiring aseptic manufacture. In 2019/20 there were 107 patients requiring aseptically prepared injectables; CTIMPs cannot be sourced via alternative commercial or NHS suppliers due to legislation governing clinical trials.
There is a risk to patient safety because QA standards for the aseptic production of medicines may not be met because the transfer hatches and air handling unit do not meet the required standards.
There is a risk to staff safety due to exposure to substances harmful to health because the transfer hatches and air handling unit do not meet the required standards.
There is a financial risk if the unit has to close because we would have to seek external provision of medicines which is likely to be at increased cost.

Costs
Increased procurement costs due to requirement to source products externally.

Option 2 – Outsource 100% aseptically prepared medicines to the commercial sector or licensed NHS providers

This option is not preferred due to volatility in the commercial sector supply chain and lack of current provision through licensed NHS providers.

This option describes the case for de-commissioning the current HDFT aseptic production unit and moving entirely to an outsourced medicines supply route (the current level of outsourcing of aseptically prepared products is 40% at HDFT). Whilst this option provides some benefits in terms of patient safety, it does not mitigate the risks associated with service delivery.

There are three main commercial providers, and two of these providers are on improvement plans to address deficits in their abilities to maintain a safe and effective medicines supply chain.

There are only two licensed NHS aseptic units in West Yorkshire and Humber Coast and Vale footprint combined. Whilst there are plans to invest in licensed units (hubs) in West Yorkshire as part of the WYAAT regional aseptic collaboration, the model is dependent on the remaining units (spokes) continuing to provide aseptic medicines supply to meet service demand.

Benefits
No requirement for capital funding
The risk to patient safety is mitigated by using a licensed commercial/NHS supplier.
The risk to staff safety is mitigated by avoiding the need for exposure of substances harmful to health.

Risks
There is a risk to service delivery that the trust is not able to provide some cancer and other treatments because the demand for outsourced aseptically prepared products exceeds available capacity and exceeds available product range in alternative commercial and NHS providers. - Closure of the unit would lead to a service model that is dependent on 100% outsourcing; the current capacity of the commercial and other NHS providers meets 40% of our requirements. The impact of this is that the Trust would be unable to source aseptically prepared medicines for 240 patients per month. - If the commercial and other NHS providers *could* meet increased outsourcing demand, there are still 25% aseptically prepared products which are unsuitable for outsourcing due to expiry dates less than 24 hours. The impact of this is that the Trust would be unable to source aseptically prepared medicines for 100 patients per month; 66% of these patients are in Cancer services and the remaining 33% are non-Cancer services.
There is a risk to service delivery that the trust is not able to provide support to clinical trials for investigational medicinal products (CTIMPs) requiring aseptic manufacture. In 2019/20 there were 107 patients requiring aseptically prepared injectables; CTIMPs cannot be sourced via alternative commercial or NHS suppliers due to legislation governing clinical trials.
There is a financial risk if the unit has to close because we would have to seek external provision of medicines which is likely to be at increased cost.
There is a risk to organisational reputation is HDFT are not seen to be an effective partner in the WYAAT regional aseptic collaboration.
There is a risk to staff recruitment and retention through the loss of a highly trained and specialised workforce as a result of re-deployment to other areas of pharmacy.

Costs
Increased procurement costs due to requirement to source products externally.

Option 3 – Combine with another acute Trust as part of the WYAAT Hub model, however with no spoke service

This option is not preferred. This option describes the case for two organisations combining to operate out of one facility. This is not feasible under Section 10 exemptions. It may only be considered in the context of a licensed unit being hosted by one named organisation; HDFT have no plans to become a licensed unit.

Licensed units are designed to deliver high volume, high efficiency for a defined product range with long expiry dates. They achieve this by using automated technology and preparing products from a strict catalogue with defined doses. Licensed units are not designed to prepare bespoke products with tailored dosage regimens or those products with short expiry dates. E.g. LTHT have a licensed unit off-site, however they retain an unlicensed facility at both their acute sites SJUH and LGI to address the unmet need not achieved from a licensed provider.

This option has not been explored any further as the concept of a hub and spoke model is being pursued via the WYAAT aseptic regional collaboration. The WYAAT model is likely to be a two hub, six spoke model to meet the service demands. This option conflicts with the WYAAT OBC.

Option 4 – Full HDFT Pharmacy aseptic replacement programme

This is the preferred option.

This option describes the case for a full HDFT Pharmacy aseptic replacement programme. This option fully mitigates all of the risks described and provides a safe and effective medicines supply service to meet current and future forecast increase in demand.

This option supports the WYAAT regional aseptic collaboration by ensuring that the HDFT “spoke” is able to meet medicines supply which cannot be met through the “hub” model. This option supports the effective partnership working with colleagues in West Yorkshire and also future proofs for similar models being explored in Humber Coast and Vale.

Benefits
The risk to patient safety is mitigated by achieving compliance with all QA standards described in EL(97)52 audit standards Quality Assurance of Aseptic Preparation Services: Standards (QAAPS 5).
The risk to staff safety is mitigated by achieving compliance with the standards for all hatches and air handling units and reducing unnecessary exposure to staff of substances harmful to health.
The risk to service delivery is mitigated by using a combination of in-house manufacture, NHS and commercial providers to meet current and predicted forecast increase in service demand.
The risk to service delivery for clinical trials is mitigated.
The risk to financial cost pressure is mitigated by using a combination of in-house manufacture, NHS and commercial providers to meet current and predicted forecast increase in service demand.
The risk to organisation reputation is mitigated by continuing to support the WYAAT regional aseptic collaboration through the provision of “spoke” facilities that meet current and predicted forecast increase in service demand.
The risk to patient safety is mitigated as the implementation of the WYAAT “Hub” model releases capacity in the “spoke” facilities to increase manufacture of other ready to administer injectables and address the sizeable burden on nursing staff (the unmet need) making up injectable medicines on wards.

Risks
The risk to service delivery if the Air Handling Unit replacement is brought forward earlier than planned.
The risk to service delivery if outsourcing is not a viable option during project phase.
The risk to service delivery if York Teaching Hospitals are not able to provide mutual aid during project phase.
The risk to service delivery and financial implications is the work exceeds estimated timescales and costs.

Costs
The total cost of an aseptic replacement programme is estimated to be £1.5 million, based on equivalent pieces of work being undertaken in other organisations.

Benefits Realisation of the preferred option

This case is likely to impact the following performance metrics:

- **Aligns with the WYAAT regional aseptic collaboration and upgrade of "spoke" facilities**
  Capacity released by the WYAAT "hub and spoke" model allows HDFT to aseptically prepare other high-risk medicines that are currently prepared at ward level e.g. MaBs and paediatric CIVAS. This releases nursing time to care and improves patient safety by reducing medication errors as a result of incorrect preparation.
- **Aligns with the WYAAT outline model for Non-Surgical Oncology**
  With the implementation of Tier 2 and Tier 3 sites for Cancer services there will be a requirement for Tier 1 sites (HDFT) to increase Cancer services activity for less complex cases which will result in an increased demand for aseptically prepared medicines. This is most likely to impact gynaecology and upper GI cancers.
- **Aligns with HDFT Research and Innovation Strategy to increase clinical trial activity**
  Increased ability and capacity to support CTIMPs involving aseptically prepared medicines. The impact of this is increased commercial clinical trial income and improved recruitment and retention of clinical research staff.
- **Increased isolator capacity** to meet current and future demand for aseptically prepared medicines
  The current unit configuration is not fit for purpose and limits the number of operators who may work at an isolator. The new unit configuration moves to two 2-glove isolators in each clean room rather than one 4-glove isolator. This effectively doubles the available isolator capacity as two operators can work independently without risk of cross contamination. This future proofs for anticipated demands in aseptic services and can be managed safely within the existing footprint.
- **Increased productivity to meet service user needs**
  There is an opportunity to increase productivity within the unit to provide a responsive service to meet service user needs and demands. This could be achieved through increased number of operational sessions per day or moving to a seven day working model. This is not possible with the current unit due to staffing limitations and the enhanced cleaning procedures to mitigate the risks with the current facilities. These changes would require a corresponding increasing in staffing resource to support. This provides the opportunity to increase in-house manufacture and reduce outsourcing products which is more expensive and a fragile supply chain.

- **Improved staff recruitment and retention**
  HDFT Pharmacy aseptic services will be attractive premises to train and develop staff. This service area already has an excellent reputation for effective staff skill mix and career progression in a pharmacy specialty that nationally is very difficult to recruit to.
- **Enhance System Partnership working both within WYAAT and Humber Coast and Vale**

10. Viability (Potential Supplier? Value for money?)

There are several suppliers of aseptic facilities, including one, Bassaire, which WYAAT trusts have worked with previously and who has an excellent track record of undertaking similar aseptic replacement programmes in NHS Trusts. Informal conversations with Bassaire have been had regarding the scope of the work, rough outline of aseptic replacement plans and a rough estimated cost of a replacement programme. The estimated costs for this aspect of the programme are £700K excluding VAT.

These conversations have been without commitment and on the basis that the trust will need to complete a procurement process to appoint a supplier. We have engaged with LTHT Procurement who have advised a mini-competitive process for providers listed on the CPC Dynamic Framework. There are currently three providers listed on the framework who we know are capable of undertaking such a project.

We have engaged with a separate supplier regarding replacement of isolators under the capital assets replacement programme. We propose a direct award to Envair for this aspect of the programme. The department already hold a maintenance and servicing contract with Envair for isolators in the current unit. Two isolators have exceeded their usual lifespan, and a further two isolators are approaching their usual lifespan. We propose the replacement of all isolators to align with the aseptic replacement programme and the new aseptic clean room layout. This will involve the procurement of two positive pressure 2-glove isolators and two negative pressure 2-glove isolators. The total cost of the isolator replacement is estimated to be £140K excluding VAT.

In conjunction with regional QC colleagues we will develop a User Requirement Specification which sets out all the requirements that we need for the work to be completed and the standards of work expected to achieve compliance with EL(97)52 audit standards Quality Assurance of Aseptic Preparation Services: Standards (QAAPS 5). We will work closely with the Planning department in the development of the User Requirement Specification so we are clear what work is covered by HIF and what work is covered by the contracted provider. We are currently obtaining examples of User Requirement Specifications from other Trusts in the region who have undertaken similar work in the last 12-24 months. We anticipate that developing our own user requirement specification will take 1 month

Once the User Requirement Specification is finalised, we will go out to tender via the CPC Dynamic Framework which will take 2 months.

11. Financial Analysis

This section of the business case has only been completed with indicative costs because the actual costings depend on the outcome of the tender process described above and discussions between the contracted supplier and HIF Estates and Facilities.

Indicative Capital costs have been based on estimates of the cost of build works (provided by a Clean room supplier) based on the square footage of the unit, accurate costings for the cost of isolators, a detailed costing provided by NLAG for a full aseptic build undertaken by a Clean room supplier in 2015/16. Information from colleagues in other trusts has also provided an indicative capital cost for this type of project of around £1.5m.

We have liaised with Directorate Finance Managers to plan for this as part of Capital allocation for 2022/23 and £1.5m capital funding has been allocated in 2022/23. However, the forecast project plan now extends into 2023/24 so we will need to determine whether the capital cost can also be spread across 2022/23 and 2023/24. Final costs and the funding profile will be confirmed following completion of the tender process.

Capital indicative costs

Build and architect work approximately £700K exc VAT (No VAT due to procurement through HIF)
NLAG project total costs 2015/16 (excluding equipment) £610K exc VAT
Estimate project total cost (excluding equipment) provided by cleanroom provider £3,800 / m2 to £4,800 / m2. The area of the space is about 120m2 so budget figure would be £450K to £570K.

Isolator replacement including delivery, installation and replacement approximately £140K exc VAT
Two 2-glove positive pressure isolators £70K exc VAT
Two 2-glove negative pressure isolators £70K exc VAT

Contingency and price increase risk due to inflation
25% of £840K = £210k

Project Implementation Costs
Project Manager B7 1.0wte approximately £50K
HIF professional fees approximately £100K

TOTAL CAPITAL COSTS (exc VAT): £990k exc contingency; £1.2m inc contingency
TOTAL CAPITAL COSTS (inc VAT): £1.188m exc contingency; £1.44m inc contingency
(NB Currently £1.5m capital funding has been allocated to the project so, since costs are only indicative at this stage, approval is sought for capital costs up to £1.5m)

Revenue indicative costs

Transport costs approximately £50K
Transport of staff and product between HDFT and York on a daily basis for duration of project £105/day

Estimated project duration 18 months (78 weeks). Estimated three transport runs per day.
Total transport costs estimated £50K

Other costs explained

There are no additional drug costs associated with outsourcing as all of these drugs as pass-through costs with NHS England.

There are no rental costs associated with using York Pharmacy Aseptic facilities.

The costs associated with preparation of the User Request Specification required for tender and subsequent commissioning of the unit on completion of the build and installation works are covered by an existing contract and SLA with Stockton QC Laboratory at no extra cost.

Summary
The indicative costs described of a full aseptic unit replacement are in the order of just under £1M, or £1.2m with contingency.

NB. Finance template based on the indicative costs to follow. A final, detailed finance template will be produced following the tender process.

12. Delivery (Is it achievable? Capacity to deliver the project? Robust systems and processes in place?)

Implementation Plan:

The aseptic replacement programme has many inter-dependencies, the table below gives a broad outline of what needs to happen and when to ensure successful delivery of this project.

The main risks associated with this implementation plan is that the timescales for the Air Handling Replacement scheme being undertaken as part of the SALIX work are not within our control. It is highly unlikely that we would be able to re-commission the existing unit after these replacement works, and any re-commissioning work takes approximately 4 months.

The consequence of this shutdown before a tender process has been completed and contract awarded is that we do not know the capacity of the supplier to deliver the project within the timescales wanted. This will be mitigated in part by including in the tender process the requirement to complete the project within defined timescales.

Milestone / Objective	Description of action	Lead	Deadline for completion
Risk register (Speciality)	Describe actual risk and impact of risk and review monthly at Pharmacy Quality of Care	RV	Completed
Risk Register (Directorate)	Escalate risk score > 12 to LTUC Directorate Quality and Safety Governance Group	KW	Completed

Risk Register (Corporate)	Raise awareness with Executive team and escalate risk for inclusion on Corporate risk register	MG	Completed 14/01/22
Engage with provider	Engage with provider regarding aseptic replacement plans and rough estimate of work	RV	Completed
Listed providers on a Contract Framework	LTHT procurement leading on getting providers listed on CPS Dynamic Framework	WH	Completed 18/02/22
Outsourcing options	Review all product line and identify outsourcing options	RV/GA	Completed
Technical agreement for mutual aid	Agree planned scope of mutual aid and technical agreement	KW/RV	Completed
Scheduling of Air Handling Unit replacement	Liaise with Phil Sturdy to agree timescales for AHU replacement and planned shutdown of aseptic unit	KW/RV	Completed
Risk assessment for mutual aid to York	York to seek mutual aid from Harrogate during their isolator upgrade April/May 2022	RV	In progress
Risk assessment for mutual aid to Harrogate	Harrogate to seek mutual aid from York during aseptic unit replacement	York	In progress
Business case approval process	Pharmacy Strategy and Planning LTUC Directorate Board Business Case Review Group SMT Resource Committee Trust Board (if exceeds £1M)	KW	01/02/22 28/02/22 09/03/22 23/03/22 28/03/22 30/03/33
User Requirement Specification	Develop specification document for use in the tender process Engage with Estates and Facilities to understand impact of work on them	KW/WH/AG	30/04/22
Tender process	Commence Tender Process	WH	01/05/22
Step up outsourcing capacity	Step up outsourcing activity to so that commercial suppliers have time to build increased capacity into system	RV/GA	10/06/22
Air Handling Replacement	Planned shutdown 10/06/22. New AHU commissioned 29/07/22	PS	10/06/22
Planned shutdown of aseptic unit	Planned shutdown to commence when AHU replacement begins. Move entirely to alternative medicines supply sources with effect from 10/06/22	RV	10/06/22
Commence mutual aid	Harrogate colleagues to work at York for duration of project phase	RV	10/06/22
Relocate Aseptics and Cancer Services team	Re-assign Chief Pharmacist office for Aseptics and Cancer Services team for duration of project phase	KW	10/06/22

Alternative SACT dispensing area	Re-assign clinical trials room in Pharmacy dispensary for SACT dispensing and checking area	RV	10/06/22
Tender process	Complete Tender Process, appoint supplier and sign contract	WH	30/06/22
Supplier commences work	To allow for mobilisation etc. There is a risk that the supplier is not able to mobilise this quickly due to other projects.	RV	01/07/22
Supplier finishes work	Based on estimated duration of project 12 months	RV	30/06/23
Re-commission unit	2 month slippage built into timescales due to number of unknown variables	RV	31/08/23
Cease contingency arrangements	Cease mutual aid with York	RV	31/08/23
New aseptic unit opens	Once new aseptic unit opens, gradually reduce outsourcing activity to pre-baseline and step-up in-house activity to pre-baseline	RV/GA	01/09/23

13. Recommendation

Resources Committee and Trust Board are recommended to approve:

- Replacement of the trust's pharmacy aseptic unit in order to mitigate the quality and service delivery risks set out in this case.
- Indicative costs for the project of up to £1.5m capital and £50k revenue
- Initiation of the procurement process to appoint the suppliers and obtain final costs for the project

Checklist

Colleagues are asked to ensure that consideration has been given to the following and is addressed in the business case.

Questions to be answered (If applicable)	✓	
Is additional space required for the workforce, where is this and has it been agreed	Yes	See section 12
Are additional Electrical sockets/network points available?	Yes	
Is sufficient Wi-Fi available?	Yes	
Is IT equipment required (eg phone/laptop/desktop)?	No	
Data storage/server requirements identified.	NA	
Is there adequate furniture available?	Yes	
Are licences required for any of the IT software and costs identified?	NA	
Are new uniforms required?	NA	
Delivery and installation requirements	Yes	See section 12
Interdependencies on other business cases	No	
Impact on other services	Yes	See section 12
Energy implications (increase in electricity, gas, water consumption)	Yes	See section 12
Maintenance requirements	Yes	See section 12
Any contract implications	Yes	See section 12
Future replacements included on operating plans	Yes	
Infection Prevention and Control implications	No	
Procurement regulations	Yes	See section 12
Radiation and non-ionising protection implications	NA	
Current asset number, location and net book value of equipment or building etc	Yes	
Contract variations need to be considered if the case impacts HIF	NA	