North Yorkshire County Council
MEETING OF THE CORPORATE DIRECTOR, HEALTH AND ADULT SERVICES AND EXECUTIVE MEMBERS CLLR MICHAEL HARRISON AND CLLR ANDREW LEE

Friday, 11 March 2022 / 1.30 pm

A G E N D A

Officer Lead

1 **Declarations of Interest**

2 **Notes of previous meeting held on 11 February 2022 (Pages 3 - 4)**

3 **Items for Corporate Director decision in consultation with Executive Members**

a. **Pilot an integrated working arrangement between the Council and the CCGs (Pages 5 - 8)**

To agree a proposal to pilot an integrated working arrangement between the Council, Vale of York Clinical Commissioning Group (CCG) and North Yorkshire CCG with a focus on quality assurance and quality improvements in care setting

b. **Targeted Prevention in local communities (Pages 9 - 12)**

To consider the options for the future commissioning of targeted prevention activity in local communities and determine the agreed approach

c. **Fees for in-house Community Care Services for 2022/23 (Pages 13 - 16)**

To approve the proposed changes in fees and charges for in-house community care services, plus meals, transport and laundry services for 2022/23

d. **Fees payable for external providers of Social Care Provision (Pages 17 - 26)**

To approve fees and annual uplift level for 2022/23

e. **S75 HARA Agreements (Pages 27 - 134)**

To consider and agree the extension of the existing Section 75 County Council/NHS Commissioner and Provider agreements for the integrated community health and social care services in the Harrogate district. Give consideration to any consultation requirements

4 **Items for Executive Member decision**

None

Circulation:

Executive Members	**Officer**	**Note taker**
Cllr Michael Harrison	Richard Webb	Dawn Day
Andrew Lee	Chris Jones-King	

Rachel Bowes
Lisa Moore
Dale Owens
Adam Gray
Abigail Barron

NORTH YORKSHIRE COUNTY COUNCIL
HEALTH AND ADULT SERVICES EXECUTIVE

Meeting of the Health and Adult Services Executive

11 February 2022 at 13:30
Via MS Teams

DECISION RECORD & MEETING NOTES

Present: Councillor Michael Harrison and Councillor Andrew Lee

Officers: Anton Hodge (AH)

Apologies: Richard Webb (RW)

Minutes: Dawn Day

NO.	ITEM	For Note/ Action
	Declaration of Interests County Councillor Michael Harrison declared an interest as a relative works in Health and Adult Services.	
1	**Items for Corporate Director Decision**	
	1. To approve the extension of the Welfare Benefits Unit Contract The Welfare Benefits Unit (WBU) is a second tier advisory service providing training and ongoing information. They support NYCC Benefits and Assessment teams, housing associations, carers resource, district councils and housing departments. The proposal was approved to allow further exploration into the current business model and service delivery options. **Agreed:** It has been agreed to extend and vary the contract for the provision of a North Yorkshire Welfare Rights, Information and Guidance Service provided by the Welfare Benefits Unit (WBU) for up to 2 years from 1st April 2022 to the 31st March 2024. Approval has also been given to vary the extension clause from 2 years to 4 periods of 6 months. It is proposed the contract will be reviewed and extended at 6 monthly break points **2. To approve the extension of the Citizens Advice Bureau (CAB)** The Citizens Advice Bureau (CAB) is a trusted and recognised public facing organisation, which provides holistic advice and information covering a broad spectrum of topics including debt,	

	housing, unemployment, benefits and bankruptcy. They provide free, confidential, and impartial legal advice, information, and support across North Yorkshire and work with over 200 partners. The CAB meets all KPIs, attends all contract monitoring meetings and routinely and reliably provides quarterly reports and extensive updates in relation to its performance and service offer overall. By extending the contract, this allows for any changes to be embedded and other considerations to be addressed as part of the local government reorganisation. The service has been provided on an initial term of 5 years from 1st April 2017 to the 31st March 2022. The two-year extension is provisioned for in the current contract. **Agreed:** It has been agreed to extend the current contract for the Provision of a North Yorkshire Information and Advice Service for 2 years from 1st April 2022 to the 31st March.	
2	**Items for Executive Member decision**	
	None.	
3	**Note of previous meeting held on 14 January 2022**	
	Reviewed and agreed.	

North Yorkshire County Council

Health and Adult Services

Executive Members Meeting

11th March 2022

REPORT TO Corporate Director of Health and Adult Services (HAS) in consultation with Executive Member for Adult Services and Health Integration and the Executive Member for Public Health, Prevention and Supported Housing, including Sustainability and Transformation Plans.

Adult Social Care: A Pilot for the Quality Team

1.0 Purpose Of Report

This proposal is to pilot a new working arrangement using a Section 113 Agreement between the local authority and the NHS Vale of York CCG which aims to improve quality assurance and improvement in care settings.

2.0 Background

2.1 Over the period of the Covid-19 pandemic response NYCC Quality Monitoring and Quality Improvement Teams have worked closely with NHS colleagues across our three main Clinical Commissioning Groups (CCG) and Integrated Personal Commissioning Teams (IPC).

2.2 There has been particularly close working between the NHS Vale of York CCG (VoYCCG) team and the Quality Improvement Team (QIT) in the Vale of York area where both teams are routinely deployed into care settings to assess quality and offer practical support to improve quality where needed. There are also excellent relationships with NHS North Yorkshire CCG (NYCCG) and NHS Bradford CCG; however, their teams are configured differently to the team at VoYCCG.

2.3 The NYCC Quality and Market Improvement Team has historically included Brokerage, Contract Management, quality assurance and provided a timely response to incidents impacting on HAS/adult social care.

2.4 During 2021, the brokerage function moved to Prevention & Service Development and plans are currently underway to transfer to contract management to the Corporate Procurement Team.

3.0 Issues for consideration

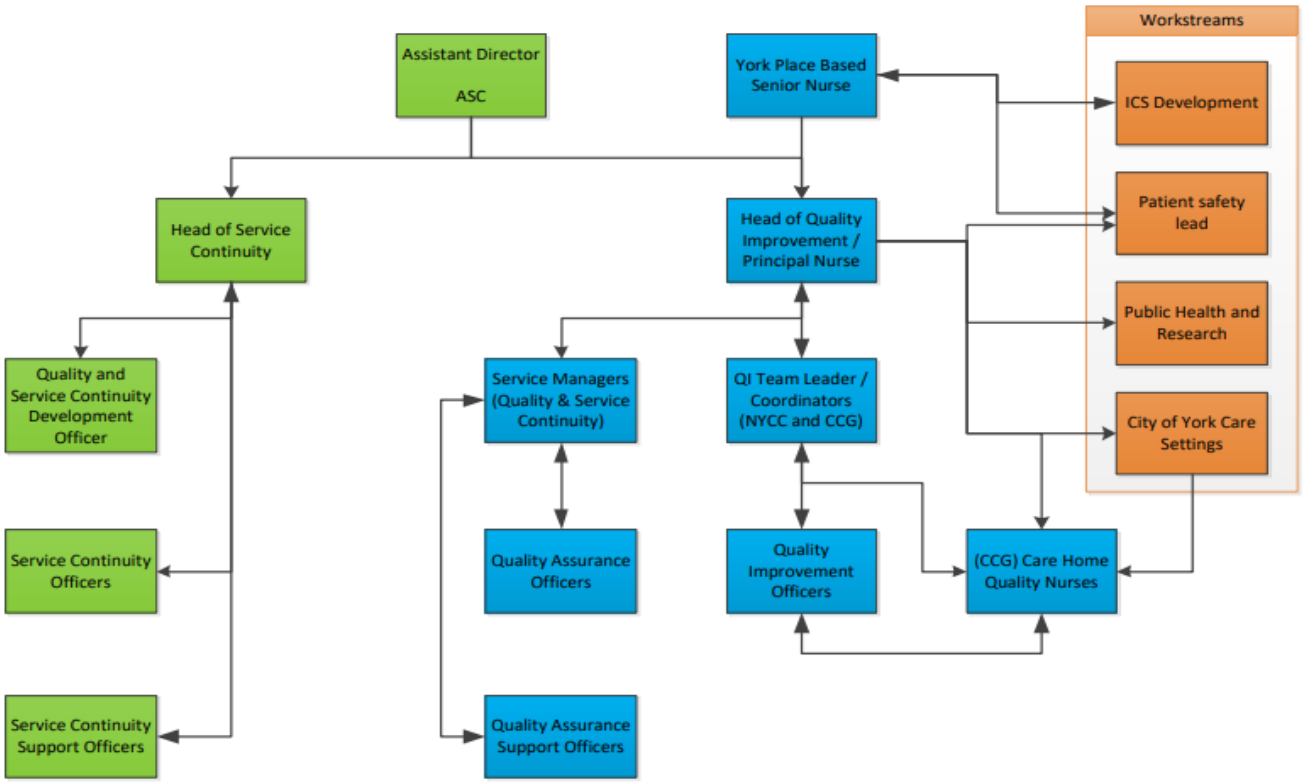
3.1 Temporary funding has been agreed for a Service Continuity Team to support resilience within teams as the pandemic continues. This will include responding to any incidents

caused by weather, utility failures etc. as well as provider failure (as a coordination point for multi-agency response). This leaves a resource that can be dedicated to quality assurance and improvement across all care settings within NYCC as well as all commissioned services.

3.2 The Quality Improvement Team (QIT) Manager has recently been promoted to the role of Head of Provider Services leaving us with an opportunity to integrate our working arrangements with CCG colleagues.

3.3 The funding for the QIT establishment, which was doubled to provide a response to diminishing quality in care settings during the pandemic, has been approved as a permanent resource. This enhances the offer around quality improvement to the care sector across North Yorkshire.

3.4 A proposed new structure is outlined below:



3.4.1 The addition of a team leader within QIT allows the new Head of Quality / Principal Nurse the continue to support some of the other work streams within their established role.

3.4.2 It is anticipated the Quality Team will work closely with the Service Continuity Team when supporting provider failure or the impact of incidents.

4.0 Performance Implications

4.1 In line with the most recent Integration White Paper 'joining up care for people, places and populations', the benefits associated with this proposal are very much in line with ambitions both at a national and local level to work together across traditional

organisational boundaries to improve the quality of care locally and in particular across the Vale of York locality.

4.2 It will also allow us to pilot new ways of working using section 113 guidance and understand how that can be applied in other service areas to create opportunities for more efficient use of resources around 'place' to improve outcomes for the people who use our care settings.

4.3 Sharing of financial and human resources offers both organisations some economies of scale while at the same time NYCC benefitting from the skills and experience of a highly respected manager from the CCG.

5.0 Financial Implications

Budget / investment

NYCC	Contribution to lead quality nurse role from QIT manager post	60995
	Service Managers - Quality and service Continuity. Ability to step into 8-8 over 7 days. 3 x fte	182985
	Senior QI Officer - to lead the coordination of the daily team work and to report to the Head of QI - would revert to L if pilot does not work out. 1 x fte	55599
	Quality Improvement Officers 9 x FTE	500391
	Care Setting Support Officers 4 x fte	183584
	Quality Assurance officers 7 x fte	321272
	Quality Assurance Support Officers 2 x fte	62718
		£1,367,544 (includes COMF funding)
VoY CCG	Band 8b (Will be the) .66 fte for NYCC	56000
	Band 7 .66 fte for NYCC	49000
	Band 6 .66 fte for NYCC	33000
	Band 5 .66 fte for NYCC	28000
		£166000
NYCCG	Band 6	46000
	1 x fte	**£46000**

	Additional funding from previous funding arrangements	**£4000**
	(This funding is in addition to the Band 8a role which supports the care setting response but will not be integrated into the team)	

6.0 Legal Implications and Governance compliance

6.1 The Council and the CCG intend to enter into a S113 Agreement for the pilot. Section 113 of the Local Government Act 1972 enables local authorities and health bodies to place their staff at the disposal of the other organisation by agreement. The health bodies covered by S113 include the CCG who NYCC propose to contract with for this pilot, and the staff who are provided pursuant to this arrangement may exercise any of the functions of NYCC that are delegated to them.

7.0 Equalities Implications

None identified

8.0 Recommendations

- That HASEX approve the proposal
- To use an S113 agreement to share staff between the local authority and CCG
- To complete approvals across CCG partners as necessary
- To use the pilot period to review current job descriptions for the Head of QMI, QIT Manager and CCG role
- To explore further integration between the quality teams of each organisation.
- To explore options for Medicines Management and IPC to have direct links / come into the team.

Author **Rachel Bowes**

Date **11 March 2022**

North Yorkshire County Council

Health and Adult Services

Executive Members Meeting

11th March 2022

REPORT TO Corporate Director of Health and Adult Services (HAS) in consultation with Executive Member for Adult Services and Health Integration and the Executive Member for Public Health, Prevention and Supported Housing, including Sustainability and Transformation Plans.

TARGETED PREVENTION IN LOCAL COMMUNITIES

This report includes a supporting Annex which contains exempt information as described in paragraphs 1, 3 and 5 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended).

1.0 Purpose Of Report

To consider the options for the future commissioning of targeted prevention activity in local communities and determine the agreed approach

2.0 Background

The paper focuses specifically around the future of the Health and Adult Services (HAS) Wellbeing and Prevention Service - a commissioned service to help people to stay well and independent in their local communities and to reduce the demand for long-term statutory services, care and support.

Key service **Outcomes** as identified in the original service specification were as follows:

- People are healthy
- People are safe and independent
- People experience social and emotional wellbeing
- People experience economic wellbeing
- Carers are healthy and experience wellbeing

Key service **Deliverables** as identified in the original service specification included;

- Information, advice and signposting (IAS)
- Social inclusion and social activities to address loneliness and social isolation.
- Low-level practical support (e.g. help with shopping, gardening, practical household tasks).

The service commenced on 1st October 2018 and the original term runs to the 30th September 2022. There is a 2 year extension clause built into the contract, plus a further 2 year extension option. The service is split across 7 lots; Craven, Harrogate, Hambleton, Richmondshire, Scarborough, Ryedale and Selby.

3.0 Issues for consideration

Over the past 12 months several large-scale, online events have brought partners together at a community and neighbourhood level to consider the following:

- How do we start to understand what the needs and ambitions of communities are?
- How best to align the different assets of the state (NYCC, Health etc.) alongside those of the VCSE sector and residents in neighbourhoods and communities?
- How to build on the various community responses to COVID by promoting the concept of Community Anchors - a clearly identifiable, recognisable network of organisations that galvanise and drive forward community energy?
- How to develop generous leadership - channelling resource to and through Community Anchors that are delivering everything themselves, but instead are networking with 40 – 50 smaller grassroots groups and voluntary organisations within a community?

A key purpose of these events was to also consider how HAS can commission wellbeing and prevention activity in a way that empowers communities e.g.

1. A clear commitment to co-production. How are we going to co-produce in all we do?
2. How to identify and fund (in a more collaborative way) hyper local, sustainable Community Anchors?
3. How to work in a collaborative way, promoting generous leadership over direct competition?

As a result of these events and additional consultation with HAS colleagues the following options have been developed around the future of the targeted prevention activity within local communities:

Option 1 Do Nothing
Through this approach NYCC would continue with existing service(s) across the 7 lots in their present form, and extend this provision to 30th Sept 2024 (with the option of a further 2 year extension thereafter).

Option 2: End the existing service on 30th Sept 2022; and develop new provision built around community anchor-style organisation(s) delivered through grant funding that is aligned to outcomes agreed in collaboration with Stronger Communities and Living Well teams.

4.0 Performance Implications

If **Option 1** were to be approved, the existing service would continue to support some vulnerable older people to live safely and independently at home, allowing some carers to take a break. The service would address some areas of loneliness and isolation through befriending, social groups and other interventions. Some new activities and support groups would be setup.

However, the service has been challenged in terms of consistency and coherence. This has been driven by generalised, high-level outcomes which do not reflect grassroots community aspirations, or the subtleties and complexities of need within different neighbourhoods.

Through this approach providers will not have the flexibility to develop their own solutions to issues presenting within their individual communities and neighbourhoods.

If **Option 2** were to be approved it would offer the opportunity to harness and build on community assets, sustaining the capacity and momentum of the new initiatives and grassroots innovations that have emerged during the COVID pandemic.

It would also offer an opportunity to align service outcomes with new and emerging neighbourhood priorities as we learn to live with COVID, and to develop a strengths and assets based approach by working with and through a Community Anchor model. The service would respond to the ebb and flow of needs within communities, using different partners and assets to find solutions for whatever that need is at that moment in time.

Refreshing the service could lead to a potential loss of revenue for existing providers, including a reduction in core funding / operating costs. However, the impact would be mitigated by working with existing providers over the next 6 months to ensure that they have a sustainable exit strategy / that no individuals are disadvantaged or left without service provision. Whilst some providers may see a reduction in funding it is likely that they will play a part of new neighbourhood partnership arrangements.

5.0 Financial Implications

Whether the existing approach is extended or a new grants based service is introduced it is proposed that, as a minimum, the existing NYCC budgetary contribution of £405,019 per annum is sustained within the new approach. This in itself will not represent a significant investment in targeted prevention across the county, but there will be opportunities for community anchor organisations to match fund and leverage additional resource (particularly through the refreshed grant based approach).

The North Yorkshire and Vale of York Clinical Commissioning Groups (CCGs) have indicated their willingness to continue making a matched funding contribution into the new service model. If the service model is refreshed this creates an opportunity to significantly strengthen the financial contribution of the CCGs (and their involvement in service shaping / delivery) since a refreshed and effective, strengths-based preventative service could have a meaningful impact on the provision of primary and community care.

6.0 Legal Implications and Governance compliance

Discussions have been held with NYCC Legal who have provided clear and detailed analysis of the differences and contexts regarding application of contracts or grants.

7.0 Equalities Implications

There no specific equalities implications associated with the report.

8.0 Recommendations

For HASEX to consider the options for the future commissioning of targeted prevention activity in local communities and recommend either Option 1 or Option 2 as set out above.

Author **Adam Gray**
Date **01/03/22**

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NORTH YORKSHIRE COUNTY COUNCIL

HEALTH AND ADULT SERVICES EXECUTIVE

11 MARCH 2022

FEES AND CHARGES FOR IN-HOUSE & COMMUNITY CARE SERVICES 2022/23
REPORT OF THE CORPORATE DIRECTOR, HEALTH AND ADULT SERVICES

1. PURPOSE OF THE REPORT

1.1 This report sets out the proposed changes in fees and charges for in-house community care services plus meals, transport and laundry services for 2022/23.

2. BACKGROUND

2.1 Each year the revised maximum charges to users of our in-house services are agreed based on the uprating of existing charges.

3. CHANGES IN CHARGES FOR 2022/23

3.1 Traditional uplift of charges is an exercise carried out annually and the new charges are implemented in April to coincide with the benefit uplift awarded by DWP (from Monday 11th April 2022 for 2022/23). The proposed new rates for services which are not subject to the means tested financial assessment are outlined in Table 1.

TABLE 1: CHARGES FOR SERVICES NOT SUBJECT TO A FINANCIAL ASSESSMENT

Description of Service	Rates 2021/22	Proposed Rate 2022/23	% Increase
Meals;			
Main	**£2.85**	**£2.95**	**3.5%**
Sweet	**£1.05**	**£1.10**	**4.8%**
Full Meal	**£3.90**	**£4.05**	**3.8%**
Laundry	**£5.25**	**£5.45**	**3.8%**

3.2 Transport charges are currently £7.50 per journey (with a cap of £40 per week). It is proposed that these figures are increased to £7.75 per journey (3.38% increase) with a cap of £41 per week (3.8% increase).

3.3 Table 2 below details the proposed charges for those services being directly provided by NYCC and which are subject to a financial assessment.

TABLE 2: FEE SCHEDULES FOR NYCC MANAGED SERVICES 2021/22

		2021/22	2022/23	% change
Elderly Persons Home		Max. charge	**Proposed Max. charge**	
Day Care	Per place per day	£35.20	**£36.60**	4.0%
Respite - EPH	Per 24 hour period	£82.75	**£86.00**	3.9%
	Weekly rate	£579.25	**£602.00**	3.9%
Learning Disability Services				
Day Centre	Per place per day	£68.80	**£71.50**	3.9%
Respite	Per 24 hour period	£248.50	**£258.00**	3.8%
	Weekly rate	£1,739.50	**£1,806.00**	3.8%
Personal Care at Home				
Per contact visit				
Days	15 min	£9.15	**£9.50**	3.8%
	30 min	£13.45	**£13.95**	3.7%
	45 min	£17.75	**£18.40**	3.7%
	60 min	£22.25	**£23.10**	3.8%
Nights	15 min	£11.30	**£11.75**	4.0%
	30 min	£16.95	**£17.60**	3.8%
	45 min	£22.55	**£23.40**	3.8%
	60 min	£28.15	**£28.15**	3.5%

3.4 Table 3 below details the proposed charges related to the deferred payments process. These reflect that there has been no increase in valuations and legal fees.

TABLE 3: FEE SCHEDULES FOR DEFERRED PAYMENT COSTS 2022/23

fee	**2021-22 rate**	**2022-23 rate**	**% increase**
Legal costs	165.00	171.00	3.6%
Land registry search	48.00	49.75	3.6%
Valuations	350.00	350.00	0.0%
	500.00	500.00	0.0%
Admin fee (set up)	134.50	139.50	3.7%
Annual fee	386.40	400.00	3.5%

4 RESOURCE IMPLICATIONS

The budget for income from in-house service provision is approximately £4.5m in 2022/23 and the planning assumption currently incorporated into the medium term financial strategy assumes 'inflation' will be charged. The actual levels of income

generated arise from a combination of the level of charges, the number of users and, critically, the assessed levels of contribution from clients.

5 CONSULTATION

Consultation originally took place as part of the introduction of the Fairer Contribution policy via the Area Committees through a questionnaire to user representative groups as well as being considered by Care and Independence Overview and Scrutiny Committee. No further consultation has been undertaken for this annual uplift process.

6 EQUALITIES IMPACT ASSESSMENT

This was undertaken as part of the introduction of the Fairer Contribution policy and it is therefore not considered necessary to undertake another assessment for routine uplift. However we do continue to monitor the impact of the change of policy regularly and this is reported to the Care and Independence Overview and Scrutiny Committee on a periodic basis.

7. RECOMMENDATIONS

The Corporate Director Health & Adult Services in consultation with the executive member for Health and Adult Services is asked to:-

(a) Approve the new charging rates as outlined in section 3, Tables 1 and 2 of this report, to be effective from 11 April 2022

Richard Webb
Corporate Director
Health and Adult Services

Report prepared by Anton Hodge, Assistant Director – Strategic Resources

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NORTH YORKSHIRE COUNTY COUNCIL

Health and Adult Services Executive
Fee uplifts for Residential, Nursing, Domiciliary Care and Community Based Services 2022/23

11 March 2022

1.0 PURPOSE OF THE REPORT

1.1 This report informs the Executive member of proposed fees for Residential, Nursing, Domiciliary Care and Community Based Services in 2022/23.

2.0 BACKGROUND

2.1 Contractually the Council has a commitment to review fee levels on an annual basis. The Council has always had an obligation to take account of the market pressures and to consult with providers on fee levels but from April 2015 new statutory responsibilities under the Care Act 2014 require the Council to shape and sustain its markets.

2.2 In setting fees the Council has a duty to pay due regard to the costs of providing care.

2.3 Since 2016 and subject to consideration of any new issues and updates on the market conditions, fee levels for residential and nursing care homes have been uplifted for pay annual inflationary increases for placements, based on a formula which took into account:

- Changes in Living Wage
- General Inflation (CPI)

2.4 This formula approach has been based on the Actual Cost of Care exercise undertaken prior to 2016 and which has now run its intended course. Work has been undertaken over the past year on a new Actual Cost of Care exercise and findings have been shared with representatives of the care sector.

2.5 Delays in the intended roll-out have been caused due to the concentration of the sector on dealing with the Coronavirus pandemic and, it has been agreed that the work undertaken will inform a roll out of the review during 2022/23. Meanwhile, and as per 2021/22, the proposal is to agree an inflationary financial settlement for 2022/23 that will complement the work on the Actual Cost of Care (ACOC) exercise and this is set out below.

2.6 Consultation has taken place with providers through the Independent Care Group (ICG) and an agreed way forward is set out in section 3 below. This continues the

process agreed for the current financial year whereby we have moved away from a universal rate while beginning the implementation of ACOC.

2.7 The rates below, if agreed, are within the funding agreed in the Council's 2022/23 budget, although inflation is of course allocated on budget and not on any overspend.

2.8 The inflationary award is separate from additional support given to providers this year to assist with the costs of the pandemic, including additional payments made to staff to cover the period December 2021 to March 2022.

3.0 PROPOSED FEE LEVELS

Residential and Nursing

3.1 The rates are as set out below:

There will be four ACOC rates and these include an amount for Return on Investment. These reflect an inflationary increase of 5% on the 2021/22 ACOC level, using the methodology set out in the ACOC which takes account of increases to national Living/Minimum Wage and general inflation (CPI).

	With ROI
Nursing	819
Nursing with Dementia	826
Residential	742
Residential with Dementia	784

3.2 The Cost of Care rate will be implemented for existing packages over three years. In essence that means that each package would receive 1/3rd of the difference between the current rate and the ACOC rate, reaching full ACOC by April 2024. However we will commit to reviewing this position and subject to funding, look to move remaining packages to ACOC levels in 2023/24. This review will look at funding available, including any unspent grants, plus the amount of packages still above ACOC level.

3.3 Each year the ACOC rate will be inflated.

3.4 For those below the ACOC rate, inflation will be applied at the full level.

3.5 For those above the ACOC rate, no inflation will be applied.

3.6 For those already above ACOC and not receiving inflation, a safeguard will be put in place to ensure they do not drop below the ACOC rate (as this is inflated each year).

3.7 All new packages will be paid the ACOC rate, *except in exceptional circumstances and where agreed otherwise.*

3.8 ACOC rates only apply to packages of care for over-65s.

3.9 This is a significant increase in care rates to be paid to providers in North Yorkshire as we move to full implementation of ACOC, but it is necessary to ensure continued provision for people with care needs in the county and to support providers. For those packages currently receiving the county rates of £592 (nursing) and £599 (residential), they will see an increase in the rate of up to 16% in April 2022. The affordability of this is reliant on new packages being agreed at the ACOC rate and not above it, and this risk will be monitored by officers during 2022/23.

Non-residential

3.10 3.1% for all non-residential services and learning disability residential services. This will include day opportunities.

3.11 Increases to domiciliary care packages will be targeted to support those currently receiving lower fee rates. This is ahead of an expected ACOC exercise for this sector in readiness for changes to care charges from next year. The offer for 2022/23 is linked to the UKHCA rate (£23.20 from April 2022) and can be summarised below:

(i) A flat rate increase of £1.68 to contracts currently at or below £21.52 (with increases up to 17% and an average increase of 7.3%)
(ii) This will reduce by 1p for every 1p currently above £21.52. In effect every package currently between £21.52 and £23.20 will now be at UKHCA rate of £23.20
(iii) A flat rate increase of 36p (average increase of 1.5%) for rates currently between £23.20 and £25
(iv) A flat rate increase of 20p (average around 0.8%), for rates currently between £25 and £25.40, up to maximum of £25.40
(v) Any rates above this to have 0% inflation, pending the domiciliary care ACOC

3.12 Increases to supported living care packages will also be targeted to support those currently receiving lower fee rates. The offer for 2022/23 is summarised below:

- 5% to those packages currently paid below £19 per hour
- 3.1% to those above that rate

3.13 All future payments will continue to be made four weeks in advance with retrospective reconciliation to support cash flow within the market.

3.14 For placements of people in care homes outside of North Yorkshire County Council we will honour an uplift agreed by the host authority where they have undertaken an

Actual Cost of Care exercise, and will consider individual business cases where there is no Actual Cost of Care exercise in place.

3.15 For placements of working age adults in care homes within North Yorkshire County Council area 3.1% will be applied to all residential/nursing placements.

3.16 The rate for Domiciliary Care providers allows for 15 minute payments. Whilst we do not usually commission care for 15 minutes only there are times when support plans require 45 minutes of care and very occasionally for 15 minutes.

3.17 We also intend to undertake a review with the ICG to begin no later than 30 September 2022 to look at the impact of this award on providers and, subject to grant conditions, the distribution of any additional funding from government. This review will also look at those packages receiving the inflation award of 3.1%, such as Supported Living.

4.0 ANALYSIS OF THE PROPOSALS

4.1 There has continued to be much national focus in the last year about the frailty of the care market in England.

4.2 In addition to the fees paid by the Local Authority Nursing care homes will receive Funded Nursing Care payments for eligible residents from health commissioners. This is set nationally by the NHS and as of 1 April 2021 the rate was £187.60 per week but the rate from April 2022 has not been set as yet.

4.3 Residential and nursing occupancy rates have reduced overall during the pandemic, however some areas of the county are seeing high occupancy rates particularly for nursing care.

4.4 A range of national and local support mechanisms have been in place since early in the pandemic to reduce the financial impact of the pandemic on the care market and, where possible, prevent provider failure. This includes support from central government, including:

- Infection Prevention Control funding;
- A national Personal Protective Equipment portal; and,
- The block purchasing of discharge beds.

4.5 At a more local level, the county council has implemented:

- Compensatory payments;
- Supplier relief and hardship processes;
- Payment on planned activity; and,
- Payments in advance for the annual inflation settlement

4.6 The Strategic Market Development Board is in place to address the wide range of challenges in the social care market, and to provide a strategic focus on the implementation of solutions.

4.7 The Board has a multi-agency membership, and has set key priorities for its development work. One of the key areas of work relates to the £167 Million spent each year via three approved provider lists (APLs), covering care homes and extra care, day services, and domiciliary care.

4.8 The process has included a workshop for the System Leadership Executive, involving people from a range of organisations, including local authorities, CCGs, NHS provider trusts, the Independent Care group and voluntary sector organisations.

4.9 It is anticipated that new contracts will start later in 2022.

4.10 The procurement will also take into account the extensive Actual Cost of Care work which has been carried out in the past two years. This will aim to ensure that providers have sustainable funding going forward while also seeking to limit where costs have exceeded council rates.

Residential and Nursing care Homes

4.11 In North Yorkshire between April 2021 – January 2022 six care homes closed. This compares to eight home closures in 2020-21, two in both 2019-20 and 2018-19, and six in 2017-18.

4.12 As of January 2022, the care home market in North Yorkshire is broadly in line with the national average in terms of quality of care provided by registered care providers.

4.13 We monitor on a monthly basis our ability to secure placements at NYCC standard rates. In all areas there have been times over the last year when we have had to purchase placements at a market premium. This has been when there has not been capacity at our standard rates at the time a placement is needed. Harrogate is the area where this is most notable.

4.14 We continue to monitor and will keep under review whether there is a need for any local market supplement. We are not recommending this at this time but discussions as part of the new Approved provider Lists will look at the impact of differential rates across the county.

Domiciliary Care

4.15 Fees to domiciliary care providers are based on hourly rates. The fee levels for new care packages are agreed with individual providers at the point of the individual care package being commissioned from an Approved Provider list.

4.16 The ICG has advocated that the Council should use the UKHCA cost model for domiciliary care. The model sets out a national minimum fee level which they recommend. It is based on national averages for costs in defined operating areas. From April 2022 the recommended minimum rate for an hour of homecare increases to £23.20 per hour.

4.17 The proposal is for a 5% uplift to all domiciliary care packages below UKHCA minimum rate and 3.1% above.

4.18 Across North Yorkshire the average fee levels are currently £20.37 (Urban), £21.46 (Rural) and £23.82 (Super Rural) an hour for generic domiciliary care, with a range between £15.24 and £36.00 an hour (Urban), £15.24 - £37.00 (Rural) and £15.36 - £41.20 (Super Rural). Our rural and super rural rates allow for longer travel times in these areas.

4.19 79.2% (-2.5%) of residential care providers were rated “good” or better, which remains better than national (82.0%, -0.2%) and Yorkshire and Humber Region (77.9%, -0.7%) averages. 89.2% (-0.3%) of domiciliary care providers were rated “good” or better, which remains better than national (87.4%, -0.2%) and Yorkshire and Humber Region (84.5%, +0.3%) averages.

Community based services

4.20 For community-based care services we do not pay an hourly rate for a number of these services and so are unable to apply the same approach as domiciliary care. The proposed increase of 3.1% is therefore in line with the other proposals in this paper.

5.0 CONSULTATION

5.1 Consultation has taken place with the ICG as referred above and this group has accepted the proposals in this paper.

6.0 IMPLICATIONS

6.1 Resource and Finance Implications/Benefits: Budget plans have already included the cost of the increased fees proposed included in this report. In future years the Council will need to provide for the inflationary increases.

6.2 Human Resources: We require our contracted providers to meet minimum wage levels and have reflected wage costs in our fees

6.3 Legal: When setting fee levels, local authorities are not obliged to follow any particular methodology; in particular, there is no obligation to carry out an arithmetical calculation identifying the figures attributed to the constituent elements, R (Members of the Committee of Care North East Northumberland) v. Northumberland CC [2013] EWCA Civ 1740.

6.4 The Care Act 2014 places duties on local authorities to facilitate and shape the care and support market. The Act also requires local authorities to provide choice that delivers intended outcomes and improves wellbeing. Unlike previous case law, the Care Act strengthens the general duties of councils when setting fees. Relevant features of the Act include: (i) An obligation on councils to: ...promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishes to access services in the market. …(and) has a variety of providers to choose from who (taken together) provide a variety of services. …(and) has a variety of high-quality services to choose from …(and) has sufficient information to make informed decision about how to meet the needs in question.

6.5 The Care and Support Statutory Guidance (CASSG) states that a local authority should have evidence that the fee levels they pay for care and support services enable the delivery of agreed care packages and support a sustainable market. When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support and allow for the service provider to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff. It should also allow retention of staff commensurate with delivering services to the agreed quality and encourage innovation and improvement. Local authorities should understand the business environment of providers offering services in their area and seek to work with providers facing challenges and understand their risks.

6.6 The CASSG states however that in fulfilling this duty “Local authorities should commission services having regard to the cost effectiveness and value for money that the services offer for public funds”.

6.7 Equality Act 2010: The county council is required by law to pay due regard to the Equality Act 2010 and in particular the general and specific duties of the Public Sector Equality Duty. The evidence that the county council has met its duties is contained in the previously published equality impact assessments (EIAs). Due regard has been paid to the actual cost of care in formulating the proposals, and it is anticipated that there will be a positive impact on both the provider market and people who receive services, by offering fee levels which support good care provision.

7.0 RECOMMENDATIONS

7.1 The Executive Member is asked to consider the contents of this report, including the analysis of the proposals in section 4 and the implications in section 6 and to agree

(i) That fee increases to care homes for both residential and nursing will be as below:

a) There will be four ACOC rates and these include an amount for Return on Investment.

	With ROI
Nursing	819
Nursing with Dementia	826
Residential	742
Residential with Dementia	784

b) The Cost of Care rate will be implemented for existing packages over three years. In essence that means that each package would receive 1/3rd of the difference between the current rate and the ACOC rate, reaching full ACOC by April 2024. However we will commit to reviewing this position and subject to funding, look to move remaining packages to ACOC levels in 2023/24. This review will look at funding available, including any unspent grants, plus the amount of packages still above ACOC level.
c) Each year the ACOC rate will be inflated.
d) For those below the ACOC rate, inflation will be applied at the full level.
e) For those above the ACOC rate, no inflation will be applied.
f) For those already above ACOC and not receiving inflation, a safeguard will be put in place to ensure they do not drop below the ACOC rate (as this is inflated each year).
g) All new packages will be paid the ACOC rate, *except in exceptional circumstances and where agreed otherwise.*

(ii) A 3.1% increase for all non-residential services and learning disability residential services. This will include day opportunities.

(iii) For domiciliary care:

- A flat rate increase of £1.68 to contracts currently at or below £21.52
- This will reduce by 1p for every 1p currently above £21.52. In effect every package currently between £21.52 and £23.20 will now be at UKHCA rate of £23.20
- A flat rate increase of 36p for rates currently between £23.20 and £25
- A flat rate increase of 20p for rates currently between £25 and £25.40, up to maximum of £25.40
- Any rates above this to have 0% inflation, pending the domiciliary care ACOC

(iv) Increases to supported living care packages will also be targeted to support those currently receiving lower fee rates. The offer for 2022/23 is below:

- 5% to those packages currently paid below £19 per hour
- 3.1% to those above that rate

(v) For placements of people in care homes outside of North Yorkshire County Council we will honour an uplift agreed by the host authority where they have undertaken an Actual Cost of Care exercise, and will consider individual business cases where there is no Actual Cost of Care exercise in place

(vi) For placements of working age adults in care homes within North Yorkshire County Council area 3.1% will be applied to all residential/nursing placements.

(vii) That a review with the ICG to begin no later than 30 September 2022 to look at the impact of this award on providers and, subject to grant conditions, the distribution of any additional funding from government. This review will also look at those packages receiving the inflation award of 3.1%, such as Supported Living.

RICHARD WEBB
Corporate Director – Health and Adult Services

Author of report:
Dale Owens
Assistant Director Commissioning and Quality– Health and Adult Services

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North Yorkshire County Council

Health and Adult Services

Executive Members Meeting

11 March 2022

Report of the Corporate Director Health and Adult Services

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

1.0 Purpose Of Report

The purpose of this report is to consider, and agree, the extension of the existing Section 75 County Council/NHS commissioner and provider agreements 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 Executive approved the two Section 75s covering North Yorkshire County Council's involvement in the HARA. 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 an HDFT Operational Director. 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 County Council 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 their 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 Corporate Director – Health and Adult Services, in consultation with Executive Members, approves a twelve month extension to the Commissioner and Provider HARA Section 75 Agreements.

- 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
2 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

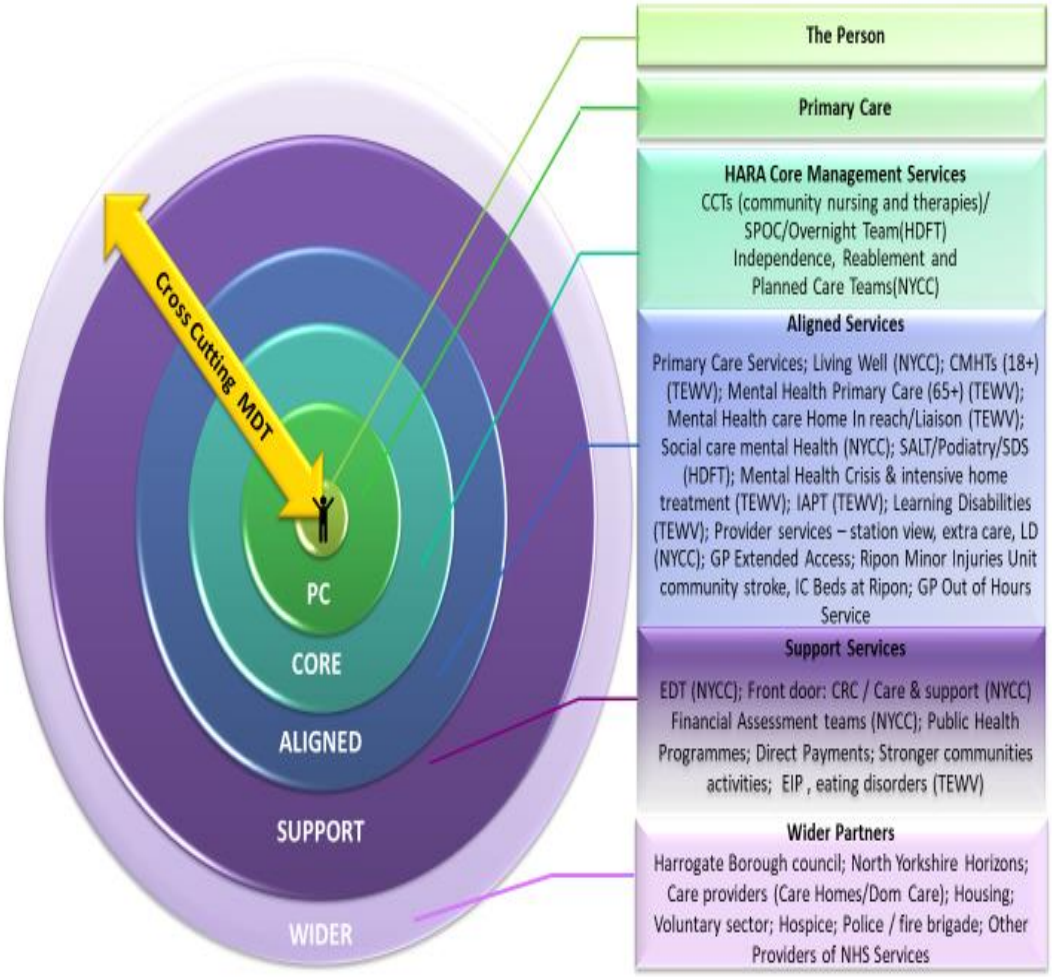
Definition	Means
	be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.
Non-exhaustive lists	Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list 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.

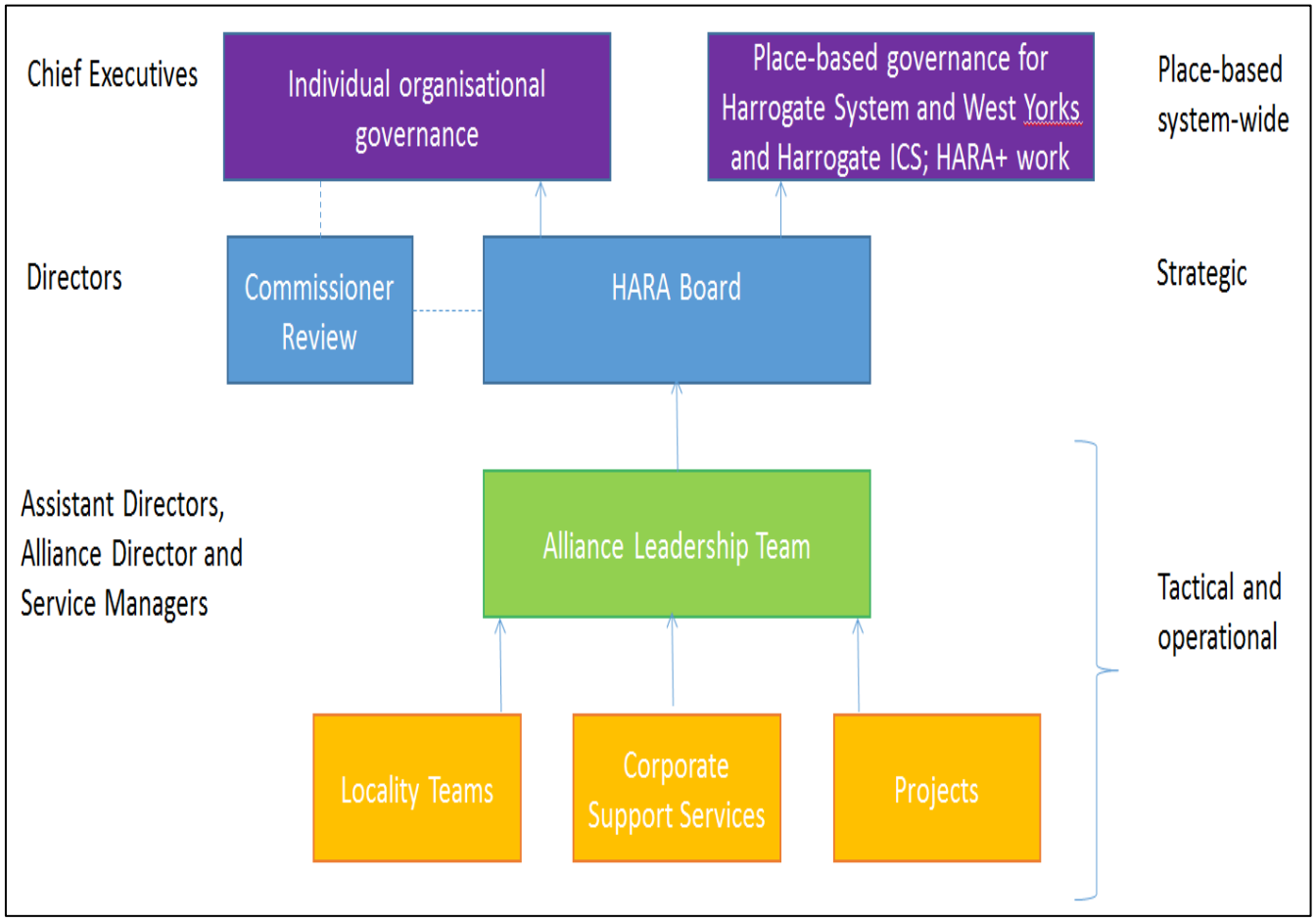
[2] Schedule 3 – Version 7 (13/8/19 from finance subgroup)

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

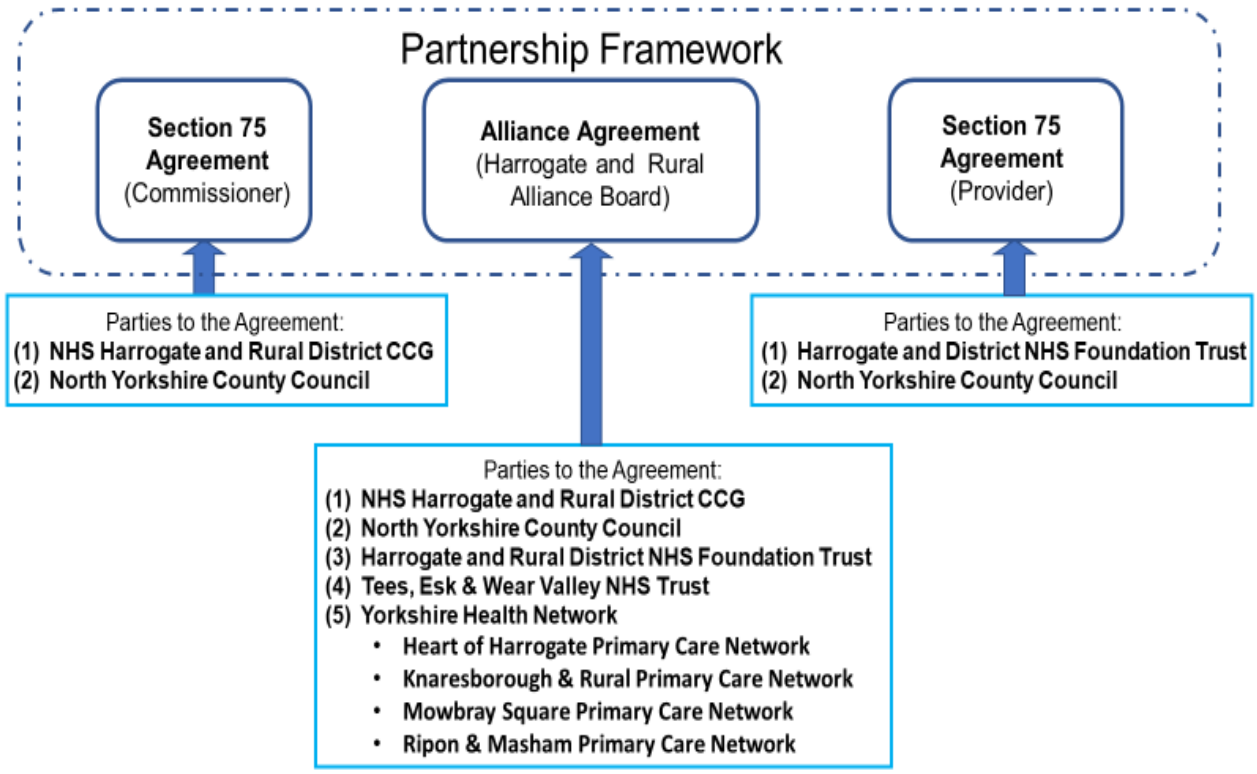
(2) The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

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	**<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. **<u>Performance Reporting</u>**

	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

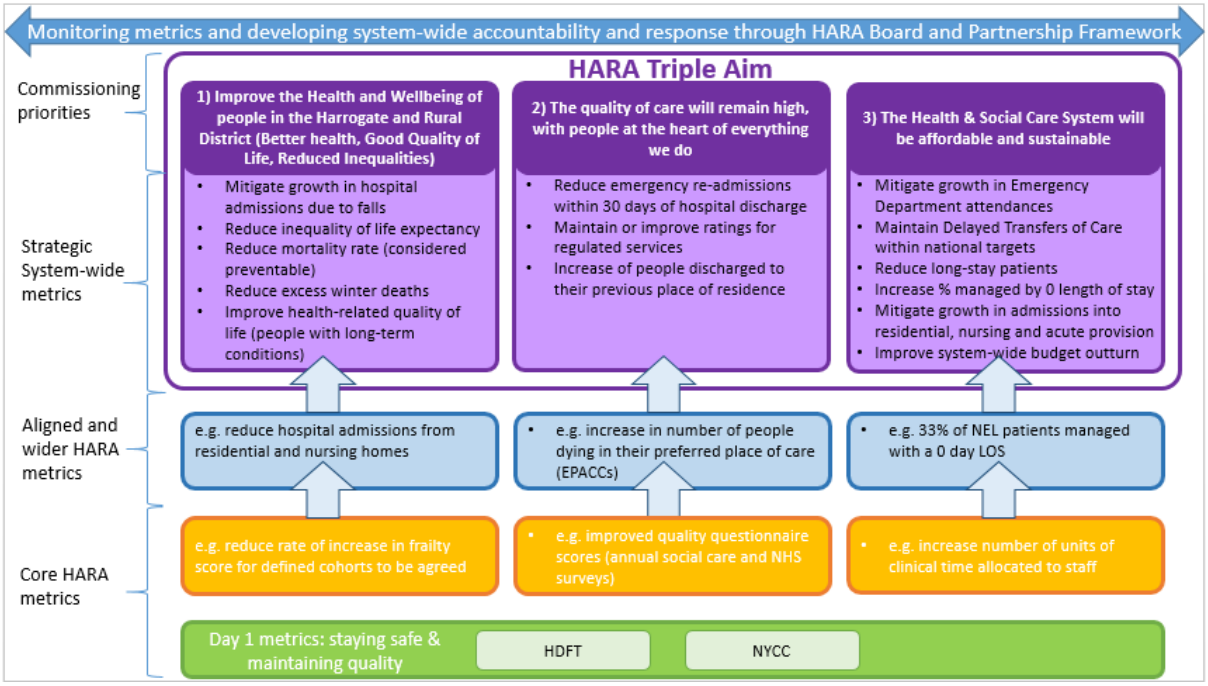
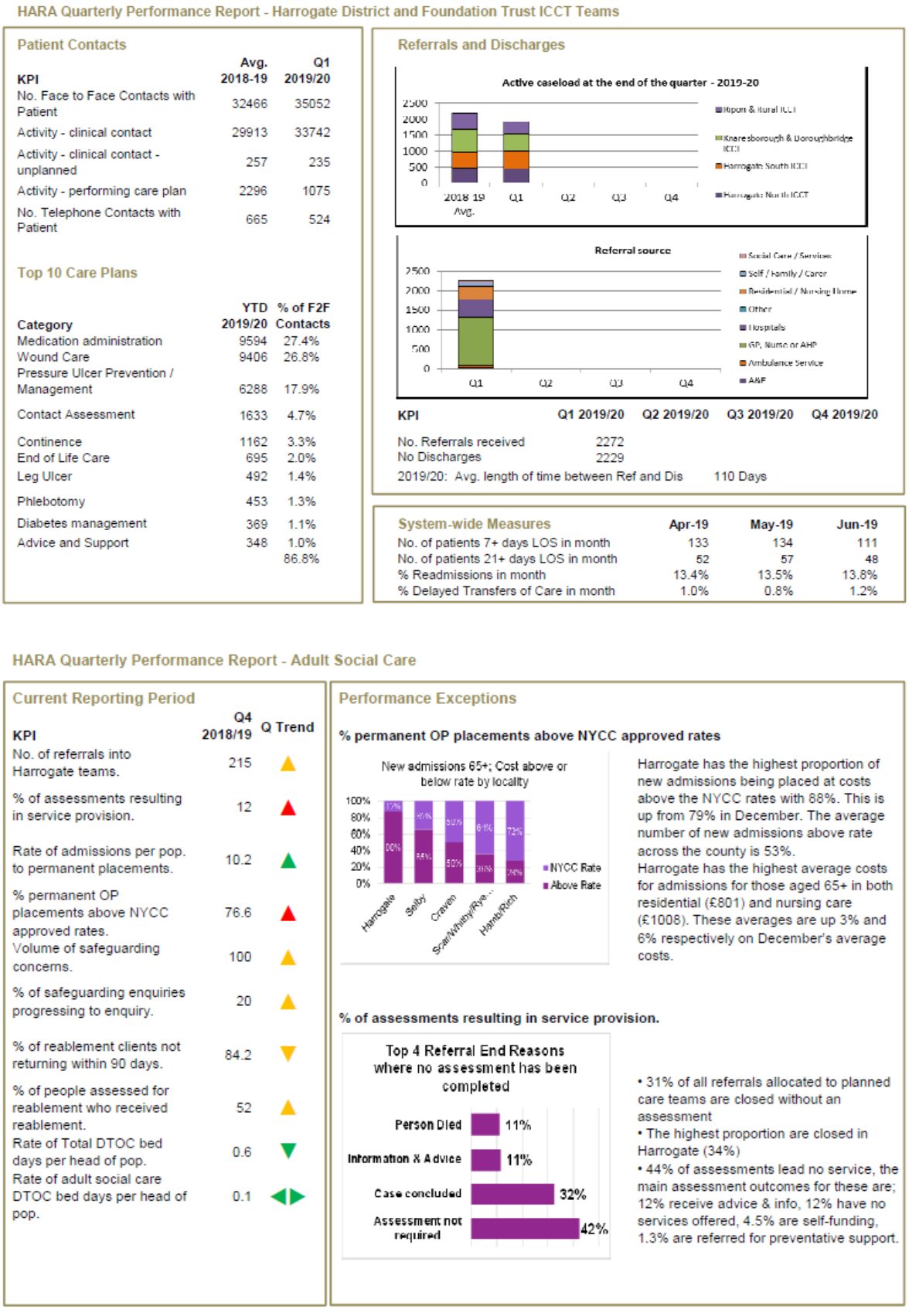


Figure Y: Operational HARA metrics for core services – day 1



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

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.

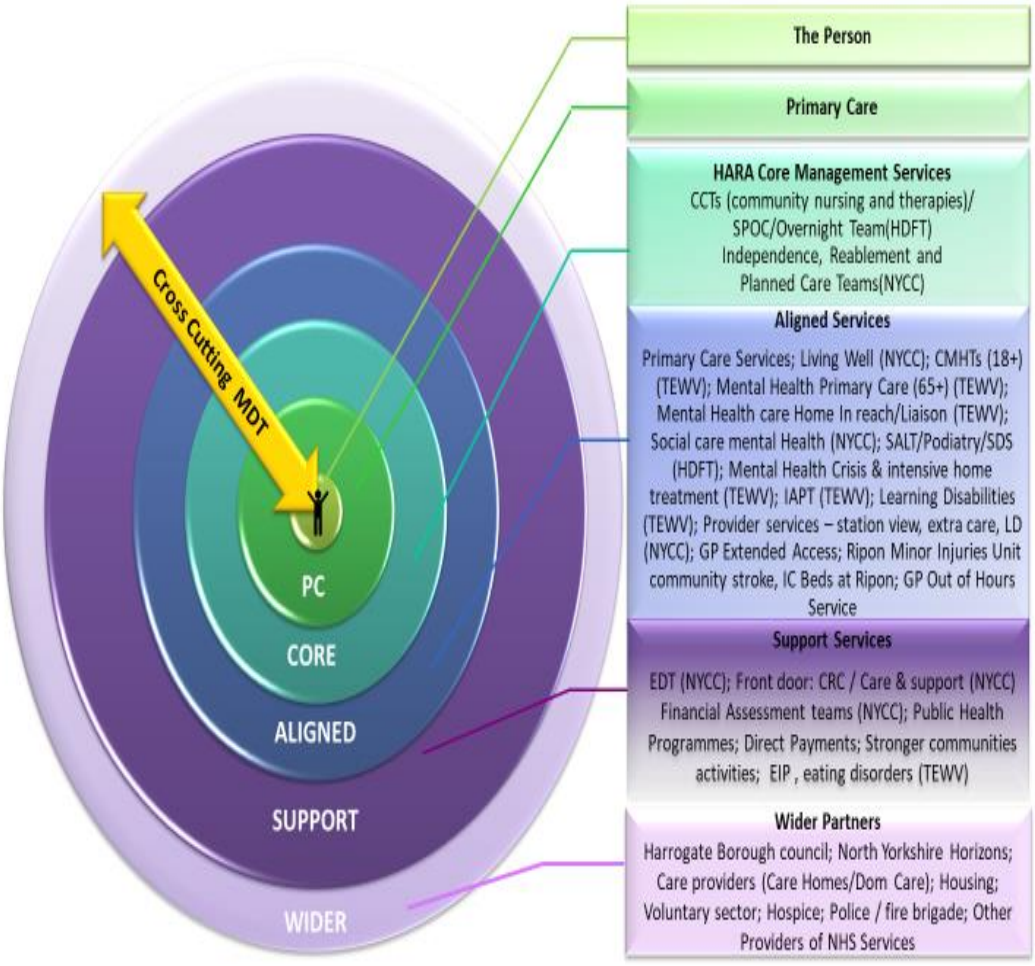
Schedule Two: Scope of services relating to this Section 75 Agreement

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.

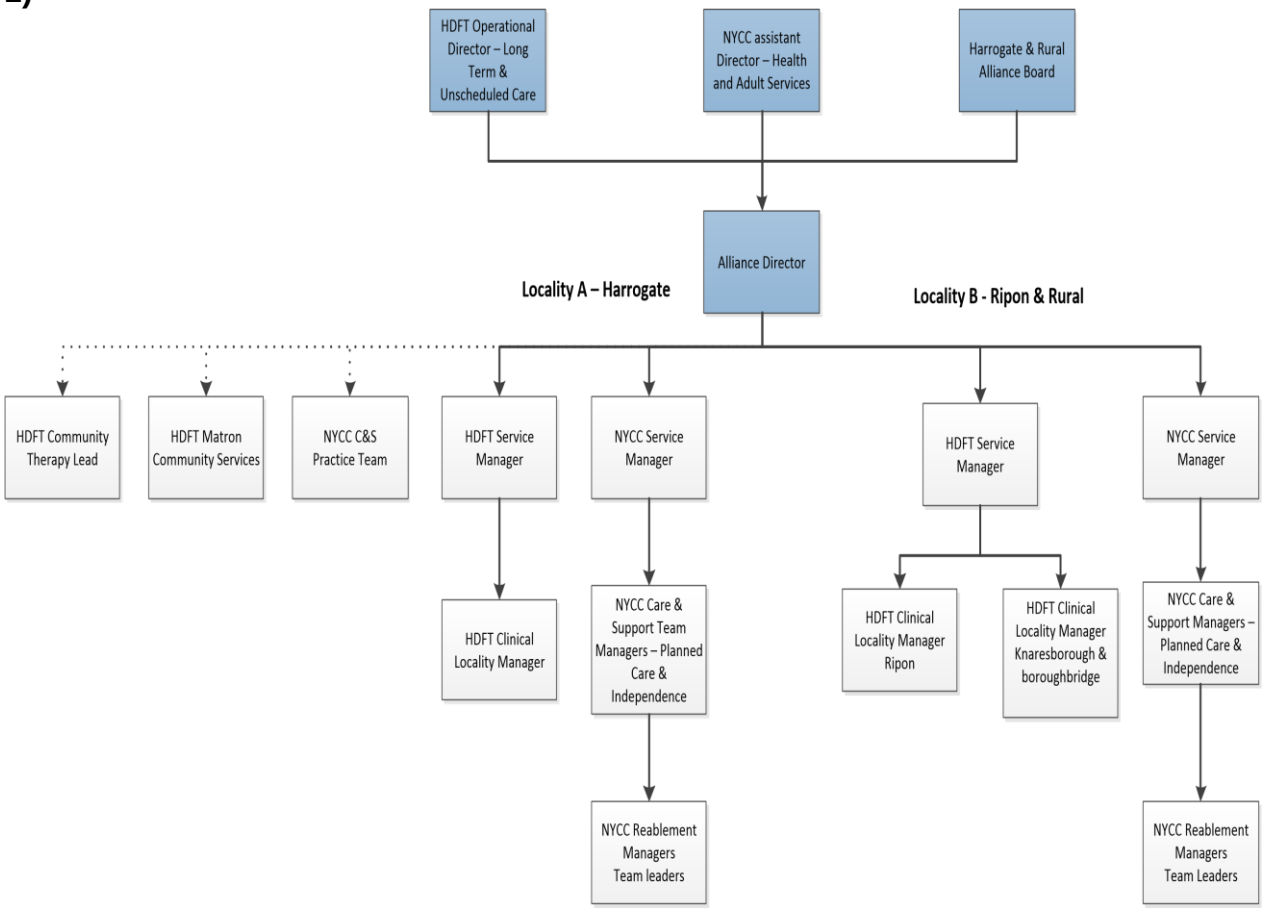
9. Where roles have joint accountabilities, e.g. as part of the integrated management structure, the Parties agree to the exchange of information regarding recruitment checks and clearances (Identity, Right to Work and Disclosure Barring Service), with the

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]



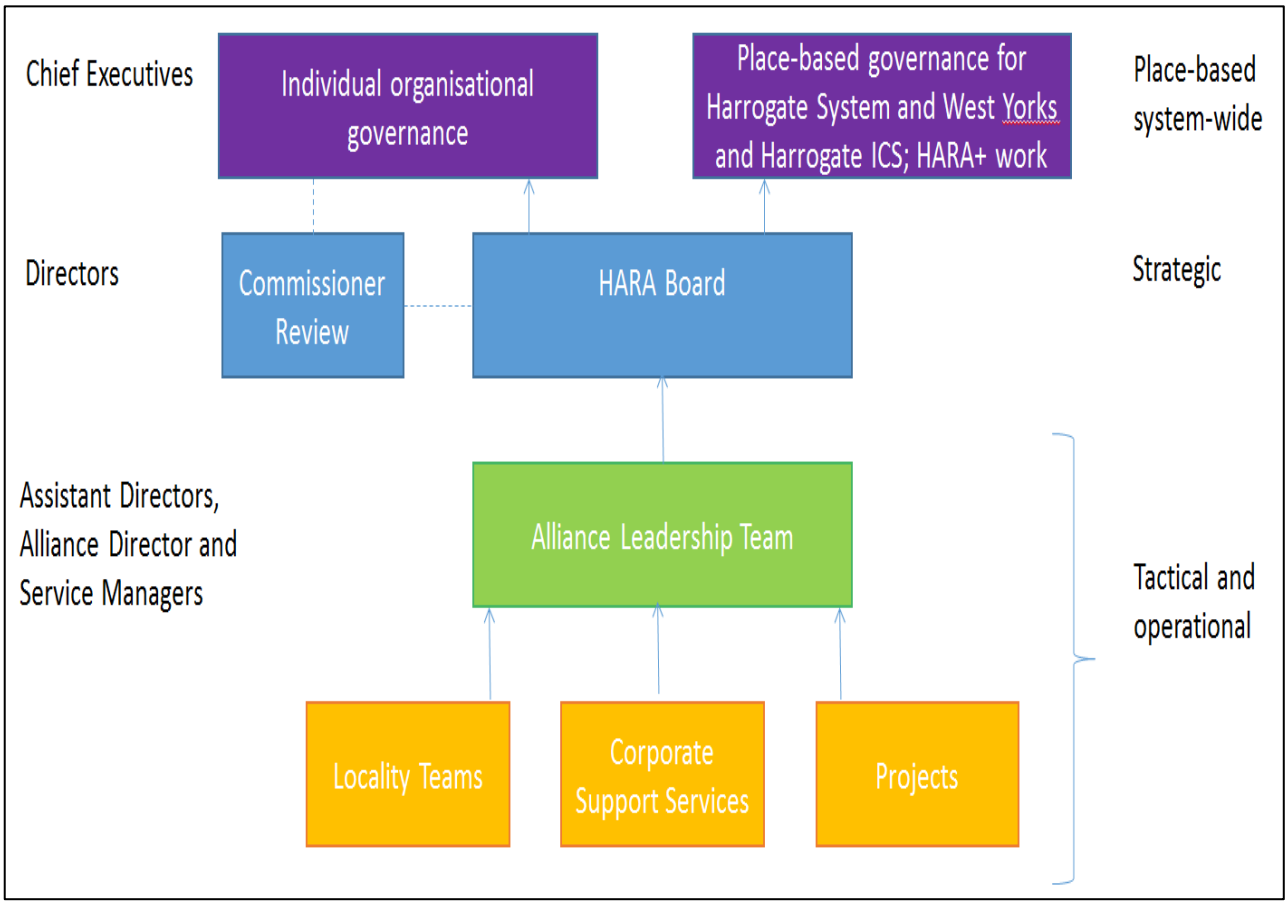
[12] HARA Management structure V4 (13/8/19)

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

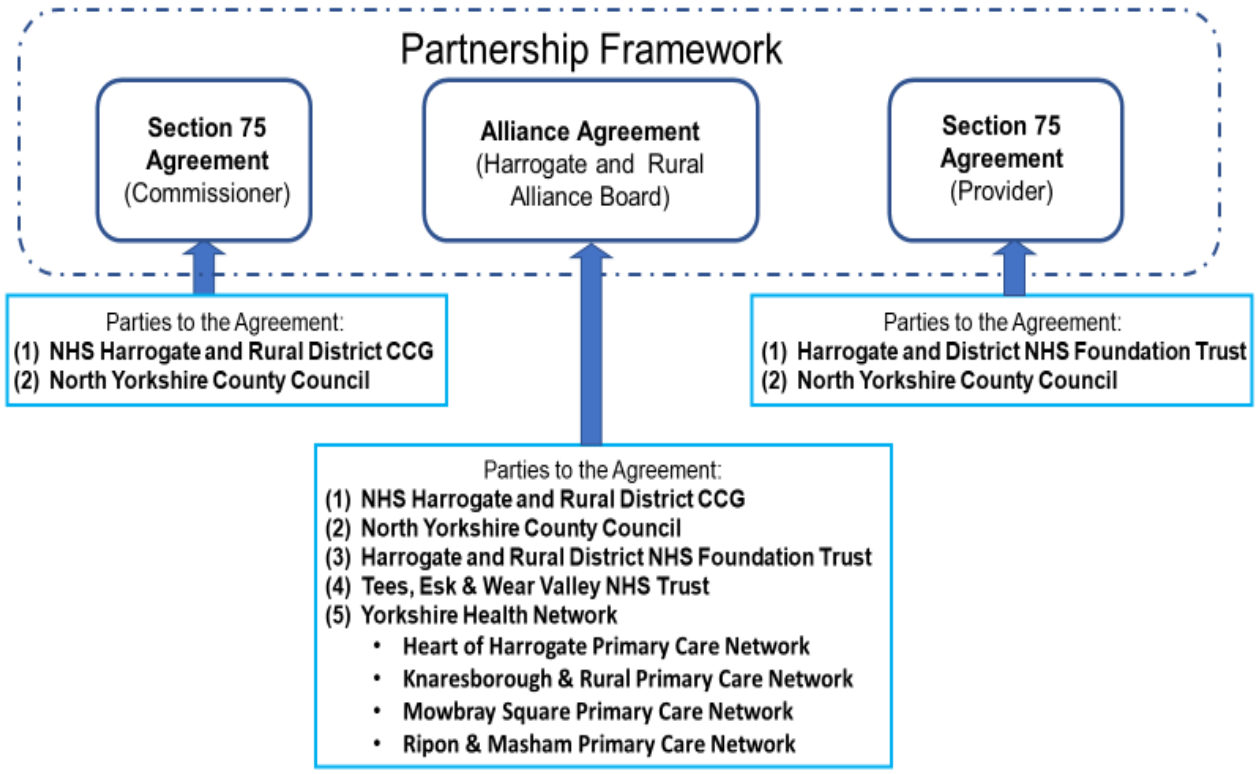
(2) The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

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

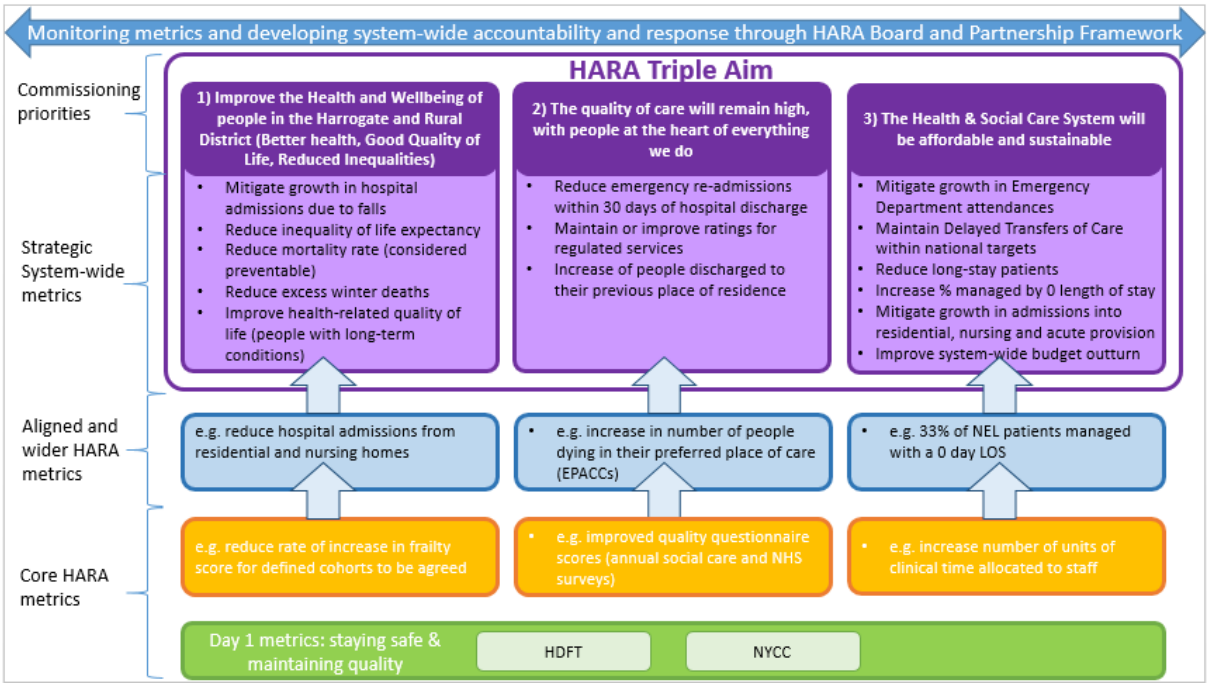
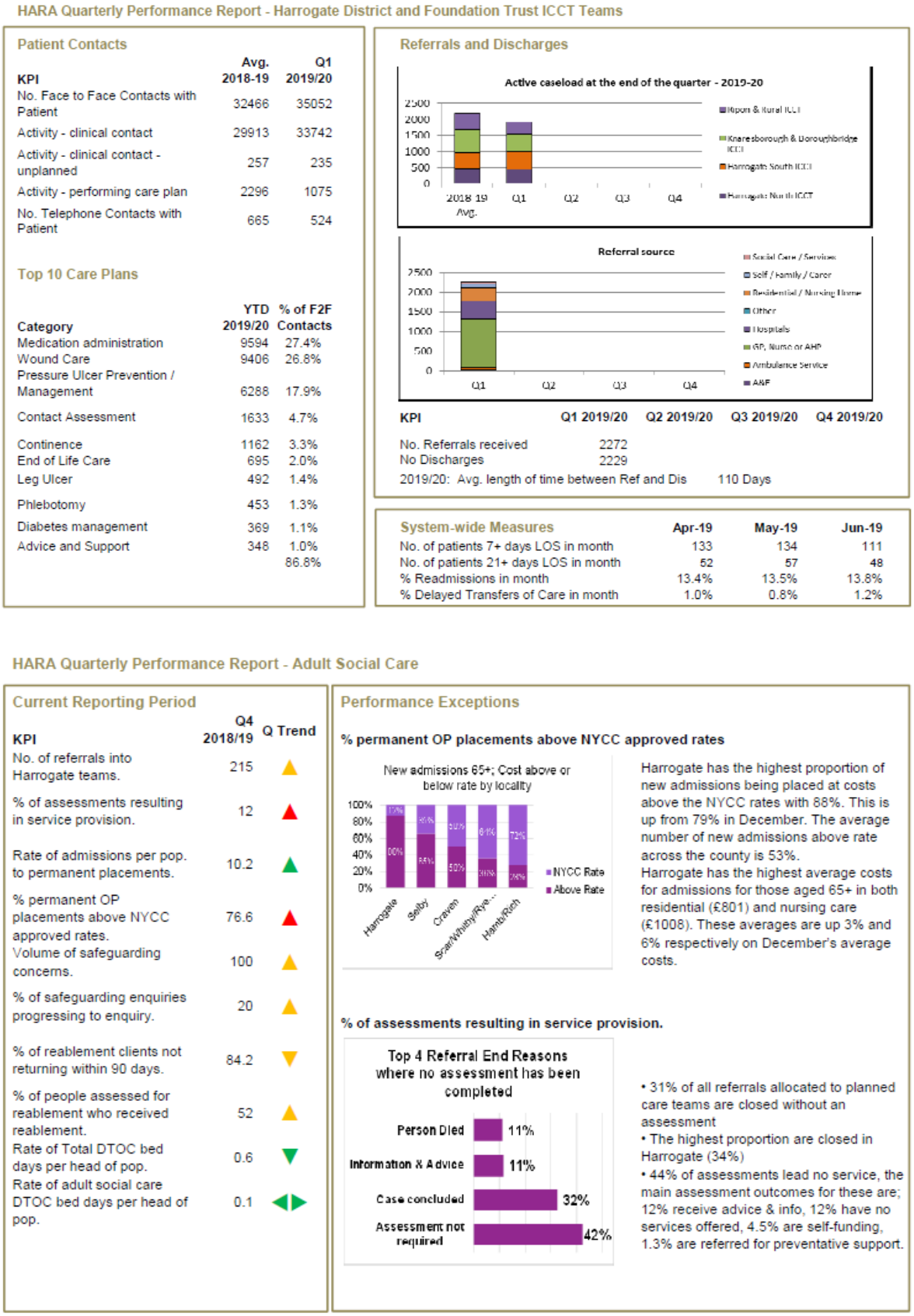


Figure Y: Operational HARA metrics for core services – day 1



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