Item 10.2

North Yorkshire and York PCT Cluster

Quality Handover Document

15 March 2013

V.4

Contents

1. The Organisation / System

1.1 Key Facts and Figures

North Yorkshire is England's largest county and includes some of the most diverse landscape in the country. The County boasts two national parks (Yorkshire Dales and North Yorkshire Moors), numerous picturesque market towns (Richmond, Skipton, Thirsk), dramatic coastline including the towns of Scarborough and Whitby as well as the large urban areas of York and Harrogate. To the south of York lies the former mining area of Selby.

The County also covers some of the most remote and rural areas in the country, which are sparsely populated and access to services in these areas is a particular challenge.

Map of NHS North Yorkshire and York boundaries:

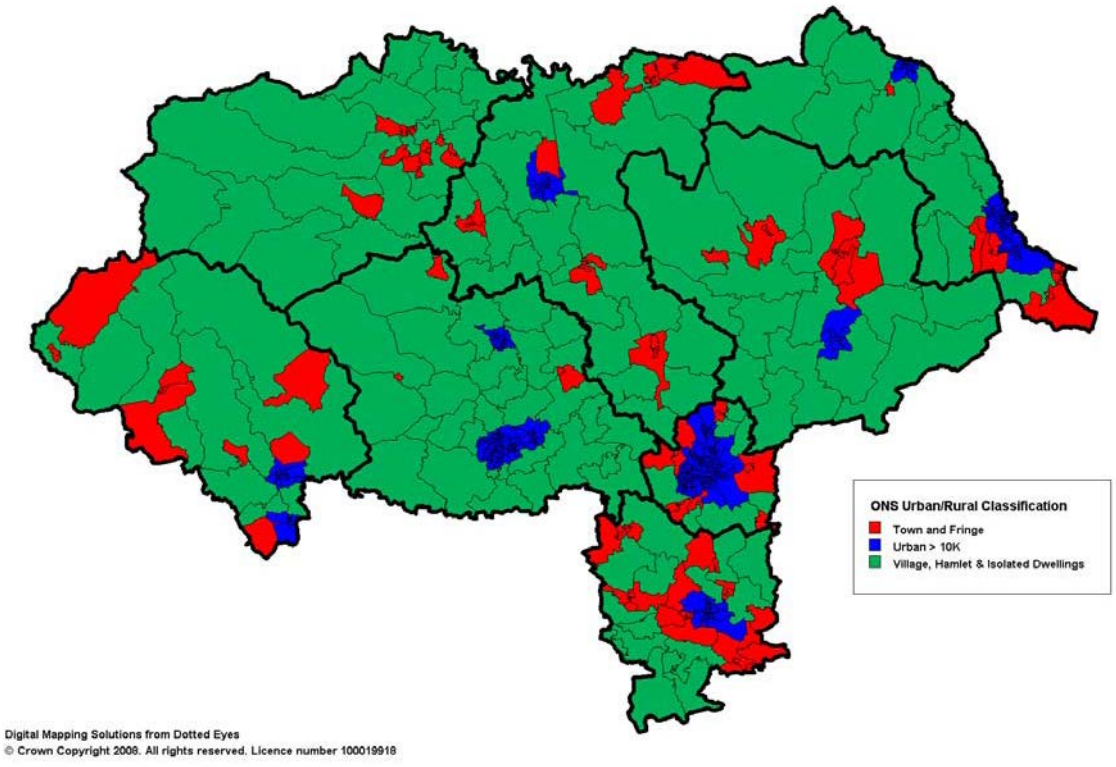
Key population characteristics of North Yorkshire and York

Characteristic	North Yorkshire and York	England average
Population size	788,400	-
Percentage of the population living in urban areas	40%	73%
Life expectancy at birth 2006/08, Male	79 years	78 years
Life expectancy at birth 2006/08, Female	83 years	82 years
Level of deprivation	very low	-

Based on key characteristics such as demographic structure, employment and industry sector, the PCT areas most similar to NYY are: East Riding of Yorkshire, Shropshire County, Somerset and Devon.

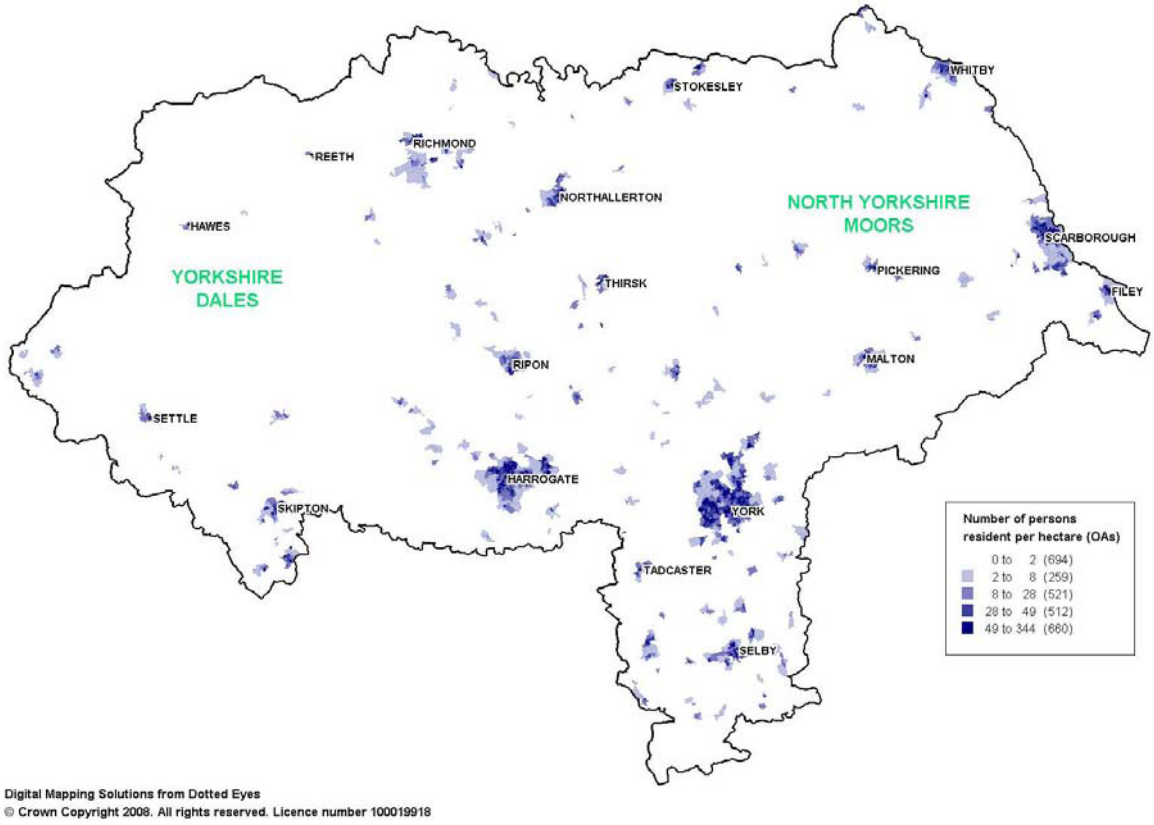
Outlined below is the North Yorkshire and York map showing the geographical areas classified as urban, town or village areas. It is important to be aware of such distinctions as this will affect the delivery of healthcare services to such diverse and often remote areas

URBAN / RURAL CLASSIFICATION



Outlined below is the same geographical map of North Yorkshire and York, shown previously, but this time detailing the population density for each area. Once again this is important to know since it helps to understand the unique elements of healthcare service delivery to each area.

POPULATION DENSITY



Being aware of the population density and urban / rural classification aids understanding of the health profiles which are published annually for each local authority in England by the Public Health Observatories. The health profile summaries for North Yorkshire and York are summarised below:

North Yorkshire at a glance:

The health of people in North Yorkshire is generally better than the England average. Deprivation is lower than average, however about 12,400 children live in poverty. Life expectancy for both men and women is higher than the England average.

Life expectancy is 6.3 years lower for men and 4.6 years lower for women in the most deprived areas of North Yorkshire than in the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.

About 15.3% of Year 6 children are classified as obese, lower than the average for England. Levels of teenage pregnancy and GCSE attainment are better than the England average.

The estimated level of adult physical activity is better than the England average. The rate of road injuries and deaths is worse than the England average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than the England average.

Priorities in North Yorkshire include physical activity, childhood obesity and alcohol.

York at a glance:

The health of people in York is generally better than the England average. Deprivation is lower than average, however about 4,200 children live in poverty. Life expectancy for both men is higher than the England average.

Life expectancy is 9.7 years lower for men and 5.1 years lower for women in the most deprived areas of York than in the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.

About 14.7% of Year 6 children are classified as obese, lower than the average for England. Levels of teenage pregnancy and GCSE attainment are better than the England average.

The estimated level of adult smoking is better than the England average. Rates of sexually transmitted deaths and hospital stays for alcohol related harm are better than the England average.

Priorities in York include physical activity, childhood obesity and alcohol.

Further details can be found in the 2012 Health Profiles:

Health Profile 2012: North Yorkshire
Health Profile 2012: York

NHS NYY Annual Public Health Report 2012

2010 - The Landscape of Health in North Yorkshire and York
2009 - Finding the mission for commissioning

1.2 The PCTs Role

The Primary Care Trust has taken the lead in the local health economy: in shaping, planning, commissioning and in some areas, providing a range of health services.

The Three Core Functions of a Primary Care Trust

- Engaging with the local population to improve health and well-being.
- Commissioning a comprehensive and equitable range of high quality, responsive and efficient, services, within allocated resources, across all service sectors.
- Directly providing high quality responsive and efficient services where this gives best value.

Primary Care Trusts Relationships and Accountability

- Perform their functions for, and with, their local population in pursuit of equality, quality, responsiveness, innovation, efficiency and affordability.
- Lead their local health system; develop and deliver their functions through effective partnerships – particularly practice-based commissioners with local authorities (e.g. in developing local area agreements) and with a full range of different types of providers.
- Accountable to their population directly and through local authority Overview and Scrutiny groups and to the Strategic Health Authority (SHA). Primary Care Trusts operate within the framework of the Department of Health policy; they are held to account for this by the SHA not directly by the Department of Health.

***HealthierLives* 2010 – 15** is the strategic plan for NHS North Yorkshire and York and outlines the ambitious five year plan to deliver world class health care for the people of NYY.

HealthierLives sets out the **vision** that "the people of North Yorkshire and York will live long, healthy lives". This vision is supported by a mission that describes NYY contribution as an NHS commissioning organisation to delivering the vision.

The **mission** is to commission the highest quality health services that:

- reduce health inequalities
- empower individuals to manage their own health
- create seamless care with our partners, which make best use of our allocated resources

To make this mission a measurable reality for NYY, the aim is that by 2015, six **goals** will be delivered to ensure that this vision becomes a reality.

Goal 1: Comprehensive services for our ageing population.

Goal 2: Reduction in health inequalities.

Goal 3: Improved health and well being of the population through the promotion of healthy lifestyle.

Goal 4: Clinically and financially sustainable healthcare system.

Goal 5: Highest quality care in the right settings.

Goal 6: Strong partnerships focused on the individual.

The over arching Quality, Innovation, Productivity and Prevention (QIPP) programme is also focused to deliver on these goals and supporting the achievement of the NYY Review.

Supporting Documents:
Healthier *Lives* 2010 – 15 NHS North Yorkshire and York's Strategic Plan

1.3 Key Public Health achievements and challenges

Commissioning healthcare to maximise health benefit from available resources is a complex challenge. In North Yorkshire and York the available resources per head of population are low, there are significant geographical challenges and we have a complex set of health and wellbeing partnerships. In undertaking this complex commissioning challenge, the PCT has always had one of the lowest staffing ratios despite having the largest number of secondary care providers and statutory stakeholders.

Each PCT allocation is determined by a complex funding formula based on the size, age structure and relative health need of the population and the ability to benefit from healthcare. Overall, the population of North Yorkshire and York tend to have better health than the regional and England average which is reflected in the PCT funding which is the 13th lowest per head of population nationally.

Key recommendations for public health in North Yorkshire and York can be summarised into three main priorities for the future:

- Strengthen, and wherever possible mainstream, existing activity to improve and protect health and reduce inequalities.

- Work across sectors to move towards the new model for public health in as seamless a way as possible.

- Ensure that our existing good practice is sustained and protected through a period of change, within the existing and future legislative framework.

1.4 Equality, Diversity and Human Rights

NYY is committed to providing high quality, appropriate services that all our population can access fairly. NYY recognise and value the diversity within our communities and have a responsibility to tackle inequality and discrimination:

- as an employer, and
- through our duty to tackle health inequalities and improve health within our local community

NYY aims to deliver healthcare services that are equitable to everyone regardless of age, disability, race, ethnicity or national origin, gender, religious belief, sexual orientation, domestic circumstances, trade union membership (or non membership), social or employment status.

The Equality and Diversity Annual Report 2010 – 11 outlining progress against the Single Equality Scheme is attached:

Supporting Documents:
NHS North Yorkshire and York Annual Equality and Diversity Report March 2010 – March 2011

Since the report has been produced a significant number of staff have been transferred to new organisations as part of the Transforming Community Services agenda.

1.5 Overview of providers

Our provider landscape is made up of primary, community, mental health, clinical assessment and treatment centres, acute and specialist providers, offering a range of services to our population:

York Hospitals Foundation Trust
Harrogate District Foundation Trust
South Tees Foundation Trust
Leeds Teaching Hospital Trust
Airedale NHS Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Hull & East Yorkshire NHS Trust
Yorkshire Ambulance Service
Private Providers
Forensic Mental Health
Continuing Care
Primary Care
Dental
Pharmacy
Ophthalmic

Tertiary or specialist market management is performed on our behalf by the Yorkshire and Humber Specialist Commissioning Group, of which we are a Board member.

Acute Care
Planned care (outpatient and elective care) activity overall is similar to the regional average per weighted population but is among the highest amongst the twenty lowest funded PCTs.

NHS North Yorkshire and York has one of the lowest rates in the region of low value surgical procedures, such as tonsillectomy, where the evidence base suggests that they are not an effective use of resources. The PCT is average compared to the 20 lowest funded PCTs. The referral rates to outpatient and follow up are low compared with other PCTs in the region and close to the average compared to the lowest 20 funded PCTs.

However, based on the 20 areas of healthcare spending known as HRGs with the highest costs, NHS North Yorkshire and York generally has higher rates for its weighted population than the regional average. These include a range of diagnostic procedures, hip and knee replacement, cardiac catheterisation, eye surgery and a range of other common general surgical operations. While these procedures have positive outcomes for individuals, on a population basis we need to understand why our levels are particularly high.

Non-elective activity in NHS North Yorkshire and York by weighted population is higher than the regional average, and is also among the highest when compared to other low funded PCTs. However, fewer emergency procedures are performed in North Yorkshire and York than expected compared to the national average.

Primary Care
The PCT holds the following primary care contracts:

83 GMS practices
1 APMS practice
13 PMS practices
120 dental practices
115 ophthalmic practices and
150 pharmacies

North Yorkshire and York has the highest rate of satisfaction with GP services in the region and relatively high satisfaction for out-of-hours services. This reflects the high quality and accessibility of primary care services in the PCT. The number of GPs per weighted head of population is 78 per 100,000 weighted population, which is the highest in Yorkshire and the Humber, but is similar to PCTs in the Office for National Statistics (ONS) cluster – a group of PCTs who have similar geographical and socio-economic characteristics. It is also similar to the 20 lowest funded PCTs.

NHS North Yorkshire and York spend on primary care, when analysed on a weighted population basis, is in the top 20% of PCTs in the country, and is the 3rd highest in its ONS cluster. There remain challenges in providing high quality and accessible general practice and out-of-hours services across the PCT, and this is perhaps reflected in the cost, although GPs have historically retained the lowest prescribing costs in Yorkshire and Humberside; in 2009-10 costs were 5% below the national average.

Given the quality and stability of primary care services, the challenge is to maximise effectiveness and efficiency across the system.

1.6 North Yorkshire Review and QIPP

It is recognised that delivering our strategy within our available financial resources has been a challenge in North Yorkshire and York. To further understand that challenge and to identify positive future transformation a Commission was established, in January 2011, by the Strategic Health Authority (SHA), with the support of future GP commissioners. The Commission was responsible to make recommendations for the future commissioning of services within a sustainable financial framework to ensure future financial balance. The Commissions purpose was to gather and review evidence from stakeholders, develop options for the efficient use of resources and to make recommendations for future commissioners.

The North Yorkshire and York Review was led by an independent Commission of 13 members appointed by the SHA Board, and chaired by Professor Hugo Mascie-Taylor. The Commission recognised that to meet the challenge, both now and in the future, the North Yorkshire and York health economy requires a radical solution and a shift in how healthcare is provided.

Stakeholder opinions were sort throughout the process and the comments of stakeholders summarised within the detailed evidence of the review and were considered alongside all the other evidence by the commission. Views from a wide range of people were included within the review; NHS and healthcare professionals, Local and National Elected representatives, Local Authority officials, patient groups and individual members of the public.

The Commission provided a total of 44 recommendations and with the acceptance of the Commission's final report; the implementation phase was initiated in late 2011. The implementation of the Commission's recommendations will be managed by the newly established Executive Leadership Group (ELG) accountable to the PCT Cluster Board and the newly formed Health and Well Being Boards for the City of York (CYC) and North Yorkshire County Council (NYCC). The ELG has representative executive level members from all Local Authorities, Acute Providers, Mental Health Providers, YAS, CCGs, voluntary sector and the PCT Cluster.

The North Yorkshire and York Review is of significant strategic importance to this health economy and the implementation of the recommendations must be integral to the efforts of all parts of the health economy. From that perspective, the ELG has proposed five principal implementation workstreams which will also form the basis of our transformational QIPP programme. The programme is focussed on improving services to patients, principally by providing more care closer to home and in settings outside of the major acute hospitals, whilst at the same time reducing the costs of services to the commissioners.

The implementation of the NYY review recommendations has been mainstreamed during the past few weeks and therefore it is not possible to differentiate NYY review activities from normal PCT/CCG planning and performance management. As such the focus of the planned QIPP schemes in 2012/13 is the first phase of taking forward the review recommendations.

The NYY Review transformational QIPP workstreams are as follows:

Workstream 1: The development of integrated models of care and their impact on existing hospital sites.

This workstream is designed to bring together the wider system partners and look at the potential to work together to reduce the acute bed base required and redesign care to enable care to be delivered in the right place, by the right clinician and at the right time. Through close working with the CCG and their locality partners we are developing local visions. This will involve widespread community engagement in the redesign of locality services.

The NYY Review objectives of this workstream include:

- To ensure that a vision is created for the potential integration of services across health and social care in each locality of North Yorkshire.
- To work with the respective organisations to help translate the vision into a specific set of proposals for service change (across health and social care) including consideration about the impact of these changes on existing hospital sites.

Once the visions are created and developed they are likely to provide additional QIPP schemes which fall under the other four workstreams.

Workstream 2: Reducing the bed base as a result of making improvements to the care and treatment of patients with long term conditions (including dementia) and urgent care

This workstream will focus on improvements which can be made to both urgent care and to the management of patients with long term conditions(LTC). The aim will be to reduce unnecessary admissions and to support early discharge thereby reducing the length of stay or admissions which will reduce the required bed base of the acute providers.

The NYY Review objectives of this workstream include:

- To ensure there are plans developed to reduce the acute bed base across the system as a result of improvements in LTCs and urgent care management, and the implementation of a strategy to provide better care for those with dementia.
- To facilitate and support the development of specific plans for implementing the levels of care project across all localities.
- To facilitate and support the further development of telehealth, telemedicine and telecare across the system to support this objective.
- To ensure that all the elements of existing plans on this topic are brought together to provide an overall costed picture of what is being planned for and to highlight the ultimate end point of these plans.

There are a three key projects within this workstream:

A. Development of Levels of Care and Community Infrastructure

Through evidence based reviews, it has been increasingly recognised that people are often not receiving care in the right setting. Building on this evidence the PCT has developed a risk management modelling tool that shows the potential impact on the health and social care system by moving to a needs-based ‘levels of care’ model and we are now actively implementing this system change in all localities. The transfer of community services to the acute trusts provides an opportunity for them to influence their services and deliver this change on a transformational basis.

People were facing unnecessary prolonged hospital stays, and inappropriate admissions to hospital or long term residential care. One of the result of which is people may feel less confident and more unsafe in their own homes. The new integrated care model will provide more equitable and more comprehensive services to deliver the right service, in the right place at the right time.

The aim of implementing this system change is to:

- Provide a health and social care system where people receive care and support in the least dependent setting bases on need (levels of care model) to reduce length of acute hospital stays, and eliminate associated excess bed days and deliver care in the right setting.

- Jointly commission (between health & social care) an integrated community and intermediate care model providing assessment, treatment and rehabilitation for people at risk of a reduction in independence after an illness or accident, the frail elderly, people with long term conditions, those with dementia and those approaching end of life.
- Develop a model for the delivery of integrated community based health and social care, based on multi-disciplinary team (MDT) working, a single assessment process, the use of generic support works, telehealth and improved access to specialist medical, nursing and mental health services.
- Develop and implement a hospital admission and discharge policy, in partnership with acute and community hospital providers; to ensure integrated working across the interface between hospital and community health and social care, and prevent delays and support earlier discharge.

This workstream continues to be supported by the reablement funding to pump prime changes within each of the CCG localities. All of the plans are progressing well.

B. Long Term Condition Management (including dementia)
The focus is primarily on the development of more efficient long term condition care pathways, along with patient education and the use of a range of assistive technologies including a particular focus on Telehealth. With these methods in place we expect non elective admissions to reduce and to be able to provide care closer to home.

The LTC QIPP workstream seeks to improve clinical outcomes and experience for patients with long term conditions. The workstream will focus on improving the quality and productivity of services for these patients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn, slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their own conditions.

The workstream will connect with the national QIPP support headed up by Sir John Oldham whose improvement programme is designed to facilitate and enable local health economy teams to deliver change at pace, in a measured and supported way. This work focuses on three fundamental deliverables:

- Risk Profiling - Using risk profiling to ensure the CCGs understand the needs of their population and manage those at risk. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised.
- Neighbourhood Care Teams - The creation of integrated health and social care teams based around a locality (or neighbourhood) to provide joined up and personalised services (as per Project A)
- Self Care / Shared Decision Making - There needs to be a systematic transfer of knowledge and power to patients to empower patients to maximise self-management and choice. This includes ensuring that; patients engage in shared decision making in order to co-produce a care plan, that both patients and their carers have access to the appropriate information about how to manage their condition and that there is ‘no decision about me without me’ and that patients are active participants in all decisions about their care.

C. Urgent and Emergency Care Pathways and Services
The vision for urgent and emergency care is to provide universal, continuous access to high quality urgent and emergency care services. In practice this will mean that whatever the urgent or emergency care need, whatever the location, the patient gets the best care from the best person, in the best place and at the best time. A key enabler for this work stream is the implementation of NHS 111 which will be in place by April 2013.

One example of the urgent care workstream is the work currently underway at York Hospitals NHS Foundation Trust which aims to provide a fully integrated unscheduled care service for patients who attend their Emergency Department. An initial triage assessment and treatment will be provided for walk in patients by a senior primary care clinician. This will provide full integration of existing unscheduled care services including A&E, Walk in Centre, Out of Hours and GPs. This integration will be supported by a local media campaign to promote services and signpost patient to access the most appropriate services in the correct setting, thus reducing the number of patients attending A&E.

The QIPP objectives are as follows:

- Provide a single point of access for urgent and emergency care services.
- Relocate the Walk In Centre (WIC) to York A&E department.
- Integrate a GP service within York Hospitals Emergency Department to provide a 24 hour integrated service.
- Reduce the number of A&E attendances and admissions.
- Ensure the right care with the right clinician is achieved.
- Reduce levels of inappropriate admissions.
- Allows Emergency Department service to focus on major acute emergency care presentations thereby reducing delays and waiting times.

Additional QIPP schemes will be completed to ensure the population of North Yorkshire can make informed decisions about where and how to seek assessment and treatment in the most appropriate setting and on renegotiation of the GP Out of hours (GPOoH) contracts and implementing local tariffs for A&E patients triaged into GPOoH, all of which will drive further QIPP efficiencies.

Workstream 3: Reducing commissioning demand of elective care activity
Need and demand for healthcare services are increasing, and are likely to continue to increase, set within the context of decreasing resource availability. Increasing focus on the quality of services will require closer attention to balancing the risks and benefits of healthcare services – particularly elective and planned procedures, which in turn may lead to increasing thresholds for access to some services. This focus on risk and benefit also places a spotlight on key issues in respect of reducing harm, waste and variation to drive better patient outcomes and efficiency.

The NYY Review objectives of this workstream include:

- To collect and evaluate the proposals developed in each CCG to manage elective demand.
- To review the plans, and where necessary, clarify timescales, milestones and delivery outcomes.
- To assist in quantifying the impact of the proposed actions on bed numbers and ensure that these are fed where appropriate into workstream one.
- To work with the key PCT / CCG staff to review threshold levels and pathways to identify the potential for further initiatives and ideas to manage demand.

The focus within this programme is to continue to implement evidence based clinical thresholds and pathways, ensuring patients receive treatments at the most effective point in the care pathway so ensuring the most efficient use of resources. There is also a focus on referral and demand management, in particular working with GP Commissioning Consortia to reduce variation in referrals between practices.

There is also a focus on moving secondary care activity into primary care where appropriate and in additional focusing on the productivity of primary care services. We plan to revise the minor oral surgery pathway and the orthodontics pathway to deliver services in a clinically and cost effective way within primary care. We are also looking at range of ways of improving primary care productivity including aligning QoF with QIPP plans and carrying out PMS practice reviews.

Workstream 4: Reducing and rationalising the health and social care estate
Both the PCT and the local authorities own a great deal of estate throughout North Yorkshire. This estate comprises buildings that date back to Victorian times and those that are considered to be modern facilities. There are also efficiencies and improvements in service that can be achieved through co-locating both health and social care. Inevitably some buildings and land may no longer be required, nor likely to be needed for health or public services in the future. This surplus land is a public asset and therefore should be used for the greatest benefit of the local population and we will explore these opportunities closely with our locality and system partners to ensure we create viable and sustainable services for the future which are valued by the local community. Wherever possible we will look to share estate with partners.

The NYY Review objectives of this workstream include:

- Ensure that this work is taken forward actively and in conjunction with an assessment of potential local authority opportunities, to ensure that surplus property is disposed of as quickly as possible and ideally before April 2013 to ensure the financial benefits are attributable to the North Yorkshire system.
- A strategy is developed for each of the retained estate which will ideally include public sector integration and co-location, and the identification of financial savings and the possible identification of further surplus properties.

Both of these objectives will link closely with workstream 1.

Workstream 5. Reviewing the transport implications (both 999 blue light and patient transport).

Ambulance Services provide a valuable service that is held in high regard for the care it provides for patients, but more could be done to improve efficiency and value for money. Variations exist in costs and efficiency across North Yorkshire. It is our intention through better benchmarking and sharing of best practice to reduce these variations, though working closely with Yorkshire Ambulance Service (YAS) and developing a cross party working group to deliver transformation. Monitoring and interventions will be the main focus to increase efficiency and achieve better outcomes and value for money.

The NYY Review objectives of this workstream include:

- To ensure that the implications of service changes and estate rationalization on the 999 / urgent transport services provided by the Yorkshire Ambulance Service and North East Ambulance Service FT are properly considered and evaluated as a whole .
- To review the current pattern of patient transport services across the system with a view to both improving services to patients and families and reducing costs in the context of any changes emerging from this programme of work.

Other QIPP Workstreams
There are two other QIPP workstreams which do not fit naturally within the 5 major workstreams of the NYY Review. These are improving medicines management and mental health services. These are outlined in more detail below:

A. Improving Medicines Management
This programme focuses on increasing the proportion of generic drugs prescribed, ensuring efficient and effective primary care prescribing and ensuring that excluded drugs are used in line with NICE guidance. The key workstreams are:

- Switching from one drug type to another type/drug or formulation.
- Reducing the use of prescribing drugs where poor evidence exists or where prescribing is not supported by local or national tariff.
- Develop supportive tools such as 'Scriptswitch' to manage and support better efficiencies.
- Better management of Payment by Results (PbR) excluded drugs which is a high cost demand led growth area.
- Reduce excess treatment costs from clinical trials.
- Realising savings outlined in the Better Care Better Value prescribing indicators.
- Partnership working with the Industry leading to better procurement of medicines.

B. Improving Mental Health
The aim of this programme is to provide care closer to home by repatriation of out of area patients, driving down costs within continuing care, having undertaken a piece of market analysis we are now formalising contractual arrangements with continuing care providers, create efficiencies through a robust procurement process for mental health, learning disability and substance misuse services.

Supporting this initiative is the procurement of the Mental Health, Learning Disability and Substance Misuse and a contract designed to provide financial savings over the three year life of the contract.

We are also redesigning liaison psychiatry across North Yorkshire to drive better patient outcomes and to provide a more responsive service to patients who are over 65 on a ward or those presenting in emergency departments because of crisis. This will provide better clinical coverage in the acute hospitals.

Supporting Documents:

Independent Review of Health Services in North Yorkshire and York August 2011, Report of the Independent Commission
Revised Draft Implementation Plan and Proposed Workstreams, NYY Review Implementation Programme

1.7 NHS Constitution

Results of a Local Survey
NHS North Yorkshire & York ran a local survey from 21 December to 7 January 2010. Letters and details of how to complete the survey either on-line via the PCT public website, or on paper, were sent out to a wide range of stakeholders. GP practices were asked to make staff and patients aware and to display a poster with details of the consultation. Local Authorities and Councils were also asked to highlight the opportunities for people to respond to the consultation. The questions used in this local survey were based on the national consultation questions, with a few additions in order to help identify any actions for NHS North Yorkshire and York.

A total of 215 people responded - 210 via the on-line questionnaire and 5 returning their completed forms to the Freepost address. A percentage breakdown for a sample of the answers to each question is provided below. We asked for comments from respondents on a

number of points, and these are reported separately at the end of this report. The survey was set up and analysed by NHS North Yorkshire & York Public Engagement Team.

Q1.Do you think that the NHS Constitution should establish and include a right in respect of waiting times?	
Yes	86%
No	10%
Don't know	3%

Q2. If Yes, should the right include the current standard for treatment within 18 weeks?	
Yes	75%
No	11%
Don't know	7%

Q3. Should the right include the current standard for urgent referrals of suspected cancer to be seen by a specialist within 2 weeks?	
Yes	87%
No	7%
Don't know	3%

Q5.Should GPs provide specific information to patients on their rights around a 2 week referral?	
Yes	83%
No	9%
Don't know	7%

Q6. Do you agree that a right to a NHS Health Check every 5 years for those aged 40-74 should be established (with effect from April 2012) and be included in a revised NHS Constitution?	
Yes	64%
No	25%
Don't know	10%

Q8. Should the NHS look at developing rights for patients and the public for the following?:			
Yes		*No*	*Don't know*
Evening and weekend GP access	73%	20%	6%
NHS Dentistry	87%	6%	5%
Personal health budgets	26%	35%	36%
Choosing to die at home	81%	8%	9%
Waiting times for cancer diagnostics	86%	7%	6%

Q10. Do you agree the role of the Constitution Champion should be determined locally by PCTs?	
Yes	47%
No	20%
Don't know	32%

Q12	Are you.... *(please tick all that apply)*
A member of NHS staff	60%
A patient/ service user	53%
A carer	11%
A Local Councillor	4%
Member of a patient organisation	3%
Member of a voluntary sector organisation	6%
Other	11%

Q13	Are you replying as an individual or on behalf of an organisation?
Individual	97%
Organisation	0%

Q15	How aware are you of the NHS Constitution?
Very aware	9%
Aware	45%
Don't know much about it	30%
Wasn't aware until now	15%

2 Quality Profile

2.1 Harrogate and District NHS Foundation Trust

2.1.1 Background

Harrogate and District NHS Foundation Trust (HDFT) was founded under the Health and Social Care (Community Health and Standards) Act 2003 and authorised as an NHS Foundation Trust from 1 January 2005. The Trust is the principal provider of hospital services to the population of Harrogate and surrounding district and also to north Leeds. This represents a catchment population of approximately 200,000. In addition, on 1 April 2011, the Trust took on responsibility for a wide range of community based services covering the Harrogate and District locality and some services covering the whole of North Yorkshire, as part of the Transforming Community Services programme.

The hospital has an Emergency Department, extensive outpatient facilities, Intensive Therapy Unit and High Dependency Unit, Coronary Care Unit, plus five main theatres and a 20 place Day Surgery Unit with two further theatres. The Macmillan Dales Unit provides assessment and treatment, principally for the diagnosis and treatment of patients with cancer or dermatological conditions. Dedicated purpose built facilities are also provided on site for Cardiology, Radiology, Pharmacy, Pathology, Endoscopy and Therapy Services. The Trust also has a central delivery ward and maternity services, together with an Early Pregnancy Assessment Unit. The Lascelles Neurological Rehabilitation Unit provides care for inpatients with a range of neurological conditions and brain injuries.

A range of hospital services are provided in partnership with York Teaching Hospitals NHS Foundation Trust (YHFT) including:

- Breast & Cervical Screening.
- Dermatology.
- Ear Nose and Throat (ENT).
- Genito-Urinary Medicine (GUM)/Sexual Health Services.*
- Neurophysiology.
- Non-Surgical Oncology.
- Ophthalmology.

- Oral & Maxillofacial Surgery.
- Orthodontics.
- Renal Medicine.
- Rheumatology.
- Urology.
- Vascular Services.
- Satellite Renal Unit*.

(*Service managed by YHFT, but provided in facilities on the Harrogate District Hospital (HDH) site.)

HDFT also has a number of established clinical links with Leeds Teaching Hospitals Trust (LTHT). These include

- Coronary Heart Disease.
- Neurology.
- Plastic Surgery.
- Specialist Paediatrics.
- Specialist Cancer Services.

2.1.2 External Assurance
Monitor
Governance: Green (no material concerns)
Financial risk rating 3: the financial risk rating for this foundation trust was changed from FRR4 to FRR3 at quarter 4 2011/12 due to a planned change in the trust's financial position.

There are currently no Section 52 or Section 53 notices for Harrogate and District NHS Foundation Trust**.**

Care Quality Commission (CQC)
CQC: Summary of latest checks on the standards published on 28 May 2012

Standards of treating people with respect and involving them in their care ✓
Standards of providing care, treatment & support which meets people's needs ✓
Standards of caring for people safely & protecting them from harm ✓
Standards of staffing ✓
Standards of management ✓

2.1.3 Quality
A) Patient Safety
The Operating Framework for the NHS in England 2012/13 includes patient safety as a key focus within the quality of outcomes that we must achieve.

Infection Control
All providers have a focus on preventing health care acquired infections including Methicillin - Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C Diff). Year on year improvements that Trusts are required to achieve are monitored via the Contract Management Boards and Sub Contract Management Boards for Quality and Performance.

The table below presents the HDFT position as at end February 2013:

	Annual Plan	Year to Date 2012/13
C Difficile	11	9
MRSA	1	2

Mortality
There are now two measures used to indicate whether a death rate at a hospital is higher or lower than expected. The Hospital Standardised Mortality Ratio (HSMR) which has been used for several years and the Summary Hospital Mortality Index (SHMI) introduced this year. Both measures are reported by Dr. Foster Intelligence, the SHMI includes patients who have died within 30 days of discharge.
The HSMR indicator focuses on deaths that occur in hospital where the number of deaths over a given period is expressed as a proportion of the expected number of deaths adjusted to account for the type of care provided by the hospital and the casemix of patients.

SHMI is a new indicator introduced by a working party set up by the NHS Medical Director Bruce Keogh to define a new single indicator that would gain consensus support across the NHS. The SHMI, like the HSMR, is a ratio of the observed number of deaths to the expected number of deaths for a provider, but includes deaths within 30 days of discharge from hospital whereas the HSMR does not.

A mortality banding similar to the one used for HSMRs is published, but two sets of control limits are published – one based on unadjusted data (PO – based on a Poisson distribution) and one based on data that excludes the top and bottom 10% of cases (OD – adjusted for 'Over Dispersion'). The OD method is used to construct the published bandings, as it is less likely to incorrectly identify providers as being in the 'higher than expected' mortality band, and thus focuses investigations onto providers that are stronger candidates for investigation than would be the case under the PO bandings.

- HDFT's latest SHMI and HSMR is 'As expected'

For both measures, the national score is set at 100 – a score significantly above 100 indicates higher than expected death rates, whereas a score significantly below 100 indicates lower than expected death rates.

Never Events and Serious Incidents (SIs)
National Patient Safety Agency's (NPSA) 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation' was issued in March 2010. Work continues to ensure that all SIs receive a detailed and thorough investigation with root causes being identified, learning shared and action plans developed to reduce the risk of recurrence.

The SI review group continues to meet on a 6 weekly basis. At the most recent meeting the pathways for the management and administration of SIs was mapped in terms of the current system and proposals made for changes following transition.

Serious Incidents 2012/13

	SIs Reported	Never Event	SIs Closed*
April	0	N/A	3
May	0	N/A	1
June	0	N/A	1
July	1	No	0
August	1	No	0
Sept	1	No	2
Oct	0	N/A	1
Nov	2	No	0

*The closed SIs refer to SIs that occurred in 2010/2011.

There is currently an external incident review process in relation to a HDFT radiology incident which is chaired by the CCG and has the involvement of SHA/Cluster members.

B) Clinical Effectiveness
The clinical effectiveness dimension of quality, means understanding success rates from different treatments for different conditions. Assessing this includes clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Equally as important is the effectiveness of care from the patient's own perspective measured through patient reported outcome measures (PROMs).

Stroke and Coronary Services – Performance against the target for stroke patients spending 90% of their time on a dedicated stroke ward was met throughout the year with an annual performance in 2011/12 of 85.3% against the 80% standard.

Transient Ischaemic Attack - Performance for patients who have a Transient Ischaemic Attack and a higher risk of stroke, who are treated (including all relevant investigations) within 24 hours of contacting a healthcare professional, was 53.4% at the yearend (2011/12) with the planned rate of 60% therefore rated at Red. Action plans are in place.

Stroke accreditation – The peer review at Harrogate District Foundation Trust was held on 11 May 2012 and the Trust did not gain accreditation at this stage. The accreditation team requested a number of essential actions prior to accreditation of the service being awarded. The team revisited on 7 September 2012 to review progress and make an accreditation decision. The essential key aspects raised were around recruitment of additional consultants for stroke care, other staffing shortages, general physicians covering out of hours of the stroke unit meet the minimum requirement of a physician with stroke skills, delivering a safe thrombolysis service 24/7 and telemedicine clarification. Verbal feedback from this re-assessment is that the service remains non-compliant.

Out of Hours (OOH)
The current North Yorkshire out of hours urgent care service is provided by Harrogate and District Foundation NHS Trust (HDFT) with a sub-contractual arrangement with Yorkshire Ambulance Service for the call handling, IM&T, driver and transport element of the service. This service covers a population of 560,000 and does not include the Scarborough, Whitby, and Ryedale population of North Yorkshire where there are different commissioning arrangements in place. On the 2nd of August 2012, Harrogate and District Foundation Trust (HDFT) wrote to North Yorkshire health commissioners setting out their intention to give notice as the main provider of this service across North Yorkshire. This letter was followed by further formal communication to commissioners on the 8th of August 2012, from HDFT setting out their concerns around the viability and sustainability of the service including an increasing clinical risk within the service as the current GP workforce is decreasing

Risks with the current service model

- Performance
  The current service is non-compliant with some key National Quality Requirements as follows:

  Clinical assessment for urgent cases within 20 minutes = 84%
  Clinical assessment for non-urgent cases within 60 minutes = 85%
  Face to face walk in urgent cases within 20 minutes = 67%
  Face to face home visits for urgent cases within 2 hours = 79%

  There has been a noticeable consistency in partial and non-compliance within the existing service over the last 12 months This service has historically been non-

compliant against these standards, prior to the transfer to HDFT from the PCT Provider.

- Workforce
  It is becoming more difficult to fill the GP rota within this service which is resulting in an increasing proportion of shifts being covered by bank and agency doctors and a small proportion of shifts going unfilled.

CCGs will be asked to review their local urgent care service models as part of the implementation of NHS111 supporting improved efficiencies and increasing productivity within the current OOH service, specifically focusing on developing integrated pathways for people with long term conditions, people within care homes and people on end of life pathways.

C) Patient Experience
Access – All access targets are being met which includes referral to treatment times, cancer waiting times and access to diagnostics.

D) HDFT Quality Account – Priorities
The trust set five priorities for improvement in 2011/12 and made significant progress against them:

- Care of the deteriorating Patient.
- Patient Experience – 'Every Patient, Every Time'.
- Integrated Care
- Outpatient Experience.
- Discharge Letters.

In 2012/13 the focus will be on:

- Infection Control and Cleanliness.
- Improving end of Life Care.
- Improving Discharge.
- Improving Fundamental Care.
- Improving incident management via NRLS and SI reporting

OVERALL ASSESSMENT – **GREEN / AMBER**

KEY RISKS:
Stroke
Out of Hours

2.2 York Teaching Hospitals NHS Foundation Trust

2.2.1 Background

YFT was formed as an NHS Trust in 1992 and authorised as a Foundation Trust in 2006. The trust had a turnover of £247m in 2010-11 and employs over 5,000 staff (approximately 4,000 whole time equivalent), with an additional 800 transferred in April 2011 as part of the Transforming Community Service agenda.

In April 2011 the trust took over the management of some community based services in Selby, York, Scarborough, Whitby and Ryedale. This included some community nursing and specialist services as well as Archways in York, St Monica"s in Easingwold, The New Selby War Memorial Hospital, Whitby Hospital and Malton Hospital. More than 92 per cent of the Trust's clinical income arises from contracts with NHS NYY.

York Teaching Hospitals NHS Foundation Trust acquired Scarborough and North East Hospitals NHS Trust on 1 July 2012.

York Hospitals is registered without conditions by the CQC.

2.2.2 External Assurance

Monitor

Governance: Amber - Green

The governance risk rating for this foundation trust was amended from AMBER-RED to GREEN in September 2012 due to improvements in compliance with CQC essential standards.

Finance: 3 (where 1 represents the highest risk and 5 the lowest)

There are currently no Section 52 or Section 53 notices for York Teaching Hospital NHS Foundation Trust**.**

Care Quality Commission (CQC)

CQC: Summary of latest checks on the standards published on 28 May 2012

Standards of treating people with respect and involving them in their care	✓
Standards of providing care, treatment & support which meets people's needs	✓
Standards of caring for people safely & protecting them from harm	✓
Standards of staffing	✓
Standards of management	✓

2.2.3 Quality

A) Patient Safety

Infection Control

All providers have a focus on preventing health care acquired infections including Clostridium Difficile (C Diff) and Methicillin – Resistant Staphylococcus Aureus (MRSA). Year on year improvements that Trusts are required to achieve are monitored via the Contract Management Boards and Sub Contract Management Boards for Quality and Performance.

Root Cause Analysis forms for the C.Diff cases have been reviewed and some common trends have been identified:

- Inappropriate use of antibiotics;
- Issues with cleaning;

- Other patients with C.Diff on the same ward;
- Staffing vacancies / sickness;
- Inter-hospital transfer forms not being completed.

The findings and actions to address have been discussed with the Trust. The table below presents the York FT position as at end February 2013:

	Annual Plan	Year to Date 2012/13
C Difficile	27	24
MRSA	2	0

Mortality
SHMI data published at the end of July 2012 stated that York Hospital's SHMI rate was 'as expected'.

Organisation	SHMI 12 months ending September 2012	HSMR 12 months ending September 2012	HSMR 12 months ending December 2012
York Teaching Hospitals NHS FT	As expected	As expected	As expected

Never Events and Serious Incidents (SIs)
National Patient Safety Agency's (NPSA) 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation' was issued in March 2010. All SIs receive a detailed and thorough investigation with root causes being identified, learning shared, and action plans developed to reduce the risk of recurrence. The PCT SI review group continues to meet on a 6 weekly basis.

Serious Incidents 2012/13

	SIs Reported	Never Event	SIs Closed*
April	4	0	0
May	2	0	0
June	3	0	2
July	5	0	2
August	2	0	6
Sept	2	0	2
Oct	6	2 1 Wrong site surgery 1 Retained foreign object	2
Nov	0	N/A	0

*The closed SIs refer to SIs that occurred in 2010/2011 & 2011/2012.

Discussions are on-going regarding the SIs relating to 'sub-optimal care of the deteriorating patient' and C.Diff rates at the hospital.

NPSA Alerts

Alert	Deadline	Outstanding Action	Status
NPSA/2011/PSA001 – Safer spinal (intrathecal) epidural and regional devices	2 April 2012	Trust are working with adjacent Trusts on these alerts and are keeping the site	Open

Part A update		updated on their progress, some of which relies on information and advice from national bodies. CCG will continue to monitor progress with Trust	
NPSA/2011/RRR003 – Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	2 April 2012		Open

Update on NPSA Alerts
There is a national meeting on 12 September 2012 at the Royal College of Anaesthetists. This is entitled 'Replacing Luer connectors for neuraxial procedures - current challenges' which will be attended by a consultant anaesthetist. Vale of York Clinical Commissioning Group and YTHFT are in discussion on any national recommendations and also how local trials are progressing.

B) Clinical Effectiveness
The clinical effectiveness dimension of quality, means understanding success rates from different treatments for different conditions. Assessing this includes clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement.

Stroke and Coronary Services – Performance against the target for stroke patients spending 90% of their time on a dedicated stroke ward at Q1 2012/13 was 86% with a planned performance of 80% for YFT.

Transient Ischaemic Attack - Performance for patients who have a Transient Ischaemic Attack and a higher risk of stroke, who are treated (including all relevant investigations) within 24 hours of contacting a healthcare professional, was achieved at Q1 2012/13.

Stroke accreditation – York Hospital has achieved full accreditation as a level 2 Stroke Centre.

Cancer

- Percentage of patients urgently referred by a primary care professional that wait no more than 62 days from the date of referral to receive their first stage of treatment for cancer. York Hospital's performance in July and was rated Amber in the dashboard at 81.1% against a target of 85%.

- Percentage of patients urgently referred by an NHS Screening Service that wait no more than 62 days from the date of referral to receive their first stage of treatment for cancer. York Hospital's performance in July was 90.9% against the target of 90%. However, the overall year-to-date position is 88.2%.

York Hospital provided the following cancer update. '*Often patients are not aware they are on a suspected cancer pathway and are not able to attend in the timescales. The Trust is not allowed to adjust the target to reflect the fact that patients chose to wait longer or go on holiday. The idea nationally is that this is covered in the tolerance of 7% but York Hospital find that 7% is not enough to cover all those patients who are not able to attend, particularly over the summer holidays and Christmas. Typically the Trust would see approximately 600 fastrack patients per month – allowing a total of 42 patients to be seen outside the targets. Weekends and bank holidays are included in the 14 day fastrack count, measured from the day or receipt to referral. The Trust see approximately 120 Breast symptomatic patients per month, allowing for only 8 patients to be seen outside of the target*'.

Ambulance Services and Out of Hours

Ambulance response times: percentage of Red 1 and Red 2 999 calls responded to within 8 minutes. This target is rated Green in the July dashboard as York Hospital achieved 80.5% against a target of 75%.

Ambulance Turnaround (% >= 25 mins)	Up to 3 hrs	Up to 2 hrs	Up to 1.5 hrs
Week ending 19 August 2012	0	3	6
Week ending 26 August 2012	0	2	17
Week ending 2 September 2012	3	7	25
Week ending 9 September 2012	0	3	14
Week ending 16 September 2012	1	1	15

York Hospital presented a report on 'Improving Ambulance Turnaround' at the August Contract Management Board based on a 2 week pilot in June 2012. During the pilot the Trust agreed to implement the following actions to understand the impact on A&E performance:

- Trial a two week placement of a Yorkshire Ambulance Service clinical supervisor in Emergency Department.
- Launch the self handover education for staff.
- Trial an Emergency Department escalation to use available space.
- Trial escalation from the bed management team during surges in ambulance activity.
- Trial the use of a wall mounted C3 screen in Emergency Department.

The evaluation of the pilot showed that during the 2 weeks pilot in June, York Hospital was placed second in the regional performance reports. This was against the background of the hospital being on red alert and under significant operational pressure.

Vale of York Clinical Commissioning Group are currently working with two local practices (Haxby & Pickering) to introduce staggered timings for admitting patients to York Hospital earlier in the day in order to reduce the afternoon peak in activity at A&E. A review of emergency admissions and alternative ways of treating patients, without admitting them to hospital, are also being undertaken.

Most recent results are shown below:

Ambulance Turnaround (% >= 25 mins)	Up to 3 hrs	Up to 2 hrs	Up to 1.5 hrs
Week ending 24 February 2013	13	13	38

C) Patient Experience
18 Weeks/52 Week Waiters
York Hospital achieved the18 weeks target in July 2012 - 90.6% of patients were admitted for treatment within 18 weeks of referral (90% target), and 97.1% were treated without admission within 18 weeks (95% target).

At the September Contract Management Board meeting, York Teaching Hospitals NHS Foundation Trust provided a verbal update and confirmed that they have increased surgeon capacity at both Bridlington and York hospitals in order to deal with the backlog of patients in General Surgery who have waited over 52 weeks.

Choose and Book

The percentage of patients that arranged their outpatient appointment using the Choose and Book system was 25.2% in July, significantly short of the 70% level planned. Work is ongoing to encourage GPs to use Choose & Book for referrals. The Choose & Book team have agreed to provide training for staff dealing with both Ophthalmology and MSK referrals so that data is captured relating to onward referrals which will help to boost the Choose & Book usage locally.

D) YFT Quality Account – Priorities
Priorities in 2011/12

- Pressure ulcer prevention in acute and community hospitals.
- Keeping acutely ill and deteriorating patients safe.
- Keeping patients safe from hospital; acquired infections.
- Ensure compliance with the World Health Organisation (WHO) surgical safety checklist.
- Ensure compliance with contractual and safety targets to reduce occurrence of VTE.
- Reduce avoidable falls in acute and community hospitals.
- Continue to reduce errors in prescribing and administration of medicines.
- Increase the percentage of patients who would recommend the hospital.
- Improve the scores on the national in-patient survey in response to the question 'were you asked your views on the quality of care?'
- Reduce the number of complaints where poor attitude is an issue.

Priorities for 2012/13:
Patient Safety
- Keeping acutely ill and deteriorating patients safe.
- Improve the care of patients with dementia.
- Improve access to food and fluids in hospital.

Clinical Effectiveness and Outcomes
- Ensure patients come to no harm while in care.
- Reduce avoidable falls in hospital care.
- Continue to reduce errors in prescribing and administration of medicines.

Patient experience
- Increase the percentage of patients who would recommend the hospital.
- Improve communication with patients, carers and relatives.

The Director of Infection Prevention and Control Annual Report shows that YTHFT are, for C-Diff, above an even spread profile YTD (18 as at the end of September against an even trajectory target of 13.5) but within the YTD target of 27 and below a Monitor target of 55. There has been a poor uptake of Infection Prevention training with only 27.5% of the Trust staff taking up the training that has been offered in 2011/12. This raises concerns in this area.

OVERALL ASSESSMENT – **AMBER**

KEY RISKS:

Care of deteriorating patient
52 week waiters
CDiff

2.3 Scarborough and North East Yorkshire Healthcare NHS Trust

2.3.1 Background

Scarborough and North East Yorkshire Healthcare NHS Trust (SNEY) provided services to approximately 200,000 people living in and around Scarborough, Bridlington, Whitby and Ryedale (this population can fluctuate up to 250,000 in summer). In 2010/11 SNEY received income of around £121 million (approximately 65 per cent is from North Yorkshire and York PCT and 25 per cent from East Riding and Yorkshire PCT). The Trust employed circa 1800 staff.

The localities of Scarborough and Bridlington have some specific challenges in terms of growing demand on healthcare across the economy most notably as a consequence of a growing and increasingly elderly population and due to significant numbers of areas of deprivation.

SNEY had long been a challenged Trust, being unable to meet either financial or performance requirements without external support. Additionally there had been considerable concern regarding the quality of services provided.

The profound financial difficulties experienced at SNEY over many years led to short term cost cutting decisions and significant challenges in terms of meeting performance requirements as determined by the NHS Operating framework. Assessment by the Healthcare Commission (HCC), predecessor of the Care Quality Commission, identified consistently low performance.

HCC Ratings

Year	Quality	Use of Resources
2005/6	**Fair**	**Weak**
2006/7	**Weak**	**Weak**
2007/8	**Weak**	**Weak**
2008/9	**Fair**	**Fair**

Results of patients‟ surveys were equally poor and staff survey results showed SNEY in the least well performing category.

SNEY has had a high Hospital Standardised Mortality Ratio (HSMR) for many years with 2007/08 at 113. Due to the significant turnover of Board members and the focus on financial issues, addressing the high HSMR did not become a factor until 2008/9. In 2009/10 Dr Foster published a league table of hospitals assessed against a range of quality factors including HSMR; SNEY was the worst performing Trust identified in this league table. The Trust placed considerable focus on improving this and reported significant year on year improvement.

In 2010 the Strategic Health Authority (SHA) led a process to support the determination of a long term strategy for SNEY in light of continuing financial and performance concerns and with the Care Quality Commission raising particular concerns regarding the quality of services. This process led to a decision by SNEY to approach York Teaching Hospital NHS Foundation Trust (YFT) for the consideration of the acquisition of SNEY by YFT.

The Cooperation and Competition Panel reviewed the merger of Scarborough and North East Yorkshire Healthcare NHS Trust (Scarborough Trust) with York Teaching Hospital NHS

Foundation Trust (York Hospitals) and found it consistent with Principle 10 of the Principles and Rules for Cooperation and Competition.

On 1 July 2012 York Teaching Hospitals Foundation Trust formally acquired Scarborough and North East Yorkshire Healthcare NHS Trust. Given the acquisition and subsequent integration of York Teaching Hospital NHS Foundation Trust and SNEY the existing Quality and Safety Strategy will be reviewed to form two separate and distinct strategies during the first 3 months of the acquisition. Key actions in year 1 will include:

- Establishment of governance structures and groups to ensure implementation and associated assurances.
- Implementation of the Quality Governance Plan for the new enlarged organisation.
- Development of separate quality and safety strategies.
- Establishment of Patient Experience Group – Executive Group to complement support and further strengthen and develop our priorities working together with our governors.

Significant work will be required to integrate services to new models of care recommended by the North Yorkshire Review and further workforce challenges will be presented to gain efficiencies from the acquisition.

2.3.2 External Assurance
Monitor

Care Quality Commission (CQC)
Scarborough Hospital:
CQC: All standards found to be met following assessment of declarations and evidence supplied by the service itself during registration ✓

Care Quality Commission (CQC) Inspection
Since applying for CQC registration in 2010, the Trust has been subject to various inspections. The timeline and outcome of those visits is shown below:

April 2010	Restricted Registration: 3 conditions: regarding medical staffing, medical records staffing and estates
July 2010	4 day Planned review: 15 areas of concern at Scarborough site: 10 areas of concern at Bridlington site
20 October 2010	Action Planning meeting - CQC/SNEY/PCT/SHA Action Work-streams put in place.
November 2010	6 Unannounced follow up review visits:
January 2011 All	15 of the previous areas of concern at Scarborough all compliant (5 of these highlighted as needing some further work) Of the 10 areas of previous concern at Bridlington – 9 were compliant with some continuing concerns and 1 area remained non compliant
March 2011	Full Registration granted
August 2011	Follow up review (report received October) 5 areas of concern on the Scarborough site: 4 areas of concern at the Bridlington site
October 2011	Action Plan compiled and work is ongoing
December 2012	Follow up meeting with CQC – Informal discussion advised Trust is now compliant with all including outcome

2.3.3 Quality

A) Patient Safety

Clostridium Difficile
Since 2008, considerable effort has been put into reducing the incidences of C.Difficile within the hospital. The table below demonstrates the improvement over the past four years.

2008	2008	2008	2008	2008	2008	2008	2008	2008	2009	2009	2009	Total
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
12	6	2	5	7	8	3	1	4	5	3	7	63
12	6	2	5	7	8	3	1	4	5	3	7	63

2009	2009	2009	2009	2009	2009	2009	2009	2009	2010	2010	2010	Total
April	May	June	Jly	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
13	8	8	4	2	2	2	6	9	9	5	9	77
13	8	8	4	2	2	2	6	9	9	5	9	77

2010	2010	2010	2010	2010	2010	2010	2010	2010	2011	2011	2011	Total
April	May	June	Jly	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
3	7	11	3	6	5	2	2	4	2	0	1	46
3	7	11	3	6	5	2	2	4	2	0	1	46

2011	2011	2011	2011	2011	2011	2011	2011	2011	2012	2012	2012	Total
April	May	June	Jly	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
1	5	3	7	4	2	2	5	0	3	0	0	32
1	5	3	7	4	2	2	5	0	3	0	0	32

The table below presents the Scarborough 2012/13 position as at end February 2013:

	Annual Plan	Year to Date 2012/13
C Difficile	24	13
MRSA	1	1

Venous Thrombosis Embolism (VTE)
The target for VTE is that 90% of patients should have VTE risk assessment on admission. During 2011/12 the Trust have introduced a quick reference guideline for VTE prescribing in all specialties and ensured that this is accessible to all staff. They have introduced an appropriate and mandatory training programme, developed a root cause analysis (RCA) process to investigate when a hospital VTE occurs and made appropriate changes to their medication chart. They have also developed a VTE patient information leaflet covering VTE prophylaxis and information on signs and

Mortality Rates
In September 2011, the HSMR showed that mortality was higher than expected in Scarborough, but the SHMI showed the trust to be "as expected", albeit at the high end of this scale. Work commenced in the Trust to analyse patterns of mortality and to better understand the higher than expected scores.

The latest SHMI figures released for 12 months ending June 2011 (published 25 January 2012) shows "as expected" for SNEY. In February 2013 both the SHMI and HSMR figures show Scarborough continue to be 'as expected'

The Trust was identified by the Care Quality Commission (CQC) as a national outlier from October 2010 for emergency admissions in the following two diagnoses:

Complex elderly with a nervous system primary diagnosis (HRG A99)

Complex elderly with a respiratory system primary diagnosis (HRG D99)

As a result of this finding, the Trust established a review team to review the case notes of a randomly selected group of patients with HRG A99 and HRG D99 who had received care and subsequently died at Scarborough and North Yorkshire Healthcare NHS Trust during 2010/11.

All case notes were reviewed using the Trust's Mortality Analysis Tool to provide a consistent and comprehensive analysis, with sufficient data to show trends and thus inform improvements in care. An Action Plan is in place with the CQC and is overseen by the CCG.

Serious Incidents (SIs) and Never Events
There have been 3 intrauterine deaths so far this year where separate supervisory midwife investigations have been undertaken, plus an overview report is being compiled – the LSA Midwife is both aware and involved

Serious Incidents 2012/13

	SIs Reported	Never Event	SIs Closed*
April	0	N/A	2
May	1	No	0
June	3	No	0
July	N/A	N/A	0
August	N/A	N/A	4
Sept	N/A	N/A	0
Oct	N/A	N/A	6
Nov	N/A	N/A	0

*The closed SIs refer to SIs that occurred in 2010/2011.

B) Clinical Effectiveness
Stroke
The target for stroke is that 80% of patients should spend at least 90% of their in-patient stay on a dedicated stroke unit. Evidence demonstrates that where patients receive care on a specialist unit there is a reduction in death and disability, as well as a reduction in the length of stay.

In the early part of 2011 performance against this indicator was poor at SNEY: Q1, 42.9%, Q2, 38.8%.

Following discussions with the Trust at the CMB and Quality group and liaison with primary care via the Clinical Commissioning Group, an action plan and performance trajectory was developed with the Trust undertaking a major programme of work to improve prompt diagnosis, direct admissions and the development of community stroke services. The Q3 position improved at 84.5%.

Stroke accreditation Scarborough Hospital underwent an assessment of its stroke services in July. There is a high possibility that it will fail this assessment on staffing numbers. If this is the case, the future role of the hospital providing stroke care will need to be considered. Verbal feedback is that the service remains non-compliant and is now out to external review.

Ambulance Turnaround Times
In 2011 SNEY reconfigured their A&E department which resulted in improved accommodation for ambulance patients. Since this development there has been an improvement in ambulance turnaround times. Latest figures are shown below:

Ambulance Turnaround (% >= 25 mins)	Up to 3 hrs	Up to 2 hrs	Up to 1.5 hrs
Week ending 24 February 2013	3	5	14

C) Patient Experience
A&E 4 hour wait and 18 weeks referral to treatment
Although the Access targets for 18 weeks Referral to Treatment and A&E four hours wait are reported as Green in the dashboard based on April and May data, there are concerns over variation in performance against these indicators. Since January 2012 the local Provider has struggled to maintain the A&E target due to pressure on beds caused by repeated outbreaks of Norovirus. This has also resulted in the backlog of patients waiting over 18 weeks for treatment growing to an unacceptable level. In July however, the percentage of patients waiting is 6.7% against a target of 8%.

Choose and Book
Performance is currently 47.4% against an indicator of 70%. Scarborough is on par with the national performance against this indicator, although will continue to work towards improving this.

D) Quality Account - Priorities
In 2011/12 the Trust prioritised the following areas:

- Minimising the number of outpatient appointments re-scheduled.
- Reducing hospital admissions.
- Improving discharge and medication information.
- Food, nutrition and feeding.
- Reducing hospital infections.

Whilst continuing to improve on the above priorities for 2012/13 have been agreed as:

- Dementia Care.
- End of Life Care.
- Supporting Nursing Homes.
- Timely psychiatric assessment in A&E.
- Improving the efficiency of discharge transport.

- Reducing the episodes of pressure ulcers, falls, catheter acquired infections and venous thromboembolism.
- Introducing a partial booking system.

OVERALL ASSESSMENT – **AMBER**

KEY RISKS:

Stroke
Mortality
IPC
Staff survey

Supporting Documents:
PCT Cluster Board Report Commissioning for Quality and Outcomes 22 May 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 24 April 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 27 March2012
PCT Cluster Board Report Quality at Scarborough and North East Yorkshire NHS Healthcare Trust 28 February 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 24 January 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 20 December 2011
Vale of York CCG Shadow Governing Body Meeting 2 August 2012
Harrogate and Rural District CCG Shadow Governing Body Meeting 19 July 2012
Scarborough and Ryedale CCG Shadow Governing Body Meeting July 2012
HDFT Quality Account
YFT Quality Account
SNEY Quality Account

Data Sources
Summary Hospital-Level Mortality Indicator - Information Centre
Hospital Standardised mortality Ratio - Dr Foster Intelligence
Healthcare acquired Infections - Health Protection Agency
VTE Risk Assessment – Department of Health
Serious Untoward Incidents - Strategic Executive Information System (StEIS)
Never Events - StEIS
Inpatient Survey Results - CQC inpatient survey data – 2011
Cancer Survey Results - National Cancer Patient experience Survey 2011
Staff Survey CQC staff survey 2011

2.4 BMI The Duchy Hospital

Background

The BMI Duchy is a 27-bedded Hospital in Harrogate, part of BMI Healthcare, one of Britain's leading providers of independent healthcare. The BMI Healthcare group have a nationwide network of hospitals and clinics performing more complex surgery than the majority of other private healthcare providers in this country.

BMI Healthcare are registered as a provider with the Care Quality Commission (CQC) under the Health & Social Care Act 2008 and BMI Duchy Hospital is registered as a location for the following regulated services:

- Treatment of disease, disorder and injury
- Surgical procedures
- Diagnostic and screening

In the last financial year BMI invested almost £44m to improve and extend their clinical services, improve hospital infrastructure and enable better business processes, as part of a continuing commitment to improve quality of facilities and services. These include major upgrades in some of the hospital's theatre complexes, ongoing upgrades in their MRI and CT scanners and the start of work to replace their existing patient administration system.

The recently initiated Competition Commission review of private healthcare is likely to focus on whether there is a lack of comparable quality data, thus impairing effective decision-making by patients. BMI Healthcare is committed to producing high quality group and hospital-level data that allows patients and referring clinicians to compare different facilities and make informed choices and we are keen that the Hellenic project, which is working across the private healthcare sector, is able to generate standardised quality measures and indicators for private providers as soon as possible.

BMI Duchy Hospital has a local framework through which clinical effectiveness, clinical incidents and clinical quality is monitored and analysed. Where appropriate, action is taken to continuously improve the quality of care. This is through the work of a multidisciplinary group and the Medical Advisory Committee. At corporate level the Clinical Governance Board has an overview and ensures that there is corporate learning and quality improvement.

Patient Safety

At BMI Duchy in the reporting period, there have been zero cases of Clostridium difficile (20 cases/100,000 bed days in NHS hospitals) over the last 5 years and zero cases of MRSA bacteraemias since the independent sector began to report to HPA in 2008. This is compared to 1.1 cases/100,000 bed days in NHS hospitals for the period April 2010 to December 2011 (latest data published).

PEAT is an annual assessment of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England. BMI Duchy Hospital has increased their scores in all 3 areas (Environment, Food, Privacy and Dignity) over the last year.

BMI Healthcare, has recently been awarded VTE Exemplar Centre status by the Department of Health across its whole network of hospitals including, The Duchy Hospital. We see this as an important initiative to further assure patient safety and care. To deliver the initiative BMI Healthcare established a National Thrombosis Team, chaired by the Group

Chief Pharmacist. The Team had the responsibility of implementing the Venous Thrombosis Prevention Policy which was launched alongside a new risk assessment tool, patient information leaflets, prophylaxis (prevention) protocols, training packages and regular audits to ensure ongoing compliance. All patients undergo an appropriate VTE risk assessment and decisions are made on appropriate prophylaxis.

Patient Reported Outcomes (PROM's)
For the current reporting period, the tables below demonstrate that the health gain between Questionnaire 1 (pre-operative) and Questionnaire 2 (post–operative) for patients undergoing hip replacement at the Duchy Hospital is higher than the average for England. For knee replacement surgery the Duchy Hospital has not carried out sufficient cases for NHS patients to provide valid data.

Oxford Hip Score average
2011/2012

	Q1	Q2	Health gain (Q2 - Q1 average)
Duchy	21.111	42.444	21.333
England	17.746	38.016	20.270

Patient satisfaction

BMI Healthcare is committed to providing the highest levels of quality of care to all of their patients. They continually monitor how they are performing by asking patients to complete a patient satisfaction questionnaire. Patient satisfaction surveys are administered by an independent third party. There has been ongoing focus on increasing the response rate to ensure that the analysis of the data collected provides reliable information on which to base our quality improvement efforts. BMI Duchy Hospital analyses the monthly reports they receive, and implements appropriate action to address any issues of dissatisfaction or areas which have been scored lower than others.

A project to improve on excellence has been ongoing over a number of years. The areas of focus have been based on our patient feedback e.g. admission and discharge processes, nursing care and this has resulted in a year on year increase in patient satisfaction scores. The focus for this year is Housekeeping and Catering.

Priorities for 2012/13

The Board will be supporting the focus on the following areas:-

- Ongoing engagement with NHS commissioners to enhance patient choice and service delivery to NHS patients will be measured by agreed quality indicators.
- Further develop and enhance availability of performance and quality indicators for patients, consultants, referrers and commissioners.
- Audit compliance with Care Bundles" to ensure that these have been effectively implemented and this will be measured by infection rates.
- Extension of collection of PROMS to include hip and knee replacement for private patients.
- Improvements in the management of complaints and responses to patients with roll out of a corporate tool kit.

2.5 Clifton Park Treatment Centre (Ramsay Healthcare)

Background

Clifton Park Treatment Centre, part of the Ramsay Health Care UK Group, is a modern, purpose built in-patient hospital located just outside York City centre. It was opened in January 2006 to deliver elective NHS activity. In October 2010 the hospital secured a three year standard acute contract (SAC) with NHS North Yorkshire and York and NHS East Riding of York to deliver orthopaedic services. In addition to this SAC activity, additional orthopaedic activity from York Teaching Hospitals NHS Foundation Trust is also undertaken.

Clifton Park NHS Treatment Centre is a 24-bedded in-patient unit providing a wide range of elective orthopaedic surgical procedures, including treatments for problems with hips, knees, shoulders, hand, wrist and elbow and foot and ankle. The hospital has a large out-patients department, on-site x-ray and physiotherapy, mobile MRI, a day case unit, two laminar flow theatres and a state of the art decontamination facility for the in-house control of all decontamination requirements for the treatment centre.

The hospital provides a full range of high quality orthopaedic services for all patients of 18 years and above. From 1st April 2011 to 31st March 2012 the hospital treated 2884 admitted patients, 95% of which were treated under the care of the NHS.

Clifton Park Treatment Centre has a unique structured secondment agreement with York Teaching Hospitals NHS Foundation Trust who provide 40 specialist consultant orthopaedic surgeons and anaesthetists to work from the facility. The hospital also has a training agreement with York Hospitals NHS Foundation Trust, enabling registrars and extended scope practitioners to work alongside consultants at the hospital.

Patient Safety

Infection prevention and control

Clifton Park NHS Treatment Centre has a very low rate of hospital acquired infection and has had **no** reported MRSA Bacteraemia in the past **6 years.** The Treatment Centre complies with mandatory reporting of all Alert organisms including MSSA/MRSA Bacteraemia, Clostridium difficile and E coli infections with a programme to reduce incidents year on year. Ramsay Group also participate in mandatory surveillance of surgical site infections for orthopaedic joint surgery and this Treatment Centre remains below the lowest percentile for infection rates. A network of specialist nurses and infection control link nurses operate across the Ramsay organisation to support good networking and clinical practice.

Falls

Each year around 282,000 patient falls are reported to the National Patient Safety Agency (NPSA) from hospitals and other health units (Jan 2011, NHS NPSA/2011RRR001). The agreed threshold for Clifton Park in relation to falls was 14 falls per year. Clifton Park failed to achieve this, reporting 17 falls in 2011/12 (a similar level to that achieved in 2009/10) however, this was a much improved position on 2010/2011 where 22 falls were reported. They do however identify any trends, formulating and implementing action plans across the hospital to help improve patients' safety. The improvement seen since 2010/11is attributed to the introduction of a comprehensive action plan focusing on assessment and patient information to reduce the risk of falling with a positive outcome in the reduction of incidents.

National Joint Registry (NJR)

Clifton Park NHS Treatment Centre participates in the National Joint Registry audit programme and the NJR provide a quarterly report to the hospital regarding compliance. Clifton Park exceeds the national 90% benchmark figure for NJR consent.

Ambulatory Day Care
This is the admission of selected patients to hospital for a planned procedure, returning home the same day. It is Clifton Park's aim that 90% of their day surgery patients are treated in their Ambulatory care facilities. Patient survey results indicate an improvement in waiting time from admission to procedure, to 82.5% satisfaction, due to the staggered admission times in the Ambulatory Day care unit.

Clinical Priorities for 2012/13
- VTE Risk Assessment and the NHS Safety Thermometer
- Improve Pain Control satisfaction
- Increase the use Ambulatory Day care
- Increase the use of Patient Reported Outcomes (PROM's) in relation to the hip compliance rate
- Improve patient experience – personal needs

2.6 Nuffield Health

Background

Nuffield Health York Hospital opened in 2004 on the site of the former Joseph Rowntree in response to increasing demand from the local region. They provide a comprehensive range of services. Nuffield Health's Quality Report emphasises the importance of joined up healthcare. Their aim is to offer healthcare that links health and wellbeing at home, in the workplace and hospital when needed.

The aftermath of the financial crisis has undermined public trust and emphasised the importance of values and integrity. Nuffield Health's not for profit model is unique enabling them to remain independent, offering choice and enabling them to always put the needs of their customers first.

The pace of change in healthcare continues to accelerate with our ageing population, increasing burden of chronic conditions, higher expectations and an ever increasing array of new treatments.

Nuffield Health is registered to provide seven regulated activities under Schedule 1 of the Health and Social Care Act 2008:

Treatment of disease, disorder or injury (Regulated Activity 5)
Surgical Procedures (Regulated Activity 7)
Diagnostic and Screening Procedures (Regulated Activity 7)
Supply of blood and blood derived products (Regulated Activity 7)
Maternity and Midwifery services (Regulated Activity 11)
Termination of pregnancy (Regulated Activity 12)
Family planning services (Regulated Activity 15).

Nuffield Health provides services to all age ranges from birth to adult; including specialist care, screening, diagnostic services, private GP services, physiotherapy and fitness. These are provided in the workplace, in the community and in hospitals.

The CQC regulates Healthcare in line with the Health and Social Care Act 2008 and no Nuffield Health facility was the subject of enforcement action from the CQC in 2011.

Highlights for 2011

Maintenance and Improvement on Standards

- Year on year improvement in infection prevention and control standards.
- NHS Litigation level 3 accreditation – the highest risk management standard in UK healthcare.
- Extension of ISO 27001 information security certificate to include all Nuffield Hospitals, Group Call Centres, Medical Centres and Wellbeing Clinics within Fitness & Wellbeing Centres.
- Maintenance of Nuffield's full decontamination accreditation to International Organisation for Standardisation (ISO) 9001 and ISO 13495 standards.
- Full pathology accreditation with Medicines and Healthcare products Regulatory Agency (MHRA) and Clinical Pathology Accreditation (CPA) standards. Full two-way barcode automation of blood transfusion system.

Recognition through Awards

- Winner of the 2011 Flame Award for Corporate Wellbeing.
- Winner of 2011 Health Investor Hospital Group of the Year.

- Finalist for 2011 Laing and Buisson Medicines Management and Use of Technology Awards.
- Finalist for 2011 Laing and Buisson Best Use of Technology in Risk Management.

Development of Facilities and Services
- Full registration of all English Nuffield Health clinical facilities with the Care Quality Commission.

Patient Safety
Nuffield Health places a very strong emphasis on governance. In 2010 it decided to seek to increase the level of accreditation it had reached with the National Health Service Litigation Authority (NHSLA) Risk Management Standards. The standards are designed to address organisational, clinical, non-clinical and health and safety risks; and to provide a structured framework within which to focus effective risk management activities in order to deliver quality improvements in organisational governance, patient care and the safety of patients, staff, contractors, volunteers and visitors.

Nuffield Health was the first independent healthcare sector provider accredited at NHSLA Level 1 and then level 2 in 2008. At the end of 2011 Nuffield Health became the first independent sector healthcare provider to achieve Level 3 accreditation with NHSLA Risk Management Standards, and the first multi-site national provider. At the time it joined only 23 NHS Trusts had achieved that level.

Infection Prevention
Nuffield Health aims to provide care in a "clean, safe environment, where the risk of infection is minimised" (Department of Health 2008). The management of Infection Prevention within each Nuffield Health hospital is led by the Director of Infection Prevention and Control (DIPC) who is the Matron; supported by a team of trained Infection Prevention Link Practitioners (IPLPs) who act as role models for best practice and monitoring practice, to ensure prompt detection of infection risks. This is achieved, in part, through a rigorous auditing programme.

In hospitals:
- Compliance to all Infection Prevention Standards in 2011 improved from 95% to 96%
- Hand hygiene improved from 94.5% to 97%.
- Cleanliness standards improved from 90% to 93%.

Nuffield Health participated in international and global initiatives including the World Health Organisation (WHO) "Save Lives: Clean Hands" Campaign where an "Advanced" level" of hand hygiene was achieved, demonstrating "*sustained and improved campaigns which have helped embed a culture of safety within the organisation"*. This was the highest level possible.

21 hospitals participated in external validation of cleanliness standards through the National Patient Environment Action Team (PEAT) programme, demonstrating transparency and openness within the organisation.

85% of hospitals were ranked as "excellent" or "good" (compared to 76% in 2010) with the remaining sites ranked as "acceptable".

Nuffield Health also participated in National Infection Prevention Awareness Week working with staff, patients, visitors and local communities to raise the profile and awareness of hand hygiene and cleanliness in minimising infection risks for everyone.

A robust framework for reporting Healthcare Associated Infections to the Health Protection Agency (HPA) combined with a rigorous process for investigating and learning lessons, ensures prompt detection of infection trends and risks.

Data for infections in 2011 demonstrates that:

- Hip surgical site infections fell from 0.28 in 2010 to 0.13% in 2011.
- Knee surgical site infections fell from 0.55% in 2010 to 0.31% in 2011.
- There were 2 cases of MRSA and 2 cases of MSSA bloodstream infections in four out of 31 hospitals, with no cases of cross infection identified.
- There were 7 cases of Clostridium Difficile reported in 2011and 6 of these cases were admitted with signs/symptoms of the infection. There were no cases of cross infection reported in any hospital.

Patient Experience

Nuffield Health remains focused on learning from customer feedback and complaints, reviewing and improving services. Headline figures for 2011 show:

Hospitals

- Stage 1 complaints were 0.9% of activity compared to 0.88% in 2010.
- The average length of time it took to close a complaint was 25 days which is an improvement of 3 days on 2010.
- There were 12 stage 2 complaints compared to 19 in 2010; and no stage 3 complaints which is the same as 2010.

30,036 satisfaction surveys were returned by patients (23.45% return) compared to 29,798 (23.6% return) in 2010.

Overall patient satisfaction was 98% which is the same as 2010.

Patient Reported Outcome Measures (PROMs)

PROMs have been measured and reported by Nuffield Health for 3 years. There are improved PROMs participation rates overall against the four identified procedures, hip and knee replacement, varicose vein surgery and groin hernia repair and shows consistently better results than the NHS.

The number of complete questionnaires received at the pre operative phase has increased from 1021 for the 12 months to March 2011; to 3408 questionnaires for the 12 months to March 2012.

Complete questionnaires received at the post operative phase (6 months post procedure) for both hip and knee replacement and 3 months post procedure for both groin hernia repair and varicose vein surgery is 65%.

All the PROMs tools have a general comments section and Nuffield Health received a total number of 171 comments from patients. Patient comments did not indicate any significant trends in either procedure or at specific sites.

Although the total number of questionnaires has increased year on year we still fall below our desired participation rate of 85% across all procedures.

Nutrition

2011 saw the development of Nuffield Health's first clinical nutrition network. A team of Nutritional Therapists now operates from selected Fitness & Wellbeing Centres, on-site corporate gyms and Medical Centres. All operate in accordance with guidelines set out by

the professional governing body and all meet minimum practice standards as set out by the Professional Head of Nutrition.

The addition of Nutrition Experts to the Nuffield Health repertoire of health and fitness professionals supports the business' joined up approach to healthcare and enables Nuffield to offer truly integrated services to clients and members alike.

Primary Care
Nuffield Health general practitioners run clinics at designated medical centres, corporate health care sites and fitness and wellbeing centres. In 2011 nearly 20,000 patients attended a Nuffield Health GP appointment to discuss health related matters. A total of nearly 6,000 prescriptions were issued in 2011 through the primary care services. This year, primary care services have been enhanced to include women's health, sexual health and travel advice services.

Revalidation for all practising doctors in the UK will be implemented in 2012. This will set the standards for doctors to be issued with a 'License to Practice' through audits and an appraisal system. All of our 41 employed General Practitioners underwent a Nuffield Health Clinical Appraisal in 2011. The process is fully compliant with the revalidation standards set by the GMC. There are in-house monthly continuing professional development meetings to give doctors the opportunity to discuss complex clinical cases and ensure their knowledge is current and relevant. Clinical complaints about the service remained at a very low level in 2011 with only two complaints of a clinical nature, neither of which caused significant harm to the patient.

Adverse incidents
Nuffield Health complies with the reporting requirements for adverse incidents. However the Nuffield Health categories for serious untoward incidents do not currently reflect the National Patient Safety Agency (NPSA) categories and will be updated to come into line with their published categories in 2012.

The total adverse events (incidents) affecting patients was 3590 (1.35% of patients) in 2011 compared to 3630 (1.38% of patients) in 2010.

Priorities for 2012/13
The organisation's priorities for quality improvement for the coming governance year are to:

- Publish activity and outcomes data for patients undergoing treatment on our website

- To retrospectively audit the use of medical devices in the organisation (including breast implants and metal on metal hip replacements) contacting patients in need of follow up review

- To seek OHSAS 18001 health and safety accreditation to provide external assurance to the changes we have made following recent incidents.

- To further drive quality improvements through development of detailed action plans to address risks identified through audit and surveillance programmes including cleanliness and hand hygiene standards - the essential standards for infection prevention and control.

- To further monitor the provision of medicines management '***as it should be'*** including Antimicrobial Stewardship and compliance with new standards from the pharmacy regulator.

Future Direction for Nuffield Health
Nuffield Health state that they are committed to delivering comparable quality information and transparency; and that this year's report is a step, but not the final destination, on that journey.

The changing NHS presents organisations with challenges and opportunities. Nuffield Health's view is that the challenge lies in differentiating themselves as a not for profit offering the best outcomes in all their activities. They realise they must face up to the cost and demographic pressures that are affecting all western healthcare. NHS reform is not an easy partner and the long term impact of commissioning, contracting as a willing provider and private patient reforms are difficult to predict. The opportunity exists in the rise of the third sector and their social mission to improve the wellbeing of the nation.

The pace of change in an ever connected smaller world continues and the power of the health consumer is rising. People are making informed choices, seeking the providers of the best outcomes in care and using their budgets carefully. Prevention is becoming as important as cure particularly in the workplace to maintain the health of employees and for individuals interested in fitness and exercise. The disruptive power of proven technologies must surely start to overtake outdated delivery models. The freedom to make decisions in care will demand ever more from healthcare.

Health consumers will have increased access to information through multiple channels to seek and analyse their health needs. Health care will be customised to monitor, diagnose, educate, and intervene regardless of location or time. Preventative healthcare will embed as a result of a convergence between consumer experiences in other markets.

In 2007 Nuffield Health published the first independent health sector annual quality report in the UK. Their open & transparent approach in UK healthcare describes what they get right and what they get wrong. Some things haven't changed; quality information is increasingly driving health insurance and consumer purchasing decisions and remains a key currency in care.

2.7 Primary Care

2.7.1 Quality and Outcomes Framework

The QOF was introduced in 2004/5 as part of the new GMS contract. It sets out a voluntary system of financial incentive and reward for GP practices to provide high quality care and management through participation in an annual quality improvement cycle. The core philosophy of QOF is that incentives are the best method of resourcing work, driving up standards, and recognising practices' achievements. All North Yorkshire & York practices participated and the eighth year of QOF was completed on 31 March 2012.

It was a mandatory requirement for each practice to have a QOF review visit in the first year of QOF (04/05). However, the contract agreement states that, in time, annual QOF review visits might become less frequent and the 4 (former) PCTs in North Yorkshire adopted different approaches to the frequency of visits. Since the formation of the single North Yorkshire and York PCT in October 2006, it has been crucial to adopt a countywide approach to the QOF process to ensure robust and equitable management of the scheme. Following a review of the number of QOF visits undertaken in Years 1-7, it was agreed that the rationale for choosing which practices would receive a QOF visit in 2011/12 would be based on the outcome of an exception reporting audit, undertaken by Primary Care Information Specialists.

In addition, the PCT notified practices that it reserved the right to visit additional practices with high or low QOF achievement scores, or where particular issues relating to achievement of QOF standards, exception coding or disease prevalence factors arose.

Criteria for the trigger of additional practice visits included:

- Lack of engagement in the QOF process.
- Outstanding issues from previous QOF visits.
- Where aspiration levels differ greatly from previous years.
- A substantial drop or increase in achievement.
- Unsubstantive evidence.
- Variance of prevalence rates to national/local averages.
- High levels of exception reporting.

The concept of exception coding was introduced to allow practices to pursue the quality improvement agenda and not be penalised, where there are legitimate reasons for "exception reporting" patients.

In 2010/11 the overall effective exception rate for England, across all clinical domain indicator groups, was 5.4% (unchanged from 2009/10)

For North Yorkshire - the average exception reporting rate in 2010/11 was 5.48% - (down from 5.62% the previous year)

Further details:
Quality & Outcomes Framework (QOF) Year End Report - 2011/12
Briefing Paper on NYY QOF Exception Reporting 6 November 2012
Appendix A QOF Toolkit 2011-12 updated 16 May 2011
Vital Signs for 5NV North Yorkshire & York PCT - September 2012
NHS NYY Exception Coding Presentation
NHS NYY Exception Reporting Guidance for Practices

2.7.2 Medical Revalidation

Organisational Readiness for Self Assessment (ORSA) follows from the earlier *Assuring the Quality of Medical Appraisal for Revalidation* (AQMAR). This process aimed to address recommendations that Strengthened Medical Appraisal should be core to revalidation. Recommendations stem from the *Trust, Assurance and Safety* White Paper (DOH. 2007), and the various reports from *Kerr/Haslam* and the *Shipman Inquiry (Fifth Report)*, pressed for clinical governance as the core to the process of revalidation.

As a guidance and assessment tool, AQMAR raised awareness in 2009/10 of the impending revalidation changes. The process ensured that organisations assess the quality and effectiveness of existing appraisal and clinical governance systems. Since that period, ORSA has appeared as the process of achieving and demonstrating quality assurance at the operational level. The Pathfinder Pilots 2010-11 aimed to test whether the proposals would meet the needs of medical revalidation and to test the elements relating to cost, benefits and practicality of implementation.

ORSA requires demonstration of how the organisation integrates appraisal and governance with revalidation. Demonstration of the processes involved also extends to; Continuing Professional Development (CPD) systems, service development, workforce planning and human resource management.

To validate the processes established, the performance tem invited the internal audit team to review prior to the next ORSA submission expected in September 2012. Assurances were received as follows:

> *The findings of this follow-up audit confirm that NHS NYY continues to make progress towards the introduction of Medical Revalidation (from Q4 2012/13), that the majority of recommendations from the last audit have, or are close to being, implemented and that the organisation is responding appropriately to national guidance as it is issued. An opinion of* ***Significant Assurance*** *is therefore provided at the current time on the adequacy of preparations ahead of the likely introduction of revalidation from Q4 12/13. Nevertheless, further work is still required in the intervening period, particularly in relation to the further development of information systems to support revalidation decisions.*

Preparation for revalidation and clinical engagement: year '0'

NHS NYY aims to roll out revalidation to all GPs over the next three years. All GP appraisers have completed the national mandatory training as required and revalidation roadshows have been completed across all localities throughout October and November.

Cohorts for each year have been identified and GPs informed of expectations and information required. This first year is known as year '0' and following discussions with YorLMC, we are prioritising those central to the revalidation process; Responsible Officer (RO) and GP Clinical Appraisal Lead, GP appraisers, CCG leads and the LMC;

Year 0	01/01/2013 - 31/03/2013	*Responsible Officer* *Clinical appraisal lead and Appraisers* *Clinical Leads (E.g. CCG leaders, LMC) are to be Revalidated*	72 Doctors (9%)
Year 1	01/04/2013 – 31/03/2014	*All Doctors with GMC numbers ending in either 4, 0, 9*	213 Doctors (28%)
Year 2	01/04/2014 – 31/03/2015	*All Doctors with GMC numbers ending in either 3, 5, 1, 7*	256 Doctors (34%)
Year 3	01/04/2015 – 31/03/2016	*All Doctors with GMC numbers ending in either 2, 8, 6*	210 Doctors (28%)

An update including the following information has been provided to all GPs;

- Confirmation with the GMC of the GPs included on the NHS NYY Performers List
- Confirmation of the allocated year of appraisal
- Tools for revalidation submission
- Access to multisource feedback/patient feedback
- Access to NHS NYY-held supporting information eg. Medicines management, complaints and compliments (includes out of hours) and Performance information held by the performance team
- Revalidation events planned across 2012 to open dialogue between GPs and the RO

Further details:
Revised Terms of Reference for Performance and Medical Revalidation Group (PMRG) 25.07.12
Medical Revalidation: Organisational Readiness for Self Assessment (ORSA) NYY Board Paper
NYY Internal Audit Medical Revalidation Report 29.11.11
GP Revalidation: Procedure for Managing Conflicts of Interest
Minutes from SWR Local Appraiser Support Group Meeting 23.02.12
GP Appraiser Training Days 2011
Performers report to PCCGG 03 November 2011
LMC Paper re Revalidation
Revalidation Update Paper 15.11.12
Occupational Health Referral Template 11.10.11

2.7.3 Clinical Commissioning Groups and Quality Improvement
Whilst CCGs will not have a direct role in managing contracts with their respective practices, they will ultimately have a duty to assist and support the NHSCB (LAT) in securing continuous improvement in the quality of primary care. NHS NYY has therefore worked with CCGs in North Yorkshire in monitoring and quality assuring the Q&P indicators within QOF and have delegated the responsibility for managing the process at local level. To assess quality countywide, and to ensure a fair and consistent approach is adopted, the NYY PCT Q&P QOF Quality Review group was established to review evidence countywide via a panel approach. This approach brings together the local knowledge and clinical expertise of the CCG and the commissioning powers of the current PCT – and ultimately the LAT - to ensure improvements in the quality of primary care.

2.7.4 Dispensing Doctors – DSQS (Dispensing Services Quality Scheme)
As part of the changes to the arrangements for dispensing doctors agreed as part of the GMS changes in 2006/07, a Dispensary Services Quality Scheme came into effect in September 2006. The Scheme rewards Practices for providing high quality services to their dispensing patients. Practices which sign up to the Scheme and achieve all the standards will receive a payment for each dispensing patient. Participating Practices must nominate a dispensing GP who will be responsible for the dispensing service. There are 57 dispensing practices in North Yorkshire. This year, a more detailed Statement of Compliance for DSQS has been produced, underpinning the quality improvements in dispensing practices (attached).

To further support practices in continuing quality improvement – a quality assured Q&A document has been produced for practices (attached).

A briefing paper is attached summarising how the quality of dispensing practices has improved within North Yorkshire via participation in DSQS (attached). The key quality

requirements of the Scheme are monitored each year by PCT contract staff via review of evidence ensuring that:

- Dispensing staff must be appropriately trained and undertake continued training with annual appraisals.
- Dispensers who work unsupervised must have at least 1,000 dispensing hours work experience over the previous five years in a GP dispensary or community pharmacy, and must be trained to Pharmacy Services S/NVQ level 2.
- Minimum levels of staff hours dedicated to dispensary services.
- Staff with a limited dispensing role must be given relevant training and competency assessment.
- Standard Operating Procedures ('SOPs') which reflect good professional practice and all dispensary procedures. SOPs must be reviewed and updated at least once every 12 months and whenever dispensing procedures are amended.
- A Significant Event Monitoring Procedure must be in place.
- An annual review must take place of the medicines use for 10% of the dispensing list.

Briefing on outcome of the Dispensing Services Quality Scheme for 2011/12

2.7.5 Optometry
A nationally produced quality framework for optometrists, linked to the GOS contract, is in place (attached) to provide assurance that standards have been met. The PCT has worked with the LOC to agree and implement this framework. A three year rolling programme of visits is in place to ensure the quality of optometry within North Yorkshire is upheld, and challenged where appropriate. The PCT's approach to underperforming optometrists has been supportive and developmental in the first instance. However, occasionally, there is a requirement to manage non-compliance to quality standards via the PCT's underperformance procedures and when appropriate via remedial notices/breach of contract procedures.

2.7.6 Primary Care Support Services (FHS)
Primary Care Support Services (FHS) are crucial to the NHS both for patients and for clinicians who deliver services. These services underpin the smooth running of Primary Care and the quality of the data managed by FHS Patient Services is essential, due to the complexity and interdependencies within Primary Care Support Services. The role of FHS Patient Services is to process the registration of patients with a GP Practice (additions/deletions); assign patients who are unable to gain voluntary registration with a GP Practice; maintain the population database which is used for NHS screening programmes and contractor payments and to obtain, forward to GP Practices, recall when a patient is no longer registered with a GP Practice and securely store patient medical records.

From 1 April 2013, the responsibility for the provision of Primary Care Support Services transfers to the NHS Commissioning Board and it is essential that excellent data quality is maintained throughout the transitional period to ensure business continuity.

Transfer of Medical Records
It is important that a patient's medical record moves with them when they change GP Practice, to ensure that their current clinician has access to the patient's full medical history. When a patient is no longer registered with a GP Practice (eg patient has died/no longer resident in UK) it is essential that their medical record is securely stored, in order that it can be retrieved should it be required in the future, ie where a patient returns to reside in the UK and registers with a GP Practice.

Patient Services transferred **15,768** medical records for the quarter ending 30 September 2012. **163** of those medical records were marked as "clinically urgent" and were requested for transfer urgently. **4.9%** of the 163 records requested for transfer urgently have not yet been received, however Patient Services cannot be held responsible for non transfer of the outstanding records, as it is the responsibility of those currently holding the record to forward them on. Patient Services continue requesting transfer of any outstanding "clinically urgent" records, until they are received.

In future a graph will be included in this section to provide a comparison between each quarters' data, starting with September and December quarters' data, then September, December and March quarters' data and thereafter a comparison of the previous four quarters.

Patient Registrations
FHS Patient Services received, checked and verified **36,747** registrations for the quarter ending 30 September 2012. Of those registrations **858** patients required an NHS Number allocating because they were either an Immigrant coming into the UK for the first time or an Ex-patriot with no valid NHS Number. Of those requiring allocation of an NHS Number, **0.7%** were later found to have been allocated unnecessarily as they already had a valid NHS Number.

In future a graph will be included in this section to provide a comparison between each quarters' data, starting with September and December quarters' data, then September, December and March quarters' data and thereafter a comparison of the previous four quarters.

Deductions
FHS Patient Services checked, verified and deducted **35,701** patient registrations because the patient had moved out of the North Yorkshire and York locality.

In future a graph will be included in this section to provide a comparison between each quarters' data, starting with September and December quarters' data, then September, December and March quarters' data and thereafter a comparison of the previous four quarters.

Verification of Patient Detail Requests
FHS Patient Services actioned **51** requests from various District Councils for verification of a patient's address history during the quarter ending 30 September 2012. The information is requested for the purpose of the apprehension or prosecution of offenders, or the detection or prevention of criminal offences in connection to Benefit Fraud and is included as part of the evidence in any court case.

In future a graph will be included in this section to provide a comparison between each quarters' data, starting with September and December quarters' data, then September, December and March quarters' data and thereafter a comparison of the previous four quarters.

FHS Patient Services Briefing Paper 18 October 2012

Additional papers**:**
Update Report NYY PCT Board Paper 24.01.12
Safeguarding Children Health Partnership Group Case Review
NHS NYY Pooled Lists
Reflective Letter Template 11.07.12

2.8 Commissioning for Quality and Innovation (CQUIN)

NHS North Yorkshire and York agreed a 2011/2012 CQUIN scheme for Acute, Community, Mental Health and Yorkshire Ambulance Service. South Tees Hospital Foundation Trust (STHFT) has a separate CQUIN scheme which was agreed following the national guidance with the Tees commissioning group. This reflects a number of our local priorities for the organisation. Achievement on the national VTE indicator is included. All of the indicators are fully reported in the quarterly performance report shared with at the Contract Management Board meeting.

There were two elements to the CQUIN scheme for 2011/12; national and local. The financial value of the scheme is set at 1.5% of the contract value.

Agreement has been reached with Harrogate District Foundation Trust, York Teaching Hospitals Foundation Trust and South Tees Hospitals on the 2012/13 CQUIN Scheme. The Scheme is worth 1.5% of the total contract value and comprises national and local indicators:

National Indicators

- VTE risk assessment
- Responsive to personal needs
- Safety Thermometer
- Dementia

Local Indicators

- Integrated Care
- Patient Experience
- Effective Discharge – communication
- Respiratory – Chronic Obstructive Airways disease

The programme looks at the quality of care from the patient's perspective and feedback will be used to redesign patient services. The agreed targets relate to reducing hospital mortality and the length of stay in acute elderly medical and community inpatient facilities.

Realtime patient experience of patients based in the community has presented a challenge, but plans are in place to establish some monitoring via internet solutions.

2.9 NHS Staff Survey Results
Results for the 2012 NHS staff survey are now available to view at http://nhsstaffsurveys.com. Each participating organisation has a detailed feedback report of their findings and a summary report. The reports include information on local changes since 2011, a benchmarked analysis of findings and data by occupational and demographic groups.

The overall indicator of staff engagement shows how York Teaching Hospital NHS Foundation Trust compares with other acute trusts. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.71 was average when compared with trusts of a similar type.

The score for Harrogate and District NHS Foundation Trust of 3.79 was in the **highest (best) 20%** when compared with trusts of a similar type.

2.10 Patient Surveys
Patient survey results are generally positive for NYY providers. Survey results can be found at the CQC website: **http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys**

The adult inpatient survey was conducted between October 2011 and January 2012 and the results are summarised below.

	HDFT	SNEY	York
The emergency / A&E department, answered by emergency patients only	8.2/10	7.5/10	8.0/10
Waiting lists and planned admissions, answered by those referred to hospital	6.7/10	6.6/10	6.9/10
Waiting to get to a bed on a ward	8.6/10	7.4/10	8.1/10
The hospital and ward	8.4/10	8.3/10	8.2/10
Doctors	8.7/10	8.5/10	8.8/10
Nurses	8.7/10	8.1/10	8.5/10
Care and treatment	7.8/10	7.1/10	7.6/10
Operations and procedures, answered by patients who had an operation or procedure	8.6/10	8.2/10	8.5/10
Leaving hospital	7.1/10	6.4/10	7.0/10
Overalll views and experiences	6.1/10	5.5/10	5.9/10

During January to March 2012 a survey of patients attending major A&E departments was undertaken. The results for York Teaching Hospital NHS Foundation Trust and Harrogate and District NHS Foundation Trust can be found at http://www.cqc.org.uk/surveys/accidentemergency. Both trusts performed better or no worse, for a particular question, than most other trusts that took part in the survey

2.11 Eliminating Mixed Sex Accommodation (EMSA)
The table below indicates breaches in 2012/13 reported in January 2013:

	Breaches (sum)	Breaches (rate*)
York Teaching Hospital NHS Foundation Trust	12	0.9
Harrogate and District NHS Foundation Trust	0	0.0

* An MSA breach rate is published alongside counts of breaches to enable comparison between provider organisations. This is the number of MSA breaches of sleeping accommodation per 1,000 finished consultant episodes (FCEs). The MSA breach rate for

England in December 2012 is 0.2 per 1,000 FCEs, compared to 0.1 per 1,000 FCEs in November 2012.

2.12 Clinical Negligence Scheme for Trusts (CNST) and NHS Litigation Authority (NHSLA) Ratings

All health providers are assessed against the level of compliance achieved against CNST / NHSLA risk management standards. All of these standards have been designed to address organisational, clinical, and non- clinical or health and safety risks.

The level of compliance ranges from 0 to 3, with 3 demonstrating the highest level of compliance to risk management standards. The scores for local acute and ambulance trusts are provided below. More detailed information on the scores can be found on the NHSLA website (**www.nhsla.com**). Individual assessment reports may also be found on the NHSLA website. Organisation names are those at 01.04.2012.

Each set of standards is revised annually to ensure that they remain relevant. NHSLA assessment levels are valid for a specified period of time. Level 1 is valid for 24 months from the date of assessment. Level 2 and 3 are valid for 36 months.

NHSLA Risk Management Standards

Trust	Pre 2012/13 Assessment Level	Pre 2012/13 Assessment Date	Current Level
Airedale NHS Foundation Trust	2	26.08.09	2
Harrogate and District NHS Foundation Trust	2	19.12.11	2
Scarborough and North East Yorkshire Healthcare NHS Trust	1	11.04.11	1
South Tees Hospitals NHS Foundation Trust	1	31.08.10	1
York Teaching Hospital NHS Foundation Trust	1	24.06.10	1
Yorkshire Ambulance Service NHS Trust	1	11.11.10	1
Leeds and York Partnership NHS Foundation Trust	1*		1*
Tees, Esk and Wear Valleys NHS Foundation Trust	2	01.12.09	2

* Level pending an assessment post restructuring

CNST Maternity Clinical Risk Management Standards

Trust	Pre 2012/13 Assessment Level	Pre 2012/13 Assessment Date	Current Level
Airedale NHS Foundation Trust	1	07.12.10	1
Harrogate and District NHS Foundation Trust	1	06.10.11	1
Scarborough and North East Yorkshire Healthcare NHS Trust	1	05.03.12	1
South Tees Hospitals NHS Foundation Trust	2	19.11.11	2
York Teaching Hospital NHS Foundation Trust	1	07.03.12	1

2.13 National Screening Programmes in North Yorkshire and York

Screening programmes are designed, commissioned and implemented in circumstances where early detection of disease makes treatment more successful. Detection is usually the application of a specific test to a target population to determine whether the disease is present at an early stage.

National screening programmes are screening services which have been centrally instigated (e.g. National Screening Committee and the introduction of screening for abdominal aortic aneurysms in men aged 65.). However implementation and commissioning of all screening programmes is currently undertaken by local commissioners.

Screening programmes are usually only adopted nationally following extensive health care economic analysis and modelling based on pilot site experience.

All cancer, non-cancer and ANNB national Screening Programmes listed below will transfer to the NHS Commissioning Board and the North Yorkshire and Humber local area Team. The School Vision Screening Programme has been included although this is not a recognised national programme.

Work is underway under the governance section for each Screening Programme which will detail the Board or Committee responsible for oversight of the programme delivery and performance. Within this section, we will link the key documents that pertain to that group (terms of reference, membership, minutes of meetings) together with the key legacy reference documents.

National Screening Programmes commissioned by the NHS NYY Cluster for the NYY Screening Population

CERVICAL CANCER SCREENING PROGRAMME (SP)	
SP Description	A cervical smear is offered to women on a three year cycle, from the ages of 25 - 50, then five yearly from 51 - 64.
Public Health Evidence	Around 900 women die of cervical cancer in England each year. The programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by regularly screening all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated.
Commissioning Arrangements	Commissioned as an additional service through the primary care contract. Human papillomavirus (HPV) sample testing has rolled out in 2012, improving the identification of women at increased risk of cancers, who are then offered preventative treatment.
Contracting Mechanism	Part of the global practice sum. PCT baseline disaggregation complete. 12/13 contract value = £1,578,795 to transfer to NYH LAT. (HPV testing funding is direct to laboratory services from National Funding until March 2014.)
Performance Reporting Framework	Cancer Screening Programmes are performance monitored/ managed by the Quality Assurance Reference Centre (QARC). SP uptake is above the 80% national target. Regionally, there is an initiative which will support the taking of smear test by appropriately trained personnel with ongoing surveillance.
Governance	*To follow*
Future Risks to Delivery	- 2012 re-commissioning of the cytology laboratory services with newly commissioned laboratories configuration commencing April 2013. - HPV test of cure will roll out in 2013. - Action plan is being implemented in response to the QARC recommendations.

BREAST CANCER SCREENING PROGRAMME	
SP Description	Offered to women aged 50 – 70 on a three year cycle. Women are invited for a digital mammography at either a fixed or mobile location.
Public Health Evidence	Breast cancer is the most common cancer in women, and one in nine women will develop breast cancer at some time in their life. The five-year survival rate for patients diagnosed in 2001-2006 in England was 82 per cent. The stage at which a woman has breast cancer diagnosed greatly influences her survival chances.
Commissioning Arrangements	Current eligible screening population = 131,000 women. Breast screening services are commissioned from four different SPs: - **NY Breast SP** (YTHFT) covers SWR, H&RD, York, Selby and most of H&R. - **Pennine Breast SP** (BTHFT) covers five Craven practices (excluding Bentham). - **North Lancashire SP** (Provider tbc) covers the Bentham practice. - **Tees Breast SP** (Provider tbc) covers two practices in H&R.
Contracting Mechanism	PCT baseline disaggregation complete. 12/13 contract value = £3,057,120 to transfer to NYH LAT. (A further check required on N. Lancs SP.)
Performance Reporting Framework	Cancer SPs are performance monitored/ managed by the QARC. Take up of this screening programme is usually above the 80% national target and achievement of programme quality standards is amongst the highest in the region.
Governance	*To follow*
Future Risks to Delivery	- Expansion of the age range to cover ages 47-73 for completion by 2016. - Surveillance pathways for women at medium to high risk of developing breast cancer. - Radiography capacity and securing appropriate sites for mobile screening units. - Action Plan is being implemented in response to the QARC recommendations.

BOWEL CANCER SCREENING PROGRAMME	
SP Description	Invites men and women aged 60 – 75 years for screening every two years. Participants are sent a Faecal Occult Blood test kit which they complete at home and send to a laboratory for testing. Anyone with a positive result is referred for a colonoscopy and any necessary treatment.
Public Health Evidence	About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent. Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective.
Commissioning Arrangements	Bowel cancer screening services are commissioned from a NE Hub (Gateshead Health NHS Trust) across four screening programmes: **East** (HEYT) covering SWR. **Central** (HDFT) covering H&RD, Selby and York. **West** (BTHFT) **c**overing Craven. **North:** (NTHFT) **c**overing H&R. From 2014 onwards, the SP will introduce flexible sigmoidoscopy as a diagnostic tool for 55 – 60 year age group.
Contracting Mechanism	PCT baseline disaggregation complete. 12/13 contract value = £1,104,375 to transfer to NYH LAT.
Performance Reporting Framework	Cancer SPs are performance monitored/ managed by QARC. Take up is above the 60% national target.
Governance	*To follow*
Future Risks to Delivery	- Financial risk associated with age extension. Not rolled out to plan in the Central SP. (Due to national bowel cancer awareness raising campaign, single sex accommodation, and capacity issues.) - Flexi-sigmoidoscopy development and roll out will be challenge in terms of capacity, skill resources and potential lack of uptake of this service. - Action Plan is being implemented in response to the QARC recommendations following QA visit to the Central SP in Feb 2012. - Access to an accredited workforce could be a future risk (*e.g.* colonoscopists).

ABDOMINAL AORTIC ANEURYSM SCREENING PROGRAMME	
SP Description	Invites all men for systematic screening using non-invasive ultrasound in the year they turn 65 years of age. If a significant aneurysm is detected the individual will be offered either ongoing surveillance or a vascular intervention.
Public Health Evidence	Ruptured AAAs account for 1.36% of deaths in men aged 65+ in England and Wales. The programme aims to save lives in men over 65 by detecting the early signs of an aortic aneurysm. As most ruptured AAAs occur in older people, the prevalence is likely to rise in line with an increasingly ageing population. Prevalence is six times greater in men than in women and there is no evidence that benefit from offering the screen to women outweighs the potential harm.
Commissioning Arrangements	The eligible screening population is served by three mobiles SPs. Each SP has their hub in an acute setting delivered alongside accredited vascular services and clinical networks. **West Yorkshire AAA SP** (CHFT) covers the Craven area, which includes Bentham. **NE AAA SP** (GHT) covers H&R and parts of the Whitby area. **NEYH AAA SP** (HEYT) covers Scarborough and parts of Ryedale. Phase 3 expansion covers Selby, York and H&RD
Contracting Mechanism	(PCT baseline disaggregation to complete.)
Performance Reporting Framework	All three SPs on target to include the target male cohort within agreed timescales (WY SP = 540 men, NE SP = 822 men, NEYH SP = 883 men). All programmes have been through a Pre-implementation QA Process and are working to the NHS AAA SP Quality Standards and Service Objectives.

Governance	*To follow*
Future Risks to Delivery	- Screening the whole NEYH AAA SP cohort (3267 men) was not achieved due to phase 3 start delays in the SP expansion and national funding flow issues. - Local commissioner responsible for service costs after the national 18 month funding ends. Unknown numbers of self-referring men will place pressure on capacity and financial planning.

DIABETIC EYE SCREENING PROGRAMME	
SP Description	The NHS DESP prevents, detects and treats sight-threatening diabetic retinopathy. All people diagnosed with diabetes over the age of 11 years of age are offered an annual digital photographic systematic.
Public Health Evidence	Untreated diabetic retinopathy is one of the most common causes of blindness in the working-age population.
Commissioning Arrangements	The eligible screening population (circa 32,000) is served by two screening programmes: **NY DESP** (YTHFT) is a mobile service covering Selby, York, SWR, H&RD and Craven locality areas. **S. Tees DESP** (STHFT) covers H&R at various fixed screening sites.
Contracting Mechanism	PCT baseline disaggregation complete. 12/13 contract value = £1,061,861 to transfer to NYH LAT.
Performance Reporting Framework	100% invitation and 80% minimum screening uptake is being achieved.
Governance	*To follow*
Future Risks to Delivery	- NYDESP will be transferring over to another national software provider in January 2013. - Implementation by both programmes of the new national common pathway moving the screening and surveillance responsibilities of patients with ungradeable and unassessable digital images from Hospital Eye Services (HES) to DESPs. - Implementation of the *Ophthalmic Photographic Diabetic Review* pathway establishing a virtual clinic to manage referable diabetic maculopathy so patients with early maculopathy can be cared for in a virtual manner helping alleviate some of the capacity pressures in HESs. - Action plan and is being implemented in response to the External QA recommendations following the August 2012 peer review visit.

ANTENATAL AND NEW BORN (ANNB) - SICKLE CELL AND THALASSAEMIA SCREENING PROGRAMME	
SP Description	Screening in early pregnancy is offered to parents so they can (a) find out if they are carriers, and (b) work out if their baby is at risk of inheriting a disorder. Newborn babies are offered screening for sickle cell disease (and carrier status) as part of the routine 'blood spot' test. Newborn babies do not get tested for thalassaemia, because the test is not always reliable this early, and the baby is not in immediate danger.
Public Health Evidence	Sickle cell disease is a genetic blood disorder resulting from the production of faulty red blood cells, causing a variety of major health problems. It is now the most common genetic condition in England, with an estimated 12,500 patients in the UK at present. In the UK there are around 1000 patients with beta thalassaemia major, and more than 214,000 people carrying the beta thalassaemia gene. At present, most sickle cell and thalassaemia is found in discrete ethnic groups who have migrated into England over the past 50 years.
Commissioning Arrangements/	This service is contracted and delivered locally via hospital and community maternity services provided by district hospitals. PCT baseline disaggregation to

Contracting Mechanism	be completed.
Performance Reporting Framework	Performance monitoring and management is undertaken by a joint commissioner and provider antenatal and newborn screening group in each acute trust. ANNB SP failsafe visits have taken place at AFT, HDFT, YTHFT and STHFT in 2012.
Governance	*To follow*
Future Risks to Delivery	- Systems for recording and follow up of completion of the Family Origins Questionnaire.

ANNB - "INFECTIOUS DISEASES IN PREGNANCY" SCREENING PROGRAMME	
SP Description	As part of their first antenatal clinic appointment, women are offered blood tests for hepatitis B, Human Immunodeficiency Virus (HIV), syphilis, and rubella**.**
Public Health Evidence	If a woman is a carrier of hepatitis B, their baby is at risk of being infected at the time of giving birth. An infected baby then has a high risk of carrying the hepatitis B virus for life, and about a quarter of such babies develop serious liver disease in later life. The HIV virus can be passed on to a baby during pregnancy, at the time of giving birth, or by breastfeeding. Syphilis is relatively rare in the UK, but infection can cause severe effects in unborn babies. Testing enables antibiotic treatment of the mother and baby during the pregnancy, and for the baby after birth as well. Rubella testing is ideally undertaken pre-conceptually, but during pregnancy it is done to check whether or not the mother has rubella immunity. If not, she is advised to avoid exposure to rubella during pregnancy, and offered MMR vaccine after the baby is born.
Commissioning Arrangements/ Contracting Mechanism	This service is contracted and delivered locally via hospital and community maternity services provided by district hospitals. PCT baseline disaggregation to be completed.
Performance Reporting Framework	Performance monitoring and management is undertaken by a joint commissioner and provider antenatal and newborn screening group in each acute trust. ANNB SP failsafe visits have taken place at AFT, HDFT, YTHFT and STHFT in 2012.
Governance	*To follow*
Future Risks to Delivery	None identified

ANNB - FETAL ANOMALY SCREENING PROGRAMME	
SP Description	Expectant women are offered; an early Ultrasound scan, undertaken after 8 weeks gestation and used mainly for dating the pregnancy and confirming viability; ascreening test for Down's syndrome including at least one blood test; a second Ultrasound scan between the 18th and 20th completed week of pregnancy to check for physical abnormalities in their unborn baby and Information to help them decide if they want screening or not.
Public Health Evidence	The aims of the Down's Syndrome SP and Fetal Anomaly SP are to provide information for women so that they are able to exercise informed choice about their screening options and pregnancy management. Identifying serious fetal abnormalities, either incompatible with life or associated with morbidity, allow women to make reproductive choices.
Commissioning Arrangements/ Contracting Mechanism	This service is contracted and delivered locally via hospital and community maternity services provided by district hospitals. PCT baseline disaggregation to be completed. Down's syndrome screening is now included within the national tariffs for maternity services.
Performance Reporting Framework	Performance monitoring and management is undertaken by a joint commissioner and provider antenatal and newborn screening group in each acute trust. ANNB SP failsafe visits have taken place at AFT, HDFT, YTHFT and STHFT in 2012.
Governance	*To follow*

Future Risks to Delivery	- Ensure completion of implementation of SP to national standards within local maternity services.

ANNB - NEWBORN HEARING SCREENING PROGRAMME	
SP Description	All parents of newborns should be offered a hearing screen for their child within 2 weeks of birth and receive information about the screen.
Public Health Evidence	The Automated Otoacoustic Emission (AOAE) screening test measures the echo effects in the cochlea following the delivery of a clicking sound into the ear.The early identification of hearing loss is known to be important for a child's development. One to two babies in every 1,000 are born with a hearing loss in one or both ears. Most of these babies are born into families with no history of hearing loss. The SP's aim is to identify all children born with moderate to profound permanent bilateral deafness within 4-5 weeks of birth.
Commissioning Arrangements	• Screening is commissioned from three separate NH SPs which provide screening for all babies born under the various maternity services: **York, Harrogate and Scarborough NHSP** (YTHFT), **County Durham, Tees Valley, Hambleton and Richmondshire NHSP** (STHFT) and **Airedale NHSP** (AFT).
Contracting Mechanism	This service is contracted and delivered locally via services within district hospitals. PCT baseline disaggregation complete. 12/13 contract value = £398,931 to transfer to NYH LAT. (A further check required on Airedale NHSP.)
Performance Reporting Framework	Performance monitoring and management is undertaken by a joint commissioner and provider antenatal and newborn screening group in each acute trust. ANNB SP failsafe visits have taken place at AFT, HDFT, YTHFT and STHFT in 2012.
Governance	*To follow*
Future Risks to Delivery	Need to ensure that governance arrangements for this programme are not adversely affected by current NHS and Public Health reorganisation.

ANNB – NEW BORN"BLOOD SPOT" SCREENING PROGRAMME	
SP Description	The parents of babies in the UK are offered screening for phenylketonuria (PKU), congenital hypothyroidism (CHT), sickle cell disease (SCD), cystic fibrosis (CF) and medium-chain acyl-CoA dehydrogenase deficiency (MCADD). The test is delivered by taking a blood sample one week after birth.
Public Health Evidence	Newborn blood spot screening identifies babies who may have rare but serious conditions. Early treatment can improve their health and prevent severe disability or even death. **Phenylketonuria** (1 in 10,000 babies) – a metabolic disorder that causes serious, irreversible, mental disability. **Congenital Hypothyroidism** (1 in 4,000 babies) - affected babies do not produce enough of the hormone thyroxine. This can cause poor growth and serious, permanent, physical and mental disability. **Sickle cell disease** (1 in 1900 babies) – see Sickle Cell and Thalassaemia SP. **Cystic fibrosis** (1 in 2500 babies) - affects the lungs and digestive system, causing poor weight gain and chest infections. Screening enables early diagnosis and treatment with a high energy diet, medication and physiotherapy, to reduce the impact of the condition and improve life expectancy. **MCADD** (medium-chain acyl-CoA dehydrogenase deficiency – 1 in 10,000 babies) – a metabolic disorder causing serious illness or death, and needs early diagnosis to enable treatment with a special diet and allow normal development.
Commissioning Arrangements/ Contracting Mechanism	This service is contracted and delivered locally by hospital and community maternity services provided by district hospitals, with samples processed by regional hospital laboratories. PCT baseline disaggregation to be completed.
Performance Reporting	Performance monitoring and management is undertaken by a joint commissioner and provider antenatal and newborn screening group in each acute trust. ANNB

Framework	SP failsafe visits have taken place at AFT, HDFT, YTHFT and STHFT in 2012.
Governance	*To follow*
Future Risks to Delivery	- Ensure continuation of a robust Child Health Record Department function.

ANNB - NEWBORN INFANT PHYSICAL EXAMINATION (NIPE) SCREENING PROGRAMME	
SP Description	The NIPE offer parents the opportunity of a physical examination for their baby, to check for problems or abnormalities carried out within 72 hours of birth and then again at 6 to 8 weeks of age. It includes a general all over physical check, as well as specific examination of the baby's eyes, heart, hips, and (in boys) testes.
Public Health Evidence	NIPE aims to maintain and improve the standards of care for babies, and is part of the Government's updated Child Health Promotion Programme. NIPE has been carried out for many years but there has been little guidance about what constitutes a good quality service. Consequently, there is considerable variation in clinical practice, policies and training, sometimes resulting in inequity and late diagnosis.
Commissioning Arrangements/ Contracting Mechanism	This programme should be commissioned from relevant providers as part of the Child Health Promotion Programme. Some aspects of this programme are contracted and delivered locally via hospital and community maternity services within district hospitals, and some aspects are provided as part of GP services. PCT baseline disaggregation to be completed.
Performance Perspective	Performance monitoring and management is undertaken by a joint commissioner and provider antenatal and newborn screening group in each acute trust. ANNB SP failsafe visits have taken place at AFT, HDFT, YTHFT and STHFT in 2012.
Governance	*To follow*
Future Risks to Delivery	- Slow progress in implementation.

SCHOOL VISION SCREENING *(Currently part of the 0-5 Healthy Child Programme BUT not recognised as a national screening programme)*	
SP Description	The 5 – 19 Healthy Child programme states that primary school aged children between 4 and 5 years of age should have a vision and hearing test. The eye screening should be conducted either by orthoptists or by professionals trained and supported by orthoptists.
Public Health Evidence	Vision screening at 4 to 5 years is primarily concerned with detecting visual impairment in one or both eye, for particular conditions such as amblyopia, refractive error (long and short sightedness) and strabismus (squint). About 1 in 25 children develop some degree of ambylopia.
Commissioning Arrangements/ Contracting Mechanism	The DH have confirmed this element of the 5 – 19 Healthy Child programme sits within the 0-5 part and will be commissioned by the NHS Commissioning Board rather than by Local Authorities. Across H&R, community orthoptists employed by STHFT screen all school entry children. In SWR, Ryedale, vision screening is commissioned from the Acute Trust Orthoptist service. In Selby and York, vision screening is provided by the York Acute Trust School Nursing Service.
Performance Perspective	Performance monitoring and management is undertaken through the usual contracting routes with the Acute Trusts as costings are included within the block contracts. PCT baseline disaggregation to be completed.
Governance	*To follow*
Future Risks to Delivery	- No specific service in the Craven, H&RD locality - Risk of litigation from parents.

Supporting Documents:
PCT Cluster Board paper of 25 January 2011: National Screening Programmes in North Yorkshire and York: Description, Progress and Performance.

2.14 Service Change

2.14.1 Children's and Maternity Services at the Friarage Hospital, Northallerton

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) commissions services for the people of Hambleton and Richmondshire district council areas and Whitby. The CCG invited the National Clinical Advisory Team (NCAT) to offer evidence and guidance for any future decision-making by the NHS after concerns were expressed by local hospital doctors about the future of children's services in July 2011. NCAT is part of the Department of Health and provides clinical experts to support and guide the local NHS on service reconfiguration proposals to ensure safe, effective and accessible services for patients.

NCAT carried out a review at the Friarage Hospital in December 2011 and agreed that there was a problem in sustaining services. It supported the ideas for the future being put forward by the hospital clinicians. The CCG wanted to ensure that the development and refinement of the options put forward were informed by local views and that the process was completely open and transparent. It launched a comprehensive pre-consultation engagement exercise, which ran from March to June 2012, to:

- Make the case for change
- Listen to and understand the views of local people
- Ensure that the views of local people were taken into account
- Reassure the local community about the future of the Friarage Hospital

NHS organisations have a statutory duty to involve and consult patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate (sections 242 and 244 of the NHS Action 2006). As the options being considered may result in a major change in the way local services are designed, organised and provided, it is expected there will be a need for formal public consultation about any proposals to secure the future of both children's and maternity services.

No decisions about changes to services will be made before a formal consultation process. Feedback obtained during the engagement process will be considered alongside clinical, financial and quality data to refine the options which will go forward to the formal consultation stage.

Subsequently the Secretary of State for Health, Jeremy Hunt, has asked the Independent Reconfiguration Panel (IRP) to review the plans.

Further information can be found at http://www.nyypct.nhs.uk/friarage/

PCT Cluster Board Report 28 February 2012: Paediatric Services at the Friarage Hospital, Northallerton National Clinical Advisory Team report (January 2012)

The future of children's and maternity services at the Friarage Hospital, Northallerton: Feedback and Outcome from the public engagement process, August 2012

2.14.2 Alexander House, Knaresbrough

Tees, Esk and Wear Valley NHS Trust (TEWV) has proposed modernising and improving mental health services for elderly people by closing an under-used inpatient unit and investing a proportion of the released funds in improving community based services, upgrading the remaining inpatient unit and strengthening hospital liaison psychiatry for older people in Harrogate District Hospital. Harrogate and Rural District (HaRD) CCG have now completed an extensive public engagement exercise about these proposals, the quality of which has been formally approved by the North Yorkshire County Council Overview and Scrutiny of Health Committee.

2.14.3 Delayed Transfer of Specialist Children's Service

NHS North Yorkshire and York PCT Cluster had retained the Hambleton & Richmondshire Specialist Children's Service and Community Paediatric Service after it had not been possible to include these services under Transforming Community Services (TCS) as part of the overall transfer transaction process of community services to South Tees Hospitals NHS Foundation Trust (STHFT) in April 2011. The services were then due to transfer to STHFT on 1 October 2012 but regrettably an agreement could not be brokered.

Against a narrowing timeframe, absolute assurance was needed that any continued service transfer negotiations with STHFT would eventually bring about a resolution. Having assessed the risk and all extenuating circumstances, the PCT Cluster informally approached Harrogate & District NHS Foundation Trust (HDFT) who indicated, that in principle, they would be interested in managing the services. The PCT Cluster notified the STHFT of the need to seek an alternative provider formally drawing transfer negotiations to a close.

Formal transfer discussions with HDFT began on 30 October 2012. Taking the necessary and reasonable time to complete due diligence, both organisations agreed that the services would transfer to HDFT on 1 March 2013 at the very latest while all efforts would be made to achieve an earlier transfer.

NHS NYY Board Paper 27 November 2012 Transforming Community Services: Delayed Transfer of Hambleton & Richmondshire Specialist Children's Service and Community Paediatric Service to a Provider Organisation

NHS NYY Board Paper 22 January 2013 Transforming Community Services: Transfer of Hambleton & Richmondshire Specialist Children's Service and Community Paediatric Service to a Provider Organisation

2.15 Continuing Healthcare Assessments

CCGs will inherit all the current statutory responsibilities of PCTs to assess for NHS Continuing Health Care (NHS CHC) and NHS Funded Nursing Care (NHS FNC) and then commission care packages for those eligible for NHS CHC and funding for NHS FNC. This will include current cases and consideration of retrospective cases including previously un-assessed periods of care dating back to 1st April 2004. In December 2012 there were in the region of 1000 applications for a retrospective review had been received by the PCT.

2.16 NHS Friends and Family Test

On 25 May 2012, David Cameron announced the introduction of the Family and Friends Test (FFT) to improve patient care and identify the best performing hospitals in England. The introduction of the test was based on recommendations from the Nursing and Care Quality Forum. The implementation guidance was published on 4 October 2012.

The FFT aims to capture simple responses to a specific question, which, when combined with follow up questions, will be used to drive improvements in quality of care. The question to be asked, at or within 48 hours of discharge is:

> "How likely are you to recommend our ward / A&E Department to friends and family if they needed similar care or treatment?"

Answers must be one of the following:
Extremely likely; Likely; Neither likely nor unlikely; Unlikely; Extremely unlikely; Don't know.

This requirement to report will be included in standard NHS contracts from 1 April 2013. NHS Trusts and Independent Providers of acute healthcare services will be required to report on total numbers of patients in the target group, numbers given the opportunity to respond, number of responses and the breakdown of response categories. Reporting is required locally at ward and site level and the intention is to publish at site level nationally, to make the results available to the public.

Organisations are expected to ask follow up questions at the same time to find out more details that can help drive improvements. The number and wording of follow up questions is to be determined locally.

The initial target group are all adult acute in-patients who have stayed at least 1 night in hospital, and adult patients who have attended A&E and left without being admitted to hospital or were transferred to a Medical Assessment Unit and then discharged. All patients in these groups should be given the opportunity to respond. Continuous surveying needs to be in place by April 2013 and this is to be rolled out to Maternity Services from October 2013. Currently excluded from the guidance are day cases, outpatients and children (under 16 years old). The expectation is that organisations will achieve at least a 15% response rate.

All acute healthcare service providers within the boundaries of North Yorkshire already provide opportunities for adults discharged from general acute inpatient wards to give feedback on their care – albeit on a much smaller scale than has been proposed. Various methods of obtaining this feedback are utilised but it is clear that some work will be required by all of our acute healthcare service providers if they are to be compliant with the Department of Health's vision by April 2013.

All of the North Yorkshire organisations to which FFT applies have provided verbal assurances that they are confident that will be able to achieve the NHS FFT timescales and will therefore be ready to submit the appropriate data from 1 April 2013.

2.17 Autism assessment waiting lists

Over 18 months ago there was growing concern in the Scarborough, Whitby Ryedale patch of the PCT of the long waits that were occurring in relation to Autism assessments. Non-recurrent investment was undertaken to resolve this issue. In order to inform future commissioning decisions a prevalence model was developed and commissioned activity for autism assessments within the whole of North Yorkshire was based upon this prevalence model.

Unfortunately, the numbers of children (0 – 19 years) within the North Yorkshire region requiring autism assessments are in excess of the commissioned activity, resulting in waiting lists being established. This appears to be reflected nationally.

In September 2011, a NICE guideline was published, 'Autism: recognition, referral and diagnosis of children and young people on the autism spectrum'. The NICE guidance is

clear that the start of the autism diagnostic assessment is within 3 months of the referral to the autism team.

The pathway approaches to autism diagnostic assessment are both complex and varied within our region as our providers have not adopted a uniform approach. Consequently, waiting lists declared in each of our localities cannot be compared since the clock starts and stops at different points on the pathway, and this makes it difficult to understand the exact nature and size of the problem within the region as a whole.

To rectify this, each of our providers have been contacted and requested to provide the Commissioning team with the current 'waiting' definition that they are applying and the size of their waiting lists. Once a full understanding of these issues within each locality has been gained a North Yorkshire and York – wide solution can be developed.

2.18 Winterbourne and Francis

In May 2011 a Panorama investigation was aired alleging abuse at Winterbourne View Hospital for people with Learning Difficulties. Following the TV programme, the Care Quality Commission undertook their own inspection at Winterbourne View and their report concluded that the hospital's owners, Castlebeck Care, "had failed to ensure that people living at Winterbournes View were adequately protected from risk, including the risks of unsafe practices by its own staff."

The CQC concluded there was a systemic failure to protect people or investigate potentially abusive practice.

Among other breaches were failures to ensure the safe use of medicines, failure to vet the qualifications of staff properly, and the absence of a mechanism to ensure complaints were listened to.

Winterbourne View was closed in June 2012 following the CQC's investigation and decision to remove it from the register of authorised care providers.

In February 2012 the Department of Health issued a letter which set out actions to be taken forward (to prevent similar systemic failures occurring elsewhere) by NHS bodies and local authorities, in advance of the report of the Department of Health review following the events at Winterbourne View. Attached is the resultant NHS North Yorkshire and York action plan that is being implemented in our region.

North Yorkshire and York has provided all CCGs with a copy of their progress against the requirements of the Winterbourne action plan. This plan takes into account those individuals in hospital placements as a priority and further clarification is required from a national level as the guidance has changed over time. North Yorkshire and York has taken the view that all patients in the placements above are required to have a full review; reviews have been done, but North Yorkshire and York cannot be satisfied that these reviews would meet all the specific requirements of the Winterbourne concordat. Case management capacity to assist the reviews is in place and the process is being managed through the CCGs as collaboration between them and the two Local Authorities.

Following the publication of Francis, all CCGs have been asked to consider the report and its implications. To some extent, the authorisation process for CCGs has picked up on some of the key themes; after the government has published its response to the recommendations, clinical commissioning groups will be able to determine in public (as is the recommendation) what their detailed response will be. The Area Team will be supporting this process from April onwards.

3 Transition Risk register

A copy of the current transition risk register is included.

Transition and Handover Risk Register - February 2013

1	2	3	4	10	6	7	9	11	12	13	14	15	16	17
Number	Source of Risk (e.g. Assurance Std, Incident Risk etc)	date added to risk register	Summary description of risk	Summary of Risk Treatment Plan	Likelihood	Impact	Likely Impact to Trust	Anticipated resource implication (£)	Responsibility for implementing plan	Expected date of completion	Source of review (e.g. HC, NHS LA, DATAC)	Date for Review	Is this rating acceptable?	Change of Risk rating
HC1	Handover and Closure	Sep-12	Staff anxiety at pace of transformational change.	Actions to include focus groups; annual staff survey action plan; quarterly local staff surveys; staff support plans, regular communications, CEO briefings.	5	3	E(15) RED		Chief Exec / AD Human Resouces	Mar-13		Feb-13		
HC2	Handover and Closure	Sep-12	Handover and Closure - Conflicting priorities and challenging timescales. Limited national guidance	Handover and Closure group setup. Each domain has a nominated Director lead and deputy. Regular updates on the programme are provided to Directors, Governance and Quality Committee and Cluster Board	3	3	H(9) AMBER		Director of Standards	Mar-13		Feb-13		
HC3	Handover and Closure	Sep-12	Complex HR environments which requires high degree of coordination	Clear HR processes have been established. Ensure staff have access to regular information and have the capacity to raise concerns and be involved in the process.	3	3	H(9) AMBER		Chief Exec / AD Human Resouces	Mar-13		Feb-13		
HC4	Handover and Closure	Sep-12	Dwindling capacity as changes are implemented. Loss of expertise in specialist areas.	Regularly monitor resources for the transition programme, QIPP and statutory duties. Realign resouces as required. Business Capacity review	3	3	H(9) AMBER		Director of Standards	Mar-13		Feb-13		

HC5	Handover and Closure	Sep-12	Risk Management Information stored on ulysses. Unsure on who will take ownership from 1 April 2013	Awaiting national guidance. Acute providers have been asked if they would like their information archived and sent to them (costs to be incurred). Ulysses will continue to be used post transfer until new system in place approx 6 months.	3	3	H(9) AMBER		Director of Nursing	Mar-13		Feb-13		
HC6	Handover and Closure	Sep-12	unsure where PCT Serious Incidents will transfer to eg safeguarding and independent investigations	Awaiting national guidance	3	3	H(9) AMBER		Director of Nursing	Mar-13		Feb-13		
HC7	Handover and Closure	Sep-12	Failure to novate contracts into new organisations	Collaborative working with new organisations and partners. PCT review of all clinical and non clinical contracts. Regular updates to be provided to the programme board.	5	3	E(15) RED			Mar-13		Feb-13		
HC8	Handover and Closure	Sep-12	Legal Services - currently unclear where existing liabilities are transferring to	Awaiting national guidance. Feb 13 National Guidance now available.	3	3	H(9) AMBER		Director of Standards	Mar-13		Feb-13		
HC9	Handover and Closure	Sep-12	Document repository. Currently working with Humber cluster on a joint solution. Unsure on information governance of proposed solution	IG to contact lead and discuss IG implications and data security	3	3	H(9) AMBER		Director of Standards	Mar-13		Feb-13		
HC10	Handover and Closure	Sep-12	Emails - archiving arrangements	limited staff capacity (both IT and users) to review emails before deletion. Limited storage capacity to archive unlimited emails. Consider future FOI requirements	3	3	H(9) AMBER		AD Informatics	Mar-13		Feb-13		
HC11	Handover and Closure	Sep-12	IT assets	Awaiting estates guidance to see if IT assets included and what the transition / handover arrangements will be	3	3	H(9) AMBER		AD Informatics	Mar-13		Feb-13		

HC12	Handover and Closure	Sep-12	No long term estates strategic planning. Uncertainty of future provision of PCT accommodation.	Awaiting national transition guidance. Locally - review current infrastructure and look to have a sustainable plan.	3	4	H(12) AMBER		Director of Finance	Mar-13		Feb-13		
HC13	Handover and Closure	Sep-12	The National Information Governance Board and Connecting for Health have issued guidance to assist organisation with maintaining good information governance during the transition. Capacity and resource issues within the PCT to comply with guidance.	Paper taken to Directors. Handover and Closure Group setup (Sep 12). Actions include map current and new information assets and both internal data flows and transfers of information externally, data controller responsibilities, ensuring all records are managed appropriately, ensure secure data transfer. Feb 13 *This is still a high risk area where the returns asked for are not providing assurance that appropriate priority and resources are in place to meet the PCT dissolution time frame.*	5	5	E(25) RED		Director of Standards	Mar-13		Feb-13		
HC14	Handover and Closure	Sep-12	Financial challenge	Ensure finances are actively monitored, deliver against QIPP plan and support CCGs in taking on financial responsibility. To ensure current financial allocations are appropriately transferred to the applicable areas.	5	4	E(20) RED		Director of Finance	Mar-13		Feb-13		
HC15	Handover and Closure	Sep-12	New deadline for applying for a retrospective NHS Continuing Care assessment. For periods of care occurring between 1 April 2004 and 31 March 2011, deadline 30 September 2012 (700 appeals received). Deadline for periods of care between 1 April 2011 and 31 March 2012 is 31 March 2013.		3	4	H(12) AMBER	Unknown liability	AD Vulnerable People and NHS Continuing Healthcare	Mar-13		Feb-13		

HC16	Handover and Closure	Oct-12	Cascade of CAS alerts to Independent Contractors. Uncertainty on who will take over responsibility for this function post March 2013	awaiting national guidance. Feb 13 The NCB have written to the Area Team to advise them that the function has transferred to them. The PCT Governance Team to arrange a meeting to handover the function.	3	3	H(9) AMBER		Director of Standards	Mar-13		Feb-13		
HC17	Handover and Closure	Oct-12	Year End - retention of staff for 3 months post March 2013 to complete year end	awaiting national guidance on who will host the staff during this interim period. Office accommodation has been identified	3	4	H(12) AMBER		Director of Finance	Mar-13		Feb-13		
HC18	Handover and Closure	Dec-12	No resources in IT to pick up handover/transition work, central returns, split asset lists by receiver organisation including completion of TCS.	To identify resources	5	4	E(20) RED		Director of Standards	Mar-13		Feb-13		
HC19	Handover and Closure	Dec-12	The asset and liability requirements during Jan - Mar 13 will have an impact on the capacity within Legal Services.	Identify if external assistance is required. Jan 13 Hempsons provided additional capacity to ensure deadline for return was met	3	4	H(12) AMBER		Director of Standards	Feb-13		Feb-13		
HC20	Specialist Children's Services	Dec-12	Specialist Children's Services did not transfer as part of TSC and must be transferred before 1 April 2013.	Ongoing. Project Group set up to work through due diligence with proposed new provider	2	5	H(10) AMBER		Director of Standards	Mar-13		Feb-13		
HC21	Handover and Closure	Feb-13	General concerns raised about robustness of transfer of commissioning of services for other providers (eg voluntary organisations), Out of Hours and Telehealth	ongoing liaision with Clinical Commissioning Groups and Area Team to ensure continuity of provision	3	4	H(12) AMBER		Director of Standards	Mar-13		Feb-13		New risk added Feb 13
HC22	HR Records	Feb-13	Transportation of open Personal files - staff transferring to other organisations or leaving the PCT on 31 March 2013. Potential for an Information Governance incident should staff start to move open files between offices without guidance from HR.	awaiting national guidance	3	3	H(9) AMBER		Director of Human Resources (Tina Smallwood)	Mar-13		Mar-13		New risk added Feb 13

4 Document control

List of document/ data sources relevant to this legacy document which should be stored electronically using a secure and approved system for data protection.

Annual Reports
NHS NYY Reporter 2011-12
NHS NYY Reporter 2010-11
NHS NYY Reporter 2009-10
NHS NYY Reporter 2008-09

Annual Public Health Reports
NHS NYY Annual Public Health Report 2012
2010 - The Landscape of Health in North Yorkshire and York
2009 - Finding the mission for commissioning

Strategic Plan
NHS NYY Healthier Lives 2010-15

Operational Plans
Single Integrated Plan 2012-13

Annual Accounts
NHS NYY Annual Accounts 2011-12
NHS NYY Annual Accounts 2010-11
NHS NYY Annual Accounts 2009-10
NHS NYY Annual Accounts 2008-09
NHS NYY Annual Accounts 2007-08

Commissioning for Quality and Outcomes
PCT Cluster Board Report Commissioning for Quality and Outcomes 22 May 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 24 April 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 27 March2012
PCT Cluster Board Report Quality at Scarborough and North East Yorkshire NHS Healthcare Trust 28 February 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 24 January 2012
PCT Cluster Board Report Commissioning for Quality and Outcomes 20 December 2011
Vale of York CCG Shadow Governing Body Meeting 2 August 2012
Harrogate and Rural District CCG Shadow Governing Body Meeting 19 July 2012
Scarborough and Ryedale CCG Shadow Governing Body Meeting July 2012

Quality Accounts
York Hospitals Foundation Trust:
Scarborough and North East Yorkshire
Harrogate District Foundation Trust:
South Tees Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust:
Yorkshire Ambulance Service:
To follow: Quality Account for NHS North Yorkshire and York Hambleton and Richmondshire Specialist Children's Service 2011–2012.

Screening Programmes

PCT Cluster Board Report National Screening Programmes in North Yorkshire and York, Description, Progress and Performance 22 January 2011

Service Change - Children's and Maternity Services at the Friarage Hospital
Friarage Engagement Report
Appendix 1 - A joint engagement strategy
Appendix 2 - List of stakeholders
Appendix 4 - Summary of media coverage
Appendix 5 - Notes of public engagement meetings
Appendix 6 - Schedule of meetings
Appendix 7 - Quantitative feedback from questionnaire
Appendix 7 - General questionnaire
Appendix 7 - Survey's general responses (excluding PDFs of surveys)
Appendix 7 - Survey's general responses (including PDFs of surveys)
Appendix 8 - Glossary of health and medical terms

Service Change - Alexander House
Harrogate and Rural District CCG Shadow Governing Body Meeting 19 July 2012: Consultation for Closure of Alexander House
PCT Cluster board Meeting 26 June 2012: Chief Executive's Report

Performance reports
Commissioner Dashboards - monthly

JSNA

City of York JSNA 2012

NYCC JSNA 2012

QIPP plans

Independent Review of North Yorkshire

Safeguarding

Governance and Quality Committee 8 May 2012: item 9.2 Safeguarding Update

Adult safeguarding policies and procedures/ LSAB reports

Child safeguarding policies and procedures/ LSCB reports

PCT Cluster Safeguarding Children Public Declaration

Complaints reports

Governance Committee paper September 2012

IFR policies and panel reports

Medicines and Technologies Policy