


<p>North East Strategic Health Authority North West Strategic Health Authority Yorkshire and the Humber Strategic Health Authority</p> <p>BOARD MEETING</p>	 <p><i>North of England</i></p>
<p>Date of meeting: 1 November 2011</p>	<p>Report author: Chris Willis</p>
<p>Title of paper:</p> <p>SHA Handover Reports</p>	
<p>Actions requested:</p> <p>The Board is requested to receive the overview handover document that sits above the three SHA 'Handover Documents' and their PCTs and endorse the proposed actions for the SHA Cluster Executive Team.</p>	
<p>Particular points to note:</p> <p>The formal Handover Documents and process are a requirement for all PCTs and SHAs in order to mitigate risks and ensure that quality is maintained during transition as required by the 2011 National Quality Board report.</p> <p>The documents are intended to reduce the risk of organisational memory loss in the process of organisational change, and to inform managerial judgements going forward.</p>	

North East Strategic Health Authority
North West Strategic Health Authority
Yorkshire and the Humber Strategic Health Authority

1 November 2011

SHA Handover Reports

1. Background

Last year, David Nicholson, NHS Chief Executive and Chair of the National Quality Board (NQB), asked the NQB to review and build on its Early Warning Systems report of 2010 to ensure that quality was maintained during the period of transition. Under the leadership of Professor Ian Cumming, the NQB published phase one of its report, Maintaining Quality during Transition in March 2011.

Drawing on the evidence from other industries and professions, the report recommended that there should be a formal process of handover between outgoing and incoming senior management teams at PCT and SHA level, so that information on the quality of care was as robust as the information we might hold on healthcare finances, underpinned by a rigorous process of both soft and hard information exchange.

Following publication of the report, a decision was taken to cluster SHAs in order to ensure resilience for the system going forward. The recommendations of the report were updated to reflect this change. The requirements for the NHS were as follows:

- PCTs to produce a handover document on all quality issues on their patch and to hold a Board level discussion by 11th July 2011.
- PCT Clusters were to receive the handover documents, and provide a cluster level document to SHAs by 5th September 2011.
- SHAs were required to receive each PCT Cluster report and have a face-to-face discussion at CEO level to ensure the transmission of both hard and soft intelligence. SHAs were also required to engage with Monitor and CQC over content of the PCT Cluster legacy documents. Each of the ten SHAs was required to aggregate the information into a handover document, and to discuss at the private session of their board before handing over to the new SHA Cluster.
- Each of the SHA Cluster Boards is now required to consider a summary paper of the handover documents and assure itself that:

- 1) a sufficiently rigorous process has been carried out to produce the documents
- 2) satisfy itself that the new Cluster Executive Team is aware of all of the key issues arising from the documents and
- 3) has an appropriate strategy to address any risks or concerns raised.

2. Process

2.1 PCT Cluster Legacy Documents

All 14 PCT Cluster legacy documents and associated PCT reports were submitted to the three SHAs within NHS North of England by the 5 September deadline, with many of these due to be signed off by their relevant Boards during September.

Each SHA took its own approach to engagement on these, including:

- Director level review of documentation
- Feedback to PCT Clusters on plans from SHA Director Review, with resubmissions required in some SHAs
- SHA CEO discussion with PCT Cluster CEOs to cover discussion on the issues to supplement the documented processes of handover.

The process enabled triangulation of data and intelligence across the Directorates of the SHA, with all involved having an opportunity to review both the SHA and PCT information. Much of the information utilised for the legacy report had also been discussed with relevant bodies such as the CQC. All parties agreed that the CEO level handover discussions were an important and valuable part of the process. Both CQC and Monitor have had the opportunity to review and discuss the documentation directly with the SHA.

Appendix 1 sets out a list of all 14 PCT Clusters within NHS North of England. The three SHA document libraries are a repository for these documents and their associated PCT documentation.

2.2 Preparation of SHA Handover Reports

Each SHA then produced their own Handover reports based upon the information provided by PCTs and PCT Clusters. These documents formed the basis for detailed conversations between the NHS North of England executive team and each of the outgoing SHA executive teams, supported by signed statements of assurance from the Nurse Director, the Medical Director and the Chief Executive. These were extremely helpful discussions. The three handover documents were submitted to the final SHA Board meetings on the following dates:-

North East - 29 September 2011
North West - 26 September 2011
Yorkshire & Humber - 30 September 2011

The three SHA Handover Reports are attached at Appendix 2, 3 and 4.

3. Proposed Actions for NHS North of England

- 3.1 The three SHA reports were received on October 3rd, and are now being assessed and reviewed by the Executive Team with specific issues being led by the relevant Executive Director.
- 3.2 It is proposed that Executive Team review the reports in detail, and provide a report for the SHA Cluster Board to advise them of the key issues and concerns arising from the reports, and the proposed mitigating actions.
- 3.3 David Nicholson has requested that Ian Cumming and Bruce Keogh (National Quality Board) meet with each of the SHA Cluster CEOs to review the process of handover and identify the top ten concerns and associated actions for each Cluster.

4. Next Steps

This report summarises the reasons for preparation of legacy/ handover documents, the process PCT Clusters and SHAs have embarked upon in this regard, and the process the new SHA Cluster proposes to take in order to identify the priority areas for action.

The three SHA handover documents are included as appendices to this paper, and the board is asked to note that the purpose of these documents is to provide a position statement to assist the handover to the new Cluster management team, supplemented by a series of 1:1s and team handovers, and is therefore a snapshot in time, but will provide the foundation for our knowledge base that will need to be continually updated through Board reporting moving forward to the handover to the new NHS Commissioning Board in 2013. The process we have embarked upon is more rigorous than any the NHS has ever implemented before, and provides a useful foundation for our new SHA Cluster to build upon and take forward.

The NHS Medical Director, Sir Bruce Keogh, and Professor Ian Cumming, Managing Director for Quality during Transition, will shortly be visiting each SHA Cluster to assure themselves of the process we have carried out, and to identify key issues and themes with a view to sharing best practice and/or providing national support and advice where appropriate.

The SHA Cluster will be required to keep the knowledge we have obtained from the system 'live' so that we can provide our own handover to the NHS Commissioning Board when we are abolished in March 2013.

5. Recommendation

The Board is requested to receive this report and endorse the proposal for the Executive Team to provide further advice on the issues arising from the Handover documents and the necessary mitigating actions required.

Chris Willis
October 2011

APPENDIX 1

PCT CLUSTERS WITHIN NHS NORTH OF ENGLAND

North East

County Durham and Darlington
North of Tyne
South of Tyne
Tees

North West

Cheshire, Warrington & Wirral
Cumbria
Greater Manchester
Lancashire
Merseyside

Yorkshire and Humber

Humber
Leeds and Bradford and Airedale
North Yorkshire and York
South and West Yorkshire
South Yorkshire and Bassetlaw

APPENDIX 2

Handover document

22 September 2011



Foreword

I am extremely proud of the achievements that we have made across the region's NHS and this handover document clearly demonstrates how collectively all local NHS organisations are working together to deliver our ambitious vision for healthcare services.

The north east has a strong track record of delivering high quality of care with the best possible outcomes and experience for our local communities – something to which we all have the right under the NHS Constitution.

We have a history of top performance and have one of the highest levels of public, patient and staff satisfaction across the country. We are the only region in England with every NHS hospital and mental health trust awarded foundation trust status and our primary care trusts have been operating in cluster form since 2006.

I believe we are in a strong position as we embrace the changes ahead and move to the future healthcare system. Above all, we must ensure that the NHS in the north east maintains its leading position for the quality of care and services we provide.

It is with much pride, therefore that I reflect on the achievements we have all made, and most importantly, share our knowledge through this handover document so that lasting improvements continue to be made as the NHS evolves.

Sir Peter Carr CBE
Chairman
NHS North East

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1. Background and key health challenges

North East Strategic Health Authority was formed on 1 July 2006 under the chairmanship of Sir Peter Carr CBE and replaced the two previous strategic health authorities for Northumberland, Tyne and Wear and County Durham and Tees Valley. Sir Peter previously had been chairman of Northumberland, Tyne and Wear Strategic Health Authority from 2002.

With a population of 2.6 million, the north east covers an area from the Scottish border, down to North Yorkshire and across to the Cumbria border in the west. The strategic health authority is responsible for making sure that health services within the region are fit for purpose, well planned, of high quality and meet the needs of local communities on behalf of the Department of Health.

The strategic health authority board includes five non executive directors in addition to Sir Peter Carr CBE:

- Kathleen Bosworth
- Professor Peter Fidler MBE
- Professor Oliver James
- Professor Royston Stephens
- Ruth Thompson OBE.

Ian Dalton CBE has been substantive chief executive since 2007, with David Stout OBE currently acting chief executive. Other executive directors are Richard Barker, Professor Aidan Mullan and Professor Stephen Singleton. Professor Peter Kelly is acting regional director of public health and Neil Nicholson is acting director of finance.

The north east NHS is made up of eight foundation trusts providing acute hospital care; two mental health foundation trusts; one ambulance service trust; and 12 primary care trusts, operating as four PCT clusters since 2006.

We have many of the best performing NHS organisations in the country, yet many of our communities still suffer from the worst ill health in England. This results in an over reliance on acute care with people using north east hospitals more than anywhere else in the county. For example, levels of deprivation are high and the health and life expectancy of both men and women living in the north east is worse than England as a whole. In recent years the overall mortality rates for males have fallen faster than the England average, however previously falling early death rates from cancer have started to level off. The region has the highest level of mothers smoking during pregnancy and high levels of obesity.

More positively, children are amongst the most physically active in the country and the north east has one of the lowest levels of violent crimes compared to other regions. Almost one in four workers in the region is employed in the public sector – the highest proportion in England.

The priorities for the NHS in the north east are to continue to encourage adult behaviour change around drinking, smoking and obesity and to instil lasting cultural changes to improve the health of children and young people across the region. All of this requires a much increased focus on prevention and changing the way we deliver services to make healthcare more convenient and closer to home for patients.

2. Our organisations

2.1 Foundation trust economy

All eight hospital trusts and two mental health trusts have achieved foundation status. Supported by chief executives and delivery directors forums, foundation trusts (FTs) continue to work together and with the strategic health authority, to share information and continue to improve the health of the north east population.

North East Ambulance Service NHS Trust is the one remaining NHS trust without foundation trust status and it is anticipated that this will be achieved later this year (subject to Monitor approval).

Trust	Type	Authorised by Monitor
City Hospitals Sunderland NHS Foundation Trust	Acute	1 Jul 2004
South Tyneside NHS Foundation Trust	Acute	1 Jan 2005
Gateshead Health NHS Foundation Trust	Acute	5 Jan 2005
The Newcastle upon Tyne Hospitals NHS Foundation Trust	Acute	1 Jun 2006
Northumbria Healthcare NHS Foundation Trust	Acute	1 Aug 2006
County Durham and Darlington NHS Foundation Trust	Acute	1 Feb 2007
North Tees and Hartlepool NHS Foundation Trust	Acute	1 Dec 2007
Tees, Esk and Wear Valleys NHS Foundation Trust	Mental health	1 Jul 2008
South Tees Hospitals NHS Foundation Trust	Acute	1 May 2009
Northumberland, Tyne and Wear NHS Foundation Trust	Mental health	1 Dec 2009
North East Ambulance Service NHS Trust	Ambulance	1 Nov 2011 *
<i>* Subject to Monitor approval during October 2011</i>		

2.2 Primary care trusts

The region's 12 primary care trusts (PCTs) have worked in a cluster arrangement since 2006. Each cluster has a senior management team, to support a more collaborative and robust approach to commissioning and provide improved value for money. There are four PCT clusters, also known as primary care organisations.

NHS North of Tyne

Primary care trusts	Population (crude 1000s)	Budget
Northumberland Care Trust	315,000	NHS North of Tyne - £1.5 billion
North Tyneside PCT	208,000	
Newcastle PCT	276,000	

NHS South of Tyne and Wear

Primary care trusts	Population (crude 1000s)	Budget
Gateshead PCT	194,000	NHS South of Tyne and Wear - £1.27 billion
South Tyneside PCT	153,000	
Sunderland Teaching PCT	276,000	

NHS County Durham and Darlington

Primary care trusts	Population (crude 1000s)	Budget
County Durham PCT	520,000	NHS County Durham and Darlington - £1.2 billion
Darlington PCT	100,000	

NHS Tees

Primary care trusts	Population (crude 1000s)	Budget
Stockton on Tees Teaching PCT	193,000	NHS Tees - £1.1 billion
Hartlepool PCT	91,000	
Middlesbrough PCT	147,000	
Redcar and Cleveland PCT	131,000	

3. Ways of working

There have been three periods in the evolution of the ways of working of the strategic health authority, which are:

Phase 1: Basic housekeeping and strategic approach – From the outset a clear strategy was put in place to ensure robustness in the system, with all providers not already foundation trusts supported to becoming one and clustering of primary care trusts in 2006. There was also a clear underpinning desire to tackle the major issue of the north east – the health gap, so the strategy *Better health fairer health* was developed (see below).

Phase 2: Developing clinical safety and quality – Two further strategies were developed – *Our vision, our future* and *Safer care north east* to ensure continued alignment of the north east's health system and a shared regional vision with everyone working towards the same goals. There was widespread recognition of the region's overdependence on hospital based treatment and tolerance of too much variation in performance. Clinical networks and clinical innovation teams have led the work on standardising high quality across the region. The focus on safety has led to a number of innovative strategies including a human factors workstream and tackling a longstanding problem with healthcare associated infections.

Phase 3: Productivity, efficiency and supporting continuous quality improvement – Well in advance of the current efficiency challenge facing the NHS, there has been a longstanding focus on maximising value and minimising waste using the North East Transformation System (NETS) approach; all organisations are focused on continuous improvement and use 'lean' methods of working. The strategic health authority had always remained a small organisation and worked closely with the PCT clusters to ensure robust planning and delivery of a productive and efficient system. The combination of vision, compact and method (see page 10) underpin the way NHS leaders across the north east continue to work together across the foundations trusts, PCT clusters and strategic health authority.

3.1 Vision and strategies

The north east NHS is guided by a vision and three strategies - *Better health fairer health*, *Our vision, our future* and *Safer care north east*.

Better health fairer health is the region's first ever health and wellbeing strategy. Launched in 2008, the 25 year strategy focuses on ten key themes which are seen as having the most relevance to improving health and wellbeing, with implementation guided by ten regional advisory groups. Each theme works across different services, support and interventions provided by a range of organisations and agencies in recognition of the fact that the health service cannot achieve the necessary change by working alone.

The overall vision for the NHS in the north east is based around seven ambitious aims and is known as the **seven nos**:

- No barriers to health and wellbeing
- No avoidable deaths, injury or illness

- No avoidable suffering or pain
- No helplessness
- No unwanted waiting or delays
- No waste
- No inequality.

Hundreds of staff from across the local NHS and partner organisations were involved in developing ***Our vision, our future*** - a ten year strategy, also launched in 2008, which sets out priorities for the NHS to improve and develop services in eight clinical themes. Eight clinical innovation teams have been scrutinising the different pathways of care, with the aim of improving the quality, efficiency and effectiveness of services.

Safer care north east was also launched in 2008 and aims to further improve the safety of services and raise standards even higher across the NHS in the region. The north east has a strong track record in providing safe and effective healthcare, using robust systems to minimise risk. Chaired by an acute foundation trust chief executive, the strategy outlined priorities for all 23 local NHS organisations to further improve the safety of services and raise standards even higher to ensure the best possible quality of care. In partnership with local NHS organisations, delivery is being driven forward in line with one of the seven nos - no avoidable deaths, injury or illness.

3.2 Local authorities

The region's 12 local authorities are coterminous with local primary care trusts and have effective working arrangements in place. The region's NHS has a history of working collaboratively across organisational boundaries both within and outside of health. In a number of areas, local authority and NHS services are co-located; several organisations have made joint appointments or created joint posts for commissioning health and social care services.

North east local authorities work together across all areas of local government through the Association of North East Councils (ANEC). ANEC, the deputy director of social care and partnerships, the regional director of public health and the strategic health authority's director of commissioning development work are working collectively to align key aspects of the transition to the future healthcare system. This includes supporting the pace and scale of change, specifically in relation to proposed arrangements for public health, establishing local shadow health and wellbeing boards and emerging clinical commissioning groups.

3.3 NHS organisations

Strategic health authority executive directors and PCT cluster chief executives meet regularly as the NHS Management Board North East to:

- ensure that the north east health economy remains at the forefront in the delivery of national standards and expectations
- monitor the quality of services and financial performance
- build consensus on key operational performance issues.

The NHS north east chief executive forum also meets regularly and includes chief executives from the foundation trusts, ambulance trust, as well as PCT clusters. This provides a forum for the discussion of key north east wide strategic and operational risks between NHS commissioners and providers. This is supported by a delivery directors forum, which provides a director level network for discussing key performance issues with leads from primary care trusts and foundation trusts.

3.4 Regional public health board

The North East Public Health board plays a key role in the overall governance of *Better health fairer health*. The primary purpose of the board is to provide professional leadership and a focus on strategy and outcomes. The board is chaired by Professor Sir Liam Donaldson, with Sir Peter Carr CBE as his deputy. It brings together representatives from the four PCT clusters, five universities (Newcastle upon Tyne, Durham, Northumbria, Sunderland and Teesside), local authorities, key regional partners and the private and voluntary sectors as well as the chairs of the ten regional advisory groups of *Better health fairer health*.

The board provides scrutiny of the implementation of *Better health fairer health* and monitors the progress of the ten regional advisory groups, ensuring that the work delivered follows a strong evidence base and maximises resources. It also has an important role in linking up work across the ten programmes.

3.5 Leadership development

The North East Leadership Academy (NELA), hosted by County Durham and Darlington NHS Foundation Trust, is a partnership involving all 23 NHS organisations in the north east and provides leadership development for clinicians and managers across the region's NHS.

Development includes programmes for emerging, aspiring and clinical leaders, coaching, leadership networks and partnership working on priority areas such as inclusion and talent management.

It aims to continuously develop future NHS leaders and managers to maximize capability and capacity to improve services for patients.

3.6 Collaborative commissioning

3.6.1 North East Specialised Commissioning Group

Hosted by NHS North of Tyne, the North East Specialised Commissioning Group (NESCG) has delegated responsibility for the commissioning of a range of specialised services on behalf of primary care trusts across the north east. It has a key role engaging with patients, stakeholders, local MPs, overview and scrutiny committees and local involvement networks (LINKs), most recently during the ongoing reviews of paediatric cardiac surgery, burns and neuromuscular services.

Recent achievements include:

- working with the paediatric rheumatology service to agree shared care arrangements and help deliver more care close to home
- the opening of a ten bed specialist adult eating disorder unit by Tees, Esk and Wear Valleys NHS Foundation Trust
- involvement in the newly formed clinical networks for neonatal intensive care and renal services and other established clinical networks across the region to ensure that they make a significant contribution to the specialised commissioning process.

The North East Treatment Advisory Group is a sub group of NESCAG which advises local NHS organisations on new pharmaceutical and non pharmaceutical treatments which have not been considered by NICE. This group has continued to grow to become the first point of contact for organisations looking for further guidance on new treatments.

3.6.2 North East Transformation System

The North East Transformation System (NETS) is an approach to continuous improvement of the quality, safety and effectiveness of local health. Used by organisations across the region, the system has three equally important parts:

1. Vision - a clear focus on a widely understood and shared regional vision.
2. Compact - an overt agreement, known as a 'compact', which provides a common understanding of mutual expectations between staff and the organisation. This underpins the culture of the organisation and clearly defines ways of working so that all staff and managers are clear about the expected approach and behaviours that should be demonstrated.
3. Method - a management system which drives quality and operational excellence by maximising value and removing waste.

NETS is now hosted by Gateshead Health NHS Foundation Trust on behalf of the coalition of organisations who continue to achieve real transformational change using the system.

3.6.3 The North East Offender Health Commissioning Unit

Hosted by NHS County Durham and Darlington, this unit achieved a national health and social care award for its innovative service which allows prisoners to be provided with high quality, specialised care within the prison environment.

The medical care of prisoners is a difficult and often costly process. Although basic medical needs are treated within prison healthcare facilities, specialised care often means transporting prisoners to local NHS hospitals, with significant cost and security implications limiting prisoners' access to appropriate healthcare services.

The unit introduced prison based outpatient and telemedicine services, delivering consultant led care within the prison environment across all prisons in the region, with outstanding results. The service focuses on the ten most common specialities used by prisoners and has resulted in increased dignity for patients, shortened waiting times, reduced disruption at local hospitals and savings for the NHS.

3.6.4 North East Primary Care Support Agency

Hosted by NHS South of Tyne and Wear, the North East Primary Care Support Agency (NEPCSA) was established to ensure continued effective cluster arrangements and in recognition of the direction of travel outlined in the health and social care bill. This interim model in the north east will streamline operations, support reorganisation and the future migration to the national commissioning infrastructure based upon the NHS Commissioning Board and local clinical commissioning groups.

The functions and activities provided by the agency are:

- primary care commissioning, including contracting and contract performance monitoring
- professional performance
- family health services (FHS) business support and performance.

It is currently the only agency of its type in the country and has achieved excellent screening results and strong contract processes.

3.7 North east procurement service

Hosted by NHS Tees, this service was established in December 2010 to support PCT clusters and commissioning organisations in procuring healthcare services in the most efficient and effective manner, whilst delivering value for money. The creation of this service has achieved a saving in transactional costs during a period of significant reduction in resources. It has also ensured that pathfinder clinical commissioning groups receive consistency of support as they move forward in their commissioning responsibilities.

3.8 Emergency preparedness and resilience

Emergency preparedness and resilience across the region's NHS has been progressed in a collaborative manner since 2009 when the strategic health authority emergency preparedness steering group was established, chaired by Dr Tricia Cresswell (deputy medical director of the strategic health authority). The group developed an action plan to provide assurance around compliance of the emergency preparedness elements in the NHS operating framework. Regular updates are provided to the NHS Management Board North East.

In addition, all local NHS organisations actively participate in the strategic health authority emergency preparedness operational group (emergency preparedness practitioners) which is used as a forum to deliver the local and national agenda, as well as interpreting national guidance for local implementation. A number of regional frameworks have been developed and adopted by all NHS organisations including the road fuel shortage framework, mass casualty framework and hospital evacuation framework.

During 2011, a review of arrangements for the establishment of a STAC (Science and Technical Advice Cell) has been undertaken and in line with the north east STAC plan a new robust rota has been implemented. A number of discussions have taken place with lead directors in the four PCT clusters to further enhance the robustness of NHS on call arrangements. As a result, 'strategic leadership in

a crisis' and 'surviving public enquiry' courses have been run for those on the 'director on call' rotas. In addition, the strategic health authority has also commissioned 'tactical leadership in a crisis' for first line managers for all local NHS organisations.

3.9 Transition programme board

In 2011, a multi agency stakeholder transition programme board was created to provide assurance to the strategic health authority board regarding the implementation of the proposed changes outlined in the health and social care bill. Board members include local authority chief executives, directors of social services and children's services, leads of emerging clinical commissioning groups, chief executives from PCT clusters and hospital trusts, LINKs and staff side representatives.

Two visits by the Department of Health and an independent survey of regional stakeholders carried out in 2011, demonstrated that the plans for transition in the north east were integrated and well developed. The transition programme board will continue to work together to steer a successful transition and wishes to maintain strong links with the new executive team at NHS North of England.

3.10 North East Commission on Rural Health

Launched in 2008, the North East Commission on Rural Health was established to voice the health needs of the region's rural communities. The north east has a significant proportion of rural communities, along with the associated challenges this brings, including improving health outcomes and access to services. The creation of the commission was testament to the region's commitment to ensure the best possible access to high quality healthcare for those in rural areas – all whilst striking the right balance between equity and efficiency.

Since launching this ambitious remit, great strides have been made to address some of the very complex issues facing not only the north east, but rural communities across the country. The commission has been successful in bringing together key partners, not only from health, but also from education, research, local and national government, as well as the voluntary and third sector, to incorporate other factors which impact on the health and wellbeing of our rural populations such as access, transport and 'telehealth'.

The NHS is evolving and as we move towards new systems of working, it has not been possible to continue with the commission in the form it was originally constituted. However, the commission has left a legacy of partnership working and a willingness to approach the issues faced by rural communities in new and innovative ways.

3.11 Clinical collaboration

Clinical collaboration is an established way of working in the north east with an active and engaged clinical workforce at the forefront of leading clinical change across the region.

Over a number of years, the strategic health authority has harnessed the expertise and enthusiasm of a wide range of clinical staff from across the region's health economy to challenge the status quo and work together to create strategic clinical priorities to improve the overall health and wellbeing of the population. Over the last three years in particular, an active consensus based model of clinical engagement has been developed to incorporate the views and expertise of over 1,300 clinical staff over 27 days at a number of events.

There are a number of clinical networks operating with strong clinical leadership and engagement. These networks encourage and promote multi-professional working and collaboration across the whole of the patient pathway. This has resulted in some significant success such as:

- the implementation of a 24/7 network wide model for primary coronary angioplasty via the cardiovascular network
- the establishment of the North of England Cancer Drug Approval Group, which has delegated budgetary authority from primary care trusts to decide on investment about new cancer drugs in advance of NICE treatments and also responsibility for the cancer drugs fund on behalf of the strategic health authority
- the introduction of a single point of access for non emergency care in County Durham and Darlington which subsequently became the first national pilot of the new NHS 111 service.

Current work in progress includes the establishment of the northern trauma system, with two trauma networks collaborating to cover both the north and south of the region. This has resulted in clinically led proposals being developed with fully commissioned services planned from April 2012. In addition, existing work around learning disabilities enabled the strategic health authority to respond promptly and positively following the recent emerging patient safety issues uncovered at Winterbourne View care home.

3.12 Designing the new system (stakeholder engagement in commissioning)

The strategic health authority has led extensive engagement work to help develop a new system in which clinical commissioning can thrive in the north east. A quarterly programme of events aimed at GPs, primary care trusts, local authorities and the third sector was held from autumn 2010 to engage key stakeholders in the overall design of the future commissioning system.

In addition, a monthly programme of workshops for pathfinder clinical commissioning groups was held covering specific topics such as finance, governance, communications and reputation management. These events aimed to ensure pathfinders consider the more detailed development of the system and are appropriately skilled to take on full commissioning responsibilities. A series of local engagement events has been held by each PCT cluster to complement region wide work.

The north east advisory group for clinical commissioning (NEAG) was established as a result of a clinical engagement event in September 2010, planned jointly with local medical committee leadership, where over 60 GPs from the north east came together and recommended its creation. The group comprises GP leaders,

primary care trust directors, local authority directors and representatives from the strategic health authority and has met monthly since November 2010 to discuss and advise on the development of high quality clinical commissioning across the north east. The members nominated pathfinder clinical commissioning groups and primary care trusts to work together on five priority workstreams for clinical commissioning as follows:

- contracting, performance management and data
- financial framework
- governance and scheme of delegation
- patient involvement and engagement
- coordinating commissioning decisions on individual cases.

4. Outcomes

4.1 Financial legacy 2006 to 2011

The NHS in the north east has performed exceptionally well in meeting financial targets. Since 2006/07, the strategic health authority has met all of the financial control total targets set by the Department of Health and has similarly contained capital expenditure within the corresponding capital spending limits over the same period. Currently, every organisation is in financial balance and projecting to do in the future.

Not only have commissioner achieved strong financial results but provider organisations have been similarly successful. Prior to 2006/07, three provider trusts had already achieved foundation status. Since then, seven of the eight remaining trusts have also become foundation trusts, leaving only North East Ambulance Service NHS Trust to complete the full foundation trust coverage and this is planned for 1 November 2011. North East Strategic Health Authority will be the first to have achieved this outcome.

The region's NHS has been able to fully adopt all of the business rules set out in the annual operating frameworks and payment by results guidance, whilst mitigating any significant financial risks through strong financial networking so that no individual organisation or local health economy has been destabilised in the process. The financial results bear witness to this cooperative approach and present a very good platform to cope with the challenging financial times ahead.

4.2 Operating performance

The north east is a high performing region with a strong track record of delivery against performance standards. This is testament to clear leadership of the strategic health authority, working co-productively with commissioners and providers.

The strategic health authority drives improvement in operating performance through robust performance management, underpinned by an agreed performance framework and delivered in an environment of high trust, with an expectation of high performance and no surprises.

The annual planning process sets challenging performance standards whilst ensuring that an appropriate balance is struck between ambition and reasonableness. The foundation trust environment means that performance management focus is through the PCT clusters, which shape the local NHS through their contracts with providers. If performance drops below the expected position, there are clear processes set out in the performance framework to hold commissioners to account.

The NHS in the north east continually strives to meet and exceed policy and performance standards. Examples of this include:

- Early and sustained achievement of the 18 weeks standards at a trust level since May 2008.

- A steady and continued reduction in healthcare associated infections, with MRSA and Clostridium Difficile infections down from 2006/07 to 2010/11 by 83 per cent and 65 per cent respectively.
- Fast diagnosis and treatment of cancer patients currently exceeds national expectations. The north east has historically performed well against the cancer two week wait and 62 day standards. Following the revision of the cancer waiting time standards methodology in January 2009, the north east has continued to meet the 62 day urgent referral target and has achieved the two week wait standard since June 2009.
- Successful delivery against eliminating mixed sex accommodation, with all trusts complying with the national standards and no breaches cited in July 2011.

The strategic health authority also maintains oversight of the patient choice agenda through the north east commercial committee and is very clear with PCT clusters that all patients must be offered choice with protocols in place to ensure this occurs.

Proactive in its approach, figures from the most recent national patient choice survey show the north east performing above the national average for both awareness and recall of offer of choice.

4.3 Health outcomes

Since 2006, public health in the north east has seen encouraging signs of improvement from a position of having amongst the poorest health in the country, people dying earlier than in the rest of England, suffering more ill health (from heart disease, diabetes, mental health, joint disease and most other causes), all putting more pressure on the NHS.

Although there are still significant challenges, over recent years overall mortality rates for males have fallen faster than the England average, north east children are now among the most physically active in the country and the region has seen most rapid decline in smoking of anywhere in England.

The development of the *Better health fairer health* strategy has led to a new level of stakeholder engagement, the forging of new partnerships and a shared focus on developing widespread and lasting cultural change.

Notable achievements have included:

- the development of the charter for a good death – considered an exemplar for other areas
- groundbreaking work to tackle the demand and supply of illegal tobacco and a social norm change programme by FRESH: Smokefree North East
- the establishment of *Balance*, the north east alcohol office – the first of its kind in the UK.

4.4 Patient safety and experience

The region has been at the forefront of innovative work on patient safety for some years and local NHS organisations hold a deservedly high reputation in the country with regard to the quality of care and innovation in safe practice.

Governance processes and assurance mechanisms are in place to ensure the region's strong quality and safety culture is maintained. Work in the region is continuously reviewed to ensure robust arrangements are in place throughout the transition phase.

The strategic health authority has worked closely with PCT clusters on a planned transfer of responsibility to commissioning organisations for the management of serious untowards incidents. Phased in across the region over a two year period, this is due to reach completion by December 2011, with evaluation of the process and robustness of systems scheduled from January to March 2012. The strategic health authority retains oversight of all serious untoward incidents ensuring appropriate management of all incidents, and taking responsibility for sharing lessons learned across the region.

Safer care north east (see page 8) reflected both national and local priorities and set out a development programme for nine collective areas of work, which aimed to further improve the safety of services whilst at the same time allowing local organisations to take forward their own initiatives. The work initiated within this strategy is now aligned with national safe care workstreams around quality, innovation, productivity and prevention (QIPP) and organisations will continue to progress the improvement initiatives under this umbrella.

4.4.1 Headline messages

- An increase in the number of serious untoward incidents reported to the strategic health authority relating to safeguarding adults has been identified. Initial analysis of these suggests this is as a result of a raised national awareness. As a result, a regional safeguarding action plan has been developed including plans for performance indicators around quality and safety measures, which will be included in primary care trust strategic plans, contracts and service specifications.
- The strategic health authority has supported human factor training with several surgical teams and departments throughout the region, which has had a significant impact. A subsequent safe surgery audit suggests a significant cultural shift regionally in this work.
- Significant improvements have been made with regard to delayed transfers and discharges, with a 45 per cent reduction in access to intermediate care.
- Over the past three years, the strategic health authority has commissioned CHKS to analyse mortality across the region. All but one provider has a decreased risk adjusted mortality (RAMI) score.

4.4.2 Patient safety and informatics

A health informatics clinical leaders forum is in place and inputs into a range of other clinical forums to ensure any data loss or information breaches are handled correctly and lessons learned shared widely. There has been full engagement with local NHS organisations to implement the NHS Connecting for Health clinical safety management system to reduce the risks associated with the implementation and upgrade of IT solution.

4.4.3 Information revolution and patient opinion

The strategic health authority is proactively releasing performance information to staff, patients, the public and key stakeholders on a regular basis. To ensure this information generates interest, it is shown in an easy to understand format using infographics.

In addition, the release of information relating to patient experience is essential to support the information revolution. The strategic health authority is working with the local NHS to agree metrics which organisations can use to measure their own patient experience. This will then be collated and released to allow comparisons for the public to use in their own decision making.

The latest public opinion research shows 91 per cent of people in the region agree their local NHS provides a good service.

4.4.4 Clinical workforce and delivering safe patient care

The strategic health authority and primary care trusts are committed to working with foundation trusts to ensure safe care for patients in the north east, with the continuation of monitoring and assessment through the patient safety dashboard.

This considers workforce and non workforce indicators. Forecasts, plans and ongoing workforce levels will be assessed and monitored against a number of key workforce indicators, including productivity, sickness absence, agency spend, staff supervision, induction, training and appraisal, knowledge and skills framework and ongoing professional and personal development. All local NHS organisations consider the impact of service changes to ensure safe care at all times and this is factored into workforce planning.

To support this work, the strategic health authority is one of eight which is working on a national project to develop a workforce assurance framework and modelling system which aims to improve quality by adopting a systemic, robust and evidence based approach to workforce issues. It will create an assurance legacy capable of being maintained by future service commissioners and providers by helping to identify any workforce issues and providing an early warning system when reviewing projected workforce changes. The assurance framework also reflects the key objectives agreed by the Department of Health's operations board to:

- automatically evaluate a variety of existing data points on workforce, quality and safety to help identify potential issues
- extrapolate and review forward looking data points on workforce, quality and safety to help identify potential issues
- help understand likely impacts of quality, innovation, productivity and prevention (QIPP) plans on workforce assurance
- help users understand and promote the links between workforce and finance and service
- create a system which is easy to use
- understand in detail how organisations have been classified with a particular assurance evaluation
- promote best practice in how workforce can enable and support quality and safety in the NHS

- encourage action to be taken in response to any potential issues identified.

4.5 Nursing

4.5.1 Energise for Excellence

Energise for Excellence is a national quality framework for nursing and midwifery that aims to support the delivery of safe and effective care and create positive patient and staff experiences that build in momentum and sustainability. Launched in 2009, the framework called for at least 200,000 nurses and midwives to sign up to take action and tell their story.

Energise for Excellence is now strategically positioned as the overarching approach to the implementation of improvement initiatives such as: high impact actions, productive care, safety express and essence of care. Many of these initiatives are not new and the emphasis is to pick and mix initiatives and ensure that improvement work is happening in each of the domains: get staffing right, delivering care, measuring impact, patient experience and staff experience. In July 2011, the Energise for Excellence call to action for senior leaders was launched, asking them to consider using this framework as a platform for delivery of cost saving and quality improvement at the scale and pace currently required.

The north east NHS is very much committed to this approach, with nursing directors implementing many of these improvement initiatives in hospitals across the region to ensure the delivery of safe care.

4.5.2 High impact actions

High impact actions for nursing and midwifery were developed following a 'call for action' which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference.

Nationally, nurses and midwives responded by submitting more than 600 examples and from these submissions, the NHS Institute for Innovation and Improvement published 'The Essential Collection' containing key case studies.

There is considerable overlap between high impact actions and initiatives which have been implemented across the region, such as *Safer care north east* and the 'productive series' which shows healthcare providers how to improve productivity through empowered teams, leadership and system development. The combined effort of the region's NHS has culminated in real success in terms of improved quality of care, reductions in incidents of patient harm and improved patient experience as well as significant cost savings.

4.5.3 Preceptorship

Workforce requirements in the future will be need to focus on the development of more independent and innovative practitioners to meet the changing requirements of future healthcare provision. The aim of preceptorship therefore is to enhance the competence and confidence of newly registered health practitioners to work as autonomous professionals.

A refreshed national preceptorship framework, which encompasses nurses, midwives and allied health professionals, is a recognised resource for NHS organisations with responsibility for establishing organisational systems for the management and development of the nursing and midwifery workforce.

The Department of Health has made funding available via strategic health authorities to invest in the regional preceptorship arrangements and activities, this funding has continued throughout 2009/10, with additional funding available for 2010/11.

The strategic health authority, as part of its commitment to the preceptorship framework is in the process conducting a baseline review of such regional activities which will provide an insight into how preceptorship is currently being delivered across the north east, to ensure equity of access to high quality preceptorship support for all newly registered practitioners and to ensure that the approaches adopted are measurable in terms of workforce competence and confidence. The majority of preceptorship programmes across the region are facilitated in partnership with higher education institutions and are delivered through an academically accredited programmes.

To further support preceptorship programmes and activities 'Flying Start NHS' is a multi-professional preceptorship programme, originally designed by NHS Education Scotland (NES) is also currently being utilised in the north east.

4.5.4 Local supervising authority

The local supervising authority is the body responsible in statute (the Nursing and Midwifery Order 2001) for the general supervision of all midwives practising within its boundaries. They have been in existence since 1902 and the first Midwives Act. Currently, the local supervising authority is deemed within the Nursing and Midwifery Order (2001) to be situated in England within strategic health authorities.

The North East Local Supervising Authority provides statutory supervision for all midwives practising within the authority's boundary, whether employed in the NHS, through agencies or the private sector, in higher education, in prisons, in the armed forces, in independent practice or employed by general practitioners.

The primary purpose of this function is the protection of the public and the authority is charged with ensuring that the statutory supervision of midwives is exercised to a satisfactory standard within its geographical boundary. This is achieved by ensuring that all midwives are eligible to practise, by maintaining the standard of midwifery practice, by ensuring appropriate training and development for midwives, and by investigating allegations of misconduct.

The local supervising authority midwifery officer is responsible for discharging the statutory function on behalf of the authority. The function is delivered locally by supervisors of midwives, who contribute to the clinical governance framework by supporting the professional development of midwives, and participating in local risk management systems.

4.6 Commissioning development

To ensure healthcare outcomes are improved and clinicians are empowered, there will be, subject to legislation, a new system for commissioning healthcare services from 2013 with groups of clinicians leading the commissioning decisions for local communities.

Together with primary care organisations, North East Strategic Health Authority is leading work across the region to ensure a smooth transition to the future health system and support pathfinders as they develop as future commissioners and before they take on statutory responsibilities from April 2013.

During 2010/11, the first groups to trial the new system – known as clinical commissioning groups – began to work together to manage their local budgets and commission services for patients direct with other NHS colleagues and local authorities.

Pathfinders are also supported by a learning network, involving frontline hospital doctors and nurses, to ensure that experience, best practice and ideas for improved quality, efficiency and productivity are shared widely.

The entire population of the north east is now covered by 14 pathfinder clinical commissioning groups who are working to test the new commissioning arrangements at an early stage.

4.7 Transforming community services

The strategic health authority worked closely to support primary care trusts in developing plans for transforming community services. All community health services in the north east have now been integrated with local hospital foundation trusts helping to create a more seamless pathway of care for patients as well as minimised management costs.

4.7.1 Status of transforming community services transactions

At the end of March 2011, the north east NHS met the Department of Health's expectation that full or substantial progress would have been made in completing all transforming community services transactions. Four of the transactions were fully completed by this deadline and arrangements were implemented in the remaining two to ensure that the acquiring foundation trust took on full or part management responsibility for the service from 1 April 2011. Full Monitor approval and complete implementation has now been achieved for all transforming community services transactions.

4.7.2 Contract duration

In March 2010, the Department of Health released new template community contracts with a standard duration of one year. Strategic health authorities were given flexibility to vary the duration of contracts to be agreed between commissioner and providers in certain circumstances, such as where the contract was linked to transforming community services.

To ensure alignment between provider contracts for community services with the underpinning transforming community services business transfer agreements

(developed with the support of clinical commissioning group leaders, primary care trusts and foundation trusts), the strategic health authority has approved the following variances to contract duration:

- South Tees Hospitals NHS Foundation Trust community services contract – three years
- County Durham and Darlington NHS Foundation Trust community contract – three years
- Northumbria Healthcare NHS Foundation Trust community contracts – two years
- The Newcastle upon Tyne Hospitals NHS Foundation Trust community contract – two years
- South Tyneside NHS Foundation Trust community contract – three years.

4.8 Estate

The north east NHS has taken the opportunities of new procurement vehicles such as private finance initiative (PFI) and NHS Local Improvement Finance Trust (LIFT) to work alongside existing capital funding mechanisms and the growth in revenue allocations, to commission a large number of capital investments which have been designed to simultaneously address:

- inappropriate service configurations (e.g. two or more hospitals serving a particular area)
- out of date buildings
- new and changing models/pathways of care and treatment, including shifts in the location of services closer to home and expansion of services.

In the acute hospital sector this has included:

- Reconfiguring Newcastle’s hospitals from three to two sites due to major new specialist tertiary facilities at the Royal Victoria Infirmary and Freeman Hospital and the closure of Newcastle General Hospital, which now houses Westgate walk in centre.
- Reconfiguration of South Tees’ hospital services by creation of The James Cook University Hospital with extensive redevelopment and extension of the South Cleveland Hospital and closure of North Riding Infirmary and Middlesbrough General Hospital.
- Planned reconfiguration of acute services in North Tees and Hartlepool with the replacement of University Hospital of North Tees and University Hospital by a new style single site hospital at Wynyard supported by a network of primary care centres in Hartlepool, Billingham and Stockton on Tees (Momentum project).

In the mental health sector this has included:

- Replacement of St George’s Hospital in Morpeth by the all new St George’s Park development on part of the same site.
- Redevelopment of the former Earls House Hospital site in Durham into Lanchester Road Hospital to provide new inpatient facilities for both older people’s mental health (Bowes Lyon Unit) and adult mental health and learning disability, and closure of the former County Hospital in Durham.

- Replacement of the former St Luke's Hospital and Hutton Unit in Middlesbrough by the major new inpatient mental health and secure unit, Roseberry Park, on an adjacent site.

Within community hospitals, primary care centres and health villages, a large number of new facilities have been constructed, many with shared facilities used by multiple NHS providers and local authority services, including:

- Bunny Hill Primary Care Centre in Sunderland
- Chester le Street Community Hospital
- One Life Centre in Hartlepool.

5. Areas for further progress

Whilst there is a strong record of delivery, there are areas where continued effort is required.

5.1 Over reliance on hospital care and the quality, innovation, productivity and prevention (QIPP) challenge

The north east has high quality NHS services and poor, but improving, population health. There is high patient, public and staff satisfaction with existing NHS services, however relative to the rest of the country, the region has an over reliance on hospital care.

The north east faces an unprecedented £859 million QIPP challenge over the next four years. Locally the NHS is relatively well positioned to face these challenges, with a full hospital foundation trust economy, newly integrated acute and community services, active clinical commissioning group engagement, and overall good partnership working. In the context of having a relatively stable local NHS and managing a significant transition in the way the NHS works, there is a major challenge to ensure that commissioning and provider clinicians and managers, work together with sufficient scale and pace of transformation to deliver the required improvements in quality and productivity. £160 million has been secured by commissioners in contracting for 2011/12, and forecasts indicate they are on target to deliver the remaining £104 million by the end of the financial year.

5.2 Clostridium difficile (C. difficile)

It is anticipated that acute hospital trusts and primary care organisations should achieve a further reduction in Clostridium difficile by 2012/13 based on the median and best quartile rate of the 12 month period October to September of the preceding year (*Patients aged 2yrs+*).

For July 2011 the region recorded a total of:

- Commissioner: 83 C. difficile infections against a trajectory of 81 infections.
 - Seven out of the 12 primary care trusts are behind their year to date trajectory for 2011/12, including Northumberland Care Trust, Sunderland Teaching Primary Care Trust, Darlington Primary Care Trust and all primary care trusts in the Tees cluster.

- Provider basis: 44 C. difficile infections against a trajectory of 43 infections.
 - Northumbria Healthcare NHS Foundation Trust, City Hospitals Sunderland NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust are above their year to date trajectory for 2011/12.

6. The future

North East Strategic Health Authority will continue as a statutory organisation until March 2013. As it has been demonstrated, the strategic health authority is in a very good position to handover to the new leaders of NHS North of England for the next 18 months, and subsequently to clinical commissioning groups and the NHS Commissioning Board.

North East Strategic Health Authority welcome the role of local authorities in taking forward the health improvement agenda for local communities across the north east. The region's transition plans are robust and this was endorsed by the recent Department of Health transition assurance visit and very positive stakeholder survey.

APPENDIX 3

NHS North West
Summary Legacy Document

September 2011

SUMMARY LEGACY DOCUMENT

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NHS NORTH WEST

SUMMARY LEGACY DOCUMENT

1. BACKGROUND

The North West Strategic Health Authority (NHS NW) was created in July 2006, replacing three former Strategic Health Authorities (SHAs); Cheshire & Merseyside, Cumbria & Lancashire and Greater Manchester. The SHA is chaired by Sally Cheshire, who replaced the SHA's previous chair, Sir David Henshaw, in February 2011. Mark Ogden took over from Mike Farrar as Chief Executive Officer in May 2011. A table of board members is included. Please see annexes -table 1.

2. OUR ORGANISATIONS

The North West has 66 NHS trusts including: 24 Primary Care Trusts (PCTs) and three community trusts; 38 NHS hospital trusts, including eight mental health trusts, seven specialist trusts, 23 acute trusts and one ambulance trust.

2.1 PCT clusters

The North West has five PCT clusters formed from 24 constituent PCTs. They are:

NHS Cumbria

- Cumbria PCT

NHS Cheshire, Warrington & Wirral

- Central & Eastern Cheshire PCT
- Warrington PCT
- Western Cheshire PCT
- Wirral PCT

NHS Greater Manchester

- Ashton, Leigh & Wigan PCT
- Bolton PCT
- Bury PCT
- Manchester PCT
- Oldham PCT
- Rochdale, Heywood & Middleton PCT
- Salford PCT
- Stockport PCT
- Tameside & Glossop PCT
- Trafford PCT

NHS Lancashire

- Blackburn with Darwen Care Trust Plus
- Blackpool PCT
- Central Lancashire PCT
- East Lancashire PCT
- North Lancashire PCT

NHS Merseyside

- Halton & St Helens PCT
- Knowsley PCT
- Liverpool PCT
- Sefton PCT

For the 2011/12 contracting round NHS North West monitored 84 NHS standard contracts with NHS providers. These contracts consisted of:-

- 32 acute contracts
- 39 community contracts
- 11 MH contracts

- Two ambulance contracts

3. KEY HEALTH CHALLENGES

3.1 Population figures

The total North West population is currently 6,897,900 residents (2009 ONS Mid Year Estimates).

3.2 Life-expectancy

The North West has the lowest life expectancy across all regions in England and also has the highest rates of early death from heart disease. Compared with the rest of England, men in the North West can expect to live 1.6 years less than average, whilst women can expect to live 1.4 years less.

There are also significant health inequalities within the North West; 14 of the 24 North West Primary Care Trusts (PCTs) have significantly higher levels of inequalities in life expectancy than the England average. No North West PCTs have lower-than-average levels of inequalities.

However, the population of the North West is living longer than ever before and health is improving for many residents. Progress continues to be made in reducing deaths from heart disease, stroke and cancer; and the life expectancy gap between the North West and England is narrowing.

In the most recent three year period (2008-2010) there has been a sharp and noticeable improvement in life expectancy; the trend in the most recent year's data is strongly positive, and analysis of the monthly provisional deaths data released by Office for National Statistics to the SHA indicates that the gap continued to narrow throughout the first 6 months of 2011.

Over 4,500 lives a year have been saved by the reductions in early deaths from cancers, circulatory diseases and stroke. However, the rising number of early deaths related to alcohol could reduce any progress made.

3.3 Health improvement

NHS North West has improved its position across the range of indicators set out in the Association of Public Health Observatories (APHO) Health Profiles, rising from being the lowest (tenth) performer of the 10 English regions in 2008 to being in sixth position in 2010.

There are two specific challenges to improving health in the region; reducing the numbers of hospital admissions for alcohol-related harm and incapacity benefit claimants for mental illness.

- The North West has the second-highest rate of hospital admissions for alcohol-related harm in England and rates continue to rise faster than in other regions; more than 160,000 admissions in the North West a year are related to alcohol use.
- The rate of incapacity benefit claims for mental illness in the North West is the highest in England, with almost 170,000 people making a claim last year.

There is a continued emphasis on improving health of the population further through the work of the public health and local government transition plans. At a local level, the NHS, together with strategic partners, is working with individuals and communities to prevent disease and improve access to treatment.

4. PUBLIC HEALTH AND LOCAL GOVERNMENT

The NHS North West approach to Public Health and Local Government reform has three main objectives:

- Work in partnership with Local Government to create the new architecture of Health and Wellbeing Boards in each of 23 upper tier Local Authorities in the North West and develop Local Government's strategic leadership role.
- Lead the development of the new Public Health system in the North West encompassing Local Government, Public Health England, Clinical Commissioning Groups (CCGs) and NHS Commissioning Board.
- Hold the ring on health and social care integration, personalisation and key policy areas such as dementia and safeguarding for children and adults.

In Local Government terms, the commissioning, provision and public health agendas are one conversation in which the role of Local Government is significantly enhanced, new relationships are built, substantial risk is managed and opportunities are seized to improve the health of the public and deliver effective integrated care.

Locally, emerging CCG are already working closely with Health and Well Being Board early implementers to ensure that there is sufficient engagement to drive broader health improvement initiatives and service developments.

The focus will be to promote integrated strategic leadership and to secure alignment at the appropriate level across a diverse region.

It will involve managing the impact of PCT Clusters that may not sit with natural Local Authority boundaries and this has the potential to affect established relationships. In addition, it will be necessary to transfer significant commissioning responsibilities to Local Government together with NHS budgets and the Public Health workforce.

Agreement has been reached with Local Government to establish a Transition Alliance which will bring together Local Government and Health leaders from across the North West to co-produce and deliver development programmes which enable transition to the new system and integrate with commissioning Consortia development.

The Regional Director of Public Health (RDPH) is charged with leading the transition to the new public health system.

Within the North West, our approach is to develop the new system in partnership with local government and Clinical Commissioning Group leads. We have established a Public Health Transition Oversight Group, chaired by the RDPH which brings together Chief Executives from Local Government and the NHS with Clinical Commissioning Group Leads and other key organisations in the Region such as Voluntary Sector North West and North West Employers Organisation.

Local areas are sharing Public Health Transition Plans with the RDPH. These are reviewed against specific criteria with feedback provided. All are at different stages of development. The RDPH regularly has meetings with Directors of Public Health, PCT Cluster Chief Executives and Chief Executives of local authorities to review progress on public health transition.

We are delivering a leadership and workforce development programme to:

- Support the NHS workforce to take on the new challenges of working in Local Government;
- Enable key groups in Local Government such as elected member to take on their new roles as strategic leaders for health.

We have set up the Transition Executive Group (TEG) to oversee the delivery of a set of work-streams and task and finish groups to ensure a smooth transition to the new arrangements and effective communication with staff and stakeholders. The work-streams and groups include: workforce; public health intelligence; financial arrangements; governance.

The development of Health and Wellbeing Boards in each upper tier Local Authority will be a key component in the effective management from the current to the new commissioning arrangements.

Over the next 12 months, the Transition Alliance will:

- Deliver a development/exchange programme for emergent Health and Wellbeing Boards to enable rapid and successful implementation;
- Drive a culture of continuous and sector-led improvement;
- Network Health and Wellbeing Board leads together to promote learning and sharing of emergent practice;
- Promote the development and utilisation of Joint Strategic Needs Assessment as a driver for health and wellbeing strategies and GP Commissioning Consortia Plans;
- Work with Local areas to move from LINks to Healthwatch; and
- Work with the Audit Commission to develop a governance self-assessment tool for Health and wellbeing Boards.

All upper tier Local Authorities will have shadow Health and Wellbeing Boards in place by April 2012. Greater Manchester Authorities are working together to develop a Health and Wellbeing Board for the 10 Councils serving Greater Manchester.

We are developing a Health and Wellbeing Board programme that supports the Early Implementer work led by DH provided through the Transition Alliance to encourage and develop best practice and shared approaches.

4.1 Public health governance

Regular reports and updates go to the Transition Oversight Group (TOG); the Transition Alliance Board; the SHA's Senior Management Team and Board; and monthly returns to Public Health England and to the SHA's transition assurance reporting system. See annex – table 2.

The TOG provides strategic direction to support public health transition to local government and the development of links between local systems and Public Health England. It does this by providing leadership and guidance informed by national policy and work across the region undertaken in the work-stream groups and 'task and finish groups'.

The TEG, originally established to lead and develop work-streams to influence the development of the Public Health White Paper, has evolved to become a 'think tank' which considers issues relevant to the transition agenda, shares examples of good practice and leads/supports relevant areas of work.

The Transitional Alliance Board, and the Transition Alliance programme of work provides leadership and support for the transition task that arises from the Health and Social Care reform agenda by supporting practice exchange and activity that is best addressed above the level of locality and to link the separate strands of NHS, Public Health and Social Care transition.

The Transition Alliance Programme also includes elements of public health transition, complementing the work overseen by the Transition Oversight and Transition Executive Groups.

4.2 Prevention spend

NHS North West was the first SHA to develop a tool to measure investment in prevention. It has undertaken an audit of PCT spend for 2008/09 and 2009/10. The 2009/10 audit found that, on average, 4.04 per cent of PCT NHS allocation was spent on public health, but also identified significant difficulties in costing some public health services (particularly those delivered through secondary care contracts). The results of the audit have been used by the DH to inform methodology for identifying the ring-fenced budget and pace of change policy to support the transition of Public Health.

5. EQUALITY, INCLUSION AND HUMAN RIGHTS IN NHS NORTH WEST

NHS North West has developed an evidence-based strategy (2008-2013), supported by the introduction of innovative tools and best practice methods for delivery of equality and diversity responsibilities. It applied cultural change management; defined the leadership competencies required; and introduced a consistent and objective framework (the Equality Performance Improvement Toolkit or EPIT) for measuring outcomes across a range of 13 key areas. An online evidence library for research, best practice and tools to support organisations and equality

practitioners (the Health Equalities Library Portal) was developed, alongside a sustainable and effective method of engaging hard to reach stakeholders (the Health Equality Stakeholder Engagement model). Other key initiatives included the introduction of a senior BME internship programme and a best practice guide to sexual orientation monitoring for use across the public sector, not just the health service.

Three years into the strategy, outcomes include the national adoption of a leadership competency framework and outcome-based performance measurement tool – the national Equality Delivery System; alongside demonstrable improvements in the cultural competencies of NHS bodies in the region. Within 18 months, the number of PCTs able to evidence tangible ‘achieving’ outcomes affecting at least three equality target groups has doubled.

In summary, the North West E&D *modus operandi* is to develop evidence-based and outcome-focused strategies, pilot a best practices approach, review, refine and roll out as appropriate.

6. CLINICAL ENGAGEMENT

NHS North West has placed a strong emphasis on building clinical engagement as this underpins the SHA’s delivery of improvements across the North West.

The Nursing and Medical Directors takes a pro-active approach to engaging with clinicians across the region and have developed excellent working relationships with clinicians, which are supported through a range of regional learning networks, meetings and events. The team also provides clinical engagement and input to the Commissioning Development agenda.

There are joint meetings of medical and nursing directors from across the North West held twice a year.

The Medical Director has responsibility for a range of specific re-design and service improvement projects (including COPD, revalidation, dementia etc) and overall responsibility for the involvement and engagement of doctors in strategic planning, design and implementation.

NHS North West pioneered a new way of bringing clinicians and managers together when they formed the Clinical Leaders Network (CLN). The network members come from a wide range of clinical disciplines, and come together monthly to discuss key topics and sit in action learning sets where they agree and implement specific improvement projects at their own places of work. The network also promotes ‘shared leadership’ between managers and clinicians. The success of the CLN in the North West led it being rolled out nationally, each SHA region now has its own CLN, and hosts an annual conference to celebrate members’ achievements.

7. PATIENT EXPERIENCE

7.1 Inspiration North West (NW)

NHS North West led the way in establishing a nationally acclaimed Service Experience Directorate to raise the profile of experience as a dimension of quality care and develop an experience movement, focusing on leadership, building capability and commissioning for quality in the region. Set up with a development budget of £90k the programme has income generated over £750,000 within three years and supports innovative, timely, cost-effective and bespoke packages of support procured through a supplier ‘call-off’ framework, called INSPIRE and focussed on: -

- a. **Building knowledge and insight** (developing a clear focus on patients’ experience in line with what matters locally and in national policy)
- b. **Strategy and planning** (embedding service experience within organisation structures including boards, senior teams and systems and processes)
- c. **Living the values and behaviours everyday** (frontline staff training)

d. **Experience based designed services** (innovative approaches to service and commissioning design)

Early benchmarking and NHS Operating Framework returns have shown that those NW organisations who engage with Inspiration NW are recognised as supporting innovative and successful improvement, and tend to take a more integrated organisational 'business approach' to improve experience for patients and staff. All Boards now have a named board member with responsibility for patient experience (executive and/or non-executive) and there was a significant shift from a reliance on traditional methods of feedback to a far greater range of patient experience techniques being applied across all organisations which inform decision making.

In December 2010 Inspiration NW was approached by the Department of Health Patient and Public Engagement and Experience Division to work in collaboration with them to deliver the requirements of the NHS Outcomes Framework Domain 4 'Ensuring that people have a positive experience of care'. This programme is called the Patient Experience Policy Programme (PEPP). The final product for this work is an Excellence Framework for Patient Experience which will be finalised by March 2012.

The Inspiration NW website has recently been refreshed to become more interactive and informative so that individuals and organisations can become involved through a distributed network approach to generate ideas and feedback on both local and national work.

8. EMERGENCY RESILIENCE

NHS Resilience in the North West is managed through the SHA and the five PCT Clusters. An assurance system is in place picking up the anticipated risks including NHS transition. This performance tool is used by the SHA/PCTs to ensure the resilience agenda is maintained. National, regional and local risks are included in the work.

The SHA maintains an on-call Director system to ensure that there is senior leadership available 24/7 and they liaise with the on-call arrangements in place in the PCT Clusters. This provides full NHS management availability for any multi-agency response that may be required and any untoward incidents that occur within any NHS organisations. Work is ongoing with the other two SHAs in the North to agree a new on-call system that is fit for purpose. It is proposed that the North of England executive team will be central to the new arrangements.

9. LEADERSHIP ACADEMY

The NHS North West Leadership Academy is an organisation providing leadership development for senior leaders within the North West region. Following consultation, and with the support and commitment of North West CEOs, the Academy was launched in 2007 and at the time was located within the SHA and supported by MPET monies.

North West CEOs were keen to have greater involvement in setting the direction and priorities for leadership development and therefore the decision was taken for the Academy to be hosted out of the SHA. Blackpool, Fylde & Wyre Foundation Trust (FT) was successful in its bid to host in April 2008. All organisations became members of the Academy paying an annual levy fee. The SHA funding via MPET monies was managed via a Service Level Agreement. A new governance structure was created including an Academy Board made up of CEOs, Chairs and Senior Clinical Leaders from the North West with the CEO of University Hospital of South Manchester NHS Foundation Trust acting as Chair and taking on the ambassadorial role.

Since then the Academy has provided a wide range of senior leadership development for whole boards, CEOs, Chairs, Non-Executive Directors (NEDs), Executive Directors and those working at sub-board level. This takes the form of national and international programmes, master classes, one day workshops, executive coaching etc. working with a range of academic and commercial development providers. The academy has been held up as a model of best practice, considered to be at the forefront of leadership development delivery and is clearly valued in the region by the continued support and commitment from member organisations.

10. FINANCIAL

NHS North West has a strong track record in delivering financial targets and has consistently delivered its control total and a healthy surplus since it was formed in 2006/07.

NHS North West has a risk based approach to financial performance management. Each PCT cluster and trust (non-Foundation Trust) has a nominated link SHA Assistant Director of Finance (DoF). Organisations are categorised into low, medium and high risk. The performance review meetings with the organisations' DoF are held on a monthly basis for the medium and high risk organisations and quarterly for the low risk. All meetings are attended by the link SHA Assistant DoF; the bi-monthly meetings for the medium and high risk include the SHA Associate DoF and the quarterly meetings for the high risk include the SHA DoF.

The SHA has a monthly Director of Finance communication meeting, chaired by the SHA DoF. The PCTs and trusts (non FT and FT) have local DoF meetings (covering Cumbria & Lancashire, Cheshire & Mersey and Greater Manchester) which are attended by the relevant SHA link to ensure SHA engagement in local issues. The SHA also has a bi-monthly PCT Deputy DoF meeting as well as groups to support specific topics such as enablement/readmissions and programme budgeting.

In 2011/12 the North West plan is to deliver a surplus of £193m in the SHA and PCT sector with a further £27m surplus in the trust (non-FT) sector. All organisations are on track to deliver the planned surplus, although some organisations are facing significant financial challenges.

During the 2010/11 planning round it became clear that a number of organisations had underlying financial problems that would turn into financial deficits unless action was taken. The response was to create a regional turnaround cohort which included nine PCTs and three trusts. The objectives of the programme included organisation boards working with the regional turnaround director to embed a turnaround culture, establishing a community of practice to share ideas, views and methods and delivery of savings to restore underlying financial balance. Two PCTs and one trust were successfully discharged from the cohort by the end of the financial year. The remaining organisations have developed turnaround strategies and are in the process of implementing them.

The risk based approach to financial performance management is flexible to allow the level of scrutiny to change in response to in year performance.

In 2010/11, the NHS in the North West delivered c. £647m of savings; PCTs £342m, non FTs, £90m, FTs (estimated) £215m. Over the next four years PCTs are planning to deliver £979m of cash releasing savings and through contracts with providers, will deliver efficiencies of £1,259m. See annexes – table 3 for a breakdown by PCT Cluster.

Table 4 shows the summary financial performance of the North West since its inception.

The SHA and North West PCTs and trusts have consistently performed well in the Audit Commission ALE, Use of Resources and Value for Money assessments. In 2010/11, the North West was the best performing SHA area with 92% of organisations receiving an unqualified VFM conclusion.

PCTs have faced challenges from increasing demand resulting in significant growth in secondary care spend, as well as the increase in the cost of continuing care and prescribing.

Table 5 is a summary of the risk ratings for the North West PCTs and non FTs which was presented to the board meeting in September 2011.

11. OPERATING PERFORMANCE OVERVIEW

Health Care Acquired Infections

This was the reporting position as at the end of July 2011:

11.1 Methicillin-Resistant Staphylococcus Aureus (MRSA)

The infection rates per 10,000 population for MRSA continues to improve to 0.26 and NHS North West is now close to the England rate of 0.25.

NHS North West is reporting a year to date figure of 58 MRSA cases against a plan of 94 which is 38% below trajectory and gives us sufficient headroom to be confident that we will deliver NHS North West's plan of 201 for 2011/12.

There are 5 PCTs and 8 Acute Trusts who are over their year to date trajectory and all have robust plans in place to recover their position.

13 Acute Trusts and 3 PCTs have successfully achieved zero MRSA bacteraemia in the year to date.

11.2 Clostridium Difficile (CDiff)

The trajectory set for NHS North West to deliver against the national objective has meant that we have a plan which is significantly lower than in previous years with a 43% reduction for commissioners and 54% for providers this year, which is a considerable challenge for delivery in 2011/12.

NHS North West has for the first 4 months of 2011/12 missed the trajectory by small numbers so we are 4% below plan year to date. However, the overall numbers continue to reduce and in July NHS North West was just one case over plan.

Intensive work continues with organisations that report over trajectory numbers. NHS North West has delivered Master Class education events for Health Care professionals with a focus on GPs to address issues with antibiotic prescribing.

NHS North West has also launched a *Cdiff* initiative which provides patients with information cards for people diagnosed with *Cdiff*, and a clinical performance lead has also been put in place.

11.3 Mixed sex accommodation

A comprehensive improvement plan has been delivered by NHS North West across the region. Breaches are now in comparatively small numbers with strong commissioner engagement in resolution.

11.4 Urgent care

Accident and Emergency (A&E) 95% 4 hour standard reporting position end of August 2011

Current year to date delivery is strong with performance at the end of August at 97.2%. NHS North West is confident that the target will be achieved for 2011/12. Providers are using the reduction of the target to ensure that patients who need longer than 4 hours in A&E can now be assessed without being admitted.

However, there are 3 Trusts whose current year to date performance is below 95%. These are:- Pennine Acute, Wirral FT and Stockport FT. All three organisations have recovery plans in place and we are confident of recovery in Stockport FT and Wirral FT.

Pennine Acute is receiving intensive support both from the IST Emergency Services team and NHS North West's performance team, and are under intense scrutiny as part of the FT pipeline process.

Trajectories have been requested from health economies whose performance last winter was challenged to ensure that robust plans are in place.

11.5 A&E clinical indicators

From 1st July 2011 the new A&E CQI are included as performance measures. In 2011/12 trusts have to achieve one threshold in the timeliness group of measures and one in the effectiveness group. A

snapshot of Trusts' own data indicates that the North West will achieve the standards in 2011/12, although this is invalidated data and must be treated with caution.

11.6 Ambulance category A 8 minutes reporting position end of August 2011

Historically the North West Ambulance has struggled to deliver this standard and in 2010/11 it was the only headline measure that the North West did not achieve. This year the Trust has developed a trajectory and robust plan following an external review and SHA challenge. The plan was signed off by NHS North West in early July, and since the plan has been in place NWS have over delivered on the agreed trajectory, with August performance at 80%. Year to date delivery is currently 76%. The trajectory set requires NWS to deliver 78% for the next 2 months. If the Ambulance Trust hit the required over performance in September and October to achieve 77% year to date, NHS North West is confident of delivery of 75% for the year. The SHA performance team reviews performance and plans on a weekly basis.

12. ELECTIVE CARE

Referral to treatment time 90% for admitted patients treated in 18 weeks.

12.1 Reporting position end of June 2011

This is currently the biggest risk for performance delivery in 2011/12. The removal of 90% admitted from the Monitor compliance framework and the cancellation of a significant number of operations due to severe winter and flu led to a number of North West organisations developing a backlog of patients waiting more than 18 weeks for treatment. This pushed the North West's 95 percentile of incompletes over the threshold and overall delivery for admitted patients fell below 90%.

NHS North West's recovery plan is based on providers treating their backlog in the shortest time possible and treating patients in time order to get to a sustainable position for ongoing delivery. This has meant that delivery of 90% fell below the required standard for June 2011, and will do so again in July and August, as providers continue to treat their longest waiting patients in order for the North West to deliver 90% by the end of quarter 2 2011/12.

This has been a significant challenge for several health economies and NHS North West is receiving eight weekly patients tracking lists to ensure delivery is on track as well as weekly calls with commissioners of Trusts most at risk, which are Central Manchester FT and Pennine Acute.

Central Manchester agreed a delivery date of Q4 with Monitor which has since been brought forward to Q3 following commissioner discussions. The constraint to earlier delivery is the paediatric capacity and is linked to contractual and financial discussions with Greater Manchester cluster.

12.2 Diagnostics over 6 weeks

NHS North West has a number of organisations with recovery plans in place to ensure that the number of patients waiting over 6 weeks falls below 100 patients. The most significant outlier is Pennine who have seen a substantial increase in May and June. The Trust has a robust plan in place to reduce over 6 weeks to zero by October 2011 and are on track to deliver.

12.3 Cancer

Historically NHS North West has delivered all cancer standards at a regional level.

However, this hides the individual poor performance of the Christie FT 62 day target which has been the focus of recent ministerial and DH focus after Christie made representation to Monitor regarding the impact of late referrals from Greater Manchester hospitals. This made it impossible for the Christie to achieve the standard as they only accept tertiary referrals.

The Cancer Tsar, Mike Richards, produced a report which recommended local changes to the contract which would penalise Trusts for late referral to Christie, and suggested a process for breach reallocation which NHS North West has lead with the cancer network.

This is now in place. NHS North West commissioned a further more detailed report in June 2011 when there were concerns that the pathway redesign work was not delivering the change required. This report has a comprehensive raft of recommendations and the GMCC Network will now be led by the Greater Manchester CEO to ensure PCT Cluster delivery.

12.4 Stroke and Transient Ischemic Attacks (TIA)

Stroke and TIA performance has shown a marked improvement in the past 12 months and in Quarter 1 (Q1) 2011/12 the North West achieved the TIA standard at 74.6%. However although improved, the 90% stroke unit standard has not been achieved at 74.9% against a target of 80% for Q1 2011/12. All PCTs who did not achieve the national threshold will continue to report to NHS North West on a monthly basis. Work continues with individual providers on data quality, as well as with the Cardiac and Stroke Networks to support improvement.

12.5 Health visitors

Monthly reporting on progress to the performance team has commenced with PCT cluster CEO engagement and challenge. A programme director is now in place to lead the programme and ensure plans are delivered. A regional communications campaign has been devised and implemented to support the programme.

12.6 Improving Access to Physical Therapies (IAPT)

PCT trajectories were required to achieve the target for IAPT (referrals entering treatment 60%) and set before the publication of national guidance. The Q1 position indicates that some trajectories, against guidance and calculation formulas, are low and likely to challenge delivery of the 60% expectation for the North West. A regional IAPT team is in place and will be working with PCTs to support recovery.

12.7 Vaccinations

Improving uptake in the national vaccination programmes has been a high priority for the North West over recent years and a continued drive to improve performance and quality has been underway. This has resulted in a sustained improvement in performance, across all programmes and places NHS North West as one of the highest performing SHAs in the country. Uptakes on the MMR vaccine by age 2 continues to improve and in Quarter 4 the North West average uptake was 91.8% against a target of 95% and England average of 89.5%.

12.8 National screening programmes

In the North West (NW), the focus of the national screening programmes has been the continual improvement of the commissioning and quality assurance functions. This is to enable the delivery of safe and effective services. A recent PCT review of programmes identified strengths and weaknesses. This analysis is being used to develop a self assessment audit tool. PCT performance against commissioning and quality standards is benchmarked in a quarterly NW Screening report. Any screening serious incidents are monitored and lessons learned are shared across other programmes.

13. DELIVERING QUALITY

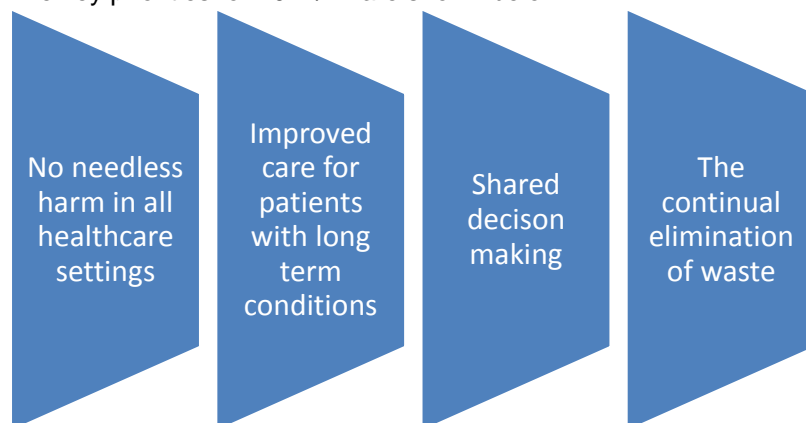
13.1 Advancing Quality Alliance

- The Advancing Quality Alliance (AQuA), the North West Quality Observatory, is formally established as a joint venture. Clinical consortia will be funded to join AQuA for 2 years. Dedicated to improving healthcare across the NHS, it is the centre for quality improvement across the North West and has had a number of notable successes which are:
- The Advancing Quality (AQ) programme aims to give patients a better experience of the NHS by ensuring the highest standards of care are consistently delivered in every hospital in the North West. Interim findings from an independent evaluation indicate that the AQ programme

is leading to fewer deaths from congestive heart failure and pneumonia across the region. There are two new care pathways

- Stroke 90:10- driving up compliance with Sentinel Audit > 90%
- Safety Networks – driving improvements in falls, pressure ulcers and VTEs
- Reduced Mortality Collaborative; reducing HSMRs in 9 Trusts with highest rates by 10 points.

The key priorities for 2011/12 are shown below.



These objectives are underpinned by a work programme for 2011/12 which provides stronger focus on demand management and productivity:

- Reducing Harm
- Mortality Collaborative Spread Phase
- Safety Express “Plus” (The Department of Health’s Safe Care Workstream)
- Long Term Conditions Management and Dementia Collaboratives
- Shared Decision Making and Patient Decision Aids
- AQuA Lean Network – to support productivity improvement
- AQuA Observatory, Academy and Partnerships – to build improvement capacity

13.2 Energise for Excellence

- Energise for Excellence (E4E) is a national improvement programme co-founded by the NW Chief Nurse who is the national lead. Locally, E4E is led by the North West Directors of Nursing. It is supported by AQuA, and the Leadership Academy and is aligned with Safe Express Plus and the Productive series, E4E is a key strategy for ensuring a robust response to the Francis Report to provide compassionate, safe care.
- The delivery plan includes: a mobilisation campaign, an action learning set for workforce tools, participation in the rapid spread programmes, implementation of the HIA, the productive series and safety express.

14. QUALITY AND SAFETY ASSURANCE

14.1 Practical steps to safeguarding quality

There are well attended medical, nursing and clinical leaders networks in place, providing a focus for clinical and professional leadership for quality and safety.

The SHA undertook a final assurance review of the PCT and trust responses to the Francis Recommendations. Endorsed by the Directors of Nursing network and aligned with E4E, the review provided assurance on each organisations’ systems, processes and outcomes relating to patient and staff experience, governance arrangements, SUI reporting and whistle -blowing, quality improvement strategies and evidence of improvement through quality indicators.

The results are shown in tables 6-9 and there is evidence of well developed assurance systems, board to ward reporting, engagement with patients and partners and quality improvement programmes across the North West.

Those organisations where the systems were assessed as giving partial assurance were either in the process of strengthening the systems or there had been recent organisational changes or challenges. The major challenge for the provider services were around the work force experience and use of tools to determine appropriate staffing levels. This is particularly important when meeting the challenge of QIPP.

The challenge for the commissioners was to maintain 'a line of sight from PCT board to the provider services'. This was becoming increasingly difficult as the changes began to take effect but PCTs provided evidence of quality strategies, programmes, dashboards, governance arrangements and quality performance management reviews being in place.

There were examples of site visits, board to boards and good clinical engagement and leadership. Once again the area for development was systems to assess workforce changes.

14.2 Harnessing existing processes

Quality and Safety Monitoring

The performance, nursing, safety and quality teams have restructured with designated cluster leads to support the QIPP, Provider and Commissioning functions. There are bimonthly meetings with CQC to address any current safety or quality issues.

All current statutory safety functions including the LSA, Mental Health Inquiries, Safety and Professional Alerts, SUI StEIS reporting, Section 12 Approval Child and Adult Safeguarding have been maintained. Governance systems are in place and scrutiny provided by the integrated governance committee.

Eighteen mental health investigations have been commissioned, a further twenty incidents reviewed and found not to meet the HSG (94) 27 criteria and have therefore been closed. Two independent investigations were published in 2010-2011, three will be published in September 2011 and number of other cases will be ready for publication in October or November 2011

Quality and Safety Assessments of the organisations in the Foundation Trust pipeline are undertaken and signed off by the Medical Director and Chief Nurse. A robust process in place, the trusts complete the monitor quality framework which is triangulated with SHA intelligence and any outstanding issues are clarified with the organisation's chief executive, medical and nursing directors.

All CQUIN schemes were reviewed and assured last year. The regional CQUIN indicators have been agreed for 2011/12. They include Advancing Quality and a locally agreed 'Harm Free Care' Indicator. Progress is monitored and the current schemes will be assured in collaboration with the clusters.

14.3 Child safeguarding

During 2010-11, the North West published twenty-seven multi-agency child safeguarding serious case reviews. The SHA hosted a conference to share the lessons from a thematic review. Further work is being undertaken by PCT/North West Ambulance Service task and finish groups in place to improve the standards, training and clinical supervision of paramedics and communication across pathways.

Lessons learnt from the Serious Case Reviews in 2010-11 have been embedded in the North West Safeguarding Policy and included in NHS Contracts. There is also an audit tool and escalation process in place for those providers that are not meeting the safeguarding standards within the contract.

14.4 Adult safeguarding

Although there is no statutory responsibility for Adult Safeguarding for SHAs, NHS North West is committed to ensuring that adult safeguarding partnership working and integration of health policy and

actions are progressed. Several North West organisations have piloted a 'safeguarding adults' self assessment and assurance framework.

There is a quarterly Adult Safeguarding Advisory Network meeting to support improvements and communication across the North West. The meetings are open to Adult Social Care colleagues and Independent Chairs of the Local Safeguarding Adults Boards as well as health care providers and commissioners. Information, policy, best practice and learning from serious cases is shared openly at these meetings.

To develop leadership within safeguarding, bespoke post graduate certificates and master classes for health professionals in adult safeguarding have been commissioned by NHS North West from the University of Salford and are available free of charge to nominated leads within the PCT Clusters (Primary and Secondary Care) and Clinical Commissioning Groups during 2011/2012. The model has been shared with social care colleagues.

14.5 Quality Innovation Productivity Prevention (QIPP)

The NW QIPP challenge is £2.2bn between 2011/12 and 2014/15 with headroom of £ 249m and a planned surplus of £193m. We have strong in year delivery overall including savings of £832m (PCT & trusts £595m and FTs £237m) in 2010/11. The SHA has supported the system through 9 regional work-streams, each led by a Chief Executive from either a Trust or PCT.

The level of input of these work-streams is currently being reviewed and rationalised. The SHA chairs a QIPP leaders' forum on a monthly basis and progress on QIPP is reported to Senior Management team and cluster delivery board meetings regularly. The SHA has held a number of "deep-dives" at PCT cluster level to gain assurance of progress on planning and delivery, and to also triangulate current monthly activity/finance/performance/workforce/pay bill information with the milestones and KPIs for QIPP.

14.6 QIPP safe care and safety express

Safety Express is the QIPP safe care work stream and is via collaboration between NHS North West and AQUA. It has laid strong foundations to help trusts reduce harm to patients. Alignment with other quality programmes ensures that organisations are able to make best use of the safety programmes and do not become overwhelmed by different competing initiatives.

There are 15 Safety Express Plus hosts in four clusters to support learning from more experienced partners, safety node networks and to encourage future scale up and spread. Several northern cluster workshops and webexs have been successful and early indications from the safety thermometer show evidence of improvement in delivering harm free care.

Safety Thermometer Evidence - please see table 10.

14.7 Triple Aim

The Triple Aim is an international learning initiative developed by the Institute of Healthcare Improvement (IHI) and is concerned with three critical goals, also described as dimensions of value that must be addressed simultaneously:

- Improve the health of the population
- Enhance the patient experience
- Reduce (or at least control) the per capita cost of care

The Triple Aim came to the North West in September 2007 when NHS Bolton PCT, one of only two sites outside the United States, was invited by the IHI to join their new prototyping initiative. Acknowledging the impact of this work and seeing the potential, NHS North West made a decision to provide funding to expand the programme across the North West by inviting PCTs to join. Overall, 16 PCTs and NWAS have participated in the programme, through five prototyping phases, concluding on 31st August 2011.

North West Triple Aim participants have achieved significant improvements through their involvement in the Triple Aim over the last few years; in particular the achievements of NHS Bolton, NHS Blackburn with Darwen, NHS Knowsley, NHS Oldham, and NHS Sefton should be acknowledged. Their achievements include reducing cardiovascular mortality and admissions for heart attacks – 20% and -50% respectively (NHS Bolton); reducing the number of GP referrals into secondary care whilst simultaneously improving the quality of referrals, (NHS Oldham); reducing COPD emergency admissions and increasing number of patients on disease registers (NHS Sefton); identifying complex high intensity, high cost users of healthcare services through development of integrated dataset to support GP led assessment of risk; not reliant on previous admission/s to trigger action (NHS Knowsley).

North West participation in the Triple Aim programme concluded 31 August 2011. All programme leads agree that they have a legacy in terms of conceptualising and delivering population level improvement, and that Triple Aim principles have been embedded in new commissioning organisations.

Phase V was funded by the Advancing Quality Alliance and whilst not funding Phase 6, AQuA will continue to support the Triple Aim concept wholeheartedly and will make explanatory material available to AQuA members on their web portal.

Furthermore, they will reinforce the principles wherever relevant, for example; in the Commissioning for Improved Clinical Outcomes project commencing with six CCGs in partnership with the SHA Commissioning Development Team; in designing and delivering the AQuA Long Term Conditions programme; and in the structure of Integration Discovery Communities focused on integrated care at population level delivered in partnership with The Kings Fund.

14.8 Shared decision making

NHS North West is involved in a national initiative of SHA led pathfinder projects to explore the clinical and staff perspectives in shared decision-making and information-giving, set against a national priority to develop and embed a culture of “no decision about me without me”. Underpinned by exploratory research through engagement with key stakeholders across the clinical, patient and public landscape in the North West, conducted by the Picker Institute for the NW SHA, the findings will be showcased at a learning event on 4 October 2011.

14.9 Self care aware e-learning for GPs

Based on research that showed the cost to the NHS for treating minor ailments is £2 billion, NHS North West recognised the significant potential to break the dependency culture through the development of an e-learning package for general practitioners and other primary care professionals to support their patients to self-care. There are 57m consultations per year involving a minor ailment, of which 51.4m are for minor ailments alone. This amounts to an average of about one hour of work a day per GP. A reduction in GP consultations for minor ailments would, therefore, benefit patients by improving access to GP care for higher risk patients and increasing time and staff resources for managing long-term conditions.

The e-learning programme, funded by NHS North West, is being developed by the Royal College of General Practitioners (RCGP) and will be launched at the national self care event on 8 November 2011. It will be immediately available to 47,000 GPs, 20,000 practice nurses and 10,000 practice managers.

15. INNOVATION IN THE NORTH WEST

Key to delivery of our clinical vision is the adoption, diffusion and spread of good practice and utilising some of the most pioneering thinking and the latest technology. Funding opportunities brought together a number of innovators, businesses and organisations from across our health care system to develop creative solutions, to make health services in the North West the best they can possibly be.

We developed a five-strand Regional Innovation Framework to support delivery of both national and regional policy. The creation of a unique regional “innovation architecture”, bringing together a range

of partners, provided a strategic focus to support innovation and has been key to ensuring the success of this framework.

We used the North West Regional Innovation Fund (RIF) to encourage and inspire clinicians, managers and support staff to be innovating within the health system and work collaboratively with a variety of partners. We wanted to change how things are done, in order to consistently increase health care quality, eradicating inefficiencies and reducing costs. As a result there are now nearly 90 projects running across the North West, all aligned with QIPP objectives.

The North West was selected to pilot the National Institute for Health Research Clinical Research Network Exemplar Programme – of national interest and importance due to its demonstrating how the NHS contributes to the UK's economic recovery and secure our place as a global leader. The North West attracted £120 million funding from the National Institute for Health Research Funding.

16. CHILDREN'S, YOUNG PEOPLE AND MATERNITY SERVICES

Health outcomes for many North West children continue to be significantly worse than the England averages on a range of issues, including obesity, alcohol related hospital admissions, mothers who smoke in pregnancy, infant mortality and teenage pregnancy.

The SHA has developed a partnership approach on the development of child and family health work, including working closely with the North West Directors of Children's Services on specific improvement programmes. As part of this work a number of guides and strategies on child and maternal health have been produced including a generic regional guide for commissioners, and specific strategies on Paediatric Surgery, Child & Adolescent Mental Health Services (CAMHS), Speech and Language Therapy, and Perinatal Infant Mental Health.

As part of the Coalition Government's commitment to reducing health inequalities, NHS NW is working to increase by over 400 the number of health visitors in the North West in the next three years.

Safeguarding Children remains a regional priority, with the SHA continuing to lead and support a number of work programmes to strengthen leadership and delivery of child safeguarding systems in health services.

17. WORKFORCE

17.1 Snapshot of current workforce

NHS NW has a 10 Year Integrated workforce, education and education commissioning strategy which was approved in 2009. The workforce monitoring report to end of June 2011 is shown in table 11, (changes are from May 2011).

17.3 Workforce and education activities

This section provides an update on activities within the workforce and education directorate. It covers the four areas of:

- Workforce strategy and planning
- Education Commissioning
- Postgraduate medical and dental education (the deaneries)
- HR Strategy.

All the activities are covered by the North West Workforce, education commissioning and education and learning strategy approved by the Board nearly three years ago.

17.4 Workforce strategy and planning

The workforce strategy team have three areas of work:

- Workforce planning
- Workforce modernisation
- Health and well being for NHS staff.

This team also leads on the workforce QIPP programme including the North West part of the national workforce work stream.

17.5 Workforce planning

This section undertakes the consolidation and production of the workforce plans for the North West NHS from the plans of our constituent organisations for the Operating Plan. Their key roles include:

- Improve workforce planning, productivity and data integrity through better systems and processes across the North West.
- Development of an SHA-wide workforce strategy and detailed pathway plans.
- Assure a system able to deliver a safe, affordable and sustainable workforce for the NW through the provision of analytical reports and input into performance conversation.
- Improve workforce development and workforce decision making across the NW through a programme of workforce capability and capacity building.
- Develop the knowledge exchange function of eWIN to include both health and social care workforce practices.

The eWIN project provides a portal for workforce analysis and is now offered through AQuA. It has over 1000 users and two other SHAs have now signed to take the product

17.6 Workforce modernisation

This team now hosted as a modernisation hub by Five Boroughs Partnership FT, leads promotion of skill mix, in particular through assistant and advanced practitioners. Their roles include:

- The provision of new roles/skills to meet local demand, achieve QIPP support HIEC priorities and implement policy initiatives.
- Working with NW organisations to ensure a sufficient supply of non-traditional roles to meet NW demand as described in the pledges. This includes increasing the number of Assistant Practitioners by 300 per year, Advanced Practitioners by an additional 100 and non-medical consultants by an additional 8-10.
- Facilitate local workforce redesign/best use of skill mix via Workforce Modernisation Networks and Workforce Improvement Managers.

17.7 Health and well being for NHS staff

This work develops on from the Boorman report on health and well being of NHS staff. It supports one of the QIPP workforce targets of reducing sickness and absence across the NW NHS organisations:

- Develop infrastructure and processes to support a healthy NHS workforce
- Follow up actions and support process improvements in the light of findings from the Boorman Review

17.8 Postgraduate medical and dental education

The two deaneries:

- North Western covering Greater Manchester except North Cumbria (N. Cumbria trainees are managed by the North East deanery).
- Mersey covering Merseyside and Cheshire.

The deaneries manage directly the education and training of all the junior doctors in training. This encompasses:

- Recruitment
- Management of placements and rotations
- Formal appraisals(Annual Review of Competence Progressions)
- Quality assurance of training
- Training the trainers
- Quality assurance of learning environments in each trust education provider
- Liaison with GMC for approval of posts.

The deaneries are split into hospital and General Practice and hospital is further split into Foundation (the first two years) and higher specialist training. The deaneries sign off doctors for registration at the end of the first Foundation year on behalf of the medical schools

The trainees are split into schools based upon specialties; each school has a training programme director and head of school. All these appointments are part time depending on the size of the school and are consultants or GPs in practice. The schools also have a specialty training committee made up of consultants or GPs in the speciality.

Both deaneries have been changing the mix of trainees in line with national guidance, moving away from hospital specialties particularly surgical specialties and increasing GP numbers. The North West remains under doctored for GPs in 14 of the current PCT areas. This movement has been minor this year but is expected to accelerate over the next two years. Nationally there have been 6800 doctors entering specialty training from Foundation training numbers of approximately 6500 which in turn mirrors medical school output. The intention is to move to 6500 trainees of which half are GPs. Currently 2800 trainee places are GPs. The current difference has been made up of overseas doctors and other doctors from previous years.

Both deaneries use lead employers to manage the employment of the junior doctors on behalf of the SHA. Both deaneries also organise dental training, most of which takes place as a single year of vocational training in a community practice.

Please see table 12 for the numbers at each level of training for each deanery.

17.9 Education commissioning

There are three key areas for the education commissioning team:

- Commissioning of nursing, midwifery, allied health professions and healthcare scientists education from Universities.
- Management of learning and development agreements with trust education providers for placements and other workforce development activities
- Development of the wider workforce

17.10 Commissioning of nursing, midwifery, allied health profession and healthcare scientist education from universities

This comprises the development of an annual commissioning plan for the North West based upon the workforce plans produced by the workforce strategy team.

These commissions are let through formal contracts with each University and include both pre registration and post registration (continuing professional development). All activity with any of the Universities goes through the contracts. The contracts are managed through:

- Formal regular contract monitoring information analysis.
- Regular contract monitoring meetings.
- Involvement of trusts in partnership with each University for placements.
- Quality assurance of education provision within the contract.
- Strategic development of education capacity.
- Day to day management of the contracts.

NHS NW is also the lead SHA on behalf of the 10 SHAs for the NHS Bursary Unit which pays student bursaries. The Bursary unit budget is £502m, of which the NGS NW share is £75m. This liaison role has widened because the bursary scheme has gone through a formal consultation process to change, which is still with Ministers for decision.

There are a number of changes taking place under the development of nationally led programmes such as Modernising Nursing Careers, Modernising Allied health professional careers and Modernising scientific careers which will enable transformation of the workforce locally and will have a material impact on contracts.

For example, nursing will be degree only for new entrants from August 2013. On average across England, it has been 35% degree and 65% diploma. In the North West we are now at 30% diploma and 70% degree but there are significant risks within this change to workforce supply and the nature of nursing in the future.

It is also through this commissioning process that changes such as the required increase nationally of 4200 health visitors will be able to be managed locally.

The numbers of commissions by profession is set out below. Most are for three year programmes and therefore the actual number of students is three times these figures. Please see table 13.

17.11 Management of learning and development agreements with trust education providers for placements and other workforce development activities

The team has responsibility for the commissioning of placements for all healthcare professions across the North West. This includes detailed liaison with the medical and dental schools for undergraduate medical and dental education placements. The learning and development agreements cover all education and training financial flows to trusts and are legal contracts with Foundation Trusts and independent sector providers.

There has been a review over the last four years about extending placements tariffs from just medical and dental students as now, to standard tariffs for each profession. This was due to begin implementation from April 2011 but has been postponed till April 2012 to enable further consideration to be given to transition. A number of teaching trusts currently receive far more support than the determined level and would lose funding as a result of these changes.

The learning and development agreements also cover the quality assurance for placements for all types of professions and involves liaison with the relevant regulatory bodies.

A number of workforce development activities are organised across the North West, hosted by a trust which also manages the steering group but which are commissioned by the education team. These include pharmacy workforce development, Allied Health professional and Healthcare scientist networks and the NW Health Care Libraries unit

17.12 Wider workforce

This area of work covers provision of vocational qualifications and apprenticeships for the unregistered workforce. This is an important part of developing skill mix as well as ensuring a widening access route for people with lower levels of academic qualifications to pursue health careers. It also covers the cadet programme

This work is commissioned from the skills academy for Health North West, who undertake the local training needs analysis with trusts and undertake the brokerage of NVQ and apprenticeship programmes with further education colleges or local providers

17.13 HR Strategy

The HR strategy team work to support the Human Resources function across the North West, particularly capacity and capability building. This includes

- Work with the North West Social Partnership Forum to engage staff side partners in the delivery of the SHA's strategic objectives
- Manage the submission of the VSM remuneration and severance proposals to the NHS North West Remuneration Committee.
- Ensure continued roll out of Electronic Staff Record across NHS North West to maximise system efficiencies
- Delivery of regional and sub regional employment clearing house arrangements to minimise risk of redundancies within the NHS in the North West
- Provide support to NHS organisations on the development of "back office" shared service arrangements and health economy employment contracts where deemed appropriate
- Facilitate the 'Towards World Class HR&OD Programme' which assesses organisational performance, benchmarks within the NHS in the North West and shares best HR practice to enhance HR & OD's contribution as a function
- Evaluation of the seasonal flu programme and development and delivery of the current year programme
- Development of shared occupational health services across the North West to provide better support
- Commissioning the NW leadership academy including contract management

17.14 Developing the Healthcare workforce arrangements

During consultation on the proposals in *Liberating the NHS: Developing the healthcare workforce*, NHSNW canvassed opinion on the most appropriate future workforce education arrangements in the North West. There was broad support for the option to provide three networks (Cheshire & Merseyside, Cumbria & Lancashire and Greater Manchester) maintaining the two Deaneries working with their respective networks and a small central support function. This has now been confirmed following consultation in August.

17.15 Provider Skills Network Programme Board

A Programme Board has been established to oversee the setting up of the proposed new Provider Skills Networks (PSNs). In addition to the senior members of the SHA Workforce Directorate and Deaneries, membership of the Board includes healthcare provider representatives. This provides good geographical and organisational representation from across the North West.

Although detailed guidance from DH is not expected until the autumn the importance of having locally driven healthcare employer engagement, in workforce development education and training, is clear. The North West Workforce and Education Networks Programme Board, agreed to proceed with establishing the three proposed local networks in the North West (Cheshire & Merseyside, Cumbria & Lancashire and Greater Manchester) so that they can be fully involved in agreeing the workforce strategy and education commissioning plans for 2012/13 and be ready to take on responsibilities during next year, subject to DH guidance.

The governance and membership arrangements for the Networks are being developed (see model in table 13).

17.6 North West stakeholder forum

A North West Stakeholder Forum has been established to maximise contribution from those stakeholders who are both sufficiently knowledgeable and committed to the objective of developing workforce and education issues, as well as those both employed by the NHS and our NHS partners.

Stakeholder forum members will be responsible for communicating and consulting with the group of organisations they represent and championing participation in workforce and education activities and issues. Equally, forum members should anticipate regular communications and dialogue with Programme Board members, with the aim of encouraging inclusivity in decision making and outcomes.

18. COMMISSIONING DEVELOPMENT

Within the North West we currently have 48 Clinical Commissioning Group (CCG) consortia that cover the geographical patch, all of whom have been approved as Pathfinders. The majority of the consortia have broad alignment with Local Authority boundaries and have representation on local Health and Wellbeing Boards alongside other key local stakeholders.

As we proceed through the CCG authorisation process it is expected that the number of consortia will reduce as some consortia join together to enable them to be successful in the authorisation process.

PCT Clusters either have, or are in the process of, setting CCGs as formal sub-committees of their (or their PCT) Boards to enable the consortia to take on responsibility for delegated budgets as we move through this year's 'dry run' process. The Dry Run process will ensure that the 2012/12 contracting cycle is owned and led by the clinical commissioners.

A small number of GP practices are still not included within a CCG. In these cases the local consortia are working with these practices to agree a way forward for them to participate.

All CCG Consortia are current proceeding through Phase 1 of the CCG Authorisation process which requires the SHA to undertake a risk assessment of each consortia's geographical make-up, membership model and viability of the CCG to undertake the full range of responsibilities. This is likely to lead some CCGs needing to review their current organisational arrangements.

To support CCG Consortia in carrying out their commissioning responsibilities, Commissioning Support Organisations (CSO) are being developed across the region. The SHA and Clusters are currently working together through the North West network to agree the local timelines and operating model for effective delivery.

19. FOUNDATION TRUST PIPELINE

There are fourteen Trusts still to achieve Foundation Trust status in the North West; eight Acute Trusts, three Community Trusts, two Mental Health Trusts and the Ambulance Trust.

All relevant trusts have Accountability Agreements in place and Tripartite Formal Agreements have been agreed and signed for ten of the Trusts (*as at 16 September 2011*) The Tripartite Formal Agreement sets out how a trust will reach the bidding point and meet all the requirements of the Foundation Trusts' regulator, Monitor, with regard to financial stability and quality of service.

The Provider Development Team at the SHA has been helping to ensure the future of these organisations. There is regular contact between the team members and the trusts for whom they are responsible and with the Department of Health who will ultimately agree the Foundation Trust bid proposals. The role of the Provider Development team is to ensure that the pathway to development as a Foundation Trust is as smooth as possible and to consistently monitor the performance of each trust along the route, reporting both to the SHA and to the Department of Health.

The 14 North West Trusts are : Pennine Acute Hospitals NHS Trust ; East Cheshire NHS Trust ; North West Ambulance Service NHS Trust ; St Helens and Knowsley Teaching Hospitals NHS Trust ; North Cumbria University Hospitals NHS Trust ; Trafford Healthcare NHS Trust; East Lancashire Hospitals NHS Trust ; Bridgewater Community Healthcare NHS Trust ; Southport and Ormskirk Hospital NHS Trust ; Wirral Community NHS Trust ; Liverpool Community Health NHS Trust ; Mersey Care NHS Trust ; Manchester Mental Health and Social Care Trust ; Royal Liverpool and Broadgreen University Hospitals NHS Trust .

In the cases of Trafford Healthcare NHS Trust and North Cumbria University Hospitals NHS Trust, it is expected they will become Foundation Trusts through a successful acquisition or merger with another Trust and not in their own right.

20. TRANSFORMING COMMUNITY SERVICES

The North West Provider Development Board agreed to undertake a post integration review of community services, six months after transfer of services and this is now underway (September 2011). The review covers the following areas:

- Lessons learned from the transfer
- Issues regarding quality of services post transfer
- Transformational opportunities six months post transfer

The report will be available in December 2011. It will be followed by an event across the North West in early 2012 to further share and build on the learning gained from the review and the report.

21. RESEARCH AND DEVELOPMENT

NHS North West supports research and development by facilitating NHS organisations and universities working collaboratively to develop and secure high quality, innovative bids for research funding and speed up the process of taking research breakthroughs to improve NHS patient care. Our work programme has spanned:

- Influencing national policy.
- Strategic engagement at a regional level.
- Collaborating with other European Regions.

Our successes include:

- Contributing to the Academy of Medical Sciences' review on the regulation and governance of UK health research.
- Contributing to the development of the National Institute for Health Research (NIHR) Research Support Services Framework of good practice and standard procedures to facilitate consistent local research management.
- Piloting the NIHR Clinical Research Network (CRN) North West Exemplar Programme to demonstrate how the NHS, NIHR CRN and the pharmaceutical industry can work collaboratively to match or exceed clinical trials performance consistent with the best standards in Europe.
- Hosting a national workshop to look at how the emerging commissioning structures could work with other parts of the system effectively to support the conduct of high quality research and ensure the great progress made with research in recent years is maintained in the transition.
- The establishment of the NW People in Research Forum to support researchers in involving and engaging patients and the public in health research.
- Developing the catalyst process to facilitate new collaborations and innovative bids for research funding.
- Supporting the development of the NW R&D workforce.
- Raising the profile of the world-class research infrastructure and expertise in the North West.
- Delivering a work programme to increase the number of successful bids for EU funding, including bid writing workshops and the development of inter-regional agreements with Catalunya (Spain), Veneto (Italy) and Flanders (Belgium)

22. RECONFIGURATIONS

There continues to be a significant level of service reconfiguration activity across the North West. All existing reconfiguration schemes have been assessed against the four service reconfiguration tests, as follows:

- Alder Hey Children's Hospital – new hospital build
- Royal Liverpool and Broadgreen University Hospitals – new hospital build
- Meeting Patients Needs – East Lancashire Acute Hospital services reconfiguration
- Cheshire & Wirral Mental Health – in-patient services reconfiguration
- Cumbria – PCT closer to Home & North Cumbria University Hospital new hospital build
- Lancashire mental Health – in-patient services reconfiguration
- Making it Better – Greater Manchester paediatric, maternity and neonatal services
- Healthy Futures – North East Manchester Acute Hospital services reconfiguration
- Out of Hospital – Liverpool Primary Care reconfiguration

All have been agreed at SHA Board level as meeting the four service reconfiguration tests except the Cumbria 'Closer to Home' scheme (for which work on the affordability of the Clinical Strategy is incomplete). Learning from the four tests assessments has been shared with North West NHS Chief Executives.

The 'Meeting Patients Needs' acute hospital services reconfiguration programme in East Lancashire was implemented in full and the programme closed in April 2011. SHA monitoring of implementation will continue where previously agreed; specifically of 'Making It Better' which is due to complete implementation in 2012.

SHA assurance and approval is planned in relation to future consultations. These include:

- Cheshire – Cheshire & Merseyside Vascular services consultation planned for December 2011 – February 2012.
- Cumbria – following finalisation of Clinical Strategy further formal public consultation required if plans vary from those which were agreed at the conclusion of the previous 'Closer to Home' Consultation. Potential Cumbria & Lancashire Vascular services consultation.
- Greater Manchester – 'Healthy Futures' further consultation on cardiology and stroke rehabilitation services planned for October 2011. Public consultation expected in 2012 on changes to services at Trafford General Hospital arising from the planned Trafford Healthcare Trust acquisition.
- Lancashire – Potential Cumbria & Lancashire Vascular services consultation. Mental health services consultation planned for 2012. Mental health services consultation planned for 2012. Fylde Coast Consultation on migration of hospital services to primary care facilities planned (timing to be determined).
- Merseyside – Cheshire & Merseyside Vascular services consultation planned for December 2011 – February 2012. Public consultation expected (date to be determined) on cancer services. 'Mini-consultations' required for phases of Liverpool 'Out-of-Hospital' changes in primary care.

No North West schemes are currently subject to Secretary of State referral/Independent Reconfiguration Panel review.

23. ESTATES AND CAPITAL

23.1 Investment Programme

In the NW seven major PFI schemes totalling circa £1.5 billion have already been built and are operational:

- South Manchester Foundation Trust (Wythenshawe)
- Central Manchester & Manchester Children's Foundation Trust (MRI)
- Salford Foundation Trust (Hope)
- Tameside Foundation Trust (Tameside)
- East Lancashire NHS Trust (Blackburn and Burnley)
- St Helens & Knowsley NHS Trust (Whiston and St Helens)
- North Cumbria NHS Trust (Carlisle)

A further four major schemes are in procurement totalling over £900m:

- PFI - Royal Liverpool & Broadgreen NHS Trust (Liverpool) £540m
- PFI - Alder Hey Foundation Trust (Alder Hey) £250m
- LIFT - MerseyCare NHS Trust (Liverpool x2) £50m
- Public capital – North Cumbria Trust (West Cumberland) £90m

For the full investment portfolio please see Appendices Table 14 for the NW (including the schemes listed above) totals over £1 billion with an additional revenue consequence of circa £55m.

Organisations and health economies can only proceed with capital investments where they can continue to demonstrate essential need, value for money across the health economy, a sustainable financial position and ability to deliver QIPP targets, and a realistic and deliverable affordability plan. Schemes included in the investment portfolio listed above will need to be continually assessed against these criteria.

23.2 Revenue support for major schemes

Transitional revenue support for the major schemes (operational and planned) is funded from specific DH funding in the SHA central bundle. Any diminution in this funding will have a significant impact on organisations with operational schemes and could adversely affect the approval of the schemes in procurement. Please see table 15 for the planned commitments in the NW.

23.3 Public capital

The NW has managed the capital budget in such a way that key strategic and operational issues have been positively addressed and under-spends have been kept within 5% of budget.

23.4 QIPP - estates

The QIPP estates work-stream has to find a £169m cash-releasing saving. £39m of this target has been realised to date.

24. OTHER AREAS OF NOTE

24.1 Informatics

NHS North West Informatics Directorate has provided not only strategic direction, but also tangible support to NHS providers, whether they are implementing NPfIT solutions or QIPP Informatics innovations in general. As a consequence of the transition and uncertainty around job security, the Informatics Directorate's capacity and capability is being steadily reduced during 2011/12 and into 2012/13. There are therefore tangible risks about our ability to support organisations going forward, particularly around the exploitation of Informatics innovation to support QIPP.

There remains a continuing need to pursue the development of collaborative alliances between Trusts to support the creation of effective local Health Informatics Services. The concept of individual Trusts providing comprehensive services is not viable going forward.

Uncertainty continues to exist around the LSP contract with CSC and how this will potentially change going forward. This issue applies to all six existing SHAs covered by this contract.

Informatics successes are particularly visible in our coordinated approach to QIPP, which has driven forward delivery in areas such as Tele-Stroke, Digital Dictation, Video Conferencing to support clinical networks and support to redesign of patient pathways (Map of Medicine).

24.2 Communications and engagement

Nationally and regionally there are concerns around the loss of communications and engagement capacity which in turn has led to further concerns about our resilience in this important area of our business. Greater scrutiny of the NHS by a wide range of stakeholders and other interest groups and an increased expectation in the involvement of the public in decision making requires higher quality communications

The existing in-house model with 'everyone doing everything' is not sustainable for the future. This is why we are working on "hub and spoke" shared service model for NHS communications and engagement. This work is being undertaken in connection to both the design work being undertaken to agree a resilient communications and engagement infrastructure to take us through transition and the on other commissioning support functions which focus on designing the future for 2013 and beyond.

24.3 Fluoridation

The Health and Social Care Bill sets out the intention that the responsibility for initiating new schemes will move to local authorities. In addition to this change in statutory responsibility there are other issues which would act as significant barriers to NHS North of England undertaking a consultation exercise for a new scheme in the North West.

- It is unlikely that the current timescales for NHS service reorganisation will permit NHS North of England to complete a consultation exercise.
- In transition it is unlikely that NHS North of England would have the workforce capacity and capability to support a high quality, authoritative consultation exercise.

At the Board meeting of NHS North West on 7th September 2011, it was recommended that on these grounds alone a consultation on a new fluoridation scheme in the North West would not be actively pursued prior to abolition of the SHAs and that all documentation on the feasibility assessment of a new scheme will be handed over formally to the successor body/bodies.

In addition the monitoring processes established by NHS North West for its schemes need to be aligned with those used for the scheme in the North East and NHS North of England should aim to negotiate an agreement with United Utilities for the renewal/refurbishing of the two Cumbria plants which offers best value for money.

24.4 Global health

NHS North West has been one of the leading SHAs in the promotion of the coalition government's Health Partnership Scheme (and the previous government's Health Links Scheme). This area of policy has a high profile and now has a budget of £5m per year attached to it. It has also helped co-found the quarterly joint SHA and DH International Health Meeting. It has supported many trusts and individuals to develop their links with the developing world and seek a share of the funding for such activity. It has done this through regular communications and annual meetings to promote partnerships with NHS employees and with the boards of NHS bodies.

Most recently it has started to have some success at linking together in partnership Higher Education Institutes and the NHS in these endeavours (e.g. Manchester Academic Health Science Centre, Health Innovation Education Clusters, etc.). It wishes to find a way to maintain the leadership in this area and there is an appetite to create a network/develop a movement to share best practice in this area.

It has also had some minor success to seek to contribute to government income by selling local NHS expertise to middle income countries but the initial consultancy has not yet been taken through to a full project. It will be important to keep these activities going within the new SHA Cluster to support DH, DFID and the Government in general to contribute to the Millennium Development Goals (MDG).

24.5 Armed Forces.

The health of the Armed Forces, veterans and their families is a high political priority. The North West makes a significant and disproportionately large contribution to the recruitment of regular and reserve forces for the Armed Services. However it has a limited regular forces component (two army units and one headquarters), this creates very limited infrastructure for the large number of veterans that settle back in their home areas. The SHA has built on its previous formal linkages to become an early adopter of a vibrant Armed Forces Forum, which is chaired by a PCT Cluster Chief Executive and has as its regional champion a local GP and (TA) Ex Commander of the Field Hospital at Camp Bastion in Afghanistan. It has a contract in place for IAPT for veterans (planned for a launch on 11 Nov 2011 (Remembrance Day)) and is in the midst of overseeing the procurement of an innovative non-clinical holistic ("wrap around") service to provide the necessary social and other support (e.g. employment, housing, finance, criminal justice etc.) needed to optimise the effect of the IAPT intervention. It will be important to keep these activities going within the new SHA Cluster to aid the delivery of the DH agenda in this field.

The Commissioning and the Performance Directorates also have a role in improving the offer of the NHS to the Armed Forces Community (Veterans and families of Regular service personnel). It is doing this both through the Armed Forces Forum as mentioned above and through the PCT Clusters as part of normal commissioning and performance assurance. This support at SHA level is also being used to ensure the proper evaluation of various pilot projects and to support common information gathering and dissemination across the North West.

25. CONCLUSION

NHS North West leaves a legacy of strong performance and delivery, which gives confidence that NHS services across the region will continue to grow from strength to strength. This is reflected in the report from the Department of Health (DH) in Spring 2011, which formed part of their Transition Assurance Visits.

The aim of these visits was to assess each region's state of readiness for the transition, and feedback from the national team helped to strengthen the strategic focus for the SHA and the North West NHS as a whole.

The DH feedback noted that there were overall improvements in performance. This was in spite of a very challenging winter period, and the positive impact of the SHA's leadership during this time was highlighted. It was recognised that the overall financial position across the NHS in the North West remains strong.

Staff survey results for North West NHS organisations were the second highest in the country in 2010, and the DH recognised this as a significant achievement. The DH also reported that the Leadership Academy is highly valued by the system, which will be critical to ensuring sufficient leadership capacity during the period of transition and beyond.

The DH team noted the impressive cohesion and commitment in the North West to delivering the NHS reforms. The SHA leadership in supporting commissioning development was reported, across the region. The SHA has played a prominent role in ensuring local government, public health and other stakeholders are playing an active role in driving the reforms.

In what has been a remarkable and challenging year for our own organisation and for the NHS within the region, our overarching vision has remained the same – to ensure that the people of the North West receive world class health care delivered in the right place, at the right time, to achieve the right outcomes.

26. ANNEXES

Table 1

Board member		Status
Sally Cheshire	Voting	Chair
John Caldwell		Non-executive Director
Alan Foster		Non- executive Director
Denis Lidstone		Non-executive Director
Mark Winstanley		Non-executive Director
Mark Ogden		Chief Executive
Jane Cummings		Chief Nurse/Deputy Chief Executive
Ann Hoskins ***		Acting Regional Director of Public Health/Director Children, Young People & Maternity
Jane Tomkinson **		Director of Finance
Dr. Mike Cheshire	Non-voting	Medical Director
Elaine Darbyshire		Director of Strategic Communications
Chris Jeffries *		Acting Director of Workforce & Education
Joe Rafferty		Director of Commissioning Development
Caroline Shaw		Director of Provider Development
Mandy Wearne		Director of Service Experience
Dr. Ruth Hussey		Seconded as DPHO to Public health England Transition Team
Jo-Anne Wass		Seconded to the Department of Health

* was Dean Royles: currently filled on a non-voting basis by Chris Jeffries

** was Mark Ogden: Interim appointment in place of Mark Ogden

*** Ann Hoskins – acting during Ruth Hussey’s secondment

Table 2

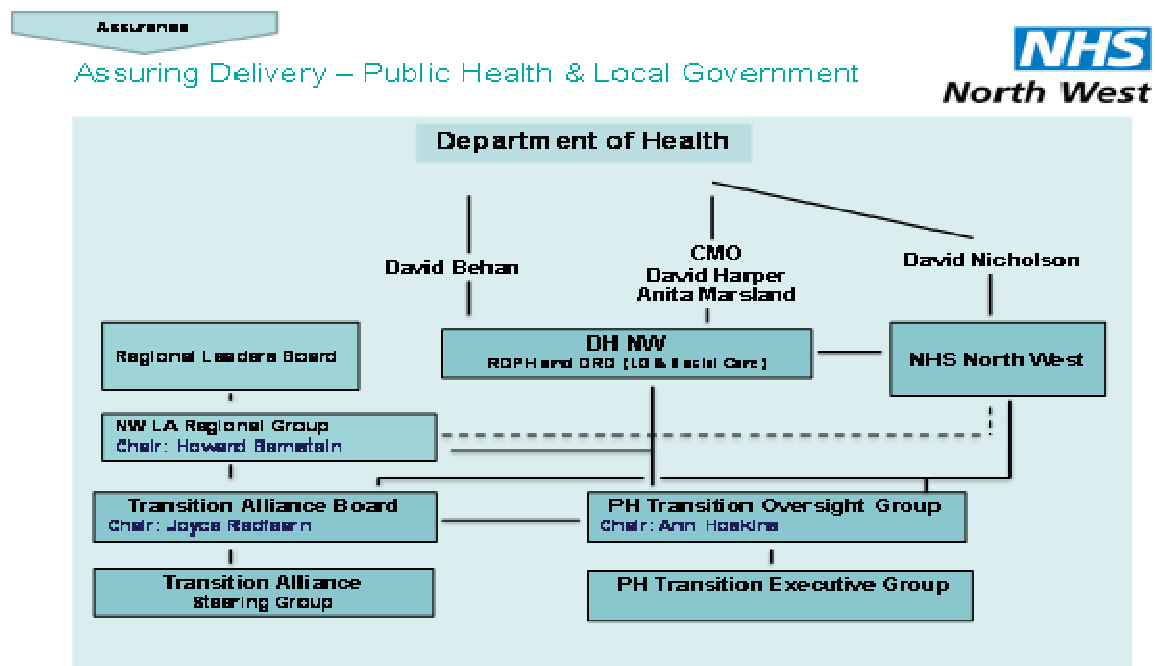


Table 3

Cluster	2011/12			2012/13 to 2014/15			Total 2011/12 to 2014/15		
	1 year			3 years			4 years		
	PCT Efficiency Plans	Efficiency Build into Provider Contracts	Total Cash Releasing Savings	PCT Efficiency Plans	Efficiency Build into Provider Contracts	Total Cash Releasing Savings	PCT Efficiency Plans	Efficiency Build into Provider Contracts	Total Cash Releasing Savings
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cheshire	66,407	49,982	116,389	124,538	147,535	272,073	190,945	197,517	388,462
Cumbria	28,100	22,048	50,148	37,700	62,781	100,481	65,800	84,829	150,629
Greater Manchester	137,456	127,347	264,803	231,110	363,950	595,060	368,566	491,297	859,863
Lancashire	66,531	73,351	139,882	153,986	177,124	331,110	220,517	250,475	470,992
Mersey	62,720	62,072	124,791	70,399	172,837	243,236	133,119	234,909	368,027
Total	361,214	334,800	696,013	617,733	924,227	1,541,960	978,947	1,259,026	2,237,973

Table 4

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
	Annual Accounts					Forecast
	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)
North West	£m	£m	£m	£m	£m	£m
PCT	(2.432)	66.652	49.439	27.533	39.720	53.659
SHA	206.355	206.829	245.142	157.339	175.418	139.341
Sub-total	203.923	273.481	294.581	184.872	215.138	193.000
Trust (non-FT) *	(19.676)	36.093	24.392	15.018	21.139	26.973
Total	184.247	309.574	318.973	199.890	236.277	219.973

* figures shown are adjusted where appropriate for 'technical' items such as impairments

Table 5

Organisation	Risk Rating	Total revenue resource limit £ '000	(Over)/under spend to month 4 £ '000	(Over)/ under spend Forecast	
				£ '000	%
Cheshire Cluster					
Central & Eastern Cheshire	●	718,361	1,132	3,444	0.48%
Warrington	●	320,929	515	1,543	0.48%
Western Cheshire	●	419,468	658	1,975	0.47%
Wirral	●	628,832	1,329	2,000	0.32%
Cheshire Cluster Total		2,087,590	3,634	8,962	0.43%
Cumbria					
Cumbria	●	858,658	67	4,146	0.48%
Cumbria Cluster Total		858,658	67	4,146	0.48%
Manchester Cluster					
Ashton, Leigh and Wigan	●	582,501	871	2,726	0.47%
Bolton	●	495,525	212	1,000	0.20%
Bury	●	316,922	75	250	0.08%
Heywood, Middleton & Rochdale	●	402,504	631	2,000	0.50%
Manchester	●	1,042,092	0	1,000	0.10%
Oldham	●	415,233	668	2,015	0.49%
Salford	●	487,067	1,382	2,260	0.46%
Stockport	●	472,670	554	667	0.14%
Tameside and Glossop	●	433,871	480	1,000	0.23%
Trafford	●	383,999	362	1,799	0.47%
Manchester Cluster Total		5,032,384	5,235	14,717	0.29%
Lancashire Cluster					
Blackburn with Darwen	●	291,947	471	1,372	0.47%
Blackpool	●	303,119	467	1,399	0.46%
Central Lancs	●	786,032	1,216	3,653	0.46%
East Lancs	●	700,804	1,108	3,324	0.47%
North Lancs	●	579,805	732	2,200	0.38%
Lancashire Cluster Total		2,661,707	3,994	11,948	0.45%
Mersey Cluster					
Halton & St Helens	●	597,531	169	500	0.08%
Knowsley	●	338,795	820	1,619	0.48%
Liverpool	●	1,042,661	1,983	9,217	0.88%
Sefton	●	542,195	849	2,548	0.47%
Mersey Cluster Total		2,521,182	3,821	13,884	0.55%
PCT Total		13,161,521	16,751	53,657	0.41%

Table 5 continued

Organisation	Risk Rating	Total income £ '000	(Over)/under spend Year to date £ '000	(Over)/ under spend Forecast	
				£ '000	%
East Cheshire NHS Trust	●	167,033	5	250	0.15%
East Lancashire Hospitals NHS Trust	●	379,229	797	1,889	0.50%
Manchester Mental Health And Social Care NHS Trust	●	100,887	692	983	0.97%
Mersey Care NHS Trust	●	190,050	1,507	4,034	2.12%
North Cumbria University Hospitals NHS Trust	●	208,792	33	1,000	0.48%
North West Ambulance Service NHS Trust	●	257,047	3,861	1,500	0.58%
Pennine Acute Hospitals NHS Trust	●	570,709	365	3,502	0.61%
Royal Liverpool Broadgreen Hospitals NHS Trust	●	401,148	1,633	5,528	1.38%
Southport And Ormskirk Hospital NHS Trust	●	171,883	4	1,693	0.98%
St Helens And Knowsley Hospitals NHS Trust	●	259,921	83	250	0.10%
Trafford Healthcare NHS Trust	●	71,690	164	482	0.67%
Subtotal		2,778,389	9,144	21,111	0.76%
Ashton, Leigh & Wigan Community Health Care Trust	●	159,754	449	1,666	1.04%
Liverpool Community Health Care NHS Trust	●	142,402	1,290	3,451	2.42%
Wirral Community Health Trust	●	61,841	283	704	1.14%
Subtotal - Community Trusts		363,997	2,022	5,821	1.60%
Grand total – Trusts		3,142,386	11,166	26,932	0.86%

Note: Financial risk 'RAG' ratings have been made based upon an assessment of financial plans and CIP performance to month 4.

Table 6

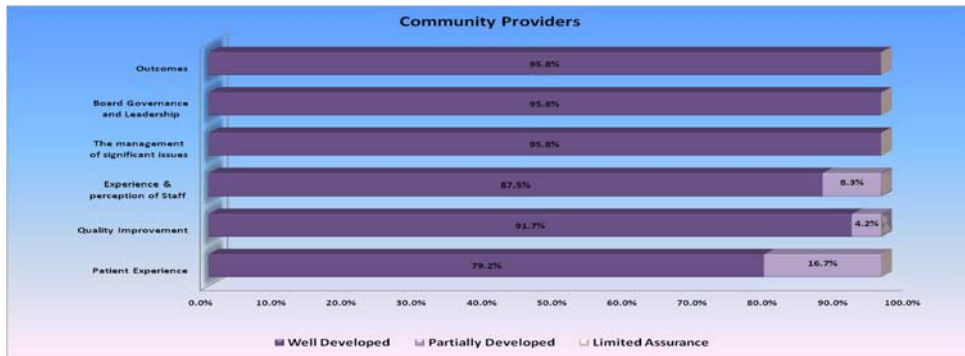


Table 7

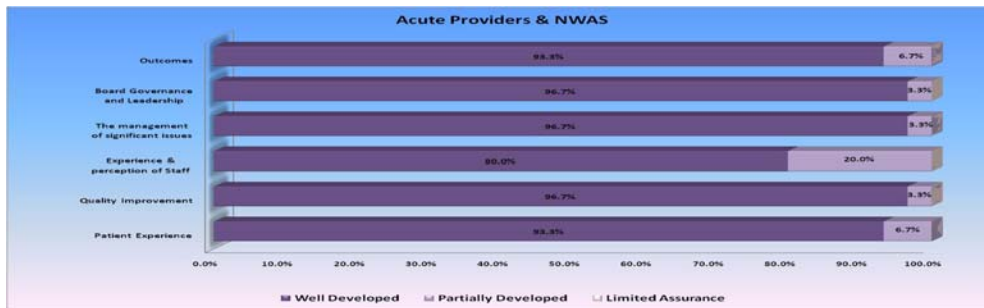


Table 8

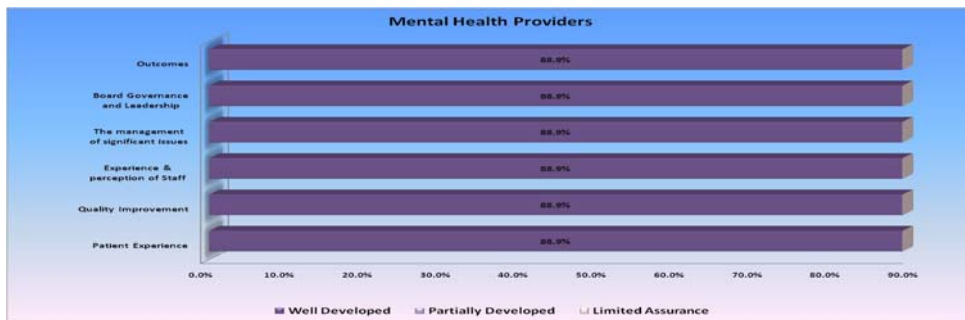


Table 9



Table 10 safety express

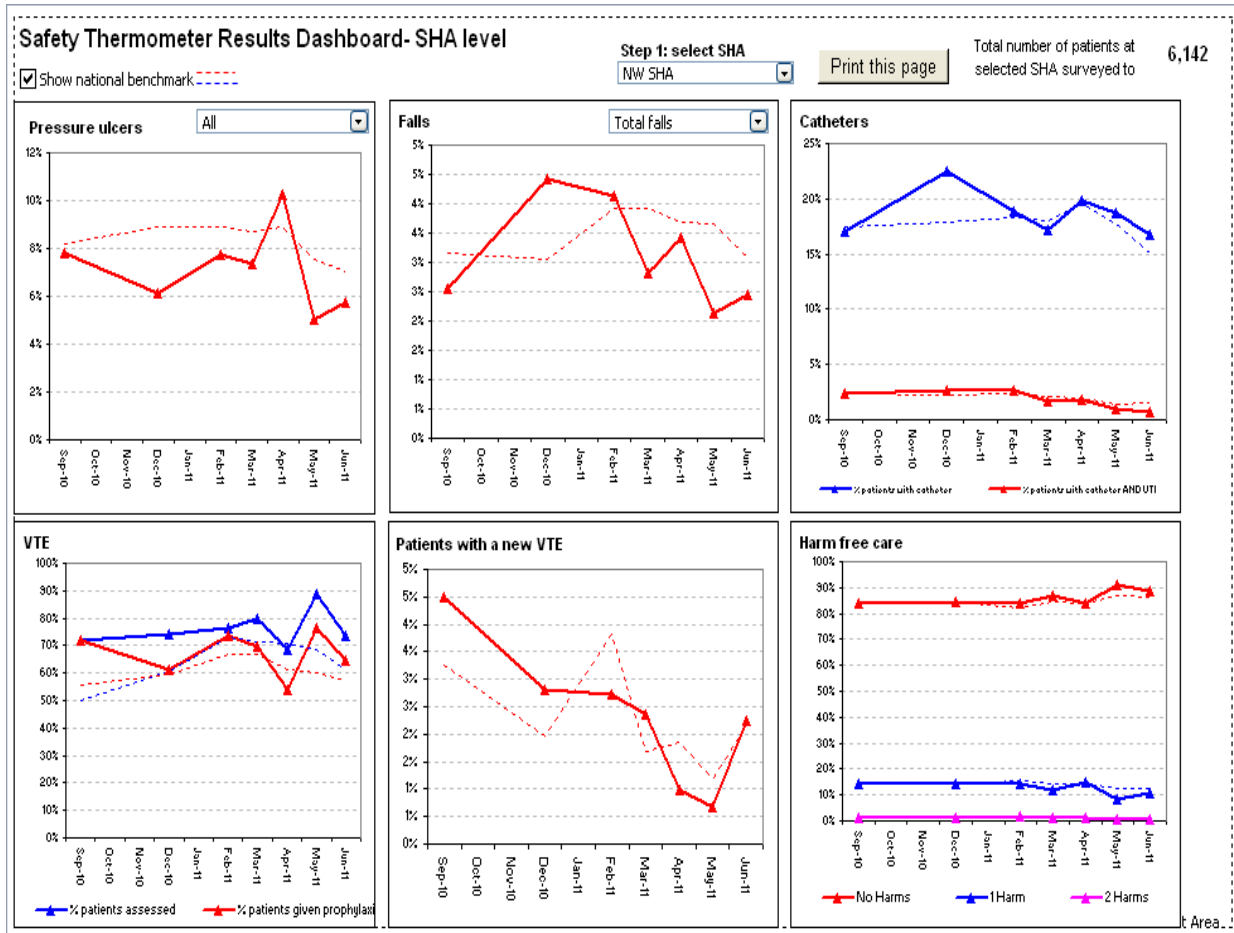


Table 11

		Measure	Current Position	Trend	Movement (+/-)	% Change
Staffing	Staff in Post	FTE	159,664	↓	-385.68	-0.24
	Managers	FTE	5,269	↓	-56.76	-1.07
	Starters	FTE	689	↓	-1,082.73	-61.12
Performance	Sickness Absence	%	4	↑	0.17	N/A
	Turnover	% Annualised	17	↑	0.60	N/A
	Data Quality	Total DQ Errors	261,139	↓	-5110.00	-1.92
Financial	Paybill	£000's	434,800	↑	2,377.88	0.55
	Cost Per Emp	£	2,803	↑	159.86	6.05
	Salary/Basic Pay	£000's	372,936	↓	-712.42	-0.19

Table 12

Deanery	Foundation	Hospital speciality	GP	Dental
NW Establishment	1122	2280	820	105
In post	1110	2199	820	105
Mersey Estab.	671	1695	436	48
In post	671	1632	417	48
Total Estab.	1793	3975	1256	153
Total in post	1781	3831	1237	153

Table 12 continued

Profession	2010/11
Nursing	3358
Midwifery	231
Diagnostic Radiography	176
Dietetics	40
Occupational Therapy	252
Operating Department Practitioners	120
Orthoptics	40
Paramedics	120
Physiotherapy	244
Podiatry	85
Prosthetics & Orthotics	30
Speech & Language Therapy	98
Therapy Radiography	44
Healthcare Scientists & Clinical Scientists	
Cardiovascular Physiology	20
Life Sciences	60
Histo-Imm	3
Clin Biochem	4
Mycology	2
Audiology	2
Med Physics	11
Embryology	3
Genetics	2
Clinical Psychology	72
IAPT High Intensity	118
IAPT Low Intensity	79
Pharmacist	70
Pharmacy Technicians	55
Audiology	41
Healthcare Science Practitioners	87
Healthcare Scientists & Clinical Scientists	27
Dental Therapists	30

Table 13

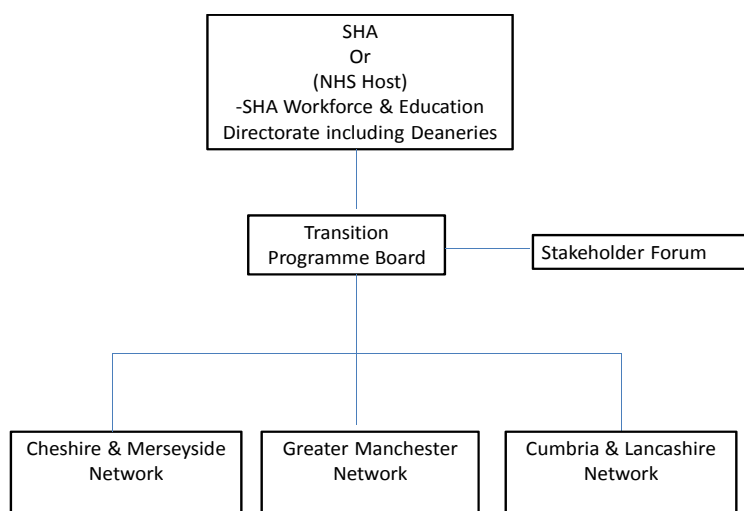


Table 14

	Capital Value £m	Likely Revenue £m
Cheshire	16.8	1.9
Cumbria	105.0	5.2
Manchester	21.8	4.3
Lancs	16.3	0.4
Merseyside	864.9	43.3
Total	1024.9	55.1

Revenue Support and Major Schemes

Table 15

	11/12 £m	12/13 £m	13/14 £m	14/15 £m	15/16 £m	16/17 £m	17/18 £m
Greater Manchester	11.352	2.850	1.900	0.950			
Cumbria			2.250	1.800	1.350	0.900	0.450
Mersey	2.198	8.454	7.265	5.691	20.380	10.935	5.269
Cheshire&Wirral							
Lancashire							
Total	13.550	11.304	11.415	8.441	21.730	11.835	5.719

APPENDIX 4

NHS
Yorkshire and the Humber



NHS Yorkshire and the Humber
Handover Document

30th September 2011

NHS Yorkshire and the Humber: Handover Document

Purpose

1. From October 3rd NHS Yorkshire and the Humber will become part of the NHS North of England SHA Cluster. This handover document provides the new Cluster board a summary of the key issues and challenges to address across the Yorkshire and Humber health system, and an overview of the way that the SHA operates in delivering its duties. It is not intended to provide a comprehensive commentary on all areas of business; rather it is an assessment of the key risks and issues, and areas of focus for the Cluster Board. This will act as annotated agenda for discussions the Cluster Chief Executive designate will have as part of the handover process.
2. The summary information included in this document has been further supported by meetings with individual PCT Cluster Chief Executives and other performance information reported routinely to the Board. A draft has been shared with the Care Quality Commission and Monitor and comments have been incorporated.
3. This document was approved by the Yorkshire and the Humber SHA Board on 30th September. The document focuses on:
 - The background to the region
 - Achievements over the last 4 years
 - Our ways of working
 - Summaries of each health system, providing the key risks and challenges
 - The key priorities for the next 18 months

Background and Context

Population and health

4. NHS Yorkshire and the Humber covers an area of over 15,000 square kilometres and a population of 5.3m. This includes major cities such as Leeds, Wakefield, Sheffield, Hull, York and Bradford, as well a number of large towns and scattered rural populations. There is significant variation in life expectancy across Yorkshire and the Humber. In Hull, men can expect to live for 75 years and women 79 years; in Hambleton men can expect to live for 79 years and in Craven, women can expect to live for 83 years.
5. There are also significant variations in ethnic profiles of populations. Across Yorkshire and the Humber 8% of people are from ethnic minority backgrounds; this varies from less than 2% in Barnsley to 24% in Bradford.

6. There has been a clear focus on improving health outcomes - in particular through the implementation of the 'Staying Healthy' element of the Healthy Ambitions Strategy. Mortality rates for the big killers – cancer and coronary heart disease - are reducing. Infant mortality has also reduced to 5.5% (2007/9).
7. On health inequalities, many local areas are now approaching their target trajectories for all age all cause mortality. However several areas still have broader challenges relating to the underlying conditions with deprivation and lack of economic opportunity being key factors.
8. 'Staying Healthy' identified three main risk factors and work has been focused on addressing these: The current indicators relating to these three priorities show:
 - Smoking prevalence is at 22% (2009/10): just above the England average of 21%. And a reduction of -3% on the previous year.
 - Obesity rates for children (age 5) are reducing and are now below the England average – at 9.2% (2009/10). England rate 9.8%. Rates for age 11 stand at 18.8% an increase of 0.2%. This is half the rate of the national average increase (0.4%).
 - Mortality rates relating to alcohol have decreased for males but increased slightly for females. Hospital admissions for alcohol related harm have increased – this is mirroring national trends.

Healthcare organisations

Commissioning arrangements

9. The old 15 PCT areas have been organised into five PCT Cluster areas:

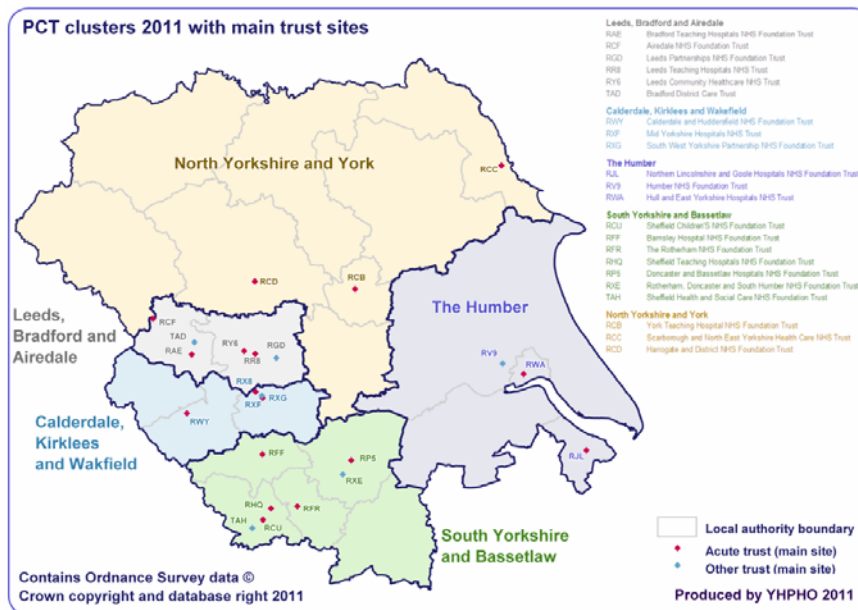
PCT Cluster	Population	Financial Allocation in 2011-12 (£bn)
Airedale Bradford and Leeds	1,295,000	£2.22
Calderdale Kirklees and Wakefield	932,000	£1.66
Humber	922,000	£1.56
North Yorkshire and York	796,000	£1.21
South Yorkshire and Bassetlaw	1,427,000	£2.66

10. At present there are 25 emerging Clinical Commissioning Groups (CCGs) across Yorkshire and the Humber.

Provider landscape

- 15 Acute Trusts (of which 11 are Foundation Trusts)
- 6 Mental Health Trusts and Social Care providers (of which 5 are Foundation Trusts)
- 1 Community Trust
- 1 Ambulance Trust
- 802 GP practices
- 8 Social Enterprises (2 multi-service and 6 service-line based)
- 20 Independent Sector Treatment Centres
- 16 independent mental health providers
- Almost 1,700 care homes as well as a number of home care providers.

Figure 1: NHS organisations in Yorkshire and the Humber



Achievements

11. Yorkshire and the Humber has a strong track record of delivery in the five years it has been in existence. Some of our key achievements have been:

- Significant improvements in service **quality and safety** resulting from the implementation of the recommendations made in *Healthy Ambitions*. These include new regional clinical standards for vascular surgery which have halted

occasional practice and established a new service configuration; a common approach agreed to bariatric surgery; and new workforce competencies developed to enable the industrialisation of brief interventions to reduce smoking, alcohol misuse, and obesity; and an end of life protocol which is being adopted as national best practice. Establishing a major trauma network is a priority for 2011-12. On stroke, performance had historically been poor in the region. New regional standards helped to deliver significant improvement throughout 2010-11 although performance has since levelled off. We are continuing to work hard to ensure these clinical standards are embedded and have just embarked on a peer reviewed accreditation process to designate units for hyper-acute and acute care. We have also had a very strong focus on ensuring that safeguarding structures and standards remain strong during the transition. In particular we have developed minimum safeguarding standards for adults which mirror those for children and have undertaken a significant audit of out of area placements for adults with a learning disability.

- **Health outcomes** in Yorkshire and Humber have been improving in recent years, although some remain below the England average. Mortality rates for cancer and coronary heart disease continue to reduce. Screening and immunisation programmes are performing well and smoking quit rates are delivered to target. Obesity levels (at age 5) now look to have levelled off in Yorkshire and the Humber reflecting the priority given to this work. The public health transition process is well developed and there is a robust picture of risks and opportunities to inform the work programme from now to March 2013.
- Consistent delivery as a region on key operating framework **performance targets**, including the 18 weeks referral to treat (95th percentile 22 weeks versus 23 week standard for admitted patients in June); the 4 hours accident and emergency target (96.8% year to date at September 4th versus 95% standard); and the 62 day referral to treat cancer standard (89.1% at July versus 85% standard). Good progress has also been made on ambulance performance as well as significant improvements on healthcare associated infections. Key performance risks still exist, and currently include the two stroke indicators and C-Difficile hospital acquired infections and we continue to work with our health systems to tackle these.
- Strong performance on **financial management**, both as a statutory organisation in its own right and in terms of performance management of organisations in the system. The SHA has consistently met the control total targets agreed with the DH as part of each year's financial planning process. The financial settlement for

the NHS is challenging and this will impose a greater risk on some organisations than others, but we believe that we are well placed to respond to this challenge.

- The Yorkshire and Humber **Quality Innovation Productivity and Prevention (QIPP) challenge** is £1.63bn between 2011-12 and 2014-15. The primary focus of the SHA has been to provide support to and assurance of health system plans that align QIPP milestones, activity, finance and workforce and have clear provider and CCG ownership. So far we have achieved strong in year delivery of QIPP, including £355m savings in 2010-11 and £157m to date at July in 2011-12.
- The creation of a new **provider landscape**, including transfer of over £800m of community services through the transforming community services programme and established a route map for the remaining non-foundation trust organisations. There are seven organisations within Yorkshire and the Humber that have not been granted Foundation Trust status, comprising four acute trusts, a community trust, a mental health and community trust, and the ambulance service. The challenges that these organisations face vary considerably but as a region we have made good progress in determining future organisational arrangements and overseeing the processes to deliver them.
- We have supported the development of a fit for purpose **Workforce** in Yorkshire and the Humber, ensuring that workforce planning and education commissioning is carried out in an integrated way to deliver productivity while safeguarding quality and safety; and investing close to £500m each year in education and training of the workforce. The total workforce in Yorkshire and the Humber (113,695 excluding GP and practice staff) has reduced by 1,970 full time equivalent or 1.7% over the last year (May-10 to May-11), of which there has been a reduction of 588 FTE (16%) in managers and senior managers. Total NHS infrastructure support staff (non-clinical) has reduced by 1,536 FTE, 6.7% FTE less than May-10. Over the same time period, all qualified midwives, health visitors and school nurses have increased by 29 (1.4%), 8 (0.9%) and 34 FTE (32.4%) respectively. All staff sickness absence was at 4.2% at the end of March 2011.
- We have made significant progress in the development of a new **commissioner landscape**, with 25 emerging CCGs covering an estimated 96% of the population as at early September 2011. Subject to confirmation by the Department of Health of the final cohort of national pathfinders, this will take the number of pathfinders in Yorkshire and the Humber to 21, including one joint pathfinder covering 3 emerging CCGs. We have also made progress in developing commissioning support arrangements with an agreed strategic approach based on a region wide scale analysis.

- The **Yorkshire and Humber Programme for IT (YHPfIT)** has implemented an integrated care record system resulting in the standardisation and simplification of a primary care IT infrastructure across Y&H. Over 60% of GP practices are using the same clinical system; to date 500 GP systems have been deployed through the NPfIT Programme. In addition 100% of prisons, 100% of child health record services, over 90% of community units and over 90% of hospices have been successfully deployed. These developments will provide opportunities for the future transformation of healthcare services supporting QIPP programmes across the region. There is a comprehensive programme of work to deliver the expectations set out in the annual Operating Framework focusing on Exploitation of Detailed and Shared Care Records; Technology and IT Infrastructure to underpin service transformation; Supporting QIPP and other innovative programmes; and Ensuring an appropriate, efficient and professional Informatics workforce.

Ways of working

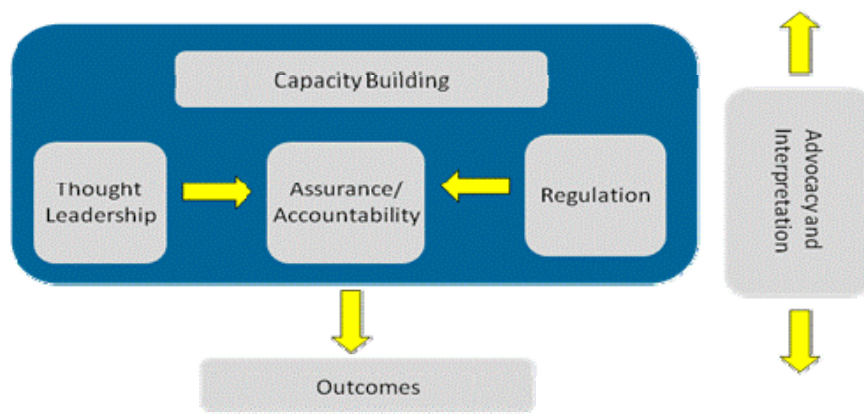
The SHA business model

12. The work of the SHA is organised around 5 functions. These are:

- Thought leadership
- Accountability and assurance
- System regulation
- Capacity building
- Advocacy and interpretation.

13. Figure 2 sets out how these functions fit together to support the delivering of high quality services across our system.

Figure 2: The SHA Business Model



14. The approach in Yorkshire and the Humber is based on the belief that sustainable change requires strong local ownership and leadership. Where possible strategies are developed locally in a way that best fits local circumstances and tailored to local needs. Where necessary work is done once regionally to ensure consistency or make the best use of scarce resources. In character, our approach to planning and delivery is more ‘bottom up within a consistent framework’ than ‘trickle down of a top down plan’.

The Single Accountability and Assurance Process (SAAP)

15. This approach does not mean that we compromise on consistency or robustness. We have developed a Single Assurance and Accountability Process (SAAP) which allows us to develop an evidence-based assessment of current operational performance, co-ordinate planning and intervention, and oversee transitional issues for the organisations in our system. SAAP covers all areas of business, and provides a comprehensive and holistic assessment of the current position, risks and challenges for each organisation.
16. The SAAP process takes stock of performance at cluster and non-FT provider level on a five weekly cycle, allowing us to focus on challenges and issues and enabling us to have a shared understanding of risk and priority areas of action.
17. The SAAP programme board incorporates the executive team and all directorates across the SHA and is used to co-ordinate our interactions with the health system across all areas of business. It meets on a rolling five weekly basis (one cluster per week). This meeting is used to share findings from the SAAP process and agree actions both parties will take to drive improvements. In the following week, the SHA executive team then meets with the cluster team to discuss findings and agree actions.
18. In addition to the regular SAAP meetings, the Yorkshire and Humber Transition and Delivery Board (comprising the SHA Executive team and PCT Cluster Chief

Executives) meets fortnightly to provide collective leadership of the delivery and transition agenda in Yorkshire and the Humber. The Yorkshire and Humber Chief Executive Forum comprises Chief Executives from all organisations in the region plus the SHA Executive team.

19. Sitting beneath the SAAP process are a number of supporting network meetings:

Supporting network meetings

Name	Frequency	Key purpose
1. <u>Directors of Finance and Directors of Performance</u>	Monthly	Chair: SHA Director of performance and finance. SHA Performance team, SHA Finance team plus DoFs and DoPs from all NHS organisations (PCT – only meeting first).
Note: If either of the chairs deem it necessary, this meeting is followed by a separate DoFs and/or DoPs meeting in the afternoon.		
2. <u>QIPP</u>	Monthly (currently being established)	Chair: Regional QIPP programme director. SHA QIPP team plus cluster lead directors for QIPP
3. <u>Medical Directors and Nursing Directors</u>		Chair: SHA Medical Director and Chief Nurse (and team as appropriate)- plus MDs and NDs from all NHS organisation.
4. <u>Directors of Public Health</u>	Monthly	Chair: (DPH NHS Doncaster) RDPH and HPA and PHO Directors engaged and all DsPH in local areas.
5. <u>Directors of Human Resources + workforce</u>	Bi-monthly	Chair: SHA Human resources Director. SHA workforce team plus Directors of HR from all NHS organisations in Y &H. This is followed by an SHA/cluster HRDs meeting, chaired by Rebecca Smith
6. <u>Directors of Commissioning Development</u>	Monthly	Chair: SHA Director of Commissioning Development. SHA CD team plus cluster Directors of CD
7. Directors of IT	6 weekly	Chair: SHA Chief Information Officer with SHA IT SMT attending and Directors of IT (PCT & Providers) from across Y&H Region
8. Emergency Preparedness Executive Group	Quarterly	Chair: SHA Chief Executive + 2-3 Directors. Cluster CEOs plus ambulance trust(s) Cluster Lead officers from each of 3 sub regions

Resilience and emergency preparedness

20. Following lessons identified from the H1N1 flu pandemic in 2009, the SHA Chief Executive established the Emergency Preparedness Executive Group to provide strategic leadership to ensure that the NHS, by working with the 4 Local Resilience Forums maintained proportionate and appropriate planning and response arrangements to manage disruptions to the NHS.
21. This Executive Group has provided written reports to both the SHA Board as well as the Regional Resilience Forum on a quarterly basis.
22. This Group has now evolved from lead PCT to PCT Cluster arrangements with a transitional assurance framework being used to continually review risks and mitigation plans and manage the diverse disruptive challenges the NHS has and continues to face. A critical success factor of these arrangements has been to maintain key relationships with multiagency partners across the region.
23. The Group met for the last time on 20th September 2011 to review the results of the assurance process. The SHA has also been working with PCT clusters and they now have local systems in place for resilience. There remains a level of risk around all of the cluster plans as they are untested; it is acknowledged that further work is still being undertaken to strengthen assurance in advance of the winter period.

Health system risk summaries

24. There is generally strong performance across the region. The following summaries focus on areas of risk. In addition, detailed information on current and past performance is available in previous performance reports presented to the NHS Yorkshire and Humber Board.

Airedale Bradford and Leeds

25. Bradford and Airedale and Leeds will become a single cluster from 3 October.
26. In terms of quality across the health system, Leeds Teaching Hospitals has a history of quality and performance challenges, although there have been significant improvements in recent years. Quality issues still exist however, particularly in relation to hospital acquired infections, 62 day cancer waits and stroke. At Bradford Teaching FT there are issues with two week wait for symptomatic breast cancer and 31 day cancer RTT standard. In Bradford, there have been serious incidents in both BDCT learning disabilities services and PCT early intervention mental health services. There are action plans in place to mitigate risks in the future. On maternity services there have been a cluster of maternity serious incidents at Airedale and frequent closures of the units at Bradford and Airedale trusts. Again, action plans are in place. The old PCTs have historically had a good grip of quality and safety issues for services

commissioned and we anticipate that the strong professional leadership will be transmitted to the new cluster organisation.

27. The Bradford and Airedale health system has a strong history of financial and performance delivery. The financial position since 2009 has been more challenging, with the PCT having made recurrent commitments against non-recurrent resources. This position has been recovered in 2010-11 and the short term financial position is secure. The health system has been slower to put in place whole system arrangements to deliver the transformational change required for longer term sustainability with the pace of change and appetite for whole system working being variable across local providers.
28. Bradford and Airedale also has a range of long standing health outcomes and inequalities issues against which progress to date has been limited.
29. Bradford District Care Trust's FT application is planned for submission to DH for July 2012. It is currently on trajectory. Their key challenges involve improving the working relationships with key stakeholders across the system and successfully integrating new services received as a result of the TCS process. The transfer out of learning disabilities services to the local authority is in its final stages of completion.
30. The emerging Airedale, Wharfedale and Craven CCG crosses the boundary into North Yorkshire and discussions are ongoing over the need for this CCG to work with two local authorities. This represents a natural health community around the catchment area for Airedale FT and Bradford District Care Trust. The other three Bradford CCGs are reviewing current configurations and will reconfigure to one or two CCGs.
31. The Leeds health economy has delivered significant performance improvements in the last two years. The financial position of the commissioner has improved significantly, and strong whole system working arrangements is delivering the transformational change required to ensure sustainability of the health system going forward.
32. The three emerging CCGs in Leeds had some overlapping geography and a significant number of unaligned practices. Discussions are taking place to reframe boundaries to include all practices within three redefined CCGs. We expect to hear the outcomes of these discussions shortly.
33. Leeds Teaching Hospital remains on trajectory for Department of Health submission for FT status for April 2012. The key remaining challenges relate to producing a sustainable long term financial model that reflects the changing commissioner landscape and financial context, and consistent delivery of key performance standards mentioned above. The Trust faces a significant workload to deliver the necessary milestones for an April submission.

34. Leeds Community Healthcare is on trajectory for a July 2012 Department of Health FT submission. This is a new organisation and their key challenge relates to establishing effective board arrangements and building on the positive working relationships they have established as the commissioner landscape changes.
35. The Yorkshire Ambulance Service has historically struggled to deliver against national performance standards, although more recently there have been significant improvements in Category A performance. The trust is on trajectory for a June 2012 submission for its FT application and ensuring consistent delivery against key performance standards, particularly over the winter period.

Calderdale Kirklees and Wakefield

36. Mid Yorkshire Hospitals faces long-standing challenges with its financial and clinical sustainability. The trust is an outlier on MRSA performance having hit their anticipated year to date position by this time in the year. However, this is a significant improvement on performance in the previous year. Concerns have also been raised regarding maternity, stroke and orthopaedics services. As a result, the trust commissioned, and is actioning, an external review of maternity services. The cluster has also invested in stroke services and improvement trajectories are in place. A new orthogeriatric model has been implemented, improving length of stay and time to theatre. Despite a slight improvement in 2010-11, the Trust remains 3.9% below the England average on inpatient satisfaction. These issues are well understood at the SHA we are working with the organisation on these. The PCT cluster arrangements have provided greater leadership impetus to develop viable whole system solutions to the issues faced at Mid Yorkshire, in particular on transforming demand and pathways. Following completion of a Clinical Services Strategy, a reconfiguration of services will go to public consultation within the next 12 months.
37. The Calderdale, Kirklees and Wakefield Cluster has historically had relatively strong financial historic performance although there have been slight concerns in Calderdale and Kirklees in recent years. Performance on the patch is variable, with A&E and RTT performance below target at Mid Yorkshire.
38. The cluster has been relatively slow in developing a cluster approach to QIPP and the whole system transformational board is not yet having a major impact. Despite this, in year delivery of QIPP has been fairly strong and both GP referral and non-elective activity are down on plan.
39. The FT tri-partite agreement for Mid Yorkshire Hospitals has yet to be agreed with the Department of Health who are working to a formal sign off of September 2011. The trust has a number of significant challenges impacting on the ability to achieve FT status, including delivery of key service and performance requirements, achievement of financial balance and longer term financial viability, and the

configuration of clinical services across sites. Clinical sustainability issues across the sites have necessitated the need for a clinical services strategy. The trust is currently rated Red/Amber on their FT trajectory.

40. Wakefield has made good progress in delivering improved health outcomes. Calderdale and Kirklees both continue to have challenges relating to outcomes for children.
41. Wakefield has two emerging CCGs, one of which is likely to be too small to be viable. There is also one practice which is currently unaligned to any CCG. There are 3 other emerging CCGs covering Calderdale and Kirklees.

Humber

42. The main quality issues in the locality have been associated with Hull and East Yorkshire Hospitals, in particular CDI infections and hospital standardised mortality rates. The trust has recently had a leadership change and there have been significant improvements in quality and performance as a result. The SHA medical director and chief nurse have also been heavily involved in improvement work at the Trust. The trust achieved a 3.5% improvement in its overall patient experience score, but remains 0.5% below the England average. At North Lincolnshire and Goole FT, concerns have been raised about variation in performance across hospital sites, particular in relation to stroke services.
43. Financial performance across organisations in the cluster has been strong. Both North Lincolnshire and East Riding have turned around previous deficit positions to deliver against control totals in recent years.
44. Health outcomes have improved across the Humber and there are good plans in place to progress further. Hull and North East Lincolnshire are the two areas of the Humber facing the most difficult health challenges.
45. On QIPP, the cluster has well established programme management office arrangements for the north bank and south bank although further work is needed to fully establish a cluster approach. Good progress has been made in developing transformational milestones, and a recently announced strategic services review will support further development of these.
46. North Lincolnshire CCG has only recently established itself as a pathfinder – this is due to be announced by the Department of Health in September. As such it is behind other pathfinders in its journey to authorisation but is making progress in catching up.
47. Hull and East Yorkshire Hospitals FT application is due for submission to Department of Health in January 2012. The trust has longstanding quality and safety issues. Their

key challenges relate to delivering sustained improvement on the above issues within the requisite timeframe; securing the delivery of the Cost Improvement Programme; and developing a cohesive approach with commissioners to deliver whole system QIPP.

North Yorkshire and York

48. The majority of quality issues in the North Yorkshire cluster area relate to Scarborough and North East Yorkshire Trust. Performance on stroke indicators has consistently been low and the trust also scored poorly on both patient and staff satisfaction surveys. Earlier in the year the Care Quality Commission removed its conditions of registration on the trust. It is anticipated that the proposed acquisition of Scarborough by York Teaching FT will strengthen clinical leadership and governance and increase scope to ensure service viability.
49. North Yorkshire and York has had a history of financial difficulties primarily due to a historic imbalance between the provision of healthcare services and the availability of resources. The recent strategic services review made recommendations for addressing this imbalance. Delivering the transformational change that underpins these recommendations will be essential to achieve financial sustainability going forward. This will require dedicated implementation capacity.
50. North Yorkshire and York currently have a number of general practices not co-terminus with upper tier and unitary local authorities. There are also a few issues of unclear geography and boundaries. The issues are being discussed to determine acceptable configurations that will meet the requirements of authorisation, secure local authority support and deliver integrated care and service planning.
51. Scarborough and North East Yorkshire Trust is pursuing an acquisition by York Teaching FT, which is planned for completion by April 2012. As part of the transaction a solution needs to be found to deliver medium term financial viability for the new organisation and there needs to be a positive outcome to the Competition and Co-operation Panel consideration of the benefits case.
52. The cluster has one outstanding TCS issue; the transfer of mental health services to Leeds Partnership FT has been delayed subject to further due diligence; hopefully a transfer will be made for December 2011.

South Yorkshire and Bassetlaw

53. The South Yorkshire cluster has given assurance of quality a priority, and the Director of Nursing for the cluster has undertaken assurance visits with each constituent PCT to give assurance to the cluster Board regarding quality and safety across the cluster, as well as inform handover documents for example. Locally, C-Diff is currently an

issue, with cases significantly above trajectory at month 4 of 2011/12. Action is being taken by the SHA, cluster and local systems (particularly Sheffield) to address this. In addition, the SHA Medical Director is working with Doncaster and Bassetlaw NHS FT and the cluster about issues of clinical quality and education at the FT.

54. The South Yorkshire and Bassetlaw cluster has a history of strong performance and financial management. Despite this 2010-11 was a difficult year financially for Sheffield PCT, with pressures associated with non-elective activity, continuing healthcare and slippage in planned efficiencies.
55. On QIPP, while individual commissioner plans are generally strong, it is clear that there are still challenges to be addressed in terms of aligning approaches across the cluster, and developing a whole system approach.
56. On commissioning development, emerging CCGs coterminous with current PCTs are in place in Bassetlaw, Doncaster, Rotherham and Sheffield. However, in Barnsley, GPs are having difficulties agreeing configuration arrangements and further discussions are taking place to resolve these issues.
57. The cluster area does not have any non-FT organisations and no major outstanding TCS issues. Bassetlaw's community services are not transferring to Rotherham FT as previously planned due to the FT's recent Monitor financial risk down-grading; working with NHS Bassetlaw the cluster has agreed to integrate the services with Nottinghamshire Healthcare NHS Trust with staff transfer completed hopefully for 1st November 2011. NHS Trust with staff transfer completed hopefully for 1st November 2011. NHS Doncaster has begun consultation about the future configuration of acute medical and intermediate care services.
58. South Yorkshire areas have made good progress in delivering improved health outcomes across a range of indicators. Challenges remain but local areas have good plans and robust partnerships.
59. NHS Barnsley hosts the region's specialist commissioning group which is highly regarded by all PCT clusters. It has for instance, taken on the commissioning of additional services at the request of all Yorkshire and the Humber cluster PCTs and as part of QIPP planning. The SCG also hosts a number of clinical networks and has a strong history service development through effective joint working with these networks.

Key challenges going forward

60. In summary, while performance in the region has been very strong, there are a number of risks we have undertaken to mitigate in the interests of patients and the local community.

61. The key priorities over the next 18 months should focus on:

- Delivering today: Building on existing arrangements to ensure sufficient performance grip in relation to key performance targets, quality and safety, and finance.
- Building the future: Continuing to support the development of the new healthcare system, including supporting the development of commissioning organisations of the future, taking forward the transformational change required to deliver QIPP, and overseeing the creation of a high quality and sustainable provider landscape, and delivering a successful public health transition to local government.

62. At organisational level, there is a particular need for Board, working with the five PCT Clusters, to focus on:

- North Yorkshire and York: including implementation of the strategic services review; ensuring financial control; and the Scarborough and North East Yorkshire and York Teaching FT transaction.
- Mid Yorkshire Hospitals: delivery of high quality and financially viable services, and ensuring that there is greater whole system working to address the challenges faced at Mid Yorkshire.
- Hull and East Yorkshire Hospitals: supporting the organisation on its foundation trust authorisation process, and ensuring that clinical quality and safety standards are delivered.
- Provider landscape: Ensuring that there is a high quality, financially viable and sustainable provider landscape across Yorkshire and the Humber.
- Commissioner development: Developing excellent and fit for purpose Clinical Commissioning Groups and commissioning support arrangements.