themonth.

for the NHS leadership community

March 2012 Special Issue 52: Gateway reference number 17493

news

This special edition of 'the month', carries a letter from NHS Chief Executive Sir David Nicholson on the passing of the Health and Social Care Bill and what this means to the NHS now and from 2013/14.

intro

"There is an enormous amount to do to prepare for the bulk of the statutory changes in April 2013. This document provides updates in each of the key areas."

The 2012/13 NHS Operating Framework set out the four priorities for the NHS over the next 12 months. These are:

- improving the quality of basic care for older and vulnerable patients
- maintaining a strong grip on performance including waiting times, finance and key quality measures
- meeting the ongoing quality and productivity challenge
- making the transition to the new health and care system.

As we enter this important year for the health service, it is vital we keep those priorities at the forefront of our minds. This edition of the month focuses particularly on what we need to do to realise the transition.

Earlier this month we published the results for the third quarter of 2011/12, which show the NHS continued to perform strongly across a range of key indicators, including finance, waiting times and key measures of quality and safety. In light of the challenging financial context and the wider uncertainties the NHS has faced, it is particularly impressive we have maintained such high standards for our patients, and I want to thank everyone across the NHS who has contributed to this success. There are of course still major challenges ahead but we have a strong platform on which to build.

This month also saw the Health and Social Care Act complete its passage through parliament, a very significant moment for the health service. While many details of the new system still need to be put in place through secondary legislation, the passage of the Bill gives us real clarity and certainty about our future direction. The onus now switches to the health and care system and the important and challenging task of implementing the changes on the ground. There is an enormous amount to do to prepare for the bulk of the statutory changes in April 2013. This

introduction

document provides updates in each of the key areas.

We have already made important progress on laying the groundwork for the transition. Prospective clinical commissioning groups are operating across the country under delegated arrangements with PCTs, while shadow health and wellbeing boards are developing nationwide. Patients are already being offered more choice and more and more data about our services is now openly available. Again, I want to thank all those responsible for the progress we have made to date.

Looking forward, the way we handle the movement of people between the old and new systems is critical to the success of the transition. The people who work across the health system – clinicians, managers and others – are the basis of our success, both now and in the future. We must retain the best talent and make sure we have the right people, in the right place, at the right time, in order to manage the transition successfully while maintaining day-to-day delivery. That will often mean asking people to cover more than one position for a period and I know from my own experience this can be a demanding balancing act for individuals. This document sets out our overall approach to the people transition but local implementation will require flexibility, determination and skill.

The scale of the agenda we all share over the next 12 months is very significant. There will inevitably be tensions between the old and new systems and between the need to deliver for today and the task of building for tomorrow. Managing these tensions maturely is a critical leadership challenge and vital to the success of the transition. In doing this, we must keep focused on the overall purpose of the changes we are making - to deliver great outcomes for our patients. This is our overriding goal and we must work together over the next year to build a system that can continue to deliver it.

Best wishes,

Sir David Nicholson, KCB CBE
NHS Chief Executive

delivering to our patients

Delivering for our patients

Providing the best possible services for patients within the available resources remains our fundamental goal. It is important we retain absolute focus on this even as we take forward the changes to create the new health system.

Our recent results are very encouraging, showing the NHS continues to perform strongly across a number of key areas:

- Key measures of quality continue to improve, with infection and mixed sex accommodation rates falling, compared with previous years
- Waiting times remain low and stable with the 90 percent standard for referral to treatment times being maintained. In addition, the number of patients waiting more than a year for treatment has been reduced to its lowest level. National standards for A&E, ambulance and cancer services have also been maintained
- The aggregate financial position remains strong with a healthy surplus forecast for 2011/12 at national level and efficiency savings being released broadly in line with expected trajectories
- In line with our approach to achieving quality and productivity improvement, the NHS continues to contain activity levels: non-elective admissions to the end of January 2012 were 1.8 percent lower than the same period last year and GP referrals similarly down by 1.6 percent.

While we should all take pride in this strong delivery track record, there can be no room whatsoever for complacency. There remain significant challenges to further improve services for our patients. In particular:

- Waiting times remain a key barometer of public confidence, so it is vital we maintain the current momentum for improvement in this area
- Improving the quality of basic care for older and vulnerable patients remains a critical priority and we must drive through the changes set out in the 2012/13 NHS Operating Framework in this area. The Prime Minister's recent challenge to the health system to improve diagnosis and care for patients with dementia is an important aspect of this
- It remains important we address the quality and productivity challenge in the right way, implementing long-term, clinically-led improvements to services, rather than taking short-term decisions that could affect the quality of care. In some areas, this will mean significant changes to the way services are delivered and we must take on those challenges where necessary.

The people transition

The passage of the Health and Social Care Bill marks the beginning of a new phase in the transition process as we move from planning, preparation and design to detailed implementation on the ground.

the people transition

At the heart of every strand of the implementation process is the movement of staff from the old system to the new - the people transition. The significant changes over the next year will impact our staff, so it is vital we manage our people well and treat all our staff with dignity and respect.

Planning for the people transition has been underway for some time, with sender and receiver organisations working to build up a clear picture of the changes that need to take place and developing policies to oversee the movement of staff. Initial implementation has begun with the appointments of senior leaders to many of the new organisations. But over the next 12 months the scale and pace of the people transition will need to increase very significantly to make sure the new system can operate from April 2013.

The challenge becomes more significant by the need to maintain current performance while building the new system. That means the timing of movements need to be planned carefully to make sure we have people with the right skills, in the right place, at the right time. It will mean asking people to work flexibly and potentially to fulfil roles in the new and old systems simultaneously. As a result, this is not a process which can be managed from a single point at the centre. It will require plans and judgements to be made across local systems, as well as nationally.

The overall timetable

Regarding the transfers of function due to take place in April 2013, it is in the interests of our staff that we align the human resource (HR) processes and, wherever possible, the timings of these processes between the different receiver organisations, in order to maximise opportunities and minimise uncertainty. Therefore, we want the different aspects of the people transition to operate to a common timetable wherever possible, and particularly for the changes to the commissioning system. Our aim is to do as much as possible as early as possible, in a consistent way and in accordance with the HR Transition Framework principles. However, we must do this while avoiding destabilising the current system.

Our intention is to confirm those functions that are transferring and agree the legal basis for transfer. Transfers will be covered by transfer orders to protect employees' current terms and conditions, as if TUPE applies. Where there are more people employed in a transferring function than are needed in the new organisation, the intention is to make sure staff know as soon as possible if they have a job in the new organisation. If there is not an identified role for them, staff can make a decision about whether or not they wish to opt out of the transfer. Not all posts will be subject to transfer and will be open for redeployment or competitive recruitment.

The aim is that by December 2012 staff will know their futures. The timetable will therefore be broadly as follows:

- By the beginning of May 2012, remaining work on organisational design to identify the details of the functions in the new bodies and the impact on sender organisations will be largely completed and plans and policies for people transition will be finalised. This will include taking decisions on the process by which different functions will move into the new organisations, including where transfers will take place. Some

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The people transition (cont'd)

organisations will make a small number of priority appointments during this period to business critical posts.

- During May and June 2012, we will aim to complete all of the remaining senior appointments. The bulk of this staff group will be at very senior management (VSM) grade or equivalent. We will make the director level appointments for national organisations. The NHS Commissioning Board Authority (the Board Authority) will appoint the leadership of commissioning support services (CSSs). The Board Authority will also provide support for clinical commissioning groups (CCGs) to allow them to make designate senior appointments at this time.

- From July to December 2012, we will complete the remaining phases of transition. The intention is to transfer staff, slotting-in either directly or via competitive slot-in. Some posts are new posts where no transfer of functions will be taking place, or substantially different and will therefore need to be filled through limited, wider ring-fenced or open competition. Where competition is required, it will be organised to provide maximum opportunity for staff at risk. During this period, there will be a need to make early appointments to the new organisations, so they can be fully operational from April 2013.

Each new organisation will need to develop specific plans and policies for moving staff into their organisation. We want all organisations to operate as far as possible within this timetable for making appointments, so we provide greater clarity for staff about the opportunities retaining essential capacity and talent.

Supporting measures

There is a particular need to retain the skills of certain staff in business critical roles, such as those linked to key aspects of transition and organisational change. To facilitate this, a retention scheme has been agreed which will enable the retention of certain key staff for an agreed period to see out current and/or closedown activities.

Consultation with trade unions at national, regional and local level will continue to take place throughout this period and beyond so HR processes are managed fairly and consistently and to make sure staff and their representatives are kept fully informed during the transition period.

To support consistency of approach we have developed an HR Transition Guidance and Toolkit, in partnership with HR professionals and trade union representatives. This guidance includes a detailed list of all HR activity and roles and responsibilities to help receiver and sender HR teams plan their transition programmes. Aligning our approach in this way will provide greater clarity for staff about the opportunities available and increase our chances of retaining essential capacity and talent.

In a minority of cases some posts in the new bodies will be so substantially different from anything we do in the current system that external recruitment might be necessary, but the immediate priority of all organisations is to maximise opportunities for existing staff. All organisations will need to be mindful of the principles of minimising redundancies and retaining essential talent wherever possible. The level of redundancy costs we incur during 2012/13 will impact directly on the budgets of new organisations and their ability to appoint more people from 2013/14, so there is a clear incentive to minimise costs.

clinically-led commissioning

Developing clinically-led commissioning

The creation of a clinical commissioning system, focused on delivering better outcomes and responding to the needs and wishes of patients, is central to the changes we are making.

Local clinical commissioning groups will sit at the heart of this system, bringing together GPs and involving other clinicians to design and implement better systems of care. CCGs will have access to expertise from commissioning support providers and from clinical networks and senates. And at national level the NHS Commissioning Board (the Board) will provide direction and leadership for the commissioning system and make sure consistent outcomes are achieved across the country, maintaining the 'N' in the NHS.

Clinical commissioning groups

The vast majority of aspiring CCGs have confirmed their member practices and established an effective geographic area. We are continuing work with those prospective CCGs not yet configured effectively for future success. The latest information from this process indicates a likely total of 220-240 CCGs across the country.

These emerging CCGs are already operating under delegated authority, increasingly taking on day-to-day commissioning responsibilities on behalf of PCT clusters. 59 percent of their future commissioning budgets have already been delegated to them and we expect that figure to increase further during 2012/13. Clinically-led commissioning is already having an impact on the ground, with numerous examples of prospective CCGs leading the way in areas which are central to the quality and productivity challenge; for example improving the quality of community-based services and thereby containing pressures on emergency admissions.

As they move through authorisation and become established CCGs during 2012-13, they will need to build up their capacity and capability so they are ready to take on their statutory powers from April 2013. An HR guide for CCGs is being produced to support this process.

It will be particularly important for CCGs to secure the right leadership. This is why we are offering national development and assessment support for potential governing body chairs, chief finance officers and accountable officers. This process started in mid-March 2012 and will run throughout the year, but ensuring early feedback by May or June so emerging CCGs can make designate senior appointments in line with the common timetable. For accountable officers, who are appointed by the Board, on the basis of the nominated individual, submitted by CCG, as part of the authorisation process, there is an expectation that all individuals will have been through this national process, though the process will take into account recent relevant assessments.

We are currently working closely with prospective CCGs on the design of the authorisation process. Final guidance on authorisation from the Board Authority will be issued in April 2012 and the first wave of applications will be made in July, with decisions by the Board from October. Subsequent waves will follow with the aim of completing the initial round of assessments by January 2013. This will allow time for arrangements to be made where authorisation is subject to conditions. Subject to authorisation, CCGs will take up their full statutory powers and responsibilities on 1 April 2013.

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clinically-led commissioning

Developing clinically-led commissioning (Cont'd)

The aim of the authorisation process is simple - to support CCGs to be as effective in their new roles and on a trajectory to be great clinical commissioners but ensuring they meet safe standards from the outset of this journey. The intention is not to create unnecessary bureaucracy or unjustified interference and this is why nascent CCGs have been engaged in developing the process. Authorisation is necessary to make sure CCGs are ready to take on their very significant commissioning and financial responsibilities - but it must be a support not a barrier to their development.

Engaging aspiring and authorised CCGs in the broader development of the commissioning system will also be critical to our success. To this end, the Board Authority is currently working with a design group of emerging CCG leaders to propose effective ways of engaging each and every CCG, including a proposed 'assembly' – a vehicle to enable effective joint-working on big shared issues, such as setting allocation rules and commissioning for quality. This approach will be tested further through informal arrangements from April 2012, with the aim of having an agreed system in place for the autumn.

Commissioning support

CSSs are now developing across the country, working with emerging CCGs to develop high value offers, in areas such as contract management, service redesign, analytical support and other professional services. A range of models is emerging, with CSSs providing a variety of bespoke offers and national offers in a small number of areas.

The first checkpoint for the development of local CSSs being developed by PCT clusters took place at the start of 2012. 36 prospective services were assessed and we expect the number of services to reduce to 20-25 by the time of the next checkpoint at the end of March 2012. The final checkpoint where CSSs submit a full business plan will be completed by the end of August and the Board will take decisions on the hosting of CSSs in October 2012. We have also set up learning networks where emerging CSSs have been working to accelerate understanding and best practice.

Alongside these local services, national offers are being developed in four areas: major clinical procurement; business intelligence; business support, and communications and engagement. The nationwide communications and engagement service will be subject to the same assessments as local services as it is developed, including key checkpoints. The other functions will be part of locally based commissioning support offers.

There will be a national assessment process and development support will be provided for prospective leaders of CSSs as part of this process. The Board Authority will aim to appoint these leaders by the end of June 2012, in line with the broader national timetable. CSSs will then be able to develop their capacity in line with the national timeline set out above.

The NHS Commissioning Board

The Board Authority has now been in place for several months and is leading on the development of the new commissioning system. Most of the very senior appointments have been made and two public board meetings have taken place where key principles for the design of the Board and the broader commissioning system were agreed.

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clinically-led commissioning

Developing clinically-led commissioning (Cont'd)

The Board will begin life as an Executive Non-Departmental Public Body (ENDPB) in October when it will take on responsibility for the authorisation of CCGs and other responsibilities for preparing the new system. It takes on its full statutory responsibilities in April 2013.

The Board will be organised into nine national directorates, four slim sub-national regions and a national network of local offices, led by local area teams, in which the bulk of its staff will be based to fulfil their NHS facing functions. These will include the oversight of CCGs, membership of local health and wellbeing boards and the direct commissioning of: primary care services, specialised NHS services, military health services, offender health services and a range of public health services. They will also have important responsibilities in relation to NHS emergency planning and response and the quality assurance of NHS services, as well as delivering responsible officer functions. The geographical footprint for the regions will mirror those of the four current SHA clusters, with those of the local area teams being developed from PCT cluster areas. A People Transition Policy for the Board has been published and recruitment will take place in line with the broader national timetable.

We are also working to develop clinical networks and senates across the country to provide support for CCGs in developing services for particular patient groups and across particular areas. We anticipate the Board will host networks and senates across 12-15 core areas, though networks will operate across a range of different geographical footprints. We will look to align these arrangements wherever possible with the development of academic health science networks and local education and training boards.

Key milestones for commissioning development in 2012/13

April-May 2012 – second checkpoint for CSSs (outline business plan)

April 2012 – final authorisation guidance issued by the Board Authority (further guidance may be issued by the Board)

May-June 2012 – development support for prospective CCG leaders; recruitment of CSS leaders and remaining NHS Commissioning Board senior leadership posts

July 2012 – first wave of authorisation applications (subsequent waves in September, October and November)

July – December 2012 – recruitment to remaining posts in CCGs, CSSs and the Board and agreement on when appointed staff will take up formal employment

August 2012 – third checkpoint for CSSs (submission of final business plan)

October 2012 – the Board becomes ENDPB; first set of authorisation decisions (subsequent decisions in November, December and January); decisions on hosting of CSSs

January 2013 – completion of authorisation decisions

April 2013 – the Board and authorised CCGs take on full statutory powers

Developing a robust and diverse provider sector

Important changes are already taking place in the provision of NHS care. Supporting all trusts to become clinically and financially sustainable and thereby achieve foundation trust status is critical to ensuring a robust provider sector.

provider sector

And the introduction of new providers in service areas where patients have told us it can help improve the quality of care is another important development.

Foundation trust (FT) pipeline

There are currently 143 FTs with 108 NHS trusts remaining in the pipeline. These NHS trusts need to organise and manage care in a manner that is clinically and financially sustainable for the long term and this may require difficult decisions. We must press ahead if we are to realise our ambition about delivering patients the best outcomes.

Following the signing and publication of Tripartite Formal Agreements (TFAs) by each of the remaining NHS trusts, the Department, in conjunction with SHAs has developed a monthly performance management regime, which includes an agreed approach to escalation. Each month a red, amber, green (RAG) rating is agreed for each NHS trust assessing performance against the milestones set out in their TFAs and against the NHS quality, service delivery and financial measures.

Missing a number of these indicators or the agreed FT application date incurs a red rating. Three consecutive monthly red ratings enters the NHS trust into the first stage of the escalation process agreed by the Department and SHAs, which has been established to identify the changes required to address the issues. 17 NHS trusts are now subject to the regime and this process will continue, More NHS trusts may join this cohort if required, so we can collectively address issues to progress NHS trusts towards long term sustainability. Work is also underway to bring together the Department's performance framework and the TFA monitoring to streamline these two processes. This will go live from April 2012.

David Flory has been appointed as the Chief Executive designate of the NHS Trust Development Authority (NTDA) and is moving forward to create a dynamic organisation able to provide oversight and accountability for the remaining NHS trusts.

Over the next three months, the chair and first non-executive director will be appointed and recruitment will begin for the senior team. The organisational design and operating model for the NTDA will also be further developed. David and his team are planning sessions with each SHA cluster and separately with each NHS trust chair and chief executive to set out the visions, values and next steps for the NTDA. Further details will be available soon.

The NTDA will be established as a special health authority (SpHA) in June 2012 and will begin formal preparatory work. The first operational function to transfer to the NTDA will be the local appointments team from the Appointments Commission in October 2012. The NTDA will take on its full responsibilities for overseeing NHS trusts from April 2013.

Any Qualified Provider

By September 2012, many patients will be able to choose from any qualified provider in at least three locally selected community and mental health services,

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Developing a robust and diverse provider sector (Cont'd)

provider sector

Any Qualified Provider (Cont'd)

giving them the chance to be treated by the provider best placed to meet their needs. This will mean patients can choose from a range of high quality providers who meet NHS standards and prices. This might be an NHS hospital department, social enterprise, local voluntary organisation, independent provider or a clinic on the high street.

Local commissioners have decided which services would benefit from extending patient choice of provider, based on local need, informed by engagement with clinicians and patients. Within each PCT cluster, three or more community or mental health services have been selected to offer greater choice. The most popular choices were adult hearing services, podiatry and diagnostic tests.

A coverage map, developed by the Department to support commissioners and providers to implement patient choice of any qualified provider, has been published to show patients and their GPs where more choices will be available from September 2012: www.supply2health.nhs.uk/AQPResourceCentre/AQPmap/AQPmap

The Department's approach to extending patient choice puts safety and service quality first and foremost, sustaining current standards and supporting continuous quality improvement and innovation. A rigorous and transparent national qualification process has been introduced to qualify new providers – consistent and proportionate to clinical risk. All providers must meet NHS quality standards, appropriate professional standards and the requirements within NHS standard contracts. Prices will be fixed, with national or local tariffs so that competition is firmly on quality, not price.

From 2013/14, CCGs and the Board will decide which services to open up to patient choice of any qualified provider, driven by local needs and priorities for improving quality. An extensive and intensive programme of engagement with commissioners, GPs, PCT clusters and providers is continuing. This will include joint work with national primary care organisations, regional workshops and meetings, along with a session at the NHS Alliance and NAPC Coalition conference in April 2012.

Sector regulation

The Health and Social Care Act establishes a comprehensive, proportionate and robust legal framework for sector regulation across the healthcare sector. Key features of the sector regulation regime are:

- a clear focus on protecting and promoting patients' interests
- joint working between the Care Quality Commission, Monitor and the Board
- a comprehensive system applicable to all types of provider
- rationalisation of existing regulatory structures and reduced duplication
- the Secretary of State retaining overall accountability and powers to intervene where necessary
- the proposed framework will be underpinned by secondary legislation.

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provider sector

Developing a robust and diverse provider sector (Cont'd)

Sector regulation (Cont'd)
It is important during 2012/13 that all NHS organisations take steps to understand the implications of the new sector regulation regime for them. To this end, a short guide for providers of NHS-funded services has been developed which explains how the regime will work for them. It outlines Monitor's role and the five core functions of the sector regulation framework. It also includes details of planned legislative changes to increase the autonomy and strengthen accountability of FTs.

Key milestones for provider development during 2012/13

Ongoing – monitoring of progress against TFAs with escalation as required

Spring 2012 – appointment of NTDA chair

June 2012 – NTDA created as SpHA (subject to parliamentary approval) to undertake preparatory work

June 2012 onwards – recruitment of staff to NTDA

September 2012 – three locally-selected services available under Any Qualified Provider

October 2012 – NTDA takes on appointments functions for NHS trusts

April 2013 – NTDA takes on full powers

patients and communities

Empowering patients and communities

Alongside changes to the way care is commissioned and provided, we need to create the right environment for local delivery.

That means doing much more to give control to patients through the extension of choice and the provision of high quality information to support decisions. It also means doing more to make sure views of patients and communities are built into everything we do, through the creation of health and wellbeing boards to bring together commissioners of NHS, public health and social care services, and through the creation of national and local HealthWatch to champion patients' interests at all levels of the system.

Choice and information to empower patients

Getting the right information to the right people at the right time – in a form they can understand, engage with and contribute to – will help individuals take control of their own care, improving self-management, shared decision making, and more informed choices. To support this vision, in 2010 we published the Liberating the NHS: Greater Choice and Control consultation document alongside the Liberating the NHS: An Information Revolution consultation.

We have already published our response to the consultation for our proposals to extend choice of provider through the any qualified provider policy and by extending choice to named consultant-led team, where clinically appropriate. In a further consultation document, which we will publish this year, we will set out proposals aimed at giving patients more say through an opportunity to make shared decisions with their health and care professionals.

We recognise it is important for people to be fully involved in decisions about their own care and to have the information they need to make those decisions. The Information Strategy, which will build upon the Information Revolution consultation and the recommendations of the NHS Future Forum report on information, which we will publish later this year, will set out our approach to providing patients with information to help them make informed choices and decisions.

Health and wellbeing boards

Health and wellbeing boards bring together for the first time leaders of the local health and care system – with CCGs, elected representatives, social care, public health and local HealthWatch at the core – to work with a common purpose to drive improved services and outcomes. We anticipate they will link with local communities and other local public services, and through the role of elected representatives, strengthen local accountability, enabling outcomes to be measured and demonstrated.

The board members will work together to develop a joint strategic needs assessment (JSNA) and joint health and wellbeing strategy to tackle issues that matter most to their community.

Integrating services, joint commissioning and pooling resources will be central to translating the needs assessment and joint strategy into action.

Health and wellbeing boards will have a duty to encourage commissioners of health services and commissioners of social care services to work in an integrated manner.

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patients and communities

Empowering patients and communities (Cont'd)

HealthWatch

In the new system, HealthWatch England will provide a powerful voice for patients and communities at the national level influencing policy and service delivery through the Board, local authorities, Care Quality Commission (CQC), Monitor and the Secretary of State for Health. Local HealthWatch will be a credible, independent champion for local people and a focal point for local communities to have a voice in commissioning and provision of health and social care. Its membership on the statutory health and well being board will empower CCGs and other delivery partners on the board with knowledge of the local consumer voice. If commissioned by the local authority, local HealthWatch will also provide NHS complaints advocacy services.

HealthWatch England will begin operating from October 2012. It is believed local authorities will need to start their commissioning preparations (and any community engagement in relation to the identity of their local HealthWatch) from around autumn 2012 to make sure they have a local HealthWatch in place for April 2013.

Key milestones for empowering patients and communities during 2012/13

Spring 2012 – publication of Information Strategy

September 2012 – three locally-selected services available under Any Qualified Provider

October 2012 – HealthWatch England begins to operate

April 2013 – Local HealthWatch begins to operate

April 2013 – Health and wellbeing boards are established and take on full roles

Developing the new public health system

The White Paper Healthy Lives, Healthy People: Our Strategy for public health in England set out how the reformed public health system will work.

new public health system

The system will focus on achieving positive health outcomes for the population and reducing inequalities in health. The Public Health Outcomes Framework sets the context for the system, from local to national level, setting out the broad range of opportunities to improve and protect health across the life course.

At a national level, the Secretary of State will set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities. The Secretary of State will have a new general duty to take steps to protect the health of the people of England, and a new power to take steps to improve their health from April 2013. The nature of various threats to health range from infectious disease to terrorist attacks, and are not always amenable to individual or local action. They require a clear line of sight from the Secretary of State down to local services. In practice, Public Health England (PHE), an executive agency of the Department will exercise these functions, bringing together the diverse range of public health expertise currently distributed across the health system. It will ensure access to expert advice, intelligence and evidence and will offer an integrated, expert service across Government.

At a local level, upper-tier and unitary local authorities will have responsibility for health improvement, supported by directors of public health and a ring-fenced public health budget. In the new system, the NHS will continue to play a critical role in securing good population health and will work closely with local authorities to achieve the best possible outcomes for local people. The NHS will deliver specific public health services, such as childhood immunisations and national screening programmes, and will use the millions of patient contacts that take place each day as opportunities to promote healthier living.

Public Health England

PHE will bring together the different elements of the system, strengthening the national response on emergency preparedness and health protection. PHE will have three key business functions - It will deliver services to protect the public's health through a nationwide integrated health protection service, provide information and intelligence to support local public health services, and support the public in making healthier choices.

As an executive agency, PHE will have the operational independence it needs to build and maintain its own identity. Its chief executive designate will be appointed shortly and there will be a board with an independent chair and a non-executive majority. It will support the development of the public health workforce, jointly appointing local authority directors of public health, supporting excellence in public health practice and providing a national voice for the profession.

PHE will bring together the wide range of public health specialists and bodies into one integrated public health service. It will have a national office including four sectors that will work with the four sectors of the Board. The national office will also include centres of excellence. In addition, it will have units that act in support of local authorities and a distributed network that allows PHE to benefit from locating its information and intelligence and quality assurance alongside NHS and academic partners across the country.

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Developing the new public health system (Cont'd)

Local Authorities

From April 2013, upper-tier and unitary local authorities will have a new duty to take steps to improve the health of their population. While local authorities will be largely free to determine their own priorities and services, they are required to have regard to the Public Health Outcomes Framework. Local authorities will also be required to provide a small number of mandatory services including:

- appropriate access to sexual health service;
- NHS Health Check assessments
- steps to be taken to protect the health of the population, in particular, giving the local authority the responsibility to make plans are in place to protect the health of the population;
- weighing and measuring children for the National Child Measurement Programme, and
- providing public health advice to NHS commissioners.

To enable them to deliver these new public health functions, local authorities will, acting jointly with PHE, appoint directors of public health who will occupy key leadership positions within the local authority and will be statutory members of the Health and Wellbeing Board.

Directors of public health will produce an annual report on the health of the local population.

Directors of public health will have chief officer status and we would expect there to be direct accountability between the director of public health and the head of the paid service (ie chief executive or equivalent post) for the exercise of the local authority's public health responsibilities.

Local authorities will be funded to carry out their public health functions by a ring-fenced grant. As a first step in estimating future funding flows to local authorities, the Department carried out an analysis to provide a better understanding of PCT and SHA spend on public health. We estimate that during 2012-13, the NHS will spend £5.2 billion on public health services, of which £2.2 billion will be spent on services that in future would fall to local authorities for their new public health responsibilities. The Advisory Committee on Resource Allocation is developing a formula to inform the future allocation of resources to local authorities for these responsibilities. The committee's recommendations will be published in due course and actual allocations to local authorities for 2013-14 will be published by the end of this year.

Key public health milestones in 2012/13

April 2012 - PCTs with local authorities to agree plans for the transfer of public health functions and teams to local authorities

Spring 2012 we will publish a consultation on a public health workforce strategy

Spring 2012 – appointment of chief executive designate and agree PHE structure

Early summer - all local areas will agree on the vision and strategy for the new public health role in local authorities

Summer 2012 – publication of full People Transition Policy (PTP) and establish the PHE staff transfer process

Autumn 2012 – publication of public health workforce strategy

April 2013 - PHE will be created

April 2013 - local authorities will take on new public health responsibilities

education and training

Education and training

In our new health system, high quality education will be essential to ensure high quality patient care. Health Education England (HEE) will be established as a special health authority (SpHA) in June 2012, taking on some functions in October 2012 and assuming full operational responsibility from 1 April 2013.

In due course, subject to legislation, it will be established as an executive non-departmental public body.

There is strong support for the role of HEE, which will make sure the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement. HEE will develop a strategic operating framework, responding to the priorities set by the Department, the Board and PHE, to plan for the medium and long-term requirements for the development of the healthcare workforce. It will also support and provide oversight of local education and training boards (LETBs) which will ensure strategic workforce planning at a local level. SHAs will establish shadow LETBs as SHA committees from April 2012 and support their readiness for authorisation by HEE from October 2012 onwards.

Senior appointments to HEE will be made from May 2012 onwards, starting with the chair and non-executive directors (NEDs). Recruitment of a chief executive and executive directors will follow with recruitment to other posts starting over the summer to be completed by the end of 2012. Recruitment of independent chairs for the LETBs will follow on from the appointment of the HEE chair so he or she can participate in this process. The structures for LETBs will be published by July, with recruitment to senior LETB roles by September 2012.

Key education and training milestones in 2012/13

March - May 2012 - Recruitment of HEE chair, audit chair (NED)

April 2012 - Publication of HEE design, structure and People Transition Policy

April - June 2012 - Recruitment of HEE chief executive

June - July 2012 - Recruitment to remaining HEE VSM roles

By July 2012 - Publication of LETB structures

July – Sept 2012 - Recruitment to LETB chair and senior roles

April 2013 – HEE and LETBs take on formal roles

Health research

The Health Research Authority (HRA) was established as a special health authority (SpHA) in December with the purpose of protecting and promoting the interests of patients and the public in health research. More information about its work, ambitions and business plan on itswebsite at www.hra.nhs.uk.

Its chair, non-executive directors and substantive chief executive posts have been advertised in the national press and also on the HRA website. The government intends to publish draft legislation to give the HRA greater independence and stability as a non-departmental public body (NDPB).

Meanwhile, the HRA has started work, in partnership with others and involving patients and the public, to shape how it will collaborate to promote proportionate standards for research regulation and governance. Feedback from stakeholders, including the life sciences industry, is that providers of NHS care have a key role to play in this: managers and researchers need to work together locally to enable research studies to be agreed, planned and started more quickly.

As the government's 2011 Plan for Growth envisaged, those organisations with new National Institute for Health Research (NIHR) contracts can now see the government's ambition to improve the initiation and delivery of research reflected in new requirements for information on the time taken to start recruiting patients to clinical trials - which will be compared against a 70-day benchmark.

A central website will be available shortly for research funders to see the research operational capability statements published by providers of NHS services, showing the types of research they are able and want to do. Candy Morris, senior responsible officer for the Department is working to develop the HRA and to champion embedding research across the NHS. She would still welcome feedback as requested in January's edition of the month.

Key Health Research Authority milestones in 2012/13

April 2012 - May 2012 - Legislation to reconstitute HRA SpHA with a full board

May 2012 - Recruitment of HRA SpHA chair

June 2012 - Recruitment of HRA SpHA NEDs (including audit committee chair) and chief executive

2nd session of Parliament (mid 2012 - mid 2013) - Intended publication for pre-legislative scrutiny of draft legislation to establish HRA as a NDPB

by April 2013 - Intended Secretary of State Directions to give HRA SpHA further functions

health research

Informatics

Our vision for the health service is underpinned by the need to harness the power of information.

For consistently high quality, safe and efficient care, we need to make meaningful, up-to-date information available to patients and clinicians, and make sure it is appropriately shared.

In the future, decisions about information and information technology will be taken as close as possible to the front line, unless there is a clear single need across the NHS. Providers will have the freedom to buy and implement their own solutions in a more vibrant and open IT marketplace.

The Department, through its external relations directorate, will be responsible for information policy and will work with the Board to commission and sponsor national infrastructure, applications and services, as well as finding the right levers to push the adoption of NHS information and IT strategies, and oversee information standards and governance.

Following the ending of the National Programme for IT (NPfIT), from April 2013, NHS Connecting for Health will be replaced by a new delivery function to make sure national infrastructure, systems and applications, used every day in the NHS, continue to be supported. The new delivery function will also approve and accredit national and local systems against technical and clinical standards set by the Secretary of State or the Board, so health and social care information can be shared securely and effectively.

The new delivery function will be responsible for the provision of high quality information and IT systems to support world-class health outcomes. The potential for this function to be housed in the Health and Social Care Information Centre (the Information Centre) is being explored.

SHA Chief Information Officers have completed mapping from current SHA and PCT informatics functions to proposed future state organisations and are working with the Board Authority and commissioning development teams to finalise the detail of this mapping. Once these are finalised, functional destinations will be communicated to SHA and PCT informatics staff. The local informatics transition programme will deliver full local transition plans (one per SHA cluster) and supporting local informatics capabilities assessments.

We have also made good progress on negotiations with CSC as the local service provider (LSP) for electronic care records in the North, Midlands and East of England, which will result in significant savings. A letter of intent has been agreed, which makes clear that a new contract, to be signed spring 2012, will make sure the local NHS has control over whether to introduce the Lorenzo electronic care record system.

Consideration is also being given to the interim management of continuing LSP contracts in London, NME and the South.

Key information milestones in 2012/13

May - June 2012 – People transition processes for informatics strategic functions to NHS Commissioning Board begins

June 2012 - Agreement on the future funding model for informatics

July 2012 – the Department's external relations directorate will hold all informatics policy functions

Sept 2012 – Future senior responsible officers for all national informatics programmes identified

Autumn 2012 – Appointment of chair designate for the Information Centre

April 2013 – the Information Centre established as an executive non-departmental public body; transition of all staff to receiver organisations completed

property and estates

Property and estates

In August 2011, we set out that aspirant community FTs, other NHS trusts, and FTs are to be given the opportunity to acquire part(s) of the PCT estate deemed 'service critical clinical infrastructure'.

That is, property directly related to the delivery of clinical services, specifically those spaces mainly used for patient consultation, diagnosis and treatment.

In January 2012 we set out the intention to create a government-owned limited company, NHS Property Services Ltd. The company will take ownership of and manage that part of the existing primary care trust estate which will not transfer to NHS community providers.

NHS Property Services Ltd will be wholly owned by the Secretary of State. The arrangements for it will be finalised in the coming months. However, its objectives will be to:

- hold property for use by community and primary care services, including for use by social enterprises
- deliver value for money property services
- cut costs of administering the estate by consolidating the management of over 150 estates
- deliver and develop cost-effective property solutions for community health services
- dispose of property surplus to NHS requirements.

Properties being transferred to NHS Property Services Ltd will include some operational estate, estate with multiple occupiers, office and administration estate, estate to be occupied by social enterprises and surplus estate.

The company will have an operational board and local and sub-national structures. The working relationship between NHS Property Services Ltd, the Board and CCGs will be developed in the coming weeks and months.

Shared services for national bodies

The new national organisations in the system - the Board, HEE and LETBs, the NTDA and PHE - will make use of shared back office services, which will both minimise running costs and facilitate sharing resources across the system, such as staff, information and estates.

We are developing shared service solutions covering finance and accounting, payroll, communications, human resources, IT infrastructure and estates.

Finance and accounting

The Board is procuring an integrated finance and accounting 'Spine' service to support and integrate financial management between the Board and CCGs. This will provide an integrated finance environment across the commissioning landscape, ensuring CCGs apply consistent financial disciplines and controls. The service will be operational from April 2013.

Other new bodies will share a finance and accounting service being developed to support the Department and all of its arms length bodies (ALB). This will provide a cost effective transactional shared service, which is expected to be operational from April 2013. Detailed implementation plans will be available in late summer 2012 and it is expected that implementation will be in a number of waves. For some organisations an interim service is being provided by the Business Service Authority (BSA).

To minimise the risks during transition, PHE will initially build on and use the current Health Protection Agency (HPA) finance system but will subsequently move to the finance shared service after 2013.

Human resources and payroll

The Board is scoping an HR service with the NTDA, HEE and LETBs. The payroll service will continue to be based on the electronic staff record, and will integrate with the HR service. The HR and payroll services are being scoped by NHS Interim Management and Support (IMAS) on behalf of the Board.

The Department/ALB shared service programme is developing a separate shared service solution for PHE and remaining Department ALBs, based on a transformation programme covering HR transactional services over the coming year. This will be followed by potential outsourcing and a transformation programme in 2013/14 of the professional and strategic HR services. For payroll, options will be developed in early 2012/13, prior to a full business case in mid 2012/13.

The new transactional HR services should be generating savings from April 2013 and, until then, the BSA will provide an interim service to the Board Authority, NTDA and HEE.

Payroll services roll out will need to account for current ALB contractual arrangements with existing suppliers if there is a change in supplier, but new arrangements should be phased in from early 2013.

Procurement

A more collaborative approach to procurement across bodies is being scoped by a Shared Services Procurement sub-Board for development in 2012/13. This includes the development of partnering arrangements between the Department and existing ALBs with larger teams, to assist both new and smaller ALBs to attain procurement best practices.

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shared services

Shared services for national bodies (Cont'd)

shared services

Procurement (Cont'd)

The Department's procurement function will continue to provide oversight to existing and new ALBs with respect to Government procurement policies, such as the mandated use of contracts for common goods and services, and making increased use of small and medium sized businesses (SMEs). The BSA will provide an operational procurement function to those new ALBs requiring it and the Department procurement function will provide strategic procurement advice to new ALBs and those existing ALBs lacking the necessary resources.

Communications

In the design of the ALBs, thought is already being given to shared service options for communications and marketing services. As a result, the NHS Communications & Engagement CSS is looking at ways it might support the Board and a number of other ALBs, subject to it successfully passing assessment as a CSS.

Staff in corporate services

We are developing a people transition approach for staff working in corporate functions in SHAs, which will map out the proposed approach for transition into shared services and the implications for staff and services.

Key shared service milestones

March – June 2012 – the Board Authority scoping detailed requirements for, and planning implementation of, corporate support services for the Board

May 2012 – People transition plan for corporate services staff in SHAs issued

July/August 2012 – Implementation plans for finance shared services finalised

December 2012 – Transition of records and data into new service arrangements

April 2013 – New shared services established and operational roll out commences
HR transactions transformational activity begins

April 2014 – Potential outsourcing of HR transactional services
Professional and strategic HR transformation activity begins
Further wave of finance shared services roll out

emergency preparedness

Emergency preparedness, resilience and response

The Health and Social Care Act will strengthen arrangements for emergency preparedness, resilience and response (EPRR), placing clear duties on the Board and NHS funded organisations.

The Secretary of State for Health will have powers to direct health services, if required, in emergencies.

The Board will be responsible for ensuring effective, tested plans are in place and mobilising NHS resources during emergencies, and will identify lead staff for EPRR at each level. Individual NHS-funded organisations remain responsible for making sure their own tested plans are in place and putting them into effect when required.

A revised system for leading and managing EPRR has been developed with health and public health partners and will be implemented by April 2013.

Existing organisations remain responsible for EPRR during transition, making sure a robust system is in place, particularly, around the Olympic Games period.

The revised system includes the development of local health resilience partnerships (LHRPs) – where those responsible for EPRR from all relevant health organisations will come together, to make sure tested plans are in place in their area to meet the requirements of the Civil Contingencies Act 2004.

Work is underway to establish and assure these Partnerships and provide guidance at all levels to provide an integrated approach to EPRR, including public health and other organisations involved in civil resilience.

Key emergency preparedness milestones

March 2012 – Identification of initial six LHRPs

July 2012 – Delivery of LHRP guidance

October 2012 – Delivery of national guidance

February 2013 – Initial LHRPs exercised / tested in each sector / hub

April 2013 – National EPRR structure and all LHRPs in place

Maintaining quality and safety

It is critical to ensure quality is maintained during transition across the system. To do this we have been drawing on national and international experience and best practice.

The National Quality Board (NQB) set out requirements for all clustering PCTs and SHAs to produce formal handover documents for their successor bodies by September 2011. A formal assurance process has been carried out, involving visits to each SHA cluster to provide assurance that the requirements had been met and to build learning into the next stage of transition. The National Quality Team will shortly produce further guidance for the system through the publication of a 'how to' guide, setting out the steps that need to be taken by each NHS organisation to maintain quality during the transition period.

This will be one of a handful of short 'how to' guides to enable the NHS to provide a more consistent and robust response to quality issues or concerns during this transition year. We are working with SHA cluster nursing and medical directors to roll out best practice and reduce variation in the system through the creation of an agreed single dashboard for quality metrics, a revised and refreshed approach to the management of 'never events' and an agreed national system for the recording and management of serious untoward incidents across the NHS.

Looking forward, the national quality team is leading work on behalf of the NQB to clarify how the new system will identify and respond to quality failings, drawing upon the lessons of Mid Staffordshire. Following a one-day event that brought together all stakeholders across the system, a report is being produced that sets out clearly the respective roles and responsibilities of individuals and organisations, with regard to quality from April 2013. In anticipation of this and the forthcoming report of the public inquiry into Mid Staffordshire, led by Robert Francis, all NHS boards should consider how they will take forward any recommendations.

planning for 2013/14

Planning for 2013/14

The decisive phase of planning for 2013/14 will take place in the second half of 2012/13.

It is important we are very clear about the roles and responsibilities of organisations in the new and old systems during this period:

- At national level, ministers and the Board Authority will agree the first mandate setting out expectations for the NHS from 2013/14 onwards in the autumn.
- The Board Authority will then issue allocations and overall planning guidance to CCGs for 2013/14 with the Department developing the 2013/14 tariff.

  At local level, CCGs will take the lead on planning for 2013/14 during the second half of 2012/13, as they will be responsible for delivery of the 2013/14 plans. The Board Authority will support CCGs and agree plans for services it commissions directly, while the NTDA will oversee NHS trust plans.
- SHA and PCT clusters will remain clearly accountable for day-to-day delivery up to 31 March 2013. Some SHA leaders will provide targeted support to the planning process in a small number of challenged health economies on behalf of the Board Authority and the NTDA.

During this final period of transition, it will be particularly important for old and new system players to work effectively together in discharging their responsibilities. The approach to planning for 2013/14 aims to draw the maximum contribution from the old and new system under clear accountability arrangements. Our aim in all of this is to maintain our grip on current performance, while setting up the new system to succeed.

expectations for 2012/13

Expectations for 2012/13

This document sets out a very significant and demanding set of changes. All of us have a role to play in making this happen during 2012/13. The scale and complexity of the task are substantial.

Below is a summary of our core expectations of PCT clusters, SHA clusters and prospective CCGs for 2012/13. This is not a comprehensive account of organisational responsibilities but provides an overview of the main items we need to focus on together over the next 12 months.

Expectation of PCT clusters

- Ensure the statutory responsibilities of constituent PCTs are fulfilled for the whole of 2012/13
- Ensure delivery of Operating Framework requirements for the whole of 2012/13, including quality, finance and waiting times
- Support the development of CCGs, delegating relevant commissioning budgets as quickly as possible and helping CCGs to prepare for and secure authorisation
- Support the development of effective commissioning support offers that are responsive to the needs of CCGs
- Support the development of a single model for the commissioning of primary care services
- Support remaining NHS trusts to achieve FT status
- Oversee extension of Any Qualified Provider in selected areas

Expectations of SHA clusters

- Ensure the statutory responsibilities of constituent SHAs are fulfilled for the whole of 2012/13
- Ensure delivery of Operating Framework requirements for the whole of 2012/13, including quality, finance and waiting times
- Overseeing development of CCGs across the patch, ensuring they take on maximum delegated commissioning responsibilities and helping them to prepare for and secure authorisation
- Oversee the development of effective commissioning support offers, responsive to the needs of CCGs
- Support the development of a single model for the commissioning of primary care services
- Support remaining NHS trusts to achieve FT status
- Provide targeted support for the 2013/14 planning process on behalf of the new system
- Oversee the people transition for their staff, whose destinations will include the Board, NTDA, HEE and the new public health and informatics systems

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Expectations for 2012/13 (Cont'd)

Expectations of prospective CCGs

- Continue to take on delegated budgets from PCT clusters and take responsibility for day-to-day commissioning under delegated authority
- Resolve any outstanding issues relating to geographic area or practice membership
- Identify, develop and make designate appointments for senior leaders and then other staff
- Build relationships with shadow health and wellbeing boards, with patients and the public, and with local multi-professional networks
- Prepare for and undertake the authorisation process
- Develop plans for commissioning support
- Develop arrangements, where appropriate, for collaborative commissioning between CCGs and for joint commissioning with local authorities
- Engage with wider design of the commissioning system, including through involvement with CCG assembly
- Prepare for and then take the lead on the 2013/14 planning round.

First published March 2012

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