Transition Programme Risks

Review of November 2010 risk register

May 2012

First published [May 2012]
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Transition Programme Risks

Review of November 2010 Risk Register

Contents

Executive summary

The purpose of this document is to describe and explain the areas of risk contained in the Transition Risk Register of November 2010. Its release follows a review of the material contained in the Risk Register, carried out by the Department in April 2012, following the passage of the Health and Social Care Act.

There are nine areas in total, covering subjects such as legislation, communications, people transition, finance and the management of the organisational changes. These areas were described by Earl Howe in the debate on the risk register release in the House of Lords on 28 November 2011 and they cover all the areas in the original register.

On each page, underneath the description of the risk area, there is an explanatory note setting out the background to the risk and the related risks contained in the original register. While the wording of the individual risks is not included, the explanatory note refers to the range of risks in each area.

For each risk area, the document includes a column with the detail on the mitigating actions undertaken by the Department of Health since November 2010. These would have been sketched out in broad terms in the original document but are described here fully along with the outcomes achieved by taking this mitigating approach.

The second column for each risk area sets out the mitigating actions that are still underway or planned in the current financial year, before the Transition Programme is completed.

In the document, hyperlinks provide access to published information and other sources of material relating to the risk area and its mitigation.

Risk Area 1	**How best to manage the parliamentary passage of the Bill and the potential impact of Royal Assent being delayed on the transition in the NHS**
	The aim was to ensure the Bill had sufficient Parliamentary time to enable Royal Assent in the current session while allowing for robust scrutiny by both Houses of Parliament. Linked objectives were to ensure that all amendments made strengthened the Bill and were aligned with the aims of the reforms and that there was clarity over the implementation timetable so that the NHS could plan effectively for the transition.

Mitigating action and outcomes since November 2010	**Further mitigating action planned and underway**
• The Bill was introduced to the House of Commons on 27 January 2011 and received Royal Assent on 27 March 2012. • During the passage of the Bill, the Government responded to concerns raised by stakeholders about the pace of change by allowing more time for external engagement; by amending the timetable for implementation; and by adopting the core recommendations of the NHS Future Forum. In its response, in June 2011, the Government published a revised implementation timetable to give the NHS clarity to plan effectively for the transition. • Ministers and officials carefully assessed the policy and cost implications of all proposed amendments and their impact on the overall coherence of the reforms. In light of this analysis, the Government agreed amendments to the Bill where it was confident that these improve and strengthen the reforms, for example by strengthening clinical leadership and patient involvement and by putting beyond doubt the continuing accountability of the Secretary of State for the NHS. • The Government remains confident that the reforms will deliver £4.5 billion savings from reduced administrative spending over the	• None required. The Department is now preparing the secondary legislation needed to supplement the provisions in what is now the Health and Social Care Act 2012.

course of this Parliament (by 2014-15) and £1.5 billion per year after 2015, as set out in the revised impact assessment published in September 2011	

Risk Area 2	How to coordinate planning, so that changes happen in a coordinated fashion whilst maintaining financial control
	The aim was to make sure that different parts of the health and care system take forward the reforms in a planned and coordinated way, within the financial allocations and constraints

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway
• Following the Bill's Second Reading, the Department put in place a carefully-planned transition programme. This was carried out under existing powers under the NHS Act 2006, which enables the Government to undertake a limited amount of preparatory work with the aim of ensuring a smooth and effective transition. The full benefits of the reforms can only be realised through the statutory framework established now that the Bill has become the Health and Social Care Act 2012. • The Government established the NHS Commissioning Board as a Special Health Authority on 31 October 2011, following the NHS Future Forum, in order to ensure focused leadership: o for improving quality and safety; o meeting the financial challenge during the transition; and o supporting emerging CCGs in their development. • The Department established an Integrated Programme Office to co-ordinate implementation and ensure that plans are robust and aligned. Governance groups chaired by the Permanent Secretary and NHS Chief Executive have been established to ensure scrutiny of decisions and plans. • The Government accepted the NHS Future Forum's recommendation to phase the timetable for transition including: o Retaining Strategic Health Authorities as statutory bodies until April 2013, but forming then into clusters for management	• The Integrated Programme Office will continue to oversee planning and coordination of transition plans. • New bodies are being set up with sufficient time to plan. Subject to consultation, the NHS Trust Development Authority and Health Education England will be established as Special Health Authorities in June 2012. They will not take on the bulk of their responsibilities until April 2013 allowing them sufficient time to undertake the necessary preparatory work. • Mitigating actions for maintaining financial control are set out under risk area 6.

purposes; o a phased introduction of Clinical Commissioning Groups, with groups established by April 2013 but only authorised to take on responsibilities when ready; o Monitor to retain transitional intervention powers over NHS foundation trusts to 2016 to maintain high governance standards; o a phased introduction of choice of any qualified provider; o a careful transition for education and training to avoid instability; o establishing Healthwatch England from October 2012, with local Healthwatch operating from April 2013.	

Risk Area 3	How to ensure the NHS takes appropriate steps, during organisational change, to maintain and improve quality
	The aim was to ensure that the system maintains a clear focus on people's health and care throughout transition.

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway

• Performance in the NHS has been maintained or improved during transition:
  • Hospital acquired infections are at their lowest levels ever: MRSA is a quarter lower (24%) at the end of 2011/12 compared to 2010/11 and the number of C. Difficile infections is 17% lower across 2011/12 compared to 2010/11.
  • The number of breaches of mixed sex accommodation have been almost entirely eradicated (96% reduction December 2010 to March 2012).
  • Waiting times remain low, with the vast majority of patients started treatment within 18 weeks of referral: 91.2% of admitted patients and 97.1% of outpatients started treatment within 18 weeks of referral. At the end of February 2012, 92.6% of patients who have yet to start treatment had been waiting less than 18 weeks, meeting the new standard early and the total waiting list is now lower than in May 2010 (2.38 million in February 2012 compared with 2.57 million in May 2010).
  • The A&E standard has continued to be met in each quarter of 2011/12 and cancer wait standards were all met in Q3 of 2011/12.
  • Non-elective admissions, in the year to February 2012, have decreased by 1.2% compared with the same period last year.
  • Access to NHS dentistry has grown by over half a million over the last year and 991,000 more patients have been
	• PCT clusters will remain in place until 2013 to maintain capacity and capability during the transition.
	
	• The National Quality Board (NQB) is continuing to undertake work on quality in the new system. Phase Two of the NQB review is focusing on how quality will be maintained and improved in the new healthcare system architecture. This includes work on a handover process for organisations to ensure a robust handover of information on quality. This handover and assurance process will continue during 2012/13 and to support this a Managing Director for Quality During Transition was appointed. The NQB will provide ongoing advice to Ministers.
	
	• The new EPRR system is being planned and tested during 2012 and early 2013 and will change over from the current system to the new planned system on 1 April 2013.

seen since May 2010. • The latest performance information from the NHS is published in The Quarter • The focus on NHS quality and performance during transition is evident from the direction set in the Operating Framework for the NHS. The Operating Framework for 2012/13 was published on 24 November 2011. • The risk of organisational change is acknowledged. The National Quality Board has therefore been asked to advise on how to enhance quality and safety during the transition and report on any additional measures needed to strengthen the system's ability to identify and respond to serious quality failings. In March 2011, the NQB published *'Maintaining and improving quality during the transition'*, which provided advice on practical steps for maintaining quality, including setting out a clear process for delivering a robust handover for quality between current and new NHS bodies which have been acted upon. • PCT capacity was consolidated into "clusters" in order to ensure capacity and capability are maintained effectively during transition. This, along with SHA clusters, particularly helped strengthen Emergency Preparedness Resilience and Response (EPRR) arrangements and reduced the potential impact of skills shortages.	

Risk Area 4	How to ensure that lines of accountability are clear in the new system, that different bodies work together effectively, and that we avoid replicating the current system
	The aim was to establish roles for the new organisations that would enable them to work effectively together to support the delivery of services. A linked objective is to ensure the new bodies are clear about the changes required and that they have robust governance arrangements to ensure services to patients are maintained effectively.

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway

• The Act increases transparency and strengthens accountability of the NHS - shifting it from a system based to a large extent on the discretionary powers of Ministers to one where the roles and responsibilities of each body are set out clearly in legislation. The Secretary of State retains ultimate accountability for the health service, setting the strategic direction for the system and holding national organisations to account for performance, and has extensive powers of intervention should they fail to meet their objectives. The duties of cooperation across arms length bodies help to ensure that the new system will be characterised by strong, autonomous bodies working together in the interests of the health service.
 	
• In response to concerns from Peers we made amendments to the Bill to clarify lines of accountability:
 	
  • We made clear that the Secretary of State will retain ministerial accountability to Parliament for the provision of the health service;
  • We also amended the duties of the Secretary of State and the NHS Commissioning Board, to make clear that in exercising this duty, the interests of the health service must always take priority; and
  • We made clear that Clinical Commissioning Groups (CCGs)
	• The Department will agree Framework Agreements with the NHS Commissioning Board, Monitor and all other arms-length bodies. These set out the roles, responsibilities and accountabilities for the Department and the ALB, and will reinforce the need for effective partnership working while avoiding duplication of roles (the Framework Agreement for the NHS Commissioning Board Special Health Authority was published in January 2012).
	
	• Formal governance mechanisms will be established for the new bodies in the system to ensure they are working together with common purpose and clarity about their roles. Senior appointments will be made over the coming months, including:
	
	  • Chair and Chief Executive roles in Health Education England
	
	  • Remaining NHS Commissioning Board senior leadership posts
	
	  • Appointment of the Chair of Public Health England
	
	  • Senior appointments to Clinical Commissioning Groups
	
	• The Secretary of State's Mandate to the Commissioning Board will be a multi-year document, published before the start of each financial year that sets: objectives, which the Board must seek to

must exercise their functions consistently with: the duties of the Secretary of State and the NHS Commissioning Board to promote the comprehensive health service, and the Government's Mandate to the Board. • An Accounting Officer system statement was published on 23 January 2012 providing further information on the role of the Accounting Officer in relation to the NHS, public health and adult social care after April 2013 • The Department has put in place a carefully-managed transition programme, including supporting CCG pathfinders, Local Authority early adopters and local Healthwatch pathfinders to prepare the groundwork for full implementation. • The Government established the NHS Commissioning Board as a Special Health Authority to work towards the establishment and operation of the NHS Commissioning Board, helping to ensure that the new commissioning arrangements are able to operate effectively from the start. • The Board Authority has also published a series of resources for emerging clinical commissioning groups, including guidance, toolkits, and other information around authorisation, establishment, governance and commissioning support. • The NHS Commissioning Board Authority published *Clinical Commissioning Group authorisation: draft guide for applicants* on 13th April 2012. This is designed to designed to help emerging CCGs develop clear plans to progress through the authorisation process and become an authorised CCG. It provides a detailed description of the criteria, thresholds and evidence for authorisation and sets out the timetable for applications in four waves, including setting out the possible outcomes: fully authorised; authorised with conditions; and established but not	achieve; any supporting requirements, which the Board must comply with; the Board's budget. There will be a formal public consultation on the Mandate later this year. • Over the course of 2012/13 emerging CCGs are preparing for establishment and taking on their full commissioning responsibilities. They are considering when they will submit an application to the NHS Commissioning Board to be authorised. 35 emerging CCGs have already agreed to submit applications for the first wave in July 2012. The subsequent three waves will run from September, October and November 2012.

authorised (shadow CCG). 35 emerging CCGs have already agreed to submit applications for the first wave in July 2012 • In relation to the new Public Health System, *Healthy Lives, Healthy People* set out the vision for the new public health system; and *Healthy lives, Healthy People: update and way forward* set out the Government's policy responses to the consultation. A series of factsheets were published in December 2011 and January 2012. *Public Health in Local Government* and *Public Health England's Operating Model* completed the overall policy design and provided clarity for the transition. *Improving outcomes and supporting transparency: a public health outcomes framework for England*, set out the high level outcomes. • Major appointments have already been made to key roles in the new system: • Sir David Nicholson has been appointed Chief Executive of the NHS Commissioning Board and will retain his current role as NHS Chief Executive for the whole of 2012-13. Professor Malcolm Grant was confirmed as Chair of the NHS Commissioning Board in October 2011. Other senior appointments to the NHS Commissioning Board can be found here • Dr David Bennett was appointed as Chair of Monitor in March 2011, and continues to act as the organisation's Interim Chief Executive. • David Flory and Sir Peter Carr have been confirmed as Chief Executive and Chair, respectively, of the NHS Trust Development Authority • Duncan Selbie was confirmed in April 2012 as the Chief Executive Designate of Public Health England.	

Risk Area 5	How to minimise disruption for staff and maintain morale during transition
	The aim is to manage the staff changes in a coordinated way, taking account of individual needs, so that workforce changes are implemented fairly and transparently during transition.

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway
• PCT capacity was consolidated into “clusters” in order to ensure capacity and capability were maintained effectively during transition, while SHA clusters were also formed into smaller clusters for management purposes. • A significant programme of work has been developed by the Department in strong partnership with the trades union and employers across the Department, NHS and arms length bodies. The aim has been to develop clear arrangements to manage the change process in accordance with proven best practice and to support staff during transition. • Leaders from the service have been engaged in developing HR Transition Plans and supporting guidance: this has been embedded in the service through usual SHA and employer engagement. SHAs have been involved in systems planning to ensure continuing performance and quality. • Working with the trades union and employer representatives in partnership through the HR Transition Partnership Forum, the Department has delivered a range of joint products including the HR Transition Framework; a HR Transition Guidance and Toolkit for sender and receiver organisations to manage HR transition processes and provided practical advice on implementing people transition policies.	• SHA and PCT clusters will remain in place and clearly accountable for day-to-day delivery up to 31 March 2013 and will oversee the people transition for their staff. • The Department plans to develop a clear resourcing plan setting out when such moves are intended to take place so that staff have clarity. All managers will maintain regular contact with staff as this develops. • The Department will continue to work with the trades union to develop HR policies which are demonstrably fair to staff. • The Department is developing HR Transition Guidance and a toolkit to provide consistency to the approach for people transition. • An integrated communications plan for workforce changes across system partners is being developed and reviewed weekly. The plan ensures consistency of information to staff from both sender and receiver organisations supports specific areas of need and facilitates an open and transparent process.

• Senior leaders across the health and care system sent letters to all staff affected by transition on 31 January 2012. This was part of the on-going commitment by the Department to provide as much information as possible about transition to those working across the system as the process moves forward. The letters outlined, as far as possible, the expected destination for functions in the future system; the timescale that the Department is working towards on transfers; and options for staff to consider going forward. After Royal Assent, David Nicholson set out the implications and next steps for staff and organisations in a special edition of The Month Similar communications were sent to non-NHS staff.	

Risk Area 6	How best to ensure financial control during transition and to minimise the costs of moving to a new system and to ensure that the new system delivers future efficiencies
	The aim was to ensure that there is tight control over budgets and expenditure during transition and that all options for the new system would be rigorously tested at each stage of the design and implementation processes in order that decisions could take account of the potential costs. Linked to this is the objective of ensuring that adequate systems are in place to alert those delivering the changes to financial issues that may arise while continuing to focus on necessary efficiency savings.

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway
• The Government has continued to maintain financial control during transition. At Quarter 3 (Q3) of 2011/12, Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) were forecasting a combined surplus of nearly £1.5bn. NHS trusts (excluding foundation trusts) are forecasting an overall surplus of £30m. • Delivery against the £20bn Quality Innovation Productivity and Prevention (QIPP) challenge continues. £1.4 billion of QIPP savings were delivered during Q3. This gives a total a year to date QIPP savings figure of £3.9 billion. Total NHS efficiency savings since 2010/11 amount to £8.26bn. At Quarter 3 PCTs are forecasting annual QIPP savings of £5.8 billion, which continue to be in line with the overall delivery of QIPP plans. • Transition plans have been costed and affordability tested, including high level allocations for the major components of the system, and signed off by the Executive Board. • The Government remains confident that the reforms will deliver £4.5 billion savings from the reduction in administrative spending over the course of this Parliament (by 2014-15) and £1.5 billion per	• Continuing to focus on the QIPP end-state vision will ensure that the NHS builds a resilient and sustainable health system for the future. Currently, local health systems are refining their QIPP programmes and associated end states during the planning round for 2012/13. There are an emerging number of examples where transformational programmes have begun implementation with positive progress, both in terms of improved quality to the patient and provision of care at a lower cost. • The Department is continuing to monitor expenditure across transition workstreams, and quarterly returns are submitted to Cabinet Office. • Costs and staff numbers are being monitored on an ongoing basis and the Department and will actively take action to contain costs in the event that they start to drift upwards. The Finance and HR workstrands are continuing to work together to manage the overall costs of redundancies.

year after 2015, as set out in the revised Impact Assessment published in September 2011. • The Department has undertaken extensive analytical work to model costs under different scenarios – especially important for redundancy costs that are the largest cost driver. • The Transition Costs Group (Special Allocations Group) has overseen costs and made allocations, and an HR workstrand has been set up to manage transition of staff whilst minimising staff losses. • All re-organisation plans are required to take account of efficiency savings requirements. Shadow budgets have been set for some organisations prior to formal establishment, so that they can prepare for formal establishment. • Clustering of SHAs and PCTs has also increased resilience and concentrated expertise so that they are better equipped to manage these changes.	

Risk Area 7	How to ensure that future commissioning plans are robust and to maximise the capability of the future NHS Commissioning Board
	The aim was to ensure there was clarity about the aims of the NHS Commissioning Board and that it has the capacity and capability to fulfil its functions. Linked to this was the objective of ensuring that clinical commissioning groups are only established when ready to take on their commissioning functions, and that any contractual obligations to the new commissioning arrangements are addressed.

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway
• The NHS Commissioning Board Authority is already providing clear leadership and capacity for the development of the new commissioning system, including supporting Clinical Commissioning Groups (CCGs) in their development and ensuring that commissioning support services are developed to aid CCGs in delivering any element of their functions. • A national pathfinder learning network has been in place since early 2011 to provide support to emerging clinical commissioning groups in developing and implementing their new commissioning roles. Pathfinder CCGs came forward rapidly: 51 in December 2010, 73 in January 2011, 41 in March 2011, 43 in April 2011, 35 in July 2011 and 13 in October 2011. • In the 2011/12 Operating Framework we committed to delegating commissioning budgets to pathfinders as formal sub committees of PCT Boards. To date, the total estimated commissioning funds for delegation are £63.1bn. Of this, £40.4bn has been applied for by emerging CCGs in 2011-12 (64%). Of the funds applied for, £37.3bn has been delegated (92% of the funds applied for). • Emerging clinical commissioning groups are increasingly taking on leading roles in commissioning through delegated responsibility	• The NHS Commissioning Board Authority is finalising a national development programme which will build on this and set out the further steps that emerging clinical commissioning groups can take to continue their development journey. It will, for example, signpost identified learning and development opportunities across three areas: development of individual leaders; organisational development and development for leading transformational change. SHA and PCT clusters are also proactively supporting the development of emerging clinical commissioning groups, helping them to become the best they possibly can. • The NHS Commissioning Board Authority is making preparations for the NHS Commissioning Board's direct commissioning from 1 April 2013 of, for example, primary care services, specialised services and a range of public health services, as well as its responsibilities in relation to emergency planning and response, patient safety and quality assurance of NHS services. • Over the course of 2012/13 emerging CCGs are preparing for establishment and taking on their full commissioning responsibilities. They are considering when they will submit an application to the NHS Commissioning Board to be authorised. 35 emerging CCGs have already agreed to submit applications

from their PCTs. • The Board Authority has also published a series of resources for emerging clinical commissioning groups, including guidance, toolkits, and other information around authorisation, establishment, governance and commissioning support. • The NHS Commissioning Board Authority published *Clinical Commissioning Group authorisation: draft guide for applicants* on 13th April 2012. This is designed to designed to help emerging CCGs develop clear plans to progress through the authorisation process and become an authorised CCG. It provides a detailed description of the criteria, thresholds and evidence for authorisation and sets out the timetable for applications in four waves, including setting out the possible outcomes: fully authorised; authorised with conditions; and established but not authorised (shadow CCG).	for the first wave in July 2012. The subsequent three waves will run from September, October and November 2012.

Risk Area 8	How stakeholders should be engaged in developing and implementing the reforms
	The aim was to engage stakeholders in the development and implementation of the reforms, ensuring the reforms were as robust as possible and that the timetable for implementation was met.

Mitigating action and outcomes since November 2010	Further mitigating action planned and underway
• The Government has engaged stakeholders throughout policy development and the Parliamentary passage of the Bill, taking steps to ensure engagement is thorough. Ministers and officials have held regular meetings with a broad range of stakeholder groups, including the medical Royal Colleges, groups representing healthcare professionals, and patients' organisations. • The NHS Future Forum was set up in April 2011 as an independent advisory panel to drive engagement during the pause in the passage of the Health and Social Care Bill. Over the course of eight weeks, the Forum heard from over 6,700 people in a series of over 200 listening events and meetings. These included: meetings with 250 national stakeholder organisations; regional events organised by Strategic Health Authorities; and two national and nine regional patient and public involvement events organised by Local Involvement Networks (LINks) • Amendments were made during the passage of the Bill to address stakeholder concerns including: o putting beyond doubt the continuing accountability of the Secretary of State for the NHS; o strengthening clinical involvement in commissioning; o placing new duties on the NHS to promote integration and to tackle health inequalities; o reformulating Monitor's core duty to protect and promote the interests of patients and to ensure competition is only used where it benefits patients;	• Stakeholder engagement throughout implementation of the reforms is planned, including: o developing the mandate to the NHS Commissioning Board, on which there will be a formal public consultation; o building on the positive work of the NHS Future Forum on integration to develop the approach on this. • A new External Relations Directorate has been set up, including a partnerships and Information team to strengthen co-ordination and engagement with stakeholders. • Engagement across the system will continue through, for example, the National Stakeholder Forum for Partnership Week. • Communications activity and change messages continue to be developed and targeted at all stakeholders to enable them to understand the process of transition and how each element of change contributes to the new health and social care system

o strengthening health and wellbeing boards; and o introducing a more phased timetable for implementation.	

Risk Area 9	**How to properly resource the teams responsible for implementing the changes**
	The aim was to ensure policy and transition teams were appropriately resourced so that they could plan and prepare effectively for the introduction and passage of the Bill and for the implementation of the reforms.

Mitigating action and outcomes since November 2010	**Further mitigating action planned and underway**
• The Department gave priority to ensuring that the teams to support transition and implementation had the right number of staff, with the right skills. This allowed the Department to ensure that the various actions to support effective transition and implementation were taken at an early stage.	• The Department will keep resourcing of teams involved in implementing the reforms under review to ensure that the transition continues to be managed effectively.