HOW TO:
Maintain Quality during the Transition: Preparing for handover

National Quality Board

May 2012

This publication has been produced by the National Quality Team on behalf of the National Quality Board.

To find out more about The How To Guides please visit the NQB web site

http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/

or email parmjit.kaur@nqb.nhs.uk

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The purpose of ‘How to’ guides

Recent failings in the health and social care system have highlighted the need for greater clarity about who is responsible for identifying and responding to failures in quality. The National Quality Board has addressed this through the publication of two reports

1. Review of early warning systems in the NHS (24 February 2010):-
   www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020
2. Maintaining and improving quality during the transition: safety, effectiveness, experience (March 2011)
   www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234

But if we are clearer about our roles and responsibilities, then we also need a more consistent approach to how these difficult judgements about quality are made and to provide the managers and clinicians who have to make them with more guidance and support. How should we judge whether a service is failing or not? What tools might be used to better understand the situation, and what action should be taken as a result?

As part of the SHA to SHA Cluster Handover Assurance Process run in 2011, we sought to understand from each region what the current ‘best practice’ operating model for key aspects of quality is in their area, with a view to encouraging adoption across the country. Rather than try and produce one overarching model, we have worked with the NHS and key stakeholders to produce a series of practical ‘How to’ guides that directly relate to the key issues that NHS staff have suggested that further guidance would be helpful. These documents and a range of other resources can be found on http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/. These guides are not set in stone: they represent our best understanding of the most effective way of responding to quality concerns, and we would welcome feedback and comment so that we can continue to incorporate any learning and experience into the operating model for quality.

Quality is complex. It is systemic: that is, the delivery of high quality care depends upon many different parts of the system working together. Therefore, the most important part of any operating model for quality in the NHS must be the culture and behaviours that our respective organisations adopt within and between ourselves.

Proposed Operating Principles

- The patient comes first – not the needs of any organisation
- Quality is everybody’s business – from the ward to the board; from the supervisory bodies to the Regulators, from the commissioners to primary care clinicians and managers
- If we have concerns, we speak out and raise questions without hesitation
- We listen in a systematic way to what our patients and our staff tell us about the quality of care
- If concerns are raised we listen and ‘go and look’
- We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others
- If we are not sure what to decide or do, then we seek advice from others
- Our behaviours and values will be consistent with the NHS Constitution

Summary: How to Handover Quality

The implementation of the Health and Social Care Act 2012 will require the largest ever transition programme in the history of the NHS. SHAs and PCTs will be abolished from April 1st 2013, and their existing functions will need to be separated out and handed over to the organisations that will form the new landscape.

This process will leave few parts of the system untouched and past experience shows that any period of structural change can put quality and safety at risk. It is therefore critical that we put processes in place to mitigate those risks. Traditionally the NHS has employed formal processes of handover for technical issues such as finance and estates, but we have not, until now, applied the same discipline to the handover of quality issues. This 'how to' guide draws upon the lessons we learned from assuring the handover process following the clustering of SHAs and PCTs, and has been developed with the advice and help of the NHS and members of the NQB. It forms part of the wider handover requirements and guidance published by the Department of Health, and focuses exclusively on quality issues.

In response to feedback from the service, this report contains clear guidance, timetables and templates, and sets out the requirements for a good handover on quality:

PCT Clusters are required to complete their plans to create a handover document for quality and submit them to their SHA Cluster, by no later **than June 23rd 2012** so that they can confirm receipt to the National Quality Team, and begin a local process of assurance as part of their responsibilities for managing the transition.

SHA Clusters are required to complete their own plans to create a handover document for quality and submit them to the National Quality Team, together with a letter confirming that they have received the PCT Cluster plans, setting out how they will assure them, by **June 30th 2012**.

But these processes are just means to an end – they are not an end in themselves. One of the key learning points from the assurance process was the central importance of the face-to-face conversations between staff. Any documents are meant to support, not replace, this vital exchange of hard and soft data. In producing this guide, our aim is not to increase the bureaucratic burden on our staff, but to provide practical support so that people can continue to deliver on their respective accountabilities for quality as we go through this transition. This process should not just be about reducing risk, but about maintaining our ambition for quality improvement, and ensuring that the drive to improve services for patients is part of our enduring legacy.

Chapter one: Learning from our experience

Background

The Health and Social Care Act 2012 requires the new system architecture for the NHS to be in place by the 1st April 2013. The implementation of the Act will affect almost every part of the NHS, and whilst the legislation seeks to improve the quality of care for patients, we know from past experience and lessons elsewhere that any period of structural change can put quality and safety at risk. In recognition of this fact, the National Quality Board (NQB) published *Maintaining and Improving Quality During the Transition* in March 2011. For the first time, this report set an expectation that the discipline and rigour that occurs in financial handovers should be applied to matters of quality. It described a form of 'clinical due diligence' and set out the formal handover requirements for PCTs and SHAs during the process of clustering their functions, to ensure that organisational memory on quality issues was captured, written down and communicated to their receiving body.

Lessons

The National Quality Team, led by Ian Cumming and Sir Bruce Keogh, carried out an assurance process to ensure that requirements had been followed and to capture the learning for the transition going forward. Following four one-day visits to each of the SHA Clusters involving discussions with several PCT Clusters, the key findings and learning points included:

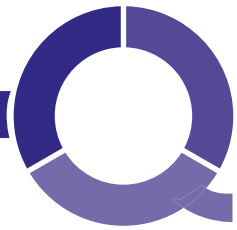
- The need for greater clarity of purpose with sufficient time for the system to understand and meet the requirements of any handover process
- The requirement to formally document information was a useful discipline, but the most valuable part of the process was the face-to-face conversations between individuals
- We should seek wherever possible not just to hand over information to reduce risk, but to hand over the ambition for quality improvement, so that services continue to improve for patients
- Any written documents need to be easy to access and navigate by the recipient, so that it is apparent where the areas of risk are in terms of quality. Too much information is as unhelpful as too little
- The documents are for the benefit of the recipient, and should tell them whatever they need to know in order to help them exercise their new accountabilities. They should not be confused with Annual Reports or be an attempt to record the achievements of the existing organisation
- Triangulation of data (both hard and soft) did not always happen between all of the relevant bodies, such as the regulators, but when it did it was extremely helpful. We need to be much clearer about the requirements of our key stakeholders
- It is vital to ensure that patient experience data is captured as part of the quality assessment and to find ways of engaging with patient groups as part of the process of triangulation

- ‘Looking and seeing’ should form part of the triangulation process wherever possible.
- Whilst data was generally strong and comprehensive on the acute sector, we need to extend and improve our inclusion of data on the quality of primary, secondary and tertiary care, social care, ambulance services, screening programmes, offender health, mental health and the independent and third sectors.
- The responsibility for the handover should sit equally with both the receiver and the sender. i.e. if there are gaps in the documentation handed over, then it is the duty of the recipient to proactively seek to fill those gaps
- The requirement to take handover documents to the public sessions of boards helped the process to be taken seriously, and was in line with the proposed new Duty of Candour. On the whole the media treated this information responsibly.
- Embedding documents is not good practice, as the information can be lost as links and websites close down. We need to use technology better to ensure that documents are kept ‘live’ and electronically available to those who need it, with better version control
- Some issues transcend individual organisations, and there may be a need for a small number of thematic handovers in order to maintain quality during transition.

This ‘How to’ guide draws on the experience and lessons learnt from around the country during the clustering process, and sets out the requirements for the system to ensure that we reduce any risk to quality during this year of transition, and maintain our momentum and ambition for quality improvement beyond April 2013. It sets out the steps you should take to ensure that any risk to quality is reduced and that business continuity is maintained. It should be read in partnership with the Department of Health’s wider handover guidance as it is issued over the coming months.

However, one of the key lessons from the past year has been the need to remain focussed on the accountabilities you hold until the point of transfer, and the need to retain flexibility to respond to changes in resilience which may require further changes to timelines and requirements. This guide aims to support you in fulfilling your responsibilities as an NHS member of staff, but like all national guidance, it has its limitations. You will still need to assess the needs of your own particular situation and adapt the broad principles and requirements to ensure that you fulfil the spirit, as well as the letter, of your public accountabilities.

Chapter two: Our expectation



The NHS employs over 1.4m staff in many different organisational settings throughout England. But we are bound together by a common set of values and purpose. As set out in the NHS Constitution, NHS staff are committed to earning the trust placed in us to provide high quality care, and putting the needs of patients and our communities before organisational boundaries or interest.

We saw these values in action during our assurance process, as managerial and clinical staff approached the handover requirements with great professionalism and diligence, despite uncertainty about their own personal futures. We fully expect to see this professionalism and dedication to public service to continue, and are confident that NHS staff will ensure that all possible steps are taken to ensure that information relevant to the quality of care provided is available to those who need to know in a format that is easily accessible and comprehensible.

However we recognise that the sheer scale of movement and change between people and organisations during 2012/13 may make this difficult. In order to ensure absolute clarity of expectations, below we set out the responsibilities of every member of NHS staff, and the principles which should be used as a guide to action.

Guiding principles of handover

Transparency

Once approved, all documents should be available in the public domain in line with existing guidance and best practice, to ensure that all successor bodies have full access to information which they may need to fulfil their responsibilities.

Honesty

All sending organisations must endeavour to be as open and honest about known areas of risk,(potential or existing) so that appropriate action can be taken by the receiving body.

Probity

Organisations need to ensure that they have governance systems in place to assure full and frank disclosure, particularly in the case of dual accountabilities (i.e. when the CEO of the sending organisation is also the CEO of the receiving organisations). Whilst continuity of staff is positive in terms of maintaining organisational memory, boards should also be alert to the potential for 'organisational blindness'.

Responsibilities of NHS Staff during transition

NHS Constitution: Staff Responsibilities

You should aim to: *maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aim of your team and the NHS as a whole.*

- All **Chairs** and **CEOs** of NHS organisations must read this guidance so that they can understand and execute their responsibilities for the transition. As Accountable Officers, whilst they may delegate certain aspects of the handover to functional leads, CEOs retain overall responsibility
- **CEOs** of both sending and receiving organisations should nominate a named **Transition Lead**, responsible for the transfer and receipt of functions and for the development of the handover plan, including resilience
- Where **dual accountabilities** are in place, you should ensure that you have someone leading on the sending/wind down of functions, as well as someone identified to receive and build the new to reduce the risk
- On behalf of the CEO, the **Medical Director** and the **Nursing Director** should share responsibility for producing and (where relevant) receiving the Quality handover document. For the *sending* body, this means not just having oversight of the work, but actually signing it off, as a fair and accurate assessment of the quality issues for which you are currently responsible for to the best of your knowledge. For the *receiving* body, this means ensuring that you not only read the Quality document, but take any necessary steps to ensure that any gaps are filled, over and above the face-to-face meetings
- In anticipation of significant staff movement, **Directors of HR** should ensure that adequate processes are in place to ensure that any relevant information is captured from individuals before they leave, such as ensuring exit interviews are carried out with **Line Managers** in accordance with good practice
- **Chairs** of both sending and receiving bodies should ensure that adequate systems are in place to ensure full probity in handovers where dual accountabilities feature. (for example a CEO should not hand over to his/her self, but to his/her board).
- The **senior teams** of the out-going and in-coming organisations should use the quality chapter of the handover document as an agenda for a face-to-face conversation to ensure that hard and soft intelligence is communicated and fully understood. As a minimum we would expect the cast list to include the CEO and the Medical and Nursing Directors. This could form part of the general handover process, but dedicated time must be set aside for the quality conversation
- **Board Secretaries/Directors of Governance** need to put in place processes to allow out-going and in-coming teams to produce, assess and sign off quality handover documents, in line with our aims to be transparent
- **Individual members of staff** should co operate fully with the process of gathering and receiving intelligence about quality, and pro-actively provide any information which they think is relevant to the quality of care. Existing NHS staff should be encouraged to provide forward contact details if they are responsible for a key piece of work or have the organisational memory for a particular quality issue.

The above is an indicative but not exhaustive check list of responsibilities, for we expect NHS staff to use their common sense and values to help ensure that the quality of patient care does not suffer as a result of the changes we are about to go through. When in doubt, the values and the staff responsibilities set out in the NHS Constitution should provide a guide to action, such as the requirement to 'view the services you provide from the standpoint of the patient'. None of us would find it acceptable if our care suffered because the person who knew about a quality issue left his post and failed to pass information on.

Chapter three: Thinking it through

Before commissioning lots of work to populate the template set out in **Annex B**, you should spend some time as a senior team thinking through some key questions. The clearer you are about the purpose of the document, how it will be used, by whom and when, the better idea you will have about what you need to provide or receive. You will save yourself a lot of time and effort and produce something of real value if you first think through some of the following questions:

Checklist for senders

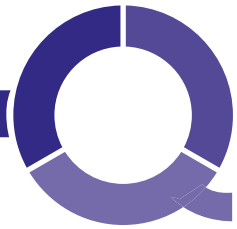
Questions
• Is my organisation being abolished or reformed? (Changes to function responsibilities should also be subject to quality handovers)
• Are my functions being closed down or transferring?
• If transferring, are they all going to one organisation or several? (If several, identify them all)
• If some of my functions are not being transferred to anyone, is this because a receiver has yet to be identified, or because they will not exist in the new system? Does this present any risks, and how might they be mitigated?
• Who are the customers for my information on quality?
• What are their particular needs? What information will they need access to and how can I provide the information in a way that is most useful to the user in the time and format that they need?
• Do I have all the information I need on quality for my areas of responsibility? If not, what steps do I need to take to fill those gaps prior to the deadline?
• Who will I need to talk to in order to fill the gaps in both hard and soft intelligence? Can I get them in the diary now?
• Who will I need to talk to/work with in order to triangulate my information on quality
• What processes do I need to put in place to prioritise any risks identified, so that the user can easily see the greatest risks to quality, perhaps in the form of a summary risk profile?
• Of those quality risks identified, is there any good reason why I can't tackle and resolve them by April 2013?
• Are there historic issues that have been resolved, but may need follow through in terms of Action Plans and other recommendations, or that I should alert the new team to in case of reoccurrence?
• Do I have processes in place to capture quality issues in primary, social and independent care sectors?
• Am I clear about what information I will convey in written documentation and what I will communicate verbally and why?
• Am I clear about the requirements of FOI, and have a strategy to meet them whilst also ensuring the frank exchange of information necessary to maintain quality of care?

- Do I have a process of triangulation of the data and intelligence I am likely to send with external bodies? (Our current thinking is that PCT Clusters should triangulate with local bodies, such as OSCs and LinKs, but that SHA Clusters should triangulate face-to-face with national bodies at sector level, such as CQC and Monitor, and that we the NQT would triangulate face-to-face with the national offices of CQC and Monitor).
- Have I put in place a process of internal triangulation, so that my functional leads can share what they have learned and understood about quality from their different perspectives/sources?
- Have I diarised meetings enough time between the key people to ensure we have face-to-face meetings following receipt of the documents? (From our experience a robust quality handover conversation with documents should take at least half a day).
- Do I have HR processes in place to ensure that key staff don't leave before documenting their knowledge and/or taking part in the vital handover conversations?
- Do I have a resilience plan in place so that I can maintain a)current responsibilities for resilience and b)have senior staff who can participate in the conversations about handover?
- Have I identified contacts in my team who will be in the new system and who could contribute to the delivery of corporate memory following handover?
- Do I have processes and people in place to keep the data live between September 2012 and April 2013?
- Are my team clear that until 1st April 2013, we retain our current statutory accountabilities? No matter who we send information and documents to, you retain responsibility for acting upon the information until the accountability transfers.
- Do I have sufficient safeguards in place to ensure full probity? (particularly where dual accountability is an issue either at CEO or Director level).
- Is my documentation easy to read, accessible to all and stored in accordance with the guidance on P19?

Checklist for receivers

Questions
• Am I clear about what responsibilities I will carry with regard to quality, and how I will exercise them and what information will I need in order to carry them out?
• Who, if anyone, currently holds those responsibilities and information now?
• Are they clear about my imminent responsibilities and my needs and expectations of them with regard to handover? Do I need to meet/communicate to ensure clarity? Do not assume they do – take proactive steps to contact them and set out your expectations.
• Have I identified a Transition Lead to manage the receipt of functions, accountabilities and knowledge from the old system, as distinct from the staff I have working on the new?
• Have I diarised meetings enough time between the key people to ensure we have face-to-face meetings following receipt of the documents? (From our experience a robust quality handover conversation with documents should take at least half a day).
• Am I clear how and when I will gain access to the documents and what I should do with them?
• Have I viewed the work in progress handover documents, and am I ready to receive and exercise my responsibilities with regard to quality on April 1st 2013?
• Do I have in place a process of triangulation of the data and intelligence I am likely to receive with external bodies? (Our current thinking is that PCT Clusters should triangulate with local bodies, such as OSCs and LinKs, but that SHA Clusters should triangulate face-to-face with national bodies at sector level, such as CQC and Monitor, and that we the NQT would triangulate face-to-face with the national offices of CQC and Monitor).
• Have I put in place a process of internal triangulation, so that my functional leads can share what they have learned and understood about quality from their different perspectives/sources?
• Have I identified a board meeting to receive and discuss the handover documents? Do I need a private session first to share soft intelligence?
• Do I have robust systems in place to ensure full probity, and the ability to challenge with diligence the information I am presented with? (particularly in the case of dual accountability)

Chapter four: Relevant Data Sources



Quality is systemic: that is, it depends upon many different individuals, inputs, process and organisations. It is also, to a degree, subjective. The data required to assess quality, therefore, needs to be drawn from from many different sources, to ensure that we are capturing relevant information on the three domains of quality: effectiveness, safety and patient experience. The metrics used to populate the national quality dashboard should be used as a starting point although other data sources should be included. In this context the following is a list of additional sources/areas which should be used. **Please note that this is not a comprehensive list**; all relevant and appropriate sources should be drawn upon:

- Performance data on the priorities set out in the Operating Framework relevant to quality (i.e. waiting times, infection rates etc.)
- Never Events and serious incident data
- CAS alerts closure rates and outstanding issues
- Hospital Mortality
- Patient survey results and other patient data such as Net Promoter scores if available and website material such as NHS Choices)
- Staff survey results
- Complaints data
- CQC inspections - registration details, warning notices and related CQC notifications
- Quality Risk Profile data
- FT Quality assessments
- Monitor ratings
- Quality Accounts
- Adult safeguarding
- Child safeguarding
- Safety Thermometer and Energising for Excellence
- Maternity Services, Local Supervisory Midwifery Authority reports and audits
- Data from the Quality Observatory
- Quality impact assessment of Provider Cost Improvement Programmes
- Homicides/unlawful killings – historic and ongoing including action plans
- Peer reviews, recommendations and action plans
- Clinical Audits

Whilst we have made great improvements in recent years in capturing hard data about quality, we must not lose sight of the importance of 'soft' intelligence. We have national staff patient surveys included in the dashboard, but in addition you should also be looking at and listening to:

- Media – traditional and social – negative and positive
- Patient websites such as Patient Opinion, NHS Choices, local user groups
- OSCs, local MPs, LinKs, etc.
- Social Partnership Forum, staff side
- Professional Regulators and Royal Colleges Trainee feedback / Deanery reports
- Whistleblowing and similar reports from staff

One of the lessons from the assurance visits was that much of the data tended to focus on acute settings. In this transition we would like to stress the importance of ensuring that quality data and knowledge is captured for non-acute settings, including primary care, independent sector, ambulances, mental health services, screening programmes and offender health.

The above list is not exhaustive, but you should use your judgement and common sense to proactively capture the intelligence that exists within the system. Once SHAs and PCTs are abolished, there is no one place where any of this hard or soft intelligence comes together, so concrete steps will need to be taken to ensure that it does not fall between organisations and individuals during the many handovers that are about to take place.

Chapter five: Capturing and keeping the knowledge

One of the key lessons from the clustering process was the value of the face-to-face conversations between Accountable Officers and functional leads. Not only did this ensure that complex data was explained and understood, it provided an opportunity to share 'soft' intelligence. Soft intelligence is the term we use to describe information that cannot always be verified, or proven. Sometimes it may be based upon anecdotal evidence; at other times it may be nothing more than a hunch or a feeling that something is 'not quite right' with an organisation, service or an individual. Such concerns often turn out to be unwarranted, but they can sometimes prove to be the 'early warning' signals that an organisation, service or individual is failing. Experienced managers and clinicians deal with these issues every day, and use their judgement to decide when to 'watch and wait', initiate further investigations or take decisive action.

During a time of transition, when responsibilities are being handed over, it becomes harder to 'watch and wait' to see if a hunch or a single anecdote proves to be more substantive, because a decision must be made as to whether to pass on concerns which may turn out to be baseless. Whilst we wish to see the principle of transparency followed in the production of handover documents, we need to avoid situations where individuals or services might be subject to libel or slander, or where soft intelligence is not shared at all for fear of this.

Therefore we would urge people to uphold the principles of transparency wherever possible, in recognition that placing data in the public domain will in itself help to increase the focus on quality and drive further improvement, but to also exercise common sense. If the sending body is aware of concerns that are not yet verifiable or able to be captured by the data sources outlined in section 4, then this information should be shared verbally at the face-to-face meetings. In order to balance the need with transparency with the desire to avoid compromising patient or professional confidentiality, we would expect notes of the meeting to detail the cast list, the topics discussed, but not be a verbatim record of the discussion.

Another key lesson to emerge from the clustering process was the importance of keeping documentation live. It became apparent that the embedding of linked documents within other documents was not a safe way of storing information, as when organisations and/or websites close down, the data disappears.

Handling data / records

Records are associated with functions. It is important that service changes are managed carefully to ensure that the functions which are to continue can do so safely and efficiently. Functions which will not continue must also be managed carefully to ensure that legal obligations are met, valuable knowledge retained and historically valuable data preserved. This is not a trivial undertaking. It will require planning and attention to detail and may require difficult decisions to be made about complex data management issues which should be taken 'at the top of the office'.

The NHS Information Governance: Effective Management of Records during a period of transition or organisational change' publication (September 2011) and the National Information Governance Board for Health and Social Care – Information governance for transition publication (November 2011) are useful reference points on good practice and provide specific guidance. Further guidance about records management in general can also be found in the Records Management: NHS Code of Practice and those with responsibility for records and information/knowledge management should ensure that they are familiar with the principles covered within the Code.

Chapter six: Governance Requirements

The primary purpose of the quality section of the handover documents is to ensure that hard and soft intelligence is not lost to the system as a result of the structural changes we are about to go through in the NHS. However, we must follow this process in a way that is consistent with our public sector duties and the principles of openness and transparency, as well as respecting the confidentiality of individual employees and patients.

Board meetings

The **sending** organisation should receive and approve a copy of their plan for handing over a quality intelligence in advance of submitting it to either the SHA Cluster or National Quality Team as required by this guidance.

The sending organisations should take their final handover document for Quality to a public meeting of their board in March 2013, with a full discussion and sign off from the Executive and Non-Executive members, who should confirm that this is a true and accurate reflection of all current known quality issues. Earlier drafts may be taken to be private sessions of the board to ensure that members are familiar with the process and have a chance to input and how best to share hard and soft intelligence. Supporting documents need not go to the public board meeting, but organisations should make arrangements for them to be made publicly available once they have been signed off.

The **receiving** organisation should take an overview of the final quality handover documents to their board at the earliest opportunity, and make supporting documents publicly available. The **receiving** organisation will hold the responsibility for the final approved documents with regard to FOI, as most of the senders will be abolished or significantly reformed. The receiving organisation should also ensure that they have robust processes in place to assure themselves that full probity is being followed, particularly where dual accountabilities feature. (For example, if the CEO of the sending organisation is also the CEO of the receiving organisation, you may wish to require the sending CEO to formally handover to members of the new board and/or a relevant deputy).

Accountability

During the period of development, the National Quality Team may access to the work in progress handover documents in order to check that the process and content requirements have been followed, and the receiving organisations may access the documents as part of their state of readiness, *but the accountability for the information and the action taken as a result remains with the sending body until 1st April 2013*.

Chapter seven: Planning for Handover

In order to meet the milestones for transition set out in Annex A, and to ensure that the system has the best chance of success, individual organisations are required to produce a plan for handing over quality intelligence during transition. The plans should be written for and approved by the boards of sending organisations, and when relevant, the receiving organisations. The plans should set out:

- The functions and responsibilities that are expected to close down or transfer
- Outline key milestones
- Identify the receiving bodies, and the information that they will need
- Outline the process by which the quality handover document will be produced, including proposed data sources (hard and soft)
- Detail of planned meetings to ensure handover conversations take place between the relevant people
- Plans to ensure triangulation of data and document control
- Identify leads for relevant pieces of work
- Outline plans for resilience to ensure accountabilities for both current quality and handover are deliverable
- Detail proposed Governance arrangements to ensure transparency, honesty and probity.

See **Annex A** for a template for the above plans.

PCT Clusters are required to complete their plans to create a handover document for quality and submit them to their SHA Cluster, by no later than June 23rd 2012 so that they can confirm receipt to the National Quality Team, and begin a local process of assurance as part of their responsibilities for managing the transition.

SHA Clusters are required to complete their own plans to create a handover document for quality and submit them to the National Quality Team, together with a letter confirming that they have received the PCT Cluster plans and their plans to assure them, by **June 30th 2012**.

The National Quality Team will assure themselves that the guidance has been followed, provide feedback where relevant to the individual bodies to concerned, and make a report on the overall situation to the national Transitional Executive Forum and National Quality Board.

Key steps and milestones

The following steps are aimed at helping you fulfil the minimum requirements within the national timescales, but you should make your own judgement as to whether additional steps are necessary locally in order to ensure quality is not compromised for your own particular function or responsibilities.

Please note that the following milestones are subject to change, as and when judgements will be made about organisational resilience. However the principles and requirements of a robust handover will remain, and should inform the judgements that managers will be required to make over the coming period.

May – June 2012

- Read the 'How to' guide, discuss the issues set out in the check list
- Appoint a named Transition Lead to deal with handover/receipt of responsibilities and close down (a distinct and separate role from creating the new)
- Develop a timed Action Plan to ensure that national timescales and requirements can be met
- Schedule relevant Board meetings and sign off processes etc.
- Take a draft plan to produce the quality section of the handover document to your Board that sets out how you will meet the requirements of this guidance for them to approve prior to submitting your plan to either the SHA Cluster or the National Quality Team as required.

June 30th SHA Clusters submit their plans for creating a handover document for quality (i.e. four in total) to the National Quality Team, together with a letter confirming that they have received copies of the PCT Cluster plans and their plans to assure themselves that suitable plans are in place to handover quality during transition.

Meanwhile start work on the handover document...

- Gather the hard and soft intelligence required as set out in Chapter 4
- Use the data to populate the template at Annex B
- Hold face-to-face meetings where necessary to obtain hard and soft intelligence
- Share the draft document with the key partner and stakeholder organisations to triangulate data
- Work with your senior team to prioritise and risk-assess concerns

July – Sept 2012

- National Quality Team receives assurance from SHA Clusters about the PCT Cluster plans, and assesses the SHA Cluster plans
- National Quality Team provides report to the Transitional Executive Forum and the National Quality Board on the plans and processes in place
- Organisations continue to maintain live documents for handover with a view to completing **Version 1** by end of September

October – December 2012

- Feedback on SHA Cluster plans and any local or national learning provided by the National Quality Team
- All organisations continue to maintain live documents for handover and follow through their plans, continually assessing for resilience as staff leave and making any necessary adaptations
- There will be visits to the four SHA Clusters to provide assurance that the appropriate plans and documents for handover are in place, providing local and national advice and learning where necessary

Jan – Feb 2013

- Quality data kept live and files all refreshed for electronic storage

March 2013

- Draft handover document on quality taken to the final board meeting of the sending organisation
- Approved version sent to receiving organisations and National Quality Team
- Face-to-face conversations take place between all relevant senior teams

April 1st 2013: ACCOUNTABILITY TRANSFERS

Beyond April 2013

- Receiving organisation receives and adopts all relevant documents formally at its first public board meeting
- Receiving organisation develops and agree an action plan to take forward the quality issues
- Maintain the quality document as a living record, and take to the board on a regular basis as a means of assessing progress on key areas of quality.
- Assurance that a robust handover process has taken place in line with guidance and plans

ANNEX A:

Template for Plans to Develop Quality Handover Documents

Section 1. Overview: Who are you, what do you do, and where will your key responsibilities go?	Short summary of the sending organisation, when it is due to be abolished/reformed, key areas of responsibility and main recipients of quality information. Named lead and date of document.
Section 2. What are your current functions and responsibilities?	A comprehensive list of all the functions and responsibilities the sending organisation currently has statutory duties to fulfil. Detail any additional functions that the local or national system has come to rely on (i.e. the hosting of information or other functions)
Section 3. Where will your functions transfer, and what are the information needs of your recipients?	A comprehensive list of all the known recipient bodies for responsibilities outlined in section 2. Where the answer is 'unknown', or you think they cease entirely, *please clearly flag for advice or confirmation from SHA or DH*. This section should include written text outlining your assessment of the kind of information you think the recipient bodies will need to fulfil their new responsibilities effectively. Please spend some time thinking this through, ideally through conversations with representatives of the recipient body, as this will form the core of your plan for effective handover. Please provide evidence in your plans for what steps you have taken to inform yourself of the needs of your recipient bodies.
Section 4. How will you gather and collate the information that they need?	Outline the process by which the quality handover document will be produced, including a full list of proposed data sources (hard and soft). Include named leads and timescales for each piece of work.
Section 5. What plans do you have to triangulate this data?	Outline the process and mechanisms you will use to ensure both internal triangulation within your team and across external bodies.
Section 6. How will you ensure face-to-face handovers?	Detail planned meetings with named key individuals to ensure that as well as a quality document the right people have enough diarised time to have conversations about the key issues.
Section 7. What plans do you have to ensure your handover plan is resilient?	Much of this is dependent on people, so how will you gather or handover some of this information if key people leave? What mitigating steps do you plan to take to manage the risks?
Section 8. What Governance arrangements do you propose putting in place to ensure transparency, probity and honesty?	Include your strategy for publication, and any necessary arrangements to avoid perceived conflicts of interests in areas of dual accountability

Section 9. **Key milestones**	Outline the key milestones that need to be met on the path to transition between now and April 13, including board meetings to sign off plans and documents.
Section 10. **Annexes**	Any further information you feel may be relevant to provide assurance that you have an effective plan to develop quality handover documents in line with the guidance.

ANNEX B:

Indicative Template for quality handover

CONTEXT

Make clear the focus, time frame and content of the handover document. Summarise the key issues of the action plan for maintaining quality during transition including arrangements for keeping the agreed action plan updated until abolition of the organisation (attach a copy of the plan). Cross reference any other relevant legacy material not detailed in this document.

TRANSITION LEAD

Confirm the details of the Transition Lead and author(s) of the handover document. Include details of their designation, work location and contact information (to include future destination details of the authors where known).

EXECUTIVE SUMMARY

Key messages - cross reference with other key documents where appropriate

THE ORGANISATION / SYSTEM

Organisational profile, geography and other key information which helps contextualise the handover on quality.

WHO IS WHO

Key contacts who have knowledge of the issues contained within the handover document other than the Transition Lead / author(s). To include a list of Board members and where possible their destination post the demise of the organisation to help promote organisational memory for a defined period. Consider including other business critical staff.

List people in receipt of this handover document and any actions taken as a consequence of the exchange of intelligence. In particular CQC and Monitor.

GOVERNANCE

Details of who approved the handover document and how it was approved. For example, through formal Board procedure or similar governance structure. Flag and explain any descent from the formally approved handover document.

TIMEFRAME

Date handover document approved. Attach a copy of the relevant minute

QUALITY PROFILE

This should form the MAIN body of the report. The nature of the content will vary depending upon the responsibilities of each sending body, but senders should ensure that this section:

a) Covers all sectors/areas/organsiations that you are responsible for or interact with including: Primary, secondary and tertiary care, social care, independent and third care sectors; covering all areas such as acute care, mental health, screening programmes, offender health and any areas of joint commissioning.

b) Covers all aspects of quality (safety, effectiveness and patient experience), and provides an overall assessment and risk profile based on analysis and triangulation of all available quantitative and qualitative data.

c) Highlights the main risks, confirms the mitigating action being taken, and whether it has been resolved.

d) Follows the guidance on Px for the kind of data sources that should be drawn upon as a guide.

RISK REGISTER

Include a copy of the risk register at the point of compiling the handover.

DOCUMENT CONTROL

List of document / data sources relevant to this legacy document which should be stored electronically using a secure and approved system for data protection (see chapter five of the guidance. Details of custody and access should be provided. Explain data storage methods, achieve retrieval protocol(s) etc

ADDITIONAL DOCUMENTS

Links to other relevant material including names of authors / sources of additional information.

FACE TO FACE COMMUNICATION

Confirmation details of the verbal handover/discussions between key staff. This to include dates, outline notes of issues discussed etc. In the event of confidential / sensitive material being shared with the receiving accountable officer a note should be made of the topic area without detail.

GENERAL COMMENTS

Signed by Transition Lead

Approved by Medical and Nurse Directors