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To:
All Chief Executives in NHS Trusts in England
All Chief Executives in NHS Foundation Trusts in England
All Chief Executives in Primary Care Trusts in England
All Chief Executives in Strategic Health Authorities in England
Cc:
All Chairs of NHS organisations in England
All Chief Executives of Arm's Length Bodies in England
All Chief Executives of Local Authorities in England
Chief Executives of independent sector partners
Monitor
Care Quality Commission
Local Government Association

Gateway ref: 15272
15 December 2010

Dear Colleague

***EQUITY AND EXCELLENCE: LIBERATING THE NHS* – MANAGING THE TRANSITION AND THE 2011/12 OPERATING FRAMEWORK**

1) Introduction

I wrote to you on 10 September to set out the design rules for the transition to the new health and social care system set out in *Equity and Excellence: Liberating the NHS*. This letter provides an update in light of the publication of the government's formal response to the White Paper consultation and the publication today of the 2011/12 NHS Operating Framework. It will reach you at a time when I know many services are facing up to the challenge of a particularly cold and difficult winter period. I want to thank you and your staff for your efforts to ensure the NHS continues to deliver for our patients at this time.

Put simply, our role over the coming period is to create the conditions for the new system to succeed. That means continuing to drive up quality for our patients, maintaining control on finance and performance, focussing on planning and delivering the QIPP challenge, and building momentum for and implementing the reforms. It means pressing forward with delivery for today and change for tomorrow, rather than retreating or hesitating. So in this letter I want to focus particularly on:

- The vision for the new system, as set out in the White Paper response, which has been refined and fleshed out following the consultation process;
- The "roadmap" for the transition process as a whole; and
- The priorities for 2011/12, the first full year of the transition, as set out in the NHS Operating Framework.

2) The vision for the new system: refining the architecture in the White Paper response and the Health and Social Care Bill

The White Paper response published today provides the next level of detail on the policy framework the government set out in *Equity and Excellence: Liberating the NHS* in July. It shows how policy proposals have been developed in light of the consultation and engagement process, and it represents a comprehensive description of how the new system is intended to operate. The vision, strategy and policy framework remain consistent with *Equity and Excellence*, but there are also important developments. I want to highlight four areas where you have raised issues of concern with me about the operation of the proposed new system, and which I think have been addressed in the White Paper response.

The QIPP challenge

The White Paper response makes clear that meeting the quality and productivity challenge remains the most important priority for the NHS over the coming period. It sets out the role of the reforms in helping us to drive quality and productivity improvements, for example by giving more power and control to patients, through a comprehensive system of quality standards, by aligning the clinical and financial aspects of commissioning and by freeing providers to innovate and drive up standards. Delivering on the QIPP challenge and implementing the reforms are mutually reinforcing processes, not competing alternatives and the reforms will support the achievement of QIPP.

Values and purpose

Critically, the White Paper response stresses shared values and purpose in the proposed new system. It makes clear that the NHS Constitution will remain at the heart of the new system. All organisations in the new architecture will have a legal duty to have regard to the Constitution, and the NHS Commissioning Board will be charged with raising awareness and promoting the Constitution. This is an important point of continuity with the current system and will be a valuable lever for supporting shared values and behaviours across the new system.

In addition, the central role of quality improvement as the guiding purpose of all parts of the new NHS will be enshrined in the new system through a legal duty for the Secretary of State and commissioners to carry out their functions with a view to securing continuous quality improvement. The new economic regulator must also have regard to this duty. The duty will cover the three domains of quality we have been working to – safety, effectiveness and patient experience – and will support a system focused on improving outcomes for patients. This is another important mechanism for providing consistency and unity of purpose.

Integrated Working

Nationally, the critical relationship between the NHS Commissioning Board and the new economic regulator is set out in more depth. The White Paper response makes clear that the important process for designated services will be led by commissioners, with the regulator providing statutory guidance. It also clarifies that price-setting will be a joint process, with the Board and the regulator required to work closely together, and that in setting prices, the regulator will need to take account of the overall NHS financial envelope. I am also determined to ensure that these arrangements will extend to an effective tripartite working relationship with the CQC.

Locally on commissioning, the White Paper response confirms that Local Authorities will have statutory Health and Well-being Boards. These will play a key role in integrating commissioning of NHS, public health and social care services more locally. These Boards will be required not only to jointly assess need, but also to contribute to a joint strategy for addressing local needs, which will influence NHS commissioning plans and create a powerful mechanism for driving integration locally. Importantly, however, it remains clear that local NHS commissioners will be formally accountable to the NHS Commissioning Board.

Managing risk

The way in which financial and performance risk will be managed in the new system is also becoming clearer. The White Paper response sets out plans for the NHS Commissioning Board to establish risk-pooling arrangements with consortia, to issue guidance on financial risk management and to intervene where there is significant risk of financial failure. In addition, the

Board and the economic regulator can establish contingency funds to manage financial risk respectively for commissioners and providers. We must ensure that the overall level of contingency in the system is not excessive, but these powers are nonetheless important in supporting a stable financial position for the NHS.

Further detail and clarification is also provided on the relationship between the NHS Commissioning Board and GP-led consortia. There will be an initial consortia authorisation process and a regime for the Board to intervene in the event of consortia failure or risk of failure. The Board will hold consortia to account for improving outcomes through a new Commissioning Outcomes Framework, and for financial management through its accountability relationship with consortia Accountable Officers. Financial incentives will be provided through a new quality premium. The Board will support effective local commissioning through a national system of quality standards, commissioning guidance, standard and model contracts and tariff development. These levers provide the potential foundation for a strong and effective new commissioning system which is clinically led and held accountable for results, not processes.

These are examples of the many features of the new system set out in the White Paper response. I would encourage you to read the response in full. These details demonstrate some of the ways in which the planned new architecture aligns with our values and our purpose and the ways in which the new system can be put into practice. The proposals remain subject to parliamentary approval and the Health and Social Care Bill will be introduced in the New Year. Steps taken towards implementation in the meantime will be within the existing statutory framework.

3) The roadmap for transition: Building the new system over the next four years

As many respondents to the White Paper consultations pointed out, our success in achieving the vision for a new system will be determined by the effectiveness of our arrangements for implementation and transition. The transition is a highly complex process. We will need to make changes to many different parts of the system simultaneously, whilst maintaining a clear focus on delivering high quality and safe care for our patients. The 2011/12 Operating Framework and Chapter 7 of the White Paper response set out the key elements of our approach to transition, and below I want to set out the intended “road-map” for the health system over the coming years.

Our approach to the transition needs to balance a number of competing tensions: between bringing early energy and momentum to the change, and creating an orderly process across the whole system; between maintaining a strong grip on finance and performance, and giving freedoms to emerging organisations to take their own decisions; and between allowing new

organisations to shape their own capacity, and controlling the overall costs of change. As leaders, our job is to chart a path that balances these tensions.

(A) Characteristics of our approach to the transition

Importantly, the White Paper response clarifies that the transition as a whole will be staged over a four year period. So while many elements of the new system are already coming into place, there will be a significant period for testing and bedding in the new arrangements. This will allow different parts of the system to move at different speeds, recognising inevitable differences across the country, and will allow us to learn from the experience of early adopters. Those early adopters are central to our efforts to gain early momentum for change, maximising the time we have to refine and improve the new arrangements. That is why we recently announced the first cohort of GP consortia pathfinders, which already cover a quarter of the population. It is why we will also be enabling local government to press ahead with testing of the new Health and Wellbeing Board arrangements. And it is why we are seeking to make early progress on delivering the Foundation Trust pipeline. The earlier we can start to model the new system on the ground, the more likely we are to succeed with the transition as a whole.

However, given the challenge we face it is not enough to allow this change process to be entirely organic. I have concluded that a number of key stakes in the ground need to be in place through the transition period. We will take steps to secure essential capacity and capability across the transition period, particularly through the formation of formal PCT clusters, the creation of a Provider Development Authority to support completion of the Foundation Trust pipeline, and a specially agreed pre-authorised Mutually Agreed Resignation (MAR) scheme to provide reassurance to business critical staff during the transition period. Ensuring we have the right capacity in the right place at the right time in this way will be crucial to stable and successful implementation of the reforms. As well as sustaining core capacity in the "old" system, we must ensure that emerging new organisations get the support that they need from an early stage. That is why the Operating Framework sets out an initial package of financial and capability support for emerging GP consortia.

Critically, we have taken steps to ensure that the transition process supports organisations in maintaining a focus on delivery in the short term and on meeting the quality and productivity challenge in the medium term. For example, pathfinder consortia must demonstrate active ownership of the local QIPP agenda, while the push to complete the Foundation Trust pipeline will ensure NHS Trusts have robust financial plans in place. The Operating Framework also sets out the need for a clear focus on delivery during 2011/12. We must ensure that the quality and safety of patient care are maintained or improved during the transition period and we have asked

the National Quality Board to lead work in this critical area.

The following section sets out how this transition will play out, firstly for each of the four main elements of the reform agenda: commissioning, provision, local government and public health, and the revolution in information, empowerment and choice. Secondly, it describes some of the critical elements of support to the transition process.

(B) The "roadmap" over the next four years

Commissioning

The transition on the commissioning side represents a highly complex set of changes. At local level, we need to develop GP consortia quickly so they can take on new responsibility, whilst ensuring PCTs have the capacity to discharge their statutory functions up to April 2013. At national level, there will be a similar dynamic between the emerging NHS Commissioning Board and Strategic Health Authorities, which remain accountable up to April 2012. And there is a particular challenge in developing effective commissioning support for consortia, whilst ensuring we retain the best of our existing talent and capability.

While PCTs will have a critical role up to April 2013, we do not expect to maintain 151 fully functional separate organisations up to that time, particularly if we want to offer capacity and space to emerging GP consortia. Because of this, and because of the broader drive to reduce running costs across the system, some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, the Operating Framework therefore sets out plans for a managed consolidation of PCT capacity to create such clusters across all regions of the NHS. Alongside this, staff will increasingly be made available to emerging consortia to support their development.

The broad role of clusters will be twofold. Firstly, clusters will oversee delivery during the transition and the close down of the old system. In so doing, they will ensure PCT statutory functions are delivered up to April 2013. Secondly, clusters will support emerging consortia, the development of commissioning support providers and the emergence of the new system. In so doing, they will provide the new NHS Commissioning Board with an initial local structure to enable it to work with consortia. In creating clusters, our aim is to maintain the strength of the commissioning system in light of the significant financial challenges ahead.

Clusters will have a single Executive Team and will be in place by June 2011 at the latest in a form that is sustainable up to April 2013, and potentially beyond that date if the NHS Commissioning Board chooses. Where clusters are already in place, current geographical

coverage will be maintained. More detail on the functions of clusters is set out in the Operating Framework and detail on governance arrangements and the process for forming clusters will be set out in January.

Clusters will identify staff whose future role will be to support commissioning. A number of these staff will be offered directly to consortia, but many will undertake commissioning support functions within the cluster. Clusters will enable staff to reshape and redefine their roles to create a comprehensive commissioning support offer for all constituent consortia. These units will offer to emerging consortia the additional commissioning support they need during the transition.

We will support staff working in these units to create social enterprises or joint ventures with private sector or civil society organisations. Our aim is to support each of them to be able to become a social enterprise, or a joint venture by April 2013. After this, the Board will be able to offer contracts to commissioning support organisations to ensure stability, but consortia will have the power to decide what support they want, and from whom. Transitional support arrangements from clusters need to be set up with that clearly in mind, with emerging consortia acting as customers.

So for the commissioning system as a whole, the transition period will run broadly as follows:

- For the remainder of 2010/11, PCTs and SHAs remain statutorily accountable. We will continue to encourage GP consortia pathfinders to emerge, building on the first cohort.

- In 2011/12, PCTs and SHAs will be statutorily accountable with more consortia pathfinders emerging and commissioning support units being developed. Our aim is to have full coverage of the population by prospective consortia by the end of 2011/12. PCTs will form clusters during 2011/12 to consolidate capacity, with some PCT staff being made available to emerging consortia. The NHS Commissioning Board will be created in shadow form and will focus on building its own capacity, developing the infrastructure of the new commissioning system, and overseeing planning for 2012/13 at national level.

- In 2012/13, PCTs and the NHS Commissioning Board will be statutorily accountable bodies with SHA abolished on 31 March 2012. PCTs, through clusters, will be accountable to the NHS Commissioning Board. Authorisation of consortia by the Board will take place with all consortia to be fully or conditionally authorised by the end of 2012/13. The Board will take on its formal statutory functions from April 2012.

- In 2013/14 the new system will be fully established with GP consortia and the NHS Commissioning Board statutorily accountable and receiving formal budgets. PCTs will be abolished on 31 March 2013 and commissioning support units will move into social enterprise and joint venture arrangements.

This is a complex transition path with arrangements changing year on year. We will need to take particular care to ensure effective handover arrangements between organisations, particularly on matters affecting quality and safety. The approach described aims to maximise critical capacity during the transition, whilst creating the conditions for the new commissioning system to develop quickly and effectively.

Provision

The changes to the provider sector are also profound and complex. We are moving towards an all Foundation Trust economy of public sector providers, increased numbers of social enterprises, a level playing field between the public and independent sectors, and a new system of economic regulation. In making the transition we need to ensure the completion of the Foundation Trust pipeline, the gradual removal of controls on existing FTs and the staged introduction of the new regulatory regime:

- For the remainder of 2010/11 and in 2011/12, the Foundation Trust pipeline will continue to be driven by SHAs, though we will increasingly seek national solutions to specific, common barriers to progress. Monitor will maintain its current compliance regime for existing and new FTs, while preparing for its new powers and functions as the economic regulator.

- In 2012/13 and 2013/14, a dedicated Provider Development Authority, created as a Special Health Authority by April 2012, will oversee completion of the FT pipeline, taking over this role from SHAs. The bulk of Monitor's controls over existing Foundation Trusts will be removed, though Monitor will be able to retain its control over new FTs and a subset of existing FTs for a maximum period of two years. The new system of economic regulation will be gradually introduced over this period, beginning with the introduction of the new licensing regime from April 2012 and price-setting from 2013/14 onwards.

- By April 2014, the FT pipeline will be completed and the Provider Development Authority will wind down. Monitor's current controls will only apply to recently authorised FTs and will be phased out altogether by 2016 at the latest. The key aspects of the new economic regulation system will be in place and Monitor will focus almost exclusively on its new functions.

The structural and statutory changes set out above are important to creating the new provider landscape, but the system will take considerably longer to fully bed in and mature. As well as developing the legal and technical aspects of the new framework, we will work with the NHS to test key elements of the system, to promote understanding and appropriate behaviours, and to ensure the NHS is prepared for the radically different provider system of the future.

Local government and public health

Alongside these changes to the NHS infrastructure, Local Councils will be developing new Health and Wellbeing Boards to integrate local commissioning across the NHS, social care and public health, we will also be developing the new Public Health Service at national and local level:

- For the remainder of 2010/11 and in 2011/12, we will support the development of a network of early implementers to test Health and Wellbeing Boards at local level. We aim to have shadow arrangements in place in most Local Authority areas by the end of 2011/12. During 2011/12, Public Health England will be set up in shadow form in order to prepare for its new national role.

- In 2012/13, a comprehensive system of shadow Health and Wellbeing Boards will be in place across upper-tier Local Authorities. Public Health England will take on its full responsibilities, including the functions of the Health Protection Agency and National Treatment Agency.

- From April 2013, Health and Wellbeing Boards will assume their statutory powers and duties in full. Local Authorities will receive their ring-fenced public health budgets for the first time, just as GP consortia will receive their first NHS commissioning budgets. Changes to Local Authority scrutiny powers will also come into effect from this date.

In developing the new arrangements, it is critical that NHS and Local Authority partners work closely together from the outset to improve integration, in anticipation of the new statutory arrangements. It is equally important that the creation of a dedicated public health service does not dilute the vital role that the NHS plays, and should continue to play, in improving public health.

A revolution in patient information, empowerment and choice

We must also ensure that our transition planning does not lose sight of the main thrust of the proposals to create a truly patient-led and customer focused NHS. Consultations on extending choice and improving information for patients remain open, and I would encourage you all to participate in these important discussions. Chapter 2 of the White Paper response confirms our

plans for the creation of HealthWatch arrangements at local and national level to ensure the views of patients, carers and the public are represented. Choice will be extended to new areas of the health system and patients will be given access to and control over significant parts of their health records. In addition, Any Willing Provider will be extended to community services during 2011/12. But these technical changes, while necessary, are not sufficient. Realising the vision of "*no decision about me without me"* will require a significant culture shift at every level of the system. In planning the transition, we must ensure that our work on commissioner and provider development focuses as clearly on achieving the '*Revolution for Patients*' as it does on the mechanics and hardware of reform.

To this end, I have launched a programme to support this change in order to:

- Deliver the significant technical changes to the system outlined above;
- Work, in particular with external partners, to make ever greater amounts of good information about outcomes and experience available in simpler and more targeted ways to patients and communities;
- Identify and pilot areas where we intend to ask commissioners to raise the offer on choice, in particular on the treatment choices available rather than simply on location. We are considering maternity, cancer and supported decision making in elective care as potential early objectives.

Workforce planning, education and training

Liberating the NHS signalled a new approach to workforce planning, education and training which aims to give employers more control over planning and developing their workforce alongside greater professional ownership of the quality of education and training. A consultation on how to put these principles into action will be launched very shortly. I encourage you all to engage with this very important debate. The consultation will include proposals for managing the transition to a new system, and the wind down of the current SHA role.

Informatics

Informatics is critical in bridging the spaces between the component parts of the new system. Using information and technology effectively will also make a major contribution to the efficiency of the overall system, individual organisations and the individuals working in them. In keeping with the White Paper the single, authoritative source of the information standards for the NHS will be the NHS Commissioning Board. Delivering an information revolution will require strong leadership and direction throughout the system supported by skilled and dynamic informatics

staff. It is important that our plans carefully consider how to retain and develop staff with these scarce skills.

Locally, many Informatics services will be too large for single consortia or smaller providers to support alone and I expect that organisations will work together to create shared services. Other informatics functions will continue to be provided nationally including managing and supporting existing national IT contracts, such as Choose and Book and the Summary Care Record, and services such as GP payments and cancer screening. We will provide more detail on how these functions will be delivered by the end of January.

Communications

During this period of major organisational change, we must not let up on the importance of effective communication and engagement with public, patients and staff. And with a commitment to empowering patients through an information revolution, we must maintain an ability to make such information available to the public in clear and effective ways. As a result, the NHS Operations Board has asked SHA Directors of Communications to work with their systems to develop shared services arrangements for communication and engagement for PCTs and SHAs. I expect these arrangements to be put in place over the coming months, taking account of the development of PCT clusters.

(C) Critical elements of support to the Transition Programme

The role of outcomes

The structural changes set out above do not represent an end in themselves, but a means of achieving the over-arching goals set out in *Liberating the NHS*: improvements to the clinical outcomes the health service achieves, a patient-centred service, and more freedom and autonomy for front-line professionals. We will shortly be publishing the first NHS Outcomes Framework, a really significant development in shifting the way we think about and measure success in the NHS. The new framework will set out the key measures we will be tracking over the next few years and will form part of the first mandate for the NHS Commissioning Board from April 2012. The new Outcomes Framework provides an opportunity to engage with clinicians and other staff about what needs to be done to improve outcomes, to start a conversation about purpose rather than structure. I will be engaging with staff across the health and social care system on this issue in the New Year and I would encourage leaders across the system to do the same.

Maintaining quality and safety

Throughout the transition, quality must remain at the heart of all that we do. Performance and quality can be affected during periods of organisational change. Importantly, the Care Quality Commission will be a point of stability during the transition, helping to ensure minimum standards of quality and safety are maintained. To strengthen arrangements further, I have asked the National Quality Board, to advise on what changes are needed in order to ensure we have the optimal ability to prevent, detect and respond to quality failings within the NHS. There will be two phases to the review: Phase 1 will consider how best to maintain quality and safety during the transition, with a view to providing guidance early in 2011. Phase 2 will consider how the early warning system might work once the new architecture for the NHS is in place, and will provide ongoing policy advice.

In the meantime, you and your teams need to remain focused on maintaining and improving quality and safety for patients at the same time as taking forward the implementation of the White Paper. In particular, you should ensure that you have plans in place to ensure quality and safety are maintained through this period of change. We must also ensure that soft and hard organisational memory is not lost as people leave the service. That means a due diligence process to ensure that there are formal handovers and legacy documents for any successors. And we must actively assess the quality impact of planned changes to workforce or services, and assuring ourselves that changes are being managed appropriately. The purpose of the reforms is to produce a system more focused on quality and able to deliver better outcomes for patients. During the period of transition we should exercise greater vigilance and take active steps to ensure that the system is resilient for quality and safety.

Human Resources strategy

The breadth and depth of the changes described above will of course have consequence for people working in all parts of the current system. The HR changes we need to make are complex as we attempt to maintain capacity in key parts of the current system while giving new players the support they need to develop quickly. I know you will do all you can to ensure that people are treated with dignity and respect. An update on the HR strategy is attached to this letter. Our role at national level will be to create broad pathways for people in affected organisations to move into the new system where they wish to; it is not possible or desirable to micro-manage all of the HR consequences of the change from the centre.

As I have said before, there will be broadly three categories of staff in organisations directly affected by the changes: those who wish to leave immediately, those who are willing to stay for the transition period only, and those who wish to be part of the future of system. For staff in the first category, a MAR scheme has already been made available. For those in the second

category, the HR update attached to this letter sets out plans to support retention of business critical staff through a separate pre-authorised MAR scheme and by using existing contractual flexibilities.

For those who wish to be part of the future system, the HR strategy will provide opportunities for PCT staff in three broad areas: roles in the new PCT clusters, roles in emerging consortia, and by creating opportunities to develop new commissioning support organisations. Opportunities for SHA staff will include being part of the NHS Commissioning Board, the Provider Development Authority, the economic regulator and the new structures for education and training. Staff in PCTs and SHAs may also of course wish to seek opportunities in the provider sector.

Running costs and locations

Across the transition period, we will be required to reduce significantly the overall running costs of the health system. Running costs are currently around £5.1 billion and will be reduced to £3.7 billion by the end of the Spending Review period. This is critical to creating a more streamlined and cost-effective system and the level of reduction is in line with our previous commitments to reducing NHS management costs. The Operating Framework sets out more detail on indicative running costs for the new system, including the expectation is that GP consortia will have an allowance for running costs that could be up to a maximum of £25 - £35 per head of population by 2014/15.

At national level, the current running costs of the functions that will transfer to the NHS Commissioning Board is around £600 million per year. The running costs of the Board will be at least a third lower than this; further work in 2011/12 will determine the precise amount, which we expect to reduce over time. The costs of the new economic regulator are expected to be around £50-£70 million per year. The NHS Commissioning Board will have its main office in Leeds with a small London base, and representation at sub-national level in a range of locations to be decided. The location of the new economic regulator is still to be finalised. It will have a London base, but as it expands to take on additional functions it is likely to require a further location outside London.

The above “road-map” sets out the key features of a highly complex and challenging process of change. The scale of the challenge speaks for itself. A summary timetable is attached to this letter to set out the key dates in full.

4) Laying strong foundations: The 2011/12 Operating Framework

With such a challenging transition period ahead, it is vital that we hit the ground running. The

2011/12 Operating Framework and PCT allocations are published today. 2011/12 will be a critical year in laying the foundations for the new system. That means balancing three priorities: the need to maintain and improve the quality of services, building on our success to date; the need to retain financial control and meet the quality and productivity challenge; and the need to make progress on the transition to the new arrangements. The Operating Framework sets out how we will achieve this by keeping a grip on delivery for today, whilst creating the new system for tomorrow.

Keeping a grip on today

2011/12 is the first year of the new Spending Review period and today's allocations to PCTs confirm the strong financial settlement for the NHS, particularly compared with our parts of the public sector. In headline terms, average growth in recurrent allocations for PCTs is 2.2%. Minimum growth is 2.0%. The settlement, particularly when considered in the broader economic context, represents a real vote of confidence in the NHS and a recognition of the financial pressures we face as a result of rising demand, changing demography, and the emergence of new technologies. It is nevertheless a very challenging settlement in historical terms, which is why we must remain focused on delivery of the £20bn efficiency savings for re-investment in improving quality across the Spending Review period. Making a strong start in 2011/12 will be critical to our success in achieving the quality and productivity challenge.

To this end, the Operating Framework sets out how we will maintain tight financial control during 2011/12. PCTs will continue to be required to invest 2% of their budgets non-recurrently in order to create financial flexibility and headroom to support change. The marginal rate of tariff payment for emergency admissions above baseline thresholds will be maintained, incentivising commissioners and providers to work together in an area that is critical to delivering local QIPP plans. And the national tariff efficiency requirement will be set at 4% in order to drive the necessary efficiencies in the provider sector.

These measures will no doubt create real challenges in some parts of the system, but they are critical to ensuring we maintain a strong financial position to get the new system on the right footing from the outset. We will continue to support commissioners and providers to make quality and productivity improvements, as we have done through the recent publication of the *NHS Atlas of Variation* and the review of *Back Office Efficiency and Management Optimisation*. The Operating Framework sets out a refinement to our estimate of the scale of the QIPP challenge at national level, resulting from the strong financial settlement and early action on pay restraint. Our revised assessment is that the NHS will need to make up to £20bn of efficiency savings by 2014/15, rather than £15-£20bn by 2013/14 as originally envisaged.

Strategic Health Authorities will continue to play a key role during 2011/12 and will remain accountable both for delivery of high quality care within available resources, and for making progress on the transition to the new system across their region.

Building the new system for tomorrow

As well as maintaining a strong grip on the system during 2011/12, we need to make progress on laying the foundations for the new health and social care system. So the Operating Framework sets out the following important measures for 2011/12:

- We will focus increasingly on improving the outcomes we achieve. The new measures of quality for ambulance and Accident and Emergency services to be published shortly will focus on measures which link to outcomes. Meanwhile, the publication of the first NHS Outcomes Framework will help us to understand during 2011/12 the outcome improvements for which the NHS will be held to account in future.

- We will provide support for the emerging organisations in the new system. That is why GP consortia will be given £2 per head of population to support their development, along with access to finance, commissioning and governance expertise. Measures like this are critical to ensuring we set up the new system to succeed.

- We will create clearer incentives to drive integration between health and social care services. That is why we have given PCTs responsibility for securing post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge. It is why PCT recurrent allocations now include funding of £150m for re-ablement and PCTs will receive separate allocations totalling £648m in 2011/12 to support health and social care integration, bringing total growth in PCT revenue funding to 3%.

- We will continue to develop the quality framework in anticipation of the new role of the NHS Commissioning Board in driving quality improvement across the system. NICE will begin work on 31 new Quality Standards next year to add to the 15 already completed or in development. Meanwhile Quality Accounts will be extended to cover community services for the first time and the CQUIN scheme will continue be worth up to 1.5% of tariff with reduction of venous thromboembolism as the national priority area.

- We will further develop the payment and contracting systems to pave the way for a more transparent system with a clear separation between commissioning and provision. The number of best practice tariffs will be expanded in 2011/12, while new currencies will be introduced for services such as adult and neonatal intensive care, smoking cessation and

podiatry. Contracts will be revised to pave the way for the introduction of choice of Any Willing Provider. And new contracts will be introduced for community providers which have integrated with acute or mental health providers.

Undoubtedly, the most significant challenge we face in 2011/12 is to maintain a grip on current performance and QIPP delivery, whilst simultaneously preparing and beginning to put in place the future system. We must ensure both of these areas are prioritised and the Operating Framework, along with the integrated approach to prioritisation and performance assessment which underpins it, aims to support you in doing that.

5) Conclusions

The change agenda set out above is perhaps the most significant and complex that the NHS has faced. It will be undertaken in a highly challenging financial context, and at a time when staff and leaders across the NHS face personal and professional uncertainty about their futures. And it must delivered while maintaining a strong grip on current performance, particularly during the challenging winter period. I do not underestimate the scale of the challenge, nor the commitment I am asking each of you to make.

Nevertheless, the vision for the new system is clear and builds in many areas on previous reforms, giving us a clear understanding of the task ahead of us. I have set out here the broad direction of travel and some of the things we are doing to try to support you in meeting the challenge. But success will ultimately be determined locally by the ability of commissioners and providers, of managers and clinicians, to bring the new system into being while continuing to deliver high quality care for our patients. Our recent track record is strong, so we should have real confidence in our ability to deliver. 2011/12 is a critical year for the NHS and I know I can rely on your continuing commitment and dedication as we take on the challenge.

Yours sincerely,

Sir David Nicholson, KCB CBE

NHS Chief Executive

Annex: Summary timetable for the transition

2010/11: Design and early adoption

- Design framework confirmed, subject to Parliamentary approval
- Pathfinders and early implementers model the new arrangements and explore key issues for wider roll-out

2011/12: Learning and planning for roll-out

- First year of QIPP delivery
- SHAs to establish PCT cluster arrangements to oversee delivery and in preparation for the NHS CB
- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, Public Health England programme
- Sharing lessons from first wave adopters of consortia pathfinder and early implementer systems of health and wellbeing boards
- More pathfinders and early implementers, including local HealthWatch
- Plans drawn up for consortia, involving all GP practices
- Emerging consortia to lead the process of securing staff, including PCT staff being made available
- Plans to be drawn up for health and wellbeing boards
- NHS trusts to apply for foundation trust status, or be planning application in 2012/13

2012/13: Full preparatory year

- Second year of QIPP delivery
- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters are accountable to the Board, and the Department will have made substantial progress on its change programme and established Public Health England. The Provider Development Authority oversees NHS trusts
- More learning from GP pathfinders and health and wellbeing board early implementers

- Authorisation process of comprehensive system of consortia begins, with all practices as members, acting under delegated arrangements with PCTs
- Health and wellbeing boards are in place
- Comprehensive local HealthWatch arrangements in place
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions
- Consortia notified on 2013/14 allocations
- By the end of the year, a significant number of NHS trusts have achieved foundation trust status

2013/14: First full year of the new system

- Third year of QIPP delivery
- From April 2013, PCTs abolished and all consortia assume new statutory responsibilities
- From April 2013, health and well being boards assume their statutory responsibilities
- From April 2013, Monitor's licensing regime is fully operational
- From April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy
- By March 2014, the firm aim is that all NHS trusts have become foundation trusts. NHS trust legislation is repealed, and the Provider Development Authority ceases to exist.

Annex to Sir David Nicholson's letter on 'Equity and Excellence: Liberating the NHS' – Managing The Transition And The 2011/12 Operating Framework

Update on the HR Strategy

Gateway reference: 15272

1. Introduction

1.1 The Government's planned reforms set out in 'Equity and Excellence: Liberating the NHS' and the response to the recent consultation exercise 'Liberating the NHS: Legislative framework and next steps' have wide-ranging implications for staff within the NHS (Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) in particular), staff within the Department of Health (DH) and staff within the Arms Length Bodies (ALBs). The estimated number of staff whose current employment is affected by these reforms is around 90,000. Because the reforms signal potential new organisations which will take over the responsibilities of SHAs and PCTs, change the functions of the DH with a more strategic role and a renewed focus on public health, and create new and change existing ALBs, developing an HR response is more complex than for any other past reorganisation. Staff who are affected by these changes also have different sets of terms and conditions including Agenda for Change and Very Senior Managers for NHS staff, Civil Service terms and conditions for DH staff, and a mixture of NHS, Civil Service and organisation specific terms for ALB staff.

1.2 In August 2010, Sir Neil McKay published an initial letter stating that we would start to issue national HR guidance, covering NHS, DH and ALB staff to support the implementation of the reforms, in a series of letters and documents; this Annex is the next in that series. We will publish further guidance in support of this 'building blocks' approach as the detail of the changes are published and as the form and functions of new organisations are established following the publication of the Health Command Paper: 'Liberating the NHS: Legislative framework and next steps'. The purpose of this approach is to ensure that staff have the best opportunities in the new system, and that we collectively minimise the number and cost of redundancies. The proposals in the Health Command Paper remain subject to parliamentary approval and the Health and Social Care Bill will be introduced in the New Year. Steps taken towards implementation in the meantime will be within the existing statutory framework.

1.3 We are planning to produce the next HR guidance early in 2011 for:

- NHS Staff
- Staff in DH
- Staff in ALBs

1.4 This guidance is being produced in partnership with trade unions nationally and they will be designed to ensure that the NHS, DH and ALBs are equipped with a workforce that has the right skills, knowledge and behaviours as well as the right leadership to deliver the change.

1.5 The guidance will cover the following issues:

- Clarity about responsibilities for implementation
- Preparing for the changes
- Definitions including 'at risk' and when the term should be applied
- Ensuring equality and diversity
- Detailed descriptions of the application of TUPE
- Relevant competition pools
- Pay arrangements including severance payments
- Suitable alternative employment
- Consultation arrangements including in the event of redundancy
- Support for staff

1.6 Consultation based on the Public Health White Paper 'Healthy Lives: Healthy People' has started and will begin soon on the reform of NHS workforce education and training. These consultations are likely to signal further important information which we will need to reflect in further publications related to the HR strategy. However, it is appropriate to put plans in place to support the transition roadmap set out and to provide as much clarity for staff as possible.

1.7 We are designing the HR strategy to take into account the different responses of staff to the Government's reforms. Sir David Nicholson has said that there will be broadly three categories of staff in organisations directly affected by the changes: those who wish to leave immediately, those who wish to stay in post to support the management of the transition, and those who wish to be part of the future system. For staff in the first category, a Mutually Agreed Resignation Scheme (MARS) has already been made available. For those in the second category, this HR Annex sets

out plans to support retention of business critical staff through a separate pre-authorised MARS and by using existing contractual flexibilities.

1.8 For those in the third category, who wish to be part of the future system, the HR strategy will provide:

- Opportunities for PCT staff in three broad areas: roles in the new PCT clusters, roles with emerging consortia, and opportunities to develop new commissioning support organisations.
- Opportunities for SHA and relevant PCT staff may include being part of the NHS Commissioning Board, the Provider Development Authority, the economic regulator and the new structures for education and training. Staff in PCTs and SHAs may also of course wish to seek opportunities in the provider sector.
- Opportunities for some ALB staff in the NHS Commissioning Board
- Opportunities for DH staff in DH, the NHS Commissioning Board, the Provider Development Authority, the economic regulator and the new structures for education and training
- Public health staff in PCTs and SHAs may also transfer to local authorities subject to the passage of the Bill.

1.9 The policies included in this annex and future publications will show how staff, including those three broad groups in paragraph 1.7, will be supported. We will strive to deliver on the pledges to NHS staff set out in the NHS Constitution.

2. Purpose

2.1 We have established five principal objectives to guide our thinking as we consider the implications of the reforms on existing organisations and their staff. They can be summarised as follows:

- Support business continuity during the very complex transition up to 2015
- Establish mechanisms to retain the knowledge and skills of people currently working in the affected organisations
- Encourage the development of new roles and skills for staff who will work in the new system
- Provide a bridge for tomorrow's leaders by providing the tools to help equip them to lead the transition and future organisations.

- Seek to avoid compulsory redundancies, maximise redeployment and avoid unnecessary redundancy costs

3. Context and Roadmap

3.1 Sir David Nicholson and Una O'Brien's letters describe the broad functions of new organisations and the roadmap sets out the milestones for transition. The letters highlight key actions and changes for organisations. They also refer to the continued approach to management cost reductions that have previously been set out, and are not related to the Health Command Paper: 'Liberating the NHS: Legislative framework and next steps'. They also emphasise the evolutionary nature of the changes and therefore the onus on staff to prepare and develop themselves for the future. Nationally, at regional level, and locally, organisations will give staff the tools and support to help them do this.

3.2 The HR milestones are set out in Section 10 of this annex.

4. Implications for Staff

4.1 It is important to emphasise that that many functions performed by current organisations will continue to be performed by new organisations. Because of this, the Transfer of Undertakings (Employment Protection) Regulations 2006 – commonly known as TUPE - and/or the Cabinet Office Statement of Practice (COSOP) may apply to a number of the functions carried out by new organisations. More content on TUPE/COSOP is contained in Section 8 of this annex.

4.2 As described above, the changes heralded by 'Liberating the NHS' and 'Healthy Lives and Healthy People' will require a complex series of moves across the NHS, DH and ALBs at a time when significant management cost savings will need to be delivered. As the functions of each organisation in the new system are fully defined and the respective cost envelope set, it will be possible to identify the broad numbers of posts in new organisations and how this may impact on existing staff. For the DH, further information will be published in January with the DH planning guidance.

4.3 Sir David Nicholson's and Una O'Brien's letters also explain that decisions are still to be made about the geographical locations of all new organisations. However, it is proposed that the NHS Commissioning Board would have its main office in Leeds with a small London base, and representation at sub-national level to

an extent and in locations to be decided. The location of the new economic regulator is still to be finalised. It will have a London base, but as it expands to take on additional functions it is likely to require a further location outside London.

4.4 To support this process, we are developing a high level people and functions migration map**.** It is primarily a planning tool and will provide a comprehensive picture over time of the final destinations of DH, ALB, PCT and SHA functions and the number of staff currently working in those functions.

4.5 For the NHS, this mapping is being road-tested by some PCTs and SHAs with the intention of identifying the number of NHS staff currently performing particular functions.

4.6 For the DH and appropriate ALBs, the mapping will be developed through the planning process which will take place between January and March 2011.

4.7 The results from this mapping, with information about the likely sizes and locations of the new organisations, will provide the basis for developing the detailed HR strategy including arrangements for TUPE/COSOP or as appropriate, the relevant competition pools.

4.8 The first iteration of the people and functions migration map for all functions will be completed in January 2011. Subsequent iterations will be developed in line with the outcomes of the consultation on 'Healthy Lives: Healthy People' and the reform of workforce education and training.

5. What we have done so far

5.1 We have already made significant progress in a number of areas:-

- 1:1 discussions should have been held with all potentially affected NHS staff by the end of September 2010. There is an expectation that Boards and Chief Executives will ensure the continuation of 1:1 discussions with staff for as long as is necessary. These discussions should continue to focus on the impact of the changes on individuals, including reviewing workload pressures and priorities, as well as focusing on personal futures.
- All DH staff should have had their mid-year reviews where they could discuss any individual concerns about their work and the implications of the transition programme for them. This should include a discussion about

their personal development needs as well as career planning aspirations. These discussions should continue to focus on the impact of the changes on individuals, including reviewing workload pressures and priorities, as well as focusing on personal futures.

- ALB Chief Executives have been engaging with their staff, who are affected in many different ways, to ensure they have an opportunity to discuss the implications of the changes for them and how they can best be supported.
- We have worked closely with trade unions nationally through the Social Partnership Forum (SPF) and with the DH trade unions on the development of this annex and the HR strategy, including agreement on a set of overarching principles which have guided our work so far and will inform the preparation of the further guidance when it is published next year.
- We introduced a national voluntary severance scheme (MARS) for the NHS and relevant ALB staff which was developed in partnership with NHS Employers and trade unions to support SHAs and PCTs with their management costs reduction targets. The scheme was entirely voluntary and supported staff who wanted to leave the NHS straightaway. The national scheme closed at the end of October/early November and around 2,200 staff have been approved to leave under the scheme across England.
- A number of PCTs, ALBs and Trusts who were unable to participate in the national MARS for timing reasons have indicated that they wish to run their own MARS based on the nationally agreed scheme. Any Trusts or PCTs who wish to do this should agree this with their SHA, who will seek the approval of the DH. ALBs should seek agreement with the ALB Unit at the DH before offering MARS to their staff. Any agreed scheme will need to be completed by the end of January 2011. The national MARS which ran in the autumn of 2010 is now being evaluated and consideration will be given as to whether a further nationwide scheme should be launched.
- The DH is planning to run its own voluntary redundancy scheme for staff in DH and ALBs on Civil Service terms and conditions in January 2011 subject to the successful passage of the Superannuation Bill 2010/11. In some SHAs and PCTs voluntary redundancy schemes are also being

implemented or consulted on in line with existing NHS terms and conditions of service to help achieve management cost reductions.

- New regulations are in place that allow Chairs and Non Executive Directors to hold multiple appointments on Boards which will help support business continuity and governance arrangements for PCTs moving to clusters.
- Guidance has been previously issued on the NHS Employers website to the NHS, DH and ALBs about the type of support employers should be providing staff who may be affected by organisational changes during the transition period. This emphasises, for example, the need to keep staff engaged in changes as they happen, ensure NHS staff have priority access to vacancies on NHS Jobs and provide help with career planning and preparation for job applications. It is important for employers to look more widely for alternative employment possibilities for displaced staff for example, through Job Centre Plus, recognising the role of the private sector in creating job opportunities. NHS Employers will publicise best practice guidance and case studies on its website in the near future
- In the NHS, all SHAs now have regional HR or Employment Frameworks in place to support staff during major changes and to help ensure that skills are developed and retention is maximised. All SHAs have been working with the national SPF and will continue to do so to ensure consistency of application of the regional Frameworks in a number of key areas:
    - Partnership arrangements to ensure that all regional Frameworks are implemented and reviewed jointly by employers and recognised trade unions.
    - Categorisation of NHS staff as ‘affected by change’ in advance of formal ‘at risk’ status.
    - Effective consultation arrangements with staff and trade unions including consultation periods which may go beyond the statutory minimum.
    - Pooling arrangements to ensure that each SHA has agreed complementary arrangements in place for giving NHS staff access to employment pools that reflect existing and emerging structures.
    - Arrangements for handling of NHS voluntary severance arrangements and local organisational change.

- The inclusion of DH, NHS and ALB staff and jobs within local regional framework arrangements and employment pools.
- The engagement of all NHS employers, including Foundation Trusts, in each SHA Area.
- Regular discussion on the roll out of new structures.

- The DH and ALB frameworks are also near completion and will be published in January 2011.

6. The Immediate Next Steps

Sustaining staff capacity and capability during transition

6.1 One of the main sources of concern identified during the consultation period on the proposals set out in 'Equity and Excellence: Liberating the NHS' centred on the scale and pace of the change and how the risks to financial and operational performance will be managed during transition. Another key concern is the loss of staff whose expertise is needed to support the development of the new organisations.

6.2 It is a priority to identify and retain those staff who will be critical to sustain capacity and capability throughout the transition period by offering some certainty around pay and terms during transition. For the NHS, guidance is being prepared in partnership with NHS Employers and the trade unions with the aim of supporting organisations to retain key staff through the application of two approaches to retention:

- The offer of a national pre-authorised MARS. This would provide a guarantee for eligible applicants of a severance payment calculated in line with Agenda for Change Section 16 for key staff who we would wish to retain until an agreed future date.
- The use of existing contractual flexibilities such as a short-term retention premium and/or the use of a special payment where staff take on additional responsibilities or a wider portfolio. The use of these flexibilities should consider the implications for equal pay.

6.3 The DH and ALBs are also considering how they retain key members of staff during the period of transition in ways consistent with this framework.

The Development of Clusters

6.4 The Health Command Paper, 'Liberating the NHS: Legislative framework and next steps' and the 'Operating Framework for the NHS in England 2011/12' require SHAs to have clusters in place by June 2011. Clusters will consolidate the functions of existing PCTs. There will however be no statutory mergers of PCTs, and they will retain their existing allocations. Where clusters are already in place, existing geographical coverage will be broadly maintained. Each cluster will operate under a single executive team. The detailed design of executive teams will be a matter for the cluster Chief Executive and the respective PCT Boards to determine.

6.5 Appointments to cluster executive teams must follow a fair and transparent process.

6.6 National guidance on the HR processes associated with the formation of clusters will be published in January 2011 to support discussions through the national and regional SPFs. These regional discussions should include consideration of the implications for staff's right to transfer to new structures under TUPE.

Assignment

6.7 We described earlier why the nature of this change means it is not possible to publish one detailed overarching HR Framework. The roadmap sets out the sequence for the establishment of the proposed new statutory bodies. It also describes the transitional arrangements to support this change.

6.8 In addition the Health Command Paper, 'Liberating the NHS: Legislative framework and next steps' makes reference to the need for organisations such as GP Commissioning Consortia to have:

> …the opportunity to plan how they intend to carry out their future functions, in particular by deciding what activities they will undertake for themselves by employing or engaging their own staff, what activities they will carry out on a collaborative basis (e.g. through a lead consortium arrangement or through collaboration with local authorities), and what activities they wish to buy from external support organisations.

6.9 'The Operating Framework for the NHS in England 2011/12' also sets out the importance of clusters supporting the development of emerging GP Commissioning

Consortia. One of the key ways in which this can be achieved is by assigning staff from PCTs in agreement with the Consortium.

6.10 In this example, **assignment** is the process of aligning relevant staff in PCTs who currently work the majority of their time in functions which are scheduled to transfer to GP Commissioning Consortia. Any transfer of functions is subject to the passage of the Health and Social Care Bill. The process of assignment must take account of the views of the GP Commissioning Consortia running cost budget and be developed in consultation with trade unions and staff.

6.11 It gives NHS staff concerned the opportunity to support GP Commissioning Consortia and it gives the Consortia resources to support the development of their new functions. GP Commissioning Consortia would have the choice of provider once they become a legal entity following authorisation. However, the process may result in the transfer of staff under TUPE.

6.12 We recognise that many PCTs and emerging GP Commissioning Consortia have begun this kind of approach already. Where this has happened, PCTs will wish to ensure that an approach is taken that is consistent with this annex.

6.13 We will ask SHAs and PCTs to work with emerging GP Commissioning Consortia to assign staff wherever possible by the end of June 2011 at the latest. Any assignment of staff is provisional pending the passage of the Health and Social Care Bill. Some Consortia will want to consider this collectively so some staff may be assigned to one Consortium leading a commissioning function on behalf of others. Assignment could also be used to progress the commitment set out in the Operating Framework for clusters to provide the following support to GP Commissioning Consortium including:

- An organisational development expert / facilitator;
- A qualified or accredited senior finance manager (this may be shared across consortia);
- An individual with expertise of appropriate governance arrangements / corporate affairs; and
- A commissioning expert to support the consortium in their assessment of how they will deliver their future commissioning responsibilities.

6.14 The ‘Operating Framework for the NHS in England 2011/12’ and the Health Command Paper, ‘Liberating the NHS: Legislative framework and next steps’ also set out the direction for the development of **commissioning support units** within clusters. Once established, each cluster will identify staff within it whose future role will be to support commissioning. Clusters will reshape and redefine the roles of commissioning support staff (not directly assigned to consortia) to create a comprehensive support function for all constituent consortia. These units will become pathfinder commissioning support, offering to consortia all the additional commissioning support they need during the transition.

6.15 In order to ensure further economies of scale and develop niche commissioning support, pathfinder commissioning support units will work together and be supported to develop expertise and capability in a specific aspect of commissioning which could then be offered across a much wider geography.

6.16 Staff assigned to work in commissioning support would be supported and given expert advice in the creation of social enterprises and a full range of joint ventures with the private or civil society organisations as well as commercial advice. Our aim would be to support them to be able to become a social enterprise, or a joint venture by April 2013.

6.17 SHAs and PCTs should use their existing HR Frameworks to ensure that assignment is undertaken in a fair and transparent way in consultation with trade unions. Emerging GP Commissioning Consortia leaders **must** be involved in these processes.

6.18 We will consider adopting assignment for all other relevant staff affected by the reforms and will produce further advice about this in partnership with trade unions as the people and function migration mapping work develops. We believe there is significant scope to pursue this policy for staff involved in the following functions:

- Provider Development Authority
- National and regional specialist commissioning
- Public health
- Workforce education and training
- ALB functions that are either moving to other existing ALBs or to new organisations

6.19 We will also test how assignment can be applied to relevant staff involved in support functions.

7. Providing a Bridge for Leadership

7.1 In order to support tomorrow's leaders the DH and the National Leadership Council (NLC) have reviewed their priorities and realigned resources to enable transition. For the NHS, this includes supporting boards to ensure they are providing and commissioning safe and high quality services. The NLC's advice, 'Governing for Quality', is very timely and is being adapted further for use by GP Commissioning Consortia. The National Equality and Diversity Council will also be providing guidance on what provider and commissioning boards can do to ensure a focus on fairness and equality is retained during the changes.

7.2 There is also a commitment to maintaining talent and leadership capability and to making people available to support new structures. The NLC's Top Leaders and Emerging Leaders programmes are being adapted so they can support people to make these moves and inform employers efforts to retain key leaders.

7.3 The DH and ALBs continue to invest in the development of leaders to ensure capability is strengthened to effectively lead and manage change through transition and into the future. In reviewing resources and priorities, the DH will extend its provision of leadership development including programmes via the National School of Government and internally led development solutions.

7.4 The NHS, DH and ALBs will work together to maximise leadership development opportunities for ALB staff.

7.5 Staff should be given an equal opportunity to participate in these programmes.

7.6 Considerable work is needed to enable new organisations to develop their own capability to ensure they are fully fit for purpose. Resources are being made available through the NLC to GP and provider leaders to identify where national action can accelerate progress through the use of commonly developed frameworks and resources.

7.7 Within the NHS, specific resources are also being identified nationally, regionally and locally to support the leadership and talent development for all staff to better equip them for the change. The DH is also developing plans to build its leadership and capability for all its staff to better equip them for the future.

8. Transfers and the law – TUPE and COSOP

8.1 The law relating to transfers is complex and changes regularly. Each transfer is different and decisions are taken depending on the particular circumstances of the transfer. The proposed Health and Social Care Bill includes provisions allowing the Secretary of State or the NHS Commissioning Board to establish staff transfer schemes in relation to bodies established or abolished by the act. Subject to parliamentary approval, the department will be publishing more details of their intentions as their proposals develop. If employers intend to make transfers prior to schemes established by the Secretary of State coming into force, they will need to establish the legal position for their own specific transfer situations. In both cases, transfers of public sector staff may be covered by TUPE. In some circumstances, regardless of whether TUPE applies, staff may be covered by the Cabinet Office Statement of Practice (COSOP), 'Staff Transfers in the Public Sector' (revised November 2007). The broad legal principle underpinning transfers is that TUPE applies when there is a 'relevant transfer'. This may include:

- a transfer of an undertaking, business or part of an undertaking or business; or
- a service provision change, where a contractor takes on a contract to provide a service for a client from another contractor.

8.2 When such a transfer or service provision change takes place, staff who are employed in the undertaking or business or delivering the service immediately before the transfer would normally transfer to the new organisation, with their contractual terms, including continuity of service, protected (other than occupational pensions).

8.3 The application of TUPE however, will always be a matter of law based on the individual circumstances of the particular transfer. In circumstances where TUPE does not strictly apply, public sector transfers may be covered by the Cabinet Office 'Staff Transfers in the Public Sector Statement of Practice' (COSOP), where the transfer is effected on terms that are overall no less favourable than if TUPE had applied. Equally, staff transfer schemes established by the Secretary of State may

transfer staff on similar or the same terms as if TUPE had applied. These are sometimes, referred to as 'TUPE-like' terms.

8.4 Whether staff transfer under either TUPE or COSOP they currently benefit from the added protection of the Cabinet Office – 'A Fair Deal for Staff Staff Pensions' (HM Treasury, 1999). Fair Deal requires that the new pension must be broadly comparable to the old one. Fair Deal is currently under review and how pensions are managed will depend on the outcome of that review next Spring. Where staff are transferred to a Local Authority they should be able to remain within a public sector pension scheme such as the NHS Pension Scheme or the Local Government Pension Scheme.

8.5 Where the new organisation has NHS employing authority status, the transferring NHS Staff will retain access to the NHS Pension scheme. GP Commissioning Consortia will have NHS employing authority status.

8.6 In situations where the new organisation chooses to outsource delivery of the transferred functions by contracting with another public, voluntary or private sector organisation, TUPE and/or COSOP and Fair Deal may still apply and the staff may be transferred to the outsourced provider of the function.

9 Partnership Working

9.1 Work on the HR strategy and related products is being developed with trades unions and, for the NHS, representatives of employers, and this process will continue nationally.

9.2 For the NHS, national engagement with NHS Employers and trade unions has taken place through a sub-group of the SPF. For the NHS at a regional level, a similar process of engagement is taking place through regional SPFs. As changes are taken forward at a local level, SHAs and PCTs or clusters are expected to engage fully with their local trade union representatives.

9.3 It is important that we work with local authorities and the private sector to support the smooth transfer of staff if services are transferred to them. This should include ensuring that those organisations are aware of staff rights on transfer and their responsibilities under TUPE. It should also include SHA leadership to ensure close liaison locally and regionally, with major employers that might benefit from the

skills and experience of displaced staff to promote opportunities for displaced staff who cannot be retrained, redeployed and retained within the NHS.

10. Timescales going Forward

10.1 The following timescales relate to the content of this HR annex and are complementary to the roadmap. A frequently asked questions and 'Influencing Your Own Future' document to support this annex will be published next week.

End of January 2011

- Produce guidance for the introduction of the national pre-authorised MARS for the NHS
- Publish the next stage of function and people migration mapping
- Publish guidance on HR process for senior cluster appointments
- DH voluntary severance scheme launched
- Commence discussions with PCTs and GP Commissioning Consortia about assignment
- Deadline for existing MARS applications
- Review of existing national MARS scheme completed
- Publish internal DH and ALBs HR Framework
- Publish DH planning guidance

By end of March 2011

- Complete the testing of the concept of assignment in all other areas
- Overarching HR strategy for NHS, DH and ALB staff published
- Publish DH plan 2011/12

No later than June 2011

- Complete the process of senior appointments to ensure clusters are in place by June 2011
- Complete the assignment of staff to GP Commissioning Consortia and where appropriate to Commissioning Support Units within clusters