Quality Handover Briefing

July 2012

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 this new architecture will require significant changes to be made to most parts of the current system. The Department of Health and the National Quality Board has recognised that this level of structural change has the potential to put quality and safety at risk as quality functions, governance structures and assurance mechanisms are being transitioned to the new model. To ensure that any potential risks to quality and safety are identified and managed during the transition the National Quality Board is requiring PCT Clusters to complete a quality handover plan. The structure of this plan is defined in the National Quality Board paper - How To: Maintain Quality during the Transition: Preparing for Handover (National Quality Board, 2012) with the key elements being:

- Identification of the functions and responsibilities of sender organisations that are expected to close down or transfer
- Identification of receiving bodies and the information that they will need
- Definition of a process for handing over quality functions that include transfer of soft and hard intelligence
- Plans for resilience to ensure that accountabilities for quality and handover are deliverable
- Governance arrangements to ensure transparency, honesty and probity during the transition.

Scope

On 23rd June 2012 the West Mercia Cluster submitted an initial plan for creating a quality handover document for receiver organisations (see Appendix D). This paper is presented to the West Mercia Cluster Board so that it may note in public session the submission to the Strategic Health Authority of the outline plan and identify the key actions needed to support the development of the quality handover process.

Key Milestones

The following timetable outlines the nationally set key milestones for quality handover.

September 2012

- Version 1 of the quality handover document complete ready for submission to SHA Cluster and National Quality Board

October 2012 – December 2012

- Organisations maintain and update quality handover documents as NHS Architecture begins to change
- National Quality Board visit SHA Clusters to gain assurance that appropriate quality handover plans are in place

January 2013 – March 2013

- Quality data kept live and handover document revised to reflect current circumstances
- Final quality handover document approved by final board meeting of sending organisation in March 2013.
- Approved version sent to receiving organisations and Nation Quality Board

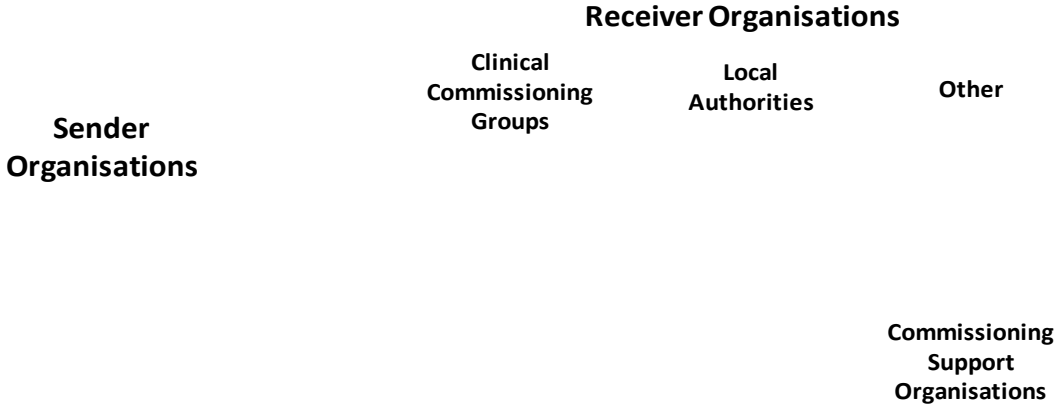
April 1st 2013 Accountability Transfers

- Receiving Organisations adopt all relevant documents formally at fist public Board
- Receiving organisation develop and agree action plan for taking forward quality issues

Sender and Receiver Organisations

The West Mercia Cluster plans for the creation of quality handover documents identify the sender and receiver organisations shown in figure 1. As the handover document develops it is probable that this number of receiver organisations will increase as the transfer of specific functions are defined in detail.

Figure 1 West Mercia Sender and Receiver Organisations



Appendix A of this document provides a more detailed list of the key questions that need to be considered by sender organisations. Appendix B provides a similar checklist of receiver organisations.

Functions and Responsibilities

West Mercia Cluster through its constituent PCT's has identified a range of statutory functions and responsibilities that need to be passed on to successor organisations. These duties have been categorised into eight areas and then assessed to see which have a quality dimension. The eight categories are:

- Overall Duties
- Strategic Leadership
- Partnership Engagement and Advocacy
- Providing or Securing Services
- Monitoring and Evaluation
- Accountability and Assurance
- Workforce
- Estates and IT

The detailed quality function mapping for each category will be finalised in July 2012 and will be available on request from Simon Collings – simon.collings@nhs.net. In August 2012 a list of quality functions and responsibilities transferring to each receiver organisation will be produced for circulation in August.

Quality Information

The National Quality Board has identified two categories of information that need to be captured for the three domains of quality: effectiveness, safety and patient experience.

Category 1 – Hard Data

This is quantitative and qualitative recorded data that is used as the basis of performance metrics and quality assessments. The four PCT's in the West Mercia Cluster have already undertaken a considerable amount of work to identify the information requirements for the receiver organisations as part of the preparation of Legacy documents. This work will be expanded on to form the core of the quality handover plan.

Appendix C provides a list of potential data sources. Please note that this is not a comprehensive list and should be expanded as necessary.

Category 2 – Soft Intelligence

Soft intelligence is the term used by the National Quality Board to describe information that cannot always be verified or proven. This may be anecdotal evidence or even a feeling that something is not quite right. If the sending organisation is aware of concerns that are not yet verifiable or able to be captured they should share this information verbally at face to face meeting as part of the quality handover.

As part of its quality handover plan West Mercia cluster will be setting up a series of face to face meeting between staff in sending and receiving organisations to ensure the transfer of soft intelligence.

Governance

In the West Mercia cluster the quality handover will be overseen by a task and finish group whose membership will include representatives from sender and receiver organisations in the region. The Quality Transition Lead for the Cluster will be the Chief Executive – Eammon Kelly. The PCT Cluster Leads for the quality handover are:

- Sue Doheny, Director of Nursing
- Kiran Patel, Medical Director

The first meeting of the Task and Finish Group is planned for August 2012.

Key Activities July – September 2012

Table 1 below sets out the key activities that need to take place across the West Mercia Cluster to ensure that the first National Quality Board milestone is met. The plan submitted to the SHA on the 23rd June 2012 is included within Appendix D of this document.

Table 1.

Activity	Due Date	Lead
Quality Leads identified by receiver organisations	Jul	Receiver Orgs
Task and Finish Group Established	Aug	SD/RM/SC
Workforce Resilience Protocol and Plan	Aug	SP
Alignment of legacy quality functions with receiver business models	Aug	SC/RM
Risk registers established in receiving organisations and aligned with senders	Aug	SD/RM/LJ/Receiver Orgs
First Draft of Quality Handover document	Sep	SD/SC
CCG Quality Assurance frameworks in place	Sep	CCG AO
QPR Report on outstanding legacy issues	Sep	SD
Set up Stakeholder Workshops	Sep	LJ/SC

Key

SD – Sue Doheny
RM – Richard Miles
SC – Simon Collings
SP – Suzanne Penny
LJ – Lyn Jonsberg
CCG AO – CCG Accountable Officer

A progress update will be provided to Cluster Executives on a monthly basis. In September this will include the key activities for the next period. A draft schedule of key activities for 2012/13 is available from Simon Collings – simon.collings@nhs.net.

Summary

West Mercia Cluster has submitted initial plans, for maintaining quality and safety during the transition to the new NHS architecture, to the SHA and National Quality Board. The primary focus of these plans over the next 2-3 months will be the development of a quality handover document. A quality handover task and finish group will manage the handover process and ensure the delivery of the key milestones set out in this paper.

Quality handover questions to be considered by Sender Organisations

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?
• 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?
• 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 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?

Quality handover questions to be considered by Receiver Organisations

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)

Quality Handover – Sources of Hard Data

- 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

Section 1. Overview: Who we are, what we do, and where will our key responsibilities go?

West Mercia PCT Cluster comprises 4 PCTs:
NHS Herefordshire;
NHS Shropshire County;
NHS Telford & Wrekin;
NHS Worcestershire.

The PCTs have a range of functions, including commissioning health care for their respective populations and the provision through contracts of primary care services.

These 4 statutory bodies and the Cluster will be abolished on 1 April 2013, but in the mean time there will be a progressive handover of responsibilities to other bodies, initially through delegation and then absolutely when different statutory bodies are established.

This plan shows how we intend to pass on quality information and responsibilities to successor organisations, including Clinical Commissioning Groups, the National Commissioning Board, and Local Authorities.

The PCT Cluster leads for this Quality Handover Plan are:

- Sue Doheny, Director of Nursing and Dr Kiran Patel, Medical Director, NHS West Mercia PCT Cluster

Section 2. What are our current functions and responsibilities?

We have identified the range of functions and responsibilities that the Cluster (through its constituent PCTs) has a statutory duty to fulfil, and which must therefore be passed on to successor organisations insofar as a statutory duty will remain from April 2013. These are shown in **Annex A**, which is based on a paper considered by the Cluster Board in May 2012.

We have identified in Annex A the functions that have a particular quality dimension, because the Board has been considering its full range of handover responsibilities, some of which will be covered in separate, complementary plans that do not specifically deal with quality.

This plan follows guidance issued by the National Quality Board (*How to Maintain Quality during the Transition: Preparing for handover*, May 2012) and other plans will follow expected further guidance from the Department of Health.

Section 3. Where will our functions transfer, and what are the information needs of our recipients?

Annex A shows in broad terms, based on current knowledge, the recipient bodies for

quality handovers from the West Mercia PCT Cluster.

More specifically, we have identified the successor organisations to which we intend to pass on quality information and responsibilities as:

NHS Herefordshire CCG
NHS Redditch & Bromsgrove CCG
NHS Shropshire CCG
NHS South Worcestershire CCG
NHS Telford & Wrekin CCG
NHS Wyre Forest CCG
(**Annex B** contains some more information about the CCGs)

National Commissioning Board
Commissioning Support Organisations (identity to be confirmed; functions will be handed over by CCGs)

Health and Wellbeing Boards and Public Health functions at:
Herefordshire County Council
Shropshire County Council
Telford & Wrekin Council
Worcestershire County Council

Public Health England

Given the number of successor organisations there will remain a risk that no one organisation has a comprehensive overview; we would wish to consider with the NCB options to address this.

The kind of quality information that these organisations will require to fulfil their responsibilities effectively arises from the functions being transferred to them. This is being identified by the directors and managers responsible for each of these functions in a process that has already commenced through the delegation of some functions to CCGs. This process of identification will continue through the CCG Authorisation process.

We will continue to identify:

- Quantitative information about performance and risks (and will use the NQB Dashboard when available)
- Information on historical issues and those that appear to have been resolved (referring for example to HCC / CQC and Prison health (PPO) reports; HSMR; and a comprehensive trackback to 2006)
- Qualitative and emerging soft intelligence.

We will use the disciplines of our QPR reports and CCG review meetings.

- Medical Director; Director of Nursing; Director of Finance; Director of

Commissioning Development; Deputy Chief Executive; Directors of Public Health

Section 4. How will we gather and collate the information that they need?

The Cluster's four PCTs have already undertaken a considerable amount of work in the preparation of their Legacy Documents to identify both the information requirements for their successors and the material that is available to pass on to them.

Work will also continue, building on the legacy risk registers, to identify potential risk areas for the effective handover of functions and information, for example in relation to the IT coding systems that underpin patient referral processes such as Choose and Book.

In addition, some functions have already been delegated to the CCGs, as committees of the Cluster Board, in preparation for their assuming full responsibility on the demise of the PCTs. Further functions will be delegated over coming months, based on dialogue between Cluster staff and CCG staff and on the Authorisation process.

Annex C identifies the current delegations to CCGs, which are subject to audit and assurance requirements. These delegations include quality functions, which will be identified in the specific handover documents that will be produced for each CCG.

In the period June to September 2012 further work will be carried out to pull together the quality functions and supporting information sources that will be required for inclusion in the Quality Handover Documents for each successor organisation. This will include the processes that the CCGs should follow in sourcing this information.

The data sources to be used for the quality handovers will be reviewed in the light of the work carried out for the previous legacy documents; the experience of delegation to CCGs; and the list provided in Chapter 4 of the NQB guidance.

- Medical Director; Director of Nursing; Deputy Chief Executive; Directors of Public Health

Section 5. What plans do we have to triangulate this data?

We will continue to move this work forward by identifying key officers across the cluster to provide refreshed information and co-ordinate handover work within their specific areas.

We will also ensure that handover work is integrated into the mainstream work of directorates and the key change programmes being implemented across the Cluster.

The Transition Lead and Governance leads will co-ordinate this information across the Cluster. The Board will continue to receive Performance and Quality Reports at each formal board meeting and these are also circulated to CCGs.

The front sheet for Board reports has been amended to include consideration of legacy/handover issues and all Committees of the Board and other critical groups are required to complete an Assurance pro-forma at the end of each meeting identifying key risks including legacy issues.

We will continue, with our partner organisations, to use our Quality Concern model to review and triangulate data. Where necessary this may lead to Risk Summits.

We expect to use the NQB Dashboard in this process.

Increasingly we will encourage CCGs to be a part of this approach, especially as they have more direct dealings with service providers and with other bodies such as the local authorities. This process will be overseen by the QPR committee.

The Cluster will meet with OSCs, LInKs, Local Health Watch specifically to ensure that any risks and issues are identified through triangulation, so that action plans to deal with them can be prepared, and successor bodies are notified through the handover process.

We will continue to take into account intelligence from such bodies as CQC, NHSLA, PPO, complaints and inquiries.

- Medical Director; Director of Nursing; Directors of Public Health; Cluster Board Secretary; CCG Governance Leads; Director of Commissioning Development

Section 6. How will we ensure face-to-face handovers?

We will prepare a schedule of dates for the final handover to successor bodies, taking into account the ultimate end date for the existence of the PCTs and the progressive handover of functions by delegation that is already underway. (See Annex D)

- Transition Lead; Director of Nursing; Cluster Board Secretary

From this, a plan for specific dates for face-to-face handovers will be prepared, identifying the responsible officers and dove-tailing with Cluster Board meetings so that the handovers (and the information contained within them) are endorsed by the Board.

The handover meetings process will include time for reflective feedback by the successor bodies, to ensure that the information can, when necessary, be challenged or verified.

- Medical Director; Director of Nursing; Directors of Public Health; Director of Commissioning Development; Deputy Chief Executive

Section 7. What plans do we have to ensure our handover plan is resilient?

We will appoint a Transition Lead for the Cluster, and in terms of Quality handover, the Medical Director and Director of Nursing will oversee the arrangements.

Each Director and senior manager will ensure, with the assistance of HR, that handover intelligence is captured before any member of staff leaves – whether from the PCT Cluster or from the CCGs prior to April 2013.

- All Executive Directors, Non-Executive Directors and Senior Managers

Staff of the CCGs, whilst they remain committees of the Cluster Board, also have responsibility for ensuring a resilient handover; it is in the interest of the services for which they will be fully responsible following the demise of the PCTs.

- COOs of the CCGs.

Progress towards handovers, and any risk factors, will continue to be monitored by the Audit Committee QPR Committee and the Cluster Board via a Task and Finish Group.

Section 8. What Governance arrangements do we propose putting in place to ensure transparency, probity and honesty?

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The handover arrangements will be kept under review by the Cluster Board and on its behalf by a Task and Finish Group (led by a NED) reporting directly to the Board; by the Audit Committee (which is the mechanism for ensuring financial probity and good governance; its minutes will be in the public domain. It will continue to review risk registers and ensure CCGs receive guidance on governance and audit requirements including conflicts of interests, gifts and hospitality); and by the QPR Committee.

We will ensure that key policy documents will be available on the website supporting the West Mercia Cluster governance agenda.

Board and Committee members will continue to be required to formally declare any interests (including any assumption of responsibilities in successor organisations) at each meeting, which will be recorded in the Declarations of Interests register.

A central risk register is maintained which records the most serious risks and reports these to both the Audit Committee and Cluster Board bimonthly.

The Custer complies with the FOI Act in recognition of the Government's commitment to greater openness. However, it will not publish information or grant requests to release

information if it is subject to the Data Protection Act 1998, for example if the information contains personal/sensitive data or breaches confidentiality.
Section 9. Key milestones
See **Annex D**
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 A PCT Functions and Duties – Managing the Transition – Handover to Successor Bodies Annex B Prospective CCGs to receive quality information Annex C Current Delegations to CCGs Annex D Key Milestones for Quality Handover Plan All Appendices are available on request from Simon.collings@nhs.net