Gateway Ref: 5832

Commissioning A Patient-Led NHS

Human Resources Framework for SHAs and PCTs

Contents

1. Introduction

On 28 July 2005, the Department of Health (DH) published *Commissioning A Patient-Led NHS* (CPLNHS), which announced proposals designed to strengthen commissioning in the NHS. Strategic Health Authorities (SHAs) submitted their plans to deliver CPLNHS to the DH on 15 October 2005.

These plans have now been scrutinised by an external panel, who have advised the DH and Ministers on whether the proposals offer a suitable basis for consultation. The DH has now written to SHAs confirming that local consultations can commence. Following this consultation, and if Ministers approve the proposals, then the configuration of all SHAs will be affected by the proposed changes. Most, but not all, Primary Care Trusts (PCTs) will need to be reconfigured.

In providing this human resources (HR) framework to the NHS, it is important to emphasise that no decisions will be taken on the local reconfiguration of organisations until after the full statutory consultation has taken place. This guidance should, therefore, be read in the light of that basic understanding.

This HR Framework has been produced in partnership with trade unions nationally. It is designed to ensure the NHS is equipped with the right leadership skills and diversity to strengthen commissioning in the NHS, in order to deliver improvements in health and health services. It provides for national consistency in handling the proposed changes if they are approved, and for NHS organisations to plan for the potential impact on staff. It also aims to be sufficiently flexible to allow for local strategies to be used where this is appropriate, and for these minimum standards to be built upon through partnership arrangements.

NHS Employers will provide support to the service. This will include the production of best practice guides to underpin this framework, developing the *NHS Jobs* service for local health communities, facilitating the sharing of good practice across networks and ongoing discussions with trade unions. *NHS Employers* will also facilitate a series of workshops to explore strategies to enable HR staff to implement the changes and make the best use of capacity available. Important items of communication in relation to supporting the service on this HR framework will be placed on the *NHS Employers* website, www.nhsemployers.org/cplnhs. This will include the collation and publication of ongoing 'Questions and Answers', starting two weeks after the publication of this document. This will further enable individuals and groups to understand how the changes will affect them. Comments and questions about this framework should be emailed to cplnhs@nhsemployers.org.

This framework is designed to clarify many issues for people during this difficult period of change. Individuals wishing to understand the implications for them may find it easier to go straight to section nine.

Changes to ambulance services are covered by a separate HR framework, working to similar principles as those covered in this guidance.

November 2005

2. Scope

1. The potential reduction in the number of statutory NHS bodies emerges from the restatement of roles and functions in CPLNHS. In particular, the development of the commissioning role is prompting SHAs to recommend fewer, larger PCTs with greater purchasing power and influence, and to anticipate, within the scope of this framework, more joint appointments with local government. It is also clear that new skills and competencies will be needed to achieve the future vision.

2. At the same time, the Government's intention is to generate greater efficiency in the commissioning and provision of services and to save £250m in administrative and managerial costs, to be reinvested in patient care.

3. To be prudent, therefore, organisations need to plan now to manage the impact of these proposed changes on their current administrative and managerial workforces.

4. The likely scale of change occurring from these proposed reconfigurations will require the NHS to make every effort to retain and redeploy staff in order to ensure that valuable skills and experience are not lost to the service, and that any potential compulsory redundancies can be minimised.

5. This makes it all the more important that the HR framework is implemented fairly and effectively, based on previous good practice and appropriate consultation. Engagement with trade unions and taking account of the interests of stakeholder groups, including local authorities and other public sector organisations will be vital.

6. The organisational reconfigurations will primarily affect administrative and managerial staff in SHAs and PCTs. They will not affect those staff who are predominantly engaged in providing clinical services to patients and the public. In SHAs, the majority of staff will therefore be affected by the proposed changes. In PCTs, a minority of staff (executives, senior managers, some administrative and clerical staff) will be affected.

7. The DH has reinforced the importance of strengthening the public health delivery system, including expanding specialist public health capacity, and the importance of robust commissioning throughout the system. This should be factored into local implementation of CPLNHS.

8. Separate to this framework, a development process for SHAs and PCTs is being designed which will include a *Fitness for Purpose* assessment. This process will focus on organisational capability (e.g. leadership, governance, financial rigour and business planning) and will help identify development needs. Further information on this will follow.

9. SHAs have been asked to work with their neighbours on CPLNHS HR issues. These "clusters" of SHAs have each identified a lead chief executive and lead HR representative. The HR leads are listed in annex A. It is expected that the trade unions will also identify a lead representative for each of these clusters.

3. Purpose

10. The purpose of this framework is to ensure that:

- Any disruption to services to patients is avoided during this period of change.
- Business continuity is maintained, allowing a smooth transition to new organisational structures.
- Those staff affected know how the changes will be managed and how this is likely to affect them personally and that they are properly supported through the change process.
- The changes can move at pace to ensure the NHS has the leadership capacity at strategic level to oversee the change process and speed up decision making on key appointments.
- We get the best people in leadership positions as quickly as possible to give personal certainty and avoid loss of momentum.
- The recruitment processes are transparent and competency based, in order to ensure that any appointments are made on merit.
- NHS organisations work together to ensure that the change is managed consistently across the NHS with scope for local tailoring within a very clear national framework.
- The timescales, processes and policies involved are explained.
- There is a consistent approach to contractual conditions and remuneration for all staff in the new employing organisations.

4. Principles

11. The following are the key principles which all NHS organisations should adopt to underpin the management of these proposed changes:

- All staff should be kept fully informed and supported during the change process.
- All reasonable steps should be taken to avoid redundancies in order to ensure that valuable skills and experience are not lost to the service.
- An integrated HR process should be applied which will be fair and transparent and which will seek to match individual abilities with available posts. This process should also be mindful of the need to move quickly and to continue to deliver a high quality service.
- No employee should receive less favourable treatment on grounds of age, gender, marital status, race, religion, creed, sexual orientation, colour, disability, working patterns, or on the grounds of trade union membership.
- All appointment and selection procedures must be seen to be fair and transparent, and meet the requirements both of equal opportunities legislation and best practice. The procedures recommended in this framework are designed to ensure that there is no direct or indirect discrimination against any particular individual or group.
- There should be partnership working with trade unions at a national level and local level. The views of trade unions should be taken into account in managing the change process.

5. Responsibility for Managing the Changes

12. **At national level:** The HR workstream of the CPLNHS project is led by David Nicholson (SHA chief executive, Birmingham and the Black Country), with support from a team drawn from a number of sources: the DH, all parts of the service affected by the changes, the Appointments Commission and *NHS Employers*. The HR workstream is one strand of the national project management arrangements which have been put in place to manage the changes if they are approved. *NHS Employers* will continue to work in partnership with the trade unions at national level. The SHA HR leads meet regularly to plan how the changes might be implemented consistently and fairly around the country, and how harmonised change management processes can be put into place if needed.

13. **At SHA cluster level:** Each SHA cluster is expected to have in place effective mechanisms for partnership working with staff representatives by the end of December 2005. Trade unions will nominate SHA cluster representatives and these, along with the HR cluster leads, will be identified on the *NHS Employers*' website.

14. **At local level:** Chief executives and HR leads of individual SHAs and PCTs are accountable for project planning and management within their own organisations; for involving staff and trade unions; and managing the implementation of CPLNHS, operating within this national CPLNHS HR framework. Existing chief executives and boards remain accountable for the delivery of service, and will, of course, play a fundamental role in managing change in the interim period, ensuring business continuity across their health economies.

15. **Partnership Working**: The change management process will be facilitated by effective partnership working, and by fully involving staff and their representative organisations in the changes. Employers should support effective partnership working by providing protected time and other facilities for trade union representatives. Continuous dialogue with the trade unions should be maintained throughout the change process.

6. Preparing for the Changes

Getting ready for the changes

16. Where a SHA or PCT's current configuration changes as a result of CPLNHS, existing employees will be transferred to a successor organisation under their existing 'Terms and Conditions of Service' by use of a NHS transfer order. Existing SHAs and PCTs will need to coordinate this process. The transfer order will reflect the transfer of the function as if the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) applies.

17. Where there is no change to the configuration of an organisation, there will be no need to transfer staff to a new employing organisation. However, the organisation will still need to consider what internal reorganisation is necessary to strengthen commissioning and to contribute to administrative and managerial cost savings. Any staff who become at risk of redundancy as a result of this should benefit from the same measures to avoid redundancy, and should receive the same support as staff in reconfigured organisations.

18. All employers must take all reasonable steps to avoid compulsory redundancies. These should include consideration of a voluntary redundancy scheme, equitably applied, and redeployment to posts elsewhere in the NHS or with other employers, as outlined in section eight of this framework.

19. Where the proposed changes mean that staff from a number of organisations are transferring to a new employer, the current organisations should engage with trade unions and staff representatives to harmonise their change management policies and procedures in advance of the transfer. In doing so, organisations will need to ensure business continuity and the ongoing provision of high quality patient care. This should cover how the following issues will be handled equitably and consistently:

    - Applications for early retirement/voluntary redundancy.
    - Appointment to posts in the new organisational structures.
    - Pay protection arrangements where members of staff move to lower graded posts in the new employing organisations.
    - Relocation expenses and excess travel.
    - Flexible working arrangements.
    - Whether individuals who are made redundant will be paid in lieu of notice or will be required to work notice.

20. Where new employers are created as a result of these changes, some of them will cover large geographical areas and have new skill requirements. These new employers will need to make early decisions about the location of their headquarters and their organisational structures, as this will have a major effect on existing staff. In addition, best practice policies on relocation, excess travel payments and flexible working will be crucial to retaining staff. Current organisations, therefore, should make every effort to progress these issues as far as possible, whilst leaving space for designate chief executives of the new employers to make final decisions in these matters.

21. Given the scale of the proposed changes, employers will also need to ensure that they have the internal capacity to meet requests for pension compensation advice and financial estimates from staff at risk of redundancy. It is therefore recommended that organisations prepare themselves in anticipation of the changes being implemented – for example, by ensuring HR and payroll staff are up-to-date on appropriate legislation and NHS terms and conditions, and that personnel records are accurate and accessible.

22. During this period of change, there may be a need for additional facilities for trade union representatives. In those employers where there is a shortage of trade union representatives it may be necessary to agree facilities to allow a representative from another NHS employer to help represent members. These are matters for local agreement, but during this process of change local arrangements should be as flexible as possible to ensure that trade unions are fully involved in the change process.

23. Current employers will recognise the importance of avoiding any changes to the contracts of employment of individuals or groups, or making changes to employment policies, which would provide additional financial protection for their employees, should the organisational changes be agreed. This might include awarding pay increases outside of national guidance or increasing notice periods. Such actions may increase later redundancy payments and therefore would be unacceptable. Any such changes would rightly be open to scrutiny.

Implementing the Changes Equitably

24. Employers must comply with all relevant employment and equal opportunities legislation when implementing the proposed changes. Any decisions in respect of appointments to jobs, promotion, identification of at risk staff and selection for redundancy must be fair, transparent and made with reference to justifiable, objective criteria. Procedures should be designed to support diversity and ensure that there is no unlawful direct or indirect discrimination against any particular individual or group of employees. Good practice guidance on this will be made available by *NHS Employers*.

25. All key decision-makers, including interview panel members, should have received training in diversity issues, including related current legislation and best practice. In the run up to the proposed changes, employers should ensure senior managers have received refresher training if necessary.

26. If the organisational changes occur, employers must keep records of decisions they take during this period which affect the employment of groups and individuals. These records should as a minimum, include details relating to gender, ethnicity, disability and age. Employers should use these records to monitor the decisions that were made to ensure that they were not directly or indirectly discriminatory.

27. The scale of the proposed changes offers a real opportunity for employers to demonstrate their commitment to diversity through their actions. The vision for the future will require new skills and competencies. If commissioning is to be suitably responsive to the needs of local populations, the need for the workforce to be representative of the people they serve is essential.

28. Employers should, within the parameters of this framework, consider now how they would encourage applications from under-represented groups, particularly to leadership positions in the new structures.

29. Employers should conduct an equality impact assessment to consider the effect of the proposed changes on services to patients and the employment of staff. Further guidance on this will be available from *NHS Employers.*

30. Employers should consider how they would avoid the “adverse impact” of the proposed changes on their workforce profiles and on the services they provide.

31. Employers should make sure that their HR staff and managers are aware of, and fully up-to-date with, forthcoming legislation which will impact on the proposed changes – for example,

age discrimination changes effective from October 2006. In particular, employers may wish to consider joint briefings with trade unions.

32. SHA HR leads should ensure that the preparations outlined in this section are being taken forward in partnership within their area of responsibility.

7. Appointment Processes

33. This section outlines the processes to be followed to appoint senior leaders and other staff to the proposed new organisations. This includes the appointments of:

    - Chairs and non-executives of SHAs and PCTs.
    - Professional Executive Committee chairs and members in PCTs.
    - Chief executives of SHAs and PCTs.
    - Directors of SHAs and PCTs. i.e. voting board-level executives and other very senior posts which report to the chief executive and carry the director title.
    - Other administrative and managerial staff.

34. There will be robust assessment and interview processes for all senior posts.

35. To ensure that the new SHAs and PCTs have the necessary leadership capacity at strategic level, selection processes for designate chairs, chief executives, directors and PEC chairs in PCTs need to be prioritised in the process. This will allow them to influence early decisions, which will affect the rest of the workforce, such as the location of the new employer's headquarters and the new organisational structure. However, no appointments would be made that would pre-empt the outcome of consultations and ministerial decisions.

36. The DH is finalising a new pay framework for very senior managers (VSMs). For these purposes, VSMs means chief executives, executive directors and those senior managers with director level responsibilities who report directly to the chief executive. The VSM pay framework will be consistent with, but separate from Agenda for Change (AfC). It will reflect the complexity and varying levels of size of the new SHAs and PCTs. There will be a mandatory requirement for the new employing organisations to determine the salaries of the new chief executive and director posts in SHAs and PCTs in line with the VSM pay framework.

Timescales

37. Once ministerial decisions have been taken following the consultation, the intention is for the new SHAs to be established during the period 1 July 2006 to 31 March 2007. To meet this timescale, the selection process for designate SHA chairs and designate SHA chief executives would run in parallel, with the intention of matching SHA chairs with designate chief executives before July 2006.

38. Subject to consultation, the timetable should allow new PCTs to be established during the period 1 July 2006 to 31 March 2007. PCT chair designate appointments would be made from May 2006 with appointments phased in line with the shadow period needed to establish the new organisation. The selection process for new PCT chief executives would run in parallel, so that new PCT chairs could appoint their chief executives from an accredited pool of candidates in June 2006 in association with the chief executive designate of the new SHA. If the PCT chair has not been appointed by this time, an interim PCT chair and/or the new SHA chair designate would make the appointment.

Chairs and Non-Executives of SHAs and PCTs

39. The appointment of chairs and non-executive directors will take place under the procedures established by the Appointments Commission.

40. For the new SHAs and for reconfigured PCTs, the recruitment process for chairs and non-executive directors will be through a process of established open competition. For PCTs with unchanged geographical boundaries, the current chairs and non-executive directors will remain in post subject to the outcome of the *Fitness for Purpose* review (see paragraph 8). If individual terms of office expire before the *Fitness for Purpose* review takes place, recruitment will be through established open competition.

41. The DH is currently reviewing the remuneration of chairs and non-executive directors, and this is due to be completed in December 2005. Appointments to the new organisations will be made in line with the outcome of this review.

42. The Appointments Commission will write individually to all existing chairs and non-executives of SHAs and PCTs in December 2005 to inform them of the detail of the recruitment processes.

Professional Executive Committee Chairs and Members in PCTs

43. High quality clinical leadership and clinical engagement will be central to developing effective and robust commissioning. Professional Executive Committees (PECs) will continue to be a vital part of the leadership infrastructure of the new PCTs.

44. A PCT should not have more than one PEC. Therefore, unless the new PCT has unchanged geographical boundaries, arrangements will need to be made to put a new PEC in place. PEC chairs and members should be appointed in line with existing guidance (Gateway reference 1999, issued 1 January 1999). Allowances paid to PEC members should be in line with existing guidance (Gateway reference 4739, issued 22 March 2005).

45. As voting board members in PCTs, PEC chairs are vital to the establishment of the new organisations. SHA HR leads should ensure that local arrangements are in place for PEC chair appointments to be made in good time.

46. PCTs with unchanged geographical boundaries will retain their existing PECs.

Chief Executives of SHAs and PCTs

47. The appointment process for SHA chief executives will be managed nationally by the DH. This will take place first to allow the appointment process for PCT chief executives to be managed in regional clusters by the new SHA chief executives.

48. For both SHAs and PCTs, the initial phase of recruitment to the new chief executive posts will be restricted to existing, substantive chief executives. This has the twin advantages of retaining talent and experience within the service and ensuring business continuity during the proposed organisational changes.

49. If any posts remain unfilled after this phase of restricted competition, there will be a second stage of national competition.

50. In the initial phase, “substantive” means those members of staff who hold permanent contracts of employment as chief executive, accountable officers of SHAs or PCTs. Individuals in “acting” or interim roles will not be included in the initial phase, but would be able to apply as part of the national competition phase. Individuals on secondment from their current chief executive roles would be eligible to apply in the first phase, provided they hold a substantive contract.

51. For SHA chief executive appointments, only existing, substantive SHA chief executives would be eligible to apply in the first phase.

52. For PCT chief executive appointments, at stage one, existing, substantive PCT chief executives and existing, substantive SHA chief executives would be eligible to apply (in line with the pooling criteria outlined in paragraph 66).

53. Chief executives in PCTs affected by any geographical boundary changes, however minor, would be subject to the process outlined above.

54. Chief executives in those PCTs whose geographical boundaries would remain exactly the same would not be subject to this process, and would remain in post as chief executive.

55. Where several PCTs are joining together to create a new single organisation and currently share a single chief executive as their accountable officer, the following processes would be followed:

    - Where the chief executive had been recruited to his/her current post through a process of national, open competition to be accountable officer for all the organisations which are joining together, the same process would be followed as in PCTs with unchanging geographical boundaries (see paragraph 54).
    - Where the chief executive has not been recruited to his/her current post through a process of national, open competition, then the process described in paragraphs 48 to 52 will apply.

56. Standard national role definitions will be produced for SHA and PCT chief executive posts to support the recruitment processes. In addition, there will be a national standard for the robust assessment process of PCT chief executives to ensure consistency across the country. Further guidance on this will be issued directly to SHAs.

57. Appointment panels for SHA chief executives will be chaired by Sir Nigel Crisp.

58. Appointment panels for PCT chief executives will be chaired by the new PCT chair (or interim PCT chair, or SHA chair if the new PCT chair has not been appointed), and will also include the SHA chief executive, the new PEC chair (or other senior clinician if the new PEC chair has not been appointed), and an independent assessor.

Directors of SHAs and PCTs

59. In designing structures and making appointments, SHA and PCT chief executives should ensure that the following essential portfolios are held by members of the executive team:

    - Commissioning and performance
    - Finance
    - Information management and technology
    - Medical
    - Nursing
    - Provider development
    - Public health
    - Workforce

    National standard portfolio descriptions will be made available for all of the above.
    This does not imply that there should be a separate post for each portfolio area. Indeed, PCTs may wish to collaborate by appointing shared directors where it makes sense to do so. However, all SHAs and PCTs should have a doctor and a nurse on the board.

60. Within the scope of this framework, chief executives should actively consider joint appointments with local government where this would strengthen services to the public, for example in public health and commissioning.

61. With regard to public health appointments, SHAs will need to consider the impact of the reconfiguration on staff employed within regional public health groups. Guidance on the process for public health appointments, including the approach to pooling, at SHA and PCT level will be issued directly to SHAs.

62. Recruitment to director posts in the new organisations will be the responsibility of the chief executive designate, working together with their chair and non-executive directors, and in PCTs, preferably with their PEC chair.

63. In order to assist business continuity, and to ensure that the changes can be completed as quickly as possible, the DH, SHAs and PCTs are encouraged to explore ways in which recruitment processes to identify candidates for director posts could be accelerated – for example, by commencing the assessment process for director appointments before the chief executive is appointed. However, the chief executive designate should be involved in the final appointment.

64. It is also important that the chief executive designate works closely with the current chief executives of the predecessor organisations where they remain in post in order to maintain the stability of the system.

65. Consistent with the chief executive appointment processes outlined above, there will be an initial phase of restricted competition for existing, substantive directors for the new director level posts – i.e. prior consideration would be given to "pools" of substantive post holders. Arrangements for these pools will be determined by SHAs and PCTs and would be expected to be no larger that the new SHA area.

66. Pools for SHA and PCT chief executives are specified within this framework. However, given the likelihood that new SHAs and PCTs will vary in size and complexity, the development of "pooling" arrangements for directors should be based on the following principles:

    - There should be consistency across the area to be served by the new SHA
    - Consultation with trade unions should take place on pooling arrangements.
    - Individuals should have access to a primary pool at the level of their current substantive post or at the tier below.
    - Individuals should be invited to express a preference for which pool they wish to join as a primary pool.
    - If unsuccessful in securing a post from their primary pool, individuals should be able to access a secondary pool of posts at the tier below their primary pool.
    - In all cases, individual circumstances regarding these decisions should be taken into account and arrangements should comply with employment best practice.

67. For directors in those PCTs whose geographical boundaries would remain exactly the same after the changes as they were before, these recruitment processes would not apply. These directors will remain in post. However, these PCTs will need to review their management structures in line with the vision of CPLNHS. Similarly, the executive team will need to ensure it can cover the range of portfolios outlined in paragraph 59. Any directors in these PCTs at risk as a result of management structure reviews should benefit from the same measures to avoid redundancy and the same support as other staff, as described in section eight of this framework.

68. Where several PCTs are joining together to create a new single organisation and currently share a director, the following processes will be followed:

- Where the director has been recruited to his/her current post through a process of national, open competition to all the organisations which are joining together, the same process will be followed as in PCTs with unchanging boundaries (see paragraph 67)
- Where the director had not been recruited to his/her current post through a process of national, open competition, then the process described in paragraphs 60 to 66 will apply.

Other administrative and managerial staff in SHAs and PCTs

69. Once the final decisions on reconfigurations are known, the structures of these new organisations will need to develop in the light of their changing role. One of the early tasks required of chief executives will be to complete the change management process to create organisations that are fit for purpose and to ensure that the position of all staff is resolved quickly.

70. The process for filling posts for all other administrative and managerial staff will be managed locally, but based on the principles contained in this document. In determining the selection processes, local management will be expected to take account of not only their statutory and contractual obligations towards staff, but also any good practice procedures that have been discussed and consulted upon with staff organisations. For example, local NHS managers will need to take account of whether posts remain substantially the same, or whether it is a new or substantially changed post, in determining whether staff can be slotted in without competition.

71. It is expected that posts should be filled from the existing pool of displaced staff within the local health economy wherever that is possible, using the criteria for “pooling” outlined in paragraph 66.

8. Supporting the Service and Staff through the Changes

Immediate Action for Employers

72. Current employers are responsible for taking immediate action to prepare for the proposed changes. The following paragraphs outline the minimum preparation required. SHA HR leads should oversee these preparations.

73. Even though these proposed changes are still subject to consultation, all staff employed by SHAs and PCTs need support and advice now. Current employers should therefore establish mechanisms at local level to provide for this. For example, all staff should be kept fully informed of developments. They should have one-to-one support from line managers to help staff to consider their future options. Employers should ensure that this includes staff currently on long-term sick leave, maternity leave, career breaks and secondments.

74. Organisations should not wait until staff are formally put at risk before taking action. There are a number of supportive measures which should be taken by NHS employing organisations immediately to support staff who might be affected by these changes.

75. Existing SHA and PCT employers should not recruit to any permanent administrative or managerial posts in affected areas. Any exceptions should be approved by the current chief executive. This is to maximise the opportunities for the redeployment of existing staff in SHAs and PCTs and minimise redundancies.

76. Furthermore, **all** NHS employing organisations should restrict the advertising of all permanent management and administrative vacancies to NHS staff. By exception, only if a post is not filled through this process, should it then be advertised more widely.

77. Foundation Trusts and Arms Length Bodies operating within SHA areas are encouraged to support the rest of the health economy by restricting the advertising of all their permanent management and administrative posts in the same way as other NHS employers and, later if necessary, by giving prior consideration to staff at risk of redundancy.

78. The use of secondments /project support and other opportunities are to be promoted through this period of change and work will take place nationally and locally to better facilitate this across NHS/independent sector and local authority employers. This will give staff the opportunity to test new skills and build alternative career development at this time. Some staff may see these options as alternatives to their current career plan. These staff will be supported to bring these about as part of the wider HR change process.

Transition Arrangements

79. This HR framework has been developed to ensure that disruption to services is minimised and business/ service continuity is maintained. This will allow smooth transition to the proposed new organisational structures.

80. Transition arrangements will be required to support the strengthening of new commissioning arrangements in SHAs and PCTs and maintain momentum.

81. The proposed reconfiguration of SHAs and PCTs will require robust project planning, leadership and governance arrangements.

82. Staff directly affected by these changes will be required to manage services and any associated risks through this period. Re-deployment processes will also need to be effectively implemented if the cost of any redundancies is to be minimised.

83. For this reason, substantive staff in SHAs who are directly affected by these changes will have extended employment until the end of March 2007. Substantive staff in PCTs who are directly affected by these changes will have extended employment until the end of June 2007. This recognises that the proposed changes for SHAs will run ahead of the proposed changes for PCTs.

Employment Issues

84. As set out in paragraph 19, the new employers created by these proposed changes should have agreed harmonised organisational change policies prior to staff transferring. These should include how appointment processes are to be managed in the new employing organisations, and following best HR practice, these should include arrangements for prior consideration, slotting in and restricted competition.

85. At the same time, and in discussion with trade unions, employers should consider voluntary redundancy and early retirement schemes for defined categories of staff, where it is clear that the number of current employees is greater than the jobs available in new organisational structures. This should be discussed and agreed at an appropriate local level.

86. Voluntary schemes are usually more expensive than other ways of managing redundancies. There is the risk that skills will be depleted in the new organisations (and in the NHS at large) if certain or too many volunteers are allowed. As the Advisory Conciliation and Arbitration Service (ACAS) comments, 'The volunteers may include some people who might be expected to contribute most to future success' ('Redundancy Handling', www.acas.org.uk/publications)

87. Employers should be sure that there is a business case for such schemes that will stand scrutiny by auditors. In particular, employers should ensure that the following criteria are met:

- that volunteers are invited from defined groups or categories of staff. A blanket invitation to all staff is not appropriate;
- that there is a demonstrably greater number of existing employees in the staff group than there are suitable jobs in the new organisation(s);
- that the volunteers are unlikely to be redeployed in alternative employment elsewhere in the NHS, e.g. because the rest of the local NHS is managing redundancies in the same category of staff, or the workplace is isolated and alternatives are not within reasonable travel distance;
- that the voluntary scheme represents value for money for a publicly-funded NHS. This could be demonstrated by volunteers agreeing to work flexibly in supporting business continuity and the closing down of old organisations or by agreeing to go relatively early and forego employment to the guaranteed date.

88. It is possible that some individuals may not secure posts in the new structures and may not have volunteered for redundancy. These individuals will therefore be at risk of compulsory redundancy.

Action to Support Staff at Risk of Compulsory Redundancy

89. The new SHAs and PCTs in consultation with the trade unions will need to agree measures to minimise the extent of redundancies amongst affected staff.

90. Every individual who is at risk of compulsory redundancy should be given the opportunity for a one-to-one meeting with a senior manager and/or HR adviser to discuss his or her options and preferences at this point. Individuals should be offered the opportunity to bring a representative to this meeting.

91. At this meeting, the individual should be informed that the formal statutory redundancy consultation is beginning, and s/he should be informed of his/her rights and responsibilities during this period.

92. SHAs and PCTs are required to have in place a range of support mechanisms for individuals who do not secure a post through restructuring and employers should assist the employee in finding suitable alternative work. This may include providing:

- training in CV and interview preparation;
- paid time off for interviews;
- career counselling;
- trial periods in appropriate posts and
- outplacement support.

93. Employers should use their networks of partner organisations and local intelligence to explore alternative employment within the wider NHS, in other parts of the public sector or elsewhere in the local labour market.

94. The employee must reciprocate by agreeing to pursue all reasonable employment opportunities. This includes the requirement to comply actively with and participate in all recruitment processes unless the individual has agreed early retirement or voluntary redundancy in line with paragraphs 85 to 87, or unless they are resigning from their posts.

95. In a redundancy situation, an employer has a legal obligation to seek to avoid redundancy by trying to identify suitable alternative employment for displaced staff. An employee may forfeit his/her right to a redundancy payment if s/he does not apply for, or accept an offer of, suitable alternative employment. When considering whether a post constitutes suitable alternative employment, employers need to consider whether it provides similar earnings; has similar status; is within the member of staff's capability; and does not involve unreasonable additional inconvenience.

96. For staff transferring into reconfigured organisations, continuity of service will automatically apply. For individuals applying for new posts in other organisations, there is no automatic right to recognise continuous service since it is a new employment contract. However, in order to support the appropriate movement of all staff, and not put inappropriate blocks into the system, employers are expected to use sensible incentives, within their legal powers, to address the continuity of service issue. This should involve taking into account previous NHS service for the purposes of contractual benefits such as redundancy, maternity, annual leave or sickness benefits**.**

97. SHA HR leads should, in consultation with trade unions, ensure that a redeployment system is established in their geographical area. Each new SHA, once it is established, should nominate a person to continue this work. The redeployment arrangements for each SHA cluster should be set up by February 2006.

98. All NHS employing organisations will be required to support the redeployment arrangements by ensuring that all permanent management and administrative vacancies are made available to those employees at risk of redundancy.

99. Any employee at risk of redundancy for whatever reason within the health economy covered by the redeployment arrangements will be entitled to be offered prior consideration of vacancies in this way.

100. Redeployment arrangements will be supported by new functionality within the e-recruitment service, *NHS Jobs*. All organisations will therefore be required to register with *NHS Jobs* for this purpose.

101. The *NHS Jobs* website will have protected areas where employers can post vacancies that are only open to staff at risk, and where staff identified as 'at risk' have exclusive rights to view these vacancies. Contained within the functionality is the capacity to view jobs outside of the local health economy if this suits individual circumstances.

102. The redeployment system cannot guarantee jobs or posts but is an effective way of matching people with relevant skills to appropriate posts, and retaining key staff. SHAs should ensure that their redeployment arrangements are as flexible and supportive to staff as possible.

Pay Protection

103. All NHS employers should have in place local protection agreements. These policies set out arrangements for safeguarding the pay and conditions of service of individual staff adversely affected by organisational change, as an alternative to redundancy or early retirement. This may involve maintaining earnings for a period of time even though staff have moved to a job with a lower salary level.

104. Protection arrangements should facilitate the management of change, taking into account management objectives as well as the aspirations and well being of employees. Employers will be expected to invoke their local protection policies where applicable.

105. In order to secure high calibre staff from within the NHS who may be displaced by the restructuring, all NHS employers are expected to honour existing arrangements on pay protection.

106. There will need to be local discussions with trade unions about how the policies of individual SHAs and PCTs on handling organisational change can be used to support the change management process.

107. Where a member of staff is prepared to take a post at a lower grade with another NHS employer as an alternative to compulsory redundancy, the existing employer should determine a period of pay protection where it is cost-effective to do so (i.e. where the cost of the pay protection is less or equal to the cost of compulsory redundancy).

Issuing Notice

108. At the end of the statutory redundancy consultation period, where a member of staff has not been successful in securing suitable alternative employment, s/he will be issued with notice of redundancy. S/he should be handed the notice during a one-to-one meeting with a senior manager and/or HR adviser. Individuals should be offered the opportunity to bring a representative to this meeting.

109. Where the statutory/contractual notice is shorter than the length of the employment guarantee, the employee would be expected to work flexibly during the remaining employment period. This flexibility would be needed

- to ensure business continuity;
- to contribute to the closure of NHS organisations;
- to undertake other temporary, alternative work in the local health community.

110. Staff may find themselves part of a diminishing team of people seeing their former employing organisation through to reconfiguration. However, not all displaced staff would be needed to ensure business continuity or to close down the organisation. In these cases, members of staff may be redeployed for the duration of their guaranteed employment to other temporary alternative work in the local health community. Payment in lieu of notice should only be made in exceptional circumstances, following the submission of a robust business case, which should be signed off by the new chief executive. The business case must demonstrate both the equity and cost effectiveness of the proposal. The accountancy treatment of redundancy costs should follow generally accepted accounting practice and in particular FRS12. Further guidance will be provided on the governance issues associated with redundancy payments.

111. Most staff will have section 16 of the AfC handbook incorporated into their contracts of employment. However, those staff who are not on AfC terms and conditions may have different entitlements to redundancy payments. Employers should always refer to the individual's contract of employment when calculating redundancy payments and seek legal advice as appropriate.

112. An employee would not be eligible for redundancy payments if s/he were offered suitable alternative employment with another NHS employer within four weeks of the effective redundancy termination date. Consequently, no NHS employer should enter into an agreement to re-engage a member of staff at a future date specifically designed to allow him/her to benefit from the redundancy and/or pension enhancements.

Potential Impact of Age Legislation on Redundancy Payments and Pension Compensation

113. *NHS Employers* and the trade unions are reviewing jointly the arrangements for redundancy compensation in the NHS to make them compliant with new age discrimination legislation, due to be introduced in October 2006. Discussions with the trade unions will commence shortly and the service will be kept closely informed of progress. Alongside this, an urgent piece of work is being taken forward to consider the protection arrangements for staff. This work will be informed by legal advice and further financial work to ensure affordability. A further note on this aspect will be issued to the service as quickly as possible.

9. Potential Impact on Individuals

114. The following section provides a summary, to help individuals understand how they might be affected by these changes and to point them to relevant sections of this HR framework.

115. If you are unable to identify what situation you are in or have questions about the support you will receive then you should first consult your line manager, and then your human resources department or your trade union if still uncertain.

116. Paragraph six defines in broad terms the staff who will be affected if the CPLNHS changes go ahead.

117. **SHA staff:** Following consultation, if it is decided that your SHA will be reconfigured, then you will initially transfer to the successor organisation -- ie the new SHA. However, some very senior staff may be required to apply for posts in the new structures before the date of transfer.

118. **PCT staff:** Similarly if following consultation, it is decided that your PCT will be reconfigured, then you will initially transfer to the successor organisation – ie the new PCT. However, some very senior staff may be required to apply for posts in the new organisation before the date of the transfer.

119. The effect of the proposed changes on existing SHA and PCT chairs and non-executive directors is outlined in paragraphs 39 – 42.

120. The effect of the proposed changes on PEC chairs and members is outlined in paragraphs 43 – 46.

121. The effect of the proposed changes on, and the appointment processes for, SHA and PCT chief executives is outlined in paragraphs 47 to 58.

122. The effect of the proposed changes on, and the appointment processes for, SHA and PCT directors is described in paragraphs 59 to 68. The term “director” is defined in paragraph 33.

123. The effect on other administrative and managerial staff is outlined in paragraphs 69 – 71.

124. The support that all employees can expect is outlined in detail in section eight. In particular, paragraphs 96 and 103 -107 discuss continuity of service and pay protection for staff moving into new posts.

125. If you are a member of staff whose post is affected by the changes and if you are “at risk” of redundancy, then you can expect the following from your employer:

- Timely and effective communication .
- One-to-one meetings with your line manager or other senior person to help you consider your future options.
- Support to help you find suitable alternative work.
- Prior consideration for suitable vacancies with your employer and other local NHS employers in line with paragraphs 97 – 102.
- Paid time off to attend interviews.
- Trial periods in appropriate jobs.

In return, you must

- Take the opportunities for communication offered to you.
- Accept that you have the lead responsibility for your own future career direction.

- Engage positively in all efforts to secure a post.
- Be as flexible as possible in the employment options you consider.

10. Timetable for the Changes

This is an outline timetable, highlighting some key milestones, such as chair and chief executive appointments. It is not definitive and may be subject to change. It is provided to give affected staff an indication of the possible pace of change. Elsewhere in this framework, the importance of completing the changes quickly – in order to maintain service continuity and to provide personal certainty to staff – has been emphasised. Employing organisations are encouraged to complete the changes as quickly as possible for these reasons, and not to be tied to the pace of this timetable if the changes can be completed more quickly without sacrificing proper procedures. However, no action should be taken on appointments that would pre-empt the outcome of consultations and ministerial decisions.

2005	**December**	**Consultation on SHA and PCT configuration begins.**
2006	**January**	Consultation continues.
	February/March/April	Consultation on SHA and PCT configuration ends. Staff consultation on transfer to new organisations begins. Ministerial consideration of outcome of consultation and decisions made. SHA chairs designate are appointed and matched with SHA chief executives designate. SHA chief executives designate make early decisions about structure and location of their SHAs and communicate these to affected staff.
	May/June	PCT chairs designate are appointed. PCT chief executives designate are appointed. PCT chief executives make early decisions about structure and location of PCTs and communicate these to affected staff.
	July	New SHAs and PCTs are established from 1 July 2006. Staff will transfer into the new organisations through NHS transfer orders. Processes begin to move to new organisational structures. This will include transferred staff being slotting in, being offered prior consideration and restricted competition for posts.
	August	Staff who do not secure posts in the new structures will be "at risk". Efforts will begin and continue during this period to support staff at risk through attempts to find suitable alternative work. *NHS Jobs* will be used to support redeployment.
	September	
	October	
	November	
	December	
2007	**January**	
	February	
	March	Employment guarantee expires for SHA staff.
	April/May	Efforts continue to support staff at risk
	June	Employment guarantee expires for PCT staff

Annex A -- SHA HR Leads

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