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BOARD PAPER - NHS ENGLAND

Title: Handling major projects

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Purpose of paper:

The purpose of this report is to provide the Board with an update on how NHS England is responding to the independent review into lessons to be learned for NHS England from the introduction of the NHS 111 service.

Key issues and recommendations:

The report proposes specific actions that NHS England should undertake to improve management of major projects of this nature. This paper sets out an initial response to these.

Actions required by Board Members:

The Board is asked to:

- note the report detailing the findings of the independent review at Annex A;
- provide comment on the proposed actions set out in this paper; and
- specifically comment on, and agree the proposed criteria for identification of major projects requiring oversight by the Major Programme Oversight Group.

Handling major projects

Purpose

1. The purpose of this report is to provide the Board with an update on how NHS England is proposing to respond to the independent review into lessons to be learned for NHS England from the introduction of the NHS 111 service.

Background

2. In May 2013, the Board commissioned an independent review into the lessons to be learned for NHS England from the introduction of the NHS 111 service. This review focussed on NHS England and the systems and processes that it employed to oversee implementation and ensure delivery of the NHS 111 service. Its purpose was to derive lessons that are applicable to the future management of large projects by NHS England.

The review

3. The review took place during May 2013 through a process of document review and interviews of relevant parties. A report was produced detailing the findings and outlining the key lessons to be learned and was subsequently shared with all NHS England Board members. This report can be found at Annex A.

Lessons to be learned

4. The main lessons from the report are:

   a) NHS England should have clear protocols for handling major new initiatives that are consistent with cross-government guidelines but also build on the lessons from NHS 111 (paragraphs 12-13).

   b) Pilots provide valuable lessons and enough time needs to be built into programmes to benefit from them. They should be externally evaluated and that evaluation should prompt a formal stocktake and reappraisal of the implementation plan. There should be a structured programme to pass on the lessons from pilots (paragraphs 14-17).

   c) Local commissioners will not necessarily have experience of complex major procurements of a specialist nature. NHS England needs to assure itself that effective external advice is available where needed to deliver one off procurements of this kind, and in particular to test quality and service delivery claims by bidders (paragraphs 18-26).

d) Services should only go live after they have been subject to robust checks about quality and capacity. Those checks need to be particularly rigorous where there has been significant downward pressure on costs (paragraphs 27-29).

e) In planning for future initiatives NHS England should pay particular attention to timetables and wherever possible look to build into them maximum levels of flexibility and de-risk implementation by phasing in new programmes (paragraphs 30-34).

f) NHS England needs to review its escalation procedures for risks associated with major initiatives (paragraphs 35-41).

g) The success of major new initiatives depends heavily on significant investment of very senior management time and clinician time (paragraphs 42-43).

h) NHS England needs to work with commissioners to develop mechanisms to ensure the right levels of help and challenge are available to support new initiatives that are centrally specified but locally commissioned and delivered within the new organisational model for the NHS (paragraphs 44-51).

i) Engaging with and listening to front line staff and clinicians is a key component of successful delivery of major initiatives (paragraph 52).

NHS England's response

5. NHS England welcomes this report and is committed to reflect on, learn from, and act upon the lessons highlighted. With engagement from all Directorates, a proposed set of actions has been developed to ensure that as an organisation we move forward in a way that is consistent with the organisational values and aims as laid out in our business plan "Putting Patients First". The actions developed have been grouped under the following four themes:

- **Risk identification and management**
- **Identification and processes for oversight of the largest and most complex programmes**
- **Robust procurement processes, including the use of pilots**
- **Joint ownership with local commissioners**

Risk identification and management

6. The review highlights the need to consider our escalation procedures for risks associated with major projects. We will take use this as an opportunity to future-proof our approach to risk management by:

- reviewing and testing the current NHS England risk management processes, specifically in relation to which risks are reported where and when;

- improving the mechanisms for raising, recording and escalating new risks, underpinned by a clear robust process;

- working with our Organisational Development colleagues to nurture a "risk culture" throughout the organisation and as an organisation we will lead by example through open and transparent communication of risk information; and

- continue to provide each Board meeting with the latest iteration of the board assurance framework.

Identification and oversight of the largest and most complex projects and programmes

7. The review makes several recommendations that suggest NHS England should oversee its small number of large and complex projects and programmes in a systematic way. Critically, this includes ensuring that major programmes have the attention of senior leaders, including the Board; and that risks are properly understood, assessed and managed at executive and Board level.

8. In response to this, NHS England proposes to establish a "Major Programme Oversight Group" which will meet on a monthly basis to carry out this role. This will enable an executive and cross-directorate spotlight on these areas, including good discussions on any associated risk and action. This will facilitate collaborative working and re-allocation of resources as necessary.

9. Where there are areas of risk that need to be highlighted to the Board, these can be escalated into the board assurance framework by this group. To underpin this, we propose to articulate a clear set of criteria to aid the organisation in identifying such programmes. We initially propose the following criteria:

- the scale of impact on health outcomes and patient and public satisfaction;
- the scale of financial cost and / or financial impact;
- the novelty, innovation or overall complexity of the project, particularly in relation to technology projects; and
- cross-cutting major projects where successful delivery is heavily dependent on partnership working.

10. The board is asked to comment on, and agree the proposed criteria as set out above.

11. Early thoughts are that at least the following would be captured:

- NHS 111 service;
- the family health services transition; and
- the customer contact centre, including the integrated customer service platform.

Robust procurement processes, including the use of pilots

12. The report highlights the need for robust procurement methodology, including appropriate use of independently evaluated pilots.

13. NHS England is committed to embedding robust procurement methodologies for all major procurements. These procurements will follow HM Treasury guidance (Green Book), using the 'five case' Business Case model (Strategic, Economic, Commercial, Financial, Management), running through the following stages of business case:

- Strategic Outline Case (SOC) - to confirm the strategic context of the investment.
- Outline Business Case (OBC) - to identify a preferred option which demonstrably optimises value for money.
- Full Business Case (FBC) - to revisit the OBC and sets out the recommendation for an affordable solution.

14. Procurements will be approved through appropriate channels, through the Department of Health (DH), HM Treasury and Cabinet Office, dependent upon the scope and costs.

15. We will ensure a phased introduction for all major programmes, allowing them to be tested, evaluated and adjusted where necessary, before being rolled out nationally. Senior responsible officers for projects who propose that phased introduction is not carried out will be required to justify such proposals and provide assurance at executive level before this is agreed.

Joint ownership with local commissioners

16. The review highlights the importance of NHS England taking joint ownership with clinical commissioning groups (CCGs) for significant projects which require local delivery.

17. We propose that NHS England works through the implications with CCGs (using the NHS Commissioning Assembly) to agree how to:

- encourage and support peer-review and involvement between CCGs;
- collectively harness expertise and share intelligence for best results;

- provide guidance for and standardise, where appropriate, the mechanisms for assessing bids for nationally specified services commissioned at a local level which may include weighting of scoring for service quality and price;
- ensure expert advice is available to support local commissioners when procuring;
- depending on the specific initiative, consider the approach of this type of commissioning once, rather than numerous times; and
- ensure coherence with the role of other organisations in the system, including Commissioning Support Units who bring together local knowledge, expertise and specialist skills with the scale, capacity and resilience to offer high value solutions to health commissioners.

Recommendations

18. The Board is asked to:

- note the report detailing the findings of the independent review at Annex A;
- provide comment on the proposed actions set out in this paper; and
- specifically comment on, and agree the proposed criteria for identification of major projects requiring oversight by the Major Project Oversight Group.

Bill McCarthy

National Director: Policy

July 2013

Review of lessons to be learned for NHS England from the introduction of the NHS 111 service

Introduction

1. This report summarises the findings of a short review commissioned by NHS England in May 2013. The review is one of a number planned or commissioned by NHS England into the NHS 111 service. Others will deal with the longer term resilience and sustainability of the NHS 111 service and whether the design and set up of NHS 111 are appropriate for the future.

2. This review is focussed on NHS England and the systems and processes that it employed to oversee implementation and ensure delivery of the new telephone call system. Its purpose is to derive lessons that are applicable to the future management of big projects.

3. The terms of reference are at Annex B.

Background

4. The case for a service along the lines of NHS 111 was made in Lord Darzi's report "High Quality Care For All" in 2008 which said *"we should consider options to introduce a new three-digit number to help people find the right local service to meet their urgent, unplanned care needs."* The concept had widespread support within the NHS and more generally.

5. The decision to pilot such a scheme was taken in 2009 and the NHS 111 service was piloted in 2010 in four different areas. In that same year the new coalition government took the decision to proceed with the roll out of the service alongside evaluation of the pilots and a commitment to introduce the service was included in the coalition agreement. A target date for full roll out of April 2013 was set in December 2010.

6. In January 2011 the Department of Health (DH) received responses to a request to launch further pilots and by August 2012 eight further sites went live.

7. In June 2012, in response to concerns expressed by the British Medical Association (BMA) among others, the Secretary of State announced that clinical commissioning groups (CCGs) that required it could apply for an extension to the April 2013 deadline. Only eight CCGs applied, covering four NHS 111 sites, and each was accepted, though two of these sites subsequently withdrew their requests.

8. On 1 November 2012 responsibility for the NHS 111 programme was transferred from the Department of Health to NHS England (then the NHS Commissioning Board but referred to throughout this report as NHS England for the sake of simplicity). By this stage, in line with the programme described above, most of the key decisions about the architecture of the system and arrangements for implementation had been taken and:

    - the programme had been the subject of two OGC Gateway reviews (in April 2010 and December 2011);
    - a full business case and impact assessment had been prepared;
    - the NHS Pathways telephone triaging system and the Directory of Services that underpins it had been developed;
    - NHS 111 providers had been appointed in almost all of the 46 areas for which bids had been sought.

9. The weeks between November 2012 and April 2013 were, however, critical because the programme was heavily end-loaded with 31 of the 46 sites due to go live.

10. In the event, whilst some NHS 111 providers launched the new service on time and achieved good service standards, there were widespread problems. In 2 sites, it became apparent late on that the provider originally chosen would not be able to deliver and the commissioners re-tendered for the service. In others there were delays in the planned launch due to clinicians' concerns and provider capacity issues. In some sites that did go live there were significant failures in terms of the quality of service and in particular a failure to meet the targets of 95% of calls answered in less than a minute and of less than 5% of calls abandoned after waiting over 30 seconds for a reply. The main problems with these appear to have been over optimistic assumptions by contractors about average call handling times and a consequent lack of trained staff to handle these calls.

11. The paragraphs that follow examine these problems in more detail focussing in particular on the systems and processes that were in place within NHS England to manage the programme and how well they functioned.

The project management programme

12. NHS England inherited a project management programme with objectives, milestones and go live dates and an infrastructure to support this. That programme was consistent with cross-government guidelines and had been subjected to two OGC Gateway reviews. There was further assurance for NHS England in the full business case and impact assessment that were signed off just as the handover to NHS England was taking place. At national level, the project management arrangements included a Senior Responsible Officer (SRO), an NHS 111 Programme Board, a clinical leads group, an operations and benefit group, and an NHS Direct transition group. At local level there were strategic

health authority (SHA) cluster SROs, SHA leads and at PCT/CCG level an NHS 111 SRO, and an NHS 111 board.

13. On paper then, the planning and preparation had been thorough and resources had been put in place to implement the programme. The overall project management infrastructure looks fit for purpose. The problems that arose stemmed from the way individual elements of the programme were implemented rather than from its overall architecture.

Piloting

14. Given the scale of this programme and the inherent risks, it was sensible to begin with relatively small-scale pilots. The four original pilots were evaluated by the University of Sheffield with reports in May 2011, October 2011 and August 2012.

15. The evaluation was at best neutral. Amongst its conclusions were:

"One year after launch, the pilots had not delivered the expected benefits in terms of improving satisfaction with urgent care or improving efficiency by directing patients to urgent rather than emergency care services."

"The primary economic analysis based on the pilot site activity identified a low probability of cost savings to the emergency and urgent care system. However, a simplistic analysis of the national implementation of NHS 111, with the service replacing the NHS Direct 0845 service and handling all GP out of hours calls, showed that NHS 111 may result in cost savings to the NHS. This is based on considerable assumptions and limited cost data."

"It takes time for early problems to be identified and resolved, for a new service to become established with users, and for reflection on how the service can be improved. However, it cannot be assumed that increase in use, and time, will produce expected benefits."

16. It is not clear what impact these findings had on the implementation programme. By the time the final report on the pilots was available in the autumn of 2012 the decision had been taken to roll out the programme nationally from April 2013 so there was little time available for amending the plans for NHS 111 implementation. But there is limited evidence that the evaluation triggered any substantial debate or rethink of the programme. There should have been a more formal re-evaluation and stocktake of the programme at this stage.

17. The other issue in relation to the pilots is whether the experience of the pilot sites was properly shared with the rest of the country. The central team in NHS England through

its various working groups did make available the pilots' learning but a more structured programme to pass on the lessons would have been helpful.

Procurement

18. As with the piloting, the procurement had largely been completed by the time NHS England assumed responsibility for the programme but it had big implications for what happened next. When the service was launched, the biggest problems arose because providers did not have the capacity required to handle the volume of calls offered to its contact centres. This raises questions about whether commissioners had a real understanding of the capacity and capability of successful bidders and if not, why not.

19. The procurement of providers of the NHS 111 service was complex and the contracting model that had been adopted resulted in 46 locally commissioned service providers. Whilst there was a centrally specified core service, local variations were also seen as important to integrate the new service into local urgent care systems. NHS 111 was always intended to replace the NHS Direct 0845 4647 service but, while not centrally mandated, local commissioners felt it appropriate to incorporate GP out of hours telephone access too in order to simplify the route to NHS care for patients and avoid unnecessary duplication. This added both to the complexity and to the uncertainty around procurement.

20. Local commissioners were allowed to develop their own methodologies for evaluating bids and scoring tenders. They used a variety of scoring systems which assigned weights and scores in areas such as quality, service delivery, finance, and bid presentation. The weights assigned to quality ranged from over 70% to 50%, with a consequential impact on the weight given to cost which ranged from 25% to 50%. This is important because the pressure to drive down cost was a factor in the problems that some providers subsequently experienced in trying to deliver the service with inadequate call taker capacity.

21. It is fair to say that, whilst the NHS was under considerable pressure to save money, cost cutting was not a major driver in setting out on this particular initiative. The mid-case estimate of savings in the full business case for NHS 111 showed modest savings of £43m over 10 years, with annual savings of around £15m by the end of this period. In NHS terms these are not large sums. There was, therefore, no central steer that cost should be weighted particularly heavily in choosing a provider and no price cap was imposed from the centre.

22. At local level, however, because of the wider financial position of the NHS, there was a strong pressure to find savings from this exercise. NHS Direct's 0845 service with cost per call of over £20 was perceived as too expensive and the call centre component of GP out of hours services, estimated to be between 20% and 40% of total costs, was also

seen as an area where savings could be made. The NHS Pathways triaging system relied less heavily on nurse call handlers and this pointed to the potential to reduce staff costs. Based on the experience with pilots, the early implementers imposed local price caps of £8 or under per call and this lead was followed in later procurements. The centre did not systematically collect and collate information on costs in contracts but it is understood that in all 46 sites costs in contracts are around the range of £7.50 to £8.50. Whilst there was some evidence from pilots that it was possible to deliver the service at this sort of cost, the level of reduction from NHS Direct's 0845 costs meant that deliverability within this envelope needed to be tested and it was important that commissioners as well as providers had a good understanding of costs.

23. With costs being squeezed, a key element in due diligence in relation to the procurement was the rigour with which the bids' claims on quality and service delivery were tested by commissioners. This too varied. At best the probing was in depth and exhaustive, particularly where commissioners had been involved in piloting and had longer experience of how the system should work. Where the tender process was at its most rigorous it had a staged approach beginning with a Supplier Questionnaire, challenging areas such as financial standing, testimonials, policies, procedures and risk handling. This was followed by an evaluation of the bid document with detailed questions on service delivery and performance and a financial model template including full service costs and ratios. The final stage was a face to face presentation to commissioners giving them direct access to the bidders and the opportunity to scrutinise and challenge them and derive additional assurance about capacity and capability. This, though, was the upper end of the spectrum and in some instances it appears from the outcome that assurances were given by bidders and accepted when the underlying evidence to support this assurance was missing. This points to a weakness in the level of challenge that was brought to bear.

24. A number of factors impacted on commissioners' ability to scrutinise bids effectively. The first was the timing of this exercise which coincided with massive changes in the commissioner map, with PCTs in the process of being first clustered, then abolished, and CCGs being established and put through the authorisation process. This meant that there were big changes in personnel in many places and some key people were leaving or had not yet taken up post. The level of expertise and experience was therefore not always as high as would otherwise be the case.

25. The other factor was that this was a complex, one off procurement requiring an understanding of call centres, but also of the interaction of this new system with the wider urgent care system locally. There were particular problems in understanding the extent to which the new system differed from the old NHS Direct and the impact this would have on average call handling times. The algorithms used in the NHS Pathways telephone triaging system took longer to go through and the Directory of Services that underpinned it had been more service options. The incorporation of GP out of hours calls brought in patients whose needs were in many cases greater than people who had accessed NHS

Direct and again this added to handling times. Those who had had experience of the new system through piloting were more aware of these issues but elsewhere there was not always an appreciation of the added demands this would place on the service.

26. The skill set that was needed to deliver this one off procurement was not something that it was reasonable to expect all CCGs to possess without help. Whilst the central NHS 111 team provided some support, two further approaches would have been helpful. Firstly, the learning that had been achieved in pilot sites by both commissioners and providers could and should have been shared more widely through a structured programme of mutual support. Secondly, a one off procurement support team could have provided additional support through this stage. The central support team was able to help in this but they were not resourced to provide the input in depth that 46 procurements as complex as this needed. Commissioners locally did not always appreciate the complexity of the procurement and had concerns about top down interference, but this could perhaps have been overcome by creating a shared resource, part owned by the centre but also part owned by local commissioners working together. It was not reasonable to expect each commissioning group to have the expertise to procure this new service without some shared and effective external expert advice.

Start up

27. Once contracts had been let there was a relatively short period before services were due to go live. The decision on whether to sign off sites as being ready to go live was taken by the boards of the relevant PCTs, advised by their CCG sub-committees. There normally followed a soft launch phase, where callers to existing numbers would be routed into NHS 111 so the service only had to cope with existing demand. This usually lasted for between 2 to 4 weeks at which stage the service would be advertised locally, with leaflet drops, radio adverts, and information in GP surgeries.

28. The NHS England central team carried out quality assurance prior to launch to test that the service was technically compliant with the service specification and capable of meeting quality standards. These tests included looking at capacity, though the team acknowledge that it was very hard to load test a service before it went live. Their assessment was fed into the PCTs but was not binding on them. There were instances where the central team concluded that the provider did not meet the service specification, because of concerns over capacity or clinical governance, but the PCTs decided to go ahead. In each case the PCT concluded that plans to decommission existing out of hours services were so far advanced that it was safer to proceed than to defer. These arguments were powerful because, whilst NHS Direct had been commissioned to provide a national contingency back up for slippage in cover for calls transferred from the old 0845 number no such contingency had been commissioned for GP out of hours. These services had always been commissioned locally and therefore the centre had not considered it should make contingency plans. Local commissioners felt they did not have

the finance to fund double running costs. So if the new service did not go ahead there would be no cover for GP out of hours.

29. Given that it was being locally commissioned and delivered it was right that the sign off of a service as ready to go live should be by the PCT. This called for a similarly rigorous approach to that needed for procurement. Again, approaches varied and the outturn proved that the level of challenge over staffing levels and other key determinants of delivery was sometimes insufficient. Again it appears that in places assurances were given and accepted without adequate probing of the underlying position. Some providers' forecasting of resources required to meet call volumes was significantly wrong. The main factor in this was not that call volumes were significantly different from forecast but that, as discussed above, average handling times were far higher than planned for by up to 200%. Others planned for staffing levels that were not achieved because of delays in recruiting and training. Responsibility for this rests primarily with the providers themselves. But, in view of the downward pressure on price at the contracting stage and that this was a new business model, a more challenging approach was needed by PCTs and the SHAs, and NHS England needed to check that the process was sufficiently robust.

Timetable

30. The timing of the launch could hardly have been more challenging. During the critical period leading up to the service going live not only were there the massive changes in organisational models at all levels of the NHS, from the Department of Health down to local commissioners, but the NHS and Department of Health were also handling the publication of the Francis Report on Mid Staffordshire hospital and the fall-out from this. These factors inevitably meant that the competing calls on senior managers' time limited that which they could devote to NHS 111. At another time it would almost certainly have commanded more of their attention and some of the problems could have been avoided.

31. Whilst the implementation date had been fixed before NHS England assumed responsibility for the programme, there may have been some room for manoeuvre. Ministers had signalled a willingness to be flexible in June 2012 when, in response to concerns expressed by the BMA among others, the Secretary of State announced that CCGs that required it could apply for an extension to the April 2013 deadline. Only eight CCGs applied, covering four NHS 111 sites, and each was accepted, though two of these sites subsequently withdrew their requests. There may have been a perception that because this initiative was high on the political agenda and featured in the coalition agreement the imperative to meet the pre-announced timetable was very strong and that arguments for delay had to be similarly convincing. This may have led to reluctance to seek a deferred launch. However, there is no evidence that issues of quality and robustness were systematically subordinated to an overriding pressure to complete on time. Rather the problems with provider capacity and capability were identified at so late

a stage that commissioners were by then committed to decommissioning the old out of hours service and had no contingency. They therefore felt it was safer to press ahead than to defer the launch. Had the problems been identified earlier it may have been possible to delay some at least of the launch dates.

32. The other problem with the timetable was that it was heavily end-loaded, with the majority of sites being launched in the eight weeks before the national start date of 21 March 2013. This meant that the ability of the national team to provide local support was very constrained.

33. There are two ways in which implementation could have been phased in to ease these pressures and de-risk the launch. First, the programme could have been rolled out across the country over a longer period which would have meant that the problems which emerged would have had a more limited impact and remedial action could have been taken before other sites went live. Second, the 0845 service could have been migrated to NHS 111 before the out of hours calls moved over. There would have been a cost associated with this due to double running but this would have meant the new call centres could have absorbed one new work stream before having to take on another, each of which represented big challenges.

34. In planning for future initiatives NHS England should pay particular attention to timetables and wherever possible look to build into them maximum levels of flexibility and de-risk implementation by phasing in new programmes.

Risk assessment and management

35. The introduction of NHS 111 was inherently high risk given the scale of activity and its potential impact on areas of the NHS already under considerable pressure, namely urgent care in all its aspects. The telephone call triaging system was for millions their point of entry to the NHS and the clinical risks of getting this wrong were therefore very significant. Forecasts of annual call volumes for the new system included 5.5 million that had formerly gone through NHS Direct, plus much more uncertain volumes from GPout of hours, with a range of 6-15 million calls, with a central estimate of 9 million. This volume, and in particular the uncertainty about out of hours numbers, meant that this was a very big programme with the potential for serious problems if things went wrong. Despite this, there are no indications that major alarm bells were ringing when NHS England took over the programme.

36. As part of its oversight of the implementation programme, the NHS 111 Programme Board maintained a risk register and that board reviewed it periodically. At the point when NHS England took over responsibility for the programme, the biggest risk was seen as lack of availability of local NHS resources during the NHS restructuring. The source of most of the eventual problems was registered as a risk, namely that “Unforeseen

operational problems may result in patient safety issues, in particular during the transition and bedding in period." While this was given a high impact rating (4 in a scale of 5) it had a low probability score (2 in a range of 5) and so a relatively low overall score and risk rating. This risk only moved up the scale as probability was seen to be higher and by February 2013 it was near the top of the programme board risk register.

37. The relatively late recognition of the scale of risk posed by provider failure may stem from the weaknesses in the challenge at the procurement stage discussed above. Yet this was new, untried territory for many providers and for the provider that won most contracts covering 34% of the country, NHS Direct, there were particular challenges. The introduction of NHS 111 was originally seen by NHS Direct as likely to lead to its demise and early planning had been around closing down the organisation. When it bid successfully for local contracts it went very rapidly from being an organisation that thought it had no future to one that had NHS 111 contracts for some 34% of the country, that needed to continue to run the old 0845 service until April 2013, and that also had a contract to keep 50% of the capacity of the old 0845 for a further three month as a national contingency for unplanned slippages in the NHS 111 service. This was a challenging agenda, especially as they also needed to deliver the new service at about a third of the cost of the old. The second biggest provider, Harmoni, that was involved in 12 successful bids, was new to the field. For all these reasons, the NHS 111 programme board's risk assessment systems should have escalated provider failure as a risk as soon as the outcome of the procurement was known.

38. It is also significant that concerns that things would go wrong were being expressed from early on in the programme from a number of quarters. A number of PCTs/CCGs registered worries and as a result of concerns raised by the BMA the Secretary of State announced in June 2012 that CCGs that required it could apply for an extension to the April 2013 deadline. There were, then, other signals that all may not have been well.

39. In view of the inherently high risk associated with introducing a programme of this scale and the concerns that were being expressed it is surprising that NHS 111 does not appear to have been extensively discussed above the level of its own programme board until the end of March 2013 when problems had already surfaced and the risks had materialised. There is no record of papers on the subject going to the NHS England Board. NHS 111 does not feature on the main risk register.

40. This raises questions about whether there was a proper understanding and assessment of the risks at board level. In particular, it raises issues about whether there were appropriate arrangements for the escalation of risks and concerns. It is very important that those most closely involved in a programme feel able to escalate significant risk areas. It has been suggested that some CCGs were preoccupied with getting authorisation and were therefore reluctant to press their concerns too far for fear of being seen as trouble makers The scale of the agenda facing all parts of the NHS and Department of Health, with major reorganisation and the handling of the Francis report

into Mid Staffordshire hospital also meant that there were unprecedentedly high demands on the attention of senior staff and competing concerns and risks. But assurance frameworks exist to support senior managers in risk management and these too failed to escalate this programme. NHS 111 warranted the attention of the main board and should certainly have featured on the main risk register.

41. NHS England needs to review its escalation procedures for risks associated with major initiatives.

Resources

42. NHS England inherited a small central team of around ten. It had three roles- first to design the service specification; second to co-ordinate and provide central support for the roll out; and finally to carry out quality assurance prior to launch. The team brought technical skills around telephony, IT, call centres, project management, and clinical governance. They were supported by working groups drawn from NHS staff which focussed on specific aspects of the programme. This was a relatively small resource for such a large programme but it was a deliberate decision to have a small team because most of the programme was intended to be delivered locally. The work they did was generally well received but it was necessarily limited both because of their size and because it was essentially technical in nature. The way the roll out was loaded so heavily to February and March 2013 put a heavy strain on the team's resources.

43. The other resources were drawn from largely from the teams in SHAs and PCTs/CCGs that were leading on NHS 111and from local clinicians. The NHS 111 programme board risk register had as one of the highest risks that "Lack of priority and resources during NHS transition and CCG authorisation may result in delays and/or lack of clinical engagement." There was some inevitable disruption in the hand over to NHS England. The programme team moved across but not the SRO. There were three different leads at NHS England board level between October 2012 and April 2013 because two National Directors left for the private sector. Resources at all levels and in all organisations at the time were stretched because of competing pressures of other projects and organisational change. This inevitably meant that it was difficult to maintain continuity of effective leadership. A bigger commitment of very senior management time and clinician time would undoubtedly have helped but these were the very people whose time was under most pressure because of other concurrent demands.

Accountability and governance

44. For NHS England there were two aspects to securing accountability for and governance of the programme. The first concerned what happened within NHS England itself and the "centrally specified" part of the programme. The second was about its oversight of

commissioners and “locally commissioned and delivered” component and this is dealt with in paragraphs 48 to 52 below. In both cases lines of accountability were complicated by the changes that were taking place as a result of restructuring and reform.

45. Until April 2013 the statutory position was that the accountability ran from PCTs who were responsible for the procurement and commissioning of the new service through SHAs to the Office of the NHS Chief Executive which was part of the Department of Health. But successor organisations were being formed and running in shadow form in the shape of CCGs and the local and central arms of the NHS Commissioning Board, which is now known as NHS England. In formal statutory terms, NHS England and CCGs had no responsibility for what happened before April 2013. In practice things were less clear cut because many of the key people had roles in both the old and new organisations and the process of handover had begun.

46. There was a relatively clear line from the central team up to board level at the centre and there is no suggestion that there was any lack of clarity in accountability and people were held to account for progress. As discussed in paragraph 35 to 41 there are issues in governance terms around risk escalation. This meant there was no substantive discussion of NHS 111 by the board of NHS England until the problems had occurred. The opportunity for challenge at board level about how things were being handled was therefore limited and by the time the board had engaged damage limitation was the top priority.

47. There is some scope for confusion in the split in responsibility for NHS 111 between the Chief Operating Officer who is responsible for operational issues and delivery and the National Director for Patients and Information who is responsible for developing policy in this area. This split makes sense because NHS 111 is part of wider plans for delivering an integrated customer service platform to provide improved access to NHS services, information and data for the public via the telephone, web and Apps. Whilst policy development needs to take account of this wider dimension this division in responsibilities needs to be kept under review.

National and local roles

48. The NHS 111 service is nationally specified and locally commissioned and delivered. This is a model that is consistent with how the NHS more generally is expected to operate and this programme was in many ways a test case for how these arrangements will work in the restructured NHS. The programme was, however, implemented just as new organisations were being set up both centrally and locally and as they were finding their feet in a changing NHS. It is not surprising that there was some uncertainty around roles and relationships.

49. The key issue was what, under this model, needed to be done centrally and what locally. Linked to this was the issue of how much support the centre should provide to commissioners and how much scrutiny commissioners should be subjected to. Every new initiative will be different and the balance between national and local roles will vary accordingly. But there are some lessons from the NHS 111 experience that have more general application.

50. In delivering a one off initiative of this complexity, local commissioners almost certainly needed both more help and more challenge. This is not about a heavy handed top down approach. The lead needed to be clearly with the commissioners. It is about securing the benefits of being part of a much larger organisation as well as responding to local factors. The 46 separate sites had more in common than they had differences. Making sure all the commissioners had the expert help they needed to challenge providers at both the procurement and go live stages was in the first instance the responsibility of the commissioners themselves. Some at least of that help and challenge could have come from mutual aid between commissioners and resources they jointly commissioned. But there was also a national dimension to this.

51. One of the main reasons for transferring responsibility for the NHS 111 programme from the Department of Health to NHS England in November 2012 was to ensure that PCTs/CCGs were held responsible for the delivery and running of the service to the required standards. The national role is described in the business case as including "Oversight of the performance and quality of the NHS 111 service to ensure a consistent level of service everywhere according to national standards." With new organisations at the centre and locally new relationships need to be forged and this oversight role needs to be developed in a way that secures as wide a level of support as possible. In the period when NHS 111 was being delivered this was only beginning to happen. As each found their feet in a changing NHS, it may be that commissioners were reluctant to seek help and NHS England reluctant to appear too ready to wade in with help and challenge. Better arrangements for supporting new initiatives that are centrally specified but locally commissioned will be needed in the future. Where the programme is as complex and difficult to deliver as this was the level of challenge needs to reflect this. NHS England needs to work with commissioners to develop mechanisms to achieve this.

52. One other point to emerge from this experience is the importance of engaging with and listening to front line staff and clinicians in particular. The pilots showed how important this was but also that it took time to get the level of engagement that was needed. The timetable elsewhere made this difficult. There were also people who were signalling that they had concerns about the programme and whose analysis turned out to be accurate. The problem at the time was to disaggregate these from the more generalised criticisms that were being levelled at the changes that were taking place in the NHS. It was not so much that these concerns were ignored, more that they were lost in the background noise. But going forward there is clearly a lesson about canvassing and listening to wider views.

Summary and lessons

53. This review has looked at what went wrong and why in the build up to and launch of the new NHS 111 service, with particular reference to the lessons for NHS England. Two contextual points need to be made in relation to the findings. First, the biggest problems related to the failure of some service providers to ensure that they had the capacity and capability to respond to call volumes. The providers themselves, rather than NHS England or local commissioners, were principally responsible for this failure. Second, most of the issues identified in this report were not formally the responsibility of the NHS Commissioning Board / NHS England, either because they happened before the transfer of responsibility on 1 November 2012 or because strictly speaking they were the responsibility of predecessor organisations and the accountability regime that underpinned them – namely the Office of the NHS Chief Executive, SHAs and PCTs. Nevertheless, NHS England existed in shadow form for most of the period and did take over responsibility for managing the central NHS 111 team. The lessons are in any case applicable to its handling of future major initiatives.

54. The main lessons are:

j) NHS England should have clear protocols for handling major new initiatives that are consistent with cross-government guidelines but also build on the lessons from NHS 111 (paragraphs 12-13).

k) Pilots provide valuable lessons and enough time needs to be built into programmes to benefit from them. They should be externally evaluated and that evaluation should prompt a formal stocktake and reappraisal of the implementation plan. There should be a structured programme to pass on the lessons from pilots (paragraphs 14-17).

l) Local commissioners will not necessarily have experience of complex major procurements of a specialist nature. NHS England needs to assure itself that effective external advice is available where needed to deliver one off procurements of this kind, and in particular to test quality and service delivery claims by bidders (paragraphs 18-26).

m) Services should only go live after they have been subject to robust checks about quality and capacity. Those checks need to be particularly rigorous where there has been significant downward pressure on costs (paragraphs 27-29).

n) In planning for future initiatives NHS England should pay particular attention to timetables and wherever possible look to build into them maximum levels of

flexibility and de-risk implementation by phasing in new programmes (paragraphs 30-34).

o) NHS England needs to review its escalation procedures for risks associated with major initiatives (paragraphs 35-41).

p) The success of major new initiatives depends heavily on significant investment of very senior management time and clinician time (paragraphs 42-43).

q) NHS England needs to work with commissioners to develop mechanisms to ensure the right levels of help and challenge are available to support new initiatives that are centrally specified but locally commissioned and delivered within the new organisational model for the NHS (paragraphs 44-51).

r) Engaging with and listening to front line staff and clinicians is a key component of successful delivery of major initiatives (paragraph 52).

Annex B

Review of lessons to be learned for NHS England from the introduction of the NHS 111 service

Terms of Reference

1. The review shall identify the lessons to be learned from the handling of the design, build and launch of the NHS 111 service, focusing from the point at which NHS England took on responsibility but taking into account the preceding context. The purpose is to ensure that NHS England can identify the reasons for the poor service and obtain recommendations for future programmes which will maximise the opportunities to deliver excellent service to the public and are value for money for taxpayers.

2. The review will comprise an immediate study of, in particular:

    a) the course of events that led to service weaknesses in order to identify what happened and why it happened from NHS England taking on responsibility up to the point of the service launch;

    b) the roles and responsibilities of different advisory and decision-making parties within the NHS and third parties in relation to these weaknesses; whether there was clarity of accountability, how well these parties performed their roles, and what can be learned from this about the appropriate structure for governance and assurance of major service launches; and

    c) the arrangements for ensuring appropriate review of the state of readiness for such a major service launch testing of the resilience and appropriate quality of assurance.

3. The review will be forward looking. It will not seek to apportion blame but instead to make recommendations on the basis of its findings to inform the development of comparable big projects in future.

4. The review will be led by an independent advisor, Peter Garland, reporting through Bill McCarthy (National Director: Policy) to the NHS England Audit Committee Chair.

5. The review should be completed as soon as possible through a process of document review and interview of relevant parties. Initial findings shall be made available to the NHS England Board by the end of May 2013.