

Developing the NHS Commissioning Board





Contents	2
<i>Foreword by Sir David Nicholson</i>	3
Our purpose	5
<i>Introduction</i>	5
<i>The new commissioning system</i>	5
<i>The role and purpose of the NHS Commissioning Board</i>	7
<i>Functions of the NHS Commissioning Board</i>	10
<i>Values and culture of the NHS Commissioning Board</i>	11
<i>Relationships</i>	12
Our processes	14
<i>Operating model</i>	14
Our people	18
<i>Structures</i>	18
<i>The leadership field</i>	25
<i>Staff and leadership processes</i>	26
<i>Timetable</i>	27
<i>Annex 1</i>	28

Gateway reference number: 16222



Foreword by Sir David Nicholson

The Government has set out a clear vision for a modernised NHS driven by a new commissioning system focused relentlessly on improving outcomes for patients. The cornerstone of the proposed system will be local clinical commissioning groups, which will put GPs – using their knowledge and understanding of patients’ needs – at the heart of the commissioning process.

Clinical commissioning groups will be supported across the country by clinical networks, bringing together experts on particular conditions and service areas, and by clinical senates, bringing together a range of clinical voices across particular parts of the country.

At national level, the new NHS Commissioning Board will ensure the new architecture is fit for purpose and provides clear national standards and accountability – it will put the ‘N’ in NHS. The Board will lead the delivery of improvements against the *NHS Outcomes Framework* and of more choice and control for patients.

The proposed system gives pride of place to clinical leaders, from top to bottom and across the country. And it has the needs and wishes of patients, underpinned by the NHS Constitution, at its heart.

I am publishing this document for patients, clinicians, staff and the public, to set out my initial thinking on how the new commissioning system could work and the Board’s role within that system. I have concentrated on the culture, style and leadership of the Board as well as on the processes it needs to make sure it achieves maximum health benefit for the nation from around £80bn of resources invested.

All of the proposals remain subject to the passage of the *Health and Social Care Bill*. However, I want to give a sense of direction to stakeholders, partners, pathfinders and staff who may potentially work for the Board so I can continue, through co-production, to challenge and test the design principles which underpin the Board’s operations. Doing this well now will provide a good basis for the members of the Board, once appointed, to develop the organisation.

Many features of the proposed commissioning system are new, but there is also important continuity with the current system. The vision for improving outcomes builds on the successful improvements the NHS has made in areas such as reducing waiting times, tackling infections and reducing mortality. And it also builds on the vision for systematically improving the quality of care set out in *High Quality Care for All*.

In building the new system, I also want to create continuity wherever possible for the many talented and dedicated staff in the current system. That is why the initial sub-national structure of the Board will reflect the arrangements we have made for PCT and SHA clusters. Blending the best of our current managerial talent with a new cadre of clinical leaders will give us the best chance of success.

And the way in which we put the new system in place will be consistent with the approach we have taken in the past. So the ideas in this document have been co-produced with a range of stakeholders and we will continue to work closely with people from all parts of the system as we develop the proposals forward.



We will always seek to ensure things are done at the right level of the new system, consistent with the principle of subsidiarity. So clinical commissioning groups will be the engine of the new system and things will only be done at a different level of the system where there is evidence – for example with specialist commissioning – that this produces better results. The role of the centre will be to support and hold local groups to account, not to domineer or micro-manage.

The new system also clearly demonstrates the principle of clinical ownership and leadership. From clinical commissioning groups at the most local level, right up to the organisation of the Board nationally around the five domains of the *NHS Outcomes Framework*, clinical leadership is written into the DNA of the new system.

And it is more important than ever that we ensure proper alignment, both between the different parts of the commissioning system, and between commissioners, regulators and professional and patient groups. That is why this document focuses on the relationships between the Board and its partners, and it is why we are seeking to align the organisation of the Board at sub-national level with the regulatory and public health systems.

Building this new system over the next two years whilst delivering for our patients, increasing productivity and improving the quality of care, is a major challenge. But I firmly believe that the end we are trying to achieve – a stronger, more innovative and more coherent commissioning system – will be critical to sustaining the NHS in the years to come.

Sir David Nicholson

Chief Executive designate
NHS Commissioning Board



1. Our purpose

(A) Introduction

This document sets out initial proposals from the NHS Commissioning Board development team about how the Board will operate and how it will be organised. It sets out:

- The role envisaged for the Board as part of a modernised commissioning system, the Board's main levers and statutory powers, the culture and values we want the Board to embody, and the Board's key relationships;
- The Board's core operating process and some of the important characteristics of how the Board will work; and
- Initial proposals for how the Board could be structured and organised in order to fulfil its role effectively.

We will shortly publish a *People Transition Policy* which sets out the rules and processes for staff to come and work for the Board.

(B) The new commissioning system

The rationale for modernising the NHS commissioning system is clear. To preserve the essential character of the NHS we have to change how the service is organised. The NHS will need change to satisfy the increasing healthcare needs and expectations of our people. We also need change to ensure that the NHS remains sustainable in tighter financial circumstances, as it continues to strive to be the best health service in the world.

Clinical commissioning groups

To deliver change on the scale required, the Government proposes to shift decision making as close as possible to individual patients by devolving power and responsibility for commissioning services to clinical commissioning groups. This change is intended to build on the pivotal and trusted role that GPs and other front line professionals already play. It will bring responsibility for management of care together with responsibility for the management of resources.

Effective commissioning will require the full range of clinical and professional input alongside that of local people. All clinicians, whether doctors, nurses, allied health professionals, pharmacists or others, will have a vital role in developing services and improving the health outcomes of local populations. Social care professionals will also play a key part.

The NHS Commissioning Board

It is not possible to devolve all commissioning to clinical commissioning groups. For example, it would be inappropriate to give them authority to commission their own member practices to provide primary care services. And it would be unrealistic to expect the clinical commissioning groups to take responsibility for services that can only be provided efficiently and effectively at national or regional level. So the Government proposes establishing an NHS Commissioning Board whose role will include supporting, developing and holding to account an effective and comprehensive system of clinical commissioning groups.



So the NHS Commissioning Board will be part of a comprehensive commissioning system for healthcare services. Clinical commissioning groups will form the key part of the new structure and they will be responsible for commissioning the majority of healthcare services. The Board will have a dual role in that it will both deliver its own commissioning functions and ensure that the whole of the architecture is cohesive, coordinated and efficient. Alongside the clinical commissioning groups and the Board, there will be commissioning support infrastructure, which will be able to provide many of the support functions that underpin the commissioning undertaken by commissioning groups and the Board.

How the Board will work with local groups

The relationship between the Board and clinical commissioning groups will be critical to the success of the new system. Clinical commissioning groups and the Board will have to work together closely at local level and commissioning groups will have a clear collective voice at national level. The relationship between the Board and commissioning groups needs to be mutually supportive, characterised by a mature and respectful approach. The Board will support clinical commissioning groups and hold them to account whilst ensuring they have the freedom to deliver improvements in outcomes for their local populations in a clinically led and bottom up way. We anticipate that they will need a wide range of development and support to develop skills and capacity across the breadth of their responsibilities, particularly during the early stages of development. The Board will work closely with clinical commissioning groups to help identify and meet these development needs.

In order to create this comprehensive support for clinical commissioning groups the Board would develop:

- A framework that provides clarity about the outcomes for which clinical commissioning groups are accountable and the resources available to them;
- A range of tools to support effective commissioning, but which clinical commissioning groups can adapt to reflect local needs – including commissioning guidance, model pathways, and standard contracts – supported by the best available evidence on how to secure improvements in quality, productivity and health outcomes;
- A continuing programme to help clinical commissioning groups understand their strengths and be aware of areas that need improvement, along with the appropriate development opportunities to address their needs;
- A robust system of authorisation to ensure that clinical commissioning groups take on commissioning and budgetary responsibilities at the right pace, together with ongoing assurance based on the outcomes that they are achieving for patients; and
- A transparent and rules-based approach that enables the Board to intervene to support clinical commissioning groups that are in difficulty, whilst promoting autonomy and allowing successful commissioners freedom to innovate.

We would do this through continued co-production with stakeholders such as pathfinders and primary care organisations.



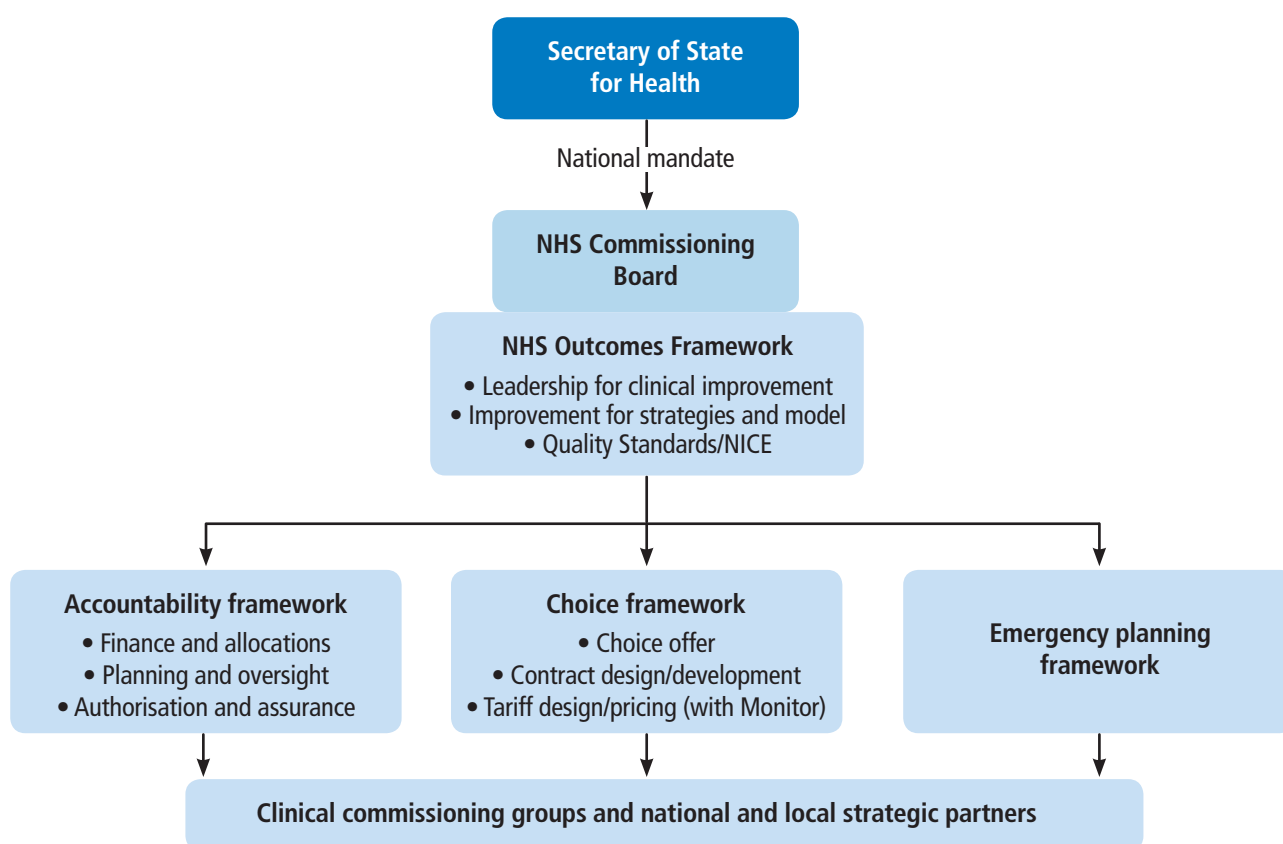
Clinical networks and senates

In addition, the NHS Commissioning Board will host clinical networks, which will advise on distinct areas of care, such as cancer or maternity services. The Board will also host new clinical senates which will provide multi-disciplinary input to strategic clinical decision making to support commissioners, and embed clinical expertise at the heart of the Board. The purpose of these groups is to ensure that clinical commissioning groups and the Board itself have access to a broad range of expert clinical input to support and inform their commissioning decisions. The relationship between the Board and clinical networks and senates is likely to change as the new commissioning system matures.

(C) The role and purpose of the NHS Commissioning Board

The Board's overarching role is to ensure that the NHS delivers better outcomes for patients within its available resources. The Board can fulfil this role through its leadership on delivering the *NHS Outcomes Framework*, supported by its accountability framework for clinical commissioning groups, its framework for choice and competition, and its framework for emergency planning and resilience. These core tools are shown in Figure 1.

Figure 1: Key frameworks to deliver the work of the NHS Commissioning Board





Leadership for the NHS Outcomes Framework

The Board will play a vital role in providing national leadership for improving outcomes and driving up the quality of care. At its simplest, the purpose of the Board will be to work with clinical commissioning groups and the wider system to use the commissioning budget of around £80bn a year to secure the best possible health outcomes for patients and communities. A definition of the outcomes that the NHS is striving to achieve was set out in the 2011/12 *NHS Outcomes Framework*, which covers five improvement domains:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover following episodes of ill health or after injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

A table showing how these five domains accommodate 51 indicators of NHS improvement is given in Annex 1.

“The purpose of the Board will be to use the £80bn commissioning budget to secure the best possible outcomes for patients.”

In each domain, major challenges confront the NHS, in common with healthcare systems across the developed world. They centre on the need to work within available resources to improve quality and productivity in tandem. This can be done by:

- Supporting local clinical improvement;
- Transforming the management of long-term conditions;
- Providing more services outside hospital settings; and
- Providing a more integrated system of urgent and emergency care to reduce the rate of growth in hospital admissions.

The Board will work with clinical commissioning groups and its other partners to provide national leadership for addressing these challenges and to improve healthcare outcomes and reduce health inequalities. The Board and clinical commissioning groups will also contribute to improving public health outcomes as set out in the *Public Health Outcomes Framework*.



Leadership for national consistency and accountability

As a single national organisation, the Board should be responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality across the country, for maintaining the 'N' in NHS. The NHS Future Forum and the Government's response were explicit about the duty of the NHS Commissioning Board to actively promote the NHS Constitution. It would do this by championing the values and principles in the NHS Constitution, ensuring commissioners across the NHS help implement agreed national standards, including NICE Quality Standards, and addressing inequalities in access to healthcare provision.

The Board can promote national consistency in the way that it conducts its direct activities and through its relationship with clinical commissioning groups. The way that clinical commissioning groups are supported, developed and held to account can be used to ensure that national standards are achieved and national accountabilities are discharged.

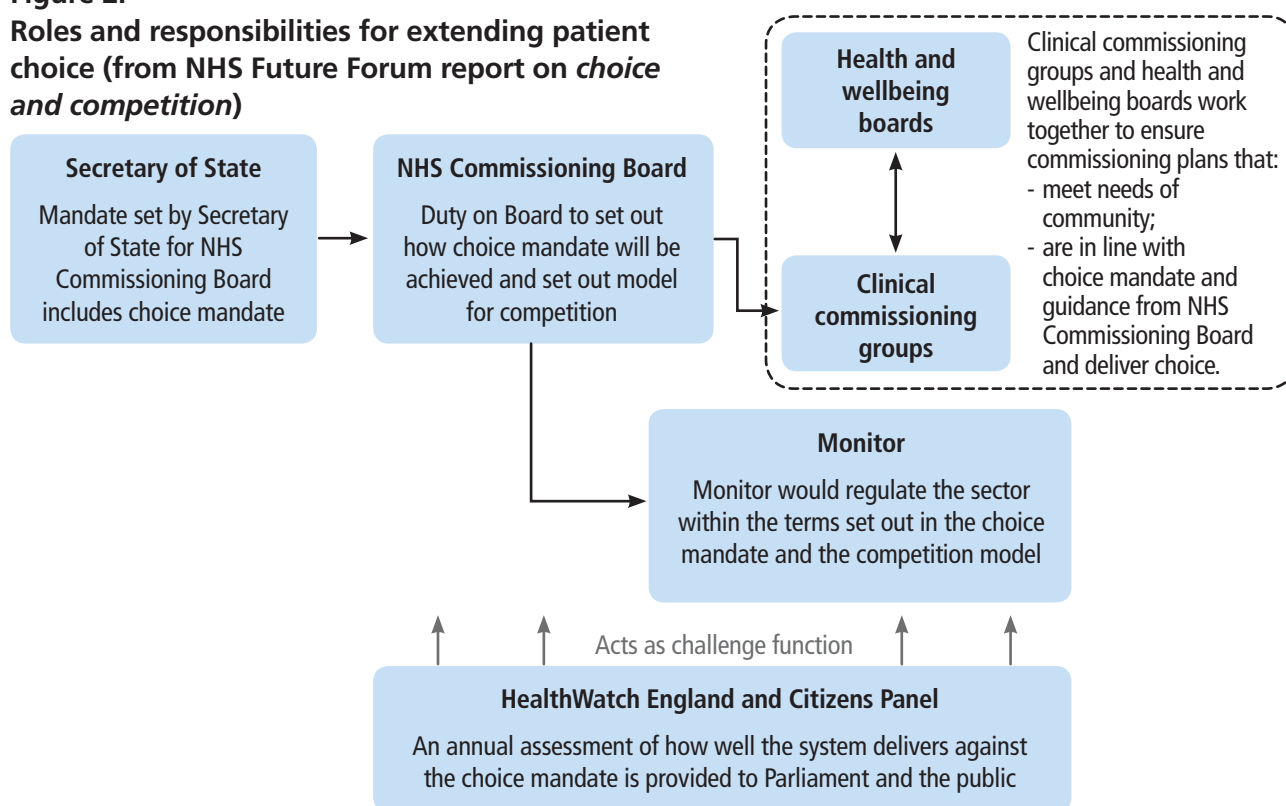
“...consistency in ensuring high standards of quality across the country, for maintaining the 'N' in NHS.”

Leadership for a patient-centred system

The Board should also act as a champion for patients and their interests. To do this, the Board will need to engage consistently with patients and have access to high quality insight into what patients, carers and the public want and expect from NHS services. The Board will also oversee the extension of patient choice and the expansion of information available to patients. The Board will promote innovative ways of demonstrating how care can be made more integrated for patients and will lead the way in engaging patients and the public in decisions about self care. It will promote the use of technology to create more accessible and personalised services with fewer bureaucratic processes and to improve the relationship between patients and the service. The Board's important leadership role in extending choice was set out in the NHS Future Forum report on *Choice and Competition* and is illustrated in the diagram below:



Figure 2:
Roles and responsibilities for extending patient choice (from NHS Future Forum report on *choice and competition*)



(D) Functions of the NHS Commissioning Board

To fulfil its purpose, the Board will have a wide range of powers and functions, many of which are set out in the current proposed legislation. The most important of these functions are:

- To agree and deliver **improved outcomes** and account to Ministers and Parliament for progress. There will be a clear mandate, setting out expectations for the Board and the broader commissioning system;
- To oversee the **commissioning budget**, ensuring financial control and value for money;
- To develop and oversee a comprehensive system of **clinical commissioning groups** with responsibility for commissioning the majority of healthcare services;
- To **commission directly** around £20bn of services including specialised services and primary care services (including holding around 35,000 contracts for primary care services);
- To support **quality improvement** by promoting consistent national Quality Standards, a culture which promotes research and innovation and providing world class support for clinically led service improvement and leadership;
- To promote innovative ways of demonstrating how care can be made more **integrated for patients**;
- To promote **equality and diversity** and the **reduction of inequalities** in all its activities;
- To develop **commissioning guidance**, standard contracts, pricing mechanisms and information standards;



- To engage with the public, patients and carers, **champion patient interests** and ensure patients have access to a wider range of information about services;
- To develop a framework to make **choice a reality for patients**, setting out guidance in consultation with Monitor about how choice and competition should be applied to particular services;
- To oversee planning for **emergency resilience** and lead the NHS operational response to significant emergencies; and
- With its partners, develop a medium term **strategy** for the NHS, which alongside the local priorities developed through health and wellbeing boards, helps form the basis for local commissioning plans.

This is not a comprehensive list of the Board's functions, but rather aims to set out the most important levers, which the Board will use in order to fulfil its purpose.

(E) Values and culture of the NHS Commissioning Board

From its inception, the Board should develop a clear set of values and a distinct culture. Fostering the right culture and behaviours will take time and will require the involvement of the Board's leaders, staff and others. But even at the outset, there are particular features that should characterise the Board's culture. These include:

- A clear **sense of purpose** focused on improving quality and outcomes;
- A commitment to putting **patients, clinicians and carers** at the heart of decision-making;
- An **energised and proactive** organisation, offering leadership and direction;
- A **focused and professional** organisation, easy to do business with;
- An **objective** culture, using evidence to inform the full range of its activities;
- A **flexible** organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local;
- An organisation committed to **working in partnership** to achieve its goals, in particular by developing an effective and mutually supportive relationship with clinical commissioning groups;
- An **open and transparent** approach, sharing information freely wherever appropriate; and
- An organisation with clear **accountability arrangements** and a grip on those things for which it will be held to account.



(F) Relationships

Alongside its key relationship with clinical commissioning groups, the Board will need to work with a range of other organisations at national and local level to achieve its goals. These organisations fall into two broad categories: those to which the Board will be accountable, and those with which the Board will work in partnership.

Once fully established, the Board will be accountable to the Department of Health and its Ministers for delivering the agreed mandate, which will focus mainly on improving healthcare outcomes through modernisation within the Board's cash limit. The mandate may also specify the Board's agreed role in delivering preventative and public health services and its role in commissioning services on behalf of Public Health England.

The Board will also be accountable to the Department of Health, and through the Department to the Treasury, for living within its annual commissioning budget and achieving good value for money. The Board will have to work closely with the Department to ensure the effective running of the overall health and care system. As an independent arm's length body, the Board will also be accountable directly to Parliament for its activities. Finally, the Board will answer to patients and the public for progress through its annual report and through more general communication and engagement.

The Board must also work in partnership with a large number of other organisations. Its most important partnerships will be with:

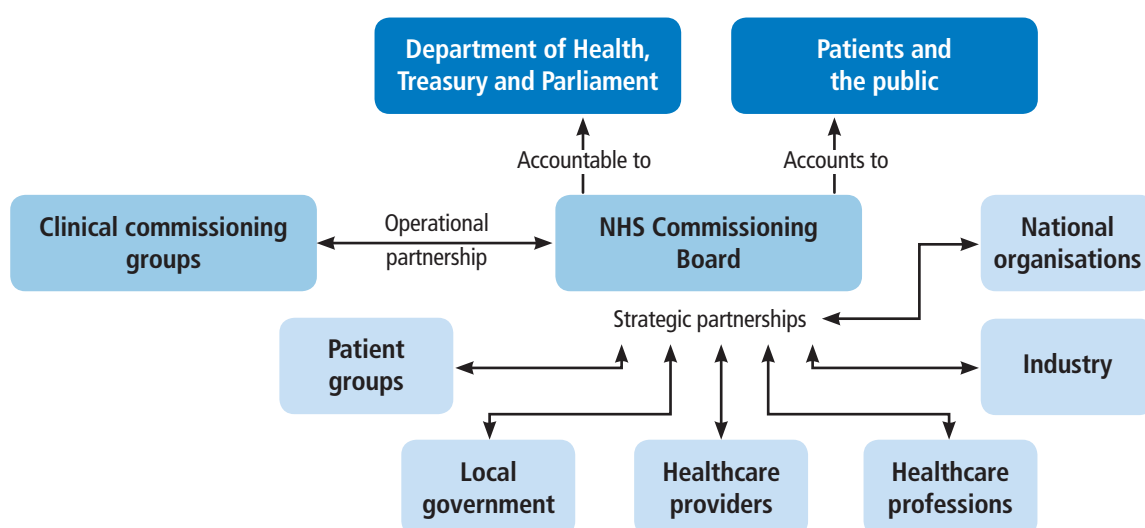
- **Patient groups**, including Healthwatch England and other key representative groups, which will also have a strong voice at national level. A close relationship between the Board and patient groups is critical to ensure the Board is equipped to champion patient interests and for the Board itself to be a patient-centred organisation;
- **The healthcare professions**, whose expertise and input will need to be built into the workings of the Board. The views of nurses and doctors from primary and secondary care, and of allied health professionals, healthcare scientists, dentists, pharmacists and optical specialists should all be represented;
- **Healthcare providers**, including those from primary, secondary and social care at local level, from specialist providers at regional and national level, and from the public, private and voluntary sectors. Alongside its commissioning relationship with providers, it will be important for the Board to develop an effective strategic partnership with this group, in particular because of the importance of commissioners and providers working together to develop integrated pathways of care;
- **Local government**, which will need to work closely with the Board to ensure there is strategic coherence and alignment in how the Board seeks to deliver its priorities in partnership with the wider public sector and at national and local level. With the increased strategic role for local government through new health and wellbeing boards, the new arrangements for Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies, and the need for joint working on emergency resilience and promoting joint commissioning – this is a critical area for partnership;



- **Industry**, including pharmaceutical and medical technology suppliers. The Board should develop a relationship with suppliers which supports its strategic approach to innovation and development; and
- **Other national organisations**, (which will be accountable directly to the Department of Health and Ministers) including Monitor, the Care Quality Commission, the NHS Trust Development Authority, Public Health England, Health Education England, the Health Research Authority, the National Institute for Health and Clinical Excellence (NICE) and the NHS and Social Care Information Centre. Alignment between the different national organisations will be more important than ever in the new system and in developing the Board we will build on the important and successful work of the National Quality Board in developing our plans in this area.

As part of the process of establishing and developing the Board we will work with each of the broad groupings of organisations listed above to establish the best way for their relationship with the Board to work. The diagram below shows the Board in the context of these key relationships:

Figure 3: The Board and its key relationships





2. Our processes

(G) Operating model

This section presents initial thinking on how the Board would operate, its most important processes, and how it would be structured and organised. Although its purpose is simple, the functions and responsibilities of the Board are wide-ranging and complex, and the Board will work over a broad and varied geographical area. As a single, national organisation operating at scale and in a complex environment, the Board will need strong and consistent processes to achieve its goals. These processes fall into three main categories:

- Core processes, which are absolutely essential for upholding the Board's key values and embedding them throughout all aspects of the organisation;
- Business processes to ensure effective and efficient delivery of the organisation's goals; and
- Processes of oversight and commissioning support to ensure that commissioning activity at national and local level is the best it can possibly be.

The key processes in each of the three areas are set out below:

Core processes to uphold the key values

- Quality as the organising principle
- Patient and public engagement
- Clinical leadership and focus
- Promoting equality and diversity
- Reducing inequalities
- Partnership working

Business processes

- Information management
- Change management
- HR systems
- Finance
- Communications

Oversight and support processes

- Commissioning outcomes framework
- Allocations framework
- Commissioning guidance
- Authorisation process
- Assurance process
- Commissioning support

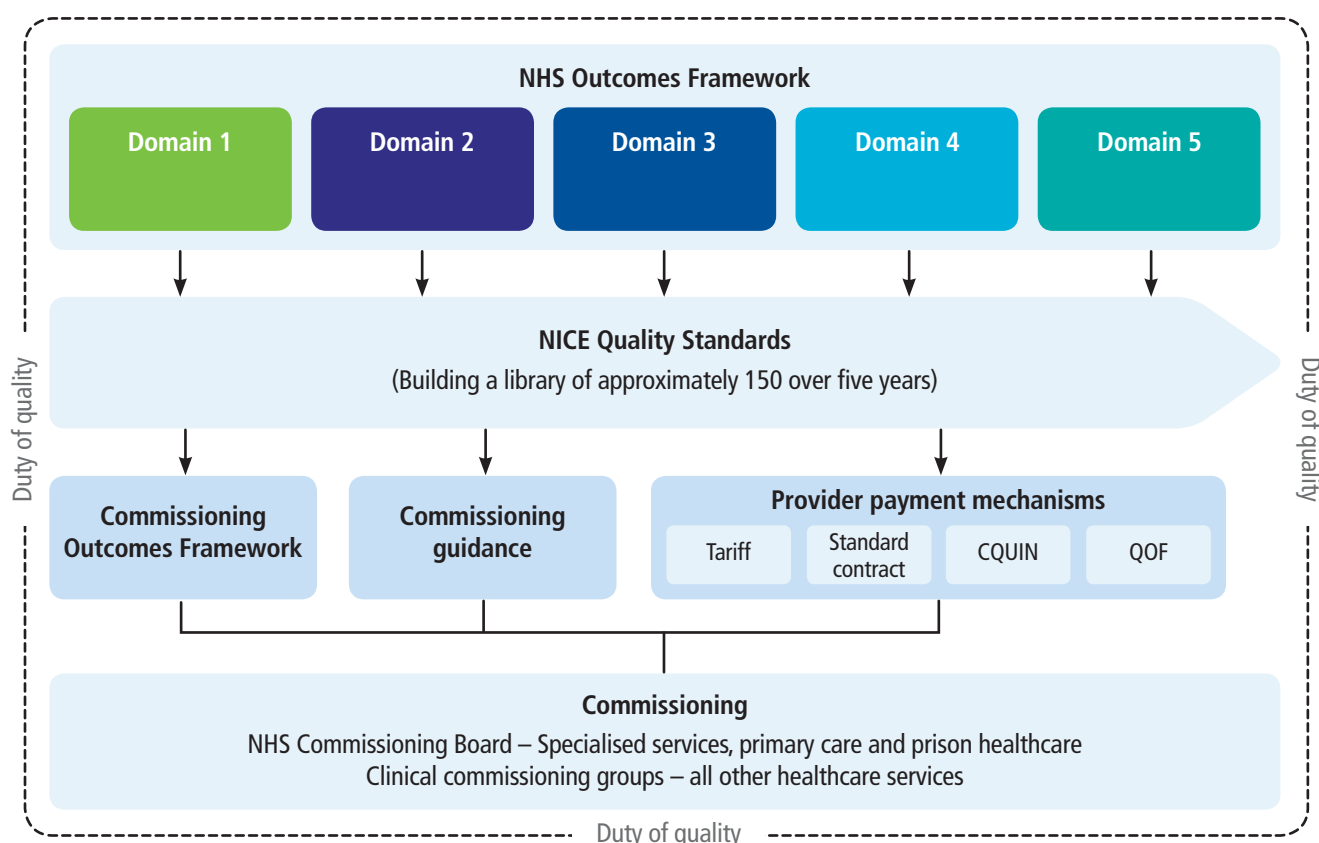


Several of these processes distinguish the new commissioning architecture from the current system. We will publish more detail in due course, but initial thinking on some of these distinctive processes is set out below:

1. Quality

The Board will have a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of health services. In particular it must aim to secure continuous improvement in outcomes, as defined by the *NHS Outcomes Framework*. The Board will therefore prioritise the pursuit of quality, helping to ensure consistent national standards across the NHS. In doing this, the Board will use Quality Standards developed by NICE to drive its commissioning processes. The standards will provide evidence-based summaries of what high quality care looks like for particular service areas. NICE Quality Standards – and accredited evidence produced by other groups such as the Royal Colleges – will underpin the *Commissioning Outcomes Framework*, through which clinical commissioning groups will be held to account. Commissioning guidance will be provided to clinical commissioning groups and the Board's own direct commissioning functions to support the achievement of the required Quality Standards. Incentives will be provided through the standard contracts developed by the Board and the approach it takes to developing new payment mechanisms. Through these mechanisms, Quality Standards will be the backbone of the commissioning system, supporting consistent improvement in all parts of the country. This is illustrated, in the diagram below:

Figure 4: The quality improvement system





2. Engagement

The Board will have a statutory duty to involve the public and will engage with patients, carers and the public to ensure it focuses first and foremost on what matters to patients. It will bring the patients' voice directly into its work from an early stage. This approach would be reflected in the Board's leadership, governance, operating model and culture.

3. Change

At present, there are a wide variety of approaches and techniques for achieving change in use across the NHS. Our ambition is to employ a single, evidence-based model for driving transformation and change. The Board would use this model in its own commissioning activities and would aim to make available world-class change and leadership development support to the commissioning system. The Board would act as a leader for change across the whole NHS by establishing integrated networks spanning commissioning and provision, across primary and secondary care.

“The role of the Board is to help clinical
commissioning groups to achieve their maximum
potential...”

4. Information

The Board will use information systems to track progress. Information should be real-time wherever possible and focus on key indicators for commissioners such as activity, referral rates, patient experience, finance and, where possible, outcomes. We also envisage a common set of information being used by the Board and clinical commissioning groups to improve efficiency across the commissioning system. Significant improvements in data quality will be needed to meet this aspiration.

5. Authorisation of clinical commissioning groups

The Board would be responsible for overseeing the establishment of a comprehensive system of clinical commissioning groups by April 2013. As indicated in the Government's response to the NHS Future Forum, the Board will also have a key role in authorising how quickly clinical commissioning groups take on budgetary responsibility for services and in identifying services that the NHS Commissioning Board may initially have to commission on behalf of a commissioning group. This will require a robust assessment of how far commissioning groups have the capability and capacity to carry out their functions effectively. We do not see authorisation as a one-off assessment, but rather as part of a broader developmental relationship between clinical commissioning groups and the Board. The role of the Board is to help clinical commissioning groups to achieve their maximum potential, to support and prepare them for authorisation, and to continue to provide development support after authorisation is successfully achieved. As part of this work, the Board would also ensure that clinical commissioning groups have secured appropriate commissioning support arrangements, and established robust arrangements for collaborative commissioning for example with other commissioning groups or local government. Where it is needed, intervention to support



clinical commissioning groups in difficulty should be proportionate and risk-based. More detail on our plans for authorisation and commissioning support will be published later.

“We do not see authorisation as a one-off assessment, but rather as part of a broader developmental relationship...”

6. Measuring and rewarding quality

The Board will develop a *Commissioning Outcomes Framework* to provide transparency and accountability about the quality of services that clinical commissioning groups commission for their patients and progress in reducing inequalities. The Board will be able to provide financial rewards for clinical commissioning groups that achieve high standards of quality and outcomes within the resources available to them. The Board will need to develop the *Commissioning Outcomes Framework* and arrangements for quality rewards in partnership with clinical commissioning groups and in a way that ensures a relentless focus on improving quality and outcomes. The focus must be on being clear about the outcomes that need to be achieved, allowing clinical commissioning groups the freedom to identify how best to achieve these outcomes, and ensuring that success is rewarded.

In describing these processes, the aim of this document is to illustrate how we envisage the Board operating and how that would look and feel different from the current system. More generally, the Board's approach would be characterised by its developmental relationship with clinical commissioning groups, the promotion of a single, evidence-based model of change, and its positioning of quality at the heart of the commissioning system.

“Quality Standards will be the backbone of the commissioning system, supporting consistent improvement across the country.”



3. Our people

(H) Structures

This section looks at how we envisage the Board will be organised at national level, the key leadership roles including the role of professional leadership, and how the Board's more localised functions could be carried out.

1. Statutory roles

Subject to the passage of the Bill, the Board will be required to have a Chair and at least five non-executive members. Their key purpose will be to ensure effective governance, consistent with Nolan Principles, to hold the Board's executives to account, and to contribute to the success of the Board's key external relationships. A robust and effective non-executive team will be critical to the success of the Board and the Chair will play an important leadership role, ensuring the Board focuses on its core purpose.

The Board's Chief Executive will provide overall strategic leadership for the Board and for the wider commissioning system. Once the Board is fully established, the Chief Executive will be the formal Accounting Officer for the overall commissioning budget, the funding allocated to both the Board and clinical commissioning groups, totalling around £80bn. As Accounting Officer, the Chief Executive will account formally to Parliament and to the Department of Health for the appropriate and effective use of the commissioning budget and for improving health outcomes and other changes in line with the agreed mandate between the Department and the Board.

The Chief Executive will be one of a number of executive members. The number of executive members must be less than the number of non-executive members, and the final decision on the numbers and the nature of their roles must be agreed with the Chair and non-executive members. But it is envisaged that the other executive members will be: the nursing director; medical director; director of finance, performance and operations; and director of commissioning development. In addition, other national director level posts are likely to be: patient engagement, insight and informatics; improvement and transformation; policy, corporate development and partnership; and chief of staff. More detail on these proposed roles is set out below.

As shown, the NHS Commissioning Board will have executive and non executive members who operate as a board of directors, and who are likely to be referred to collectively as the board of the organisation. This is potentially confusing, and it may therefore be more appropriate for the NHS Commissioning Board to be referred to by another name in practice, so that confusion between the organisation and its board of members does not arise. It is common practice for organisations to adopt a different name for operational purposes from that set out in legislation and this is something to be considered. In its response to the NHS Future Forum, the Government has indicated that clinical commissioning groups will have individual names that include the term NHS and a geographical description. An alternative operating name for the NHS Commissioning Board, based on this rationale, could be NHS England.



2. Staff numbers

Although the organisation is in the early stages of its development, some initial broad assumptions have been made about the total number of staff and the functions to which they might be deployed. These remain high-level estimates and will be developed further by the Board's leadership. However, it is useful to set some numbers out to give a sense of scale for the description of the structures that follows.

There have been around 8000 staff performing functions which will be the responsibility of the Board and this is likely to reduce to around 3500. Of these approximately two thirds will be deployed locally within the "field force" managing relationships with clinical commissioning groups and performing direct commissioning and other associated functions.

3. Professional advice and leadership

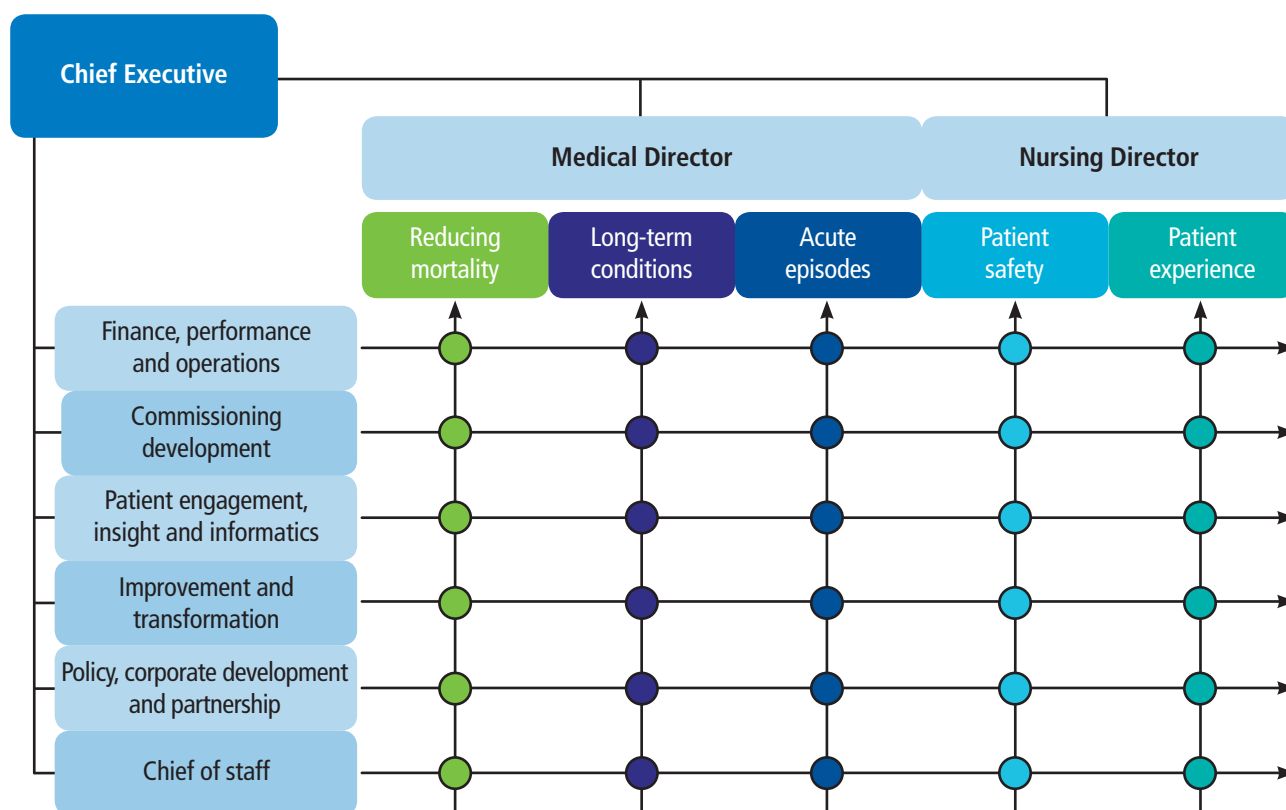
Our ambition is for the overall structure of the Board to clearly reflect its priorities. The Board should therefore be organised to ensure that each member of staff is working to improve health outcomes as well as taking on a particular functional responsibility, such as finance or patient engagement. The Board will need a relatively complex structure to achieve this result at national and local level and the thinking is that it will be designed to achieve our goals across three key dimensions:

- The Board would be organised nationally around the five **outcome domains** of the *NHS Outcomes Framework*. This reflects the importance of professional and clinical leadership to the Board's success. There would be national professional leads for each of the five outcome areas, reporting to a Medical Director and Nursing Director at national level.
- To support work on improving outcomes, the Board would have a number of **supporting functions** organised under directors at national level. The role of these functions would be to support the achievement of better outcomes.
- Because of the breadth of its responsibilities, the Board would need functions organised across **geographical areas** below national level. In fact, the majority of the Board's staff would operate below national level and the organisation of these sub-national teams is the third dimension of the Board's structure.

The proposed national structure of the Board, reflecting the role of the outcomes domains and the supporting functions, is represented graphically in the matrix below:



Figure 5: Proposed discharge of the functions of the Board at national level



As the diagram suggests, the professional leads for improving outcomes on mortality, long-term conditions and acute episodes would report to the Medical Director. The leads for improving patient safety and patient experience would report to the Nursing Director. The core role of the professional leads would be to harness the different functions and tools available to the Board (including commissioning, finance, patient and public engagement, transformation and other functions shown on the left side of the diagram) to drive improvements in outcomes.

The circles on the diagram represent teams of staff who would work together to achieve improvements in outcomes. Each team would come under the control of a particular professional lead (shown on the grid as a vertical line of authority). But each team would also report to the national director who is responsible for the delivery of its particular supporting function, such as commissioning or finance (shown on the grid as a horizontal line of authority). A more detailed description of the supporting functions is given in section 4, below.

In addition, we envisage that each of the professional leads would have a small clinical advisory team to support their work.

Through this proposed way of working, the ambition is to put healthcare outcomes and professional and clinical leadership at the heart of the Board's business. It is a new way of working which would require a flexible and integrated approach, as well as strong and effective communication between different areas of the Board.

The Board's broader professional and clinical leadership capacity should extend beyond these arrangements for the five outcomes domains. So in addition to this, the Board would include:



“...our ambition is to put healthcare outcomes and professional and clinical leadership at the heart of the Board’s business.”

- Clear arrangements for key service areas, which would gain particular benefit from dedicated professional and clinical leadership. These might include children’s services, mental health, older people’s services, dementia, learning disabilities, maternity and primary care.
- Dedicated professional advice and leadership for more specific outcome areas within the five domains, for example cancer, diabetes or infection control. The specific areas and the appropriate level of support would depend on the specific outcome improvements required to deliver the mandate.
- Healthcare professionals working together in clinical senates to give expert advice about how to best make patient care operate effectively in each area of the country. Clinical senates would provide advice and support on a range of issues, providing a more robust and reliable system for ensuring that commissioners are able to fulfil these statutory responsibilities in ways that draw on and take account of the very best clinical leadership, advice and support. They would work with the Board in their support of clinical commissioning groups, advising on whether commissioning plans are clinically robust and on the clinical implications of major service changes.
- The creation of a broader advisory system for the Board at national level, include medical Royal Colleges, specialist societies and other colleges taking in the views of all of the healthcare professions, including nursing, medicine, allied health professionals, healthcare scientists, dentistry, pharmacy and optical services, which would ensure that a broad range of stakeholders are able to influence and be involved in improving quality.
- Arrangements for the Board to act as a repository of professional and clinical advice for other organisations in the system, potentially including the Department of Health, Monitor and Health Education England. The level and nature of this support will be discussed with these organisations as plans for the Board are developed.
- Opportunity for the Board’s clinical and professional leaders to work with a wide range of local clinical networks. The networks would act as a transmission belt, conveying the Board’s mission to improve quality and outcomes to local professionals (both commissioners and providers).
- The definition and format of local and wider networks will be reviewed to consider how they will fulfil their functions. This would include networks for clinical conditions or client groups, for example cancer, stroke, trauma, children or mental health but also professional networks such as healthcare scientists or pharmacists.
- The combination of clinical networks and senates would ensure that the Board, as well as all other levels of the commissioning system, would have access to expertise on specific conditions and pathways, together with high quality advice and support on the overall local health and care landscape. This would ensure that clinical leadership from all of the healthcare professions is embedded within the Board’s ways of working.



We also want to ensure that the public, patients and carers influence the Board's work at every stage of developing policy, strategy and operations. To this end we would expect:

- To establish a culture and leadership approach which puts engagement and involvement at its heart;
- That the model of engagement adopted by the Board sets the tone for the commissioning system;
- That all staff employed by the Board have core skills in engagement and involvement; and
- That our decisions show that the Board knows and understands patient insight and intelligence.

4. Supporting functions

The Board will need to perform a very significant and varied set of tasks to support improvements in outcomes. The current proposal is that tasks should be organised at national level within six broad functional portfolios, each organised under a director reporting to the Board's Chief Executive. The six areas are shown in the diagram and they would comprise:

- **Finance, performance and operations.** This portfolio would include financial strategy and financial performance for the Board and clinical commissioning groups, across the £80bn commissioning budget. It would also cover broader operation and performance monitoring of clinical commissioning groups and of the Board in its role as a direct commissioner of services. It would include oversight of the Board's sub-national commissioning sectors and the wider "field force" which is described below. Other responsibilities would include authorisation of clinical commissioning groups, intervention in the event that clinical commissioning groups experience difficulties, emergency resilience and tariff development.
- **Commissioning development.** The core function of this portfolio would be to support the development of clinical commissioning groups through authorisation and beyond. The portfolio would contain responsibility for commissioning support and for delivery of capacity and capability across the commissioning system. The responsibility for the overall commissioning architecture would include the design of national primary care contracts. The portfolio would also cover the development of commissioning tools and commissioning guidance ensuring that patient care is commissioned so as to support the conduct of research in the NHS. The role would be particularly important during the initial stages of development and the nature of the role is likely to change once the new commissioning arrangements mature.
- **Patient and public engagement, insight and informatics.** This portfolio would seek to ensure that the Board is a truly patient-centred organisation. The work would include engaging with and representing the views of the public, patients and carers, ensuring the Board has the best possible insight into public, patient and carers' needs and expectations and supporting public, patient and carer involvement and education. It would also include the extension of choice and patient involvement, in line with the ambition for "*no decision about me without me*". This portfolio would also cover both



the provision of information and the use of informatics in service improvement. By positioning this patient-focused role as an enabling function, our intention is to ensure a patient-centred approach across each of the five outcome domains. Patient insight would also have a particular role to play in driving necessary improvements in patient experience.

- **Improvement and transformation.** This post will coordinate the development of the NHS Commissioning Board's commissioning strategy. At the heart of this portfolio is the need to drive change and improvement, applying a single evidence-based methodology to the work of the Board and in support of the wider commissioning system. It would include oversight of a dedicated programme to foster world-class capacity for change, potentially through a relationship with an external partner, and leadership development.
- **Policy, corporate development and partnership.** This post will lead on health system policy and design, including the choice and competition framework, negotiating the mandate with the Department of Health, and managing relations with the other major parts of the health system including local government and the regulators. It would also oversee the Board's operating model and corporate development, governance, strategic communications and public accountability.
- **Chief of staff.** This portfolio would cover the Board's core human resources functions as well as people development. It would include responsibility for fostering a new culture and new behaviours and for talent management within the Board and across the wider commissioning system.

5. How the Board will work locally

The Board will be a single national organisation with a single operating model. However, many of its functions will need to be carried out at a much more local level. These functions include:

- The Board's day-to-day **relationships with clinical commissioning groups**, which will need to be carried out at a relatively local level. We envisage dedicated teams performing the range of functions which make up this relationship, including providing development support, monitoring finance and performance, measuring outcomes and providing information and more general communication. These teams would also harness ideas and input from local clinical commissioning groups to help shape the Board's work at national level.
- The Board's **direct commissioning** functions, the bulk of which will need to be organised in part at a sub-national level. In particular, significant aspects of the commissioning of primary care services will need to be carried out locally to reflect the large number of local providers of primary medical care, dentistry, pharmacy and optical services. Some aspects of primary care commissioning will continue to be organised nationally, particularly contract negotiation and some back office and payment functions. In addition, there is likely to be a significant role for clinical commissioning groups themselves in overseeing primary medical care contracts and improving the quality of primary care, supported by the Board. Significant aspects of the Board's specialised commissioning functions will also need to be arranged at sub-national level, though a more uniform approach to this work across the country would also be developed.



- The Board's **professional and clinical leadership** functions, which would need to reach into local clinical networks to support and drive change. It is envisaged that there would be a sub-national footprint for the Board's clinical functions, which would help to transmit the focus on quality and outcomes from national through to local level and allow local networks to feed ideas and input back to the Board.
- The management of a number of other functions including significant local **stakeholder relationships**. This includes relationships with local government and HealthWatch; the provision of information to parliamentarians and the public locally; the local investigation of complaints and arrangements for emergency preparedness.

To carry out these functions, the Board would need to deploy the majority of staff at sub-national level. These teams, potentially comprising around two-thirds of the Board's staff, would be dispersed across the country and would perform a wide range of functions, including those set out above.

We are not yet in a position to specify all the details of how these local teams would be organised, in part because it is not yet clear how many clinical commissioning groups there will be, and also because final decisions are subject to agreement of the board. However, as the Government's response to the NHS Future Forum made clear, current PCT cluster arrangements will be reflected in the initial local arrangements for the Board.

We also anticipate that the different local teams would need to come together under clear leadership at sub-national level. We therefore envisage dividing the country into four "commissioning sectors", within which the local teams would be organised. The initial geographical footprints for these sectors would reflect the four SHA clusters which we are in the process of developing. London would therefore be a distinct area and the remaining SHA cluster areas would be confirmed by the end of July. With respect to future locations, we envisage the Board having a number of bases for local teams as well as four larger bases for its sector leaders, in addition to the main base of Leeds. However the main feature of the local workforce is field working and as such they should be co-located with those with whom they interact the most.

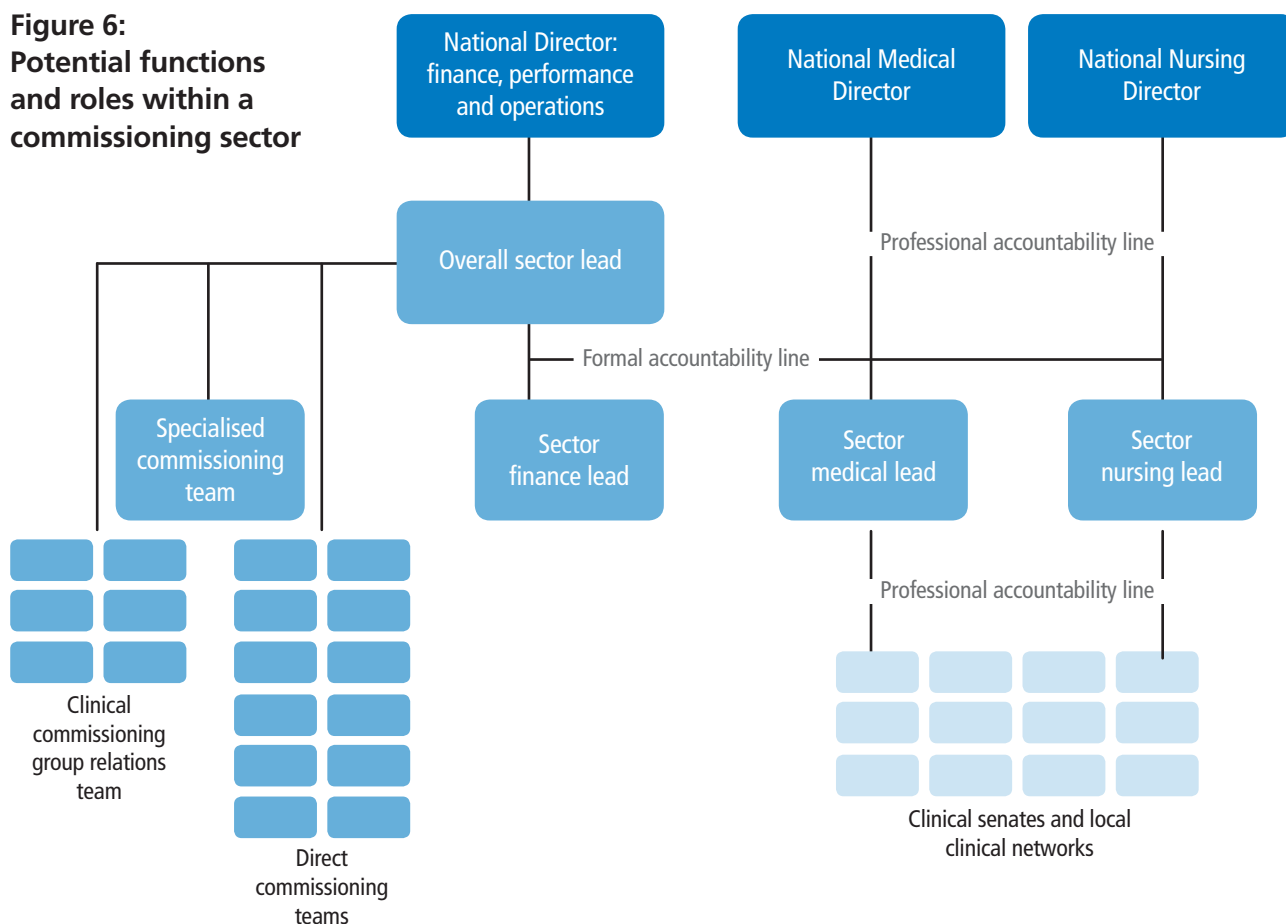
Functions and features of these commissioning sectors could include:

- Leadership of a number of more local teams overseeing the Board's **relationships with clinical commissioning groups**, its **direct commissioning functions**, and its **relationships with other partners** such as local government. These teams could operate initially within areas covered by PCT clusters;
- Hosting a **specialised commissioning** team, overseeing arrangements across the sector;
- Having **leads for key functions** which the Board will need to carry out at a more local level, including finance and professional leadership; and
- Being organised under **an overall lead** to whom these functional leads would report and who would in turn report to the national Director for Finance, Performance and Operations.



The potential structure and organisation of a commissioning sector is set out in the diagram below.

Figure 6:
Potential functions
and roles within a
commissioning sector



There are of course a number of other national organisations in the proposed new system, which will need to deploy significant numbers of their staff at sub-national level. Such organisations include Public Health England, the Care Quality Commission, Health Education England and potentially Monitor. There would be real value in aligning the functions of the different organisations so that they work across common geographical areas wherever possible. So we will be talking to these organisations before taking any final decisions about how the commissioning sectors would operate.

(I) The leadership field

Based on the proposed structures described, the following key leadership groups would come together to drive the business of the Board:

- The **board of the organisation itself, the members**, comprising the Chair and the five other non-executives, the Chief Executive and the four other executive members. The board will be formally accountable for the organisation and provide overall strategy and direction;



- The **executive leadership team**, comprising the Chief Executive, the eight national directors, the five professional leads, and the four commissioning sector leads. This group of 18 would provide operational leadership for the Board and ensure coherence across the Board's functions; and
- A broader **leadership field**, which brings together the executive leadership team and a larger group of leaders who are responsible for the Board's national and local functions. This is likely to include leads of the Board's local clinical commissioning groups-relations teams and those reporting directly to national directors or clinical and professional leads. Around 100 people would make up this wider leadership field.

“...putting patients' views at the heart of its activities will require the Board and its staff to think and behave differently.”

(J) Staff and leadership processes

It will be important to ensure that the Board operates as a single, national organisation despite its diverse range of functions. To achieve this, the Board will have to adopt an innovative and consistent approach to interacting with staff. Several processes should typify its approach. Developing these processes will require significant further work, but initial thinking is that they will include:

- **Induction**, which focuses on the core purpose of the Board and its ways of working as well as more traditional practical and functional areas. Many staff will be joining the Board from organisations in the current system and they need to understand right from the outset how the Board will be different, and to contribute to building a new and distinct culture.
- **Recruitment** of those staff who do not transfer directly to the Board, where the approach the Board takes to selecting staff focuses on behavioural strengths and attitudes as well specific skills and experience. The Board would look to secure the most talented staff wherever possible, and in accordance with the principles of the agreed *People Transition Policy*. The Board would use the recruitment process to showcase its values and to promote diversity.
- **Assessment**, which should reflect the organisation of the Board across a matrix. That means staff being assessed not only for their contribution in their particular functional area, but also for their contribution to improving quality and outcomes. This approach will link assessment and staff development with the Board's core purpose and ensure a rounded appraisal of individual contributions.
- **Staff development**, which uses innovative techniques and focus on patient and public insight to improve staff understanding of the Board's core purpose. Staff would be encouraged to move across different parts of the organisation to improve understanding of how it operates as a whole, and there would be a formal system of talent development, fast-tracking the most able to give them the most rewarding opportunities.



- **Communications**, where the Board uses technology and space to support its flexible and geographically dispersed organisation. All of the Board's staff should have access to high quality technology to support remote working, video conferencing and other flexible forms of communication. And we want the Board's office space to be as open and integrated as possible to support new and more flexible ways of working.

(K) Timetable

The ideas and proposals set out in this document are intended as the basis for ongoing engagement with staff, clinicians, patients and the public on the role of the NHS Commissioning Board. All of the proposals of course remain subject to the passage of the *Health and Social Care Bill* and agreement with the members of the Board.

Looking forward, we are anticipating the following timeline for further developing and establishing the Board:

- July 2011: Arrangements for senior and priority appointments published.
- Summer/Autumn 2011: Further detail published about the proposed operating model of the Board including its key processes.
- Autumn 2011: Further publication setting out proposed structure for the Board in more detail.
- October 2011: Start date for Board in shadow form as a Special Health Authority.
- October 2011 – October 2012: Shadow running phase and further recruitment of staff.
- In 2012, further information published about the process for staff appointments.
- By October 2012: Subject to the passage of the *Health and Social Care Bill*, the Board would be established as an independent statutory body and take on some formal statutory accountabilities from this date such as the authorisation of clinical commissioning groups and the planning for 2013/14.
- April 2013: Subject to the passage of the *Health and Social Care Bill*, the Board would take on its full formal statutory accountabilities.



Annex 1 Figure 1: The 2011/12 NHS Outcomes Framework

One framework

defining how the NHS will be accountable for outcomes

Five domains

articulating the responsibilities of the NHS

Ten overarching indicators

covering the broad aims of each domain

Thirty one improvement areas

looking in more detail at key areas within each domain

Fifty one indicators in total

measuring overarching and improvement area outcomes

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare (*The Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate*)
1b Life expectancy at 75

Improvement areas

Reducing premature mortality from the major causes of death

- 1.1 Under 75 mortality rate from cardiovascular disease*
- 1.2 Under 75 mortality rate from respiratory disease*
- 1.3 Under 75 mortality rate from liver disease*
- 1.4 Cancer survival
 - i One- and ii five- year survival from colorectal cancer
 - iii One- and iv five- year survival from breast cancer
 - v One- and vi five- year survival from lung cancer

Reducing premature death in people with serious mental illness

- 1.5 An indicator needs to be developed*

Reducing deaths in young children

- 1.6i Infant mortality*
- 1.6ii Perinatal mortality (including stillbirths)

* Shared responsibility with Public Health England

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

- 2 Health-related quality of life for people with long-term conditions

Improvement areas

Ensuring people feel supported to manage their condition

- 2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions

- 2.2 Employment of people with long-term conditions

Reducing time spent in hospital by people with long-term conditions

- 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- 2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers

- 2.4 Health-related quality of life for carers

Enhancing quality of life for people with mental illness

- 2.5 Employment of people with mental illness

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

- 3a Emergency admissions for acute conditions that should not usually require hospital admission
- 3b Emergency readmissions within 28 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures

- 3.1 PROMs for elective procedures

Preventing lower respiratory tract infections in children from becoming serious

- 3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma

- 3.3 An indicator needs to be developed

Improving recovery from stroke

- 3.4 An indicator needs to be developed

Improving recovery from fragility fractures

- 3.5 The proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury

- 3.6 Proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into rehabilitation services

4 Ensuring that people have a positive experience of care

Overarching indicators

- 4a Patient experience of primary care
- 4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care

- 4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs

- 4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services

- 4.3 Patient experience of A&E services

Improving access to primary care services

- 4.4 Access to i GP services and ii dental services

Improving women and their families' experience of maternity services

- 4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives

- 4.6 Survey of carers

Improving experience of healthcare for people with mental illness

- 4.7 Patient experience of community mental health services

Improving children's experience of healthcare

- 4.8 An indicator needs to be developed, although this may be difficult to measure

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

Three part measure patient safety measure consisting of:

- 5a patient safety incident reporting
- 5b severity of harm; and
- 5c number of similar incidents

Improvement areas

Reducing the incidence of avoidable harm

- 5.1 Incidence of hospital-related venous thromboembolism (VTE)
- 5.2 Incidence of healthcare associated infection
 - i MRSA
 - ii D Difficile
- 5.3 Incidence of newly-acquired category 3 and 4 pressure ulcers
- 5.4 Incidence of medication errors causing harm

Improving the safety of maternity services

- 5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings

- 5.6 Incidence of harm to children due to 'failure to monitor'