Designing the NHS Commissioning Board

(A) Foreword by Sir David Nicholson

An important part of the proposed modernisation of the NHS in England is the creation of an independent NHS Commissioning Board, which I have been asked to lead. I am publishing this document to inform patients, clinicians, staff and the public about my thinking with regard to the creation of the Board .

The rationale for the establishment of the Board is clear. To preserve the essential character of the NHS, we know that we have to change how the service is organised. We 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.

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.

However, it is not possible to devolve all commissioning to clinical commissioning groups. For example, it would be inappropriate to give them authority to commission themselves 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.

The Board will have a vital role in providing national leadership for improving outcomes and driving up the quality of care. It will do this by supporting clinical commissioning groups as well as through its own direct commissioning role. The support will include: publishing commissioning guidance and model care pathways based on evidence-based quality standards; supporting locally-led clinical change; developing leaders; and helping to improve data quality and ensure that high quality information is available across the commissioning system. 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 affecting their own care as well as more broader developments and changes to services.

This document sets out my initial thinking on how the new commissioning system is going to 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. In due course, we will publish further details about how the Board will operate as set out in section G.

The NHS Commissioning Board has to have a statutory Board but and this is potentially confusing. 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 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 as we establish and develop the organisation. In a similar way, Consortia remain named as such in legislation, but the Government response to the Future Forum requires these groups to have the NHS prefix, a geographical description and be referred to as clinical commissioning groups. An alternative description for the NHS Commissioning Board, based on this rationale, could be NHS England.

DN. IS THIS TOO FAR…….

It is important to say that all of the assumptions 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 we 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 board members of the Commissioning Board, once appointed, to develop the organisation.

(B) Purpose of the NHS Commissioning Board

At its simplest, the purpose of the Board will be 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 following injury;
- Ensuring that people have a positive experience of care; and
- Treating and care 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 lead a national commissioning system, which addresses these challenges in order 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.

As a single national organisation, the Board will be responsible for ensuring a consistent approach to commissioning across the country, for maintaining the 'N' in NHS. The Future Forum and the Government's response were explicit about the duty of the NHS Commissioning Board to actively promote the Constitution. It will do this by championing the values and standards in the NHS Constitution, ensuring commissioners across the NHS adhere to agreed national standards, including NICE Quality Standards, and addressing inequalities in access to healthcare provision.

The Board will also act as a champion for patients and their interests. To do this, the Board will need to engage consistently with patients and to have access to high quality insight into what patients 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. 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.

"As a single national organisation, the Board will be responsible for ensuring a consistent approach - for maintaining the 'N' in NHS."

(C) 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 bulk of services;
- To **commission directly** around £20bn of services including specialised commissioning and local primary care services (including holding around 33,000 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 **equality and diversity** and the **reduction of inequalities** in all its activities;
- To set **commissioning guidance**, contracts, pricing mechanisms and information standards;
- To promote and extend **choice**, champion patient interests and ensure patients have access to a wider range of information about services;
- To oversee planning for **emergency resilience** and lead NHS operational response to significant emergencies; and
- With its partners, to develop a medium term **strategy** for the NHS, which together with the Commissioning Outcomes Framework, forms the basis for 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.

(D) Values and culture of the NHS Commissioning Board

We want the Board to work from its inception to 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, we know there are particular features that will need to 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 pro-active** 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 task 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 commissioning consortia;
- 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.

(E) The commissioning system

The NHS Commissioning Board will be part of a comprehensive commissioning system. Clinical commissioning groups will form the key components of the new structure and they will deliver the bulk of commissioning activity. 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 deliver many of the technical aspects of commissioning for the commissioning groups and the Board.

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 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 local outcome improvements in a clinically led and bottom up way. We anticipate that they will need a wide range of development and support to develop their competence and understand the breadth of their complex responsibilities, particularly during the early stages of development. The Board will work closely with clinical commissioning groups to identify and help meet these development needs.

In order to create this comprehensive support for clinical commissioning groups the Board will develop a full range of processes, guidance and operating plans, which will:

- Create the framework through which the clinical commissioning groups will operate, giving clarity on the outcomes each must deliver, the resources available and, over time, comprehensive guidance on best practice;
- Maintain 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;
- Ensure a robust process of authorisation and ongoing assurance, which demonstrates an open, transparent and rules-based approach towards respecting the autonomy of clinical commissioning groups, while facilitating any necessary intervention.

“The relationship between the Board and clinical commissioning groups needs to be mutually supportive, … mature and respectful.”

(F) Relationships

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 improvements in health outcomes. The mandate will also specify the Board's agreed role in delivering preventative and public health services and its role in commissioning services on behalf of the Public Health Service.

The Board will also be accountable to the Department of Health, and through the Department to the Treasury, for living within the annual commissioning budget and achieving good value for money. The Board will 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 will also work in partnership with a large number of other organisations. Its most important partnerships will be with:

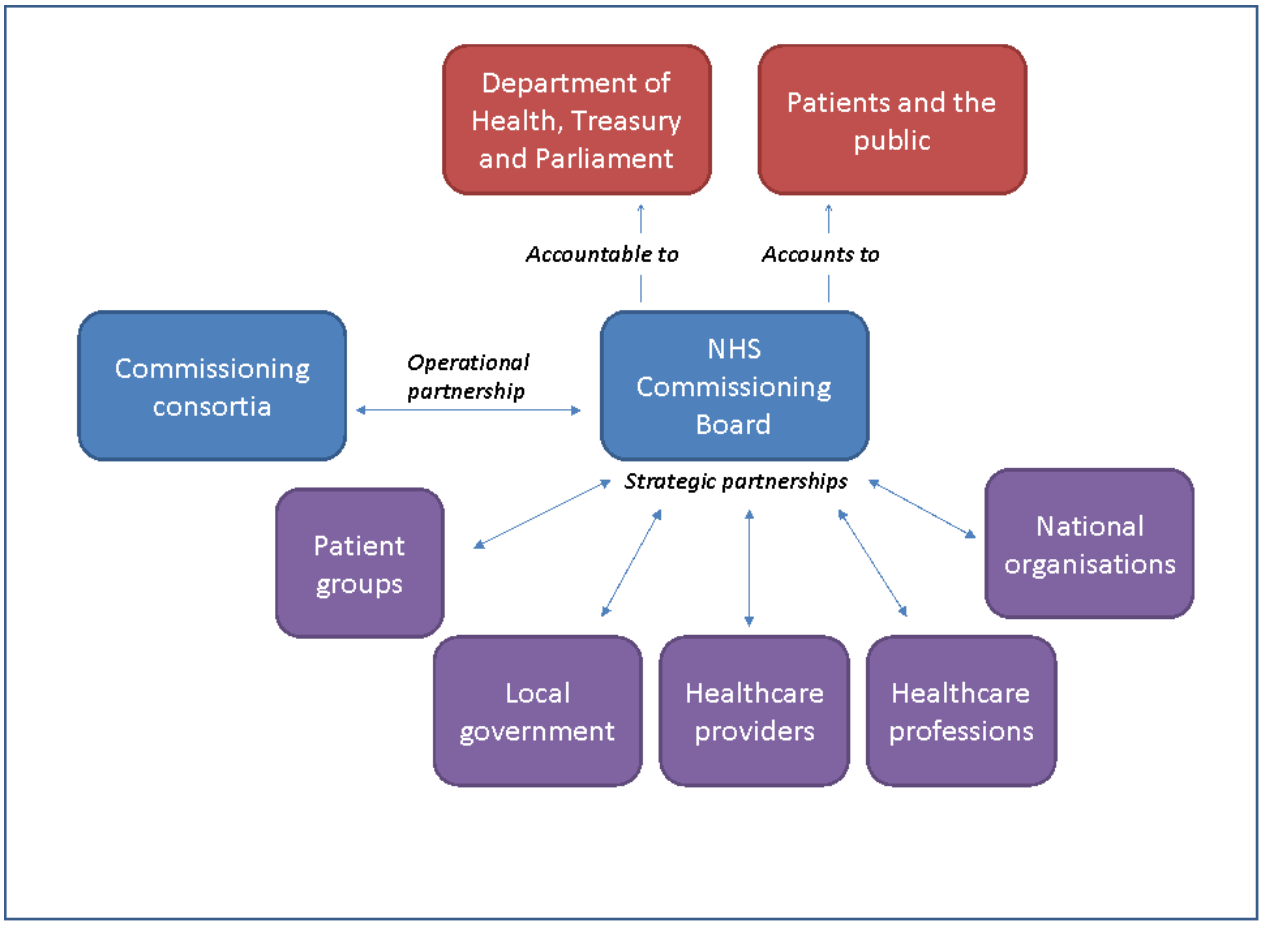
- **Patient groups**, including Healthwatch England and other key representative groups, which will also have a strong voice at national level. A close relationship between the Board and patient groups is critical to ensure the Board is equipped to champion patient interests and for the Board itself 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. To successfully drive improvements in quality and outcomes, the Board will need a close relationship with all parts of the professional community and in particular with local clinical networks which are critical to driving the development of integrated local services;
- **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 work closely with the Board at local level to ensure there is strategic coherence and alignment in how the Board seeks to deliver it's priorities in partnership with the wider public sector and at national level where local government will be given a national voice to articulate themes that emerge from its NHS activities. With the increased strategic role for Local Authorities through new Health 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, this is a critical area for partnership; and

- **Other national organisations**, 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 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 we will build on the important and successful work of the National Quality Board in developing our plans in this area.

We want to 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 1: The Board and its key relationships



(G) Operating model

This section presents initial thinking on how the Board will operate, its most important processes, and how it will 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;
- 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 in the boxes 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

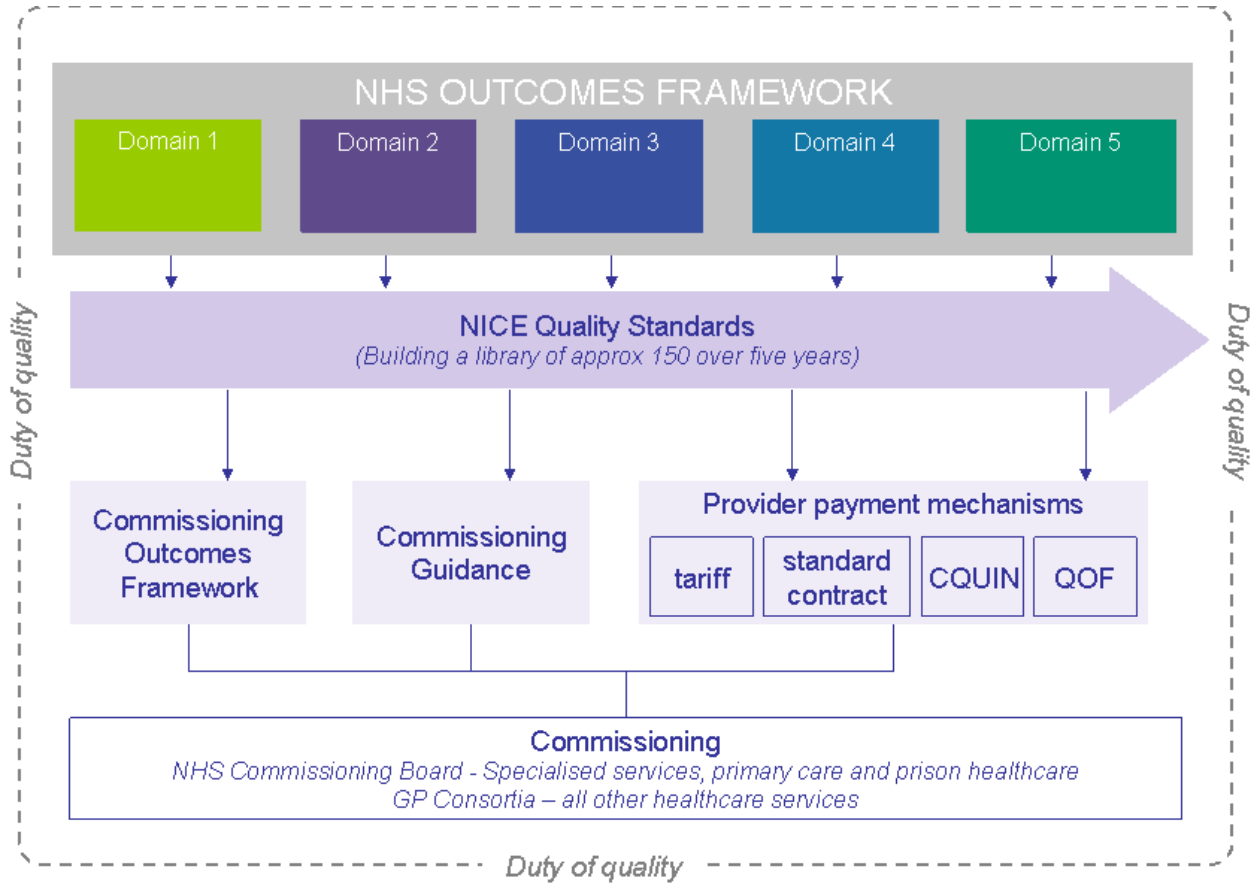
- Commissioning Outcomes Framework
- Allocations Framework
- Commissioning Guidance
- Authorisation Process
- Assurance Process
- Commissioning Support

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

1. **Quality.** The Board will 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 agreed standards produced by other groups such as the Royal Colleges - will underpin the commissioning guidance provided to clinical commissioning groups and its own direct commissioning functions, by the Board, the standard contracts developed by the Board and the approach the Board takes to developing new payment mechanisms. As such, Quality Standards will be the backbone of the commissioning system, supporting consistent

improvement in all parts of the country. This system, and its links with the NHS Outcomes Framework, is shown in the diagram below:

Figure 2: The quality improvement system



2. **Engagement.** The Board 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 will 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. My 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 will 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. I want information to be real-time wherever possible and to focus on key indicators for commissioners such as activity, referral rates, patient experience, finance and, where possible, outcomes. I 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.** The Board will need to assure itself that clinical commissioning groups have the capability and capacity to carry out their functions effectively. I 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 will 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 authorities. 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. **Reward.** The Board will assess and reward the performance of local clinical commissioning groups according to the quality and outcomes achieved by clinical commissioning groups through their commissioning activities. We are developing a Commissioning Outcomes Framework to measure local progress on improving outcomes. . A "quality premium" payment system will reward clinical commissioning groups that improve outcomes and reduce inequalities within the resources available to them. What is important about these processes is that they will make the relationship between clinical commissioning groups and the Board depend on the core purpose of the commissioning system – improving outcomes for patients.

In describing these processes, my aim is to illustrate how I envisage the Board operating and how that will look and feel different from the current system. More generally, the Board's approach will 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."

(H) Structures

This section looks at how I 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 five Non-Executive Directors. Their key purpose will be to ensure effective governance, 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, i.e. the funding allocated both to the Board and to 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 five Executive Directors. I envisage that the other Executive Directors will be: the Nursing Director; Medical Director; Director of Finance, Performance and Operations; and Director of Commissioning Development. In addition, I envisage other national Director level posts to deliver the functions in Figure 4 being: Patient Engagement, Insight and Informatics; Strategy and Transformation; Policy and Corporate Development; and Chief of Staff. More detail on these roles is set out below.

2. Staff numbers. Although we are in the early stages of developing the organisation, I have made some initial broad assumptions 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 I envisage this reducing 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.

"We estimate the Board could employ around 3,500 staff across all its functions … compared with around 8,000 staff performing the same functions at present."

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. We will need a relatively complex structure to achieve this result at national and local level and I am thinking that it will be designed to achieve our goals across three key dimensions:

- The Board will be organised nationally around the five **outcome domains** in the NHS Outcomes Framework. This reflects the importance of professional and clinical leadership to the Board's success. There will be national professional leads for each of the five outcome areas, reporting to a Medical Director and Nursing Director at national level.

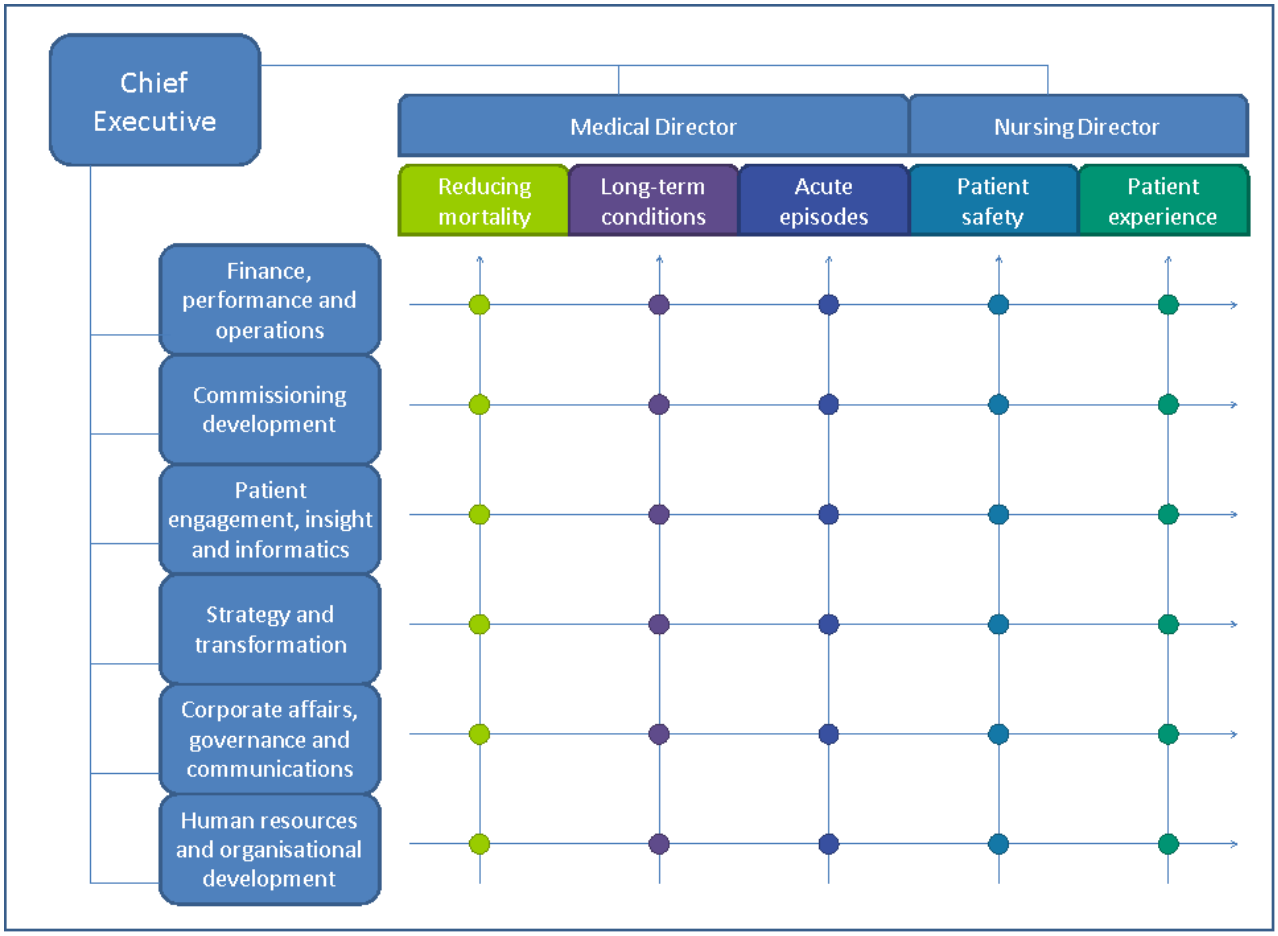
- To support work on improving outcomes, the Board will have a number of **supporting functions** organised under directors at national level. The role of these functions will be to support the achievement of better outcomes.

- Because of the breadth of its responsibilities, the Board will need functions organised across **geographical areas** below national level. In fact, the majority of the Board's staff will 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 4: Structure of the Board at national level

DN – this diagram below has always described functions rather than posts. Changes have been made to other post references to describe their 'job titles' rather than their functions. Do we now want to have consistent labelling?



As the diagram suggests, the professional leads for improving outcomes on mortality, long-term conditions and acute episodes will report to the Medical Director. The leads for improving patient safety and patient experience will report to the Nursing Director. The core role of the professional leads will 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 will work together to achieve improvements in outcomes. Each team will come under the control of a particular professional lead (shown on the grid as a vertical line of authority.) But each team will 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 will have a small clinical advisory team to support their work.

Through this way of working, my 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 will 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 will extend beyond these arrangements for the five outcomes domains. So in addition to this, I envisage:

- 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 will depend on the specific outcome improvements required to deliver the mandate.

- 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 will 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. I will be discussing the level and nature of this support with these organisations as we develop our plans.

- Opportunity for the Board's clinical and professional leaders to work with a wide range of local clinical networks. The networks will 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 will 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. Clinical leaders for networks will be brought together in groupings at appropriate levels in the system to provide a comprehensive advisory function to both commissioners and health and well being boards.

"…our ambition is to put healthcare outcomes and professional and clinical leadership at the heart of the Board's business."

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

- establishing 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
- that our decisions show that we know and understand 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. These 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 comprise:

- **Finance, Performance and Operations.** This portfolio will include financial strategy and financial performance for the Board and clinical commissioning groups, across the £80bn commissioning budget. It will 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 will include oversight of the Board's sub-national commissioning sectors and the wider "field force" which we describe below. Other responsibilities will 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 will be to support the development of clinical commissioning groups through authorisation and beyond. The portfolio will contain responsibility for commissioning support and for delivery of capacity and capability across the commissioning system. This responsibility for the overall commissioning architecture will include the design of national primary care contracts. The portfolio will also cover the development of commissioning tools and commissioning guidance. The role will 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 will seek to ensure that the Board is a truly patient-centred organisation. The work will include engaging with and representing the views of patients, ensuring the Board has the best possible insight into patients' needs and expectations and supporting patient involvement and education. It will also include the extension of choice and patient involvement, in line with the ambition for *"no decision about me without me"*. This portfolio will 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 outcomes domains. Patient insight will also have a particular role to play in driving necessary improvements in patient experience.

- **Strategy and transformation.** 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 will include oversight of dedicated programme to foster world-class capacity for change, potentially through a relationship with an external partner, and leadership development capacity.

- **Policy and corporate development.** This post will cover the Board's traditional corporate functions, ensuring a consistent and disciplined approach across all of the Board's activities and ensuring that the matrix approach works successfully at national level. It will ensure the effective running of the Board on a day-to-day basis. It will also ensure effective communication between the Board and clinical commissioning groups and support the Board in being publicly accountable for its use of NHS resources.

- **Chief of Staff.** This portfolio will cover the Board's core staffing functions as well as broader organisational development. It will 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 will 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, I envisage 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 we envisage the development of a more uniform approach to this work across the country.

- The Board's **professional and clinical leadership** functions, which will need to reach into local clinical networks to support and drive change. I therefore envisage a sub-national footprint for the Board's clinical functions, which will 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 Authorities 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 will need to deploy the majority of staff at sub-national level. These teams, potentially comprising around two-thirds of the Board's staff, will be dispersed across the country and will perform a wide range of functions, including those set out above.

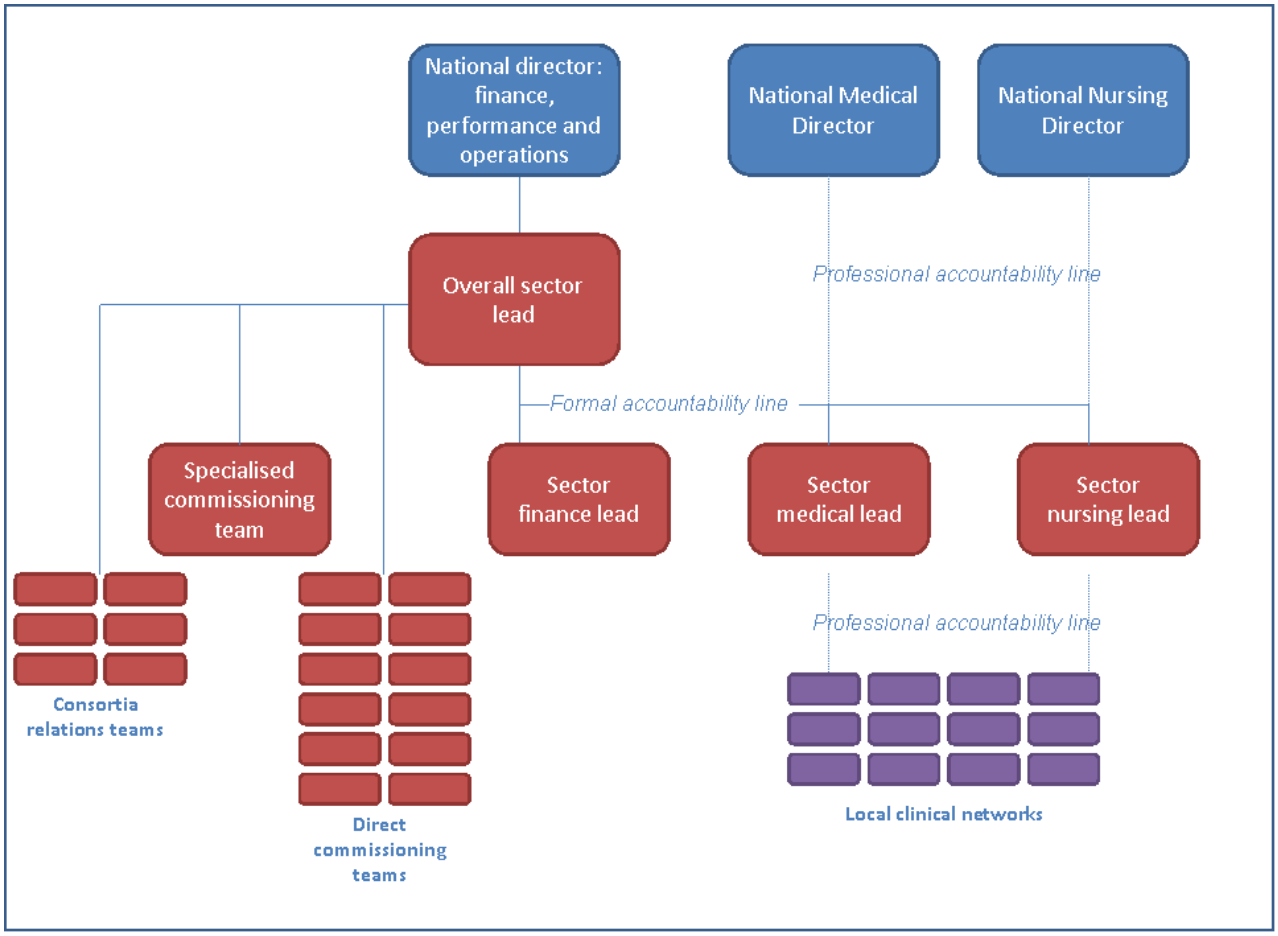
We are not yet in a position to specify all the details of how these local teams will be organised, in part because we do not yet know how many clinical commissioning groups there will be. However, we anticipate that the different local teams will need to come together under clear leadership at sub-national level. We therefore envisage dividing the country into four "commissioning sectors", within which the local teams will be organised. We have not settled on the precise geographical divisions for these sectors, but we envisage London being a distinct area. With respect to locations, we would 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 local workforce is field working and as such they could 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 5: 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. I believe there is 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 will operate.

6. The leadership field. Based on the structures described, I envisage the following key leadership groups coming together to drive the business of the Board:

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

- The **executive leadership team**, which I envisage comprising the Chief Executive, the eight national directors, the five professional leads, and the four commissioning sector leads. This group of 18 will provide operational leadership for the Board and ensure coherence across the Board's functions; and

- A broader **leadership field**, which will bring 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. I envisage around 100 people will 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."

(I) 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 will typify its approach. Developing these processes will require significant further work, but my initial thinking is that they will include:

- **Induction**, which will focus 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 we want them 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 will focus on behavioural strengths and attitudes as well specific skills and experience. The Board will look to secure the most talented staff wherever possible, and in accordance with the principles of the agreed HR Transition Framework. The Board will use the recruitment process to showcase its values and to promote diversity.

- **Assessment**, which will 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 will use innovative techniques and focus on patient and public insight to improve staff understanding of the Board's core purpose. Staff will be encouraged to move across different parts of the organisation to improve understanding of how it operates as a whole, and there will be a formal system of talent development, fast-tracking the most able to give them the most rewarding opportunities.

- **Communications**, where the Board will use 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 I want the Board's office space to be as open and integrated as possible to support new and more flexible ways of working.

(J) Conclusions and next steps

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.

Looking forward we envisage the following timeline for further developing and establishing the Board:

- Summer 2011: Further detail published about the operating model of the Board including its **key processes.** Arrangements for senior appointments published.
- Autumn 2011: Further publication setting out proposed structure for the Board in more detail . More detailed arrangements published about staff appointments.
- October 2011: Potential start date for Board in shadow form as a Special Health Authority;
- October 2011 – October 2012: Shadow running phase and recruitment of staff to fill all posts in the Board
- October 2012: Subject to the passage of the Health and Social Care Bill, the Board would 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

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
1.6.i Infant mortality*
1.6.ii 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
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii 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

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

The NHS Outcomes Framework 2011/12 at a glance

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 developing, 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 C 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'