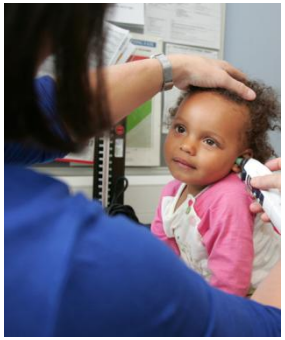
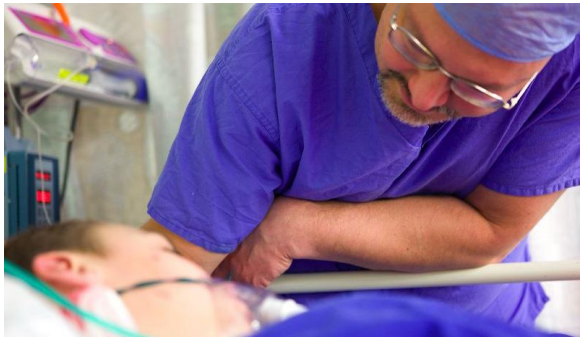
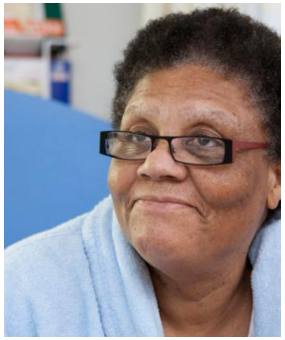
NHS
Commissioning Board
A special health authority

Design of the NHS Commissioning Board







NHS Commissioning Board
Authority
Board Meeting
2 February 2012

THE NHS CONSTITUTION
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Introduction

This paper presents recommendations for the organisational design of the NHS CB. It sets out:

- The context for the design process;
- The recommended disposition of the Board's running costs budget;
- Details of how the Board will operate through a matrix working approach
- Detailed recommendations on the design of each of the Board's directorates, including the Sectors and Local Offices;
- The key issues and risks associated with the design process; and
- The next steps

1. Context

1. Context

The proposals in this paper build on the vision set out in *Developing the NHS Commissioning Board*, published in July. This document set out some initial thinking on how the new commissioning system could work and the Board's role within it. It described the culture, style and leadership of the Board, and the processes that it will need to make sure it achieves maximum health benefit for the nation from the resources available. The document described:

- The NHS CB's over-arching role in ensuring that the NHS delivers better outcomes for patients;
- Its main functions;
- The values and culture it will foster;
- The key processes for transacting business, operating through a matrix working approach;
- How the Board will work at sub-national and local levels, with a single operating model, through sector and local teams; and
- The Board's main locally managed functions, which will include its day-to-day relationships with Clinical Commissioning Groups, direct commissioning functions, professional and clinical leadership functions, and the management of local stakeholder relationships.

The design of the NHS CB has been informed by the values and culture which the Board will foster. These include:

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

A number of key assumptions were made at the outset of the design process. These are set out below together with the rationale on which they were based.

Area	Assumption	Rationale for this Assumption
1.Staff numbers	An overall workforce total of 3,500 was assumed. Of these around: • 2,500 will be in the local offices; • 200 will be in the sectors; and • 800 will be at the centre.	• The assumption of 3,500 staff was based on initial expectations about the likely running costs of the Board. • To carry out its key functions of direct commissioning, supporting and assuring CCGs and managing relationships with local stakeholders, the Board will have to deploy the majority of its staff at sub-national level. *Developing the NHS CB* (July 2011) stated that around two thirds of staff would be deployed locally. The figure of 2,500 is based on this commitment, together with the requirement that there should be 50 local offices. • The balance between sectors and the centre was based on the assessment that the sectors should have narrow, focused functions and should be seen as effectively part of the central structures.
2.Levels of management	• In most cases there should be no more than five layers of management in each directorate, from National Director to the 'front line'. • The exception to this will be the Performance and Operations Directorate, where an additional layer (or layers) will be required to link through to the local offices.	• The principle of no more than five layers of management is based on extensive evidence of effective organisational structures which has been applied in DH and other public sector organisations.

Area	Assumption	Rationale for this Assumption
3.Division of functions between centre, sectors and local offices	• The NHS CB will have a single operating model. • There will be four commissioning sectors. • There will be 50 local offices. • The role of the sector will be relatively 'narrow', and will be an integral part of the Operations Directorate. The staff working in the sectors and local offices will be part of the Operations Directorate. Other Directorates will not have staff formally attached to the sectors or local offices.	• The need for a single operating model reflects the fact that the NHS CB will be a single organisation, and will work in a much more consistent way than the diverse range of its predecessor organisations. • The four commissioning sectors will be based on the areas now covered by the SHA Clusters. • The Government's response to the NHS Future Forum made it clear that current PCT Cluster arrangements would be reflected in the initial local arrangements for the Board. The 50 local offices will therefore cover the same areas as the current PCT Clusters. This will be important in managing the transition to the new system. • The sectors will be very different to the current SHA Clusters. They will be significantly smaller and will not operate as separate entities in their own right. The Board's matrix working model means it would not be necessary or appropriate for all directorates to have their own staff in the sector teams. The sectors will operate as part of the central Operations Directorate structures, linking with other directorates through the matrix to support the delivery of key business processes.
4.Services that will be outsourced	• The NHS CB will model the change it expects to see in CCGs: it will operate in as lean and flexible a way as possible. Functions will be shared and/or outsourced wherever this would be practicable and provide value for money.	• Back office functions, including payroll, legal advice, and procurement support will all be outsourced to achieve the greatest value for money.

Area	Assumption	Rationale for this Assumption
5.Functions that will be provided corporately	A number of functions will be carried out in corporate teams, rather than in individual directorates, including: analytical services, finance support, human resources, communications, and programme management support .	• It will not be appropriate or affordable to replicate corporate support functions across directorates, sectors or local offices. Expertise and capacity will be centralised in corporate teams.
6. Matrix working	The NHS CB will deliver improved outcomes through matrix working, by hard-wiring into the ways of working: • Quality, as the organising principle; • Clinical leadership; • Patient and public voice; and • Promoting equality and reducing health inequalities.	*Developing the NHS Commissioning Board* committed the NHS CB to matrix working. It did so for three purposes: • To provide simplicity for the NHS; • To aid efficiency; and • To ensure singularity of approach.
7. Model of Change	The NHS CB will have a consistent approach to leading change and transformation running through the matrix working approach. The change model will have two components: • A massive improvement approach; and • Having clear principles for the application of that approach.	• The scale of transformation needed in the NHS in order to deliver improved quality from available resources is huge. It requires an evidence-based, systematic and skilled application of change management approaches in order to achieve it.

Further assumptions were made about inclusions and exclusions from the running costs budget. A number of these have been resolved through discussions with DH:

- The costs of providing clinical advice to the wider system will be separately funded.
- The costs of Commissioning Support Units (CSUs) are excluded from NHS CB running costs.
- The cost of commissioning public health services on behalf of Public Health England will be separately funded.
- Costs associated with the Patient Record and other technology functions will be separately funded.
- The NHS CB will fund the new Leadership Academy.
- The new Improvement Body will become self-funding. Transitional funding will be required to achieve this.

2. Disposition of the running costs budget

DH has applied a model to calculate the end-state running cost envelopes for 2014/15 for the NHS CB and other bodies in the reformed system.

- The NHS CB running costs budget for 2014/15 will be £492m.
- This represents a reduction of around 50% for the NHS CB.
- It is expected that additional transitional funding will be available in 2013/14, the Board's first full year of operation. This will be used non-recurrently and not played out into recurrent directorate budgets.

The table below shows the overall distribution of the running costs budget.

	£m	£m
Total NHS CB Budget	**492**	
Contingency Reserve		60.0
Non Pay costs		154.0
Corporate / Outsourced Functions		41.5
Operations – Local Office Teams		175.0
		430.5
Budget to be allocated to Central Directorates	**61.5**	
Medical		7.5
Nursing		5.0
Operations (central and sector functions)		15.0
Commissioning Development		5.5
Improvement & Transformation		5.0
Patient Engagement, Insight & Informatics		5.5
Finance		8.9
Policy, Partnership and Corporate		3.2
Chief of Staff		5.9
Total Directorate Allocations		**61.5**

The key assumptions which underpin the proposed disposition of the overall £492m running costs budget include the following:

- In line with the average for NHS organisations, 35% of the budget (after taking out a contingency) will go on non-Pay costs, including facilities and other fixed costs.
- A range of corporate functions will be provided from single teams, rather than replicated between directorates. 10% of the total budget, £49m, was set aside for these functions.
- 50 local offices will each have an average of 50 staff. £180m was set aside to cover these costs and the costs of Family Health Services.
- A contingency budget should be held in reserve. Initially in this process a contingency of £50m was set aside. Through the engagement process it was subsequently agreed that this should be increased to £60m. The additional £10m has been taken from the Local Office allocation (now £175m), central directorate allocations (now £55m), and the corporate functions budget (reduced to £48m).
- It was confirmed that the corporate HR support function (£3m) should be hosted by the Chief of Staff and the Finance support function (£2m) should be hosted by the Director of Finance. These functions have now been incorporated into the relevant directorate allocations.
- Following further minor adjustments, £41.5m has been retained for the remaining corporate functions to be hosted by the Policy, Partnerships and Corporate Development Directorate.

The table below shows how the proposed distribution of the running costs budget relates to staff numbers in each directorate.

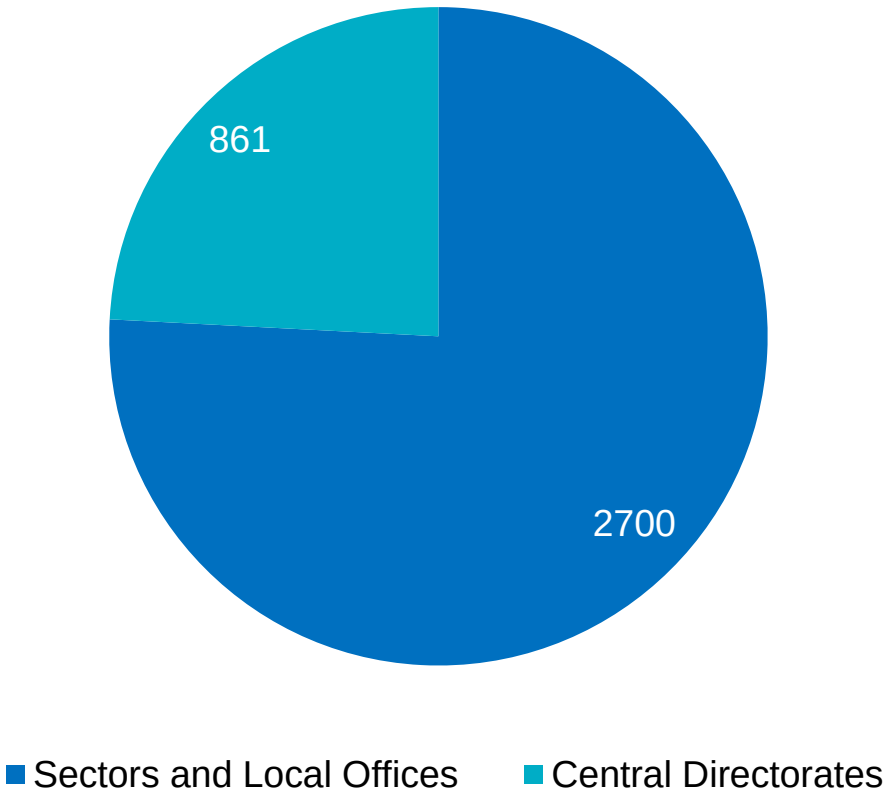
	Pay £m	Staff WTE
Medical	7.5	98
Nursing	5.0	75
Operations Directorate (local office functions)	175.0	2,500
Operations Directorate (central and sector functions)	15.0	230
Commissioning Development	5.5	70
Improvement & Transformation	5.0	72
Patient Engagement, Insight & Informatics	5.5	91
Finance	8.9	104
Policy, Partnership and Corporate	3.3	46
Chief of Staff	5.9	48*
Total Directorate Allocations	**236.5**	**3,334**
Corporate Functions – in house	28	227†
Corporate Functions – outsourced	13.5	
Total	**278**	**3,561**

Note

*Only £3m of the Chief of Staff allocation will be spent on 48 WTE in-house staff. £2.5m will go on outsourced services.

† The staff numbers for corporate functions are indicative and subject to further work

Around three quarters of the Board's staff will work in local offices and the four commissioning sectors.



Work is continuing to resolve a number of outstanding funding issues. Some of these may result in additional calls on the contingency reserve.

- The cost of hosting and supporting clinical networks will be met by the NHS CB. Further work is being undertaken to identify which elements of existing network costs will be covered by running costs.

- Work is continuing with the DH Information Directorate to identify the full costs associated with delivering information standards, governance, national IT applications, infrastructure and services.

- A number of national functions are currently hosted by SHAs. Work is currently taking place, through SHAs, to confirm which of these will need to be funded from the Board's running costs.

3. Matrix Working

3. Matrix Working

Developing the NHS Commissioning Board committed the NHS CB to matrix working. It did so for three purposes:

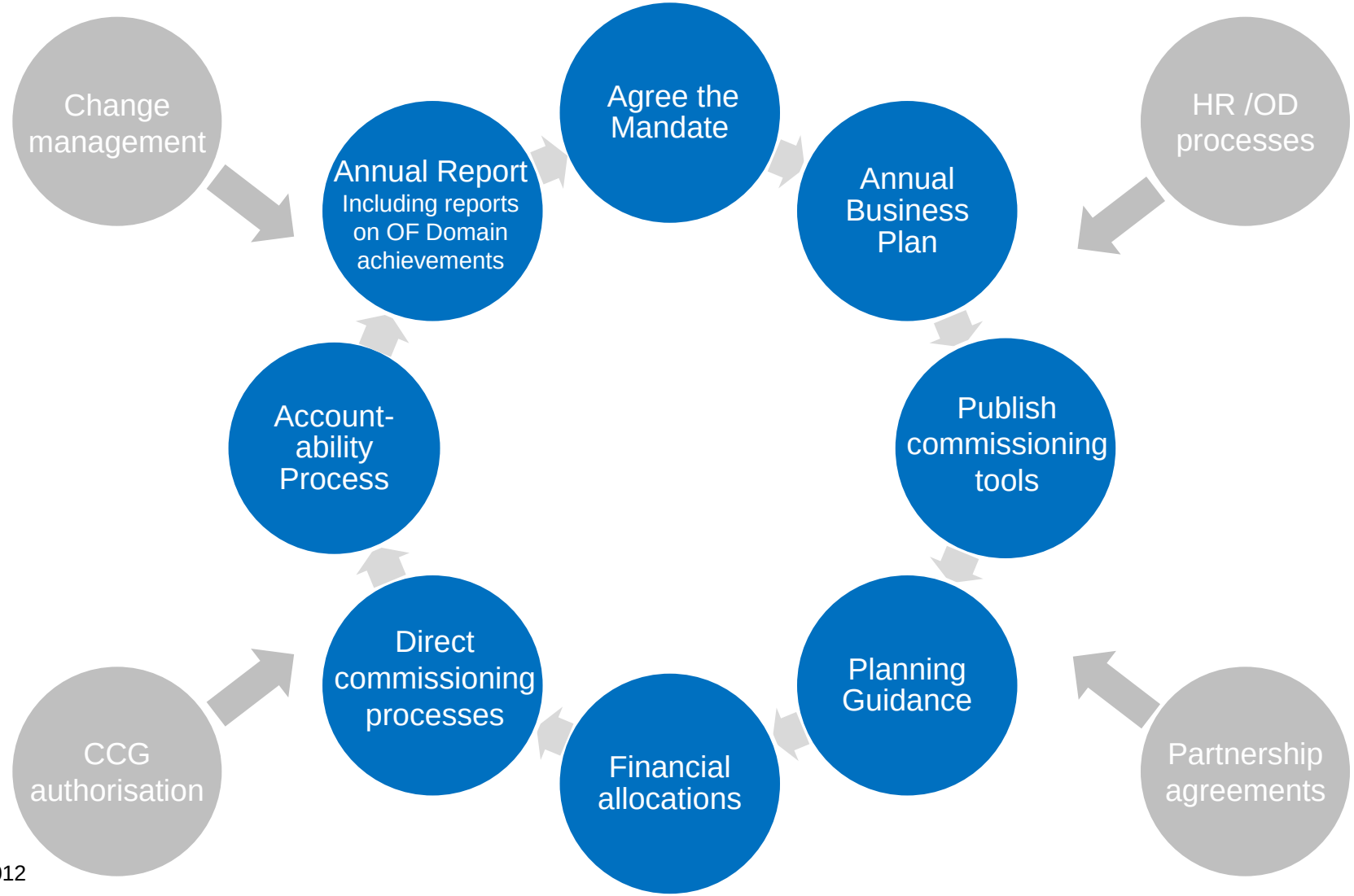
- To provide **simplicity** for the NHS;
- To aid **efficiency;** and
- To ensure **singularity** of approach.

To achieve these purposes:

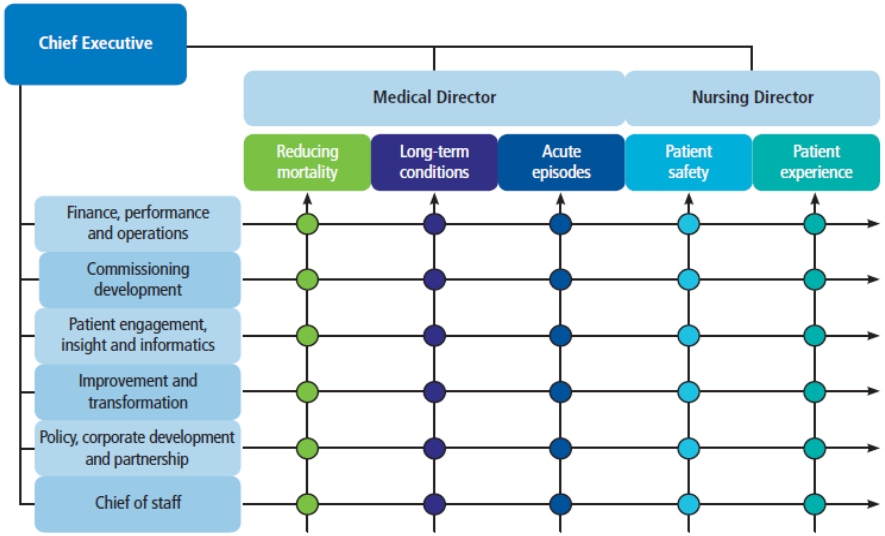
- Matrix working must **align** all the business of the NHS CB towards shared aims and the common purpose it shares with other organisations;
- All of the Board's key systems, **processes, policies and products** must work through the matrix;
- There must be a consistent **style of working**;
- The **organisational structure** must be built around effective matrix working, with all perspectives 'at the table'.
- The organisational **culture and behaviours** need to reflect the expectations of matrix working and will be the most critical factor. Implicit and explicit reward mechanisms need to reinforce this.

The Board's key processes and products should be delivered through a clear and consistent annual business cycle, such as that illustrated in the example below. Each product or process in this cycle will be developed and implemented through the matrix approach.

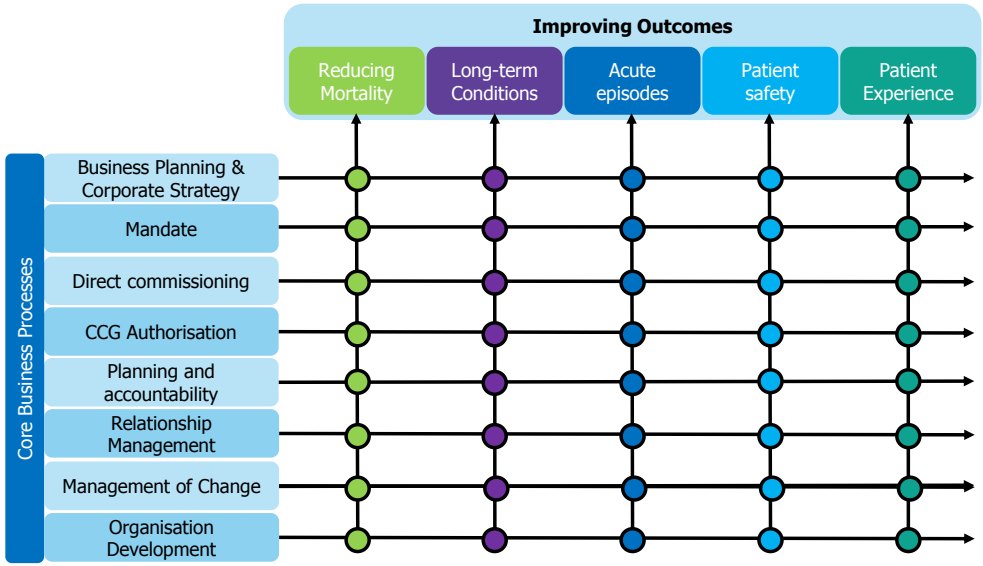
An Example Business Cycle



Developing the NHS CB described how teams and members of staff will be managed through a matrix working approach to improve outcomes:

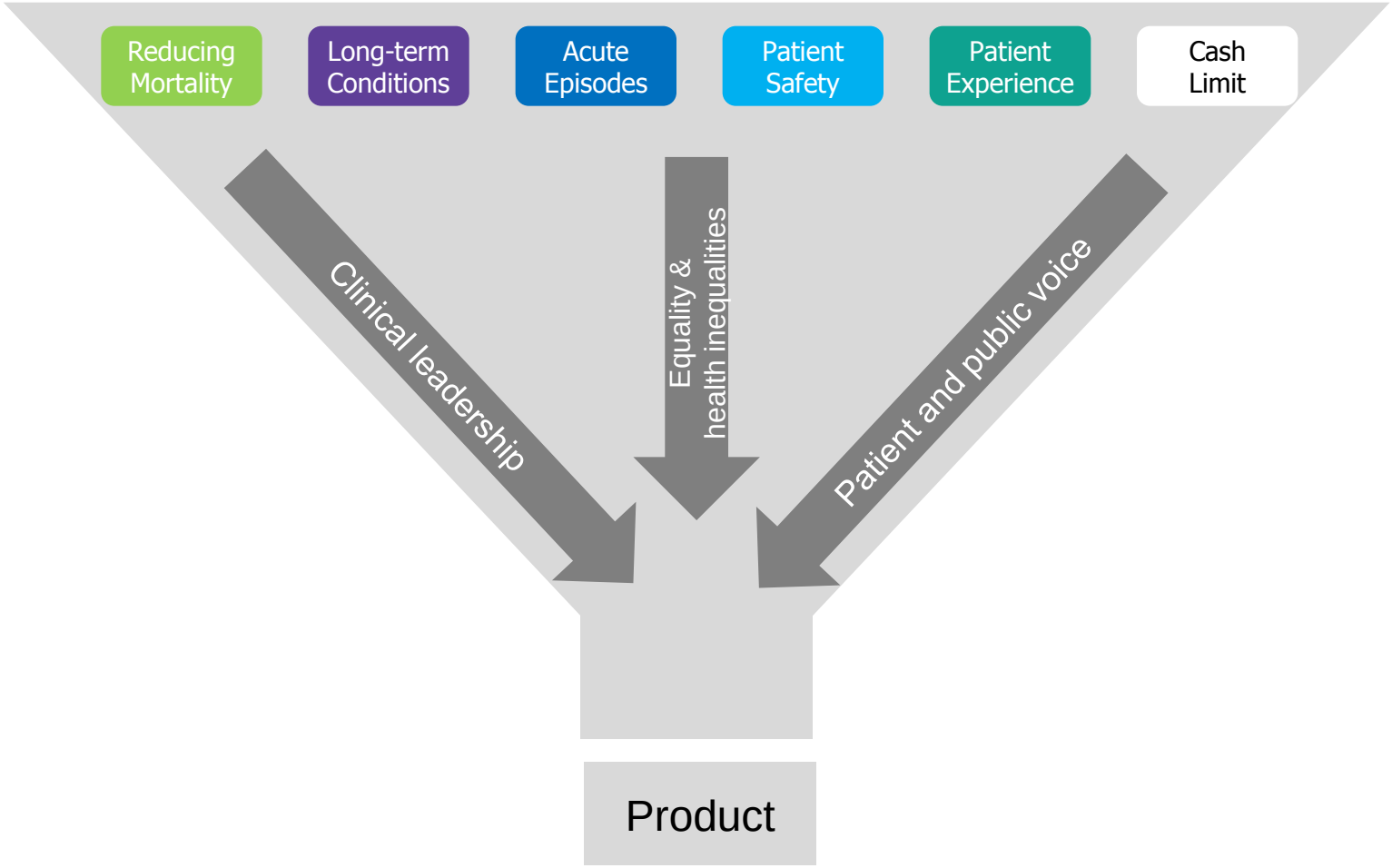


In practice, directorates will need to contribute to improving outcomes through a set of core business processes, as this is how the NHS will 'feel the touch' of the NHS CB.

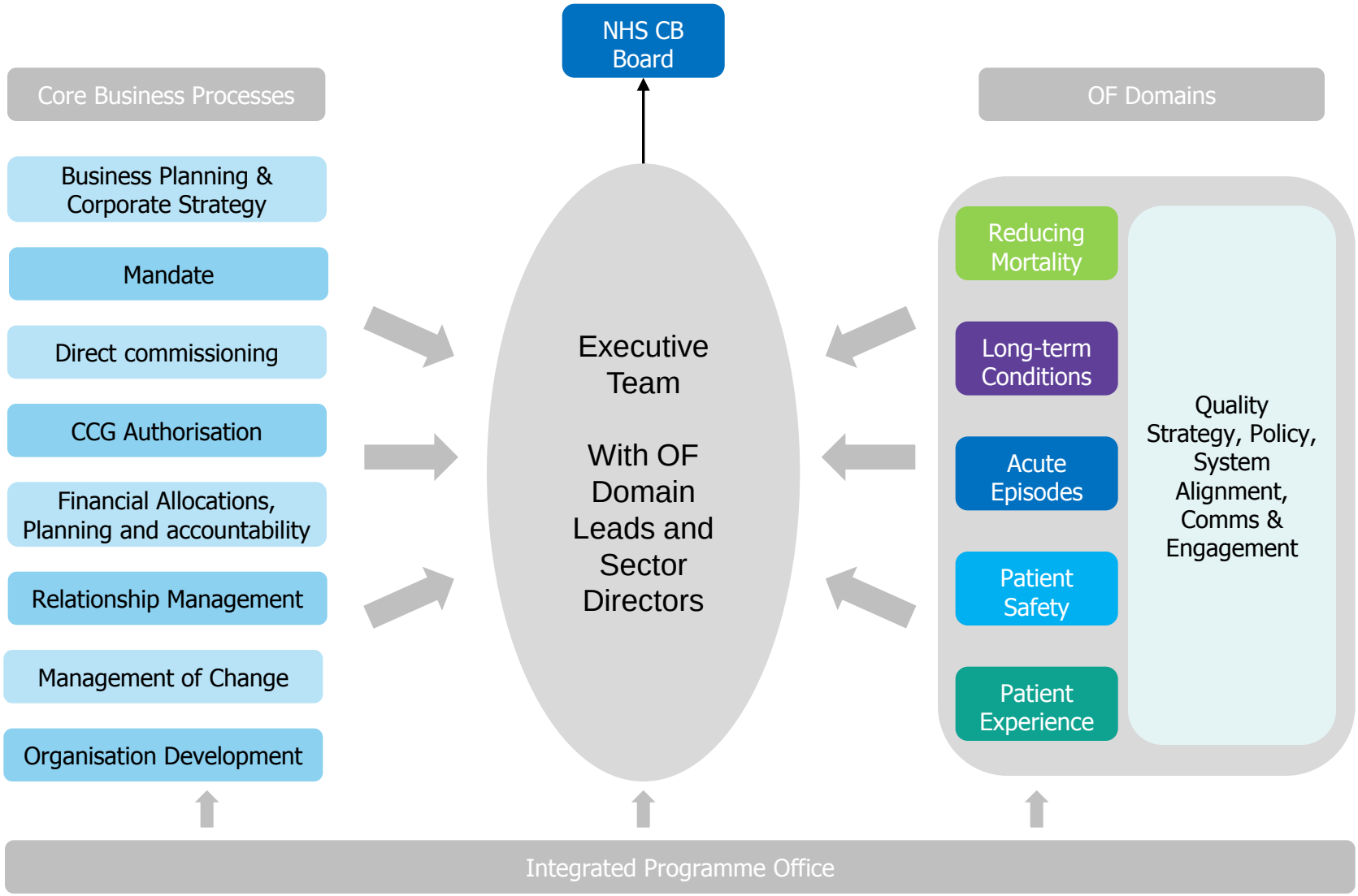


Business processes will result in a series of products. The matrix approach will ensure that each product (eg, the standard NHS contract or the Commissioning Outcomes Framework) will have been funnelled through a process which tests that they:

- Contribute to the 'Outcomes Framework domains plus the cash limit;
- Have been clinically led;
- Promote equality and support a reduction in health inequalities; and
- Are informed by the patient and public voice.



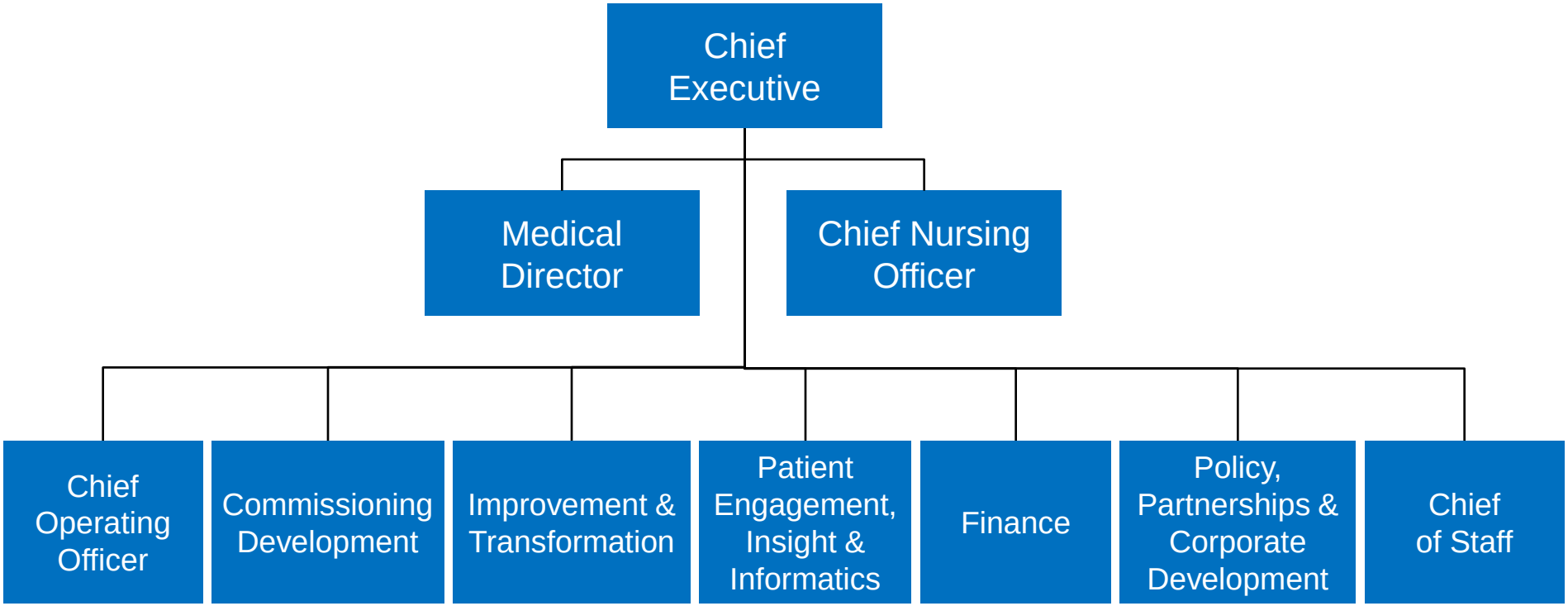
A co-ordinating mechanism led by the Board's extended executive team, as illustrated below, will be required to ensure rigour and discipline in delivering the matrix approach, underpinned by an integrated programme office.



4. Directorate Design Proposals

4. Directorate Design Proposals

The NHS CB will have nine directorates. The proposals for the design of each directorate are set out in the following slides.

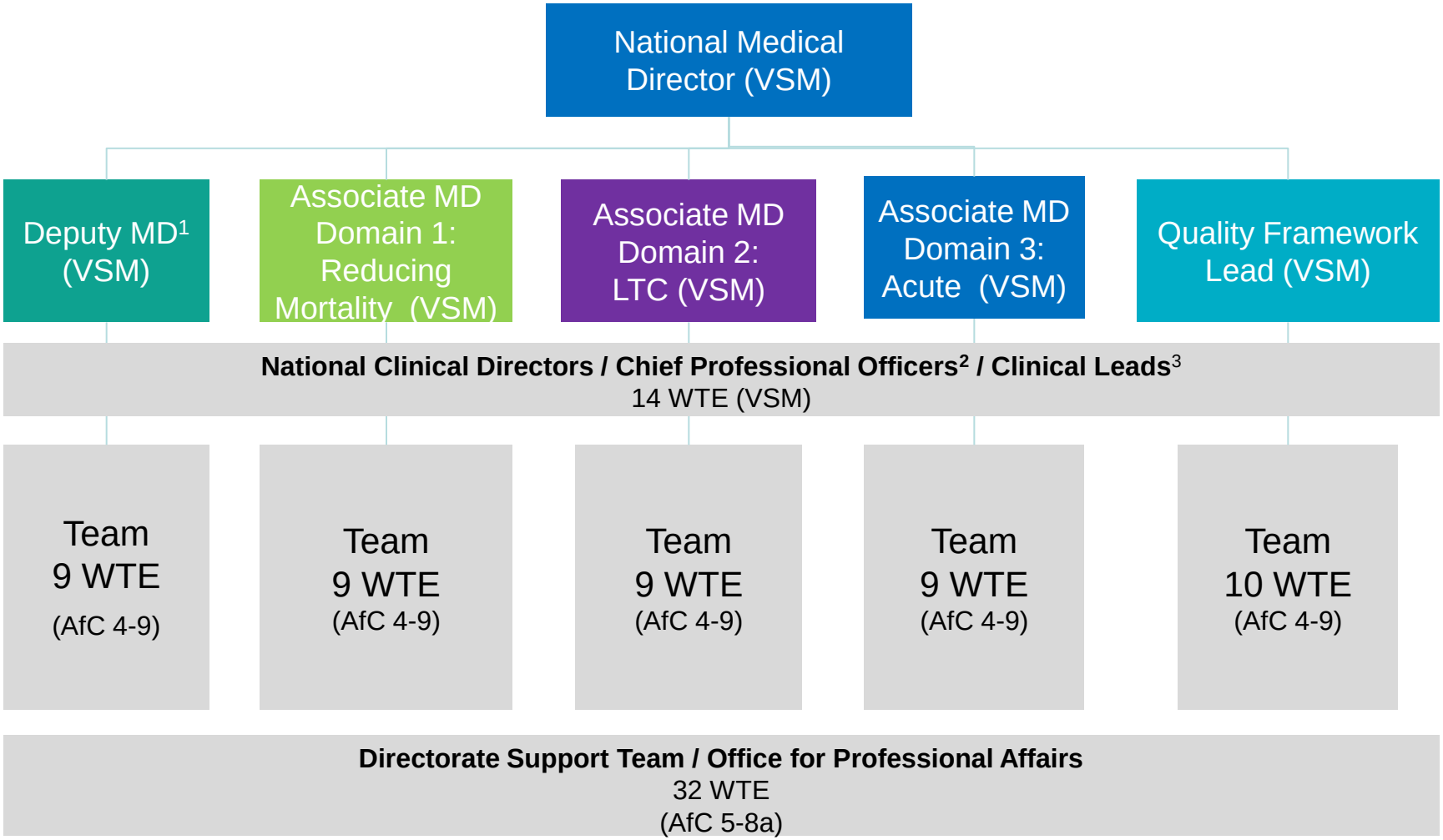


NB: Directorate names will be reviewed following National Director appointments

Medical

Core role and purpose	To drive quality improvement through clinical leadership to achieve the required outcomes in the three domains of: • Preventing people from dying prematurely • Enhancing quality of life for people with long-term conditions • Helping people to recover from episodes of ill health or following injury
Summary of functions	• Oversee the delivery of improved outcomes for patients in Domains 1-3 of the NHS Outcomes Framework • Quality improvement • Provide clinical leadership • Clinical advice to DH, ALBs and across government • Oversee and support clinical senates and networks • Support the work of the National Quality Board
Staff numbers	98 WTE
Pay costs	£7.5m

Medical Organisation Chart

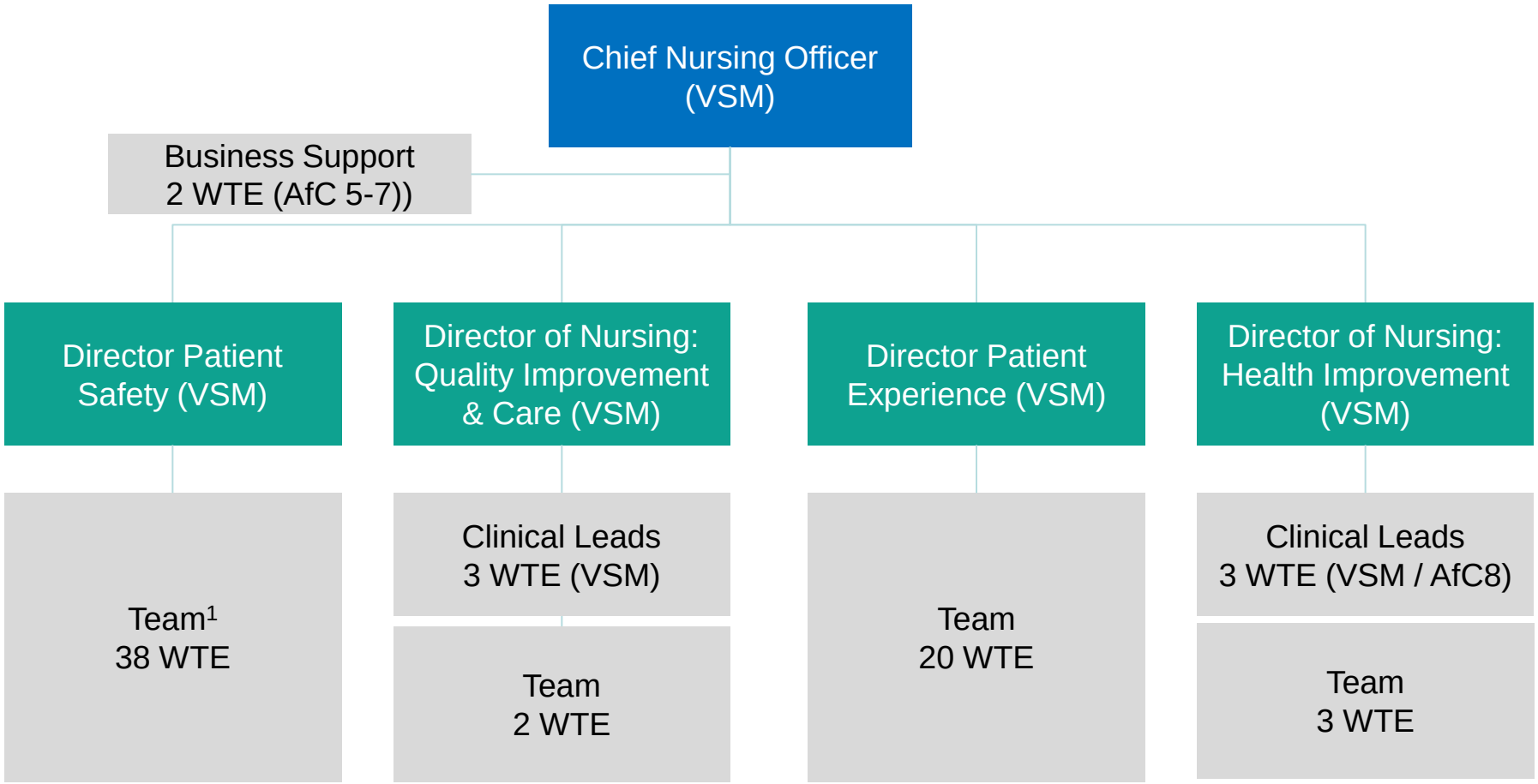


1. The role of the Deputy Medical Director post will be broad, including a focus on commissioning guidance and quality of primary care
2. CPO, CDO, CAHPO, CSO
3. Includes the equivalent of 3.0 to be secured on sessional , call-off arrangements

Nursing

Core role and purpose	To drive quality improvements and better outcomes for patients by leading on domains 4 and 5 of the outcomes framework: • Ensuring that people have a positive experience of care; and • Treating and caring for people in a safe environment and protect them from avoidable harm The Nursing Directorate will also provide clinical leadership support to the NHS and national professional leadership for nurses and midwives.
Summary of functions	• Clinical Leadership • Professional nursing and midwifery leadership • Patient safety • Patient experience
Staff Numbers	75 WTE
Costs	£5m

Nursing Organisation Chart



[1]The patient safety team covers the full range of patient safety functions, not just former NPSA functions.

Operations

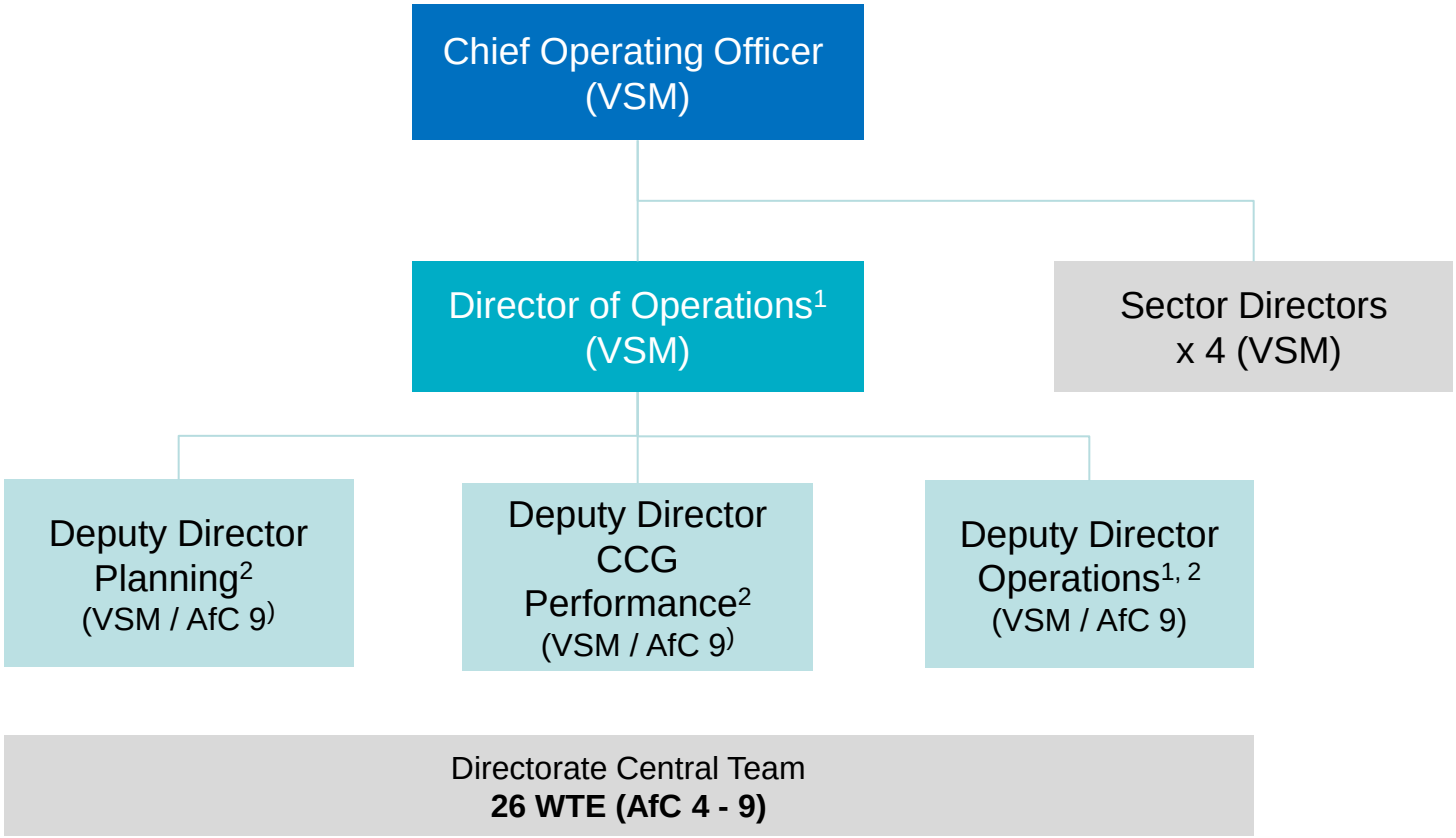
A number of key principles have informed the proposed design of the Operations Directorate:

- The NHS Commissioning Board will be a single organisation, with a strong culture and identity, exhibiting professional values and behaviours.
- Clinical leadership will be hard-wired into the NHS CB structures at all levels.
- The Centre, Sectors and Local Offices will be working to achieve shared goals of improving outcomes, using a single, transparent, rules-based operating model.
- The NHS CB will follow an “hour glass” model, in which the sectors are relatively small and sub-national influence in the Board is concentrated at local office level; and
- Medical, nursing and finance leads in the Operations directorate will all report upwards to the Chief Operating Officer, with dotted professional lines to their Heads of Profession in the NHS CB.

Operations - Centre

Core role and purpose	The Operations Directorate will work to achieve shared goals of improving outcomes and delivery of mandate, using a single, transparent, rules-based operating model.
Summary of functions	1. Direct Commissioning - oversight of delivery of: • primary care commissioning; • specialised commissioning; • military health; and • offender health. 2. Assurance and assessment of CCGs, including: • Planning guidance for CCGs to deliver mandate, Outcomes Framework, NHS constitution, etc; • CCG delivery against planning guidance; and • Information flows to allow public and parliamentary accountability. 3. Emergency preparedness
Staff numbers	30 WTE
Costs	£3m
Options	The proposed structure is indicative. Further work will be undertaken to determine the detailed design of the central functions.

Organisation Chart for Operations Central Functions



Notes

1. Includes national lead on emergency preparedness.
2. An option will be considered to combine the three deputy director roles into two.

Operations – Sector and Local Arrangements

- The vast majority of the Operations Directorate's functions will be carried out through local offices, with the support and co-ordination of the four commissioning sectors.

- To achieve economies of scale, some functions will be undertaken by small numbers of local offices on behalf of groups of the others. This will result in some variation in the size of local office teams.

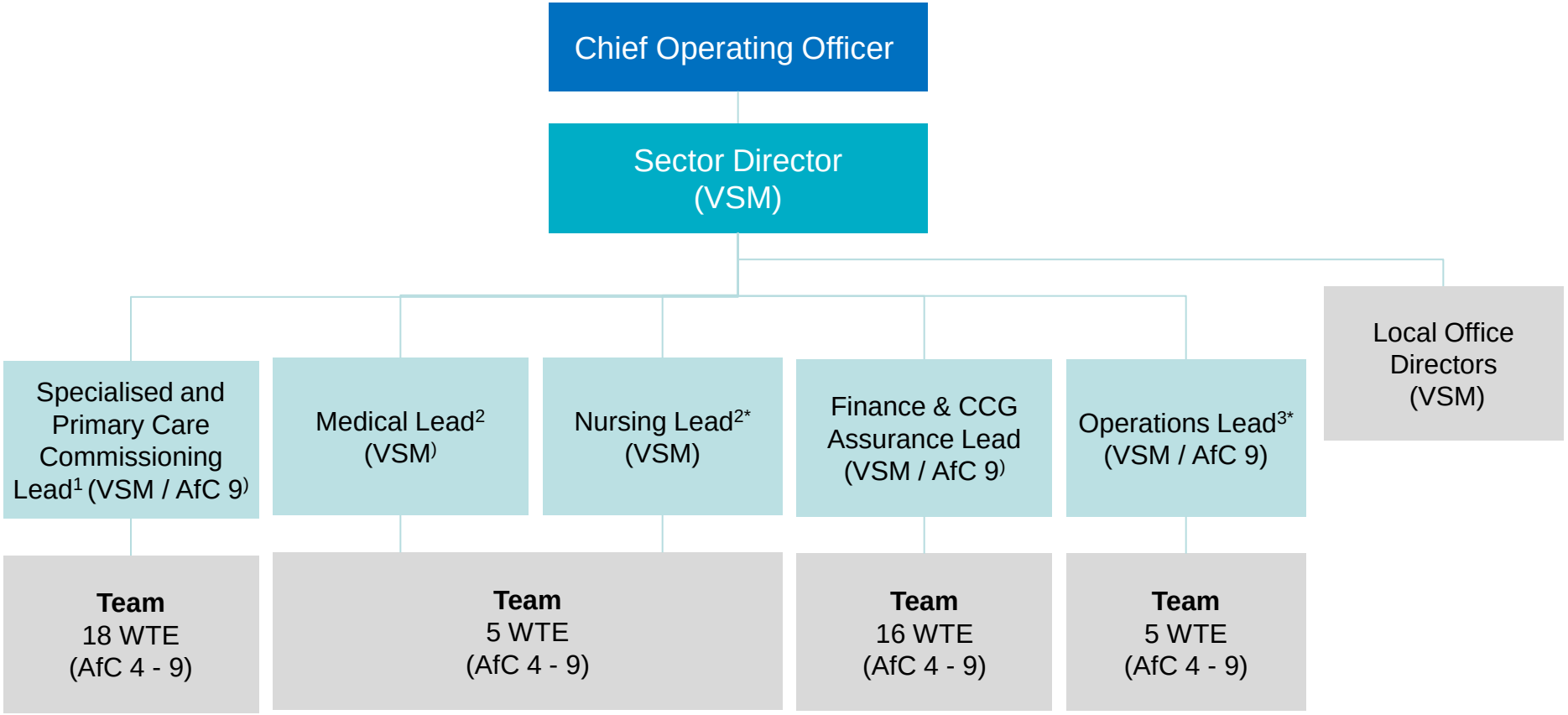
- Work is being undertaken through SHAs to confirm the locations from which the local office teams will operate.

- The Operations Directorate functions in London will be organised on a slightly different basis to the other three sectors. London will have an integrated mix of sector and local office structures, recognising the distinct pattern of services and relationships with partners and stakeholders in the capital.

Operations - Sector

Core role and purpose	The four commissioning sectors, operating as part of the central functions of the Operations Directorate, will have a very focused role, providing clinical and professional leadership at sub-national level; co-ordinating planning, operational management and emergency preparedness where a sub-national focus is required; and undertaking direct commissioning functions and processes within the single operating model.
Summary of functions	• Co-ordination and oversight of local offices • Management of delivery of specialised commissioning • Support and co-ordination of clinical senates and networks • Performance oversight, including intervention and failure regime • Involvement in large scale reconfigurations • Co-ordination and oversight of emergency preparedness • Stakeholder engagement, particularly with subnational presence of bodies such as CQC and Monitor • Information functions on behalf of PEII.
Staff numbers	200 WTE (4 units of 50 WTEs)
Costs	£12m
Options	The proposed structure is indicative. Further work will be undertaken to determine the detailed design of the sector functions.

Organisation Chart for Operations Sector Functions (excluding London)



Notes

1. This post will lead on specialised commissioning and oversee other aspects of direct commissioning
2. The Medical and Nursing leads will work closely with AHSCs on major reconfiguration issues

* Consideration should be given to combining the Nursing and Operations lead roles

3. Includes lead on emergency preparedness in line with agreed EPRR model

Operations - Local Offices

Core role and purpose	The local offices of the NHS CB will commission high quality primary care services, assess and assure the performance of CCGs and manage the Board's local partnerships and stakeholder relationships.
Summary of functions	• Managing the Board's day-to-day relations with CCGs, including providing development support, and monitoring performance and outcomes • Direct commissioning, covering offender health; military health, specialised commissioning; and primary care, including management of family health service functions • Professional and clinical leadership • Partner and stakeholder engagement, including representation on Health and Wellbeing Boards
Staff numbers	2,500 WTE (50 units of an average 50 WTEs)
Costs	£175m
Options	The proposed structure is indicative. Further work will be undertaken to determine the detailed design of the sector functions.

Variation in Local Office Structures

The structure described on the following slide represents the average resource for the 50 local offices.

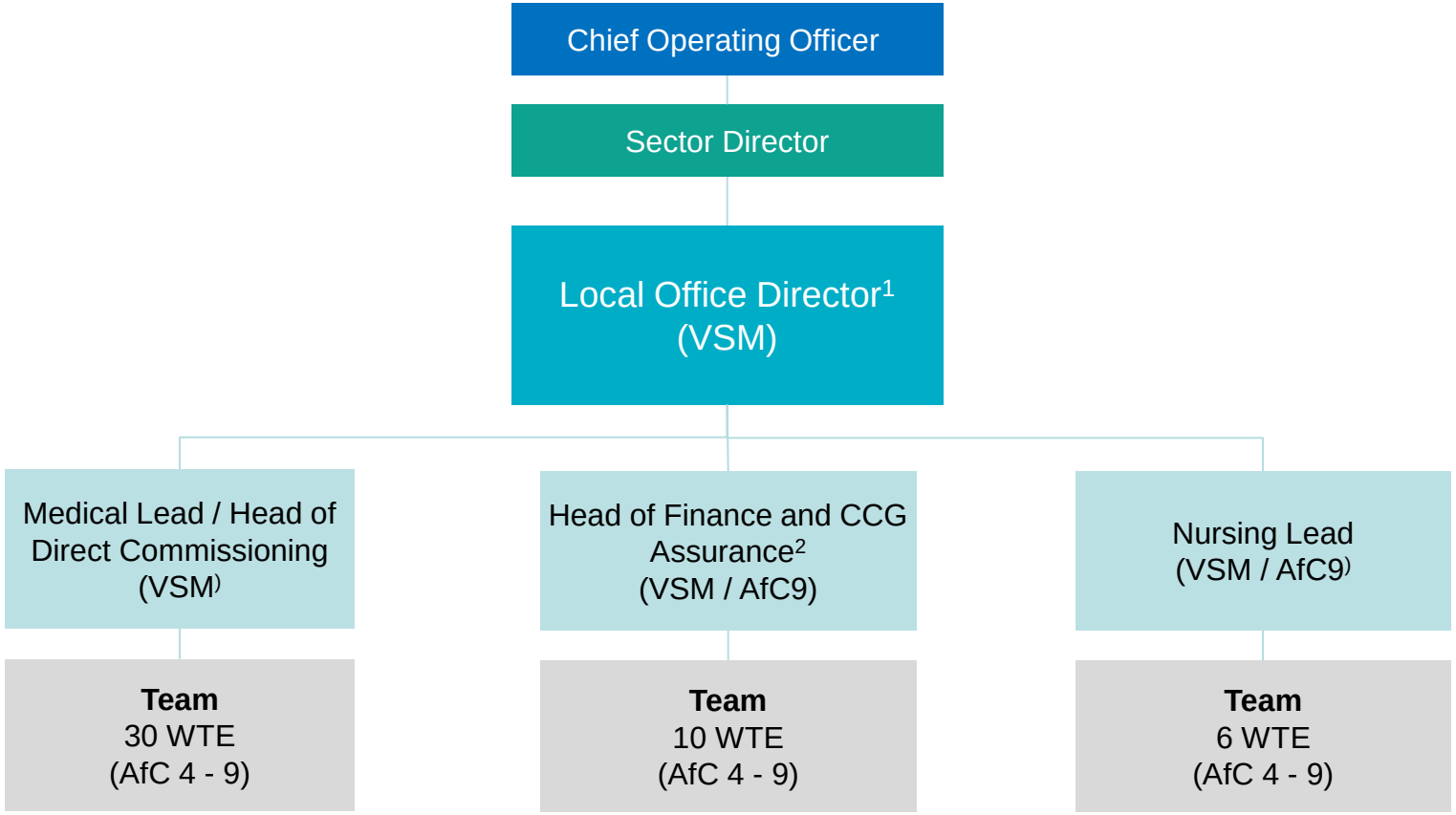
There will be scope within the overall budget of £175m for local office functions for the Chief Operating Officer to determine whether particular functions should be undertaken by small numbers of local offices on behalf of groups of the others.

These are likely to include:

- Specialised and primary care commissioning;
- Military and offender health;
- Support for clinical networks and senates; and
- Family Health Services

The distribution of the management resource between local offices will take account of these arrangements.

Organisation Chart for an average Operations Local Office Team (excluding London)



Notes

1. The Local Office Director will lead on partner and stakeholder relations, and will normally be the rep on the Health and Wellbeing Board. (Where there are a number of HWBs, the Director may delegate membership to other members of the senior team)
2. This role will require a qualified finance professional, either full-time or shared between a number of local offices, depending on the number and complexity of CCG relationships.
3. The Local Office Director may have a fourth senior post where they manage a wide range of shared functions on behalf of other local offices.

Family Health Services

- Family health services (FHS) support functions will be a responsibility of local offices and will be funded from the £175m budget available for local office running costs (on average £3.5m for each local office, plus non-pay budgets).
- The average total staff number of 50 per local office team is indicative.
- The number of staff employed in each local office involved in FHS functions will be based on a local assessment of requirements, and the grade mix affordable within the running costs envelope.
- PCT clusters will work together to ensure that an effective and affordable FHS function is developed.

Organisation Chart for Operations Functions in London

Sector Director[1]

Finance & CCG Assurance	Specialised Commissioning	Medical	Nursing	Local Operations Leads[2]
• Financial performance of CCGs • Support direct commissioning • Ensuring best use of capital resource	• Commissioning specialised services • Contract management • Commissioning high-secure forensic services	• Clinical leadership and advice on direct commissioning • Clinical senate • Responsible for leading local improvement and transformation • Clinical networks	• Clinical leadership and advice on direct commissioning • Clinical senate • Responsible for safeguarding, patient safety and patient experience	• Primary care commissioning including LPNs • Prison health • CCG development, assurance, support and intervention • Local winter planning and EPRR • Relationships with Health and Wellbeing boards

London-wide:
- Winter planning & EPRR
- Primary care commissioning processes
- Military health

Notes

1. The Operations Directorate functions in London will be an integrated mix of sector and local office structures, recognising the distinct pattern of services and relationships with partners and stakeholders in the capital. The sector will have up to 350 WTE staff.
2. The NHS in London is currently reviewing the management arrangements for its six PCT Clusters. The number of local operations teams in the NHS CB structure in London will be based on the outcome of this.
3. The sector will have an important role in overseeing major service reconfigurations. The Sector Director will decide how best to allocate this responsibility in the senior team.

Commissioning Development

Core Role and Purpose	The repository of expertise on commissioning: • Continuously identifying what an excellent commissioning system (CCGs, commissioning support, specialised, primary care and other direct commissioning and the tools, levers and enablers they use) looks like to deliver the best outcomes within the resource envelope • Developing the appropriate commissioning strategies, processes and best practices which will translate the NHS CB's overarching strategy for improving outcomes through better health services into delivery; and • Providing the overarching framework through which the capability of the commissioning system is assessed and developed.
Summary of Functions	• Strategic oversight of CCG effectiveness • Identify path for continuous improvement of CCGs, support needed and how capability is assessed • Oversee development of commissioning rules, tools, levers and guidance including COF and quality premium • Strategic oversight of commissioning support, including development of NHS units to become free standing • Translate NHS CB strategy for improving outcomes into the appropriate commissioning strategy, practices and processes for specialised, primary care and other direct commissioning, including the national primary care contracts
Staff Numbers	70 WTE
Costs	£5.5m
Additions	• There will be additional resource in commissioning support for oversight and governance from hosted units. • There will be additional resource from Public Health England (to be agreed) for public health commissioning

Commissioning Development Organisation Chart

National Director of Commissioning Development (VSM)

National Deputy Director Specialised, Primary Care and Direct Commissioning	Director CCG Support & Development (VSM)	Director Commissioning Enablers (VSM)	Director Commissioning Support (VSM)
20 WTE posts	12 WTE posts	25 WTE posts	8 WTE posts
• Specialised commissioning strategy and protocols • Primary care commissioning strategy and protocols • Prison, military and public health services commissioning strategy • Oversight of matrix working and system cohesion on integration	• Strategic oversight of CCG effectiveness, including for joint commissioning • Criteria for CCG improvement and capability • CCG development and support	• Strategic direction on commissioning guidance and tools • Commissioning rules including regulations and directions • Commissioning Outcomes Framework and Quality Premium • National primary care contracts • Standard contract	• Strategic oversight of commissioning support market • Development and support of NHS commissioning support units • Ensure business viability of NHS units to minimise risks of hosting to NHS CB • Ensure appropriate operational delivery of hosted CSUs

Improvement & Transformation

Core role and purpose	To enable and support the NHS CB to ramp up the pace and scale of change and improvement, in order to deliver better outcomes for patients and productivity across the commissioning system. To achieve this, we will develop and employ a single, evidence-based model for driving transformation and change.
Summary of functions	• Innovation and change – centred around enabling delivery of continuous quality improvements whilst driving productivity • Strategy • Leadership development • Reducing health inequalities and promoting equality (including hosting and supporting the Equality and Diversity Council)
Staff numbers	72 WTE
Costs	£5m

Improvement & Transformation Organisation Chart

Improvement Body[1]

Managing Director Transformation

NHS Leadership Academy[1]

Senior Partner Team (VSM) x4

- Oversight of core programmes: Innovation, Improvement and Change, Strategy, Leadership, Health Inequalities
- Leadership of strategic interfaces with wider NHS Commissioning Board
- Deliver large scale transformation change model
- Ensure system alignment
- Develop people, capacity and capability
- Sponsorship of Improvement Function and Leadership Academy

Senior partner team admin support (AfC 5) x 4

Associates[2] **(AfC 8c to 9) x26**
Lead portfolios of work on behalf of senior partners and ensuring delivery against fixed points

Project Managers[2] **(AfC 7 to 8b) x 29**
Implementation of fixed points and commissions for change and improvement work from other directorates

Project Support[2] **(AfC 6 and 7) x 8**
Project management support to Associates and Project Manager

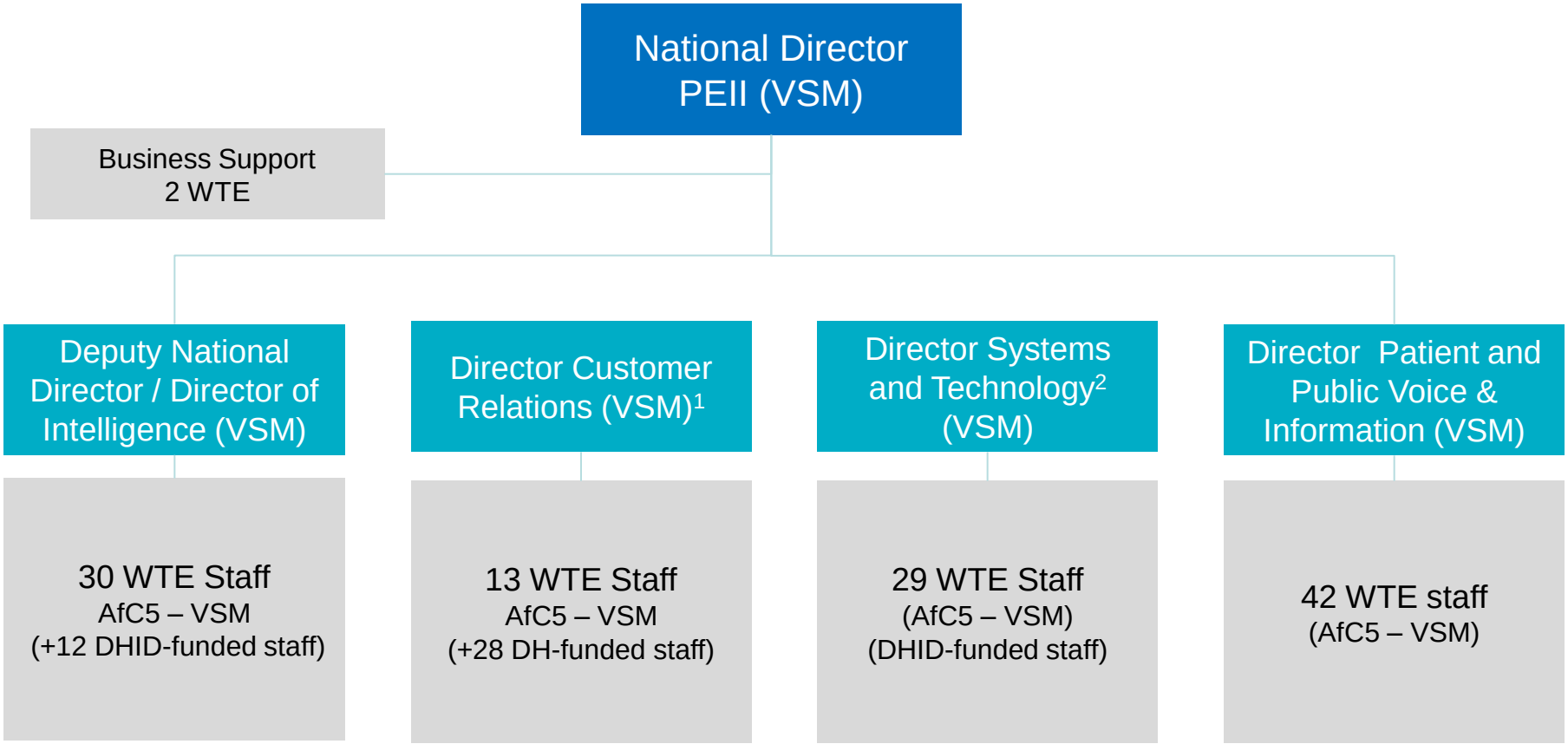
Notes

1. These bodies will be hosted by the NHS CB.
2. This is a project pool with multiple posts at each tier.

Patient Engagement, Insight & Informatics

Core role and purpose	• To shape our health service to be open, responsive and transparent and give patients, carers, public and those who serve them the information and support they need to make the best decisions and choices they can. • To transform patient experience with information and technology .
Summary of Functions	• Patient and public voice • Open data: information, intelligence and insight • Channels for choice • A patient service: communicating values • My Health – to commission programmes using info and technology to, eg, enable patient access to care records • Chief technology office
Staff numbers	• 91 WTE funded from running costs • Additional £4.8m funding expected to transfer from DH and DHID (will support an estimated additional 70 posts)
Costs	• Pay - £5.5m • Non-pay / programme costs of £34m have been identified. These have yet to be resolved
Options	• The proposal assumes the directorate will have a role in NHS brand management and marketing. These have been described as discrete functions, and agreement will be reached on whether they should sit here or with the corporate communications function.

PEII Organisation Chart



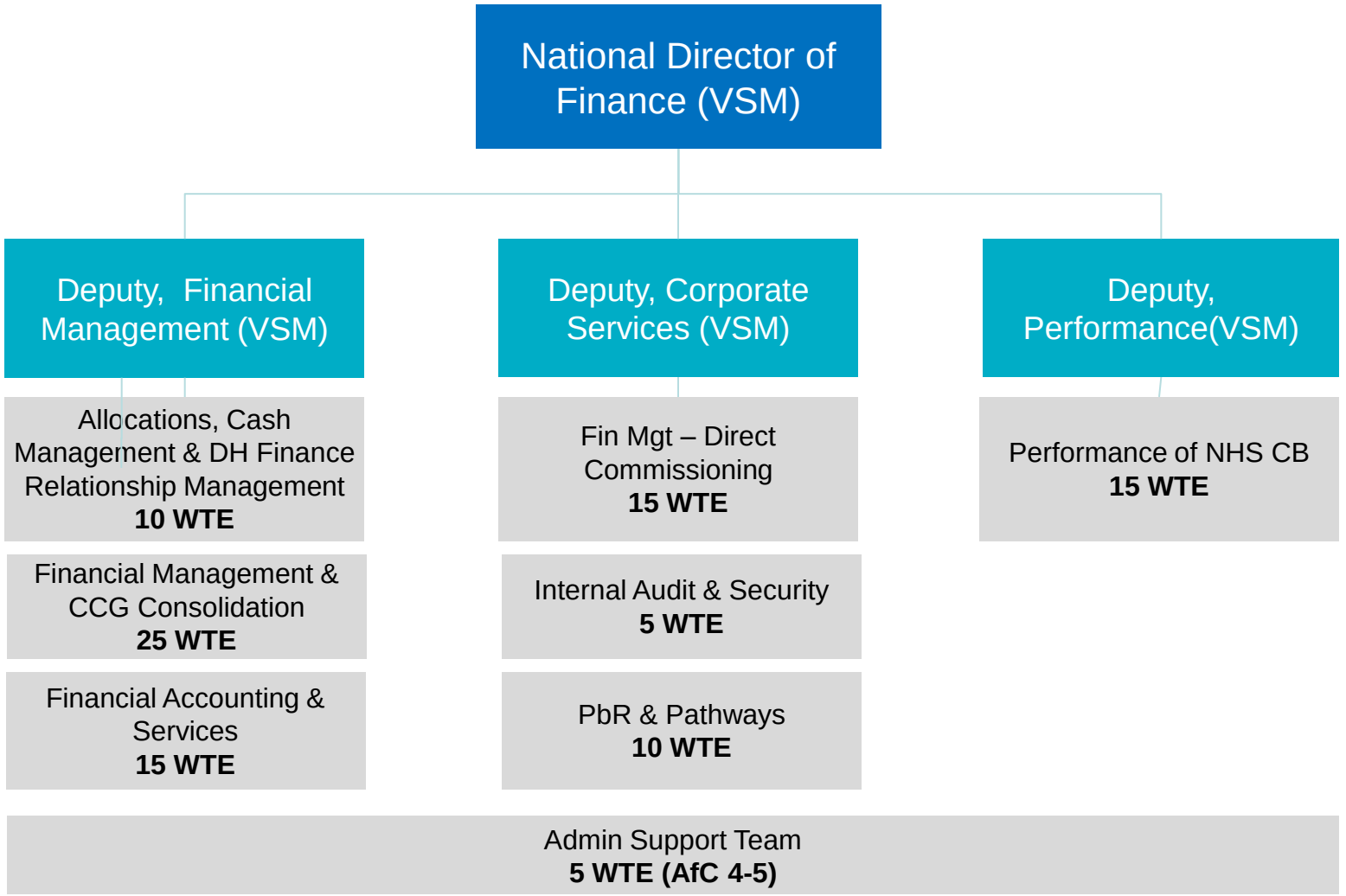
Notes

1. Agreement will be reached on whether the customer relations functions should sit in this directorate or with the corporate communications function.
2. The 30 posts in this function are DHID-funded and additional to the NHS CB running costs.

Finance

Core role and purpose	To provide financial support, financial services, and performance management to the NHS CB.
Summary of Functions	• PbR and Pathways Team • Allocations, cash management and DH finance relationship management • Financial management & CCG consolidation • Financial accounting & services • Performance management for NHSCB direct commissioning functions • National specialised services financial management and co-ordination of specialised services • Internal audit and security
Staff Numbers	104 WTE
Costs	£8.9m (including hosted corporate functions)
Options	• The proposal includes the PbR team (10.0 WTE at a cost of £0.9m). Agreement will be reached on whether this should be aligned with the Finance Directorate or with choice and competition policy in PPCD

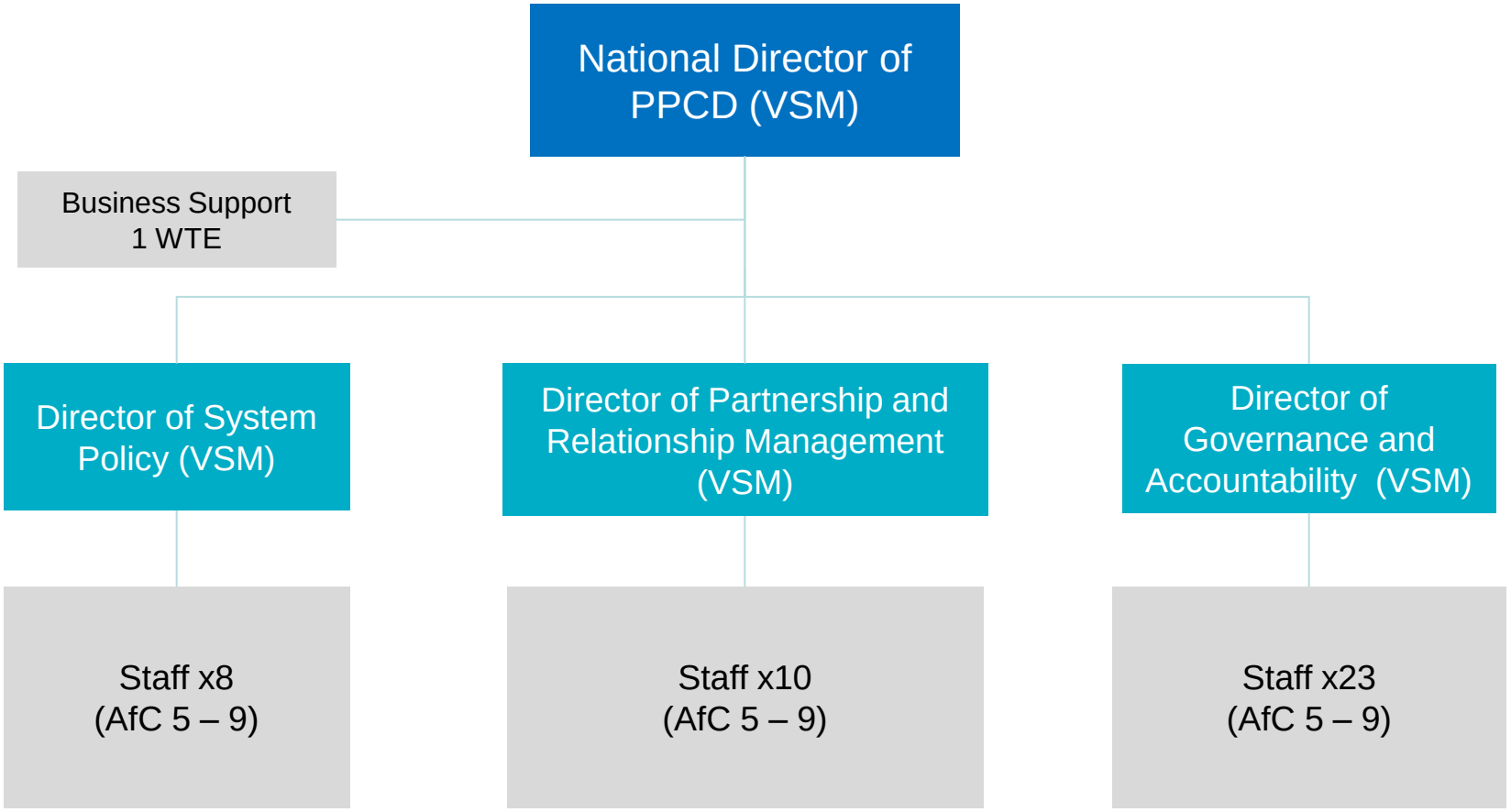
Finance Organisation Chart



Policy, Partnerships & Corporate Development

Core role and purpose	Leading on health system policy and design, managing relations with other major parts of the health system, and developing and operating the Board's business model.
Summary of functions	• System policy • Negotiating the NHS Mandate with DH • Strategic communications • Partnership and relationship management • NHS CB business model • Business management and accountabilities (including public and parliamentary accountability) • Choice and competition • Governance and programme management
Staff numbers	46 (excluding hosted corporate functions)
Costs	£3.2m (staff costs excluding corp. functions)

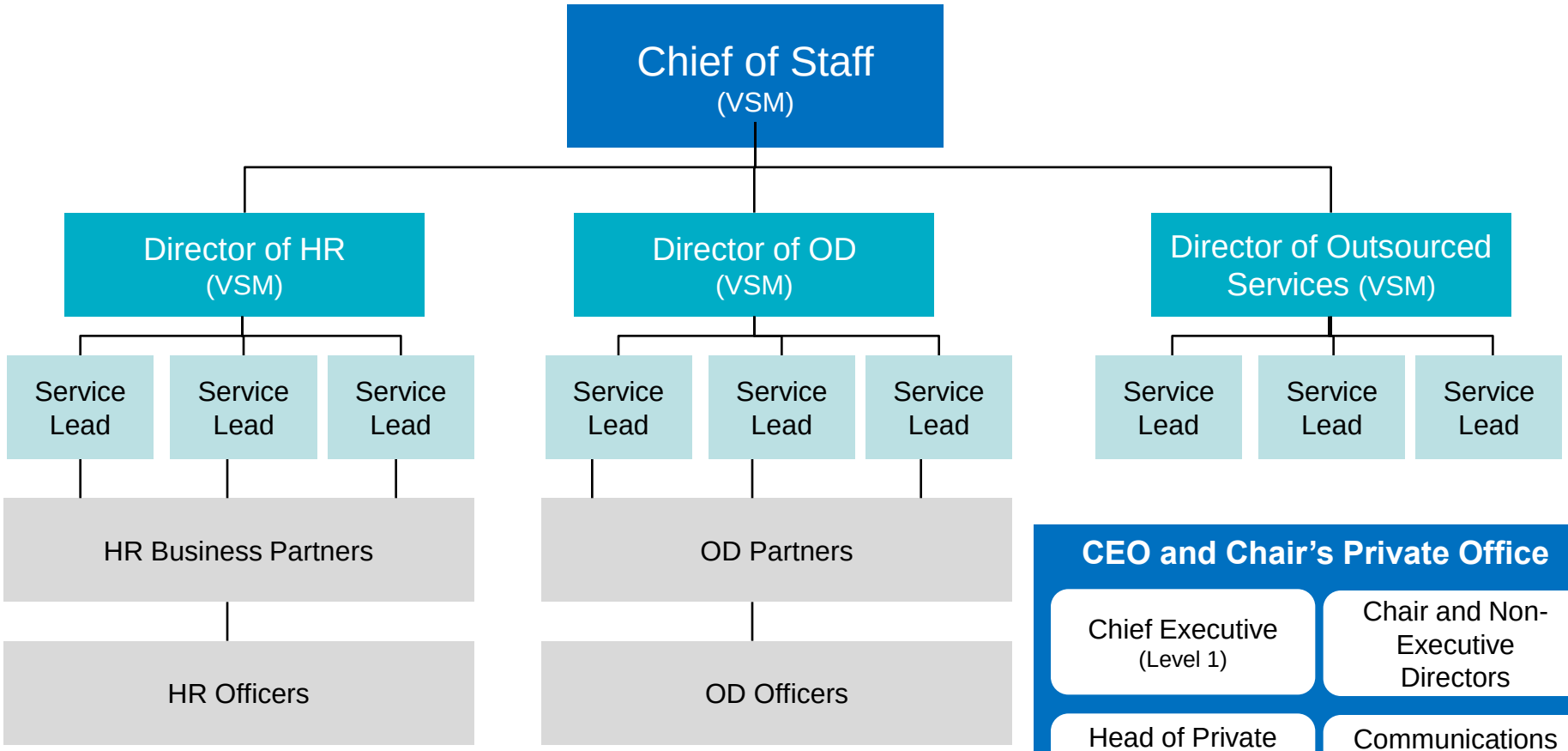
Policy, Partnerships and Corporate Development Organisation Chart



Chief of Staff

Core role and purpose	To provide HR and organisational development services to the NHS CB and to provide a private office function for the Chair and the Chief Executive.
Summary of functions	• HR transformational service • HR transactional service • Staff development • Mandatory training • Skills training • Organisation development and leadership development for employees of the NHS CB • Management support and advice to Chair and Chief Executive and non-executive directors
Staff numbers	• 48 WTE (includes 32 HR staff for corporate function not included) • In addition, the Chief Executive, Chair and non-executives are also included within this directorate.
Costs	£5.9m

Chief of Staff Organisation Chart



CEO and Chair's Private Office

- Chief Executive (Level 1)
- Chair and Non-Executive Directors
- Head of Private Office (Level 3)
- Communications Advisor (Level 3)
- Level 4
- Level 4
- Level 4
- Level 5
- Level 5

Specialised Services Commissioning

- One of the NHS CB's key direct commissioning responsibilities will be for specialised services (a nationally-defined set of high cost, low volume services currently commissioned at either national or regional level).

- Responsibility for specialised services will not sit wholly within one directorate. Rather, all parts of the Board will play an important role in the arrangements for these services, providing an exemplar for matrix working.

- Within this approach the Board will maintain a clear focus on the entire spectrum of specialised services, with a single national director taking overall responsibility for co-ordination.

- The specific functions of each directorate in relation to specialised services commissioning are set out in the following two slides.

- NB: specific transitional arrangements will be maintained for the reconfiguration of paediatric cardiac surgery.

Specialised Services Directorate Functions

Directorate	Specialised Commissioning Function
Medical and Nursing	• Clinical advice on service design, prioritisation, safety (inc safeguarding) and patient experience • Service specifications and clinical policy development • Clinical leadership of service improvement • Advice and leadership on workforce development inc professional regulation issues • Evidence appraisal • Eligibility and access criteria • Outcome frameworks • National framework for individual funding requests
PEII	• Public engagement and patient insight • Intelligence and information management • National co-ordination of services' databases and registries • Provide systems for national performance management
Commissioning Development	• Identification of best commissioning practice and processes, and any specific national commissioning strategy • Identify support to improve commissioning effectiveness • Standard national contracts, commissioning guidance and national protocols
Operations	• Delivery of all commissioning processes, budgets, contracts and contract oversight • Aggregation of local need, including Health and Wellbeing Board input • Coordination and oversight of all field force delivery and performance • Generating innovation and roll out of service improvement strategies

Directorate	Specialised Commissioning Function
Improvement & Transformation	• Co-ordination of National Specialised Services Innovation Fund • Supports the determination of the best shape and most innovative service provision including reconfiguration • Supports spread and adoption of good practice • Horizon scanning
Chief of Staff	• Leadership and OD for direct commissioning teams
Finance	• Access to procurement services • Oversight of all budgets and support to large-scale procurement • Strategic oversight of specialised commissioning budgets and prioritisation • Leadership of commercial partnerships including risk sharing
PPCD	• Parliamentary business • Agree mandate specifics on these areas • Appropriate communications • Analytical support • Legal advice • Manage and budget for judicial reviews

Corporate Functions

£48m was allocated for a set of corporate functions which will be undertaken in single teams for the NHS CB as a whole, rather than replicated in individual directorates.

It was confirmed that the HR support function (£3m) should be hosted by the Chief of Staff and the Finance support function (£2m) should be hosted by the Director of Finance. These functions have been incorporated into the relevant directorate allocations. Following further adjustments, £41.5m remains for the remaining corporate functions to be hosted by the PPCD Directorate.

The budget allocation between functions is illustrated below, with indicative staffing levels.

Function	Budget £m	WTE
Analytical support	10.5	150
Payroll	0.3	*
Legal services	5.0	*
Procurement	5.0	*
Communications	7.3	34[1]
Programme management	3.0	43
IT support	4.0	*
Held in reserve pending further work	6.4	
Total	**41.5**	**227**

Note

* These functions will be largely outsourced and not require directly employed staff.

[1] Only £2.3m of the communications allocation will be spent on 34 WTE in-house staff. £4m will go on outsourced services.

Corporate Functions

Analytical support	• Single integrated team, comprising all professions including health economists, and analytical supporting staff, professionally led by the NHS CB chief economist.
	• Staff drawn from DH, NHS and external bodies.
	• Offer a secondment model for GES, GSS and GORS to provide for career development.
	• Assume that there is a need to support:
	  • Analysis that transfers from DH;
	  • Analysis that is currently undertaken sub-nationally (PCT / SHA / Quality or Public Health Observatory), e.g. for performance or contract management purposes; and
	  • Analysis to support new functions – such as developing the mandate, authorisation and assurance of CCGs.
	• Assume this team supports all parts of the NHS CB, including sectors and local offices.
	• Resource estimated at 150 WTE, with costs of around £10.5m.

Legal services	• Initial estimates are based on payments to DH Legal Services. • This benchmark is increased to take into account additional funding streams such professional fees. • Expect this service to be outsourced.

Procurement	• Very provisional estimate made. • Potentially strong links with PEII, so some might build a generic procurement team around expertise in IT procurement.
Programme management	• Initial estimates are based on cost of DH Integrated Programme office • This benchmark is increased to take into account significant challenge in delivering matrix working and to provide for a project bank function.
IT Support	• Provisional estimate made. • Expect this service to be outsourced.
Communications	• Director of Communications will have functions around media relations, strategic communications and marketing, corporate communications, and transparency. • Resource estimated at 34 WTE, with a cost of £2.3m. • Outsourced communications support (including delivery of substantial digital communications, local media relations, FOI and briefing management, local stakeholder relations management, campaign management support and brand management) is estimated at £4m to £5m. • Further costs will be incurred in relation to advertising, publications, event hire and management, production of web content, media cuttings / evaluations and marketing research. This could vary anywhere between £4m to £10m.

Locations

- The Board's corporate base will be in Leeds and it will have a presence in London. The four sectors to be formally co-located with the central functions of the Board in Leeds and London.

- This does not mean that all sector staff will have to work from those offices. Flexible arrangements will be explored together with opportunities for working with local office and other teams.

- Work will now be undertaken through the SHAs, with PCT clusters and aspirant CCGs to confirm the locations of the 50 local offices and CSUs. The local offices will be in the areas covered by the current PCT clusters.

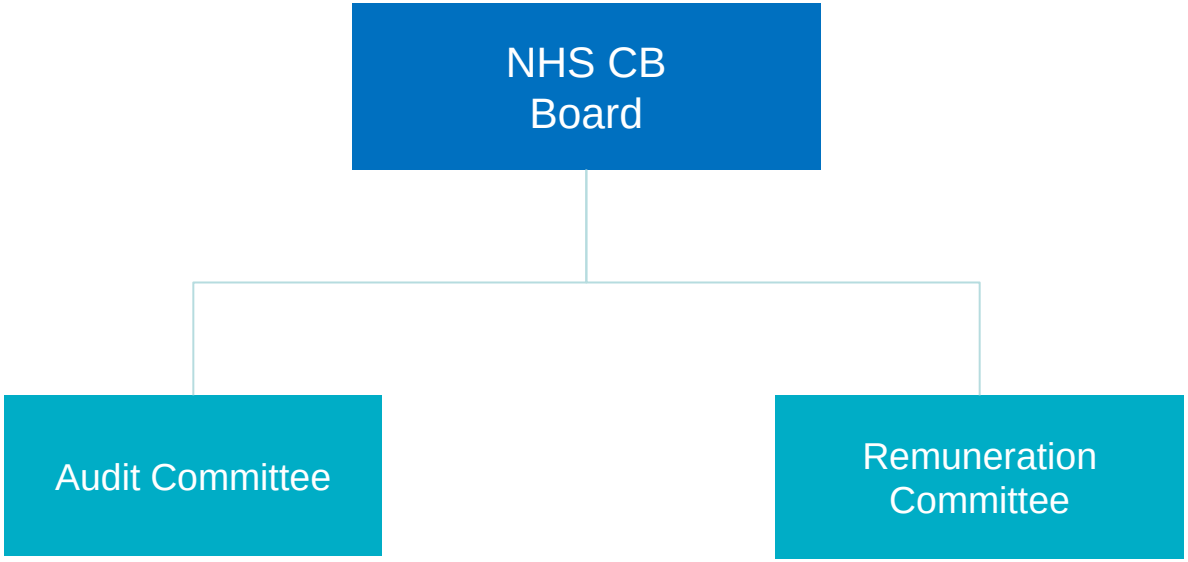
Governance of the NHS CB

The design of the NHS CB includes its corporate governance structures as well as its management arrangements.

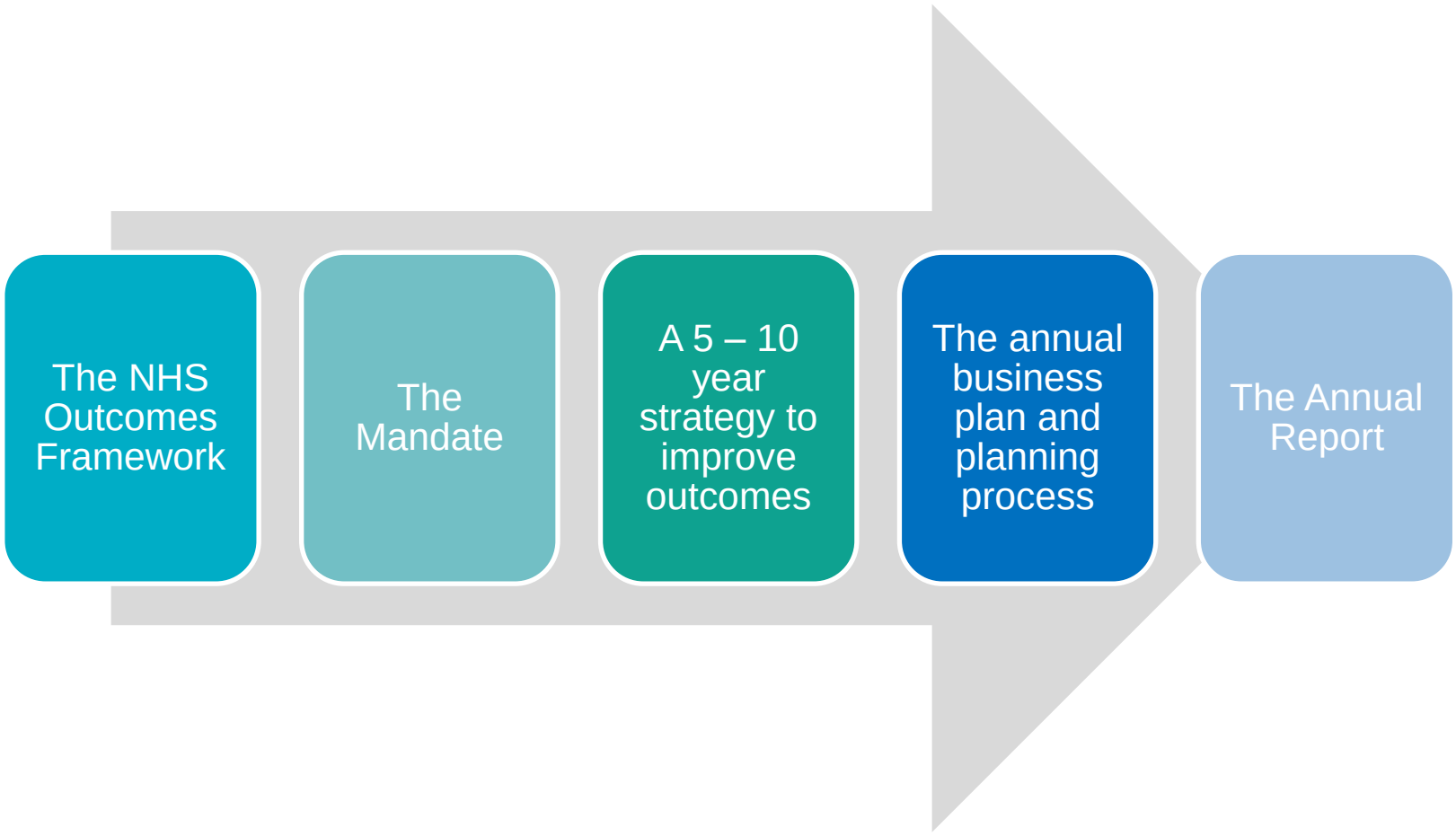
The Board will have three components to its corporate governance structure: the Board, an audit committee and a remuneration committee.

The Board's governance arrangements are set out in the following documents:

- Matters reserved to the Board;
- Ways of working (incorporating standing orders);
- Standing financial instructions; and
- Scheme of delegation.



The Board's key governance frameworks and mechanisms will include:



5. Key Issues and Risks

Risks

Key Risk	Issues	Mitigation
Resilience	• Delivery of functions with 50% less resource by 2014/15 • Capacity for specialised commissioning • Capacity for FHS functions • Potential loss of senior leaders, esp. PCT cluster CEOs	• Matrix working • Greater focus (OF domains) • OD programme • Senior pay arrangements agreed • Road-testing of proposals with CEOs • Managed voluntary exit programme
Budget Pressures	• Differences with DH about what is assumed to be included in the £492m • Pressure to take on extra functions without funding	• Contingency fund • Negotiations with DH • FDG to agree any proposed function transfers

Key Risk	Issues	Mitigation
HR and OD process	• Giving staff greater clarity about the system architecture, HR options and process • Ensuring key posts are filled to support transition	• NHS CB directorate structures agreed • JDs developed for all posts • Updated PTP • Recruitment processes under way
Delivery through transition	• Ensuring that resources, matrix working and business processes are in place to deliver key processes during transition (eg, CCG authorisation, 2013/14 planning round)	• CCG authorisation programme under way • PPCD to work with FPO in the new year to design the new planning process
Transitional pressures	• Securing the funding to maintain the existing Family Health Services requirements in advance of new contractual arrangement • Establishing new information standards and governance requirements	• Transitional funding confirmed • New requirements agreed