NHSCBA/02/2012/5

BOARD PAPER TEMPLATE - NHS COMMISSIONING BOARD AUTHORITY

Title: Designing the NHS Commissioning Board
Clearance: Bill McCarthy
Purpose of Paper: To seek the Board's approval to proposals for the organisational design of the NHS Commissioning Board (NHS CB)
Key Issues and Recommendations: The paper sets out recommendations for: • the disposition of the NHS CB's running costs from April 2013; • directorate structures and staffing, including how the NHS CB will work locally; and • matrix working to ensure that all the NHS CB's activities contribute to improving outcomes, are clinically led, and informed by the patient and public voice.
Actions Required by Board Members: To approve the recommendations.

NHS Commissioning Board Special Health Authority

Board Meeting, 2 February 2012

Designing the NHS Commissioning Board

Purpose

1. This paper sets out recommendations for the organisational design of the NHS Commissioning Board (NHS CB). It includes proposals for:

    - The disposition of the NHS CB's running costs budget from April 2013;
    - Directorate design, including how the NHS CB will work locally; and
    - Matrix working to ensure that all the NHS CB's activities contribute to improving outcomes, are clinically led and informed by the patient and public voice.

2. The proposals are set out in detail in Annex A.

Context

3. The proposals in this paper build on the vision set out last July in *Developing the NHS Commissioning Board* by Sir David Nicholson, Chief Executive of the NHS Commissioning Board Special Health Authority. The document set out initial thinking on the NHS CB's role based on the Government's proposals for the NHS. It described the NHS CB's overarching role in ensuring that the NHS delivers better outcomes for patients through its own direct commissioning function and by supporting, developing and holding to account clinical commissioning groups. Good relationships with CCGs and a range of other stakeholders will be key to this. The document set out how the NHS CB will discharge this role through: its main functions; the values and culture it will foster; its key relationships; the key processes for transacting business; and its work at sub-national and local levels, with a single operating model through sector and local teams.

4. The NHS CB will, subject to legislation, assume responsibility in April 2013 over a commissioning system that has been changing over the last year. In particular, emerging CCGs have become increasingly involved in commissioning in collaboration with existing PCT clusters. There has been a reduction in GP written referrals into the acute sector and a continued reduction in the level of emergency admissions, both of which are an indication of active GP engagement in re-shaping services.

5. Since *Developing the NHS Commissioning Board* was published, the Department of Health has confirmed the recurrent running cost budget for the NHS Commissioning Board for April 2013. Decisions by the NHS Commissioning

Board Special Health Authority on the deployment of this budget and the NHS CB's organisational design are needed now in order to:

- Enable preparatory work on the transfer of functions to the NHS CB, including early transfer of patient safety responsibilities following abolition of the National Patient Safety Agency scheduled for July 2012; and

- Support the HR processes and give staff greater clarity about potential options by February.

The NHS CB's Running Cost Budget

6. Table 1 below sets out the proposed disposition of the NHS CB's recurrent running cost budget (including staff) for 2013/14. The overall budget of £492m represents a reduction of around 50% compared to the current running cost of functions transferring to the NHS CB.

Table 1	**£m**	**Staff WTE**
Total NHSCB Budget	**492.0**	
Contingency Reserve	60.0	
Non Pay Costs	154.0	
Total Available for Allocation	**278.0**	
Medical	7.5	98
Nursing	5.0	75
Operations (local office functions)	175	2,500
Operations (inc. 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 Development	3.2	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 Allocated	**278.0**	**3,561**

7. Key points are:

   - Around 75% of the total budget will be deployed at sub-national level (mainly in the NHS CB's local offices). This reflects the expectation that many of the NHS CB's functions (eg relationships with CCGs; direct commissioning; clinical leadership; and relationships with local Government, Healthwatch and others) will need to be carried out at relatively local level;
   - The NHS CB will have an overall workforce of around 3,560 (with 2,500 in 50 local offices, 200 in the four sectors, and 860 at the centre). There are currently around 8,000 staff performing functions which will be the responsibility of the NHS CB;
   - In order to aid efficiency a number of functions will be carried out in single corporate teams (either in-house or outsourced) rather than within individual directorates, sectors or local offices. These functions include analytical services, finance support, human resources, communications and programme management support;
   - £60m of the budget has been set aside as a contingency reserve.

8. The following are not included in Table 1:

   - The running costs of clinical networks which will be a call on the contingency. Work is underway to establish the future shape and resource requirements of clinical networks. These are currently largely funded out of programme expenditure and we expect the same to be the case in future;

   - The running cost of Commissioning Support Units, which are expected to be hosted by the NHS CB as an interim arrangement. Funding for this will be from the running cost provision for CCG support.

Organisational Structure

9. The proposed organisational structure for the NHS CB is set out in Annex A. It is designed above all to support the NHS CB in its overarching role to improve health outcomes. The NHS CB will need a relatively complex structure to achieve this aim because it needs to address a number of issues:

   - Ensure that a focus on health outcomes and clinical leadership is "hard-wired" into every aspect of the NHS CB's work: The NHS CB will be organised nationally around the five outcome domains of the *NHS Outcomes Framework*. There will be national professional leads for each of the five outcome areas reporting to a Medical Director and Nursing Director. The Medical and Nursing Directors will have explicitly to sign off all the NHS CB's process and products to ensure the contribute to improving health outcomes;

- Ensure that there are supporting functions with strong leadership to aid the achievement of better outcomes: To achieve this it is proposed that supporting functions will be organised under national directors for Finance; Chief Operating Officer; Commissioning Development; Patient Engagement, Insight and Informatics; Improvement and Transformation; Policy, Partnerships and Corporate Development; and Chief of Staff;

- Ensure that the NHS CB is able to deliver the breadth of its responsibilities across geographical areas below national level: While the NHS CB will be a single national organisation with a single operating model, many of its functions will need to be carried out at a more local level. These functions include: supporting the development of CCGs and assessing their performance; direct commissioning; clinical leadership and links with local clinical networks; and managing relationships with local stakeholders, including local government and HealthWatch. In the proposed structure, the delivery of these functions sub-nationally will be done through the NHS CB's local offices and sectors which will be part of the Chief Operating Officer's Directorate.

- Ensure there is capacity and resilience to manage a complex and challenging set of changes across the NHS: Whilst new NHS commissioning structures will be in place by April 2013, there will be a major role for the NHS CB beyond this date to ensure the changes are embedded successfully. One of the reasons we are proposing 50 local offices is to help manage the transition to the new system.

10. The new structure is designed to enhance the delivery of improvement and transformation; and patient and public engagement:

- Improvement and transformation: The NHS CB will need to up the pace and scale of change and improvement, in order to deliver better outcomes for patients and achieve greater productivity. The National Director for Improvement and Transformation will apply a single evidenced-based model for drive change and improvement in support of the wider commissioning system;

- Patient Engagement: The NHS CB will need to act as a champion for patients and their interests. This will be supported by the creation of a National Director for Patient Engagement, Insight and Informatics. This portfolio will include engaging with patients, the public and carers; ensuring the NHS CB has the best insight into their views and needs. It will also cover the extension

of choice, the provision of information and the use of informatics in service improvement.

11. Further detail on the role, structure and resourcing of the proposed nine directorates (including the sectors and local offices) is set out in Annex A.

Matrix Working in the NHS CB

12. Delivery of the NHS CB's wide-ranging and complex functions will need to be supported by new ways of working for three reasons:

- To provide simplicity for the NHS. It will be the role of the NHS CB to clarify and simplify on behalf of the commissioning system. Matrix working will be needed to achieve this;

- To aid efficiency. The NHS CB's running costs will be 50% lower in real terms than the current baseline. This will require streamlined, unduplicated, collaborative working practices;

- To ensure singularity of approach. The NHS CB will need a "one team", no silos culture.

13. Annex A sets out a proposed model of matrix working for the NHS CB. The aim is to ensure that all the NHS CB's go through a process which tests that they:

- Contribute to improving health outcomes;
- Have been clinically-led;
- Promote equality and support a reduction in health inequalities;
- Are informed by the patient and public voice; and
- Support innovation.

14. Subject to the Board's views, it is proposed to further develop and implement matrix working arrangements in three ways:

- Developing more detailed matrix governance arrangements for all the Board's core business processes;

- Working with external stakeholders to ensure that strong relationships and partnership agreements are in place to ensure their effective engagement in the NHS CB's business processes; and

- Putting matrix working at the heart of the NHS CB's organisational development programme.

Specialised Services

15. One of the NHS CB's key direct commissioning responsibilities will be for specialised services. Matrix working will be key to the effective commissioning of these services. The Chief Operating Officer's directorate will be responsible for commissioning specialised services. But all Directorates will have an important contribution to provide effective clinical advice, patient and public insight and so on. And there will be a particular onus on the NHS CB to engage with knowledgeable patient groups, clinical networks and others as part of this.

Next Steps

16. Subject to the Board's views on the proposals for NHS CB organisational design, the proposed next steps are:

- HR Process: The proposals for the structure and staffing of the NHS CB will affect staff in PCTs, SHAs, DH and several arms-length bodies. A decision on the NHS CB structure is needed now in order to give further guidance to staff on HR options in February and to inform the development of the Phase 2 People Transition Policy and recruitment strategy;

- Partner Engagement: The development of the NHS CB organisational design proposals has been informed by discussions with a range of stakeholders. Work is now needed to engage partner organisations in the further design of the NHS CB's business processes and priorities;

- Local Offices and sectors: Leeds and London will be the corporate bases for the NHS CB centre and sectors. (This does not necessarily mean that all sector staff will have to work from those offices. Flexible arrangements will be explored, including some sector staff working from local offices). SHAs will undertake further work with PCT clusters and aspirant CCGs to make recommendations to the Board on the location of local offices and CSUs.

17. Inevitably for a change programme of this scale, a number of risks have been identified. Progress has been made to mitigate a number of these, and others will continue to be managed through the ongoing implementation process

Decision for the Board

18. The Board is asked to agree the recommendations for:

- The disposition of the NHS CB's running cost budget;
- The directorate structures and staffing;
- The model of matrix working as the basis for further work.