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Paper NHSCBA/31/05/12/3

BOARD PAPER - NHS COMMISSIONING BOARD AUTHORITY (NHS CBA)

Title: Design of the NHS Commissioning Board's Operations Directorate
Clearance: Ian Dalton, Chief Operating Officer and Deputy Chief Executive
Purpose of Paper: • This paper updates the Board on progress with the operating model and shape of the Operations Directorate. It explains the rationale for the revisions and refinements to the design of the Directorate since the NHS Commissioning Board Authority (NHS CBA) Board meeting in February 2012. • The paper also explains the approach myself and the four recently appointed Regional Directors are taking throughout May to engage with SHA and PCT cluster colleagues, clinical commissioning group (CCG), clinical leaders and local government partners to co-produce the final design of the Operations Directorate's local area teams.

Key Issues for the Board to be aware of:

- Our thinking on the operating model for the NHS Commissioning Board's (NHS CB)Operations Directorate has developed over the past three months, based on the principles and approach set out in *'Designing the NHS Commissioning Board'* in February 2012.

- The proposed operating model, with significantly fewer local area teams, will help to ensure that the Directorate locally does not risk 'constraining CCGs' autonomy' while at the same time ensuring CCGs are appropriately supported and held to account for the commissioning outcomes the mandate, the Outcomes Frameworks and the NHS Constitution will require of them and of the Board through its direct commissioning and system leadership responsibilities.

- I also believe it will create an attractive career structure for senior NHS leaders from a wide range of generalist and specialist skills and backgrounds.

Recommendations and actions required by Board Members:

- To note the progress with, and refinements to, the design of the Operations Directorate over the past three months since the Board's discussion on the design of the CB's role, functions and form in February 2012.

- To support the approach to co-producing the final design of the Operations Directorate, led by myself and my four Regional Directors working with SHA colleagues, PCT cluster chief executives, CCG leaders and local government colleagues.

- To agree the next steps so we can get out to advert by early June for the key leadership roles at VSM level in the national support centre, the four regions and the director posts of the local area teams.

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DESIGN OF THE COMMISSIONING BOARD'S OPERATIONS DIRECTORATE

Introduction

1. This paper updates the Board on progress with the operating model and shape of the Operations Directorate. It explains the rationale for the revisions and refinements to the design of the Directorate since the NHS CBA Board meeting in February 2012.

2. The paper also sets out the approach that I, and the four recently appointed Regional Directors, are taking during May to engage with SHA and PCT cluster colleagues, CCG clinical leaders and local government partners to co-produce the final design of the Operations Directorate's local area teams.

Background: where we were

3. The document "Designing the NHS Commissioning Board" (February 2012) was endorsed at the Board meeting in February following the presentation of a draft of the document to PCT cluster chief executives (CE's) at the national conference on 25 January 2012.

4. This set out the design principles, values and behaviours of the NHS CB and provided initial running costs and illustrative structures for the nine directorates of the organisation, consistent with the outcome of discussions with Her Majesty's Treasury (HMT) and the Department of Health (DH).

5. The Operations Directorate was described as a single, integrated team of leaders working together across one corporate team, four sector teams and 50 local office teams, with workforce across the directorate (excluding Family Health Services) transactional services staff of around 2,700 staff. The point was made strongly, however, that the 'fixed point' was the running cost budgets and not the headcount numbers.

6. The document also presented an indicative structure for the four sectors and 50 local offices, consisting of a local office director and three main direct reports, namely a medical director, nurse director and a chief finance officer to oversee the delivery of the NHS CB's direct commissioning responsibilities; support and assure CCG performance; and play a full part in partnership working with local authorities through Health and Wellbeing Boards.

7. It also acknowledged that a bespoke regional and local structure might be needed across London, reflecting the particular population needs and service challenges of the capital as part of the single national operating model and leadership team of the Directorate.

Current position: where we are now

8. Over the past three months, the initial design proposal has been further developed and refined, reflecting:

    - discussions internally with design leads and fellow National Directors of the NHS CB;

    - further dialogue with the DH, CCG leaders, SHA and PCT cluster colleagues, local government leaders and other key partners (for example, Public Health England (PHE), the NHS Trust Development Authority (NTDA), Care Quality Commission (CQC) and Monitor);

    - further analysis of the optimal scale of the NHS CB's direct commissioning responsibilities around primary care, specialised commissioning, military health commissioning, offender health commissioning and those areas of public health commissioning to be discharged by the NHS CB on behalf of PHE; and

    - the leadership pool available to fill these senior leadership posts at both regional and local area level to ensure the NHS CB's Operations Directorate is credible, effective and influential with CCGs, local amenities, primary care, secondary care and specialist providers.

9. The following revisions to the Operations Directorate's operating model are proposed as a result:

    - revised nomenclature: from ‘sectors’ to ‘regions’ and from ‘local offices’ to ‘local area teams’, the latter to recognise the fact that the Operations Directorate's local staff are likely to operate from a multitude of office bases, just as PCT and SHA cluster staff do now rather than from a set number of locations;

    - a refined local structure: from the initial shape mirroring SHA and PCT clusters, to the same number of regions but combined with a significant reduction from the originally proposed 50 local offices to a smaller number of local area teams; with less local director posts but the addition of general management direct reports (for example, around commissioning and/or operations); as well as specialist direct reports, such as medical, nursing and financial leaders, in recognition of the greater geographical span of each area team and the scale of the direct commissioning and system leadership task;

- a refined local area internal structure: operating within the agreed running costs envelope for the Directorate, with each team having the same core functions around CCG development and assurance; Emergency Planning Resilience and Response; the strategic assurance of quality and patient safety locally; partnerships; service transformation and configuration and oversight of the local NHS and care system, but with variations in the scope of their direct commissioning responsibilities as indicated in '*Designing the NHS Commissioning Board'*; and

- it is proposed that the circa £22bn of direct commissioning responsibilities of the Board are discharged through:

    - all local area teams taking on direct commissioning responsibilities for GP services, dental services and pharmacy services;

    - around one third of local area teams leading on specialised commissioning across England to reflect patient flows and the efficient and effective deployment of specialist commissioning skills nationally;

    - a smaller number of local area teams carrying out the direct commissioning of optometric services, military health services and offender health services with regional colleagues; and

    - the commissioning of NHS public health services and interventions, where the detail has still to be finalised, with some most likely commissioned on a larger geography than individual local area teams (for example, screening programmes) and other possibly at individual local area team level (for example, public health services for the under 5s).

Next steps: co-producing the detailed directorate build

10. As Board members will be aware, we presented our revised ideas for the form of the Operations Directorate to SHA and PCT cluster CE's at their national conference on 27th April. Sir David Nicholson agreed to ensure that they, along with CCG leaders, local authority colleagues and other key partners were involved in "locking down" the organisational form of the regions and local area teams during the rest of May 2012. (See the slides used on the 27th April at Annex A.)

11. As promised at the cluster CEs' conference, I then wrote out to PCT cluster CEs on 30th April to indicate how myself and the four Regional Directors who were appointed on 4th May 2012, would be involving them in the detailed design of the Directorate, and in particular the function and form of the local area teams (see letter of 30th April 2012 at Annex B).

12. I will update the Board on the outcome of these discussions at the Board meeting. This will include the proposed responsibilities, number and shape of the local area teams and the work progressing in parallel to firm up the job descriptions and person specifications for the very senior manager (VSM) posts in the Directorate which will include the two corporate direct reports in the structure to complete the corporate leadership team of the directorate, plus the direct reports to the four Regional Directors, including the local area team directors.

13. With the Board's support, we are aiming to go out to advert for these posts in early June 2012 so that the detailed design of the corporate team, regions and local area teams (including their geographies) can progress apace.

Conclusion

14. Our thinking on the operating model for the NHS CB's Operations Directorate has developed over the past three months, based on the principles and approach set out in *'Designing the NHS Commissioning Board'* in February 2012.

15. I believe that the proposed operating model will work and should command the support of key national and local stakeholders. In particular, it should help to ensure that local area teams do not risk 'constraining CCGs' autonomy'.

16. At the same time, it should ensure CCGs are appropriately supported and held to account for the commissioning outcomes the mandate, the Outcomes Frameworks and the NHS Constitution will require of them and of the Board through its direct commissioning and system leadership responsibilities.

17. I also believe it will create an attractive career structure for senior NHS leaders from a wide range of generalist and specialist skills and backgrounds.

Recommendations

18. The Board is asked to:

- note the progress with and refinements made to, the operating model and shape of the Operations Directorate over the past three months since the Board's discussion on the design of the NHS CB's role, functions and form in February 2012;

- support the approach to co-producing the final design of the Operations Directorate, led by myself and my four Regional Directors working with SHA colleagues, PCT cluster CEs, CCG leaders and local government colleagues; and

- agree the next steps so we can go out to advert by early June 2012 for the key leadership roles at VSM level in the national support centre, the four regions and the director posts of the local area teams.

Ian Dalton
Chief Operating Officer and Deputy Chief Executive
15th May 2012

Annex A

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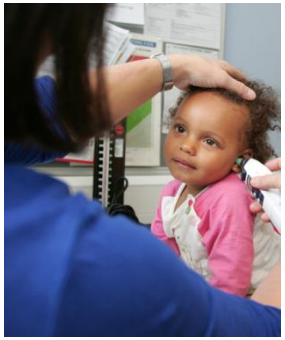
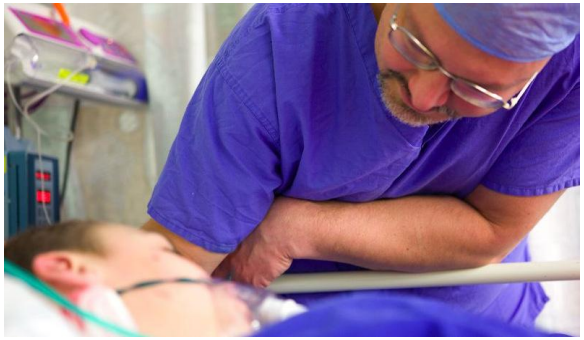
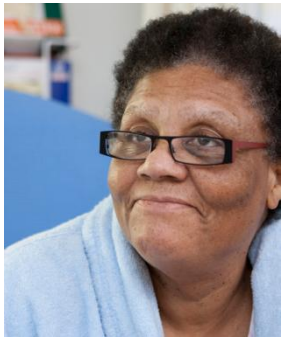
Design of the Board's Operations Directorate







Ian Dalton,
Chief Operating Officer
27th April 2012

THE NHS CONSTITUTION
the NHS belongs to us all

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Operations Directorate

What I'd like to share with you today:

- Purpose of the Directorate and its leadership task
- Design of the Regions and Local Areas
- Issues where I would like your input
- Next steps with the Directorate build

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Purpose of the Directorate

- The aim of the Commissioning Board is to improve outcomes for patients across England. To do this it will have to engage effectively with both national and local partners
- The key purpose of the Operations Directorate is to be the Commissioning Board's interface with the NHS, Local Government and other key local stakeholders
- Our structure needs to enable this - to achieve a national span with real local reach
- A "single conversation" through local area teams will be the means to achieve all of the above

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Leadership across the Directorate

To make this happen, the Commissioning Board, including its Operations Directorate, will need:

- To create an integrated leadership team of very senior NHS professionals from a wide range of leadership skills, backgrounds and breadth of experiences.
- To facilitate the “Single Conversation”, the directorate will need;
  - Leaders working as a single team corporately, regionally and locally with the skills to carry off the whole conversation; building a coalition locally to make sense of national strategy with partners.
  - People with breadth, judgement and the ability to flex their leadership styles, who are comfortable working with ambiguity and capable of working across the system nationally, regionally and locally

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Leadership Responsibilities

A Commissioning Board whose Operations Directorate has the confidence and strategic capability to:

- Support and assure CCGs' commissioning
- Participate fully in local Health and Well Being Boards
- Support the delivery of national strategies and objectives
- Support and assure the delivery of QIPP and service transformation
- Assure quality, safety and patient experience and coordinate emergency planning, resilience and response…

…nationally, regionally and locally

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Design of the Regions and Local Areas

What we said at Weetwood Hall in January 2012:

- Single corporate leadership team, operating across England
- 1: 4: 50, with matrix working across all Directorates
- Senior Medical, Nursing and Finance posts in each
- Broadly consistent shape and size of each local office/area

How has our thinking evolved?

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Drivers influencing our thinking

Emerging issues since January have included:

- Outcomes of discussions across the CBA with other Directorates
- Further dialogue with a range of CCG leaders, SHA and PCT cluster colleagues, as well as other key stakeholders
- Further analysis of the optimal scale of the CB's direct commissioning responsibilities
- Simultaneously making the best use of the available talent, creating big enough leadership teams to manage the 'single conversation' without constraining CCG freedoms
- The number of CCGs has reduced and as a result the geography they will serve has increased

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Implications for the Design (1)

Not all local area teams will necessarily look the same, for example:

- Specialised commissioning is likely to be led from between 10 and 12 local areas.
- We need to understand how best to deploy available talent to ensure national reach
- There may be a need for very senior Generalists as well as Medical, Nursing and Finance specialists
- The structure needs to accommodate multidisciplinary teams capable of creating effective relationships with HWBs, CCGs, GPs, providers and other key partnerships e.g LRFs.

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Implications for the Design (2)

This is where I'd like your help to fine tune the design

In Groups I'd like you to consider what the key issues are that you believe we should pay particular attention to over the next few weeks, working through the Regional Directors once appointed next Friday to get this right for the Commissioning Board, for the NHS, and for the patients and public of England.

For example:

- What is the appropriate number of CCGs that a local area team should work with?
- Should all local areas commission the full range of Primary Care Services?
- What should be the ratio of local areas to HWBs?
- At what geography are we best to commission Public Health services?
- How can we use talent flexibly across geographies while ensuring a local focus?
- How much flexibility should there, therefore, be in the design of the Local Area leadership teams?

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Next steps

The timetable for the Directorate build is expected now to be:

- Regional Director posts were advertised on 16 April with interviews to be held on 4 May
- The detailed design of the Directorate should be 'locked down' by end of May
- With RDs, structures, senior roles and job descriptions for senior leadership posts in the regions and local areas will be developed during May and early June
- We anticipate Local Area Team Directors to be in post by July at the latest

We are committed to working with you in the coming weeks to ensure we get this right. Thank you.

Annex B

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ID/JS

30 April 2012

To: **PCT Cluster CEOs**
Cc: **NHSCB National Directors**
SHA Cluster CEOs

Dear Colleague

NHSCB Local Area Teams: Composition and Geographical Coverage

I am writing to follow up our helpful session on this last Friday.

As we discussed, things have moved on since our session at Weetwood Hall three months ago when we considered 50 NHS Commissioning Board (NHS CB) local offices with boundaries replicating the current PCT Clusters.

Since then, CCGs have continued to develop and we now expect to have fewer CCGs serving larger populations than we had anticipated at that time. It is important that we have a number of local area teams that gives CCGs real space and head room to take the local lead. Thinking on the delivery of the Board's responsibilities for direct commissioning has also evolved and given us better understanding of how these should be distributed across our geography.

We now need to move ahead and agree the number of NHS CB Local Area Teams and the geographies that they will serve. I am keen to use your local knowledge to help us with this important and urgent task.

There is no single, ideal model or geographical footprint for a Local Area Team. The design must take account of related local geographies, service patterns and relationships to develop a resilient and realistic solution that will establish the definitive local presence of the NHS Commissioning Board. Some of the salient design issues are listed below:

Commissioning responsibilities
The NHS CB will have direct commissioning responsibilities for a significant (and varied) portfolio of NHS and public health services. These will necessarily have a shaping impact upon the design of the national network of Local Area Teams. As discussed last Friday, it is likely that the Board will decide to concentrate specialist commissioning into hubs within a number of Local Area Teams that make sense based upon patient flows. Likewise not all Local Area Teams may be expected to commission the full range of public health services or care for military personnel and their families or offenders.

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Ian Dalton CBE
Chief Operating Officer

Managing local relationships
The Local Area Team geography must take account of the number of relationships it will need to maintain. We will therefore need to identify and test the manageability of the number of relationships that would be included in the proposed final form.

The Local Area Team will need to take account of the set of complexities and boundaries of its clinical commissioning groups (CCGs) and consider carefully the ratio of CCGs per Local Area Team. I do not expect to set a definitive rule on how many CCGs should relate to any Local Area Team but will want to be convinced that the number is neither too high to enable strong relations to be built between senior leaders or so low as to create any sense that the Board is 'crowding out' the legitimate role of the CCG. Although I want to take local circumstances into account prior to reaching any decisions, current thinking is that each Local Area Team should relate to a minimum of three CCGs.

We will need to take into account the interface with local government when signing off geographies. It is a given that the Board must have a senior representative on every Health and Wellbeing Board and I will therefore want evidence that we will be able to discharge our role effectively across the geography of each local authority served by a Local Area Team.

Other key relationships that warrant consideration relate to the Local Area Team's relationships with providers (both primary care - general practice, optometry, pharmacy and dentistry - and secondary care).

Related local footprints
Local Area Team geographies will need to demonstrate their relationship to the pattern of other local footprints. Key examples include clinical networks and senates and to Local Resilience Forums/Local Health Resilience Partnerships.

We now need to move rapidly in order to deliver a sensible network of CB Local Area Teams. It has been agreed that proposals should be put to the May meeting of the NHS Commissioning Board in order that they can be used as the basis on making appointments to senior posts in Local Area Teams shortly thereafter.

I expect to be appointing the four Regional Directors later this week. I will then be asking the four appointees to rapidly meet with both you and the relevant SHA Cluster CEO in order to prepare a proposal that identifies the optimal geographies of Local Area Offices within their region.

Yours sincerely

Ian Dalton CBE
Chief Operating Officer and Deputy Chief Executive