NHS
Commissioning Board

NHSCB8/11/12/1

BOARD PAPER - NHS COMMISSIONING BOARD

Title: NHS Commissioning Board programme status

Clearance: Bill McCarthy, National Director: Policy

Purpose of Paper:

- To inform the Board of progress made in delivery of the NHS Commissioning Board establishment programme.

Key Issues and Recommendations:

- The report provides a progress update covering the period between 31 August 2012 and 23 October 2012.
- Also set out are the strategic risks in the form of the board assurance framework at **annex A**.

Actions Required by Board Members:

- To note current progress with delivery of the establishment programme.
- To note the latest iteration of the board assurance framework and plans for further development of this.

NHS Commissioning Board programme status

Summary

1. This paper provides an update on the establishment programme of the NHS Commissioning Board (NHS CB). Monitoring this programme – its development and implementation – provides a mechanism for assuring the Board that the work underway is building an excellent organisation. One that is lean and light, defies organisational boundaries, and is an exemplar in customer focus, professionalism, rigour and creativity – all leading to a positive impact on patient outcomes and the public. The programme update illustrates the NHS CB's commitment to its responsibility for ensuring the improvement of outcomes for all patients. In support of the update, the board assurance framework (BAF) is attached showing the mapping of critical success factors and strategic risks identified with the establishment programme.

Background

2. The NHS CB establishment programme is focused on setting up the new NHS CB, in line with its overarching objective of improving outcomes for patients, and making sure it is operational by April 2013.

3. In keeping with the open approach the new NHS CB wishes to work by, at the Board meeting on 13 April 2012 a commitment was made to provide a programme update to every meeting of the Board. The programme update is designed to provide assurance regarding delivery and to help enable the Board to manage progress. This is the latest of those updates.

Programme update

4. The NHS CB establishment programme continues to make good progress, continually striving to embed the qualities of clinical leadership, patient and public voice, equality and health inequalities, innovation, and improved outcomes for all. This is checked and monitored regularly to make sure momentum is kept up and that resources are directed to priority areas of work. Highlights of recent progress are outlined below.

Legal establishment and sponsor relations:

5. The establishment of the NHS CB and dis-establishment of the NHS Commissioning Board Authority (NHS CBA) took place on 1 October as planned, following which a full suite of governance documents was adopted by the NHS CB Board.

6. The Government's consultation on the mandate *Developing Our NHS Care Objectives: a draft mandate to the NHS Commissioning Board* setting out 22 objectives for the delivery of NHS care by the NHS CB, closed on 26 September. The NHS CBA published its response to the consultation via the website on 25 September and continues to work closely with the Department of Health (DH) and other partners over the coming weeks to finalise the draft.

People transition and recruitment:

7. Agreement has been reached with trade unions to streamline elements of the recruitment process which will ensure priority is still given to those health service employees at risk but will aid in speeding up the recruitment process.

8. The NHS CB has made several more announcements of key appointments at the national support centre, and regional and local area teams. Among these, Paula Vasco-Knight has been appointed as the National Equalities Lead, Professor Steve Field as the Deputy National Medical Director (Health Inequalities), and Richard Murray as the Chief Analyst.

Commissioning development:

9. Two proposed CCGs in Birmingham (NHS Birmingham CrossCity and NHS NorthEast Birmingham) have made a pre-application change to their configuration to become NHS Birmingham CrossCity CCG. The practices of NorthEast Birmingham CCG will become a locality of Birmingham CrossCity CCG and focus on supporting strategic delivery and local commissioning priorities. This move makes the combined CCG the fourth largest in the country in terms of population, with 117 GP practices looking after more than 730,000 people in the city. As a result, the number of proposed CCGs in England has reduced from 212 to 211. The documents on the NHS Commissioning Board website will be updated shortly in line with this change.

10. Dates have been agreed for the key parts of the clinical commissioning group (CCG) authorisation process and meetings have now been set up for each wave of CCGs for the following:

    - the moderation panel which reviews each waves' results to ensure consistency and makes recommendations as to whether a CCG should be fully authorised or authorised with conditions;
    - the conditions panel which considers what support is required where a CCG has not supplied sufficient evidence to meet a threshold for one or more authorisation criteria; and

- the CCG authorisation sub-committee which makes the authorisation decisions.

The first meeting for the CCG Wave 1 Moderation Panel took place on 23 October 2012. The membership of the panels which make up the authorisation process (described above) have also been agreed.

11. In considering the clinical commissioning group (CCG) authorisation process at the September Board meeting, the NHS CB has decided to share the recommendations of the Conditions Panel with individual CCGs prior to a formal decision being made on authorisation. This approach will allow CCGs time to comment and provide further evidence to the Board before any formal decision is taken. As a result of this additional assurance mechanism, the first decisions on CCG authorisation will now be taken by the CCG Authorisation Sub-Committee from 5 December 2012.

12. The NHS Commissioning Board Authority (NHS CBA) and NHS Business Services Authority (NHS BSA), along with the DH, have agreed that the NHS BSA will provide an employment partnership service for commissioning support unit (CSU) staff during the hosting period up to 2016. This means the NHS CB will host – provide oversight and direction to – CSUs, while the NHS BSA will be the legal employer of CSU staff.

Direct commissioning:

13. Local area teams for offender health service commissioning have been identified.

Partnerships:

14. Draft partnership agreements for the NHS Trust Development Authority (NTDA), Monitor, Care Quality Commission (CQC), and National Institute for Health and Clinical Excellence (NICE) have now been approved by the NHS CBA Board. Good progress is being made on the compact with Health Education England (HEE) which, due to the later appointment of senior staff at HEE, is less advanced in its development.

15. The agreement or 'concordat' between the Local Government Association (LGA) and the NHS CB has also been approved by the Board and will be launched formally at the joint LGA and NHS CB conference on 29 October by Sir David Nicholson and Sir Merrick Cockell.

Director and leadership development:

16. The first of the monthly leadership forums was held on 27 September. The agenda included discussions on the NHS CB purpose, and what sort of organisation we need to be to deliver that purpose.

Board Assurance Framework

15. In May 2012, 13 critical success factors (CSFs) for 2012/13 were developed and agreed by the Board of the NHS CBA to determine the success of the programme for the establishment of the NHS CB. The identified strategic risks (currently 11) to the delivery of the establishment programme have been mapped against the CSFs and presented in the form of a board assurance framework (BAF). The BAF also provides additional details, including mitigating actions, which enables the Board to identify gaps in assurance of the reduction of the risk and develop action plans for addressing these.

16. The BAF is a 'live' document that is continually monitored and updated to accurately reflect the successes of, and strategic risks facing, the establishment programme. The latest iteration of the BAF is attached at **annex A**.

17. The Board is asked to note:

- Strategic risk 2: *"There is a risk that directorate designs are not completed in a consistent way, leading to delays in recruitment, incomplete implementation of duties and transfer of functions, and lack of clarity about allocation of resources."* This has been closed as the directorate designs were completed, and approved by the Future Design Group (FDG) on 5 September 2012.
- Strategic risk 11: *"There is a risk that if not established as an Executive Non Departmental Public Body (ENDPB) on 1 October 2012, it would lead to the inability of the organisation to authorise clinical commissioning group (CCGs)."* This has been closed as the NHS CB was established as an ENDPB on 1 October 2012.
- Following a discussion at the executive team meeting (ETM) on 18 October 2012, the executive team are undertaking a review of the BAF with a particular focus on CSFs 10, 11, 12 and 13 to ensure that any associated strategic risks are identified. These will be reported to the December Board meeting.

18. Overall, the programme of establishing the NHS CB remains on track with good progress being made in several areas and an unwavering focus on improving outcomes for patients. There is still a high level of inherent risk, particularly around the movement and recruitment of approximately 4,000 staff (plus Family Health Services staff) over a short period, as evidenced in the BAF. This is being closely monitored and managed, with mechanisms in

place to raise risks and resourcing issues to both the executive team and the Board as necessary.

Bill McCarthy
National Director: Policy

October 2012

NHS Commissioning Board (CB) Board Assurance Framework (BAF) As At 11 October 2012

The following risks are the NHS Commissioning Board (CB) Programme's Strategic Risks (Open)

Current assessment of level of risk to achievement of objective – based on controls and assurances in place | **Action plan to reduce probability or impact of risk**

Critical Success Factor: 1

Safe transfer of functions from current organisations (Department of Health (DH), Primary Care Trusts (PCTs), and Strategic Health Authorities (SHAs)) to a new commissioning system comprised of an NHS Commissioning Board, clinical commissioning groups (CCGs) and commissioning support organisations.

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
National Director: HR	**S1**	There is a risk that the NHS Commissioning Board (NHS CB) may fail to populate its organisational structure by March 2013. This risk has a number of causes: 1. there may be delays in finalising the NHS CB organisational design, reducing the time available for recruitment; 2. there may be delays resulting from disagreements with sending organisations regarding the nature of functional transfers; 3. the NHS CB may fail to secure sufficient capacity to manage the large volume of recruitment required at the necessary pace; and 4. Trade unions (TUs) may challenge elements of the transition process if processes are not properly agreed and implemented.	5	4	R	**Very High**	1. Programme management of recruitment strategy. 2. Regular review of progress by National Director HR senior management team. 3. 'Footprints' database being implemented to track all appointments.	1. Recruitment plan developed for each directorate and region. 2. Job descriptions being finalised for all posts. 3. Agreement to streamline elements of the the recruitment has been confirmed with TUs. 4. Additional HR capacity secured for the people transition team and regional teams. 5. The Department of Health (DH) has increased the capacity of the transition resourcing team (TRT) which manages the advertising of posts in receiving organisations. 6. A framework for job matching has been developed to support sending organisations with the development of local arrangements. 7. There has been continued emphasis on work in partnership with TUs. A NHS CB partnership forum has been established with TUs. A second full day partnership event was held on 28 September and a joint work programme has been developed. 8. Monthly progress reports to the executive team meeting (ETM) and progress reports to every NHS CB Board meeting.	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. Regular monitoring by Department of Health (DH) transition Integrated Programme Office. 4. Programme assurance meeting held on 1 August 2012. 5. A state of readiness assurance review planned September to December 2012.	1. Need for more robust monitoring database for dynamic reporting. 2. Need for closer monitoring of job matching progress.	1.Automated monitoring database ('Footprints') to be fully implemented and tested. 2. Weekly monitoring of job matching and recruitment to be put in place. **The following actions have been completed since the last submission of the BAF**: 1. Final organisational design signed off by David Nicholson. 2. Policies and procedures and updated recruitment strategy have been presented to the NHS CBA Board. 3. Agreement with sending organisations about the process for identifying functional transfers has been finalised. 4. Agreement has been reached with senders and TU's on "filling of posts in receiving organisations" policy. 5. Further support for the People Transition Team has been procured by NHS Employers and mobilised. 6. Contingency plans have been completed.	Identified actions to be implemented by 31 October 2012	5	3	R
Chief Operating Officer	**S3**	There is an overarching risk surrounding the directorate build of the operations directorate (including the regional and local area teams). For example, current costs of Family Health Services (FHS) functions (to be transferred from primary care trusts (PCTs) to the NHS Commissioning Board (NHS CB) and the variety of existing delivery models, may not be sustainable within the planned NHS CB running costs budget. In addition, we need to retain talent within the system and the risk is that we will see key talent migrating to other agencies and organisations on the basis that the recruitment process is taking too long and also that we will not be able to offer appropriate grade or interest in the jobs if we implement too flat a structure. ***Please note that this risk also appears under Critical Success Factor 4.***	4	3	AR	**Medium**	Chief Operating Officer (COO) has a small senior team addressing directorate build. The team includes regional directors (RDs) and corporate directors.	A cost structure has been produced, confirmed and signed-off.	1. Regular reports to NHS CB Board. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4.Assurance meeting to include external scrutiny July 2012.	None identified.	1. A structure that is affordable has been produced and work is in hand to complete the job descriptions. 2. Work is under way to define the detail of the operations directorate build, so that the vision for new roles is understood and recruitment can progress. As part of this, we are seeking to ensure in design work, that posts are attractive to prospective applicants. HR capacity in the regions has been strengthened, a timetable to complete recruitment within NHS CB is being finalised and formal project management of key workstreams has been introduced. This work is on track. 3. In relation to FHS, a new delivery model is being developed to rationalise current arrangements and achieve efficiency gains. Work is underway to test these design proposals and finalise the funding model. The new FHS delivery model is likely to take two - three years to implement and is expected to release significant savings against the 2010/11 baseline cost of these services. Funding for the end-state FHS functions will need to be identified from several sources. Non recurrent funding for FHS to cover pay and non pay of £40m has been identified. The four regional directors have commissioned leads to undertake a review of current staffing against the available budget. Based on information provided to date from London/South, this funding is likely to be sufficient for 2013/14. The change plan therefore needs to be in place for 1 April 2013 so that the changes can be delivered in 2013/14. 4.For the regional and local area teams (LAT) VSM posts, approval regarding salaries has now been received and the recruitment process has commenced. Recruitment of the final VSM posts at the national support centre is expected to commence shortly.	Ongoing to 31 March 2013	3	2	A
National Director: Commissioning Development	**S6**	There is a risk that commissioning support is less than fully developed to support clinical commissioning group (CCGs) by April 2013, which may lead to CCGs receiving inefficient and ineffective services from Commissioning Support Units (CSUs). ***Please note that this risk also appears under Critical Success Factors 6 and 9.***	4	3	AR	**Medium**	Robust programme governance arrangements in place to monitor and manage each milestone.	1. Ongoing business review process. 2. Development programmes. 3. Recruitment of CSU managing directors and finance directors following thorough process to ensure right calibre of leadership. 4. Engagement with key national bodies and CCG leads. 5. Hosting secured through NHS CB and Business Services Authority (BSA) from April 2013.	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. Independent 'viability review' of every Commissioning Support Unit (CSU) planned for November and December 2012 and external check carried out in January 2013 to ensure all CSUs are complying with NHS CB corporate policies.	1. Clarity of CCG intentions and ability to sign Service Level Agreements (SLAs) with CSUs (2013/2014) for Checkpoint 3. 2. Operational arrangements and control during hosting needs to be defined i.e. performance management of CSUs.	1. Ongoing business review process which will assure both NHS CB and CCGs that the emerging commissioning support units (CSUs) models are responsive, business focused and fit for purpose, assessment of CSU readiness by the NHS CB through checkpoint 3 currently underway. 2. Commercial / customer orientated development programme underway to support organisational development of CSUs. 3. CSU managing director recruitment taking place. 4. Ongoing engagement with key national bodies and CCG leads through the GP stakeholder groups and 'informed customer' programme. Series of events and products planned for CCGs to support the design of their commissioning support intentions and CSU arrangements. 5. Underpinning governance arrangements for hosting being agreed by Board and plans in place to progress meeting arrangements for CSU staff. 6. CCG authorisation process.	1. October 2012 2. Ongoing 3. October 2012 4. Ongoing 5. January 2013	4	2	A

National Director: Policy	S10	There is a risk of a lack of strong stakeholder engagement during the design process, leading to lack of support and lack of rigour in the design. Also a risk of the broader system, in particular the NHS, not understanding the role of the NHS CB (and special health authority before it).	4	3	AR	Low	1. Ongoing programme of design workshops. 2. Development of partnership strategy. 3. Presentations to stakeholder forums and organisations. 4. Involvement of stakeholders in NHS CB executive team Meeting (ETM). 5. Detailed process of clinical engagement on networks, senates and other aspects of design. 6. Regular updates on design to ETM and the Board, including reports on stakeholder engagement.	1. A communications team has been recruited which is developing a strategy to ensure strong, coherent messages about the NHS CB are heard throughout the system. 2. There is a key piece of work on clinical leadership with a strong element of stakeholder engagement. 3. An engagement plan will be developed for each core business process; this has begun, critically in areas of commissioning development. 4. Beginning to engage clinical commissioning groups (CCGs) in the broader programme. 5. There has been significant work on a partnership strategy and to develop partnership arrangements with a range of stakeholders. 6. Building on the organisational design workshops, monthly workshops are held on an on-going basis with design leads and senior responsible officers to support co-production and implement matrix working. 7. Design updates were reported to the board in February, April May and September 2012, and will continue as required.	1. Reported to NHS CB Board and when necessary. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012.	There is not yet any systematic assessment of stakeholder engagement in, or understanding of, the organisation design.	Proposals are being developed for regular assessment of stakeholder and partner satisfaction as part of the development of the NHS CB partnership strategy. This will be integrated into the NHS CB corporate dashboard.	An initial feedback process will be introduced by the end of 2012.	4	1	A

Critical Success Factor: 2

Safe transfer of Emergency Preparedness, Resilience and Response (EPRR) responsibilities at all levels.

Lead Director (SRO)	Risk Ref	Potential Risk *Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control*	Risk Level: Impact	Risk Level: Likelihood	Risk Level: RAG Status	Inherent Risk Level *Is a risk which is impossible to manage or transfer away*	Key Control Mechanisms *The systems and processes in place that mitigate this risk*	Management Assurance/Actions *What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	Action Plan *How the identified gap is to be addressed and how the risk is to be diminished*	Expected date of completion	Anticipated Risk Score After Action Plan Completed: Impact	Anticipated Risk Score After Action Plan Completed: Likelihood	Anticipated Risk Score After Action Plan Completed: RAG Status
Chief Operating Officer	S4	There is a risk that while the Department of Health (DH), Public Health England and the NHS CB have approved the Emergency Planning Resilience and Response (EPRR) Policy, the effective delivery of the model is dependent on the timely and effective transfer of roles and responsibilities to existing and emerging organisations, and excellent communications and engagement with the service.	4	3	AR	Medium	1. Governance structure in place ultimately reporting to Chief Operating Officer (COO) via the NHS EPRR Implementation Programme Group. 2. Reports also submitted to the DH EPRR transition programme board.	1. Four workstreams reporting to a weekly NHS EPRR Implementation Programme Group (chaired by NHS CB Director of Operations and delivery (corporate)). Director of Operations reporting to COO on exception basis between NHS EPRR Steering Group meetings. 2. Reports also submitted to the DH EPRR transition programme board.	1. Regular reports to NHS CB Board. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. Active membership in fortnightly DH EPRR transition programme working group 5. Regular reports submitted to the DH EPRR transition programme board and NHS EPRR transitional programme. 6. EPRR transition assurance process published (October 2012). This assurance process includes: a) progress reports in October 2012, December 2012 & February 2013; b) completion of pro-forma templates; and c) impartial assessment reviews and 'statements of readiness'.	None identified	1. Establish an NHS CB implementation group to focus on the NHS element of the EPRR policy. 2. Recruit EPRR critical staff at national, regional and local level to avoid corporate memory loss and maintain operational response capability. 3. Statement of assurance of meeting the requirements for delivering EPRR across the NHS by 31 March 2013. 4. Work with partner agencies and stakeholders to ensure these organisations understand the changes in health EPRR. 5. Establish Local Health Resilience Partnerships (LHRPs) and identify NHS CB co-chairs prior to regional testing in November. 6. Identify and align EPRR roles and responsibilities to reflect emerging organisational design and accountability of the NHS CB. 7. Support provider organisations to identify and train accountable emergency officers. 8. Support clinical commissioning groups (CCGs) to understand the need for own organisational resilience/business continuity planning, and the need for EPRR to be included in commissioning/contracts. 9. Integrate new health EPRR arrangements into local contingency plans. 10.Training, test and exercise of new arrangements.	Ongoing to 31 March 2013	3	2	A

Critical Success Factor: 3

The NHS Commissioning Board is established with the full set of legal powers required to deliver its functions.

Lead Director (SRO)	Risk Ref	Potential Risk *Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control*	Risk Level: Impact	Risk Level: Likelihood	Risk Level: RAG Status	Inherent Risk Level *Is a risk which is impossible to manage or transfer away*	Key Control Mechanisms *The systems and processes in place that mitigate this risk*	Management Assurance/Actions *What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	Action Plan *How the identified gap is to be addressed and how the risk is to be diminished*	Expected date of completion	Anticipated Risk Score After Action Plan Completed: Impact	Anticipated Risk Score After Action Plan Completed: Likelihood	Anticipated Risk Score After Action Plan Completed: RAG Status
		Strategic risk 11 has been now been closed and moved to the closed element of the BAF.													

Critical Success Factor: 4

The NHS CB is adequately resourced to enable it to carry out its functions, with people transferred from existing organisations (DH, SHAs, PCTs, and Arms Lengths Bodies (ALBs)) in accordance with the People Transition Policy.

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
		Strategic risk 2 has been now been closed and moved to the closed element of the BAF.													
Chief Operating Officer	**S3**	There is an overarching risk surrounding the directorate build of the Operations Directorate (including the regional and local area teams). For example, current costs of Family Health Services (FHS) functions (to be transferred from primary care trusts (PCT) to the NHS Commissioning Board (NHS CB) and the variety of existing delivery models, may not be sustainable within the planned NHS CB running costs budget. In addition, we need to retain talent within the system and the risk is that we will see key talent migrating to other agencies and organisations on the basis that the recruitment process is taking too long and also that we will not be able to offer appropriate grade or interest in the jobs if we implement too flat a structure. ***Please note that this risk also appears under Critical Success Factor 1.***	**4**	**3**	**AR**	**Medium**	Chief Operating Officer (COO) has a small senior team addressing directorate build. The team includes regional directors (RDs) and corporate directors.	A cost structure has been produced, confirmed and signed-off.	1. Regular reports to NHS CB Board. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4.Assurance meeting to include external scrutiny July 2012.	None identified.	1. A structure that is affordable has been produced & work is in hand to complete the job descriptions. 2. Work is under way to define the detail of the operations directorate build, so that the vision for new roles is understood and recruitment can progress. As part of this, we are seeking to ensure in design work, that posts are attractive to prospective applicants. HR capacity in the regions has been strengthened, a timetable to complete recruitment within NHS CB requirements is being finalised and formal project management of key workstreams has been introduced. This work is on track. 3. In relation to FHS, a new delivery model is being developed to rationalise current arrangements and achieve efficiency gains. Work is underway to test these design proposals and finalise the funding model. The new FHS delivery model is likely to take two - three years to implement and is expected to release significant savings against the 2010/11 baseline cost of these services. Funding for the end-state FHS functions will need to be identified from several sources. Non recurrent funding for FHS to cover pay and non pay of £40m has been identified. The four regional directors have commissioned leads to undertake a review of current staffing against the available budget. Based on information provided to date from London/South, this funding is likely to be sufficient for 2013/14. The change plan therefore needs to be in place for 1 April 2013 so that the changes can be delivered in 2013/14. 4.For the regional and local area teams (LAT) VSM posts, approval regarding salaries has now been received and the recruitment process has commenced. Recruitment of the final VSM posts at the national support centre is expected to commence shortly.	Ongoing to 31 March 2013	**3**	**2**	**A**
Chief Financial Officer	**S8**	There is a risk of failure of effective and co-ordinated finance and information flows through the new system (including information systems, finance spine). ***Please note that this risk also appears under Critical Success Factor 8.***	4	4	R	**Very Low**	1. Information flows working group reports on progress and escalates issues to senior management team.	1. Information flows working group oversight of detailed workstreams making recommendations for issue resolution or escalation as appropriate. 2. Dedicated resource in place working with directorates to confirm detailed information requirements (financial and non-financial).	1. Reported to NHS CB board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. A Programme Assurance meeting including external scrutiny occurred during July 2012. 5. Financial assurance framework agreed with the Department of Health, first monthly meeting scheduled for 17 October 2012.	Confirmation of operating model detail required so that finance and information flows can complement this.	1. A working group has been established, chaired by the Chief Financial Officer, overseeing financial issues, information flows, and tariffs. This reports to the executive team meeting (ETM). 2. Procurement of an integrated finance accounting system is complete and its development continues towards implementation in clinical commissioning groups (CCGs) on 1 April 2013 (finance system implemented at the NHS CB on 1 October 2012).	1. Working group established and in operation. 2. Finance system implemented (NHS CB national support centre 1 October 2012, remainder by 1 April 2013).	**4**	**2**	**A**
Chief Financial Officer	**S9**	There is a risk that clarity on resource allocations to clinical commissioning groups (CCGs) and the NHS Commissioning Board may not be available in time to enable effective planning for 2013/14.	4	3	AR	**Low**	Working Group led by Chief Financial Officer and involving nominated CCG leaders reporting to senior management team.	1. Financial framework being agreed as part of a shared finance agreement with Department of Health (DH) and other national bodies, to include overall programme and admin resources for the commissioning system. 2. Working group is overseeing adoption of agreed new formula allocations from Advisory Committee on Resource Allocation (ACRA) process, completion of baseline expenditure exercise and modelling programme allocations to CCGs for 13/14. 3. CCG running cost allocations being finalised in line with latest ONS population projections. 4. Processes underway for distribution of resource within the NHS CB - including allocation of programme resources and finalising of costed operating structures.	1. Reported to NHS CB board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. A Programme Assurance meeting including external scrutiny occurred during July 2012.	1. Final resources for the commissioning system not yet known. 2. Policy to be finalised and signed off in some key areas of allocations. 3. Methodology for internal distribution of NHS CB direct commissioning programme resources still in an early stage of development.	1. See management assurance/actions for key elements of programme, overseen by a working group led by the Chief Financial Officer and involving key stakeholders. 2. Note: as the key resources involved in allocations are currently located in the Department of Health (DH) central team, we are undertaking this work with in intensive collaboration with DH colleagues.	Allocations to be signed off by the NHS CB at its December board meeting and published thereafter.	4	2	A

Critical Success Factor: 5

There is full coverage across England by established CCGs, with the majority fully authorised.

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
National Director: Commissioning Development	**S5**	The authorisation of 212 clinical commissioning groups (CCGs) (211 CCGs as of 22 October 2012) between October 2012 and January 2013 is a challenge. There is a risk that, if there is insufficient capacity this will lead to the process being less robust. The organisational change during this period, as NHS Commissioning Board (NHS CB) becomes established, presents an additional risk. We must also mitigate the risk of CCGs not being ready for full authorisation.	**4**	**3**	**AR**	**Medium**	1. Robust programme governance arrangements in place to monitor and manage each milestone. 2. Work with NHS CB regions to assure readiness of CCGs.	1. Development programme for all CCGs. 2. Resource to support authorisation assessment. 3. Applicants guide published setting out requirements for authorisation. 4. Establishment of the four waves of authorisation. 5. Assessors guide to authorisation . 6. Assessor training. 7. First wave of applicants on track to submit.	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012.	1. Securing adequate and stable assessor resource during transition. 2. Targeting appropriate development needs for CCGs during transition together with Regional Directors.	1. Identify further targeted support to meet the development needs of CCGs as agreed with regional directors. 2. Identify and train extra assessors for remaining waves. **The following actions have been completed since the last submission of the BAF**: 1. Full development programme for all CCGs. 2. Identify NHS resources to support authorisation assessment and procure external support. 3. Draft applicants guide for authorisation published setting out requirements for authorisation alongside details of the authorisation process and timetable 4. Establish the make-up of the four waves of authorisation. 5. Assessors guide to authorisation made available. 6. Training of assessors to take place to ensure nationally consistent approach to authorisation. 7. First wave of CCG applications to be received.	1.State of readiness Complete 2. November 2012	**4**	**2**	**A**

Critical Success Factor: 6

Commissioning support services, with robust oversight arrangements, are in place, providing high quality support to the NHS CB and CCGs.

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
National Director: Commissioning Development	**S6**	There is a risk that commissioning support is less than fully developed to support clinical commissioning group (CCGs) by April 2013, which may lead to CCGs receiving inefficient and ineffective services from Commissioning Support Services (CSS). ***Please note that this risk also appears under Critical Success Factors 1 and 9.***	**4**	**3**	**AR**	**Medium**	Robust programme governance arrangements in place to monitor and manage each milestone.	1. Ongoing business review process. 2. Development programmes. 3. Recruitment of CSU managing directors and finance directors following thorough process to ensure right calibre of leadership. 4. Engagement with key national bodies and CCG leads. 5. Hosting secured through NHS CB and Business Services Authority (BSA) from April 2013.	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. Independent 'viability review' of every commissioning support unit (CSU) planned for November and December 2012 and external check carried out in January 2013 to ensure all CSUs are complying with NHS CB corporate policies.	1. Clarity of CCG intentions and ability to sign Service Level Agreements (SLAs) with CSUs (2013/2014) for Checkpoint 3. 2. Operational arrangements and control during hosting needs to be defined i.e. performance management of CSUs.	1. Ongoing business review process which will assure both NHS CB and CCGs that the emerging commissioning support services (CSUs) models are responsive, business focused and fit for purpose, assessment of CSU readiness by the NHS CB through checkpoint 3 currently underway. 2. Commercial / customer orientated development programme underway to support organisational development of CSUs. 3. CSU managing director recruitment taking place. 4. Ongoing engagement with key national bodies and CCG leads through the GP stakeholder groups and 'informed customer' programme. Series of events and products planned for CCGs to support the design of their commissioning support intentions and CSU arrangements. 5. Underpinning governance arrangements for hosting being agreed by Board and plans in place to progress meeting arrangements for CSU staff. 6. CCG authorisation process.	1. October 2012 2. Ongoing 3. October 2012 4. Ongoing 5. January 2013	**4**	**2**	**A**

Critical Success Factor: 7

The NHS Commissioning Board has an agreed mandate, which provides the freedom and resources to deliver its full set of functions.

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
National Director: Policy	**S7**	There is a risk that the commitments in the mandate are unaffordable and / or not flexible enough to allow for local clinical leadership to flourish.	**4**	**3**	**AR**	**High**	1. Provide sounding board to the Department of Health (DH) regarding the implications of implementing mandate objectives. 2. NHS CB participation in the engagement process being led by the DH.	1. Monthly Programme Management Office (PMO) reporting through workstream 14 (NHS mandate and relationship with DH). 2. Strategic risk reported to NHS CB Board at every meeting. 3. Regular discussion at NHS CB Board.	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012.	None identified	Outlined in the key control mechanisms.	31 October 2012 (recurring annually).	**4**	**2**	**A**

Critical Success Factor: 8

A new finance spine is in place and continuity of Family Health Services (FHS) payments has been delivered.

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
Chief Financial Officer	**S8**	There is a risk of failure of effective and co-ordinated finance and information flows through the new system (including information systems, finance spine). ***Please note that this risk also appears under Critical Success Factor 4.***	4	4	R	**Very Low**	1. Information flows working group reports on progress and escalates issues to senior management team.	1. Information flows working group oversight of detailed workstreams making recommendations for issue resolution or escalation as appropriate. 2. Dedicated resource in place working with directorates to confirm detailed information requirements (financial and non-financial).	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. A Programme Assurance meeting including external scrutiny occurred during July 2012. 5. Financial assurance framework agreed with the Department of Health, first monthly meeting scheduled for 17 October 2012.	Confirmation of operating model detail required so that finance and information flows can complement this.	1. A working group has been established, chaired by the Chief Financial Officer, overseeing financial issues, information flows, and tariffs. This reports to the executive team meeting (ETM). 2. Procurement of an integrated finance accounting system is complete and its development continues towards implementation in clinical commissioning groups (CCGs) on 1 April 2013 (finance system implemented at the NHS CB on 1 October 2012).	1. Working group established and in operation. 2. Finance system implemented (NHS CB national support centre 1 October 2012, remainder by 1 April 2013).	**4**	**2**	**A**

Critical Success Factor: 9

Agreed operating plans are in place focused on delivering the NHS Outcomes Framework, the NHS Constitution, any other requirements that flow from the mandate and statutory requirements for:
a) fully or partially authorised CCGs;
b) in the NHS Commissioning Board for all services that will be commissioned directly by the Board (offender health, military health, specialised commissioning and primary care); and
c) shadow CCGs (established but not authorised).

Lead Director (SRO)	Risk Ref	Potential Risk	Risk Level			Inherent Risk Level	Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Impact	Likelihood	RAG Status	*Is a risk which is impossible to manage or transfer away*	*The systems and processes in place that mitigate this risk*	*What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	*External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	*Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	*How the identified gap is to be addressed and how the risk is to be diminished*		Impact	Likelihood	RAG Status
National Director: Commissioning Development	**S6**	There is a risk that commissioning support is less than fully developed to support clinical commissioning group (CCGs) by April 2013, which may lead to CCGs receiving inefficient and ineffective services from Commissioning Support Services (CSS). ***Please note that this risk also appears under Critical Success Factors 1 and 6.***	**4**	**3**	**AR**	**Medium**	Robust programme governance arrangements in place to monitor and manage each milestone.	1. Ongoing business review process. 2. Development programmes. 3. Recruitment of CSU managing directors and finance directors following thorough process to ensure right calibre of leadership. 4. Engagement with key national bodies and CCG leads. 5. Hosting secured through NHS CB and Business Services Authority (BSA) from April 2013.	1. Reported to NHS CB Board at every meeting. 2. Gateway review February 2012. 3. A state of readiness assurance review planned September to December 2012. 4. Independent 'viability review' of every commissioning support unit (CSU) planned for November and December 2012 and external check carried out in January 2013 to ensure all CSUs are complying with NHS CB corporate policies.	1. Clarity of CCG intentions and ability to sign Service Level Agreements (SLAs) with CSUs (2013/2014) for Checkpoint 3. 2. Operational arrangements and control during hosting needs to be defined i.e. performance management of CSUs.	1. Ongoing business review process which will assure both NHS CB and CCGs that the emerging commissioning support services (CSUs) models are responsive, business focused and fit for purpose, assessment of CSU readiness by the NHS CB through checkpoint 3 currently underway. 2. Commercial / customer orientated development programme underway to support organisational development of CSUs. 3. CSU managing director recruitment taking place. 4. Ongoing engagement with key national bodies and CCG leads through the GP stakeholder groups and 'informed customer' programme. Series of events and products planned for CCGs to support the design of their commissioning support intentions and CSU arrangements. 5. Underpinning governance arrangements for hosting being agreed by Board and plans in place to progress meeting arrangements for CSU staff. 6. CCG authorisation process.	1. October 2012 2. Ongoing 3. October 2012 4. Ongoing 5. January 2013	**4**	**2**	**A**

Critical Success Factor: 10

Partnership agreements are in place which capture the way the NHS Commissioning Board will co-operate and collaborate with external partners to deliver its statutory functions, consistent with its organisational objectives.

Lead Director (SRO)	Risk Ref	Potential Risk *Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control*	Risk Level			Inherent Risk Level *Is a risk which is impossible to manage or transfer away*	Key Control Mechanisms *The systems and processes in place that mitigate this risk*	Management Assurance/Actions *What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	Action Plan *How the identified gap is to be addressed and how the risk is to be diminished*	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
			Impact	Likelihood	RAG Status								Impact	Likelihood	RAG Status
		No identified risk at this time.													

Critical Success Factor: 11

The NHS Commissioning Board has received positive feedback from partners on its values, behaviours and whether the NHS CB is delivering on its commitments.

Lead Director (SRO)	Risk Ref	Potential Risk *Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control*	Risk Level			Inherent Risk Level *Is a risk which is impossible to manage or transfer away*	Key Control Mechanisms *The systems and processes in place that mitigate this risk*	Management Assurance/Actions *What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	Action Plan *How the identified gap is to be addressed and how the risk is to be diminished*	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
			Impact	Likelihood	RAG Status								Impact	Likelihood	RAG Status
		No identified risk at this time.													

Critical Success Factor: 12

The NHS CB can demonstrate that patients, the public and their representatives have participated in, and the NHS CB has responded to their views on, the establishment of the NHS CB.

Lead Director (SRO)	Risk Ref	Potential Risk *Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control*	Risk Level			Inherent Risk Level *Is a risk which is impossible to manage or transfer away*	Key Control Mechanisms *The systems and processes in place that mitigate this risk*	Management Assurance/Actions *What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	Action Plan *How the identified gap is to be addressed and how the risk is to be diminished*	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
			Impact	Likelihood	RAG Status								Impact	Likelihood	RAG Status
		No identified risk at this time.													

Critical Success Factor: 13

An organisational development strategy and plan is in place, providing interventions designed to create a high performing, healthy organisation where people want to work and with whom others want to do business.

Lead Director (SRO)	Risk Ref	Potential Risk *Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control*	Risk Level			Inherent Risk Level *Is a risk which is impossible to manage or transfer away*	Key Control Mechanisms *The systems and processes in place that mitigate this risk*	Management Assurance/Actions *What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board ?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking*	Action Plan *How the identified gap is to be addressed and how the risk is to be diminished*	Expected date of completion	Anticipated Risk Score After Action Plan Completed		
			Impact	Likelihood	RAG Status								Impact	Likelihood	RAG Status
		No identified risk at this time.													