What we know so far… The NHS Commissioning Board

April 2012

STANDING UP FOR DOCTORS

BMA

Contents

1. What we know so far…

This paper forms part of a series of BMA briefing papers, which set out what we know so far on a range of key topics following the Government's health reforms.

The Health and Social Care Act 2012, which concluded its 15-month passage through Parliament on 20 March and received Royal Assent on 27 March, now defines much of the Government's proposals in primary legislation. The Act legislates for the NHS reforms first set out in the White Paper, *Equity and excellence: Liberating the NHS*[1], which was published in July 2010.

This briefing note describes the new NHS Commissioning Board, identifying uncertainties that remain around implementation and where proposals will be further developed through secondary legislation and guidance.

Where of significance, the papers highlight changes that have been made to the Government's original proposals for reform through the parliamentary process, but otherwise reflect the information/detail of where we are now.

The briefing papers focus on bringing together the available facts and drawing attention to gaps in knowledge rather than giving an account of BMA policy. Documents stating the BMA's policies and positions are referenced in the papers where appropriate, to allow readers to examine these in more detail if they wish to do so.

They are living documents and will be updated as and when new information emerges. We would be interested to hear your views, and any information you may have, on the various topics covered in the briefing papers. Please use the contact details below to get in touch.

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1 Department of Health (2010) *Equity and excellence: Liberating the NHS.*

2. Introduction

Introduced in the Coalition Government's White Paper 'Equity and excellence: Liberating the NHS' in July 2010, the role of the NHS Commissioning Board (NHS CB) in the NHS reforms is twofold. First, it forms part of the agenda to rationalise commissioning structures in the NHS following the abolition of SHAs and PCTs. The NHS CB will oversee the new commissioning architecture and will be responsible for holding Clinical Commissioning Groups (CCGs) – groups of GP practices with local commissioning responsibility – to account. Second, the establishment of the Board forms part of a wider agenda to devolve more responsibility away from ministerial level and to create an 'independent and accountable' board that will be responsible for running the NHS on a day-to-day basis.

The NHS CB has been operating in shadow form as a special health authority since October 2011. It will be established as an executive non-departmental public body from October 2012, with limited functions and will take on its full functions from April 2013.

3. Before the White Paper

3.1 NHS Commissioning

Primary Care Trusts (PCTs) have been responsible for the bulk of NHS commissioning since 2002, holding around 80 per cent of the NHS budget. This includes primary care services, such as GP and dental contracts, community and secondary care, and some public health-related services, for example those relating to sexual health. GP involvement in commissioning through Practice Based Commissioning was introduced in 2005. An optional scheme, GPs were given practice-level, indicative commissioning budgets and were incentivised to work with PCTs in planning health services and making commissioning decisions.

Strategic Health Authorities (SHAs) were responsible for the performance management of PCTs, including in their role as NHS commissioners. The World Class Commissioning assurance process was the main mechanism for doing so in recent years (2008-10).

3.1.1 Specialised commissioning

Specialised services, such as haemophilia and blood & marrow transplantation, were commissioned by regional, Specialised Commissioning Groups (SCGs), which were coterminous with SHAs. The National Specialised Commissioning Group (NSCG) oversaw the work of the 10 SCGs and facilitated supra-regional commissioning for certain services, such as severe burn care.

3.2 Strategic running of the NHS

The Departmental Board of the Department of Health was set up to focus on 'high-level strategy, performance and delivery'[2] for the NHS, chaired by the Secretary of State for Health. Details of the full membership can be **found online**. The Departmental Board has been replaced by the NHS Transition Executive Forum.

2 See the Department of Health website accessed 15 February 2012 http://www.dh.gov.uk/health/about-us/directorates/boards-and-committees/.

4. Transitional arrangements – until April 2013

As the Health and Social Care Bill made its way through Parliament in 2011 and the first quarter of 2012, there was much activity on the ground in preparation for the new structures originally proposed in the White Paper.

4.1 The NHS Commissioning Board Authority

The NHS Commissioning Board has been operating in shadow form as a special health authority, the NHS Commissioning Board Authority (NHS CBA), since October 2011. It will assume its full statutory status as an executive non-department public body from October 2012, but will only carry out limited functions during the transitional period until April 2013. For more information visit **the NHS CBA's website**.

4.2 PCT and SHA clusters

Towards the end of 2011, the 152 PCTs that existed across England came together to form around 50 PCT clusters[3]. Similarly the former 10 SHAs were reorganised into four SHA clusters, these are NHS North of England, NHS Midlands and East, NHS South of England and NHS London. Under the Health and Social Care Act 2012, SHA and PCT clusters will be abolished in April 2013. The temporary NHS Trust Development Authority, operating in shadow form since October 2011, has taken over responsibility from SHAs for overall governance of NHS Trusts.

4.3 Specialised commissioning

The former 10 Specialised Commissioning Groups (SCGs) have also been instructed to cluster in line with the new SHA configurations. A national-level Specialised Commissioning Transition Oversight Group has been established to make recommendations to the NHS CBA about the future of specialised commissioning. A Clinical Assurance Group, also at national level, will ensure that the Transition Oversight Group has the necessary clinical support and advice[4]. Their work will be supported by 55 service-specific National Clinical Reference Groups, which will be organised over 5 programmes of care[5].

4.4 Shadow clinical commissioning groups

GP practices have formed clinical commissioning groups (CCGs), in preparation for the establishment of CCGs as statutory commissioning bodies from April 2013. A pathfinder programme provides support, guidance and access to a learning network for emerging CCGs. There are currently approximately 220 shadow CCGs, covering the whole of England (although this number is likely to change as CCGs progress through the authorisation process and are assessed for viability in terms of size and geographical coverage). Shadow CCGs, operating alongside PCT clusters, are starting to work towards authorisation. For more information on CCGs **see the guidance** produced by the BMA's General Practitioners Committee (GPC).

3 Some SHA websites have details of the new configurations in their area, but a national list of the 50 or so PCT clusters is not currently publicly available.

4 Department of Health and South West Specialised Commissioning Group letter to cluster SHAs of 15 December 2011, *Clinical Assurance Structure National Specialised Commissioning Transition. Expressions of Interest for Chairs of the Clinical Reference Groups*.

5 The five programmes are: (1) mental health; (2) women and children's health, congenital and inherited diseases; (3) infection, cancer, immunity, and haematology; (4) traumatic injury, orthopaedics, head and neck, and rehabilitation; and (5) digestion, renal, hepatobiliary, and circulatory systems.

4.5 Strategic running of the NHS

The Department of Health has also begun to reconfigure its strategic teams by creating the NHS Transition Executive Forum. Chaired by the NHS Chief Executive, it comprises a similar membership to that of the NHS Management Board, which it replaces. This includes the Chief Executives of the four SHA clusters, the Chief Medical and Nursing Officers and a number of senior civil servants from the Department of Health. It 'has been established to oversee the transition to the new health and care system' and 'is responsible… for the day-to-day running of the NHS' until the end of March 2013 when it will cease to exist. For full details see the **Department of Health website**.

5. Changes in the NHS – from April 2013

5.1 What is the NHS Commissioning Board?

5.1.1 Rationale

As set out in the introduction above, the rationale behind the establishment of the NHS CB is two-fold. First, as a statutory and independent board (an executive non-departmental public body), the NHS CB is intended to de-politicise the day-to-day running of the NHS by limiting ministers' powers[6] and by being free from political micro-management[7]. Second, the NHS CB will play a central role in the new commissioning and managerial architecture of the NHS, following the abolition of SHAs and PCTs and the establishment of Clinical Commissioning Groups (CCGs).

5.1.2 Corporate governance

The overarching, corporate governance structure of the NHS CB will have three components: the Board; an audit committee and a remuneration committee[8]. The key governance functions and responsibilities include delivery against the NHS Outcomes Framework and the Secretary of State's Mandate to the Board, production of a five to 10 year strategy to improve outcomes and an annual business plan and report[9].

The membership of the Board is set out in schedule 1 of the Health and Social Care Act 2012, comprising:

- A chair, appointed by the Secretary of State;
- A minimum of five other non-executive members, appointed by the Secretary of State;
- A chief executive, appointed by the chair and non-executive members and approved by the Secretary of State;
- A number of other executive members, fewer in number than non-executives, and appointed by the chair and non-executive members.

The arrangements for suspensions from the Board are also set out in schedule 1 of the legislation and give the Secretary of State the power to remove or suspend a non-executive member on the grounds of incapacity, misbehaviour or failure to carry out their duties. As a public body, members of the Board will be required to adhere to the seven principles of public life, also called the Nolan principles[10]. The Board will hold its meetings in public and papers will be available in advance, via the NHS CB's website[11].

6 Op. cit. *Equity and excellence: Liberating the NHS.*
7 Department of Health (2010) *Liberating the NHS: legislative framework and next steps.*
8 NHS Commissioning Board Authority (2012) *Design of the NHS commissioning board* (paper to Board meeting of 2 February 2012).
9 Ibid.
10 Parliamentary debates, House of Commons official report General Committees, Public Bill Committee, Health and Social Care Bill, *tenth sitting, Tuesday 1 March 2011 (afternoon).*
11 Department of Health (2011) *Developing the NHS Commissioning Board.*

5.1.3 Organisational structure

The NHS CB will operate at a national, regional and local level. The central office or 'corporate base' will be in Leeds, with additional London presence. Four regional 'sectors' will be based on existing SHA clusters as follows: [12]

1. **NHS North of England**
   - comprising former NHS North West, NHS Yorkshire and the Humber and NHS North East
2. **NHS Midlands and East**
   - comprising former NHS West Midlands, NHS East Midlands and NHS East of England
3. **NHS South of England**
   - comprising former NHS South West; NHS South Central and NHS South East Coast
4. **NHS London**

Fifty local offices will be based on the current PCT cluster configurations, although the precise details of the NHS CB's local office network, and locations, has yet to be determined. While the sector offices will formally be co-located in Leeds and London, not all sector staff will work from those offices and a number will work from local offices. London sector and local arrangements will differ from those elsewhere in the country.

The NHS CB will be divided into nine directorates, full details of which can be found at **annex A**.

5.1.4 Personnel

A number of executive and non-executive directors have already been appointed to the interim NHS CBA, and will be transferred to the NHS CB once it becomes an executive non-departmental public body in November 2012. One final executive appointment has yet to be made, that of the National Director of Patient Engagement, Insight and Informatics (PEII). A number of other non-executive posts, which in total should outnumber the executive posts, will also be made in due course.

Full details of the personnel thus far appointed are available at **annex B**.

5.1.5 Staffing

It is anticipated that there will be around 50 members of staff per sector and local office and around 860 staff in the central office, making 3,560 NHS CB staff in total[13]. This represents about a half of the number of staff currently fulfilling these functions in SHAs and PCTs.

Phase 1 of the NHS CB's People Transition Policy was published in July 2011. This involved recruitment of around 150 people - mostly 'senior and other priority posts' - in 2011. Staff transferring from PCT and SHA clusters will receive employment protection and will transfer on their existing terms and conditions of service (excluding pensions), with continuity of service.

12 Op. cit. *Design of the NHS commissioning board.*
13 Ibid.

The second phase of the NHS CB's People Transition Policy is anticipated shortly now that the Health and Social Care Bill has become an Act. Further transfer and recruitment of staff from PCT and SHA clusters will begin in Spring 2012[14].

5.2 What will the NHS Commissioning Board do?

Broadly speaking the Board will provide leadership to the NHS, hold CCGs to account for delivering their statutory responsibilities, and commission services such as primary care, specialised services, prison health and military health[15]. Many of its responsibilities will be those formerly of PCTs and SHAs, which are to be abolished in April 2013. The NHS CB will also allocate and account for NHS resources, champion patient and carer involvement[16], lead on quality improvement[17] and the NHS operational response in the event of an emergency[18]. It will also play a part in the new foundation trust failure regime. For more information refer to another briefing note in this series **'Foundation trusts'**.

5.2.1 Secretary of State's mandate

From 2013/14, the Secretary of State will set a formal mandate to the Board every three years, updated annually. The mandate will be subject to public consultation and Parliamentary scrutiny, including by the Health Select Committee[19]. It will include the Board's responsibility in terms of outcomes – as based on the NHS Outcomes Framework[20] – and the financial allocation for NHS commissioning. For more information on the NHS Outcomes Framework, see the **BMA's summary** here.

14 Department of Health (2012) *NHS Commissioning Board factsheet*15 Department of Health (2011) *The operating framework for the NHS in England 2012/13.*
15 Department of Health (2011) *The operating framework for the NHS in England 2012/13.*
16 Op. cit. *Equity and excellence: Liberating the NHS.*
17 Department of Health (2011) *Government Response to the House of Commons Health Select Committee Fifth Report of Session 2010-11: Commissioning.*
18 Op. cit. *Liberating the NHS: legislative framework and next steps.*
19 Op. cit. *Equity and excellence: Liberating the NHS.*
20 Op. cit. *The operating framework for the NHS in England 2012/13.*

5.2.2 Legislative duties

The NHS CB has a concurrent duty with the Secretary of State to promote a comprehensive health service. In doing so, both must give priority to this duty if any conflict arises from their simultaneous duty to promote autonomy. The Board is required to arrange for the provision of services (i.e. commission services), and secure that services are provided in relation to those commissioned by CCGs. However it is the Secretary of State who has ministerial responsibility to Parliament for the provision of the health service in England.

The NHS CB must publish a business plan before the start of each year and annual report at the end of each year. The Health and Social Care Act 2012 also sets out a number of general duties for the Board, most of which[21] also apply to CCGs. They are as follows:

- Promote the NHS Constitution;
- Exercise its functions effectively, efficiently and economically;
- Secure continuous improvement in quality of services;
- Promote autonomy*;
- Reduce inequalities (access and health outcomes);
- Promote involvement of each patient;
- Enable patients to make choices;
- Obtain appropriate advice (to discharge functions);
- Promote innovation;
- Promotion research;
- Promote education and training;
- Promote integration;
- Have regard to impact on services in certain areas* (Wales and Scotland, near England borders); and
- Not to vary provision of health services intentionally* (i.e. proportion of public versus private-sector provision).

The Secretary of State has the power to 'intervene where he considers that the Board is failing to discharge its functions consistently with what he considers to be the interests of the health services, provided that he considers that the failure is significant'[22].

21 The duties that do not apply to CCGs are indicated with an asterix and are the promotion of autonomy, having regard to impact on services in certain areas and variation of provision of health services.

22 House of Commons Library (12 March 2012) *Health and social care bill: summary of Lords Committee and Report stages.*

5.2.3 Direct commissioning

The NHS CB will commission around £20bn worth of services directly, holding around 35,000 contracts[23], as set out in the list below.

- National and regional specialised services;[24]
- Primary care at general practice level;[25]
- Dentistry;
- Community pharmacy;
- Primary ophthalmic services;
- High-security psychiatric services;
- Healthcare for the armed forces and their families;[26]
- Immunisation programmes;*
- National screening programmes;*
- HIV treatment;*
- Children's public health services from pregnancy to 5yrs, including health visiting;[27]*
- Public health services for those in prison or custody;*
- Contraception (as part of GP contract).*

Some of the services above that relate to public health (as indicated with an asterix) will be funded from the national public health budget[28]. A number of other public-health related services previously commissioned by PCTs will in the future be commissioned by local authorities. For example, the remainder of sexual health services, children's public health services from five to19 years and from pregnancy to five years from 2015. A full breakdown of which body/bodies will have responsibility for commissioning public health services can be found in the Department of Health document **'Healthy lives, healthy people: update and way forward'** (section A10, p27).

Local authorities and the new Public Health England (PHE) will provide public-health specialist advice to CCGs and the NHS CB respectively in order to inform the commissioning of services and the NHS CB will be able to commission services on behalf of PHE.

As part of direct commissioning, the NHS CB will be responsible for negotiating the national General Medical Services (GMS) contract for GP services, previously negotiated by the Department of Health, and holding Personal Medical Services (PMS) contracts (also for GP services), previously held and negotiated by PCTs.

23 Op. cit *Developing the NHS Commissioning Board*.
24 As set out in the Specialised Services National Definition Set.
25 This will include the performance management of general practice (as in Op. cit. *Liberating the NHS: legislative framework and next steps).*
26 Op. cit. *Liberating the NHS: legislative framework and next steps.*
27 This responsibility will transfer to local authorities from 2015.
28 Department of Health (2011) *Healthy lives, healthy people: update and way forward.*

The services that the NHS CB commissions will be explicit and CCGs will be expected to commission the remainder of NHS services by default[29]. The NHS Commissioning Board will also be able to commission services on behalf of CCGs if agreed by both parties[30]. The government's original proposals included that the Board should commission maternity services, but following a number of bodies voicing their concern over this, the responsibility for commissioning maternity service was changed and will lie with CCGs[31].

When commissioning services directly, the principles and rules around procurement and competition that will apply to CCGs will also apply to the Board[32].

5.2.4 Clinical Commissioning Groups and commissioning support

The NHS CB will be responsible for the authorisation, oversight and performance management of CCGs. Authorisation is the process by which Clinical Commissioning Groups (CCGs) are deemed ready and able to take statutory responsibility for the commissioning budget. If any CCGs are not ready for authorisation by April 2013, the NHS CB will commission services on their behalf until they are. For more information on the authorisation process, **see guidance** produced by the BMA's General Practitioners Committee.

The Department of Health has said that the NHS CB 'will be less of a hierarchical performance manager than a quasi-regulator of commissioners…' and that 'The headquarters of the NHS will be in the consulting room, not the NHS Commissioning Board[33].'

The NHS CB will develop a medium-term strategy for the NHS, which, together with local priorities, will form the basis of local commissioning plans[34]. It will also translate the NHS Outcomes Framework into the Commissioning Outcomes Framework against which CCGs' performance will be measured. The Health and Social Care Act 2012 sets out that the Board must conduct an annual assessment of the performance of each CCG in the country, and allows payments to be made to CCGs 'in respect of quality'. Secondary legislation (Commissioning Regulations) is expected to flesh out the details of this financial incentive by April 2013.

As part of its role in providing national leadership on commissioning improvement, the NHS CB will develop high-level commissioning guidance for CCGs, drawing upon NICE quality standards[35], which CCGs 'must have regard to' under the Health and Social Care Act 2012. It will also design model contracts for local commissioners to adapt and use with providers[36].

29 Op. cit. *Liberating the NHS: legislative framework and next steps.*
30 Ibid.
31 Ibid.
32 Ibid.
33 Ibid.
34 Op. cit *Developing the NHS commissioning board.*
35 Op. cit. *Liberating the NHS: legislative framework and next steps.*
36 Op. cit. *Government Response to the House of Commons Health Select Committee Fifth Report of Session 2010-11: Commissioning.*

The Board will calculate practice-level commissioning budgets, allocate commissioning budgets to CCGs and hold them to account for financial performance. 'As Accounting Officer, the NHS Commissioning Board's Chief Executive will be accountable to the Department of Health for the overall commissioning revenue limit. The NHS Commissioning Board will be responsible for preparing a consolidated annual account in respect of all consortia, which will form a key element in the Department's overall resource account'[37].

The Health and Social Care Act 2012 allows the Board to provide financial assistance and support to a CCG, as well as pool funds with one or more CCG. It may also use various intervention powers if it believes that a CCG is, has or may fail to discharge its functions. These include the ability to dismiss the accountable officer of a CCG and then re-appoint, vary the membership and boundaries of a CCG and dissolve a CCG.

Commissioning support encompasses a range of functions, from transactional services such as payroll and IT services, to equipping CCGs with the complex population level data required to inform commissioning decisions. Many PCT clusters are developing commissioning support services (CSSs) for their local CCGs.

The NHS CB will temporarily host CSSs (this means that the NHS CB will be the employer of CSS staff) that grow from PCT clusters from April 2013 where those services demonstrate, through the business review, that they will be viable. It is proposed that all these services will move to freestanding models, for example by forming social enterprises or to partner with other organisations, including the private sector, by April 2016 at the latest[38].

5.2.5 Clinical networks and senates

The establishment of clinical networks and senates was announced following the first set of recommendations made by the NHS Future Forum on the reform proposals in June 2011[39]. Clinical networks will be condition or service area specific, and clinical senates 'are intended to bring together

37 Op. cit. *Liberating the NHS: legislative framework and next steps.*
38 Department of Health (2012) *NHS Commissioning Support Services factsheet.*
39 Department of Health (2011) *Government response to the NHS Future Forum report.*

a range of experts, professionals and others from across different areas of health and social care to offer access to independent advice about improvements in quality of care across broad geographical areas of the country'[40]. Both senates and networks are intended to pool specialist expertise and thereby support the work of CCGs [41] and will be hosted by the NHS CB.

5.2.6 Choice and competition

Following recommendations from the NHS Future Forum in June 2011, the Government announced that the Secretary of State would issue a 'choice mandate' to the NHS Commissioning Board. This will establish the parameters for choice and competition in all parts of the NHS, setting out clear expectations about the scope and operation of patient choice[42] and will be translated into guidance on procurement by the Board, in consultation with Monitor, for CCGs[43].

In addition, secondary legislation (in the form of Commissioning Regulations and Standing Rules) will be put in place by April 2013 in order to flesh out much of the detail around commissioning arrangements, and in particular commissioners' requirements around choice and competition.

For more information on choice and competition in the NHS reform proposals refer to another of the briefing notes in this series **'Choice and any qualified provider'**.

5.2.7 Pricing

The NHS CB and Monitor will be jointly responsible for the national tariff, Payment by Results (PbR)[44]. The Board will design the pricing structure for PbR, as well as that for the Commissioning for Quality and Innovation (CQUIN[45]) payment framework and best-practice tariffs[46], and Monitor will set the pricing levels. For more information on pricing and Monitor's role in particular, refer to another of the briefing notes in this series **'Monitor and regulation'**.

40 Department of Health (2011) *Developing clinical senates and networks* (Dear colleague letter from Kathy McLean, 15 September 2011).
41 Op. cit. *Government Response to the House of Commons Health Select Committee Fifth Report of Session 2010-11: Commissioning.*
42 Op. cit. *Government response to the NHS Future Forum report*.
43 Op. cit *Developing the NHS commissioning board.*
44 Responsibility for PbR currently lies with the Department of Health.
45 For more information about CQUIN see the NHS Institute for Innovation and Improvement's website http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html.
46 For more information on best-practice tariffs see the Department of Health's website http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_105080.

5.3 How will the NHS Commissioning Board do it?

5.3.1 Funding

The Board's running costs budget for 2014/15 will be £492 million[47], representing 50% less funding than will made available in the first year of full operation (2013/14). This figure is also a third lower than the running costs of predecessor organisations in 2010-11[48]. Staffing will account for around 65 per cent of costs, as is in line with NHS norms.

5.3.2 Values and culture

A set of values and way of working have been established, in summary the NHS CB will:

- Focus on improving quality and outcomes;
- Make patients, clinicians and carers central to decision making;
- Offer leadership and direction;
- Be easy to do business with;
- Be objective and use evidence to inform activities;
- Be flexible, promote integration, work across boundaries and at the right level;
- Be committed to partnership working, particularly with CCGs;
- Be open and transparent; and
- Have clear accountability arrangements[49].

5.3.3 Accountability and partners

The Board will be accountable to the Secretary of State, Parliament, the Department of Health and the Treasury[50]. CCGs will be accountable to the NHS CB.

Advice will be provided to the NHS CB by both NICE[51] and the new national patient group, Healthwatch England[52]. New Health and Wellbeing Boards, operating at local authority level, will have a duty to have regard to the Secretary of State's mandate to the Board when preparing the joint health and wellbeing strategy[53]. Further Health and Wellbeing Boards will be able to write formally to the NHS Commissioning Board if CCGs' local commissioning plans do not adequate regard for the JHWS. For more information on Healthwatch and Health and Wellbeing Boards, refer to another of the briefing notes in this series, **'Local accountability'**.

47 Op. cit. *Design of the NHS commissioning board.*
48 Op. cit. *The operating framework for the NHS in England 2012/13.*
49 Op. cit *Developing the NHS commissioning board.*
50 Ibid.
51 Op. cit. *Equity and excellence: Liberating the NHS.*
52 Op. cit. *Liberating the NHS: legislative framework and next steps.*
53 Ibid.

The NHS CB will need to work closely with Monitor, in relation both to pricing and regulation of the health sector in terms of how rules around choice and competition are to be applied. It will also need to work with local authorities and Public Health England in relation to emergency planning and direct commissioning, and with local authorities specifically on the promotion of joint commissioning (between health and social care).

For more detail on the partnerships that the NHS CB will be developing see the Department of Health document **'Developing the NHS Commissioning Board'**.

6. What we don't know

While a lot of information is already available on the NHS CB, much detail is still lacking. The NHS CBA will be firming up arrangements for the Board's future operations during the transitional year, 2012/13, before it takes on its full, statutory operations from April 2013. However given that the Board is part of such a major structural re-organisation of the NHS' commissioning and managerial infrastructure, it is likely to be some time until we have a full understanding of the impact it will have on the NHS, those working within it and those using it.

The list below outlines just some of the areas where uncertainty remains. Gaps will be filled in a number of ways including with secondary legislation, guidance, further policy development and on-the-ground solutions and experience.

Corporate governance

- The frequency of Board meetings
- How appropriate levels of professional advice and expertise will be incorporated into the Board's deliberations, particularly around public health

Organisational structure

- The final structure and responsibilities of the NHS CB's directorates
- Precise details of the 50 local offices, including location

Personnel

- Who will be appointed to the post of National Director of Policy, partnerships and corporate development
- A minimum of nine further non-executive appointments to the Board

Staffing

- The final numbers of staff that will be employed at national, regional and local level
- The second phase of the NHS CB's People Transition Policy and the recruitment process
- How the NHS CB will deliver all of its functions with a significantly reduced workforce compared with predecessor organisations

Secretary of State's mandate

- How it will look, what the specific requirements will be and how the NHS CB's performance will be measured against it
- The scope of the 'choice mandate'

Legislative duties

- How the NHS CB will reconcile the numerous potentially conflicting duties it has. For example, promoting integration and education and training, at the same time as promoting patient choice (and thereby competition).

Direct commissioning

- We are awaiting further guidance from the Department of Health during 2012/13 on the operational requirements for the transfer of direct commissioning responsibilities from PCTs to the NHS Commissioning Board[54]
- How the NHS CB will manage the transfer of around 3,000 PMS contracts for GP services currently held by PCTs, on top of the transfer of many other existing primary care contracts
- The national operating model that will be designed for specialised commissioning
- Whether the NHS CB will commission services on behalf of PHE in the future
- How dividing the commissioning of public-health-related services between the NHS CB and local authorities will work in practice
- Whether PCT PFI debt will be transferred to the NHS CB or CCGs, and how the new national property company PropCo being set up by the Department of Health will manage the estate of PCTs once they are abolished
- Whether existing contracts between PCTs and providers, for example 'right to request/provide' social enterprises and ISTCs, will be transferred to the NHS CB or CCGs

Clinical commissioning groups (CCGs) and commissioning support

- How the authorisation process will go and whether all shadow CCGs will be authorised by April 2013
- If some CCGs are not authorised by April 2013, how the NHS CB commissioning services on their behalf will work in practice
- Whether the Board will use its intervention powers in respect of CCGs
- The role the Commissioning Outcomes Framework will play in the performance management of CCGs and how any financial incentives for commissioning will be awarded
- The NHS CB will be developing a revised standard NHS contract, procurement guidelines and commissioning guidance for CCGs
- The final configurations of commissioning support services and ownership models after 2016, once the NHS CB no longer hosts them

Clinical networks, senates

- Details and configurations of clinical networks and senates, and how they will interact with the NHS CB and CCGs in practice
- Whether the NHS CB will host networks and senates in the long term

Choice and competition

- We are awaiting secondary legislation (Commissioning Regulations and Standing Rules) as well as procurement guidance from the NHS CB

54 Op. cit. *The operating framework for the NHS in England 2012/13*

Pricing

- Whether the NHS CB will make any significant changes to the national tariff and other pricing mechanisms (CQUIN, best-practice tariffs)
- How the division of responsibility for the national tariff between the NHS CB and Monitor will work in practice

Funding

- What precisely the £492 million budget for 2014/15 will need to cover (the NHS CBA is currently in discussion with the Department of Health on this[55])

55 For more information on what we already know the budget covers, see op. cit. *Design of the NHS Commissioning Board*

Annex A
Provisional details of the nine directorates of the NHS Commissioning Board

The following information is taken from a paper to the NHS CBA's meeting of 2 February 2012, making detailed recommendations for the establishment of nine directorates. The provisional structure and responsibilities is summarised below.

1. ***National Medical Director*: key responsibilities**
   a. Drive quality improvement through clinical leadership in domains one to three of the NHS Outcomes Framework[56].
   b. Support clinical networks and senates
   c. Provide clinical advice to the Department of Health, arms-length bodies and across government

2. ***Chief Nursing Officer*: key responsibilities**
   a. Drive quality improvement and better outcomes for patients in domains four to five of NHS Outcomes Framework
   b. Clinical and professional nursing/midwifery leadership
   c. Patient safety and experience

3. ***Chief Operating Officer***
   a. Centre Operations: key responsibilities
      i. Oversight of delivery of direct commissioning
      ii. CCG assurance and assessment
      iii. Emergency preparedness
   b. Sector Operations: key responsibilities
      i. Co-ordination and oversight of local offices
      ii. Management of delivery of specialised commissioning
      iii. Support and co-ordination of clinical senates and networks
      iv. Performance oversight, including intervention and failure regime
      v. Involvement in large scale reconfigurations
      vi. Co-ordination and oversight of emergency preparedness
      vii. Stakeholder engagement, particularly with sub-national presence of bodies such as CQC and Monitor
      viii. Information functions on behalf of PEII (see directorate 9 below).
   b. Local Operations: key responsibilities[57]
      i. Commission primary care services
      ii. Assess and assure CCG performance
      iii. Manage local partnerships and stakeholder relations (including Health and Wellbeing Boards)
      iv. Family health services

56 See the BMA's summary of the NHS Outcomes Framework http://www.bma.org.uk/healthcare_policy/nhsoutcomesframework20112012.jsp.
57 Note that some local offices may take on some of these functions on behalf of others.

4. *National Director: Commissioning Development:* key responsibilities
   a. Strategic oversight of CCGs and commissioning support
   b. Develop commissioning rules, tools, guidance and incentives

5. *National Director: Improvement and transformation:* key responsibilities
   a. Strategy for improving quality and productivity (Improvement Body)
   b. Leadership development (NHS Leadership Academy)
   c. Reducing health inequalities and promoting equality

6. *National Director: Patient engagement, insight and informatics (PEII):* key responsibilities
   a. Patient and public voice
   b. Transforming patient experience through information and technology

7. *National Director: Finance:* key responsibilities
   a. Payment by Results/the national tariff
   b. CCG allocations
   c. General financial management and accounting

8. *National Director: Policy, partnerships and corporate development:* key responsibilities
   a. System policy
   b. Negotiation of the Mandate with the Secretary of State
   c. Choice and competition
   d. Accountability and governance

9. *Chief of staff:* key responsibilities
   a. HR and organisational development

Annex B
Personnel appointed to the NHS Commissioning Board

Executive directors

Sir David Nicholson, Chief Executive
Currently NHS Chief Executive

Sir Bruce Keogh, National Medical Director
Currently NHS Medical Director

Jane Cummings, Chief Nursing Officer
Currently Nursing Director of NHS North of England

Ian Dalton, Chief Operating Officer
Currently Chief Executive of NHS North of England

Dame Barbara Hakin, National Director for Commissioning Development
Currently National Managing Director for Commissioning Development at the Department of Health

Jim Easton, National Director for Improvement and Transformation
Currently National Director for Improvement and Efficiency, leading on QIPP

Bill McCarthy, National Director for policy, corporate development and partnership
Currently Managing Director of the NHS CBA, formerly Chief Executive of NHS Yorkshire and the Humber

Paul Baumann, Finance Director
Currently Director of Finance, NHS London

Jo-Anne Wass, Chief of Staff
Currently NHS Chief of Staff

Non-executive directors

Professor Malcolm Grant, Chair of the Board
President and Provost, University College London

Ed Smith, Chair of the Audit Committee
Pro-Chancellor and Chairman of Council, University of Birmingham