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The Government's strategic objectives for the NHS Commissioning Board Authority

The Health and Social Care Act has now passed into law. At its heart are two simple principles. First, that patients should have more control over the care they receive. Second, that those responsible for patient care – the doctors, nurses and others who work in our NHS – should have the freedom and powers to lead an NHS which delivers continually improving care for its patients.

The Health and Social Care Act explicitly supports the core principles of the NHS: care provided free at the point of use, funded from general taxation, and based on need and not ability to pay. But the Act is only the beginning of a journey. My ambition is for a clinically-led NHS that delivers the best possible care for patients. I look to you and your colleagues in the NHS to take advantage of the new freedoms that the Act has put in place.

NHS Commissioning Board Authority - accountability

I would like to thank you and your team for engaging so positively in our first DH-NHSCB accountability meeting, on 21 February. I was very glad to hear your commitment to bring to life our shared vision of a vibrant clinical commissioning system.

In the meeting, we discussed my ambitions for developing the Board, and I said I wanted to take the opportunity to put these on the record. So I am using this letter to set out formally the Government's strategic objectives for the Authority; this will help provide a clear basis for future meetings.

The letter is formally about the NHS Commissioning Board Authority, and is the basis against which Ministers will hold the Authority to account. But the objectives in it are about the whole transition stage of developing the new commissioning structures. So they will be relevant not only to the period when the Authority is operating (until October 2012), but also to the full NHS Commissioning Board when it is established, in its preparatory phase from October 2012 until March 2013.

From April 2013, when the Board takes on its full statutory powers, Ministers will set their objectives, on behalf of the Government as a whole, through the mandate. We are currently starting to develop proposals for the mandate, and we aim to consult this summer, before publishing the first mandate in the autumn. As you know, among other objectives, the mandate will incorporate our ambitions against the NHS Outcomes Framework, which will be at the heart of the Board's work in driving improvements in the quality and outcomes of care.

Because the letter reflects our discussion, I am not issuing a separate note of our meeting. However, for the sake of transparency, I intend to publish minutes of all our future accountability meetings.

The Government's objectives

The Department will hold the Authority to account for its performance against four strategic objectives, relating to:

- transferring power to local organisations;
- establishing the commissioning landscape;
- developing specific commissioning and financial management capabilities; and
- developing excellent relationships.

These objectives flow from the Authority's role to prepare for the establishment and operation of the NHS Commissioning Board which will be established in line with the Health and Social Care Act 2012. The

Act provides a clear legal framework for the operation of the Board and for its accountability to the Department. The objectives will need to be delivered in the context of the Board's responsibility to contribute to the achievement of:

- improvements in health for the whole population;
- better quality of care and outcomes for all patients; and
- increased value for the taxpayer through robust financial management and improved efficiency and productivity.

Delivering the transfer of power to local organisations

As you know, at the heart of our shared agenda for the NHS is a commitment to achieving a fundamental shift of power from national and regional organisations to Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards, local providers and patients.

The challenge for the Authority is to ensure that preparations for the Board make a reality of this commitment. The principle of decentralisation of decision-making and promoting the autonomy of CCGs must be embedded within the culture of the Board. It should inform the approach that the Board takes in relation to all of its functions, and CCGs and their leaders should be closely involved in the development of the Board.

<u>The first – and overarching – objective is to design the Board so that it transfers power to local organisations.</u>

Establishing the commissioning landscape

A first step in transferring power to local clinicians is for the Board to authorise Clinical Commissioning Groups.

A core task of the Authority is to prepare for the Board to deliver a rapid, effective and safe authorisation process. CCGs will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so. Therefore the role of the Board will be to engage and support emerging CCGs, to maximise the number that can be authorised fully, without conditions, by April 2013. For each of those authorised with conditions, there should be a clear timetable and path to

full authorisation. All authorisation conditions will be time-limited rather than enduring.

A number of CCGs are already pressing ahead and taking on delegated budgets. The Government expects this process to accelerate so that many CCGs are able to operate in this financial year in a similar way to next year. I expect lessons to be learnt from the PCT clustering process so that the Authority is able to plan for a transition to CCGs that delivers excellent knowledge management and a focus on quality and safety, while maintaining robust financial management and delivering against QIPP plans.

Clinical Commissioning Groups will have the freedom to work with whomever they want to in securing support for commissioning health services. As statutory organisations, CCGs will be able to choose commissioning support from whatever organisations in whatever sectors are best able to meet their needs. CCGs will hold the money for commissioning support and there will be no topslicing for this purpose. It is understood that, in the first instance, as commissioning support is further developed, there is likely to be a need for central hosting of support organisations; but, the Board will not have a long-term role in providing or hosting commissioning support services. The Authority should prepare for the establishment of the Board on this basis, and ensure that arrangements for 2012/13 support both the rapid achievement of this expectation as well as choice for CCGs.

In order to support the aims of clinically-led commissioning and the promotion of effective partnership and collaborative working, the role of clinical networks and senates will be to provide leadership and insight rather than oversight and compliance. The Authority and Board should closely involve CCGs and their leaders in the development of networks and senates. In relation to specialist services, we would expect the Board to commission within the context of local need; and for this to be reflected in the preparatory work of the Authority.

Our aim is to move away from the top-down management of the NHS to a system where fully authorised CCGs will have, as the Future Forum put it, ‘assumed liberty’; within our common framework of the comprehensive National Health Service as set out in the Health and Social Care Act. The Authority will therefore need to prepare for the

Board to establish a transparent, rules-based system in which the Board's approach to issues such financial risk pooling, and interventions in the event of poor performance, distress and failure, are clearly set out for CCGs. I look forward to hearing more from the Authority on this topic.

The second objective is to support the establishment of the commissioning landscape by making arrangements for:

- comprehensive establishment of CCGs and full authorisation of as many CCGs as possible by April 2013;
- any conditions on authorisation to be non-enduring and time-limited with support for moving CCGs from partial to full authorisation;
- CCGs to be in full control of commissioning support;
- clinical networks and senates to become invaluable sources of advice and insight to commissioners; and
- developing a transparent, rules-based approach to the Board's interactions with CCGs.

Developing specific commissioning capabilities

Our ambition for the commissioning system is likely to require significant development of existing capabilities in a number of specific areas.

The Board will have a vital leadership role in making a reality of 'no decision about me without me' and greater personalisation of care. This includes opening up the choices available to patients, and the development of personal health budgets where appropriate. An information revolution, with greater transparency, is essential to support choice and reduce variation in the quality and outcomes.

We are committed to making rapid progress in integrating health and social care around the needs and wishes of users and carers, and I expect the Authority to make plans for how the Board will play a full part in delivering this ambition.

Related to this, the way the Board commissions primary care, working closely with CCGs, will be critical to tackling variation in services and driving quality improvement: for example, in early diagnosis.

Providing patients with greater choice will depend in part on the development of a level playing field in which the best providers can flourish, and the Board will, with others, have a crucial part to play in making this happen.

The Government is also committed to major expansion and development of the current NHS pricing systems, and this is likely to require investment by both the Board and Monitor in significant additional capacity and expertise.

The third strategic objective is for the Authority to prepare the Board so that it has the capability and capacity to drive significant improvements in:

- patient empowerment;
- integrated care around the needs of users;
- supporting the development of a level playing field for providers;
- the commissioning of primary care; and
- currencies for pricing systems.

Developing excellent relationships

The Board will need to form productive and enduring relationships with a wide range of organisations within and beyond the NHS, not least the Department's other Arm's Length Bodies, each of which has its own defined statutory duties, powers and responsibilities. The Department will look to all of its ALBs, including the Board, to work effectively in collaboration in pursuit of our common purpose.

The fourth strategic objective is for the Authority to lay the foundations for the Board to develop excellent relationships with its main partners, supporting common purpose and recognising unique and respective roles.

Conclusion

I am very grateful for all you and your team have done in the early phases of your work in the Authority. I look forward to hearing about your progress in preparing for the establishment and operation of the Board in accordance with the objectives set out in this letter. I am confident that we can build on this positive start to create a successful partnership between the Department and the Authority and, in future, the Board, to help secure the improvements in patient care and outcomes that we all want to see.

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