NHS Commissioning Board: Organisational Design

Discussion draft – OD workshop

14 February 2011

Goals for today

- Take stock of where we are in creating the new NHS Commissioning Board and broader system
- Reach an agreement and agree next steps on:
  - **Structures:** Problem-solve around potential models for sub-national structure to guide the ongoing OD work
  - **Culture:** Set aspirations about how we work - and how the new NHS will embody our values and culture
  - **Physical space:** Leveraging the power of the physical space to strengthen our culture
  - **Managing change:** Agree on key aspects of whole system change, such as co-production
- Agree next steps and deliverables
- Anything to add?

Proposed agenda

Agenda item	Format	Lead	Time
Welcome, introductions, goals for the day	▪ Discussion; buffet lunch	Colin	13:15
Overview of context, aspirations and goals	▪ Facilitated discussion	Tim/Helen/ Colin	13:30
1. Structures: ▪ **Selected organisational examples**	▪ Presentation and discussion	Angela	13:50
▪ **Potential models for sub-national structures**	▪ Presentation ▪ Facilitated discussion	All Colin/Helen/ Angela	14:20
Break	▪ Coffee/tea		14:50
2. Creating a new culture	▪ Presentation ▪ Facilitated discussion	Colin	15:00
3. Physical space	▪ Video ▪ Facilitated discussion	Andrew M	15:30
4. Managing change	▪ Discussion	All	16:15
Close			16:45

Facilitation guide

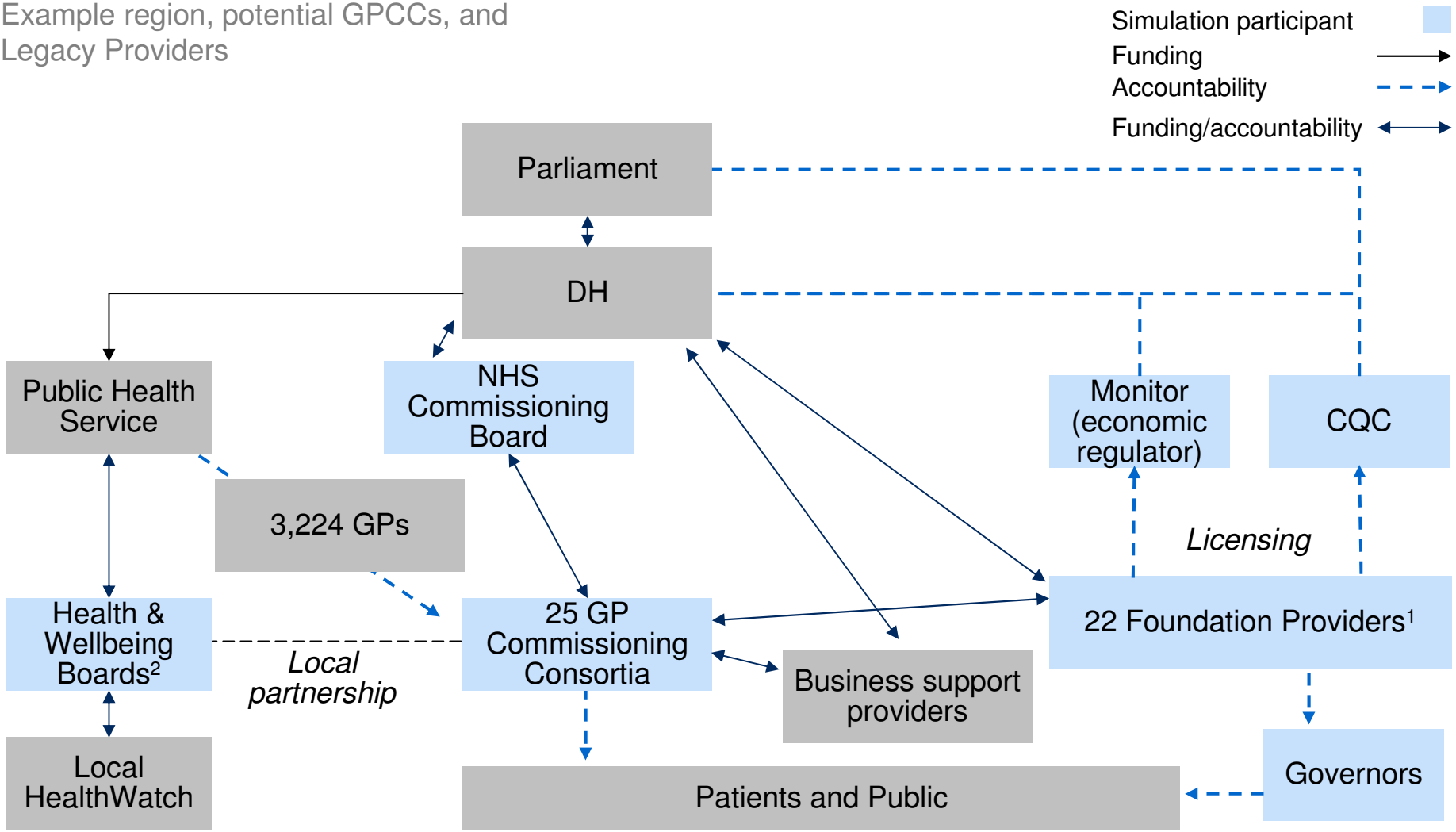
Agenda item	Description
Welcome, introductions	▪ Setting aspirations for the afternoon
Overview of context, aspirations and goals	▪ Setting context and goals (David) ▪ Taking stock on work to-date (value, culture, structure); Tim/Helen ▪ Facilitated discussion on emerging design criteria (Colin)
1. Structure ▪ **Selected organisational examples**	▪ Presentation of selected organisational examples (Angela). Proposed models: – Kaiser Permanente – Professional Services model – Health systems model (New Zealand Health Board)
▪ **Potential models for sub-national structures**	▪ Presentation of selected models (Colin/Tim/Helen/Angela) ▪ Facilitated discussion (Colin) ▪ Stress-testing new models through 3 scenarios: GPC development and/or default; reconfigurations; delivering QIPP and innovation
2. Creating a new culture	▪ Facilitated discussion on performance and health for the new organisation: culture, values, people (Colin)
3. Physical space	▪ Video and facilitated discussion on enacting changes to physical space to strengthen our vision (DH team/Andrew Mawson)
4. Managing change	▪ Emerging values ▪ Defining a vision and principles for managing change (e.g. co-production) ▪ Agreeing key next steps, interactions and deliverables (Helen/Angela) ▪ Wrap up (Colin)

Proposed materials

- **Goals for the day**
- **Overview of context**
- Selected organisational examples
- Potential models
- Creating a new culture
- Physical space
- Managing change

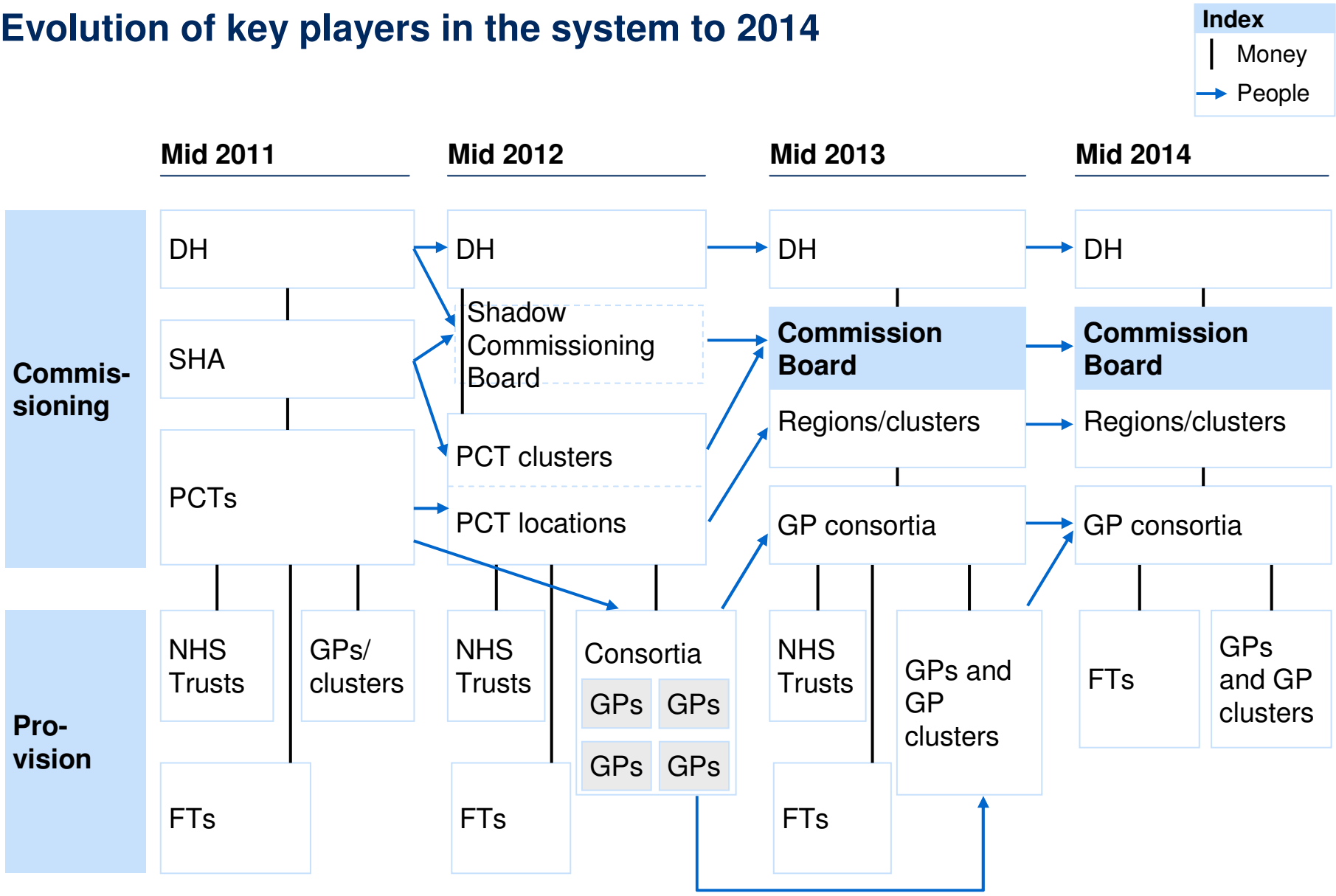
Towards a new system structure by 2014

Example region, potential GPCCs, and Legacy Providers

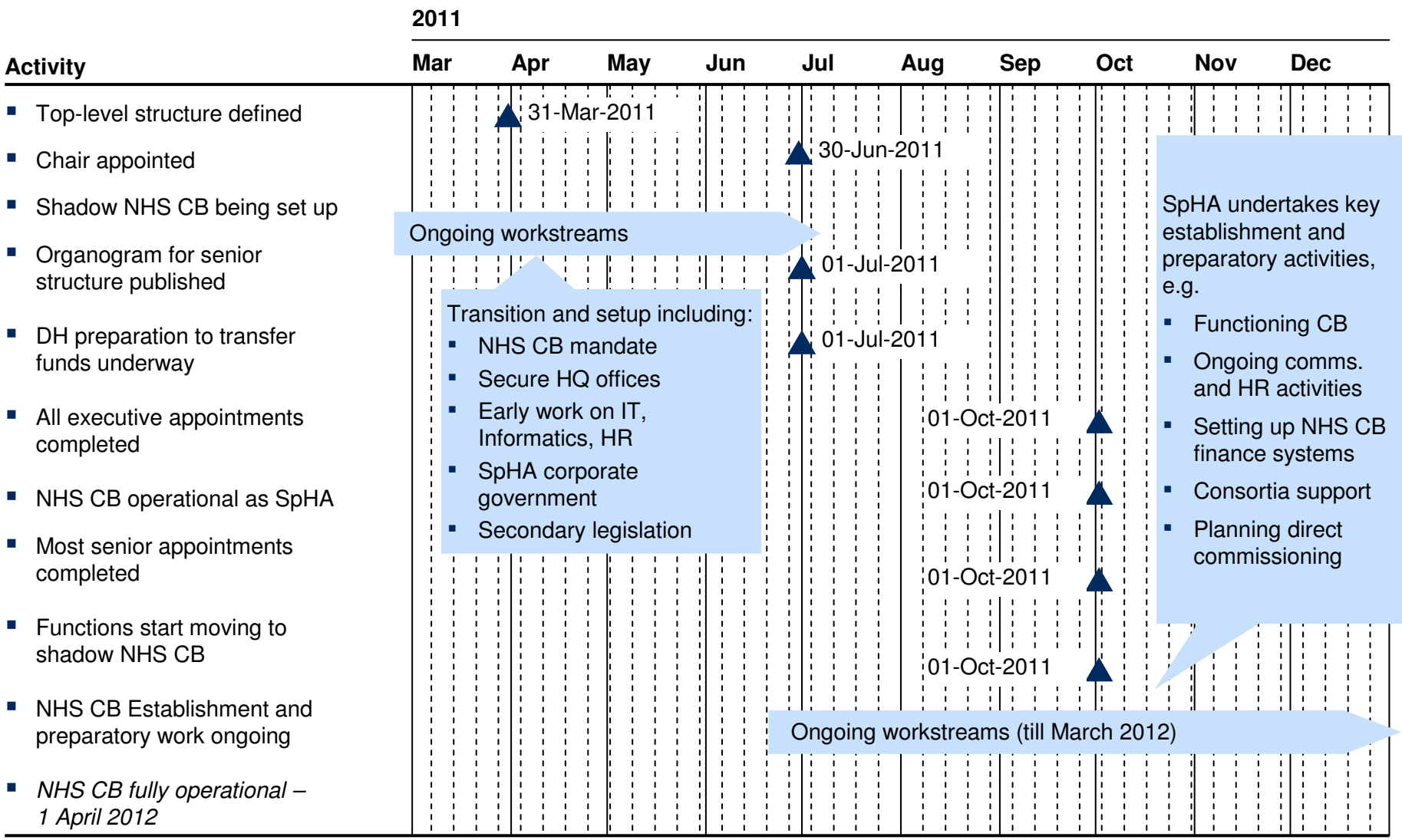


1 Includes14 Acute Trusts 1 Children's Trust, 6 Mental Health Trusts, 1 Ambulance Trust
2 Local Authority link and representation

Evolution of key players in the system to 2014



High-level milestones



What we know so far: Commissioning Board Duties and accountabilities

Objectives of the NHS CB

- *Supporting continuous improvements in quality and outcomes of NHS funded services*
- *Promoting choice and patient engagement*
- *Establishing, supporting and holding to account GP consortia*
- *Directly commissioning certain services (e.g. Primary Care)*
- *Allocation of and accounting for NHS resources*
- *Reducing inequalities in access to healthcare*

Broader duties and accountabilities

- Promote a comprehensive health service
- Ensure every provider of primary medical services is a member of a consortium and that collectively they cover the whole of England
- Promote autonomy for consortia and other bodies
- Perform functions effectively, efficiently and economically and ensure overall commissioning expenditure does not exceed the allocated budget for that year across the NHS
- Continuously improve quality of services
- Reduce inequalities, promote choice/involvement
- Emergency preparedness
- Promote innovation
- Commission and promote research
- Promote local integration of NHS and LA services and collaboration of consortia with LAs
- Operate systems for collecting and analysing information relating to patient safety
- Collaborate with regulators, e.g. Monitor on tariff setting

Early design criteria – for discussion

- Culture of co-production
- Only doing at national level what needs to be done at national level
- Lean structure, including the top team, and effective spans of control
- Quality, standards and patient empowerment at the heart of all we do
- Authority and accountability transparently linked
- Low running costs across the system
- Do not default to traditional regional/sub-regional arrangements, but…
- …leverage local resources and structures (e.g. LAs) to deliver jointly through new models
- Focus on key enablers for commissioning system success, such as:
    - New, empowering culture and behaviours
    - Developing and supporting our people to think and act as suits the new model
    - Robust and shared information flows
    - Robust management of performance
    - New structures and physical space reinforcing new ways of working and values
    - Strategic outsourcing to keep the system lean and focused

Agenda and goals for the day

- Goals for the day
- Overview of context
- **Selected organisational examples**
- Potential models
- Creating a new culture
- Physical space
- Managing change

Selected examples – for discussion

1. **Kaiser Permanente**
   - Overview of leadership
   - Potential learnings

2. **Professional services firms**
   - Overview of model
   - Structures, systems, talent and other processes, as well as values underpinning quality of delivery

3. **Other Healthcare systems**
   - New Zealand Health Board

1 The new NHS Commissioning System bears similarities to the Kaiser Permanente model

NHS

NHS Commissioning Board

GP Commissioning Consortia

Doctors/Groups

Hospital

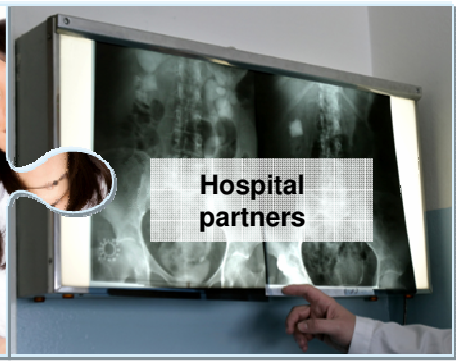
KAISER PERMANENTE

Kaiser Foundation

(non profit)

Permanente Medical Groups

Hospital



1 Kaiser Permanente is a world-class primary care-led integrated healthcare delivery system

US EXAMPLE

KAISER PERMANENTE

- The pre-eminent integrated model in the U.S. for delivering high-quality, primary care led, affordable health care
- 8.7 million health plan members, ~157'000 employees, ~13'000 physicians, 32 medical centres, 416 medical offices, $34.4 billion in annual operating revenues across 8 regions

- Quality programs in every region systematically help maintain the highest levels of quality performance
- KP Colorado ranked in top US 10 health plans in 5 key areas in respiratory, diabetes, and cardiovascular disease

- Effective, primary care-led management of chronic conditions
- Registries and care management programs utilize data to support population-based care.
- Use of clinical pharmacists and commitment to generic to manage drug costs.
- Proactive health education programs and preventive medicine patient outreach

Kaiser engages its patients fully in disease prevention and care management, closely monitoring

- ***Health status***
- ***Usage patterns***
- ***Compliance***
- ***Quality outcomes***
- ***Patient satisfaction***
- ***Risk***

- Physician leadership ensures engagement in all KP programs, initiatives and strategies.
- It is critical to the successful implementation of innovations such as electronic medical records, patient support tools or use of disease registries

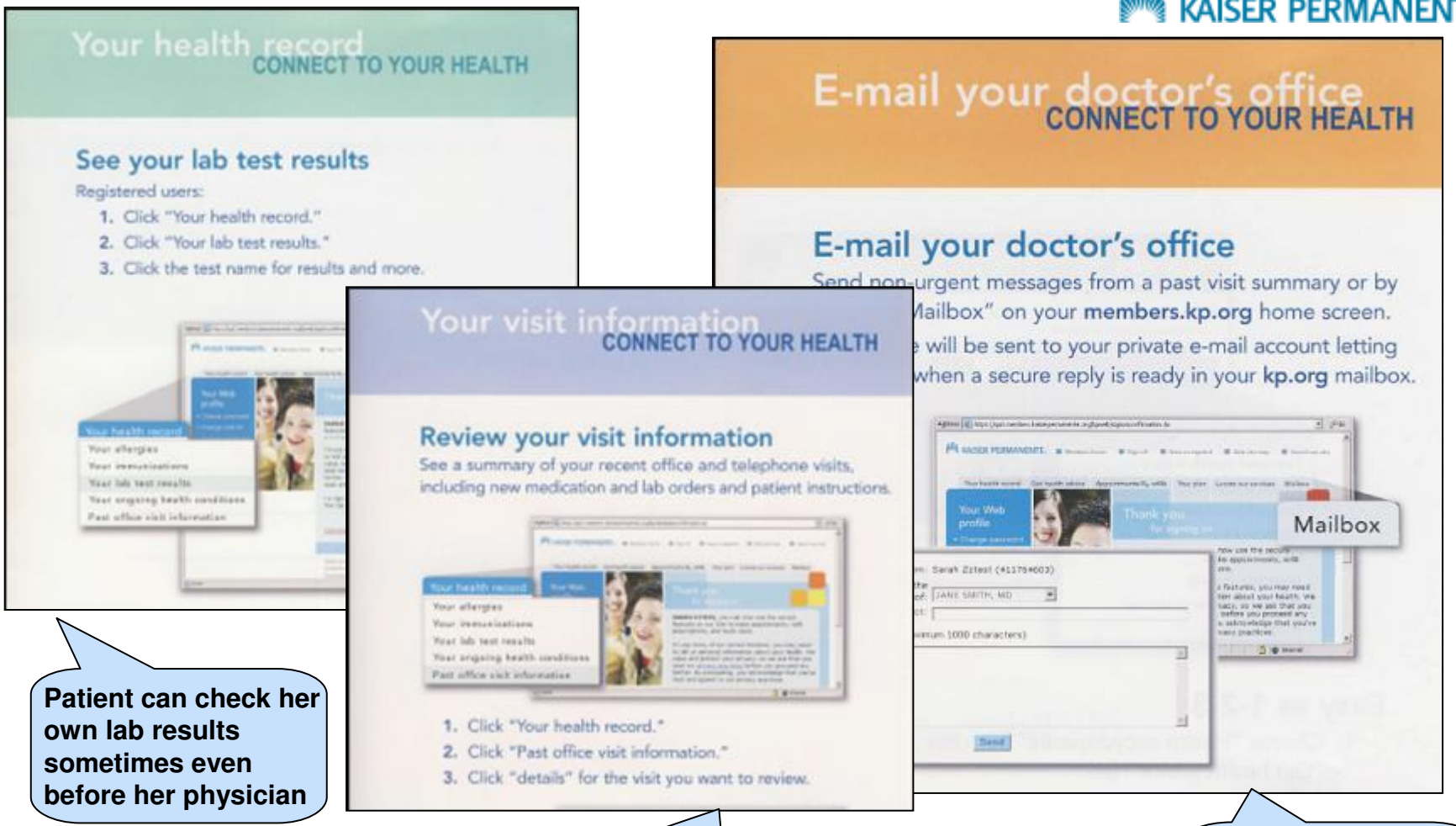
- Integrated health informatics system, "KP Connect" across inpatient and ambulatory care settings –Electronic Medical Record, billing, referral management, laboratory, and external provider interfaces.
- Enables integrated operational decisions in real time, and research to shape better evidence-based medical care

Source: Kaiser Permanente, 2007

1 KP's 'Health Connect' is an integrated care management system with a rich patient interface

US EXAMPLE

KAISER PERMANENTE®



Patient can check her own lab results sometimes even before her physician

Patients can view visit info and refill prescriptions online for home delivery

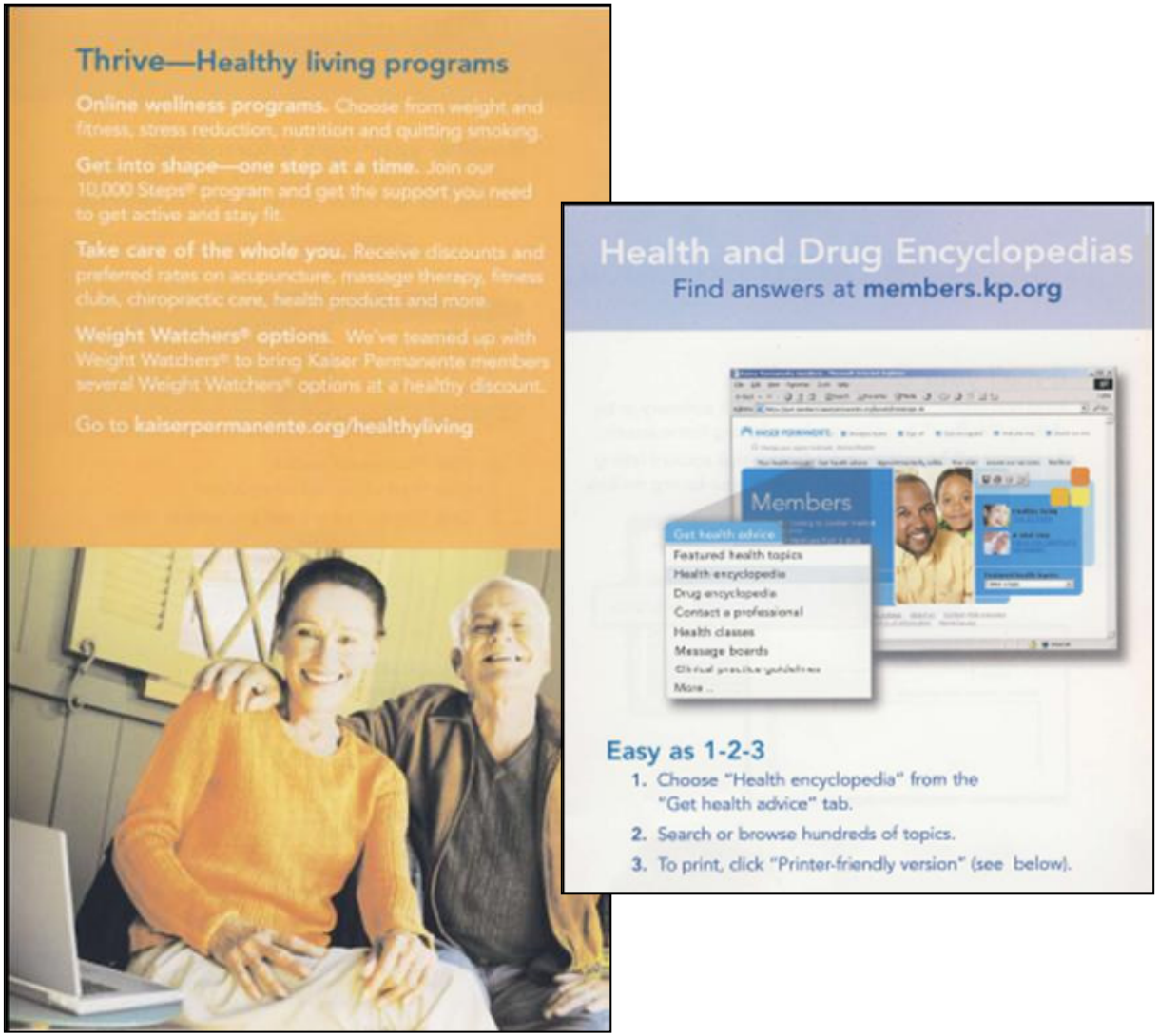
Doctors receive on average 5 patient emails per day

Source: Kaiser Permanente

1 The patient interface is also used for patient education and social marketing

US EXAMPLE

KAISER PERMANENTE®



Use of the internet for patient care leads to

- Excellent patient service: customers ask for, appreciate and use the online capabilities.
- Increased productivity for employees at work – less absenteeism, less loss of productivity due to health conditions while at work.
- Efficient use of clinical providers' time: questions can often be answered without a clinic visit.

Source: Kaiser Permanente

1 The system combines centralism and devolution, through shared values and use of incentives, processes and systems to reinforce them

PLACEHOLDER –

New Org Chart page to be added

Source: Kaiser Permanente

1 Key features and learnings

Key features

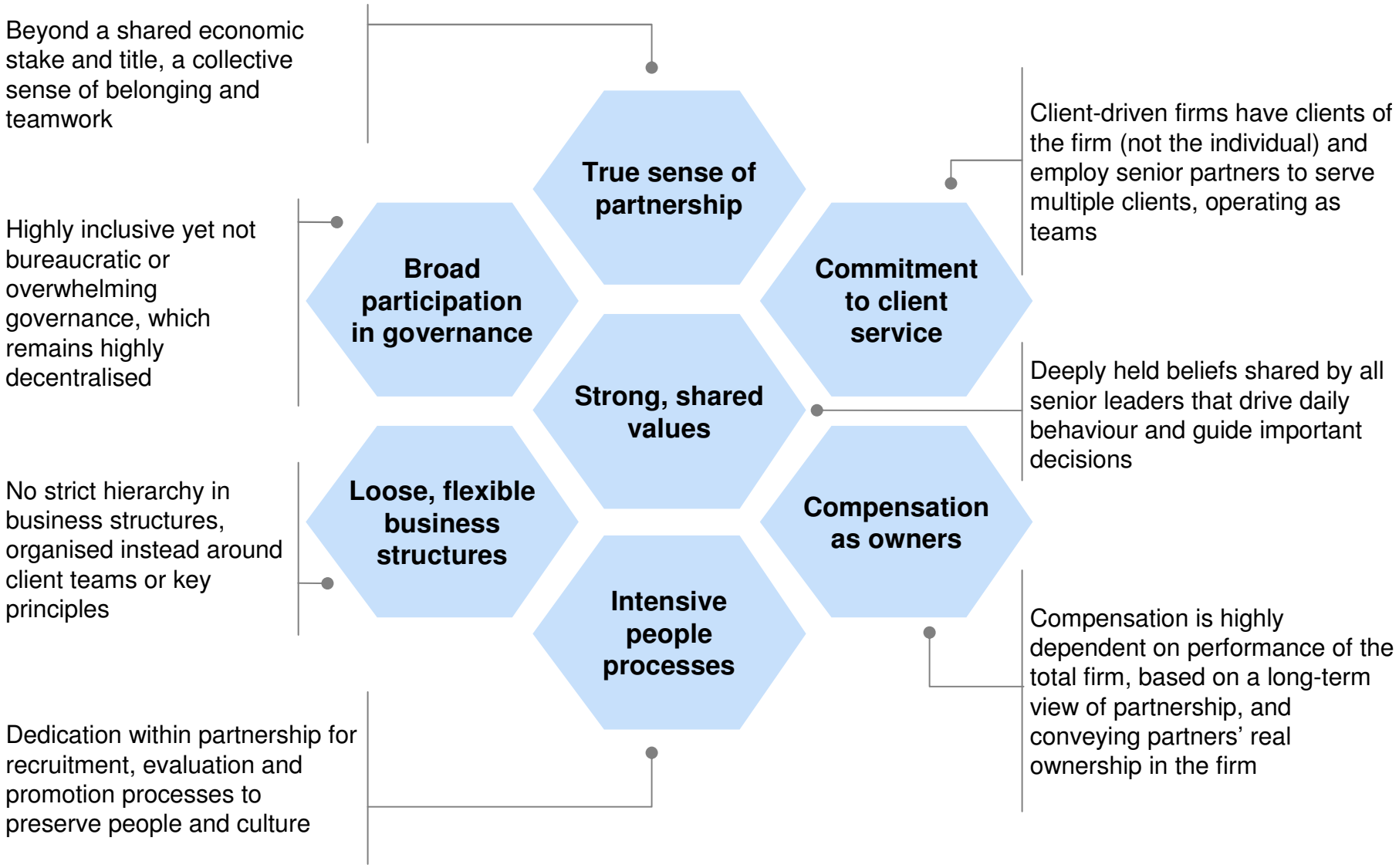
- Joint non-profit/for-profit structure in each region (e.g. Kaiser Foundation Health Plans and Physician-owned Permanente Medical Groups)
- Locally-led by independent legal entities (PMGs) with own management and governance structures, organising nationally through the Permanente Foundation
- Set industry standards in clinical management through early detection and management of disease
- Dramatic improvement of quality through
  - Joint regional boards of clinicians/owners and health plans leads to improve quality and share best practice
  - Physician leadership in both care delivery and quality improvement
  - Embedded project managers and analysts locally by Kaiser's Care Management Institute
  - Informatics and patient care coordination seen as paramount

Learnings for the NHS Commissioning Board

- Harnessing the power of information is critical both for performance transparency and for sharing best practice
- Integrated care models could be tested further in the NHS assuming the right incentives are in place
- Combination of organisational/personal incentives for physicians and for profit/non profit structures may not work everywhere

Source: team analysis

2 Professional services: key elements of a partnership model



Source: McKinsey Quarterly

2 Key features and learnings

Key features

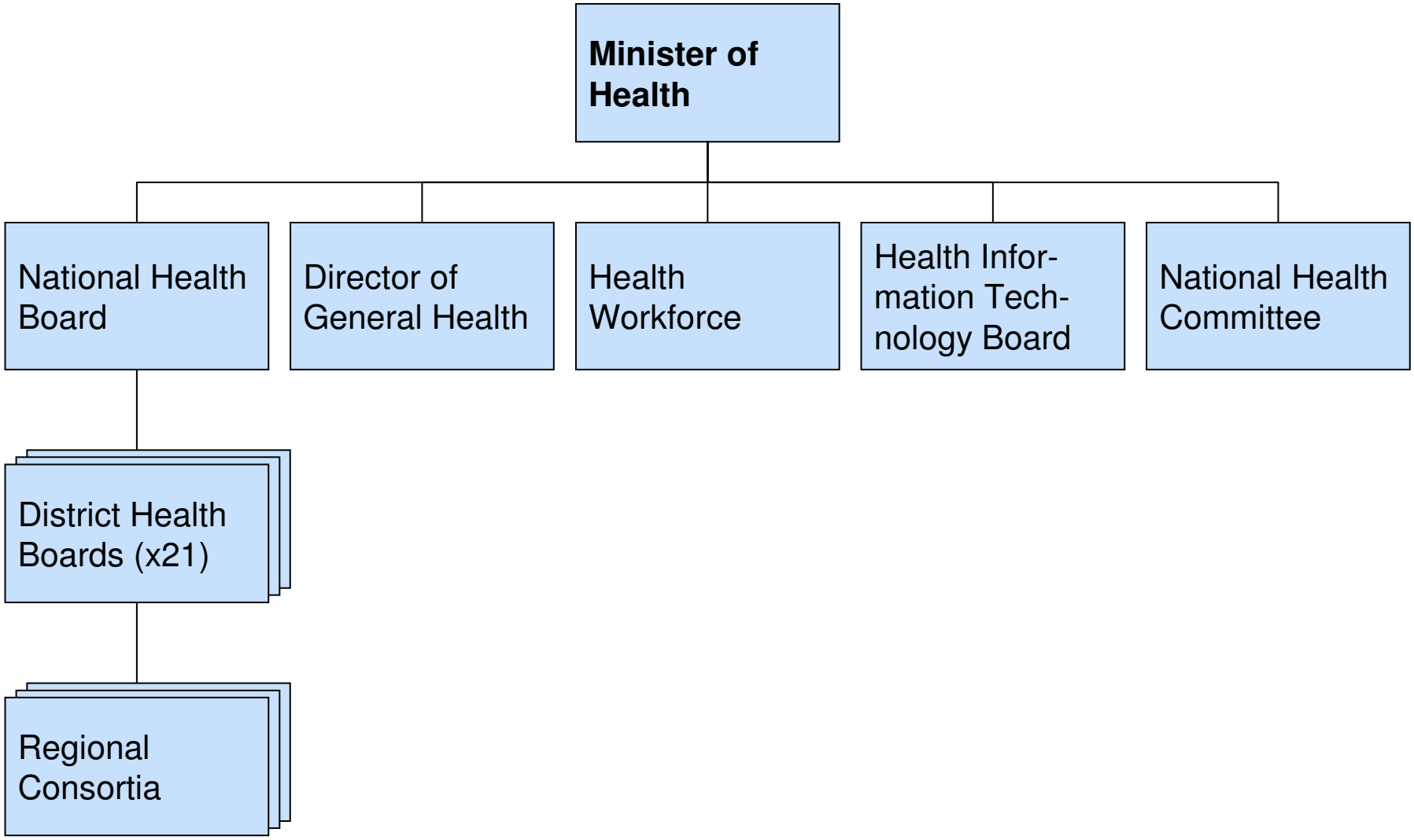
- Empowered individuals taking key decisions
- Loose business structures – emphasis on matrix networks, fluid over time to reflect changing business needs or focus (e.g. project, product, client, geography)
- Common culture shaped by shared values and intensive people processes, including:
  - Recruiting top talent for each job
  - Strong 'up or out' incentives to foster excellence at every level
  - Ongoing training, development and upskilling
  - Joint purpose emphasised within each and every team
- Ownership model and related compensation
- Broad participation in governance

Learnings for the NHS Commissioning Board

- Clarity of vision and setting parameters is crucial in setting parameters for employee empowerment to work
- Intensive people processes key to attracting, developing and retaining the talent needed, combined with a clear path to the top
- Combination of set structures and fluid networks could be beneficial to leverage best talent for key priorities but will yield most if built into performance and reward systems
- Other thoughts?

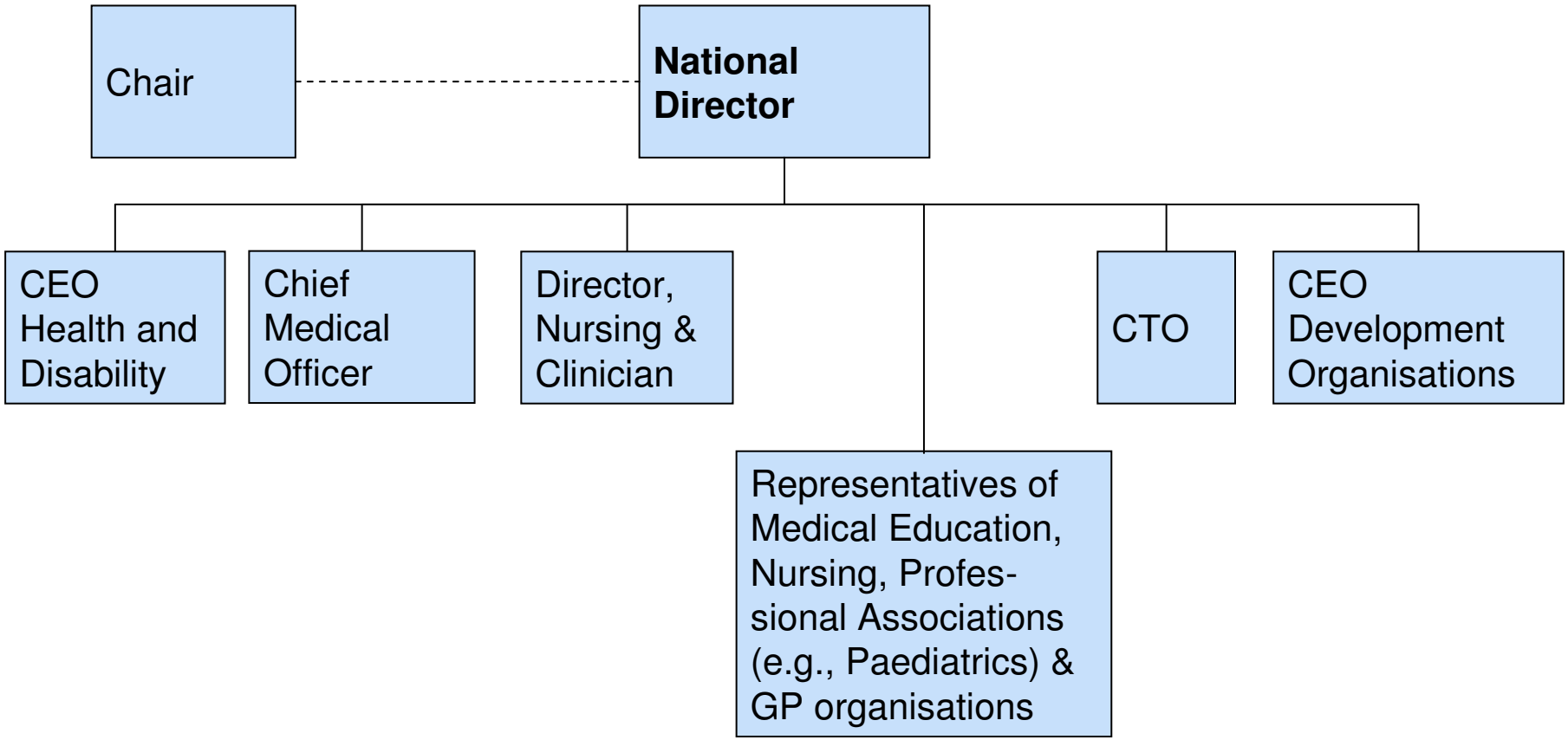
Source: team analysis

3 Health systems: New Zealand Health Board



Source: DH; Coster G. 2010

3 New Zealand Health Board key portfolios



Source: DH; Coster G. 2010

3 A comparison of the 2 systems

NHB	NHS CB
▪ Ministerial Advisory Committee	▪ Statutory commissioning board
▪ Responsible for national funding, monitoring and planning of health services	▪ Lead on the achievement of health outcomes, allocate and account for NHS resources
▪ Deciding which services should be planned, funded and provided at national, regional and local levels	▪ Ensuring the development of GP commissioning consortia
▪ Planning and funding of designated national services	▪ Commissioning responsibility for national and regional specialised services
▪ Management of certain national services	▪ Promoting and extending public and patient involvement and choice
▪ Oversight of regional service planning and funding, including arbitration of disputes	▪ Ensure commissioning decisions are fair and promote competition
▪ Strategic planning and funding of future capacity (IT, facilities, workforce)	▪ Determining health data standards for collection and transfer of information
▪ (Improve quality and safety – Health Quality and Safety Commission)	▪ Lead on quality improvement
▪ . . .	▪ Promote equality and tackle inequalities in access to health care

Source: DH; Coster G. 2010

For discussion

- Which element of each system made the strongest impression?
- How can we leverage the best of each system to complement the values and strengths of the NHS?
- How can we make sure we learn from others' experiences to avoid making the same mistakes?
- What would it take for a network/matrix based model to work in the NHS?
  - Where have we seen this work best in the NHS?
  - What aspects can be replicated in the new commissioning system?

Agenda and goals for the day

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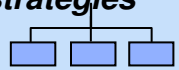
Design principles of organisational structures reflect complexity

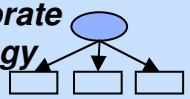
Does the structure fit?

Unit strategies



- Does design direct sufficient management attention to intended priorities?

Corporate Strategy



- Does design help the top management add value – for example, by enabling them to coordinate key functions or drive specific strategic initiatives?

People & Culture

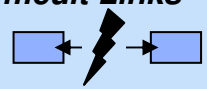
- Can key people implement design and function well within it?
- Does design fit the culture and traditions of the organisation?

Resources

- Is design feasible given available resources – for example, capital, IT systems, partnerships?

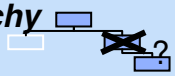
What else is important?

Difficult Links



- Does design provide solutions for important but potentially difficult links between units?

Redundant Hierarchy

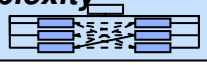


- Does design ensure that each management level creates value?

Accountability

- Do all units in design have clear performance measures that balance time spent managing them with value they add?

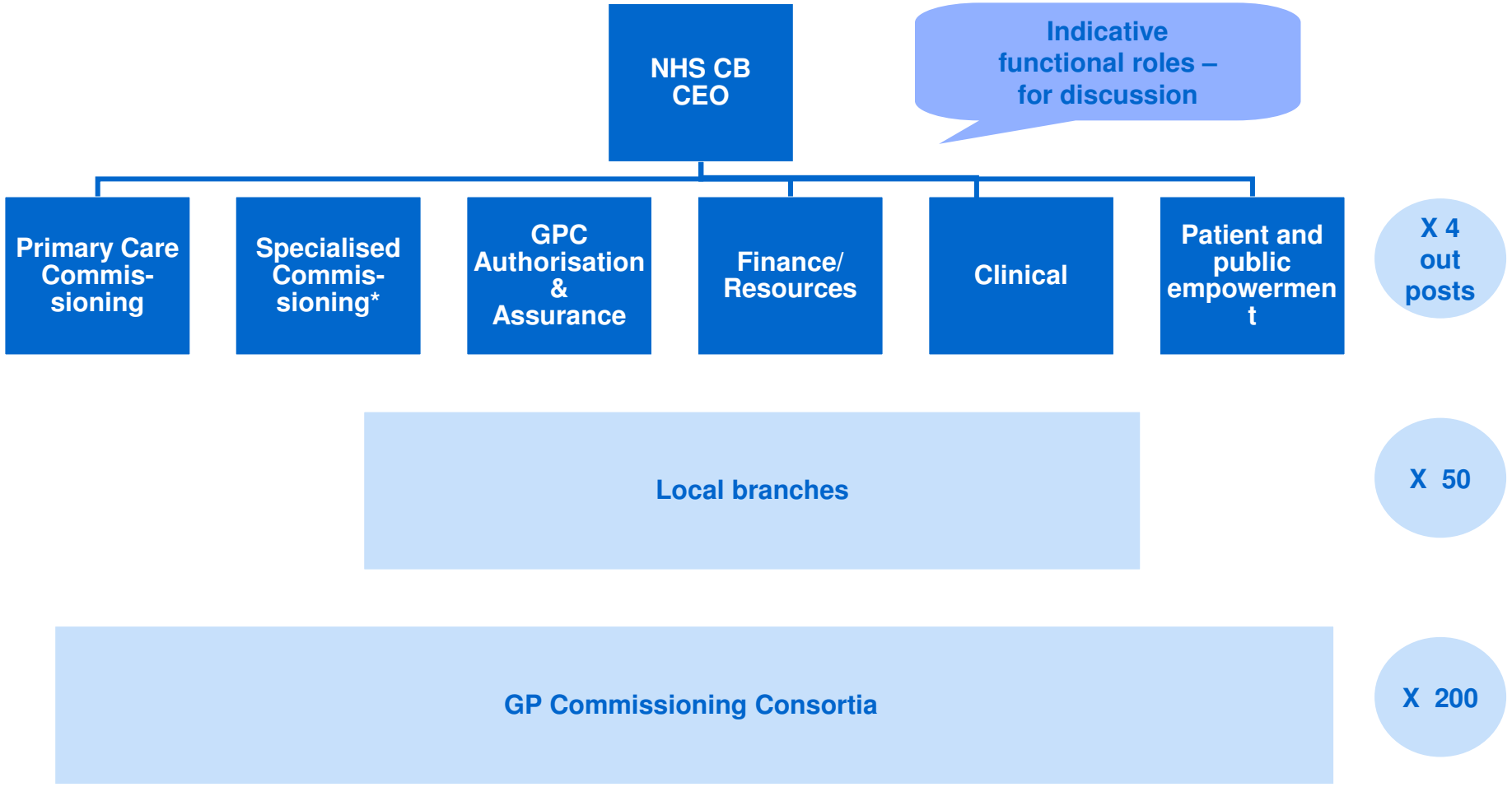
Excessive Complexity



- Does design reflect complexity of relationships while being sufficiently straightforward for external parties to work with?

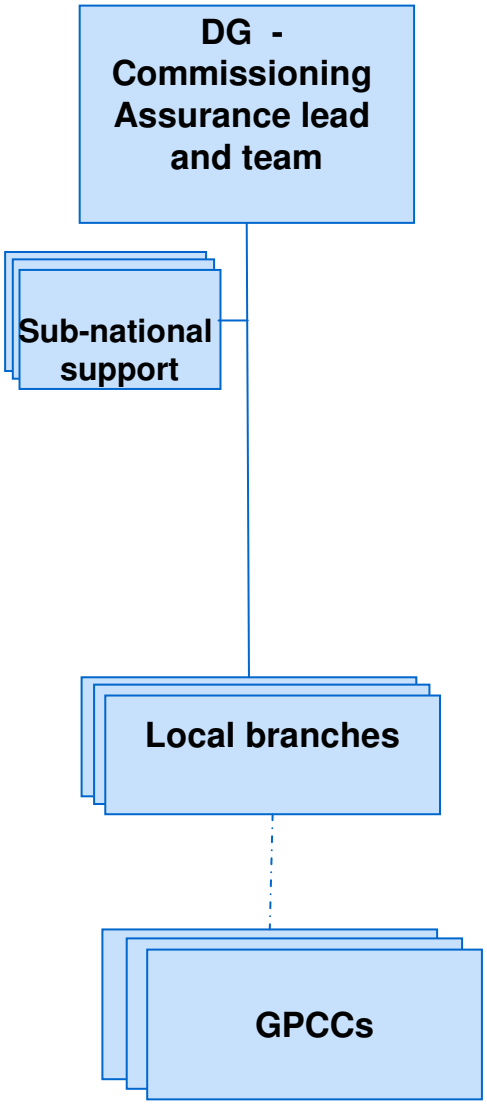
SOURCE: McKinsey & Co.

What are the ‘givens’? Towards a function-based system



* Including other services such as dental, opthalmic and pharmaceutical services

1. Authorisation and Assurance of GP Commissioning Consortia (GPCCs)

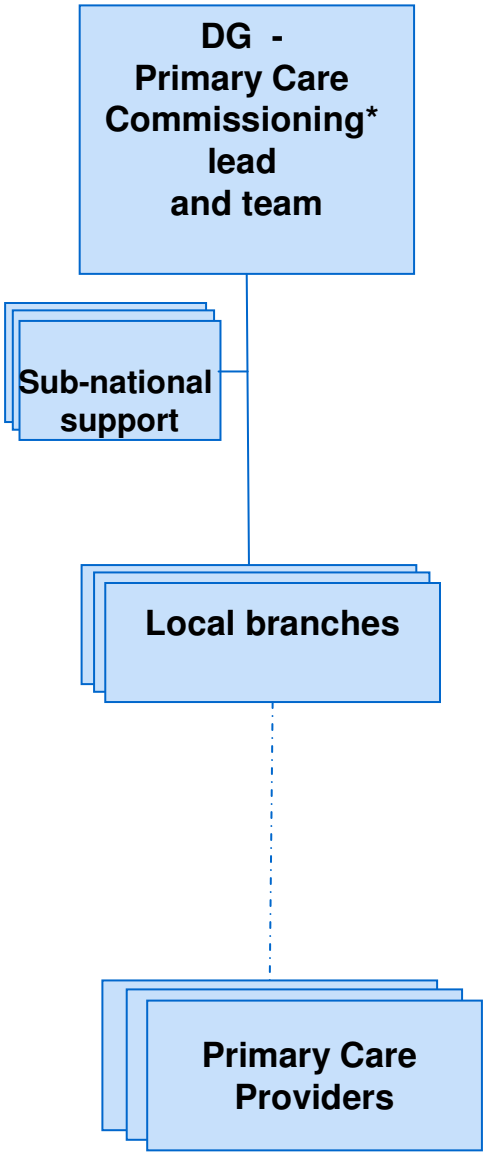


- Develop authorisation system and assurance system
- Define GPC development strategy
- Provide functional support best delivered at national level
- Sub-national support functions across 4 locations:
  - Oversee local implementation of authorisation and assurance by local branches of the Commissioning Board
  - Provide functional support best delivered across local branches
  - Deliver developmental support to GPCCs, where best to do this at scale (e.g. informatics)

- Conduct GPCC authorisation and assurance locally
- Provide functional support best delivered at local level
- Deliver tailored developmental support to individual GPCCs

- Two-way interaction with local authorisation and assurance system

2. Commissioning Primary Care*



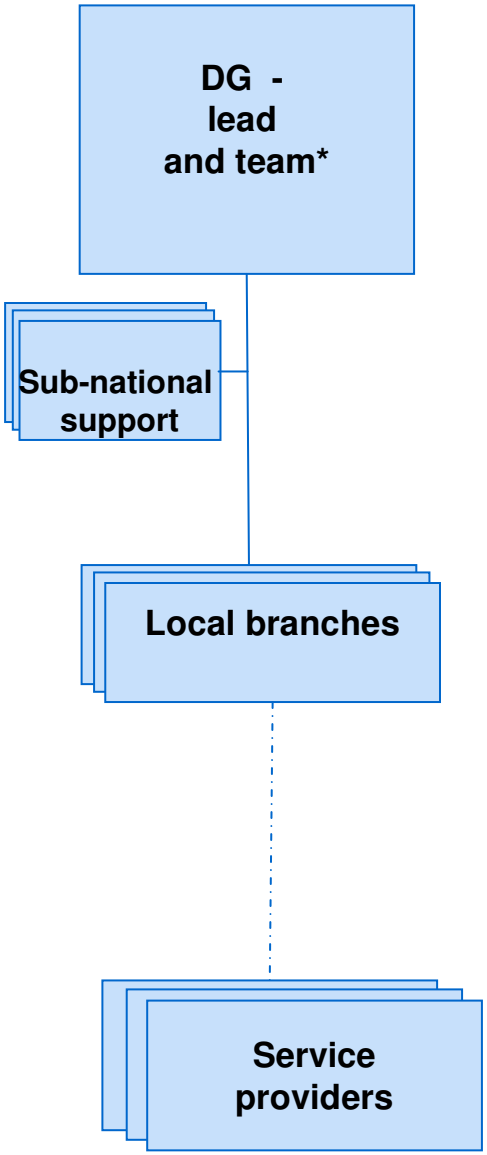
- Assess needs and define national, outcomes-based, Primary Care strategy
- Decide which direct commissioning functions led by the NHS Commissioning Board can be delegated to other bodies (e.g. GPCCs)*
- Sub-national support functions across 4 locations:
  - Oversee primary care commissioning undertaken locally focusing on quality, performance and value-for-money
  - Ensure financial balance of commissioning budgets locally and nationally
  - Provide functional support best delivered across local branches

- Understand local needs based on quality information and analysis
- Plan and improve services needed by the population
- Commission primary care locally
- Manage provider performance to improve local outcomes
- Ensure financial balance in managing local commissioning budgets
- Engage patients, public and clinicians along commissioning journey
- Provide functional support best delivered at local level (e.g. sharing information with providers to facilitate discussions on outcomes)

- Provide Primary Care services focusing on outcomes
- Provide input into Primary Care local and national strategy

* Including other services such as dental, opthalmic and pharmaceutical services

3. Other commissioning functions, e.g. Specialised Services*



- Assess needs and define national, outcomes-based, strategies
- Decide level at which different services need to be commissioned (e.g. nationally, regionally, locally) leveraging existing networks
- Sub-national support functions across 4 locations:
  - Commission specialised or other services as appropriate, including managing providers and ensuring financial balance
  - Oversee commissioning undertaken locally
  - Ensure financial balance of commissioning budgets managed locally
  - Provide functional support best delivered at this level

- TBC – For some local branches acting as 'hubs' this could include commissioning specialised or other services as appropriate, including managing providers and ensuring financial balance
- Leverage existing specialised commissioning networks (tbc)

- Provide services focusing on outcomes
- Provide input into relevant commissioning strategy

* Other services could also include for instance offender services and some military health

For discussion: At what level should each of these functions take place?

Functions	National	Regional/local
Direct Commissioning		
Primary care commissioning	✓	✓
Dental commissioning	✓	✓
Specialised commissioning	✓	
Procurement (PPRS, ISTC contracts)	✓	
Primary care capital	✓	✓
Commissioning system management		
Performance management of GP commissioners	✓	✓
System risk management (quality, access)	✓	✓
Intervention	✓	✓
Commercial & incentive design (CCP, Monitor relationships)	✓	
Clinical Director		
Commissioning quality standards	✓	
Transparency	✓	✓
Information	✓	✓
Finance		
Financial risk management	✓	
Accounting	✓	✓
Allocations	✓	
Patient and public empowerment		
Choice	✓	✓
CQC/HealthWatch relationships	✓	
Strategic planning		
Demand forecasting	✓	✓
Requirements for financial settlement	✓	
Long term workforce requirements	✓	
Corporate & Government Affairs		
Briefing and accounting upwards	✓	
Internal overhead functions (HR, IT, Finance)	✓	

- **What is the role of the NHS CB to shape provision e.g., capital?**
- **How does the NHS CB lead the system? What levers are available?**

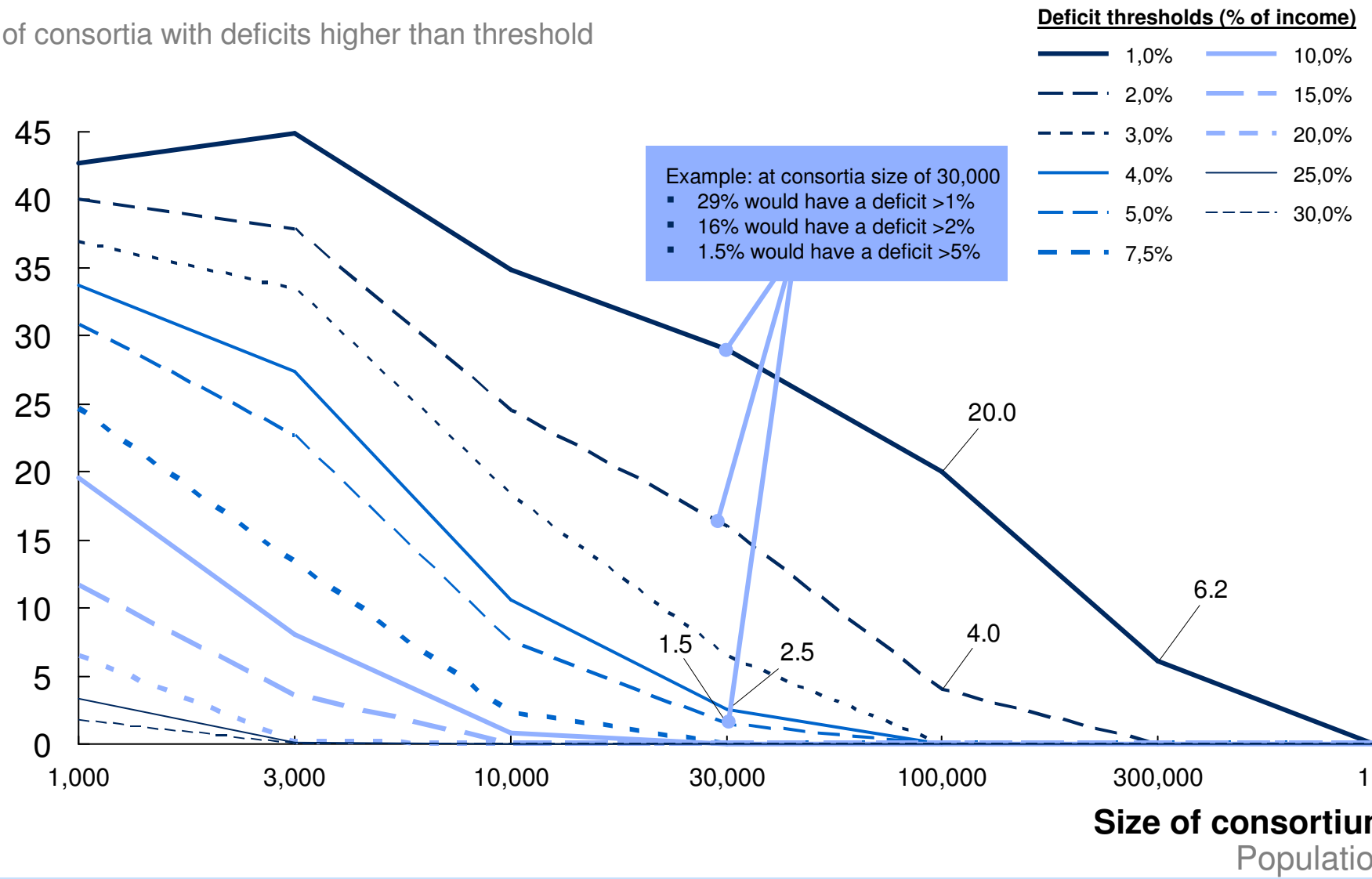
SOURCE: McKinsey analysis

How would each model respond to system stress tests? 4 scenarios

	Potential scenario	This could look like:
1	**GPCC development and assurance/failure issues**	▪ GPC development stalling and/or GPC defaulting
2	**Reconfiguration**	▪ Major regional reconfiguration including closing/downsizing Acute and/or provider default
3	**QIPP / innovation**	▪ GPC delivery of QIPP priorities ▪ GP-led commissioning as a driver of innovation across the NHS
4	**Strategic Commissioning for provider development**	▪ Collaboration with Economic Regulator, CQC and other bodies to promote provider development ▪ Strategic commissioning as a system improvement tool

SOURCE: Team analysis

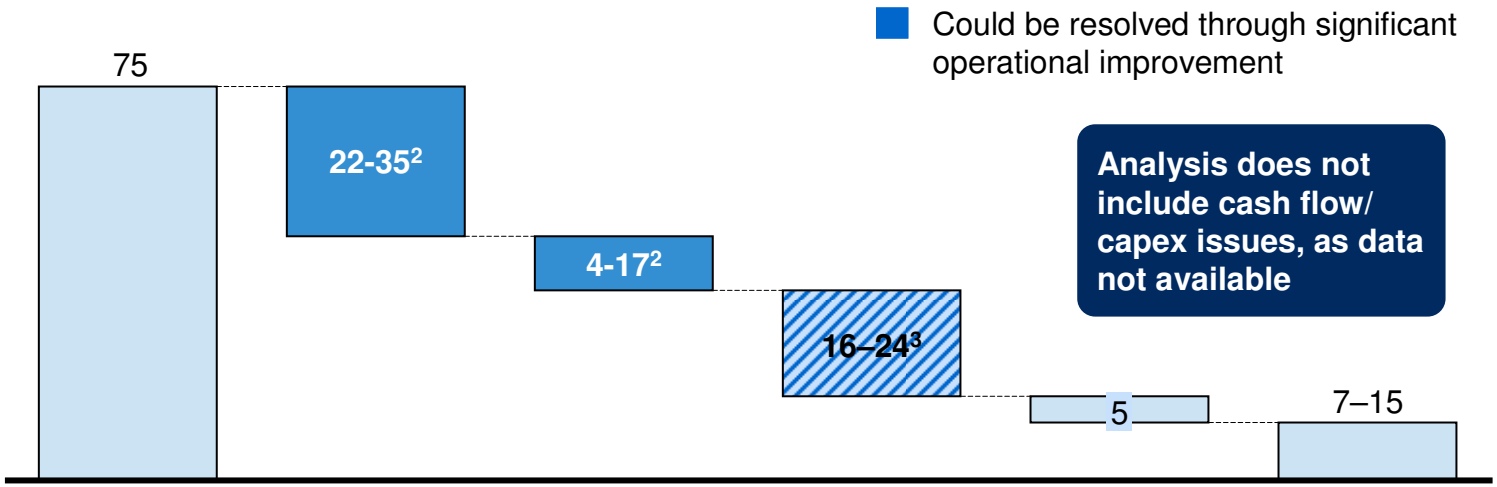
Example 1: Financial risk as related to consortium size



SOURCE: McKinsey Medical Risk Group, Monte-Carlo-Simulation based on actual 2008 data of German payor

Example 2: Significant challenges to the acute sector during the transition period, with unprecedented turnaround efforts required

Issues to be resolved for non-FTs to meet financial and quality requirements for FT status[1]



Requirements for standalone viability 2012/13 (cumulative)	Total acute non-FTs	Strongly improve productivity (3.5% annual CIP 2010-2013)	Solve quality issues	Transform productivity (additional 0.5%-1.0% annual CIP)[3]	Deal with legacy debt[4]	Drive reconfiguration

1 The impact of potential solutions are cumulative from left to right
2 Based on CQC quality score rating 2009/10. Range depends on whether 'weak' or 'fair' CQC rating set as staNDTrd
3 +1.0% CIP for non-FT's with '09/10 EBITDA < 5.6%, +0.5% CIP for non- FT's with '09/10 EBITDA between 5.6% and 7.5%, no additional CIP for non-FT's with 2009/10 EBITDA > 7.5%. Range indicates difference between bottom quartile reaching 0.5% vs. 1.0%
4 Resolution of legacy debt for those Trusts with legacy debt > 20% of income in 2008/09, which has ruled out Trusts such as RUH Bath and Hinchingbrooke from achieving FT status

SOURCE: Acute non-FT financial forecast model 2008/09 – 2012/13; Care Quality Commission 2009/10; Laing & Buisson NHS Trust accounts 2008/09

Additional questions to resolve: reporting lines

- **Sub-national functions:**
  - How are reporting lines shaped, functionally (e.g. to NHS CB lead for Primary Care Commissioning) or locally (e.g. to local CEO)?
  - Do we need a COO for each location to coordinate across functions (e.g. including local HR) in any case?

- **Local branches:**
  - As above, how should reporting lines be shaped? Possible options
    - Local branch CEO reporting across all branch performance to sub-national lead in the same geography (in one of 4 locations)
    - Local branch CEO reporting across all branch performance to national lead, who could be based in London or a sub-national location
    - Local branch functional leads report upwards through functional lines, possibly with local COO for supporting functions (e.g. admin, HR)

- **What are the pros and cons of each option? What risks does each pose for the system (e.g. lack of clear accountability or focus on key priorities)**

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Emerging values: 30 November 2010 Top Leaders Design workshop

The NHS Commissioning Board will be…

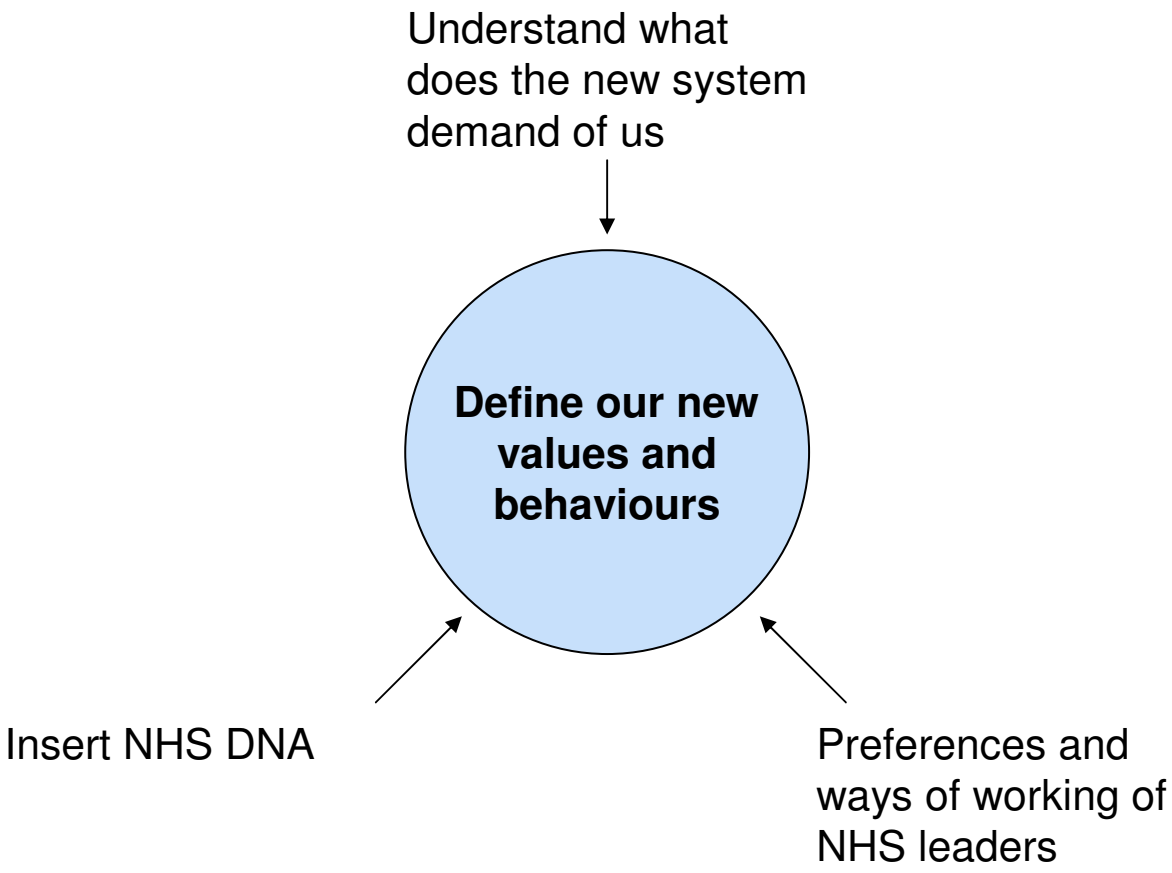
- Supportive but empowering
- Proportionately light touch
- Simple, consistent and robust in style of decision making
- Inclusive and understanding of stakeholders' development
- Clearly publicly accountable, open, transparent and stable
- Encouraging 'working in the field'
- Sharing knowledge and information and making sure it is robust
- Managing upwards
- Self-managing downwards
- More 'managerial' (consultancy model)

…but not…

- Similar to the current model, i.e. headquarter model, PCT, SHA, physical regional offices model
- Reflecting traditional intermediate tier arrangements (e.g. regional offices)
- Duplicative
- Shaped by 'silo-thinking'
- Commissioning services as 'default': GPCCs will be the 'default' commissioners, with NHS CB commissioning directly only service that cannot be reasonably commissioned by the consortia
- What else?

- **Are these still the right values for the new commissioning system and CB organisation?**
- **What has changed?**

The new direction



Our new values

The values in action of the NHS Commissioning Board will be…

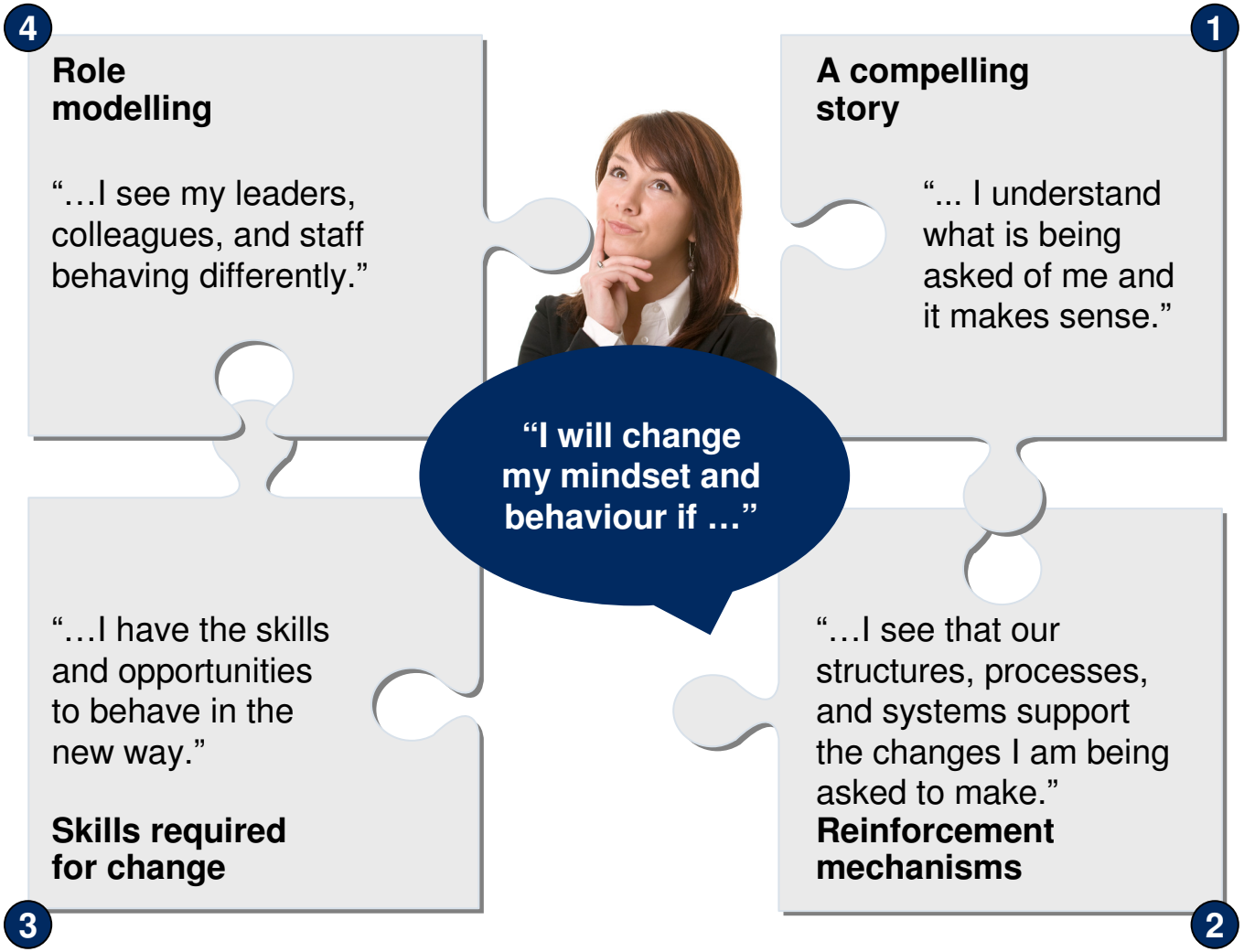
- We exist to enhance the health of our country. We will FOCUS all our activities on this objective. We will ruthlessly prioritise and will challenge any resources not directly related to this mission.
- We will put the patient, their carers and their clinicians at the HEART of decision making.
- We will work at pace and with URGENCY. We will always remember that we are here to save lives.
- We will work in TEAMS, bringing the best possible skills to bear, with no regard for internal divisions. We will eliminate bureaucracy on sight.
- We will take ownership, accountability and RESPONSIBILITY for our actions, individually and collectively
- We will create a great place to work. A place characterised by equality, fairness, development and PASSION.

How do we get there? Vital signs of organisational health

Direction	A clear sense of where the organisation is heading and how it will get there that is meaningful to all employees
Leadership	The extent to which leaders inspire actions by others
Culture and climate	The shared beliefs and quality of interactions within and across organisational units.
Account-ability	The extent to which individuals understand what is expected of them, have sufficient authority and take responsibility for delivering results
Coordination and control	The ability to evaluate organisational performance and risk, and to address issues and opportunities when they arise
Capability	The presence of the institutional skills and talent required to execute strategy and create competitive advantage
Motivation	The presence of enthusiasm that drives employees to put in extraordinary effort to deliver results
External orientation	The quality of engagement with customers, suppliers, partners and other external stakeholders to drive value
Innovation and learning	The quality and flow of new ideas and ability to adapt and shape the organisation as needed

SOURCE: Scott Keller and Colin Price, 'Performance and Health: An evidence-based approach to transforming your organisation', 2010.

Shaping employee mindsets to make change happen



SOURCE: Scott Keller and Colin Price, 'Performance and Health: An evidence-based approach to transforming your organisation', 2010.

Agenda and goals for the day

- Goals for the day
- Overview of context
- Selected organisational examples
- Potential models
- Creating a new culture
- **Physical space**
- Managing change

Physical space

PLACEHOLDER – Andrew Mawson
video to be inserted

Agenda and goals for the day

- Goals for the day
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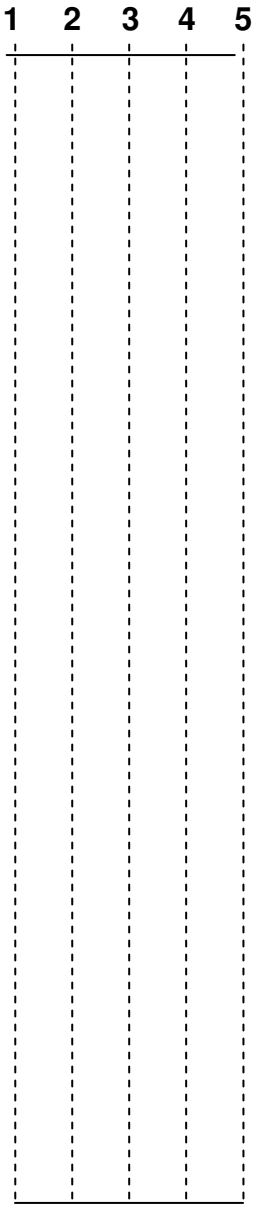
- Selected organisational examples
- Potential models
- Creating a new culture
- Physical space
- **Managing change**

Managing change needs to start with setting clear aspirations: the ten tests of organisational excellence

1. **Do we have a compelling, widely understood, and jointly owned vision of change and set of performance targets for our organisation?**
2. **Do we have a robust baseline and shared aspirations for the health of our organisation?**
3. **Do we have a solid assessment of our organisation's capability to deliver our change vision?**
4. **Do we have insight into the root-cause mindsets that inhibit or enhance our organisation's health?**
5. **Do we have a concrete, balanced set of performance improvement initiatives defined to deliver our change vision?**
6. **Do we have a clear plan for how to reshape our work environment to influence healthy mindsets?**
7. **Do we have a well-defined scale-up model for each of the initiatives in our portfolio?**
8. **Do we have a reliable method to ensure that energy for change is continually infused and unleashed during the change process?**
9. **Do we have the structure, processes, systems, and people to drive continuous improvement in performance and health?**
10. **Do we have a group of committed leaders who can lead transformation and sustain high performance from a core of self-mastery?**



SOURCE: Scott Keller and Colin Price, 'Performance and Health: An evidence-based approach to transforming your organisation', 2010.

Change relies on identifying key system enablers that are critical for implementation

Enabler	Description	Status
Vision	▪ Shared vision and narrative across the NHS Commissioning Board organisation and the broader NHS	
Physician leadership and co-production	▪ Recognition and support for strong GP leadership across the NHS ▪ Culture of co-production of the new NHS Commissioning Board	
Information	▪ Robust information about quality and costs shared across the NHS ▪ IT support information-sharing with commissioners	
Incentives	▪ Financial flows ▪ Aligned individual, team and organisational incentives	
Contracting arrangements	▪ Value add strategic contracting with providers	
New organisational models	▪ Workforce models and actual resources across the system ▪ New organisational arrangements to support delivery across Acute and non-Acute settings	

Immediate priorities – for discussion

Description	Date
▪ Refining the CEO narrative	
▪ Engaging GPs in co-production of the new system	
▪ Finalise organisational model, direct reports and sub-national arrangements	
▪ Agree implications for estates, e.g. Quarry House and Maple Street, and for physical space more broadly	
▪ Anything else?	