1. Introduction

NHS England (formerly the NHS Commissioning Board) assumed full statutory powers on 1 April 2013, although it has been operating in shadow form since October 2011. Its role in the reformed NHS is twofold. First, it forms part of the agenda to rationalise commissioning structures following the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). NHS England will oversee the new commissioning architecture and will be responsible for holding Clinical Commissioning Groups (CCGs) – groups of GP practices with statutory, local commissioning responsibility – to account. Second, the establishment of NHS England 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.

2. What is NHS England?

Corporate governance

The overarching, corporate governance structure of NHS England will have three components:

1. The board;
2. An audit committee; and
3. A remuneration committee.1

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 for Health (SoS);
- A minimum of five other non-executive members, appointed by the SoS;
- A chief executive, appointed by the chair and non-executive members and approved by the SoS;
- 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 SoS 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 are required to adhere to the seven principles of public life, also called the Nolan principles.2 The board holds its meetings in public and papers are available in advance, via NHS England’s website.3

1 NHS Commissioning Board Authority (2012). Design of the NHS commissioning board (paper to Board meeting of 2 February 2012)
2 Parliamentary debates, House of Commons official report General Committees, Public Bill Committee, Health and Social Care Bill, tenth sitting, Tuesday 1 March 2011 (afternoon)
3 Department of Health (2011). Developing the NHS commissioning board
NHS England is accountable to the SoS, Parliament, the Department of Health and the Treasury.\(^4\)

**Organisational structure and personnel**

NHS England will operate at national, regional and local level. The national office is in Leeds, with additional London presence. Four regional ‘sectors’ and 27 ‘local area teams’ (LATs) have been established: for full details see annex A.

Details of the executive and non-executive members of the board, national directorate appointments, sector directors and LAT directors can all be found online.

**Staffing**

It was originally anticipated that there would be around 50 members of staff per sector and per LAT, with 860 staff in the central office, making 3,560 NHS England staff in total.\(^5\) However this original prediction was based on there being 50 LATs and since the number has reduced to 27 it is unclear whether the original staffing levels have been maintained or reduced. NHS England staff have been recruited for the most part from the Department of Health and former PCTs and SHAs.

### 3. What does NHS England do?

**Secretary of State’s mandate**

The SoS published the first mandate to the board in November 2012, which applies from April 2013 to March 2015. NHS England is legally obliged to pursue the objectives contained in the mandate, which corresponds with the NHS Outcomes Framework 2013/14 (NHSOF). For example, its first objective is to demonstrate progress against all of the indicators included in the NHSOF by March 2015. This corresponds with NHS England’s stated, principle aim: to improve the health outcomes for people in England.

NHS England is required to report on its progress annually and the Government will publish an annual assessment of its performance. This will involve gathering feedback from CCGs, local councils, patients and others.

**Legislative duties**

NHS England has a concurrent duty with the SoS 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. It 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 SoS who has ministerial responsibility to Parliament for the provision of the health service in England.

The Health and Social Care Act 2012 also sets out a number of general duties for NHS England, most of which also apply to CCGs (except for those marked with an asterix). They are:

- Promote the NHS Constitution;
- Exercise its functions effectively, efficiently and economically;

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\(^4\) Ibid.

\(^5\) Ibid.
• Secure continuous improvement in quality of services;
• Promote autonomy*;
• Reduce inequalities (in both access and health outcomes);
• Promote involvement of each patient;
• Enable patients to make choices;
• Obtain appropriate advice (to discharge functions);
• Promote innovation, research and 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 SoS 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’. 6

**Direct commissioning**

NHS England is responsible for commissioning £27.2bn worth of services directly,7 holding around 35,000 contracts,8 as set out in the list below.9 Some of these services will be funded from the national public health budget (as indicated with an asterix).10

- Specialised and highly specialised services
- Primary care at general practice level, including essential, additional and urgent care
- Out-of-hours primary care for GP practices who have retained OOH responsibility
- All dental services (hospital, community, urgent and emergency)
- Community pharmacy
- Primary ophthalmic services
- High-security psychiatric services
- Antenatal and newborn screening
- Health and infertility services for the armed forces and their families
- Health and public health services for those in prison or custody (excluding emergency care)*
- Children’s public health services from pregnancy to five years, including health visiting (until 2015)*
- Immunisation programmes*
- National screening programmes*
- Sexual assault referral services*
- HIV treatment*
- Contraception (as part of GP contract)*

A number of public-health related services previously commissioned by PCTs will now be commissioned by local authorities. For example, the remainder of sexual health services, children’s public health services from five to 19 years and from pregnancy to five years from 2015.

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6 House of Commons Library (12 March 2012). *Health and social care bill: summary of Lords Committee and Report stages*
8 Op. cit [Developing the NHS commissioning board](http://www.commissioningboard.nhs.uk/allocations-2013-14/)
9 NHS Commissioning Board (2012). *Commissioning Fact Sheet for Clinical Commissioning Groups*
10 Department of Health (2011). *Healthy lives, healthy people: update and way forward*
Local authorities and the new Public Health England (PHE) should provide public-health specialist advice to CCGs and NHS England respectively in order to inform the commissioning of services. NHS England can commission services on behalf of PHE. It can also commission services on behalf of CCGs if agreed by both parties.\(^{11}\)

A full breakdown of which body/bodies have responsibility for commissioning which services can be found in the paper ‘Commissioning Fact Sheet for Clinical Commissioning Groups’.

As part of direct commissioning, NHS England is responsible for negotiating the national General Medical Services (GMS) contract for GP services. This was previously negotiated by the Department of Health, although the timescales for the transfer of responsibility are unknown. NHS England, at LAT level, will also hold Personal Medical Services (PMS) contracts (also for GP services), previously held and negotiated by PCTs.

When commissioning services directly, the principles and rules around procurement and competition that will apply to CCGs will also apply to NHS England.\(^{12}\)

Ten LATs have been designated as specialised commissioning hubs. See annex A for more details. More information about specialised services can be found on the NHS England’s website.

**Clinical Commissioning Groups**

NHS England is responsible for the authorisation, oversight and performance management of CCGs. Authorisation was the process by which CCGs were deemed ready and able to take statutory responsibility for the commissioning budget. By 1 April only 106 CCGs were fully authorised. The remaining 105 were authorised with conditions, 15 of which with legal directions meaning that they could only exercise their functions with another CCG or NHS England. NHS England will continue to support and monitor CCGs until all are full authorised.

NHS England calculates and allocates commissioning budgets to CCGs, which in 2013/14 total £63.4bn. It has also allocated their running costs, at £1.3bn. More information can be found here. It is accountable to the Department of Health for the overall commissioning revenue limit, including that allocated to CCGs.

The Health and Social Care Act 2012 allows NHS England 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.

**CCG outcomes indicator set and the quality reward**

Together with NICE, NHS England has developed the CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework). This is a mix of

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\(^{11}\) Ibid.

\(^{12}\) Ibid.
outcome and process indicators, against which CCGs’ performance will be measured. It will also seek to provide comparative information for CCGs, Health and Wellbeing Boards, local authorities, patients and the public. More information can be found here.

The Health and Social Care Act 2012 sets out that NHS England 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’. Regulations and guidance have laid out the requirements for CCGs to be eligible for a quality premium payment in 2014/15 (in respect of performance in 2013/14).

The quality reward comprises four national measures taken from the CCG Outcomes Indicator Set and three local ones. The national measures are:

1. Reducing potential years of lives lost through amenable mortality (12.5 per cent of quality premium)
   • Measurement: minimum reduction of 3.2 per cent
2. Reducing avoidable emergency admissions (25 per cent of quality premium)
   • Measurement: reduction or 0 per cent change for specific conditions
3. Ensuring roll-out of the Friends and Family Test (FFT) and improving patient experience of hospital services (12.5 per cent of quality premium)
   • Measurement: all providers have delivered an agreed roll-out plan, improvement in average FFT scores for acute hospitals from the first quarter of 2013/14 to the first quarter of 2014/15
4. Preventing healthcare associated infections (12.5 per cent of quality premium)
   • Measurement: no cases of MRSA and C. difficile at or below defined CCG thresholds

The three local measures need to be based on Joint Health and Wellbeing Strategies and agreed with LATs (12.5 per cent of quality premium each).

In addition, in order to qualify for the quality reward payment, CCGs will need to meet a number of other requirements as follows:

• There should be no serious quality failures (NHS England may withhold payment)
• There should be no overspend on the 2013/14 budget
• Reduced payment if the CCG does not meet the following rights contained in the NHS Constitution
  – maximum 18-week waits from referral to treatment
  – maximum four-hour waits in A&E departments
  – maximum 62-day waits from urgent GP referral to first definitive treatment for cancer
  – maximum eight-minute responses for Category A red 1 ambulance calls.

Regulations set out that CCGs can spend the quality reward payment to secure improvement in patient services or reducing inequalities. See the NHS (Clinical Commissioning Groups – Payments in Respect of Quality) Regulations 2013 for more information.
Commissioning support

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. NHS England is temporarily hosting the 23 commissioning support units (CSUs) that have emerged from PCT clusters. This means that NHS England will be the employer of CSU staff. CSU director appointments can be found here. 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.13

Clinical networks and senates

Clinical networks are condition or service area specific. Four strategic clinical networks (SCNs) have been confirmed for 2013:

1. Cancer;
2. Cardiovascular disease (incorporating cardiac, stroke, diabetes and renal disease);
3. Maternity and children; and
4. Mental health, dementia and neurological conditions.

SCNs will be established for up to five years in the first instance and NHS England can identify new conditions or patients groups that require a specific SCN in the future. In addition to a small number of SCNs there will be a series of other networks that can develop as part of the new NHS commissioning architecture. These include:

- Operational delivery networks: coordinate patient pathways between providers over a large geographical area to ensure access to specialist resources, such as critical care beds or burns units;
- Local professional networks: developed by NHS England to advise on the commissioning of a specific service such as dental, pharmacy and optometry services;
- Local networks: decided on and resourced by CCGs to support their commissioning activities; and
- Provider networks: established and maintained by a group of providers to enable the joint delivery of a service.

Twelve new clinical senates across England now provide strategic clinical advice and leadership to CCGs, Health and Wellbeing Boards and NHS England on a geographical basis. They are multi-professional and include patient representatives. For details of the senates see annex A.

Twelve corresponding support teams provide clinical and managerial support to the SCNs and clinical senates in the area. Funded and hosted by NHS England, each support team is based in a LAT office and clinical and network directors will be accountable to the LAT director.14

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13 Department of Health (2012). NHS Commissioning Support Services factsheet
14 NHS Commissioning Board (2012). The way forward: Strategic Clinical Networks
**Pricing**

NHS England and Monitor are jointly responsible for the national tariff, Payment by Results (PbR). NHS England is tasked with designing the pricing structure for PbR, as well as that for the Commissioning for Quality and Innovation (CQUIN)\(^{15}\) payment framework and best-practice tariffs. Monitor is responsible for setting the pricing levels. For more information on pricing and Monitor’s role in particular, refer to another briefing note in *this series* on ‘Monitor and regulation’.

**Other**

NHS England also performs the following functions:

- Champions patient and carer involvement;
- Provides leadership to the NHS;
- Leads on quality improvement;
- Leads on the NHS’ operational response in the event of an emergency, in conjunction with local authorities and Public Health England;
- Plays a part in the new foundation trust failure regime. For more information see another briefing note in *this series* on the ‘Failure regime’.
- For information on NHS England’s role in relation to choice and competition, in conjunction with Monitor, see another briefing note in *this series* on ‘Choice and any qualified provider’.

**Contact us**

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\(^{15}\) 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
## Annex A

### NHS England sectors, local area teams and clinical senates

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<thead>
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<th>NHS NORTH OF ENGLAND (sector)</th>
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<td>4. East Anglia (specialised commissioning hub)</td>
<td>4. Kent and Medway</td>
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<tr>
<td>5. Merseyside</td>
<td>5. Essex</td>
<td>5. Surrey and Sussex (specialised commissioning hub)</td>
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<td>7. North Yorkshire and Humber</td>
<td>7. Leicestershire and Lincolnshire (specialised commissioning hub)</td>
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<td>8. South Yorkshire and Bassetlaw (specialised commissioning hub)</td>
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<td>9. West Yorkshire</td>
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**Clinical Senates (4)**

1. North East, North Cumbria and the Hambleton & Richmondshire districts of North Yorks
2. Yorkshire & The Humber
3. Greater Manchester, Lancashire and South Cumbria
4. Cheshire & Mersey

**Clinical Senates (3)**

1. East Midlands
2. West Midlands
3. East of England

**Clinical Senates (4)**

1. Thames Valley
2. Wessex
3. South East Coast
4. South West

**Clinical Senates (1)**

1. London