NHS England

CCG Assurance Framework 2013/14

(outline proposal and interim arrangements)

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Contact Details for further information	Chris Garrett Head of Delivery NHS England Skipton House London Road London SE1 6LH

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CCG Assurance Framework 2013/14

(outline proposal and interim arrangements)

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Introduction

NHS England has three key roles in working with CCGs: a development role to work with and support CCGs to become the best they can be; an assurance role to ensure as a statutory organisation, CCGs deliver the best possible services and outcomes for patients within their financial allocation; and a co-commissioning role to ensure the direct commissioning undertaken by NHS England works across the care pathway for patients and supports the delivery of local outcomes.

These roles can be defined separately, but in their implementation they are interlinked. Therefore, when we come to describing the process of assurance we must be clear about respective and joint accountabilities and responsibilities.

A key part of this is the assurance process which identifies how well CCGs are performing against their plans to improve services and deliver better outcomes for patients, as well as working together to assess how they can realise their full potential and provide support on that journey. Sitting alongside NHS England as fellow commissioners, CCGs need to secure quality today and transform services for the future.

This document describes NHS England's outline proposal and interim arrangements for the assurance framework which we intend to discuss widely with CCGs (especially through the vehicles established through the NHS Commissioning Assembly) and other key stakeholders, over the coming months. The definitive assurance framework for 2013/14 will be published following these discussions, in the autumn. It is our expectation that the framework will continue to evolve as CCGs and the wider commissioning system continue to develop over future years.

The framework is designed to give assurance that CCGs are delivering quality and outcomes for patients, both locally and as part of the national standards, as

well as being the basis for assessing that they are continuously improving from the start point of authorisation. Of necessity, it therefore looks at both the organisation's performance and its health.

NHS England assumes that CCGs will wish to publish their progress against their locally agreed plans and hence their performance on delivering key standards and outcomes to their local population. The performance aspect of assurance will be based on this published information.

It will be important that an interim process is in place to monitor CCGs during their first few months. This document outlines how we will do this through 'checkpoints' in July and October which we propose will be used as pilots to inform how similar checkpoints operate in the long term.

We propose that the framework is built on a clear set of principles:

- the approach will always place the assurance of quality for patients, both todays' and future generations, at the heart of the process
- the approach will promote the accountability of CCGs to their local populations
- we will support CCGs to develop ambitious plans for improvement;
- a key feature will be the identification of the support a CCG needs to realise its full potential
- there should be a clear, consistent basis on which any NHS England support or intervention is predicated. Our underpinning principle should be to support the CCG to deliver good outcomes
- the approach will focus heavily on the role of CCGs in securing patient and public engagement
- the approach should only use information that CCGs need to manage their own business and to demonstrate accountability to their local populations
- the process will continually evolve in collaboration with CCGs, HWBs, patients and the public

- the output of CCG assurance should be proportionate and transparent.

NHS England is committed to a new style of working with CCGs, working in partnership, not hierarchy. We have already begun work with CCGs, and NHS Clinical Commissioners, to co-create shared expectations of the behaviours that will enable effective relationships to drive improvements. We will support CCGs to be high performing organisations, working together as a co-commissioner of services for local populations, but providing the right assurance to patients and the public that CCGs are good commissioners. NHS England will only intervene in the few circumstances when this is necessary. This will require a fundamental cultural shift and a mind-set change for many working within the healthcare system.

To commission high quality care successfully, we will need to promote engagement, transparency and successful relationships between all involved in the delivery of health and care services. This is in order to realise our collective vision of a health system shaped by patient and citizen participation and designed with improved outcomes and patient experience at its heart. Future iterations of the assurance framework will significantly increase the focus on patient experience as we develop a completely fresh approach to transparency, and patient engagement and insight. New organisations call for a consciously new approach with emphasis on a mature and equal conversation between CCGs and NHS England, informed by rich sources of evidence.

Key sources of such evidence are highlighted in the planning guidance, *Everyone Counts: Planning for Patients 2013/14* which makes a number of offers to support the successful development of the system's ability to commission high quality care, including the development of care.data - a modern knowledge service for the NHS.

This proposal is focussed firmly on CCG assurance. Alongside this we also need to consider mutual assurance which is fundamental to the on-going relationship

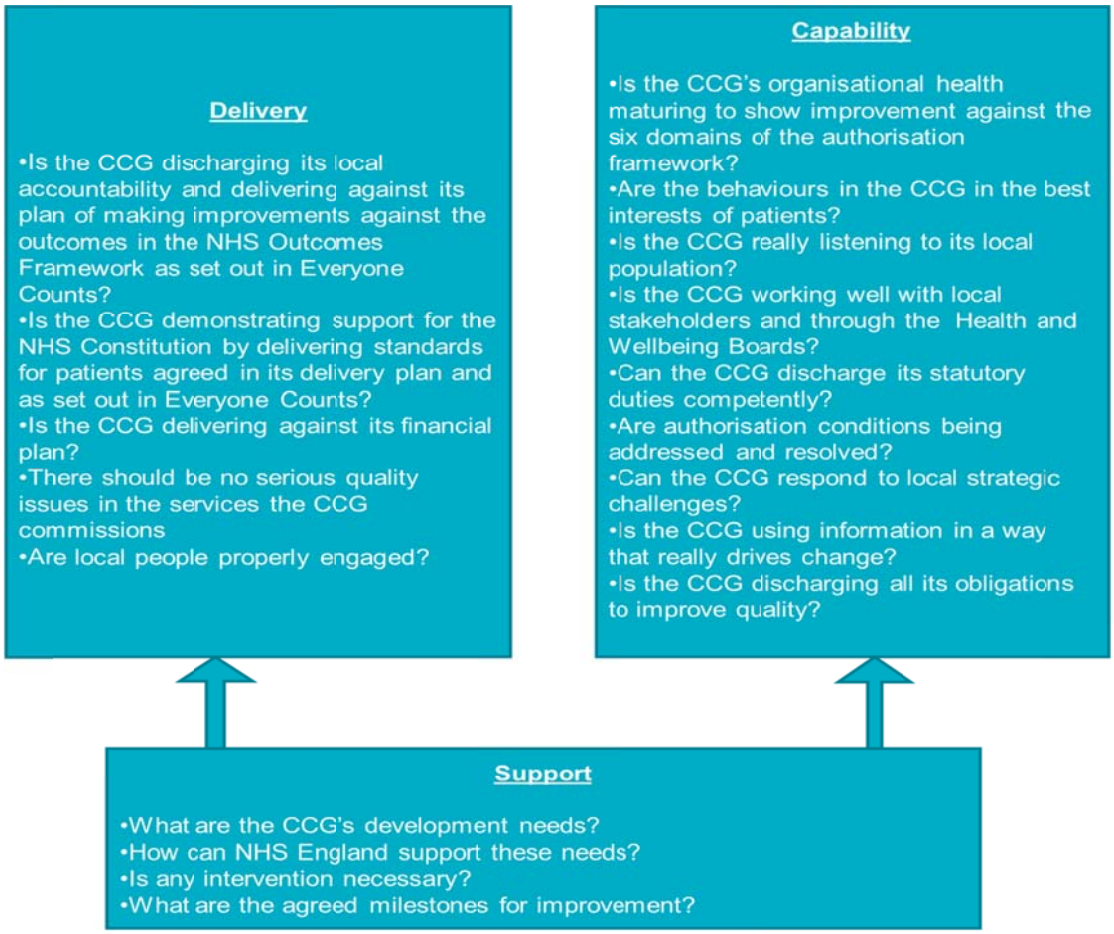
between NHS England and CCGs as co-dependent commissioners of NHS services. In designing mutual assurance, we need to consider interventions with local authority commissioners as they commission public health services for their population as well as social care. The model of mutual accountability must be anchored within the local Health and Wellbeing Board (HWB). HWBs play a key role in bringing organisations together for the mutual interest of their population. It is the place where all key commissioners of health and social care services come together alongside other vital stakeholders to hold each other to account to local people for their use of public money and the results they deliver. We will explore with CCGs, local authorities, HWBs and other key stakeholders how we can best develop this approach to mutual assurance.

NHS England will also ensure that the same level of scrutiny is applied to its own direct commissioning responsibilities. This will be developed along the same timeframe, and apply parallel principles to assure organisational health and performance of NHS England in its capacity as a commissioner, using the same assurance framework as CCG assurance wherever this is practicable. What is important is that practical, mutual assurance takes place at the same time through a unified and coherent process. We will be working through the engagement exercise to build this into the final process.

Core elements of assurance

We propose that the process should have three main elements.

- **Delivery** – ensuring that the CCG is delivering for its population the full range of outcomes and standards (both national and local) agreed in its plan.
- **Capability** – ensuring the CCG is set up to serve patients and communities effectively, both now and for future generations with the required skills and knowledge, and is exhibiting the appropriate behaviours.
- **Support** – determining the nature and level of support a CCG needs to be a great commissioner.



For the most part, assurance about delivery against plan will be undertaken through a series of quarterly checkpoints and will be based on information which we would expect a CCG would wish to make available publicly as part of its responsibility for local accountability. This will include delivery against its agreed strategic plan, which will include the standards in the NHS Constitution, and improvement against the Outcomes Framework as set out in section two of Everyone Counts. It will also assess that the CCG is on track financially. Whilst these checkpoints will mainly be about the assurance of performance, there will also be some assessment of capability in these quarterly checkpoints, in particular the assessment of progress against authorisation conditions aligned to the formal process for the rectification of any conditions of authorisation.

Capability will be assessed on an annual basis, and will be based on and build upon the authorisation process. We will review the CCG's organisational health with a particular focus on its relationship with patients and the public, its capacity to assure quality and its behaviours with key stakeholders. It will inevitably draw on the outputs of the checkpoints but it will also be a key opportunity to review whether the CCG is dealing with local strategic challenges.

The final stage will be to identify support needs. Our expectation is that the majority of CCGs will receive support from NHS England on an informal basis and that this will be integral to the on-going relationship between organisations. However, we need to identify the mechanisms by which NHS England would use its statutory powers to intervene where there were serious concerns. The assurance framework sets out the basis for such intervention.

Assessing delivery and assuring performance

The quarterly checkpoints of the assurance process should be a key element of the on-going relationship between CCGs and NHS England and we expect the discussion to include an assessment of progress being made against plans and agreement about appropriate support where necessary. It is also a key opportunity to discuss collaboration around areas of joint interest and developmental support in line with the principle of continuous improvement.

It is important that discussions about CCG performance through the assurance process take place on the basis of the information that CCGs publish locally as part of their accountability to their local population.

There will be a much greater role for the assessment of the quality of healthcare provided and the outcomes achieved in the CCG area, including taking into account the assessments of providers by the Care Quality Commission (CQC) and a much greater role for the voice of the patient and other local stakeholders. CCGs and direct commissioners will need to require and support their providers to seek increasingly real-time, rich patient and public feedback on their services and to demonstrate how that feedback is shaping service improvement, beyond the friends and family test. Complaints data will be an important component of this wider context view, especially in terms of measuring the quality of complaints resolution, and how commissioners learn from the outcomes of the complaints process

Based on feedback from CCGs and other key stakeholders including NHS England area and regional teams, the proposal is for a balanced scorecard to be generated based on an agreed set of data which CCGs will publish. Annex A sets out initial proposals for this information in more detail. NHS England will work to ensure that reporting requirements and the impact on CCGs is minimised wherever possible and supported through existing data tools such as the ‘integrated intelligence tool’.

The quarterly checkpoint is also an opportunity to discuss provider performance concerns and make an assessment of the actions that CCGs are taking to provide challenge to their local providers through contracting arrangements, and to discuss mutual support options to deliver improvement.

Where a CCG identifies itself as needing improvement against an element of the balanced scorecard, support should be discussed and agreed in line with a nationally consistent framework. An initial proposal is set out at Annex B.

For practical reasons, the quarterly checkpoint will be based around available and timely data but will make an assessment about the following domains:

- are local people getting good quality care?
- are patient rights under the NHS Constitution being promoted?
- are health outcomes improving for local people?
- are CCGs commissioning services within their financial allocations?
- are conditions of CCG authorisation being addressed and removed (where relevant)?

Process

NHS England will work to minimise the data reporting requirements on CCGs and a template will be made available to inform the checkpoint conversation. To ensure that each CCG is treated equally, in principle the scorecard should contain published data which is consistent with a pre-published cut-off date. We expect these requirements to be consistent with the data that CCGs will use to ensure that they are meeting local transparency requirements, and for this to be published no more than six weeks after the end of the quarter.

During the engagement exercise, we will also consider the design of a process to ensure consistency of approach by area teams (for example, training for area teams, review of proposed intervention, and benchmarking).

The formal checkpoint meeting should be used as an opportunity to discuss the results of the balanced scorecard and we expect that following the meeting, and once agreed CCGs would want to publish the results on their websites as a record of progress to date.

Where performance concerns are identified under the balanced scorecard, the national support framework provides a guide to ensure consistency in approach and to ensure that the correct level of support is agreed to deliver the necessary improvements. The outcome of any support conversation should also be published alongside the scorecard.

Each balanced scorecard domain represents a separate element of assurance which gives a framework for the monitoring of the quality of services on an in-year basis. The data that underpins each domain is set out at Annex A and is grouped and assessed using the following guidelines:

Are local people getting good quality care?

Quality assurance sits within a much broader framework of existing regulation across the health service through the CQC, NHS Trust Development Authority and Monitor. It is proposed that the quality domain for CCG assurance reflects elements from each of these frameworks.

The domain should be completed on the basis of self-assessment, local reporting and intelligence. An overall domain assessment should be agreed which is consistent with nationally agreed principles. An assessment should be made for each provider where CCG commissioning constitutes more than five per cent of provider income.

A number of CCGs have suggested that we should cover quality in primary care as part of this domain. We will consider this and the wider views of CCGs on this issue before the final framework is agreed.

Are patient rights under the NHS Constitution being promoted?

The NHS Constitution contains a number of core standards which both NHS England and CCGs have a legal duty to have regard to and to promote. We would expect all CCG plans to be ambitious in delivering these standards. To give assurance that patients' rights are in place, we would expect CCGs to ensure that their providers deliver to these standards within the thresholds set out in Everyone Counts. Both NHS England and CCGs need to ensure that the providers that they commission from are meeting the constitutional standards as required by the standard contract.

An overall domain assessment should be agreed in line with nationally defined principles. These principles have been set around the core standards and where these are not being delivered, NHS England will need to get a detailed understanding of CCG actions to resolve these issues and to make an assessment of the effectiveness of their planned response, including evidence from more contemporary data where available.

Are health outcomes improving for local people?

Everyone Counts sets out those outcomes contained in the NHS Outcomes Framework that can be measured at CCG population level. Because progress against the whole NHS Outcomes Framework will be judged over a longer period of time, the quarterly checkpoint assessment should be made on a smaller subset of indicators which are more frequently available and which are directly linked to the criteria set for the CCG Quality Premium.

An overall domain assessment should be agreed in line with nationally defined principles. Quarterly checkpoints should be used as an opportunity to discuss the CCG approach to performance improvement, including any subsequently collected local data that demonstrates subsequent improvement in the performance position.

Are CCGs commissioning services within their financial allocations?

The financial requirements for CCGs are set out in Everyone Counts and this domain requires an assessment that CCGs are planning to meet their own financial plan as agreed with NHS England through the planning round.

The finance domain should be completed on the basis of agreed financial data and local intelligence. An overall domain assessment should be agreed in line with nationally agreed principles

Are conditions of CCG authorisation being addressed and removed (where relevant)?

The formal discharge of authorisation conditions will be agreed through a separate rectification process, but there will be broad alignment between the two processes. The quarterly checkpoint represents an opportunity for NHS England and CCGs to review rectification plans and test progress.

Where conditions remain, the quarterly checkpoint is an opportunity to discuss which conditions should be formally submitted into the review process prior to formal rectification. More broadly, the discharge of authorisation conditions will be a key measure of the capacity of a CCG to develop.

The authorisation domain will not have formal assessment criteria or guidelines for domain rating.

As part of the engagement exercise we will want to test with CCGs and other key stakeholders if this is the correct approach to the quarterly checkpoints.

One issue we want to test is whether it is appropriate to use CCG assurance as a way of promoting the use of the NHS number by providers, as the primary patient identifier.

Are CCGs ensuring that information is appropriately used to drive change?

Although not included in the balanced scorecard at this point, we propose that in the future, use of the NHS number by providers is part of the quarterly checkpoint review and would like CCG and other stakeholders' views on this and on the other key information markers as described below.

There are several key areas where use of information will be key to delivering real change for patients. As well as use of the NHS number, these include:

- digitisation of care records in secondary care
- metrics derived from complaints data
- patient access to online primary care services

Of primary importance is the use of the NHS number, to allow a smooth and confident linking between primary and secondary care, and the confidence that the correct patient has been identified. Indeed, it is a requirement of the NHS Standard Contract that providers use the patient's NHS number on all patient health records and datasets.

Through the engagement process over the coming months, we want to test whether the quarterly checkpoints, as described above, have been correctly framed and defined, in particular, whether there should be an additional domain covering the appropriate use of information to drive change.

Assessing capability and organisational health

The capability of CCGs, ensuring they are set up to serve patients and communities with the skills and knowledge and behaviours to be effective will build on the shared understanding of organisational health already established with CCGs during the authorisation process.

Organisational health is an established approach with an evidence base which relates directly to the capability to deliver. For CCGs, how well they are able to discharge their outcomes and standards (both national and local) agreed in their plan will relate directly to their organisational health. Based on the tested and generally well received CCG authorisation process, the framework will include assessment that the CCG has made progress over the past year and has robust plans for the future to ensure:

- a clinical and multi-professional focus, with quality central to the organisation
- good engagement with patients and the public, listening to what they say and truly reflecting their wishes
- a clear and credible plan over the medium-term to deliver great outcomes within budget, which has been determined in partnership locally, and reflects the priorities of the health and wellbeing strategy
- the capacity and capability to discharge all of its functions – not only good governance arrangements but the ability to commission well, ensuring quality, financial control and environmental sustainability as well as the full range of information and data management capability
- collaborative arrangements with other CCGs, local authorities and NHS England, appropriate commissioning support and good partnership relationships with their providers
- great leaders who individually and collectively can make a real difference.

A proposal for the assurance of organisational health can be found at Annex C and will be tested further during the engagement exercise.

The detailed content and process of annual assurance of capability will be co-produced across CCGs and NHS England during the first half of 2013/14. It is recognised that we need to work with the whole system to refine these proposals further and that they cannot be made definitive without further discussion. This interim framework sets out an initial proposal to be tested via discussion over the next six months to ensure that it is fit for purpose, and will be used as the basis for CCG assurance whilst the engagement process takes place.

In particular, NHS England has set out its ambition to secure sustainable high quality care for all, both now and for future generations. We welcome feedback on how we can better ensure that the assurance process supports CCGs in leading transformation for tomorrow, not just securing quality for today.

Initial discussions have identified some important principles to guide this work. CCGs are ambitious to become as good as they possibly can be. They are setting their development trajectories against a vision of what a great CCG looks like, not a minimum bar of assurance. Assurance should not inform CCG ambition.

Assurance thresholds should build on the safe thresholds of capability for all CCGs agreed in CCG authorisation, focusing on assuring that no CCG falls back below the safe threshold of capability and identifying, where appropriate, any new minimum expectations of all CCGs over time.

CCGs recognise the importance for delivery of the relationship with other local commissioners. This mutual dependency and accountability across local commissioners should be reflected in a mutual and coherent approach to capability assurance and development across CCGs, area teams and where possible other local commissioners including local authorities and Public Health England. This will include the capabilities needed to fully participate in HWBs,

deliver integrated care, for instance through joint commissioning and recognise the role of patient and local communities in decision making. NHS England will be fully engaged in this shared assurance.

The focus of CCG capability will continue to be supporting CCGs to be successful in meeting the major challenges of improving outcomes locally, leading the redesign of local care delivery systems and releasing resources for re-investment.

The means of assuring CCG capability should be as light touch as possible, using existing information and development mechanisms such peer review, 360 degree surveys and self-certification wherever possible. We will work with CCGs to identify the precise nature of the annual assessment. We propose that this is proportionate with the principle of earned autonomy being central. We do expect to do comprehensive site visits but this will be on a rolling programme with high performing CCGs only receiving site visits perhaps every three years. Site visits will be in-depth and similar to authorisation visits in their inclusion of peer review and lay member involvement. We have already heard feedback from CCGs that the test of this process will be in how it is conducted,

For CCGs with a track record of capability there will be much more of a focus on the support the CCG would wish to have in order to become even better. Development support for CCGs should be agreed annually with all CCGs, wherever they are on their development journey, not just those which are challenged in relation to assurance thresholds.

Identifying support needs

The assurance process exists to ensure that there is a consistent method of identifying support requirements across the CCG landscape. Whereas in the past there has been a tendency to focus on poorly performing organisations, in the future we want to be able to tailor a support offer to all CCGs in recognition that the majority of organisations will be performing well. On the basis of engagement to date, we know that this broad offer is what CCGs would want us to provide.

Through this approach we aim to push the bar in terms of overall delivery and encourage the identification and sharing of the best practice which will make it possible for all CCGs to reach their full potential. We need to be equally able to support CCGs at both ends of the spectrum. To make this a reality, the assurance process will map very closely to the overall CCG development framework and assurance will be a key tool to tailor the support which comprises the NHS England national offer to CCGs.

In certain circumstances, the assurance framework will identify concerns where CCGs are beginning to struggle to deliver their agreed plans and where the broader development offer does not give sufficient scope to deliver the necessary improvements. In these exceptional circumstances, NHS England will need to consider the use of a more formal process to either support organisations to improve or act to use intervention powers where the quality of patient care is felt to be at risk.

Where challenges are identified, at a minimum NHS England will want to seek information, explanations or documents from a CCG to gain assurance about its approach to problem resolution and to discuss the support that NHS England or, where relevant, partner organisations can provide.

Where concerns are more serious, NHS England has the ability to exercise formal powers of intervention where it believes that a CCG is failing or is at risk of failing to discharge its functions. Nothing within the assurance framework should

prevent a CCG from acting to prevent a significant quality breach and nothing should prevent NHS England taking steps to ensure that this quality oversight is in place including acting to ensure that patient care is not compromised.

We would not expect the exercise of formal intervention powers to be considered lightly and the threshold for their use should be high. Our approach will be to develop regular dialogue and only in exceptional circumstances, and as clearly prescribed, will we use intervention. Annex B sets out a broader approach to escalation which codifies the way in which NHS England will look to gain more in depth assurances and where a more formal support conversation would be required.

For the most part, we assume that any intervention will be agreed between the CCG and the area team and should be on an informal support basis. Regional teams will have an important part to play in this process in ensuring consistency. In some instances NHS England may need to use its formal powers of direction as part of the intervention. We expect that this process will be broadly in line with conditions setting and the application of directions used in the authorisation process. We will define this process precisely over the coming months.

For the purposes of the interim assurance framework and to underpin the first quarterly checkpoints for 2013/14, it is suggested that support and intervention under the domains of the balanced scorecard should be considered as outlined in Annex B.

Conclusion

A strong feature of the partnership between NHS England and CCGs will be the co-production of key policies and processes. CCG assurance is a vital example of where such collaboration is essential. This document, tested early on with some CCG leaders, represents NHS England's initial proposal for how CCG assurance will be undertaken, but this more detailed period of consultation is needed to ensure that all CCGs can contribute and re-shape this.

The document clearly differentiates between:

- the on-going assessment of performance and delivery which we propose involves quarterly checkpoint meetings where NHS England will review information which CCGs will publish for the local populations; and
- an annual health check which will consider both the CCG's track record and its organisational health as a predictor of its future success.

The main aim of the process will be to identify the support each CCG needs to be the best it can be. This must be tailored to every CCG and as much effort must be directed to leading edge and front runner CCGs as to those very few who are in danger of failing their population and may need directed intervention. The way in which it is conducted will be important, and we will build on the early work with CCGs on mutual expectations of behaviours to design this.

We welcome the views of all key stakeholders and will publish a final assurance framework in the autumn.

Meanwhile, the proposed nature and content of the quarterly checkpoints will be tested in order to help us learn and inform the final shape.

Whilst not a formal consultation, all stakeholders can send views to the following email address – england.ccgassurance@nhs.net

Meanwhile, we will work closely with the NHS Commissioning Assembly. A programme oversight group will be established, co-chaired by a CCG leader and an NHS England Area Team Director, with input from all directorates across NHS

England as well as other members of CCGs, local authorities and patient representatives.

Annex A: Proposed balanced scorecard domain assessment

CCG Balanced Scorecard	
Are local people getting good quality care?	G/AG/AR/R
Are patient rights under the NHS Constitution being promoted?	G/AG/AR/R
Are health outcomes improving for local people?	G/AG/AR/R
Are CCGs commissioning services within their financial allocations?	G/AG/AR/R
Are conditions of CCG authorisation being addressed and removed (where relevant)?	

Are local people getting good quality care?

Indicator	Outcome			
Providers:	**Provider 1**	**Provider 2**	**Provider 3**	**Provider 4**
Has local provider been subject to enforcement action by the CQC?	Y/N	Y/N	Y/N	Y/N
Has local provider been flagged as as a 'quality compliance risk' by Monitor and/or are requirements in place around breaches of provider licence conditions?	Y/N	Y/N	Y/N	Y/N
Has local provider been been subject to enforcement action by the NHS TDA based on 'quality' risk?	Y/N	Y/N	Y/N	Y/N
Does feedback from the Friends and Family test (or any other patient feedback) indicate any causes for concern?	Y/N	Y/N	Y/N	Y/N
Has the provider been identified as a 'negative outlier' on SHMI or HSMR?	Y/N	Y/N	Y/N	Y/N
Do provider level indicators from the National Quality Dashboard show that:				
MRSA cases are above zero	Y/N	Y/N	Y/N	Y/N
the provider has reported more C difficile cases than trajectory	Y/N	Y/N	Y/N	Y/N
MSA breaches are above zero	Y/N	Y/N	Y/N	Y/N
Does the provider currently have any unclosed Serious Untoward Incidents (SUIs)?	Y/N	Y/N	Y/N	Y/N
Has the provider experienced any 'Never Events' during the last quarter?	Y/N	Y/N	Y/N	Y/N
CCG:				
Clinical Governance				
Does the CCG have any outstanding conditions of authorisation in place on clinical governance?	Y/N			
Has the CCG self-assessed and identified any risks associated with the following:				
Concerns around quality issues being discussed regulary by the CCG governing body	Y/N			
Concerns around the arrangements in place to proactively identify early warnings of a failing service	Y/N			
Concerns around the arrangements in place to deal with and learn from serious untoward incidents and never events	Y/N			
Concerns around being an active participant in its Quality Surveillance Group	Y/N			
EPRR				
If there was an emergency event in the last quarter, has the CCG self-assessed and identified any areas of concern on the arrangements in place for dealing with such an event?	Y/N			
Winterbourne View				
Has the CCG self-assessed and identifed any risk to progess against its Winterbourne View action plan?	Y/N			

Green – all 'NO' responses

Amber/Green – One or more 'YES' responses but action plan in place that successfully mitigates patient risk

Amber-Red – One or more 'YES' responses and no action plan in place / plan does not successfully mitigate patient risk

Red – Enforcement action is being undertaken by the CQC, Monitor or TDA and the CCG is not engaged in proportionate action planning to address patient risk.

Are patient rights under the NHS Constitution being promoted?

Indicator	Operational Standard	Lower Threshold	Numerator	Denominator	Data collection frequency	CCG Assurance Reporting period	Data Source	Basis	Comments
Referral To Treatment waiting times for non-urgent consultant-led treatment									
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	85%	Total number of completed admitted pathways where the patient waited 18 weeks or less	Total number of completed admitted pathways	Monthly	Quarter actual	RTT collection, Unify2	Commissioner	
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	90%	Total number of completed non-admitted pathways where the patient waited 18 weeks or less	Total number of completed non-admitted pathways	Monthly	Quarter actual	RTT collection, Unify2	Commissioner	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	87%	Total number of incomplete pathways where the patient was still waiting 18 weeks or less	The total number of incomplete pathways at end of the period	Monthly	Quarter actual	RTT collection, Unify2	Commissioner	
Number of patients waiting more than 52 weeks	0	10	Total number of incomplete pathways where the patient was still waiting 52 weeks or more		Monthly	Last month in the quarter	RTT collection, Unify2	Commissioner	
Diagnostic test waiting times									
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	94%	The number of patients waiting 6 weeks or more for a diagnostic test (15 key diagnostic tests) at the end of the period	The total number of patients waiting at the end of the period	Monthly	Quarter actual	Diagnostics collection (DM01), Unify2	Commissioner	
A&E waits									
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%	The number of patients spending four hours or less in all types of A&E department	The total number of patients attending all types of A&E department	Weekly	Quarter actual	SitReps collection, Unify2	Provider	Data not collected on a commissioner basis. Provider data mapped to CCGs using weights derived from A&E HES.
Cancer waits – 2 week wait									
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	88%	Patients urgently referred with suspected cancer by their GP (GMP or GDP) who were first seen within 14 calendar days within a period	All patients urgently referred with suspected cancer by their GP (GMP or GDP) who were first seen within a period	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	88%	Patients urgently referred for evaluation/investigation of "breast symptoms" by a primary or secondary care professional during a period (excluding those referred urgently for suspected breast cancer) who were first seen within 14 calendar days during the period.	All patients urgently referred for evaluation/investigation of "breast symptoms" by a primary or secondary care professional within a period, excluding those referred urgently for suspected breast cancer who were first seen within the period.	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Cancer waits – 31 days									
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	91%	Number of patients receiving first definitive treatment for cancer within 31 days of receiving a diagnosis (decision to treat) within a given period for all cancers (ICD-10 C00 to C97 and D05)	Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	89%	Number of patients receiving subsequent surgery within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.	Total number of patients receiving subsequent surgery within a given period, including patients with recurrent cancer.	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	93%	Number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.	Total number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a given period, including patients with recurrent cancer.	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	89%	Number of patients receiving subsequent/adjuvant radiotherapy treatment within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.	Total number of patients receiving subsequent/adjuvant radiotherapy treatment within a given period, including patients with recurrent cancer.	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Cancer waits – 62 days									
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	80%	Number of patients receiving first definitive treatment for cancer within 62-days following an urgent GP (CDP or GMP) referral for suspected cancer within a given period, for all cancers (ICD-10 C00 to C97 and D05)	Total number of patients receiving first definitive treatment for cancer following an urgent GP (CDP or GMP) referral for suspected cancer within a given period, for all cancers (ICD-10 C00 to C97 and D05)	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	85%	Number of patients receiving first definitive treatment for cancer within 62-days following referral from an NHS Cancer Screening Service during a given period (covers any cancer ICD-10 C00 to C97 and D05)	Total number of patients receiving first definitive treatment for cancer following referral from an NHS Cancer Screening Service within a given period (covers any cancer ICD-10 C00 to C97 and D05)	Quarterly	Quarter actual	Cancer waits database	Commissioner	
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	No operational standard set	No operational standard set			Quarterly	Quarter actual	Cancer waits database	Commissioner	
Category A ambulance calls									
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	70%	The total number of Category A (Red 1) incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	The total number of Category A (Red 1) incidents, which resulted in an emergency response arriving at the scene.	Monthly	Quarter actual	AmbSys collection, Unify2	Provider	Data not collected on a commissioner basis. CCGs will be allocated the overall performance of the ambulance trust that they are covered by.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	70%	The total number of Category A (Red 2) incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	The total number of Category A (Red 2) incidents, which resulted in an emergency response arriving at the scene.	Monthly	Quarter actual	AmbSys collection, Unify2		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	90%	The total number of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	The total number of Category A incidents with ambulance response arriving	Monthly	Quarter actual	AmbSys collection, Unify2		
Mixed Sex Accommodation Breaches									
Minimise breaches	0	>10	The number of MSA breaches for the reporting month in question		Monthly	Quarter actual	MSA collection, Unify2	Commissioner	
Cancelled Operations									
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	Not Rated	Not Rated							Data not collected on a commissioner basis and cannot be mapped to CCG.
Mental Health									
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%	90%	The number of people under adult mental illness specialties on Care Programme Approach receiving follow up (by phone or face to face contact) within seven days of discharge from psychiatric in-patient care during the reference period	The number of people under adult mental illness specialties on Care Programme Approach discharged from psychiatric in-patient care during the reference period	Quarterly	Quarter actual	MH Community Teams Activity Return	Commissioner	

Indicator RAG rating

Green - Performance at or above the standard
Amber - Performance between the standard and the lower threshold
Red - Performance below the lower threshold **OR** same indicator has Amber performance for two consecutive quarters

Domain RAG rating

Green – No indicators rated red
Amber/Green – No indicator rated red but future concerns
Amber-Red – One indicator rated red
Red – Two or more indicators rated red

Are health outcomes improving for local people?

NHS Outcomes Framework measures which NHS England and CCGs will use in annual assurance (as described in Annex A of Everyone Counts)

Indicator	Indicator used in quarterly checkpoints	Indicator included in Quality Premium	Threshold	Indicator detail	Data collection frequency	CCG assurance reporting period	Data Source	Basis	Comments
1. Preventing people from dying prematurely									
Potential years of life lost (PYLL) from causes considered amendable to healthcare	No	Yes	To earn this portion of the quality premium, the potential years of life lost (adjusted for sex and age) from amenable mortality for a CCG population will need to reduce by at least 3.2% between 2013 and 2014. This is based on the 10-year average annual reduction in potential years of life lost from amenable mortality	Potential years of life lost (PYLL) from causes considered amenable to health care expressed as a rate per 100,000 population. The PYLL rate uses the average age-specific period life expectancy for each five-year age band for the relevant calendar year as the age to which a person in that age band who died from one of the amenable causes might have been expected to live in the presence of timely and effective health care. The age-specific period life expectancy is different for each calendar year, and will be published at alongside the data. These age-specific life expectancies are used to weight the number of deaths in that age band to give the number of years of life lost for that age band.	2011 mortality data were released in November 2012. The ONS Statistical Bulletin on avoidable mortality for 2011 will be published in March 2013. Mid-year population estimates for 2011 were released in September 2012.	Annual Assurance only	ONS mortality and population estimates	Commissioner	Data only available annually so not used in quarterly CCG Assurance checkpoints. See indicator CB_A1 in Everyone Counts: Planning for Patients 2013/14 - Technical Definitions for further details, including details of the ICD-10 codes included in this measure
Under 75 mortality rate from cardiovascular disease									
Under 75 mortality rate from respiratory disease									
Under 75 mortality rate from liver disease									
Under 75 mortality rate from cancer									
2. Enhancing quality of life for people with long term conditions									
Health-related quality of life for people with long-term conditions	Combined measure : Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults), Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, Emergency admissions for acute conditions that should not usually require hospital admission and Emergency admissions for children with LRTI, Emergency readmissions within 30 days of discharge from hospital	Combined measure : Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults), Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, Emergency admissions for acute conditions that should not usually require hospital admission and Emergency admissions for children with LRTI, Emergency readmissions within 30 days of discharge from hospital	To earn this portion of the quality premium, there will need to be a reduction or a zero per cent change in emergency admissions for these conditions for a CCG population between 2012/13 and 2013/14. The NHS CB may apply an adjustment for CCGs with the highest baseline levels of emergency admissions.	The measure is the proportion of persons admitted to hospital for conditions aggregated across the four indicators, expressed as a rate per 100,000 population. The NHS Outcome Framework contains four indicators measuring emergency admissions for those conditions (sometimes referred to as 'ambulatory care sensitive conditions') that could usually have been avoided through better management in primary or community care. These are indicators 2.3i and 2.3ii focusing on chronic (ie long term) conditions and indicators 3a and 3.2 focusing on acute conditions. For the purpose of the quality premium these complementary measures are being combined to create a single composite measure.	HES reports provisional data monthly, annual data by financial year is available in the autumn/winter after the end of the period. ONS population estimates available annually (calendar year).	Quarterly and Annual Assurance	HES, ONS population estimates	Commissioner	See indicator CB_A6 in *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details, including details of the ICD-10 codes included in this measure.
Proportion of people feeling supported to manage their condition									
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)									
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s									
Estimated diagnosis rate for people with dementia									
3. Helping people to recover from episodes of ill health or following injury									
Emergency admissions for acute conditions that should not usually require hospital admission									
Emergency readmissions within 30 days of discharge from hospital									
Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins									
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)									
4. Ensuring that people have a positive experience of care									
Patient experience of primary care i) GP Services ii) GP Out of Hours services									
Patient experience of hospital care									
Friends and family test	Yes	Yes	To earn this portion of the quality premium, there will need to be: 1) assurance that all relevant local providers of services commissioned by a CCG have delivered the nationally agreed roll-out plan to the national timetable 2) an improvement in average FFT scores for acute inpatient care and A&E services between Q1 2013/14 and Q1 2014/15 for acute hospitals that serve a CCG's population.	The Friends and Family Test is a simple, comparable test which, when combined with follow-up questions, provides a mechanism to identify poor performance and encourage staff to make improvements where services do not live up to the expectations of patients. This leads to a more positive experience of care for patients. Patients will be asked a standard question at the point of discharge from hospital. They will be asked to record a response against a six point scale: Extremely likely/ Likely/ neither likely or unlikely/ unlikely/ extremely unlikely/ don't know. The comparability of the data (through the use of a standardised question and methodology) will allow commissioners to understand overarching levels of patient experience for the services that they commission.	Monthly (from April 2013 for inpatient wards and A&E departments, and from October 2013 for maternity services)	Quarterly and Annual Assurance	FFT collection, Unify 2	Commissioner	Details of central reporting will be specified in separate technical guidance, to be published in due course. The current position is that providers should not compromise anonymity of patient responses by asking for CCG identifying information such as postcode. The expectation is that aggregate responses will be attributed to CCGs using other centrally available data. See indicator CB_A13 in *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm									
Incidence of healthcare associated infection (HCAI) i) MRSA	Yes	Yes	A CCG will earn this portion of the quality premium if there are no cases of MRSA bacteraemia for the CCG's population	The total number of MRSA cases assigned to CCGs	Monthly	Quarterly and Annual Assurance	Public Health England	Commissioner	See indicator CB_A15 in *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details.
Incidence of healthcare associated infection (HCAI) ii) C.difficile	Yes	Yes	A CCG will earn this portion of the quality premium if C. difficile cases are at or below defined thresholds for CCGs.	The total number of C. difficile cases assigned to CCGs	Monthly	Quarterly and Annual Assurance	Public Health England	Commissioner	See indicator CB_A16 in *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details.
6. Others									
IAPT Coverage - performance against plan	Yes	No	A CCG will be rated as Green if they are at or below their plan. These indicators are not included in the Quality Premium.	The primary purpose of this indicator is to measure improved access to psychological services (IAPS) for people with depression and/or anxiety disorders. This is done using two indicators : 1) The proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes); and 2) The proportion of people who complete treatment who are moving to recovery	Quarterly	Quarterly Assurance only	Omnibus returns, NHSIC	Commissioner	See indicator CB_S5 in *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details.
Local Priorities									
1	No	Yes							
2	No	Yes							
3	No	Yes							

Green – all relevant indicators on track for achievement of Quality Premium
Amber/Green – Not all indicators on track for achievement of the Quality Premium
Amber/Red – At least one indicator statistically significantly off track for achievement of the Quality Premium
Red – All indicators statistically significantly off track for achievement of the Quality Premium

Note:
The document *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* can be found at the following link:
http://www.commissioningboard.nhs.uk/everyonecounts/

Are CCGs commissioning services within their financial allocations?

Financial performance			Individual indicator RAG rating threshold			
No.	Indicator	Primary / Supporting Indicator	Green	Amber/Green	Amber/Red	Red
1	Underlying recurrent surplus	Primary	>= 2%	1% - 1.99%	0% - 0.99%	< 0%
2	Surplus - year to date performance	Primary	>= 1%	>= 0.8%	>=0.5%	< 0.1%
3	Surplus - full year forecast	Primary	>= 1%	>= 0.8%	>=0.5%	< 0.1%
4	Management of 2% NR funds within agreed processes	Supporting	Yes			No
5	QIPP ** - year to date delivery	Primary	>= 95% of plan	>= 80% of plan	>= 50% of plan	< 50% of plan
6	QIPP ** - full year forecast	Primary	>= 95% of plan	>= 80% of plan	>= 50% of plan	< 50% of plan
7	Activity trends - year to date	Supporting	< 101% of plan	< 102% of plan	<103% of plan	< 104% of plan
8	Activity trends - full year forecast	Supporting	< 101% of plan	< 102% of plan	<103% of plan	< 104% of plan
9	Running costs	Primary	<= RCA			>RCA
10	Clear identification of risks against financial delivery and mitigations	Primary	Indicator met in full	Indicator partially met - limited uncovered risk	Indicator partially met - material uncovered risk	Indicator not met

** QIPP to include transactional and transformational schemes

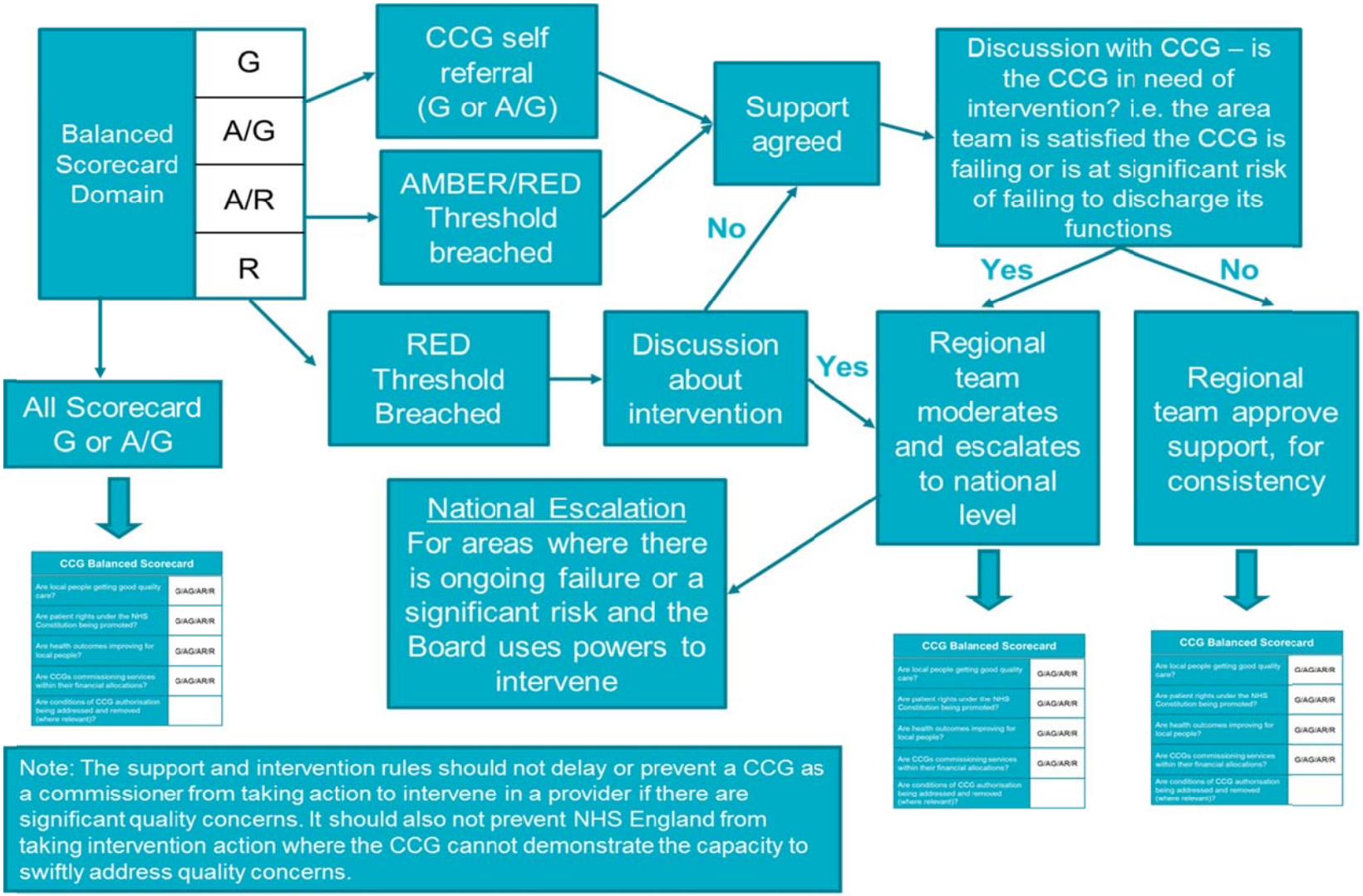
Financial management			Individual indicator RAG rating threshold			
No.	Indicator	Primary / Supporting Indicator	Green	Amber/Green	Amber/Red	Red
11	This covers Internal and external audit opinions, and an assessment of the timeliness and quality of returns.	Supporting	To be defined	To be defined	To be defined	To be defined
12	Balance sheet indicators including cash management and BPCC	Supporting	To be defined	To be defined	To be defined	To be defined

Overall rating (subject to over-riding rule below)

Green	**To be defined. However, an overall green rating can only be achieved if all primary indicators are individually rated green. 2 or more red primary indicators would lead to a overall red rating.**
Amber/Green	
Amber/Red	
Red	

Over-riding rule
Qualified audit opinon would lead to an overall RED rating

Annex B: Proposed support, intervention and escalation framework under the balanced scorecard



Annex C: Proposed domains for assurance of organisational health and capability

Domain 1: A clinical and multi-professional focus, with quality central to the organisation
Quality is at the heart of governance, decision-making and planning arrangements, with examples of CCGs delivering local quality improvements. Member practices are involved in making and implementing decisions, and views and input are sought, heard and valued from a range of professionals across all providers, not just GPs.

Domain 2: Good engagement with patients and the public, listening to what they say and truly reflecting their wishes
CCG is an active member of its Health and Wellbeing Board, and sees engagement with patients, carers and members of the public and developing an open and transparent culture, as intrinsic to what it does. Examples of how CCG systematically monitors and acts on patient feedback, particularly in identifying quality issues.

Domain 3: A clear and credible plan over the medium-term to deliver great outcomes within budget, which has been determined in partnership locally, and reflects the priorities of the health and wellbeing strategy
CCG has detailed financial plan that delivers against the finanical business rules, sets out how it will manage within its management allowance and is integrated with its commissioning plan, and CCG can demonstrate progress and delivery against its plan. There are on-going discussions between CCG, its neighbouring CCGs and provider organisations about long-term strategy and plans, and member practices understand their local plans and priorities and are engaged in their delivery.

Domain 4: Proper constitutional and governance arrangements, and the capacity and capability to deliver all their duties and responsibilities including:
a) ability to manage all aspects of quality b) ability to commission the full range of services c) use of information to deliver an open and transparent culture d) financial control and capacity e) environmental and social sustainability

Domain 5: Collaborative arrangements with other CCGs, local authorities and NHS England, appropriate commissioning support and good partnership relationships with their providers
CCG has deep collaborative ties to their local authority, clinical senates and area teams, with shared governance of joint commissioning with area teams and, where relevant, strong integrated commissioning with their local authority partner. The CCG has developed a strong and insightful working partnership with the local Health and Wellbeing Board. CCG has contract in place with an assured commissioning support services provider, and can articulate clear plans for its commissioning support services between 2013 and 2016.

Domain 6: Great leaders who individually and collectively can make a real difference
CCG has individual and collective leadership who demonstrate commitment to partnership working and have the necessary skillset to lead commissioning and drive transformational change. Distributed leadership throughout the culture of the CCG and the governing body means that there is extensive engagement and communication across practices, with effective processes for two-way accountability in use.