

The CCG
Assurance
Guide 2013/14:
operational
guidance



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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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The CCG Assurance Guide 2013/14: operational guidance

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Introduction and context

Purpose of document

1. This guide accompanies the CCG Assurance Framework and is a secondary document which provides further detail on how the framework should be used to inform local assurance conversations. This guidance is published in the context of the first planning framework (Everyone Counts: Planning for Patients 2013/14: Planning for patients) and is a retrospective process which assures delivery against the planning requirements set out in this document and the core statutory duties which each CCG has to deliver.
2. Significant work has taken place since the publication of the first planning framework to develop the approach to NHS delivery. We recognise at the time of publication, work is about to begin to prepare for 2014/15 and beyond. This guidance is not intended to reflect the requirements of the new planning framework but will be delivered in the context where these issues are being considered including the need to write and assure plans on a broader footprint than the CCG area alone.
3. In particular, this document includes guidance on:
 - The overall process of assurance and the core steps involved in its delivery
 - How to prepare for each quarterly assurance meeting – including information on how local and national intelligence can be used to inform discussions
 - How assurance assessment should be decided following each assurance meeting – including case study examples
 - The key documents needed for assurance, including an example of the assurance report to summarise each assurance conversation

Aims of the assurance process

4. NHS England has a responsibility to assure that CCGs are capable commissioning organisations and to support them to develop and improve. The purpose of the assurance framework is to enable NHS England, through area teams, to meet the statutory responsibility to make an assurance assessment. One of the outcomes of the assurance conversations will be a joint understanding of the development needs of the CCG and how NHS England can support them to meet these needs.
5. The CCG assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high quality and sustainable services within their resources. The assurance framework sets out six broad assurance domains under which this assessment will be made – allowing for a tailored conversation to take place locally which results in an assessment which meets statutory requirements but also contributes to on-going ambitions for CCG development.

6. The six assurance domains reflect the key elements of an effective clinical commissioner which were integral to CCG authorisation and are shared with the direct commissioning assurance framework. These are listed below:
- Domain 1: Are patients receiving clinically commissioned, high quality services?
 - Domain 2: Are patients and the public actively engaged and involved?
 - Domain 3: Are CCG plans delivering better outcomes for patients?
 - Domain 4: Does the CCG have robust governance arrangements?
 - Domain 5: Are CCGs working in partnership with others?
 - Domain 6: Does the CCG have strong and robust leadership?
7. As co-commissioners of healthcare, CCGs and NHS England need to work together to contribute jointly to improving services for patients and each organisation has a mutual responsibility to identify areas for improvement. Assurance conversations provide the opportunity to underpin a supportive and developmental approach that helps CCGs to become the best commissioning organisations they can be – building on what CCGs are already doing to hold themselves accountable to their communities, members and stakeholders. Assurance conversations should be used to highlight areas of good practice and innovation as well as areas for development and improvement.

Development

8. NHS England is strongly committed to working collaboratively with CCGs and the wider commissioning system to pursue continuous improvement in clinical commissioning. Throughout the development of the CCG assurance proposals, work has been on-going with the NHS Commissioning Assembly, the Assembly working group on CCG development, and external partners to develop a strategic framework for CCG development. Based on the views and feedback from CCGs across the country, the CCG development team is pursuing a number of key areas of work to support continued CCG development. These include:
- The identification and presentation of insight into excellent practice in clinical commissioning across the six assurance domains, based on input from NHS England Insight roundtables, the codified best practice of leading CCGs, academic research and international best practice. The findings are set out in the *Framework of Excellence in Clinical Commissioning: For CCGs*¹ the first version of which was published in November 2013. It will be continuously updated, and published annually from here on.
 - Working with colleagues within the system, including CCGs, to co-produce a process which will support CCGs to identify their development needs and to select the appropriate support to meet these needs
 - Listening to CCGs and marshalling resource at scale where it makes sense to do so, for example from within NHS England itself; NHS Improving Quality; and the NHS Leadership Academy, to respond to the development needs that have been identified by CCGs.

¹ <http://www.england.nhs.uk/wp-content/uploads/2013/11/frmwrk-exc-cc1.pdf>

- The *Directory of Development Support* which sets out in one place all the development support available to CCGs. The Directory is part of the CCG learning environment, an on-line resource which also includes the Learning Exchange (where CCGs can share and exchange experiences and learning with one another) and CCG Connect (a national learning network designed around CCG learning preferences). The learning environment can be accessed via www.learnenv.england.nhs.uk
- A programme of planning support to help CCGs and area teams to develop and deliver ambitious and transformative strategic and operational plans as part of their local response to the challenges set out in *The NHS belongs to the people: A call to action*.
- Exploring the specific shared development needs of CCGs and their local partners within Health and Wellbeing Boards, including area teams, public health and local government, as local system leaders and fellow commissioners
- A commissioning skills programme of new help and support on those themes identified by CCGs as being needed and where help has not previously been available. This includes the Commissioning for Value project which supports individual CCGs to identify real opportunities to improve outcomes and increase value for local populations. The localised information supports discussions about prioritising areas for change, utilising resources and will help local leaders make improvements in healthcare quality, outcomes and efficiency. More information can be found here:
<http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/>
- A full list of the commissioning skills support products in place or under development can be found here:
<http://www.england.nhs.uk/resources/resources-for-ccgs/commskillsprog/>

Delivering the assurance framework

9. CCG assurance should become a model in line with the ways of working agreed with NHS Clinical Commissioners². The challenge for assurance is to ensure that the principles which were agreed in the design of the framework are realised in the delivery of assurance conversations. The principles should also underpin the approach to development and support. A number of key aspects of positive behaviours have been identified to support the assurance process and the wider relationship between CCGs and NHS England.

Respecting mutual accountability

10. The assurance process should form an on-going part of the relationship between CCGs and NHS England. Assurance meetings are an opportunity to reflect on how well the CCG and NHS England are working together, and recognise that the resolution of delivery concerns is the responsibility of both parties. It is the responsibility of both CCGs and NHS England to work collaboratively to improve performance and ensure that both are discharging their responsibilities effectively.

Open and transparent relationships

11. The relationship between CCGs and NHS England should be open and honest, with a mutual trust built up over time. Issues or challenges should be discussed early to allow for both parties to work towards their resolution. There should be an ongoing dialogue between the CCG and NHS England, with frequent meetings and informal conversations to share information and work collaboratively. The assurance process puts a formal framework around some of this but there should be a 'no surprises' approach throughout the relationship. This allows for risk to be managed effectively whilst maintaining the autonomy of CCGs.

Effective collaboration

12. To realise the potential of the working relationships between CCGs and NHS England, there will need to be effective collaboration to support the achievement of CCG goals including the delivery of CCG plans and the discharge of statutory duties. The assurance process has been designed to be a joint process throughout, from the agreement of data sources and agenda items through to the content of the final output.

Respecting CCG autonomy through a proportionate approach

13. Through the assurance process, a joint assessment will be made of the level of risk within each CCG, and the most appropriate approach to managing performance. The lower the level of risk, the more autonomy a CCG can operate with. This is reflected in the flexibility of the assurance process, which may reduce from quarterly for high performing CCGs after the first full year. If a CCG is operating with more risk, it is expected that NHS England will be more actively involved in supporting the CCG to manage the risk.

² <http://www.england.nhs.uk/wp-content/uploads/2013/07/ways-of-working.pdf>

Working together

14. Some of these behaviours have already been demonstrated during the interim assurance process. It is expected that the assurance meeting agendas will develop locally into much broader conversations, subject to local agreement, including mutual assurance, ongoing development needs and local strategic priorities. The meeting agenda should not be constrained and assurance should be an opportunity to identify areas where mutual support can be agreed.

Assurance domains

15. The domains used for CCG assurance are aligned to those used during the CCG authorisation process. The six assurance domains reflect the key elements of an effective clinical commissioner. The Framework of CCG Excellence of Clinical Commissioning sets out in more detail the key elements of great practice in each of the six domains. As CCGs develop beyond authorisation, they will be expected to continue to demonstrate and build on each of the six domains, described in more detail below:

Domain 1: Are patients receiving clinically commissioned, high quality services?

16. A great CCG will have a core focus on improving the quality of services that it commissions on behalf of their population. It will have systems and processes in place to understand the quality of services that are being provided, benchmarking appropriately to gain an understanding of variation in comparison to other services or other CCG areas. It will actively identify opportunities to improve the quality of services that are provided working in partnership with its providers, with other partners within the health economy and with other commissioners.
17. The CCG will continuously monitor the quality of commissioned services seeking to identify potential quality problems early and taking proactive action with the provider to address any problems and protect patients. The CCG will share information and intelligence about quality with partners in the health economy as part of the local Quality Surveillance Group, of which there will be ongoing senior representation from the CCG, usually the Accountable Officer.
18. There will be strong clinical input into the design and monitoring of contracts with providers. The governing body will take a regular and active interest in quality and the impact on quality of services will be made explicit in their considerations. The CCG will be actively engaged with local partners, constituent practices and other clinical colleagues including the clinicians providing local secondary care, community and mental health services, learning disability services, public health experts and social care professionals.
19. In continuing to demonstrate delivery against this assurance domain, a CCG will:
 - Co-design a clear vision and priorities including aims for improving quality, agreed and shaped by member practices
 - Ensure there is strong clinical input into the design of contracts with providers, stipulating the desired outcomes that the CCG wants to achieve
 - Engage regularly with providers to monitor the quality of services and outcomes achieved, and actively seek out information on quality from other sources, seeking to identify potential quality problems early on
 - Where problems are identified, the CCG will work proactively with the provider and other partners to address the problems and protect patients

- Ensure the CCG is an active participant in Quality Surveillance Group meetings and that senior representation, usually the accountable officer is in regular attendance
- Underpin delivery through robust constitution and governance arrangements
- Conduct stakeholder surveys in order to canvas views of member practices and other key partners such as the Health and Wellbeing Board and Healthwatch

Domain 2: Are patients and the public actively engaged and involved?

20. CCGs need to show how they listen to and act on the views of patients, carers, public, communities of interest and geography, Health and Wellbeing Boards and local authorities. It should be evident how the views of individual patients are translated into commissioning decisions and how the voice of each practice population will be sought and acted on. CCGs need to ensure that patients and carers can participate in planning, managing and making decisions about their care and treatment. NHS England has produced guidance³ to support CCGs in their statutory duties around patient and public participation.

21. In continuing to demonstrate delivery against this assurance domain, a CCG will:

- Know their community, understand their needs
- Jointly develop a Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy, and participate in its on-going refresh, ensuring alignment with the CCGs integrated plan and commissioning intentions
- Have transparent arrangements in place to feed patient and public insights into CCG decision making, including evidence from local Healthwatch, patient feedback and complaints and concerns
- Have plans in place to promote support for self-management, shared decision making and personalised care planning, including personal health budgets
- Use information technology as an enabler to delivering patient and public engagement activity

Domain 3: Are CCG plans delivering better outcomes for patients?

22. CCGs should have a clear plan for how they will improve outcomes for patients using broad evidence to support this, including measures within the CCG Outcomes Indicator Set. They will work with the local Health and Wellbeing Board to identify priorities for the local population, and seek interventions that will have the biggest impact on priority areas. They will use data available to measure the baseline, and benchmark themselves against other CCGs to identify areas that require improvement, and to learn from best practice in other areas. CCGs will have robust systems in place to measure the outcomes achieved and be able to demonstrate improvement over time.

³ <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

23. At the same time, they need to continue to plan effectively to deliver the requirements set out in the NHS Constitution and the requirements of the local QIPP challenge for their health system. These plans will set out how the CCG will take responsibility for service transformation that will improve outcomes, quality and productivity, whilst reducing unwarranted variation and tackling inequalities, within their financial allocation.
24. In continuing to demonstrate delivery against this assurance domain, a CCG will:
- Develop a clear plan to improve outcomes for patients, based on a detailed understanding of priority areas that require greatest improvement in outcomes, and seek interventions to address these
 - Use data available to measure baseline position against outcome indicators, and measure improvement rates over time
 - Develop a clear and credible integrated plan which includes an operating plan and draft commissioning intentions including a high level strategic plan each year. QIPP will be integrated within all these plans
 - Develop detailed financial plans that deliver the business rules for CCGs from *Everyone Counts: Planning for Patients 2013/14*, and sets out how it will manage within its management allowance
 - Contracts with main providers are agreed and signed off each year, including systems in place to track performance against contracts

Domain 4: Does the CCG have robust governance arrangements?

25. CCG's capacity and capability to carry out their corporate and commissioning responsibilities should continue to grow and evolve to meet the changing needs of the local community. This means they are properly constituted with robust governance arrangements. CCGs will deliver all their statutory functions, strategic oversight, financial control and probity, as well as driving improvement in quality and outcomes, encouraging innovation and managing risk. They deliver the NHS Constitution including in areas such as equality and diversity, safeguarding and choice. CCGs have processes in place to effectively commission services for which they are responsible, from the early health needs assessment through service design, planning and reconfiguration to procurement, contract monitoring and quality control.
26. In continuing to demonstrate delivery against this assurance domain, a CCG will:
- Have well-developed governance arrangements, including a robust constitution that meets the requirement of legislation including standard financial management arrangements
 - Maintain a robust risk management framework including clinical, financial, performance, and corporate risk
 - Have effective systems and processes for monitoring and acting on information about quality including patient feedback, so that the CCG is able to identify early warnings of a failing service
 - Have arrangements in place to deal with and learn from serious incidents and never events

- Identify health inequalities issues and addresses them through Joint Strategic Needs Assessment, and an integrated plan
- Have established appropriate systems for safeguarding
- Focus their commissioning plans on securing improvements in quality and outcomes
- Ensure there is a focus on quality at governing body level, with frequent reports to the governing body and discussions focussed on improvement in quality and outcomes
- They will also safely discharge those statutory functions delegated by NHS England, such as the commissioning and monitoring of out of hours services, and GP IT.

Domain 5: Are CCGs working in partnership with others?

27. CCGs have robust arrangements for working with other local partners including the NHS England area team and other CCGs when commissioning services and planning major service reconfigurations. They have strong shared leadership with local authorities to develop joint health and wellbeing strategies, and strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care is vital and the ability to secure expert public health advice when this is needed. They have credible commissioning support arrangements in place to ensure robust commissioning and economies of scale.

28. In continuing to demonstrate delivery against this assurance domain, a CCG will:

- Have robust governance arrangements and a constitution in place
- Have collaboration arrangements in place, with strong links with the health and wellbeing board, evidenced with the production of a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy
- Have agreements in place on safeguarding arrangements

Domain 6: Does the CCG have strong and robust leadership?

29. CCG leaders guide health commissioning for their population and drive transformational change to deliver improved outcomes. These leaders demonstrate their commitment to, and understanding of, partnership working in line with such senior public roles, as well as the necessary skill set to take an oversight of public services. They need individual clinical leaders who can drive change, and a culture which distributes leadership throughout the organisation. The Accountable Officer is capable of steering the organisation and the chief finance officer must be both fully qualified and have sufficient experience. All those on the governing body have the right skills to ensure the CCG delivers their responsibilities effectively.

30. In continuing to demonstrate delivery against this assurance domain, a CCG will:

- Have a robust organisational development plan
- Involve clinicians in service redesign and improvement

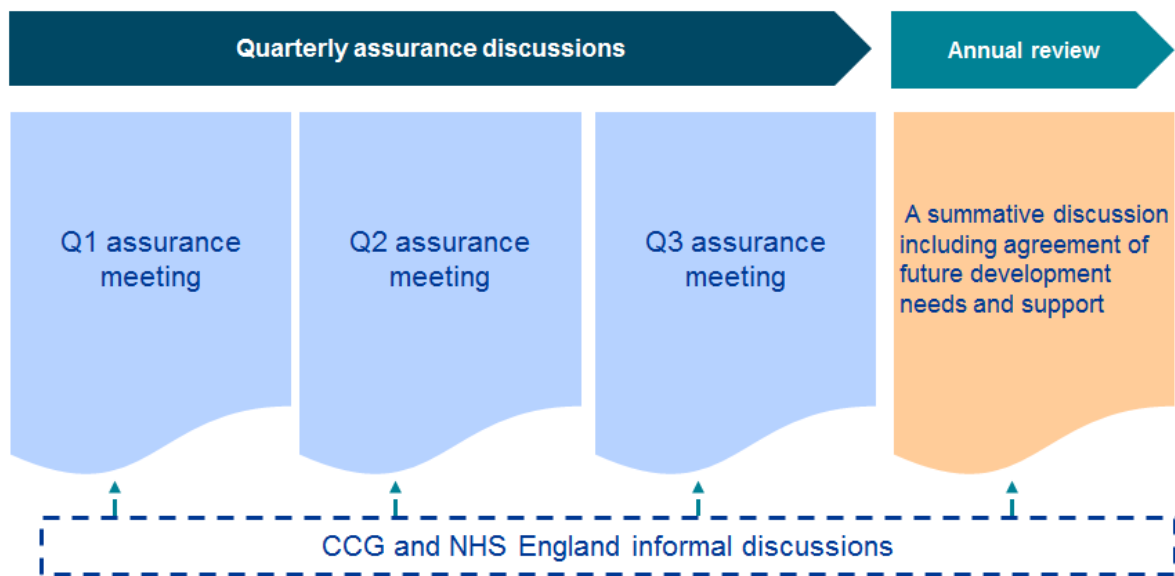
- Select senior leaders with appropriate attributes and competencies
- Have a clear and robust plan in place for nurturing and developing future leadership talent

Assurance process

Overview

31. Each annual assurance cycle will generally consist of four quarterly meetings, to discuss progress against each of the assurance domains. The content of each quarterly meeting may vary, depending on the focus of discussion as identified by the CCG and NHS England. For example, planning and contracting may be discussed during quarter three. The output of each assurance meeting will be a summary report.
32. The fourth meeting of the year will be an annual review meeting, summative in nature with 'no surprises', including agreement of future development needs and support. The output of the annual review meeting will be a summary letter.
33. This process is outlined below:

Figure 1 – annual assurance process



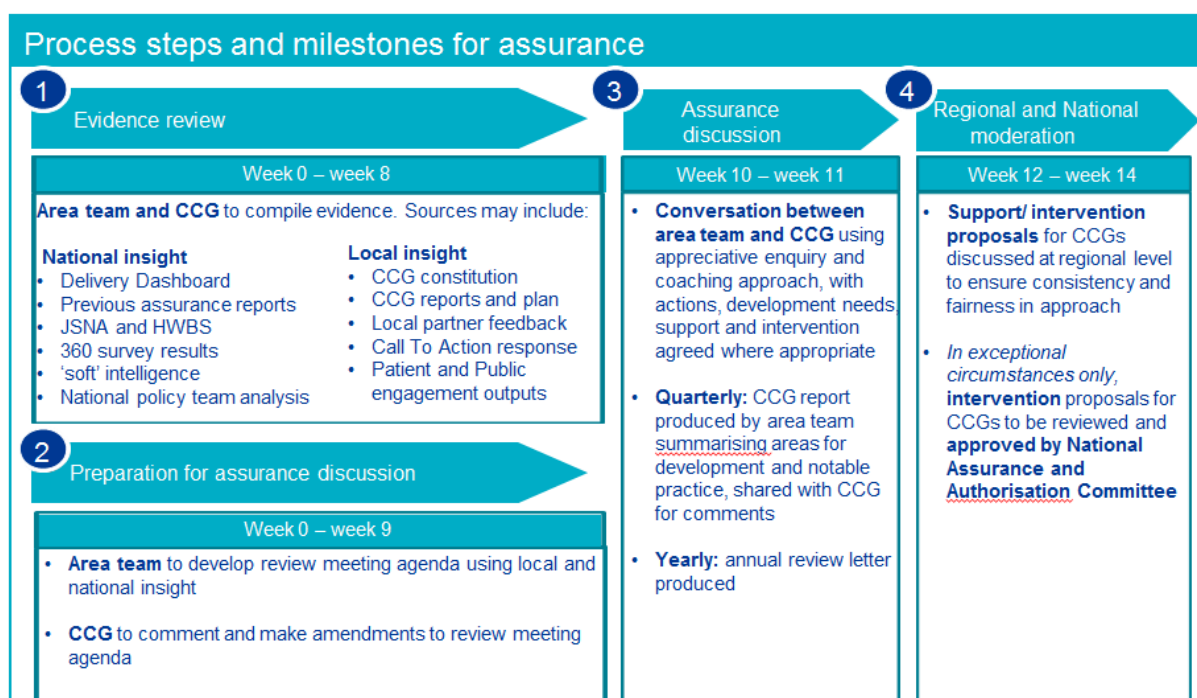
Process steps

34. There are four key steps involved in the preparation of an assurance meeting.

1. Evidence review
2. Preparation for assurance discussion
3. Assurance discussion
4. Regional and National moderation

35. These steps are outlined in figure 2 below, with more detail behind each step outlined underneath.

Figure 2 – process steps and milestones for assurance



Step 1 – Evidence review

36. The review of evidence should be continuous and integral to on-going relationships. For the purposes of assurance, NHS England area teams will collate relevant data and documentation at a national and local level, fed where appropriate by CCGs. Each assurance meeting may need different inputs, and there are a number of key documents that may be used to develop the 'areas for discussion' in the assurance meeting. Some examples of these documents or data sources are shown in figure 2. The assurance framework is intentionally not exhaustive and NHS England area teams and CCGs are encouraged to use creative and diverse evidence to contribute to a supportively challenging assurance conversation.

Key behaviours / activities in step 1:

- Sharing of all relevant information
- Proactively managing challenges
- Minimal additional bureaucracy
- Open and transparent relationships

Step 2 – Prepare for assurance discussion

37. This step should run in parallel with the evidence review, for completion within the first nine weeks of the quarter. NHS England area teams will collate information from national and local sources, and develop an outline agenda for the meeting, highlighting the key areas for discussion. Based on their assessment of available evidence, NHS England area teams will propose an agenda with areas for discussion under each of the six assurance domains. This will be shared in good time with the CCG in advance of the assurance discussion. The CCG will then have the chance to reflect and comment on the proposed agenda with a revised agenda agreed and circulated. This should respect the principle of ‘no surprises’

Key behaviours / activities in step 2:

- Co-designed agenda and documents
- Equal input to preparation for meeting
- Joint working
- Open and transparent relationships

Step 3 – Assurance discussion

38. In recognition that each conversation will be unique and different, the agenda and attendance at the quarterly assurance meeting should be agreed locally. The attendance should be appropriate to ensure a comprehensive discussion of the agenda, which could include requesting specific expertise where appropriate – e.g. lay representation, nursing representatives.

39. Each quarterly meeting should be an opportunity for CCGs and NHS England to discuss areas for support and development, to inform conversations and CCG ambitions, and to develop the relationship between the CCG and NHS England. These quarterly meetings should also be used as a way of identifying notable practice, where a CCG is excelling or has developed practice that should be showcased more broadly. These quarterly meetings will also highlight emerging development needs. A key role for NHS England in this process will be to use this information to tailor centrally funded support and development to meet the emerging needs of CCGs.

40. After each assurance meeting, NHS England will draft a report, which contains a headline assessment and summary report. The headline assessment should be a clear assessment of whether NHS England is ‘assured’ or ‘not assured’ on the basis of the assurance domains. Informing this headline assessment, there should also be a brief summary report which identifies the assessments made under each domain and include supporting evidence. It should also reference particular areas of best practice identified through discussion. In addition, where assurance requires agreed support, the

summary report should also contain any agreed action plans and improvement trajectories.

41. This will be shared with the CCG in draft format following the assurance conversation and NHS England would expect this to be published locally as a record of the assurance conversation for the purposes of transparency. A sample report is shown in annex 1.

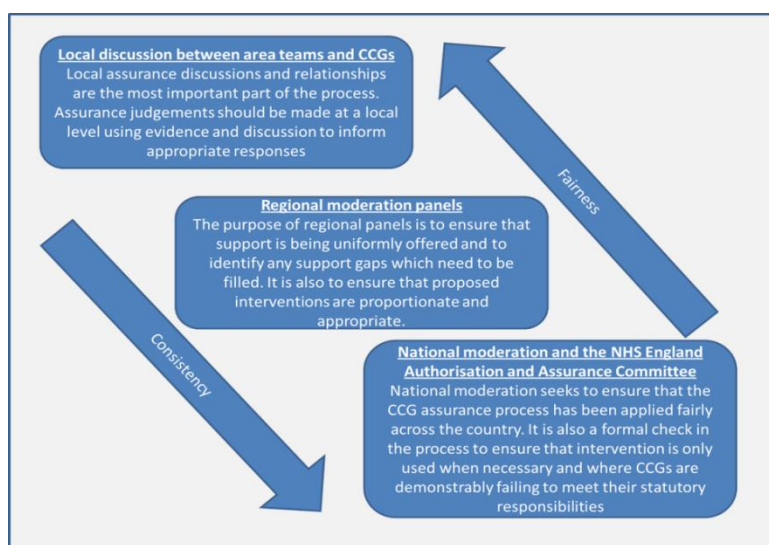
Key behaviours / activities in step 3:

- Open and honest discussion
- Risk based, proportionate approach
- Agreement on outputs
- Collaborative working

Step 4 – Regional and National moderation

42. Moderation is important because it gives CCGs the confidence that assurance is being delivered fairly and it gives NHS England assurance that the process has been consistently applied. This is important in the context of assurance because ultimately the process could result in intervention action being taken which would result in the autonomy of a CCG being reduced.
43. Support proposals, agreed at CCG assurance meetings, will be discussed at regional level within NHS England to ensure assessments have been applied consistently and to identify any gaps in existing support offers to CCGs. Regional moderation also gives the opportunity to gain insight into each of the assurance domains where issues are emerging. It will also offer valuable insight for NHS England policy teams in making an assessment of delivery against the requirements of the planning guidance *Everyone Counts: Planning for Patients 2013/14* which contributes to the delivery of the NHS Mandate. Recommendations for intervention will be discussed at regional level, ahead of approval at regional moderation level.
44. Once completed, a national moderation process will be completed by the Regional Operations and Delivery Directors within NHS England to ensure consistency across all CCGs. Proposals for intervention will be discussed, to ensure fairness and consistency in approach. This is outlined in the diagram below.

Figure 3 – assurance moderation process



45. The process concludes at the NHS England Assurance and Authorisation Committee where proposals for intervention are approved and proposals for support are shared.

Key behaviours / activities in step 4:

- Consistency of approach
- Minimal additional bureaucracy
- Sharing of best practice
- Two way accountability

Annual assurance

46. The results of the quarterly assurance conversations will inform the annual assessment and will also encourage discussions about further development or support required. One of the key elements of the annual assessment should be an agreement between CCGs and NHS England about development needs which should be used to set development priorities in the year ahead.

47. An annual letter from NHS England to the CCG governing body will be produced which summarises the annual assessment against each of the assurance domains. It should summarise assurance conversations throughout the year and also identify any agreed improvement required and ambitions for further development. The focus should be on areas for development, in a constructive, supportive way to share challenges and local risks. This letter may be supported by annexes, including key evidence which was used to make the assurance judgements. In order to allow for CCGs and area teams to develop a document appropriate to their conversation, no set template has been proposed for the annual letter within this guide however further work will be undertaken to develop a number of potential example templates with CCGs and NHS England area teams.

Publication of assurance outputs

48. To ensure transparency in the output of assurance conversations, we would expect that CCGs will want to make these materials available for public review.
49. To meet statutory requirements, NHS England will publish the summary results of the annual assessment, as well as the outcome of any formal assessment made by the Authorisation and Assurance Committee as a result of quarterly assurance conversations.

Inputs to the process: evidence

50. This section provides further information on what types of evidence can be collected as part of **step one** of the preparations for an assurance meeting.

Assurance through insight

51. It is important to recognise that the formal assurance process is just one element of how NHS England gains assurance that the key statutory and planning requirements are being delivered. Overall, assurance falls into three broad categories:

1. On a day to day basis, through professional networks and relationships, NHS England, at both a policy level through intelligence, and through local relationships get the deepest level of assurance about CCG performance across the spectrum of delivery
2. Through assurance conversations, NHS England will use both national and local intelligence to inform the assurance agenda and where concerns for a CCG are identified, these are discussed through assurance. Where improvement is needed, development and support are agreed and where it is clear that a CCG is failing to discharge its duties, NHS England have stronger levers of intervention as a last resort
3. On an annual basis, CCGs are required through their annual reports to make a full assessment of their delivery against their statutory obligations. This then becomes a key source of intelligence for subsequent assurance conversations.

52. The most thorough assurance possible is given by working together, building relationships and participating in professional networks. These elements underpin the assurance framework and contribute to realising the potential of assurance to be insightful, bespoke and driven by evidence.

National insight

53. The use of nationally available information will enable local discussions about delivery to be informed by appropriate benchmarking against national standards, and other CCGs. National data gives a definitive position on a number of key issues, including delivery of improved outcomes and the maintenance of core NHS Constitution standards. National intelligence also gives an insight into areas where performance may present challenges to delivery against the NHS Mandate.

360 degree survey

54. The national 360 degree survey will be developed between CCGs and NHS England over quarter three of 2013/14 and will be used to give insight into local relationships. The survey will be based on the six domains of assurance, and will have the following objectives:

- A longitudinal analysis of the relationships forged by CCGs before, during and beyond authorisation

- Broad comparisons of the relative maturity of these relationships across all CCGs in England
- Assurance of continuing organisational development within CCGs across England
- Triangulation of evidence of stakeholder and partnership working across the local health economy through the quarterly assurance process

55. The design of the content and core participants for the 360 degree survey will be subject to further development but in principle will be developed to represent a rich view of both CCGs and area teams for the purposes of insight and mutual assurance. NHS England will also work to further develop the proposals to include local questions within the 360 degree survey to better reflect local requirements.

Delivery dashboard

56. The delivery dashboard (described at annex 3) builds on the principle adopted under the interim CCG Assurance Framework that a consistent set of national data should inform assurance discussions. This is to ensure that each CCG is assured on an equal basis but recognises that additional local information needs to be used in context to inform the final assurance judgement. Unlike the interim balanced scorecard, the delivery dashboard is not linked to support, intervention or escalation and is simply a source of national insight which will be provided for the purposes of assurance.

57. Each section of the delivery dashboard reflects a specific area of insight based on planning requirements set out in *Everyone Counts: Planning for Patients 2013/14* and key elements of statutory duties. As such it does not fit neatly within the domains of assurance; however, any issues identified within the dashboard will be intrinsic to the assurance conversation and should be reflected appropriately within the wider assurance assessment.

58. The delivery dashboard is largely informed by data but does include an element of self-certification where data or evidence is currently not systematically collected. The intention is that over time, the self-certification element will be reduced and phased out on the principle that this assurance can be drawn from either new data or other sources of evidence.

National policy input into the assurance process

59. A key element of the national offer to support the CCG assurance process is the insight and information drawn from NHS England policy teams. The challenge for the CCG assurance process is ensuring that the principles of the framework are respected through the use of national sources of insight. It is not desirable for national policy teams within NHS England to be sending information for the purposes of assurance unilaterally either internally to area teams or directly to CCGs because this could produce significant additional work and lead to an imbalance in local prioritisation. The role of area teams within NHS England in holding the relationship with CCGs and agreeing assurance agendas needs to be respected.

60. A key role of the NHS England central operations team will be to manage the liaison with policy leads and to ensure that any national policy insights are disseminated appropriately. In keeping with the principles of assurance, national insight will be disseminated regularly on the basis that it is:

- Proportionate in the identification of areas of concern alone
 - Linked directly to underperformance against the requirements set out in *Everyone Counts: Planning for Patients 2013/14* or against key statutory responsibilities
- OR
- Indicative of significant quality issues

61. This insight should inform assurance discussions but should not dictate the agenda of meetings. A proportionate balance needs to be struck locally, recognising that specific challenges exist but approaching them in the wider context of organisational performance.

62. CCG assurance engagement delivered some challenging messages about the need to respect CCG autonomy through assurance. Blanket assurance is neither sustainable nor desirable under the final assurance proposals. This represents a significant challenge within NHS England, particularly to national teams to ensure that organisational behaviours demonstrate a commitment to this. It presents a challenge to think differently about policy levers and to use insight to develop supportive arrangements to ensure that where delivery challenges are identified, appropriate support is available to aid local resolution.

63. In addition to the delivery dashboard, national policy input and the 360 degree survey, NHS England and CCGs should be using a wide range of information to inform assurance conversations. These include the CCG Outcomes Indicator Set, information from Public Health observatories and intelligence from national bodies responsible for regulation or quality assessment such as the CQC.

Local insight

64. A wide range of different sources of local insight should be used to inform assurance conversations. This will allow NHS England and CCGs to tailor assurance conversations to reflect local circumstances. It will also add context to national insight when deciding the agenda for assurance conversations. It is expected that, through regular dialogue, specific pieces of pre-existing evidence would be highlighted for consideration.

65. Local information gives a contextual position on delivery and how the CCG is accounting to its governing body for performance. Additionally it gives the opportunity to consider insight from local partners about the strength of relationships and agreed responses to mutual challenges.

CCG constitution

66. Information contained within the CCG constitution sets out how CCGs will operate. As statutory organisations it is important that CCGs are demonstrably operating within their constitutional arrangements. Where evidence suggests that CCGs are failing to do this, this should be considered for local discussion.

CCG governing body papers

67. The function of the CCG governing body is important to the effective functioning of the CCG as an organisation. Governing body papers demonstrate publicly that CCG plans are being delivered, that quality is being systematically discussed and that any challenges are being effectively recognised and addressed. NHS England will use these rich sources of insight when considering areas for discussion through assurance.

Local partner feedback

68. There are a range of local partners who provide key insight into the effective functioning of CCGs. It is important that both NHS England area teams and CCGs maintain good local relationships with regulators, partners and providers. These could include, but would not be limited to:

- Care Quality Commission
- NHS Trust Development Authority
- Monitor
- Local Authorities
- Health and Wellbeing Boards
- Quality Surveillance Groups
- Health watch
- NHS providers
- Independent sector providers
- Neighbouring CCGs

69. Evidence from local partners should be gathered regularly and used to inform the assurance agenda wherever challenges are identified.

Other suggested sources

70. Through engagement in developing the assurance framework, a number of other sources have been suggested. These, alongside others, could be helpful to area teams and CCGs in setting the assurance agenda.

- How accessible is the CCG website and annual report – language, layout, navigability (“one click principle”)
- Input from local patient groups / lay members
- Conversation with the Chair/s of local patient forums
- Soft intelligence e.g. 18 weeks and A&E performance – looking at acute trusts’ views of the CCG

- Organisational Development Plan – Development needs, succession planning (especially for GPs), LETB, staff barometer
- Five year plan (response to 'Call to Action')
- Engagement with wider health systems and co-commissioners
- Joint Strategic Needs Assessment
- Joint Health and Wellbeing Strategy (with a mandatory section on a local 'Call to Action')

Outputs of the process: assurance categories

71. During and after each assurance conversation, area teams will make a judgement under each assurance domain on the basis of the conversation and any additional information presented, as described in **step three** of the process above. This judgement will be based on the level of risk associated with the CCG's current plans and progress, and wherever possible, will be a joint decision made with the CCG.
72. There are three categories that can be applied for each assurance domain at the end of the assurance conversation:
- Assured
 - Assured with support
 - Not assured, intervention required
73. The judgement of the assurance category can be based on a number of interrelated factors for example:
- a. The level of risk associated with each CCG
 - b. The approach taken by the CCG in managing their current and future positions
 - c. The risk within the wider environment in which the CCG is operating.
74. Where CCGs have not been able to provide assurance based on the conversation or any additional information provided, support should be agreed, alongside clear improvement objectives, documented and subject to further monitoring and discussion.

'Assured' and 'Assured with support'

75. Where the CCG can demonstrate that they are continuing to perform and develop well across the domain, the judgement should be that the domain is **'assured'**. This includes CCGs that are performing well, or have some identified challenges but are proactively managing them.
76. Where the CCG has performance concerns which can be mitigated by mutually agreed support from NHS England, the judgement should be that the domain is **'assured with support'**.
77. The difference between the two categories can be defined by the level of risk associated with the CCG's current performance – if this risk is being actively managed within the CCG, this will give assurance to NHS England. If a risk is not being managed appropriately, this will require additional support and will move the CCG to the 'assured with support' category.
78. Some examples of each of the categories are shown below, and an example case study is used to demonstrate the categorisation of CCG assurance:

Assured	Assured with support
<ul style="list-style-type: none"> • CCG is open and honest regarding key areas of development needs and challenge and provides insight into the root cause of these • CCG can demonstrate there is a clear action plan in place to mitigate any challenges identified, with measurable outcomes • CCG actively manages against agreed plans and takes action when timescales are not met to support progress • Level of risk is being actively managed by CCG 	<ul style="list-style-type: none"> • CCG does not yet understand key challenges, or have an action plan in place to identify root cause and mitigate challenges and the role of NHS England is to support the delivery of that challenge • CCG could benefit from additional expertise from relevant organisations / teams • CCG does not manage against plans to ensure improvement trajectories are met • Level of risk associated with CCG is higher than could be managed by the CCG acting without the additional support of NHS England

Case study:

In Q1, Anyshire CCG has been focussing on their financial and performance position. There has been good progress made and it is likely they will meet their QIPP plan target this year. However, they are likely to be in a difficult financial position next year.

Response 1:

The CCG is proactive in analysing the challenges and data, and understanding the root cause. They provide detailed insight into the potential solutions, including where external support is needed. An action plan has been drafted but is still being worked up to outline the key next steps and timelines.

Category: Assured

Response 2:

The CCG has not thought through the challenges in any great detail, and is not able to provide much insight or analysis for the root causes of the challenges. There are some initial ideas of potential actions and timeframes, but these have not been thought through in detail and are not supported by evidence.

Category: Assured with support

79. Support can include every action from providing information and advice to providing additional expertise and capacity to resolve performance concerns. It is **not** an indication that the CCG is failing, and should not be viewed as such. Through agreed support, the collective efforts of local partners can be mobilised. Support conversations should drive creative and innovative responses and should include a much greater focus on the identification of peer support and shared learning in addition to more established approaches.

Intervention

80. In rare circumstances, the assurance process will identify concerns where CCGs cannot provide evidence that they are capable of mitigating the risks they face, or may have demonstrated over time that agreed support is not sufficient to deliver agreed improvement.

81. There should be evidence that the CCG and NHS England have tried all reasonable options available, prior to formal and legal intervention. NHS

England will require clear evidence to support any decision to legally intervene with a CCG.

82. Where these serious concerns arise, NHS England has the ability to exercise formal powers of intervention where it is satisfied that (a) a CCG is failing or (b) is at risk of failing to discharge its functions, supported by legislation. In these limited circumstances, the judgement should be that the domain is 'not assured, intervention required' and formal intervention action would be proposed, as laid out in the legislation in section 14Z21.

83. A flowchart showing the steps to each assurance outcome is shown in annex 2. The next stage of the case study shows the difference between assured with support and intervention:

Case study:

In Q4, Anyshire CCG has narrowly met their QIPP target in year. However, their planning work has shown that their financial position is very challenged in the following year and their local acute provider is experiencing financial and clinical quality challenges. The CCG has been 'assured with support' to develop and deliver an action plan for the mitigating actions for the last three quarters.

Response 3:

The CCG is making some progress on delivering their action plans, and have come to the assurance meeting with some progress to report, including close clinical engagement between the CCG and provider clinicians. The CCG agrees with the NHS England area team that some additional support is required in order to mitigate the additional risk they have identified.

Category: Assured with support

Response 4:

The CCG does not acknowledge the severity of the current situation, and the risk level associated with their current position. Minimal progress has been made and the situation has not improved. Action plans and timelines that were previously agreed to have not been followed, and there has been little / no action from the CCG to mitigate the risk of financial failure. The CCG does not agree with the area team that further support is necessary to ensure delivery and mitigation of financial or clinical risks.

Category: Not assured, intervention required

84. As outlined above, NHS England recognises that the continuum of support is broad, from basic advice, guidance and access to good practice at one end, through to intensive development and turnaround work, potentially from external providers, at the other. A principle of the assurance framework is that formal, legal intervention in a CCG by NHS England will only be necessary where support arrangements cannot be mutually agreed between area team and CCG.

85. Further information on support and intervention can be found in annex 4.

Development

86. NHS England is strongly committed to working collaboratively with CCGs and the wider commissioning system to pursue continuous improvement in clinical commissioning. Throughout the development of the CCG assurance proposals, work has been on-going with the NHS Commissioning Assembly, the Assembly working group on CCG development, and external partners to

develop a strategic framework for CCG development. Based on the views and feedback from CCGs across the country, the CCG development team is pursuing a number of key areas of work to support continued CCG development. These include:

- The identification and presentation of insight into excellent practice in clinical commissioning across the six assurance domains, based on input from NHS England Insight roundtables, the codified best practice of leading CCGs, academic research and international best practice. The findings are set out in the *Framework of Excellence in Clinical Commissioning: For CCGs* (<http://www.england.nhs.uk/resources/resources-for-ccgs/dev-insight/>), the first version of which was published in November 2013. It will be continuously updated, and published annually from here on.
- Working with colleagues within the system, including CCGs, to co-produce a process which will support CCGs to identify their development needs and to select the appropriate support to meet these needs.
- Listening to CCGs and marshalling resource at scale where it makes sense to do so, for example from within NHS England itself; NHS Improving Quality; and the NHS Leadership Academy, to respond to the development needs that have been identified by CCGs.
- The development of the Directory of Development Support which sets out in one place all the development support available to CCGs. The Directory is part of the CCG learning environment, an on-line resource which also includes the Learning Exchange (where CCGs can share and exchange experiences and learning with one another) and CCG Connect (a national learning network designed around CCG learning preferences). The learning environment can be accessed via www.learnenv.england.nhs.uk
- Supporting CCGs to have a clear strategy for securing its commissioning support services, whether in-house or bought in from an external supplier (see <http://www.england.nhs.uk/2013/11/13/ccg-mk-shr-buy-tool-kit/> for the make, buy, share tool), with an aim to support their understanding of how any proposed changes would impact on its own operational and financial resilience and that of other NHS organisations.
- A programme of planning support to help CCGs and area teams to develop and deliver ambitious and transformative strategic and operational plans as part of their local response to the challenges set out in *The NHS belongs to the people: A call to action*.
- Exploring the specific shared development needs of CCGs and their local partners within Health and Wellbeing Boards, including area teams, public health and local government, as local system leaders and fellow commissioners.
- A commissioning skills programme of new help and support on those themes identified by CCGs as being needed and where help has not previously been available. This includes the Commissioning for Value project which supports individual CCGs to identify real opportunities to improve outcomes and increase value for local populations. The localised information supports discussions about prioritising areas for change, utilising resources and will help local leaders make improvements in healthcare quality, outcomes and efficiency. More information can be

found here: <http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/> A full list of the commissioning skills support products in place or under development can be found here: <http://www.england.nhs.uk/resources/resources-for-ccgs/commskillsprog/>

Annex 1 – Example summary report of quarterly assurance review

Anyshire CCG assurance report

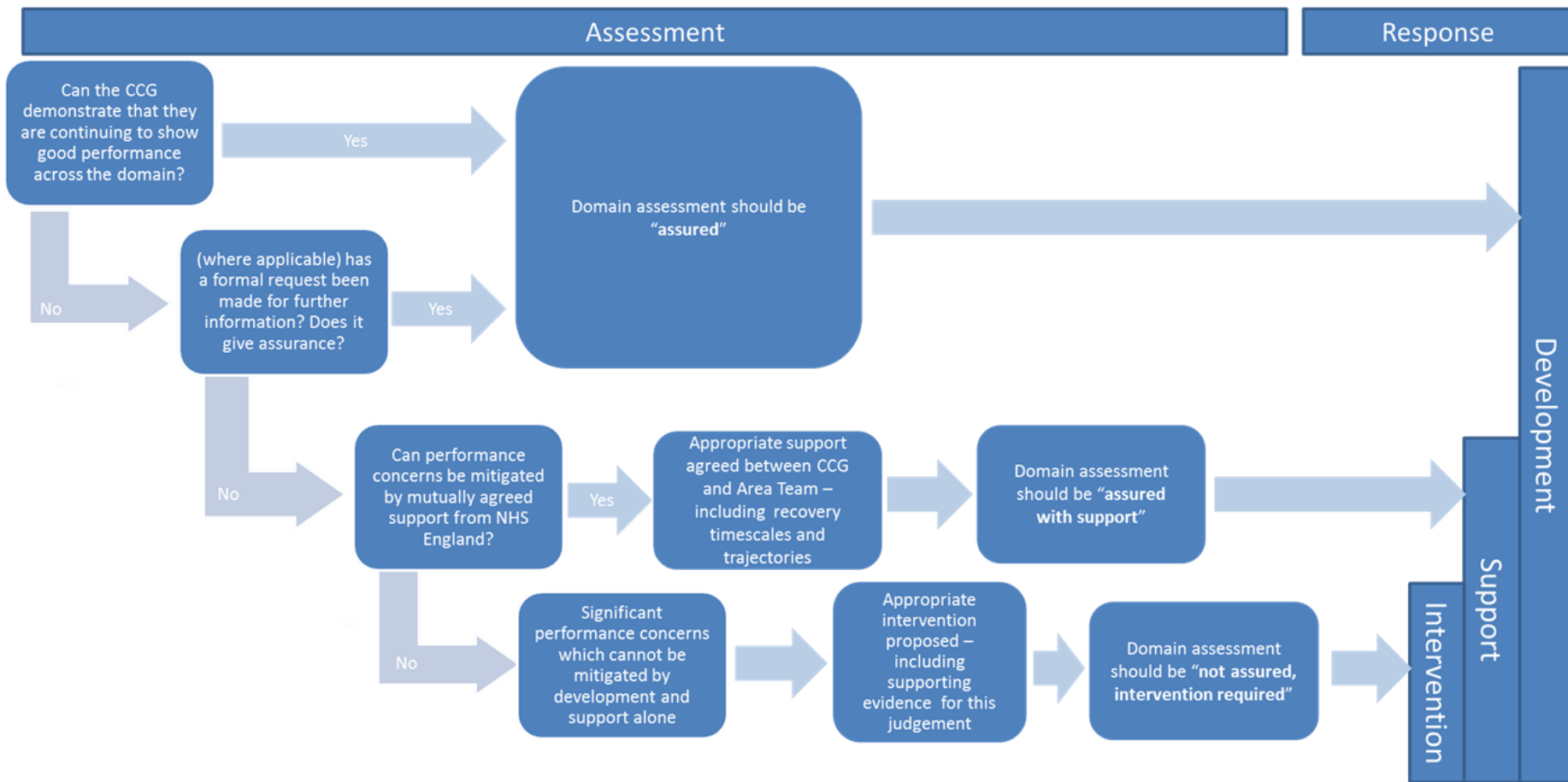
Headline assessment – Assured

Focus	Assurance level	Particular achievements noted/examples of good practice	Issues identified	Any issues identified requiring further action and actions agreed
Are patients receiving clinically commissioned, high quality services?	Assured	<ul style="list-style-type: none"> A strategic plan has been aligned with joint health and wellbeing strategies and has gained support of partners in engagement 	<ul style="list-style-type: none"> Need to increase involvement of members in design and delivery of service change. 	
Are patients and the public actively engaged and involved?	Assured	<ul style="list-style-type: none"> Recent consultation on changes in service configuration in line with best practice. 		
Are CCG plans delivering better outcomes for patients?	Assured with support	<ul style="list-style-type: none"> CCG is on track to deliver local priorities for improvements in outcomes in 2013/14. 	<ul style="list-style-type: none"> 62 days cancer waits – issues with capacity and succession planning in some specialties. A&E waits – Anyshire NHS FT not yet delivering target consistently. 	<ul style="list-style-type: none"> 62 days cancer - the CCG have requested a revised action plan. Key themes include reducing time waited for radiology and pathology tests to be completed. Additional Haematology consultants recruited. A&E - Monitor is reviewing DNHSFT process currently and will be making recommendations. NHS England is active member of the Urgent Care Working Group and will review progress against recovery actions and trajectory at the monthly assurance meetings.

Does the CCG have robust governance arrangements?	Assured		<ul style="list-style-type: none"> Awareness of procurement requirements and best practice amongst members needs to be increased. Support from CSU does not always meet CCG needs. 	<ul style="list-style-type: none"> CCG working to separate 'GP as provider' and 'CCG as commissioner' discussions. CCG having discussions with CSU re rectification plan for underperforming support services.
Are CCGs working in partnership with others?	Assured with support	<ul style="list-style-type: none"> CCG has worked effectively with other CCGs to assure the progression of the local 111 provider. 	<ul style="list-style-type: none"> Local Health and Wellbeing Board is at an early stage of development. Urgent Care Working Group is evolving but could be more effective in terms of prioritising decision making to deal with immediate issues. 	<ul style="list-style-type: none"> CCG planning to use the Health and Wellbeing Board Development Tool to gauge the maturity of the HWB and identify areas of development. NHS England and CCG as active members of the Urgent Care Working Group to drive forward prioritisation of UCWG objectives to implement those actions needed as part of winter resilience.
Does the CCG have strong and robust leadership	Assured	<ul style="list-style-type: none"> The CCG has reviewed and updated its organisational development plan alongside its strategic plan. 	<ul style="list-style-type: none"> The four localities within CCG are working together but engaging membership requires significant focus and effort. The CCG remains reliant on a small number of strong leaders. 	<ul style="list-style-type: none"> CCG plans to use the strong leaders to engage and develop others. CCG to develop a leadership succession plan. NHS England to lead piece of work around best practice in utilisation of practice managers. CCG participating in leadership development programme and will share learning with NHS England.

Annex 2 – Flow chart showing the assurance assessment steps and the outcomes

The diagram below demonstrates the process that area teams and CCGs will go through together to determine their assurance category, and level of assistance required by the CCG. For the CCG to be categorised as requiring intervention, there should be an audit trail over a period of time of increasing levels of support offered by the area team prior to moving to intervention. This is set out in section 14Z21 of the NHS Act 2006 (as amended).



Annex 3 – The 2013/14 delivery dashboard

What is the purpose of the delivery dashboard?

Where performance challenges are identified under the delivery dashboard, they should be discussed through assurance conversations. However, the dashboard is only an input to the process. The most important element of assurance is the local conversation and the judgement about any actions taken as a result of any delivery concerns, with a focus on support and development as the default response. The dashboard itself should be read alongside local performance information and intelligence through assurance discussions with a judgement reached about the level of assurance.

How should the delivery dashboard be used?

The dashboard forms a key element of the national insight which informs the assurance process. It will be generated centrally to a consistent template and should be used to supplement local considerations about areas for discussion through assurance. The sections of the dashboard are formulated on the basis of the following principles:

Quality

The assessment of the quality of care is explicitly linked back to the shared statutory duty to improve the quality of services. It is important that quality is discussed and monitored systematically both through CCG governance and through contract management with providers. The quality section of the delivery dashboard is designed to inform a discussion across both of these dimensions of quality assessment.

Internally, CCGs need to demonstrate robust governance including the regular consideration of quality through governing body discussions. CCGs need to be demonstrably taking a proactive approach to understanding the quality of care in their local area, supporting improvement where necessary and collaborating across local partners.

Externally, CCGs need to demonstrate that quality and outcomes are a routine part of the contract managing process with providers including clinical input and the consideration of patient and public feedback to inform the assessment.

NHS Constitution

The assessment of delivery is explicitly linked back to the shared statutory duty to promote the NHS Constitution. It is important that delivery is discussed and monitored systematically both through CCG governance and through contract management with providers. The NHS Constitution section of the delivery dashboard is designed to inform a discussion across both of these dimensions of assessment.

Internally, CCGs need to demonstrate robust governance including the regular consideration of performance against the NHS Constitution standards. CCGs need to demonstrably be taking a proactive approach to understanding delivery in their

local area, supporting improvement where necessary and collaborating across local partners.

Externally, CCGs need to demonstrate that delivery against the NHS Constitution standards are a routine part of the contract managing process with providers.

Outcomes

The assessment of improved outcomes delivery is explicitly linked back to the shared requirement to improve outcomes for patients across the NHS Outcomes Framework. For the purposes of the delivery dashboard it is necessary to use a subset of these data to ensure that a contemporary discussion can take place. In 2013/14, these indicators include those used to assess entitlement to the quality premium. In future this section of the delivery dashboard will be further developed to include broader data across the CCG Outcomes Indicator Set in line with changes through planning.

It is important that the improvement of outcomes is discussed and monitored systematically by CCGs. The assurance assessment should take potential entitlement to the quality premium as the start point of a conversation and take other sources of insight alongside this to make a more comprehensive assessment of CCG under domain three of the assurance framework.

Finance

The assessment of financial performance is integral to the statutory responsibilities of CCGs. Financial returns are populated from CCG financial returns in the delivery dashboard. It is important that delivery of financial requirements is closely monitored by CCGs. The assurance assessment should take account of performance and any agreed deviations from financial planning rules.

Quality

Indicator	Provider One	Provider Two	Provider Three	Provider Four
<i>Providers (where CCG commissioning constitutes more than 5% of the providers income):</i>				
Please identify the percentage of provider income for CCG:				
What type of service is commissioned from this provider?				
Has the provider been subject to local enforcement action by the CQC?	Y/N	Y/N	Y/N	Y/N
Has the provider been flagged 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 the provider been subject to enforcement action by the NHS TDA based on 'quality' risk?	Y/N	Y/N	Y/N	Y/N
Does feedback from patients and the public, including from the Friends and Family test, other surveys, and complaints indicate any causes for concern?	Y/N	Y/N	Y/N	Y/N
Has the provider been identified as a 'negative outlier' on SMHI 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
Do provider level indicators from the National Quality Dashboard show that the provider has reported more C difficile cases than trajectory?	Y/N	Y/N	Y/N	Y/N
Do provider level indicators from the National Quality Dashboard show that MSA breaches are above zero?	Y/N	Y/N	Y/N	Y/N
Does provider currently have any unclosed Serious Incidents (SIs)?	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

Overall section RAG-rating criteria

Green	All 'No' responses
Amber-Green	One or more 'Yes - action plan in place' responses
Amber- Red	One or more 'Yes - no action plan in place' responses
Red	One or more 'Yes - enforcement action taken' responses

NHS Constitution

Indicator	Operational standard	Lower threshold
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%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	90%
Patients on incomplete non emergency pathways (yet to start treatment) should have been waiting no more	92%	87%
Number of patients waiting more than 52 weeks	0	10
Diagnostic test waiting times		
Percentage of Patients waiting 6 weeks or more for a diagnostic test	1%	6%
A & E waits		
[Provider 1]Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%
[Provider 2]Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%
[Provider 3]Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%
Cancer patients - 2 week wait		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	88%
Maximum two week wait for first out patient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	88%

Cancer waits - 31 days		
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	91%
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	89%
Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	98%	93%
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	89%
Cancer waits - 62 days		
Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	80%
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	85%
Maximum 62 day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	No operational standard	No operational standard
Category A ambulance calls		
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	70%
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	70%
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	90%

Mixed sex accommodation breaches		
Minimise breaches	0	10
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 data within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Data not available by CCG	Data not available by CCG
Mental health		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in patient care during the period	95%	90%

Indicator RAG-rating criteria

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

Overall section RAG-rating criteria

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

Outcomes (and supplementary indicators)

Indicator	Thresholds for RAG Rating	Unit	Comments
1. Preventing people from dying prematurely			
Potential years of life lost (PYLL) from causes considered amendable to healthcare	Detail on how this indicator will be RAG-rated (and dependent on the availability of data) will be available within the delivery dashboard, but will be linked to whether a CCG is on track to receive this portion of the Quality Premium.	Rate per 100,000 population	Indicator will only be used in Q4/annual dashboard (subject to data availability) 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.
2. Enhancing quality of life for people with long term conditions AND 3. Helping people to recover from ill health or following injury			
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. Emergency admissions for children with LRTI, Emergency readmissions within 30 days of discharge from hospital.	Detail on how this indicator will be RAG-rated (and dependent on the availability of data) will be available within the delivery dashboard, but will be linked to whether a CCG is on track to receive this portion of the Quality Premium.	Rate per 100,000 population	To earn this portion of the Quality Premium, there will need to be a reduction or zero percent change in emergency admissions for these conditions for a CCG population between 2012/13 and 2013/14.
4. Ensuring that people have a positive experience of care			
Friends and Family Test*	Detail on how this indicator will be RAG-rated (and dependent on the availability of data) will be available within the delivery dashboard, but will be linked to whether a CCG is on track to receive this portion of the Quality Premium.	Score out of 100 AND Response rate	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.
FFT (order by acute trust self-cert providers)			
Provider 1	Response Rate	Score (out of 100)	
Provider 2	Response Rate	Score (out of 100)	

5. Treating and caring for people in a safe environment and protecting them from avoidable harm		
Incidence of healthcare associated infection (HCAI) i) MRSA	Red : Number of cases > 0 Green : No of cases = 0	Number of bacteraemia assigned to CCG
Incidence of healthcare associated infection (HCAI) i) C difficile	Red : Number of cases above objective Green : Number of cases on or below objective	Number of cases
6. Others		
Is the CCG progressing as expected against the IAPT trajectory submitted during the planning round?*	Detail on how this indicator will be RAG-rated (and dependent on the availability of data) will be available within the delivery dashboard, but will be linked to how a CCG is performing against its planned trajectory.	Percentage coverage
Is the CCG on track to be able to deliver the mandate commitment that by 2015 everyone with a long term condition who wants one should have a personalised care plan?	For 2013/14, these two indicators will not be subject to RAG-rating	Y/N
Are the CCG's plans on track to meet the statutory duty to deliver personal health budgets to people who receive NHS Continuing Healthcare from April 2014?		Y/N
Local priorities (Self-Certification)		Are you on track to deliver against this local priority?
LOCAL PRIORITY 1		Y/N
LOCAL PRIORITY 2		Y/N
LOCAL PRIORITY 3		Y/N

*Where data is not available for these indicators, there may be a need to self-certify

Overall section RAG-rating criteria

Green	No indicators red-rated
Amber- Red	One indicator red-rated
Red	Two or more indicators red-rated

Finance

Financial Performance				Individual indicator RAG rating threshold			
No.	Indicator	Primary/Supporting Indicator	2013/14 Quarter Performance	Green	Amber-Green	Amber-Red	Red
1	Underlying recurrent surplus on exit of 2013/14	Primary		>= 2%	1% - 1.99%	0% - 0.99%	< 0%
2	Plan - Year to date (variance to plan as % of YTD allocation)	Primary		Variance <= 0.1%	0.1% > variance <= 0.25%	0.25% > variance < 0.5%	Variance => 0.5%
3	Plan - full year (variance to plan as % of YTD allocation)	Primary		Variance <= 0.1%	0.1% > variance <= 0.25%	0.25% > variance < 0.5%	Variance => 0.5%
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	tbc	< 101% of plan	< 102% of plan	< 103% of plan	>= 103% of plan
8	Activity trends - full year forecast	Supporting	tbc	< 101% of plan	< 102% of plan	< 103% of plan	>= 103% of plan
9	Running costs	Primary		<= RCA			> RCA
10	Clear Identifications 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	2013/14 Quarter Performance	Green	Amber-Green	Amber-Red	Red
11	Assessment of internal and external audit opinions and on the timeliness and quality of returns	Supporting		No non-satisfactory audit reports in relation to finance related systems and processes and all finance returns submitted on time and of satisfactory quality.	One or two non-satisfactory audit reports in relation to finance related systems and processes and/or finance returns sometimes submitted late and/or of a poor quality.	A number of non-satisfactory audit reports in relation to finance related systems and processes and/or finance returns often submitted late and/or of a poor quality.	Significant number of non-satisfactory audit reports in relation to finance related systems and processes and/or finance returns consistently submitted late and/or of a poor quality.
12	Balance sheet indicators including performance against planned Cash Limit and BPPC performance	Supporting	tbc	To be defined	To be defined	To be defined	To be defined
13	Financial plan meets the 2013 surplus planning requirement	Supporting		>=1% surplus but planned	<1% surplus but >=0.5% surplus planned	>=breakeven position but <0.5% surplus planned	Deficit plan

Overall section RAG-rating criteria

Green	All primary indicators are green
Amber-Green	<=3 primary indicators are amber-red
Amber- Red	One primary indicator red-rated or >3 are amber-red
Red	Two or more primary indicators red-rated 43

Annex 4 – support and intervention

Underpinning the assurance assessment is the need to proportionately respond to identified risks. NHS England have a number of statutory powers under the NHS Act 2006 (as amended) which can be exercised to deliver the CCG assurance process. The most relevant in the case of support and intervention are as follows:

14Z10	Power of NHS England to provide assistance or support
14Z18	Power to require documents and information etc.
14Z19	Power to require explanation
14Z21	Power to give directions, dissolve clinical commissioning groups etc.

It is important that when these powers are used, NHS England are clear with CCGs on how they are being exercised and for what purpose. The powers themselves give the scope for a flexible and nuanced approach, supporting the principles of the assurance framework.

With the exception of intervention powers under section 14Z21, it is expected that statutory powers should be transparently and frequently exercised through assurance to ensure that any identified risks are managed appropriately and that assurance is being delivered in line with the underpinning legislation.

Requiring documents, information and explanation

Through assurance, risks will be identified and appropriate action should be agreed to mitigate these risks. Requiring documents, information and explanation should be a routine response to identified concerns and will provide an important starting point for supporting and monitoring improvement.

Requests for information should not in themselves lead to a domain assessment of “assured with support” but should inform this assessment and will be an important element of escalation if issues cannot be satisfactorily resolved over time. The establishment of a record of requests will be an important way in which NHS England can demonstrate the consistency and fairness in approach described through the assurance framework.

Providing assistance and support

During assurance meetings, CCGs and area teams should discuss the progress being made to address any identified concerns. Agreement should be reached on appropriate assistance or support, taking into consideration the following factors before final decision:

- Impact of any historical legacy of the performance concern
- System partnerships and other external relationships
- The CCG internal process for performance improvement
- Organisational development of the CCG including capacity and capability
- Governance of the performance risk through the governing body or delegated committee
- Improvement trajectory timetables

- Clarity of action plans and progress between assurance conversations

Support and assistance under section 14Z10 of the NHS Act 2006 (as amended) is drawn broadly and gives significant scope to adapt a flexible approach which can be strengthened with agreement over time.

The support that could be made available includes:

- Providing model document and guidance, with informal advice available if needed
- Making advice and expertise available to the CCG
- Facilitating peer review and partnership with other CCGs
- Creatively collaborating with partner organisations such as NICE and NHS Improving Quality to gain broader professional input into problem solving
- Facilitating conversations with key partner organisations and facilitating best practice modelling
- Area team provide expertise and challenge to the CCG Governing Body
- Area team brokered conversations between CCG and providers
- Area team brokering conversations between wider stakeholders and system partners
- Agreement on the need for specific and time limited capacity needs.
- Agreement on the need for input from expert teams, such as the improvement team or leadership academy

Where support is agreed, it is important that there is a clear understanding of the required improvement as a result. Under the NHS Act 2006 (as amended), NHS England can impose restrictions on the use of any financial or other assistance or support provided under section 14Z10. This should be considered through assurance conversations and confirmed in writing following the meeting. It is expected that the agreed level of support should be adjusted responsively over time. Where agreed improvement is made, this should be recognised. Where it is not, more intensive support should be considered.

In the same way as for requiring documentation, the establishment of a record of agreed support should be kept and it is expected to be published as part of the quarterly assurance assessment, in addition to any improvement trajectories.

Escalation

Where recovery of identified issues is not delivered or where expected progress is not made in accordance with previous discussions, the CCG and the area team will need to understand the level of support and scrutiny attached to assurance and make an assessment of appropriate escalation. If necessary, this will be clearly signalled through:

- The area team developing a single coordinated view having triangulated all available information including soft intelligence
- The area team articulating this view to the CCG, preferably face to face and discussing it with them

- The area team and CCG agreeing specific escalation actions to address issues. This should include a timeline, milestones and explanation of clear consequences should this not happen

Escalation demonstrates that both CCGs and area teams are responding to challenges and it is expected that the exceptional use of intervention powers should not be proposed without strong evidence of effective escalation.

Intervention

In exceptional circumstances where either the exercise of existing powers over time has been insufficient, or in the extraordinary situation where the quality of patient care was at serious risk, the exercise of intervention powers under 14Z21 of the NHS Act 2006 (as amended) would be necessary.

Since intervention is the element of the assurance framework which most affects CCG autonomy, area teams need to consider this carefully. Any proposed intervention action should be appropriate to the risk identified.

NHS England has the ability to exercise formal powers of intervention where it believes that a CCG is failing or is area team risk of failing to discharge its functions, these include:

- Directing the CCG as to how it discharges its functions
- Directing the CCG or the Accountable Officer (AO) to stop carrying out any functions for a defined period
- Terminating the AO's appointment and appoint a new AO
- Varying a CCGs constitution
- Carrying out certain functions on behalf of a CCG or arrange for another CCG to do so
- Dissolving the CCG