PRIVATE BOARD PAPER - NHS ENGLAND

Title: Assurance 2015/16
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Rationale for this paper being discussed in the private session: • The policy is in early stages of formulation
Actions required by the Board: • The Board is asked to discuss CCG assurance and give a steer on next steps.

Assurance 2015/16

Background

1. The Health and Social Care Act 2012 (the Act) created CCGs as membership organisations of GP practices to promote clinical leadership and local ownership of the way health services are delivered.

2. NHS England has a statutory duty to assure CCGs, defined in section 14Z16 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) as "*a performance assessment of each clinical commissioning group in respect of each financial year*".

3. At the time of the Act, there was a strong feeling that CCG autonomy was a vital component to delivery and hence the legislation described a limited performance assessment role and the resulting powers of intervention for NHS England, with a high threshold for implementation.

4. The predecessor of the assurance process was CCG Authorisation, a process which every CCG went through before being constituted. This was based on six domains to assess whether a CCG was safe to undertake its functions:

    i. Are patients receiving clinically commissioned, high quality services?
    ii. Are patients and the public actively engaged and involved?
    iii. Are CCG plans delivering better outcomes for patients?
    iv. Does the CCG have robust governance arrangements?
    v. Are CCGs working in partnership with others?
    vi. Does the CCG have strong and robust leadership?

5. This process was widely acclaimed, not only as successful in providing assurance about CCG capability (CCGs not fully ready were subject to conditions) but also in adding significant value to CCGs as part of their development. Hence the early and current Assurance Framework is still structured in this way.

6. However, the process was inevitably limited to an assessment of capability and potential to deliver. CCGs had no record of performance on which we could draw. CCGs have now been in existence for almost two years, their record of performance and improvements for patients is really material.

7. Additionally, much has changed since that time. The health service has seen more challenging performance and financial positions, and there is a perception that processes and levers are not as slick or straight forward as they should be. For example, NHS England currently has no remit for formal sign off of CCG plans and, hence, has seen ambitious plans for reductions in activity which have failed to deliver. And, whilst the original ambition for CCGs to improve outcomes remains absolutely central, an assessment based on outcomes alone (many of which take years for measurable change) leaves the system exposed in terms of certain essential elements we wish to deliver for patients, but which are not truly defined as outcomes.

8. Another recent change is that NHS England has determined that CCGs should have a much greater role in commissioning some of the services originally commissioned by NHS England itself. We need specific and additional assurance for such delegated functions. Whilst this is currently only GP out-of-hours services, we have agreed that from April 2015 it will include primary care and other functions, including specialised commissioning, over time.

9. So we now need a new framework to take us forward, one which looks at track record and performance not just capability, one which takes account of additional roles and one which is fit for purpose in the current environment.

10. The new framework should also acknowledge that CCGs have different starting positions, with different populations and challenges. Some are operating in an extremely difficult environment, within challenged health economies or with legacy financial issues. In these circumstances our framework needs to reflect the additional leadership response required of a CCG.

11. The proposals in this paper have been produced following engagement with CCGs, front line and other NHS England staff, and this issue has been discussed at the CCG Assurance Committee. The proposals focus on three aspects of assurance:

- Content
- Process
- Our response

Content

12. We need to consider the breadth of the assurance process. It is our only real lever in statute to performance manage CCGs, but too broad a content may diminish its usefulness. Six components are suggested:

i. **Capability:** Consultation suggest that the six domains of the original authorisation process hold good for assessing capability and that we should still use them as the framework for assessing capability. However, Domain 3 assessed the CCGs' plans for delivery. Given that we are proposing closer examination of these aspects, this domain would not be needed.

ii. **Performance and Delivery:** how well CCGs deliver improved services and outcomes for patients is inevitably a key part of assurance. We need to cover their progress on outcomes as well as their role in helping us deliver key Mandate and Constitution standards as well as priorities such as patient safety, dementia and our response to Winterbourne View. We also need to know they are delivering against their own plans. This is collectively a huge range of what are potentially targets, yet it is difficult to see how any could not be included. We have a delivery dashboard, which is still evolving, which covers all of these.

iii. **Planning:** assurance of plans is a key part of current CCG oversight, with clarity needed on NHS England's response when plans are inadequate. This is likely to be a continuous process where we are assuring not only annual operational plans, but also longer term strategic plans, as well at System Resilience Group and Better Care Fund plans.

iv. **Financial management:** it is clearly essential that we have all the appropriate controls.

v. **Delegated functions**: there are specific additional assurances which we must have on functions we have delegated to CCGs compared to their own statutory functions.

vi. **Services for specific patient groups**: we have recently begun to consider how we could include an assessment of services, for example for mental health, cancer, or other groups.

Process

13. The current CCG assurance process comprises three quarterly assurance meetings and one annual review, at the end of which CCGs are categorised as "assured", "assured with support" or "not assured". The last category is then subject to specific intervention from NHS England.

14. This year's process has included performance as well as the original authorisation domains. It is clear that the way this process is undertaken and the nature of the conversation is critically important to its success, even more so than the nature of the framework itself. We have also started to take a proportionate approach with less frequent or lighter touch interventions for high performing CCGs.

15. It is not surprising that the process has mixed reviews from CCGs. We do hear that it is overly bureaucratic from some quarters, although interestingly significant numbers of CCGs when offered less frequent meetings chose to continue with quarterly sessions!

16. We want to move further towards a tailored approach for every CCG and one which really adds value. Whilst complex, the delivery dashboard should represent a clear and common information source and can be the basis for reflection and appreciative inquiry.

17. We also need to be aware of the reducing management resource in both CCGs and NHS England.

18. We therefore propose much less prescription about the nature or frequency of the interaction our local teams have with CCGs with very light touch for high performing, well led, capable organisations, and much more intervention in those who are not delivering or where leadership or capacity concerns exist. We need to ensure a degree of consistency but also a way of differentiating between those CCGs who are able to manage their own business and those who are not. This will not be the same, in all instances, as those who are delivering all key priorities since this will be highly dependent on the environment in which they operate and the legacy they have inherited.

19. We propose publishing achievement metrics quarterly through the CCG dashboard and in line with the transparency agenda, and at the end of the year we will bring all this information into the statutory assurance report which we must create, but of course we will expect CCGs to publish individually.

Our response

20. For most CCGs, NHS England's response to assurance will take the form of support and development. We will always have available to us the opportunity to issue directions if there is any aspect of sufficient concern to trigger our powers of intervention.

21. Any principles for development and support for CCGs will need to take into account the limited resources available post March 2015. Increasingly we will look to CCGs to source and fund any development identified as required through assurance.

22. The NHS Forward View also set out our intention to introduce "special measures regime " for CCGs. This is in line with its use for hospitals, GP practices and other public bodies. Engagement with CCGs and Area Teams welcomed the introduction of a 'special measures' category for those CCGs requiring the highest level of support.

23. Whilst it was agreed that this category would be helpful, it is important that this new process reflects the flexibility that NHS England has to intervene differently in a range of circumstances and that we always act on concerns within CCGs rather than 'waiting for failure'. NHS England has considerable latitude to intervene where necessary and further work with our regional teams is needed to ensure these powers are used where necessary.

24. A new working group with CCG membership will be convened to consider this further, including the parameters and triggers for CCGs to be in special measures, the process by which CCGs can leave this category and the options we will consider for a CCG in special measures which is not improving.

Conclusion

25. Assurance is a key part of our role. It is vital we get it right in order to:

- Secure the best commissioned services for patients;
- Provide the right levers so that NHS England can deliver its Mandate and the NHS Constitution;
- Not be overbearing to the service; and
- Be wide ranging enough to look at hard to measure aspects.

26. The Board is asked to consider the following questions to help steer this work:

- The extent to which assurance covers functions – should it catch all; if not how do we assure other things?
- How we really measure outcomes and what proxies do we use?
- Is assurance a finance and delivery performance management tool or do these conversations take place outside the process? If so, how do we secure the right language?
- How do we incorporate softer elements which are harder to measure?
- What is needed to respect autonomy and how is it earned?
- What is our approach to challenged circumstances?

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