Paper NHSE131112

BOARD PAPER - NHS ENGLAND

Title: CCG and direct commissioning assurance
Clearance: Dame Barbara Hakin, Deputy Chief Executive and Chief Operating Officer
Purpose of paper: • This paper presents the proposed clinical commissioning group (CCG) and direct commissioning assurance frameworks for consideration by the NHS England Board, with a view to granting authorisation to publish the assurance frameworks in November 2013. These are attached at annexes A and B.
Key issues and recommendations: The interim CCG assurance framework published in May 2013 set out how NHS England would deliver an annual assurance assessment, alongside a commitment to engage with CCGs on the proposals. In line with the principles of mutual assurance, it also committed to developing proposals for how we hold ourselves to account to the same standards. Further to a significant period of engagement on CCG assurance undertaken during the summer with CCGs, area teams and national stakeholders, alongside a separate programme of engagement on proposals for direct commissioning, we now present the two aligned assurance frameworks. Both are underpinned by a shared approach to assurance, and by behaviours that emphasise mutual support and continuous development.
Actions required by Board Members: • Agree the content and publication of the two assurance frameworks.

CCG and direct commissioning assurance

Executive summary

1. This paper presents the CCG and direct commissioning assurance frameworks for clearance and approval for subsequent publication later in November 2013.

2. The interim CCG assurance framework published in May set out how NHS England would deliver an annual assurance assessment, alongside a commitment to engage with CCGs on the proposals. In line with the principles of mutual assurance, it also committed to developing proposals for how we were holding ourselves to account to the same standards. To this effect, a significant period of engagement on CCG assurance was undertaken during the summer with CCGs, area teams and national stakeholders, alongside a separate programme of engagement on proposals for direct commissioning.

3. The outcome of these programmes of engagement are proposed assurance processes that have shared approaches – they are underpinned by six assurance domains reflecting the key elements of an effective clinical commissioner; they are both delivered through summative, quarterly conversations, bespoke to each area and based on robust sources of evidence (including a delivery dashboard, an annual 360 degree survey and insight from key local partners such NHS Trust Development Authority (NHS TDA), Monitor, the Care Quality Commission (CQC), Healthwatch and local authorities); they are both underpinned by behaviours that emphasise mutual support and continuous development.

4. It is important to note, however, that the frameworks are also necessarily different in some aspects. Although CCGs went through authorisation, area teams have not been through the same type of benchmarking process – we are in the process of running a baseline exercise for the current position of area teams, using self-certification and performance data (where available/appropriate).This exercise will help us to determine the factors of organisational health that are needed to underpin the direct commissioning function of area teams; interdependencies of teams across NHS England; and where further development is needed, aligning any consistency gaps and identifying the type of development work required.

5. We believe that we have established a robust position through assurance on all of our statutory duties, and our proposal has now been reviewed by our lawyers who confirm that it is consistent with the requirements of the Act.

6. Subject to clearance of the two assurance frameworks, we will also publish an area team/CCG guide for CCG assurance and a regional team/area team guide for direct commissioning assurance. These will include the operational timetable for delivery of both assurance processes so that they run together to offer the best opportunities for mutual assurance.

Introduction

1. Following comprehensive engagement and development over the summer, the proposals for CCG and direct commissioning assurance are presented here for clearance and approval to proceed to publication.

Context

2. NHS England has a statutory duty to make an assurance assessment of CCGs on an annual basis. It is also important to demonstrate our own commitment to hold ourselves to account to the same standards.

3. The interim CCG Assurance Framework (published in May) set out how NHS England would deliver an annual assurance assessment, informed by quarterly checkpoints which would be underpinned by a balanced scorecard. It also set out the commitment to a detailed engagement programme with CCGs to develop proposals for how a broader annual assessment of organisational health and capability could be delivered.

4. In line with the principles of mutual assurance, the interim framework also committed NHS England to developing proposals for how we could demonstrate that we are holding ourselves to account to the same standards.

5. The Direct Commissioning Assurance Framework describes the assurance process that covers the performance and team health of the direct commissioning function of the area team. Further work is needed to extend the framework to assure the whole of NHS England, its organisational health, and the contribution made by everyone to direct commissioning. This work will follow when further progress is made on the assurance process of the direct commissioning function of area teams.

6. A significant engagement programme has been delivered over the summer with CCGs, area teams and national stakeholders where we spoke to over 80 per cent of CCGs in the country about the interim CCG process. In addition, a separate programme of engagement has been delivered alongside this to develop proposals for direct commissioning assurance.

Process of engagement

7. CCG assurance engagement was delivered through five engagement events around the country which tested the assurance principles and developed the proposals. Additional summative events were convened as the final framework was developed. In addition, an oversight group was formed comprised of representatives from throughout the system, including national policy directorates, regional and area teams and CCGs to oversee the development process.

8. Similar governance has also been established to steer the development of direct commissioning assurance. Direct commissioning engagement has been delivered through set piece events and working groups involving CCG

representation alongside the commissioners of public health services, specialised services, armed forces health services, health and justice services and primary care services. Financial and analytical experts have directly contributed to working groups along with regional and area team representatives. It has been recognised from the outset that the model of maturity is different between CCGs and NHS England and this has informed much of the direct commissioning assurance development.

Shared approaches

9. Both the CCG and direct commissioning assurance frameworks are underpinned by six domains of assurance which reflect the key elements of an effective clinical commissioner and were integral to CCG authorisation. These allow for an assessment to be made of key deliverables as well as broader factors such as governance, organisational health, leadership and resilience.

10. The six shared assurance domains are:
    i. Are patients receiving clinically commissioned, high quality services?
    ii. Are patients and the public actively engaged and involved?
    iii. Are plans delivering better outcomes for patients?
    iv. Are robust governance arrangements in place?
    v. Are CCGs/commissioning functions working in partnership with others?
    vi. Does the CCG/commissioning function have strong and robust leadership?

11. It is proposed that both assurance processes are delivered through quarterly conversations which are summative in nature, bespoke to each area and based on robust sources of evidence. In advance of quarterly meetings, a range of national and local sources of insight will be used to develop areas for discussion under each domain. This will include a delivery dashboard offering consistent insight into key delivery areas and an annual 360 degree survey which will give a rich picture of local relationships.

12. Insight from key local partners, including the NHS TDA, Monitor, CQC, Healthwatch and local authorities will also be integral to ensuring that any concerns raised about delivery are systematically explored.

13. Both processes should be underpinned by behaviours that emphasise mutual support and continuous development, with agreed support as the default response to performance concerns.

Necessary differences

<u>Different stages of development</u>

14. For CCGs, the authorisation process produced a static benchmark which all CCGs had to meet and gave a strong foundation to build an assurance process which was more dynamic in nature.

15. It is important to recognise that area teams have not been through this same benchmarking process and therefore, at this stage, it is not appropriate to run entirely aligned processes. On direct commissioning by NHS England, we are in the process of undertaking a baseline exercise of the current position in ATs. This involves self-certification by area teams against the six assurance domains prior to an assurance discussion led by regions. Subject to data availability, performance data will be provided to regions and area teams in support of the assurance discussions but not as an integral part of them. The assurance conversation will help identify any areas for development for area teams including any support they require.

16. This baseline assessment will provide significant information on the hygiene factors that should exist to underpin the direct commissioning function of area teams. It will also ensure we appropriately acknowledge the interdependencies of teams across NHS England. Furthermore, it will support the further development that needs to done to develop the cross cutting approach to direct commissioning assurance through the whole of NHS England.

17. Following the benchmarking exercise, we will be in a position to identify any consistency gaps nationally and align identified development work within the area team. We are committed to rapidly developing the Direct Commissioning Assurance Framework beyond benchmarking to develop a strong dynamic process as quickly as possible.

Statutory assurance of CCGs

18. It is also important to recognise that assurance of CCGs is a fundamental statutory responsibility of NHS England. Whilst presumed autonomy is embedded within CCG assurance, where CCGs are found to be demonstrably failing to meet their statutory obligations, intervention remains an important safeguard in the system which NHS England can ultimately exercise.

Robust assurance output

19. The output of assurance should respect the principle to minimise the bureaucratic impact of the assurance process. However, there is a need to demonstrate that assurance is taking place and action being taken in response to the findings. It is therefore recommended that there are formal headline outputs from the assurance assessment which the area team should produce and share with the CCG for CCG assurance. NHS England will consider the development of similar outputs on direct commissioning assurance and how these would be shared publicly to support local and national accountability.

Effective discharge of statutory responsibilities

20. Both frameworks are designed to provide a rigorous assessment methodology that meets all statutory duties but use existing evidence wherever possible.

21. We believe that we have established a robust position through assurance on all of our statutory duties, and our proposal has now been reviewed by our lawyers who confirm that it is consistent with the requirements of the Act.

22. The assurance frameworks are written on the basis that we need to use both soft and hard intelligence in order to make an intelligent assessment of where we believe that CCGs or ATs in their direct commissioning activities are failing to deliver on either their statutory obligations or their plans and then challenge them appropriately. We have therefore had to be more targeted and effective in the way we draw our assurance, working at three levels :

- On a day to day basis, through professional networks and relationships at both a policy level through insight, and through local relationships get the deepest level of assurance about CCG performance across the spectrum of delivery
- On a quarterly basis, we use both national and local intelligence to inform the assurance agenda and where concerns are identified, these are discussed through assurance and where improvement is needed, development and support are agreed.
- On an annual basis, CCGs are required through their annual reports to make a full assessment of their delivery against their statutory obligations. This is then a key source of intelligence for in-year assurance conversations.

Next Steps

23. Subject to clearance of the two assurance frameworks, we will also publish an area team/CCG guide for CCG assurance and a regional team/area team guide for direct commissioning assurance. These will include the operational timetable for delivery of both assurance processes so that they run together to offer the best opportunities for mutual assurance.

24. For 2014/2015, our planning guidance will present the outcomes that we expect from commissioning and these will be central to assurance for 2014/2015 and both guides will be updated appropriately to reflect this. The guides will also be refreshed as required to reflect other changes such as the Mandate refresh.

25. We will also consider the proportionality of assurance as we learn from the use of both frameworks and if necessary in due course will submit further proposals for approval. In particular where is the move towards a more risk sharpened application of assurance.

Recommendation

26. The Board is asked agree the content and publication of the two assurance frameworks.

Barbara Hakin
Deputy Chief Executive and Chief Operating Officer
October 2013

DRAFT

Direct Commissioning Assurance Framework 2013/14

THE NHS CONSTITUTION
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D R A F T

Direct Commissioning Assurance Framework 2013/14

First published: TBC, expected publication in November 2013

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Executive Summary

NHS England is a commissioner responsible for significant annual spend in five key areas of healthcare services. The NHS England Board, along with patients, the public and fellow commissioners, need to be assured that the organisation is able to demonstrate the effective use of public funds in commissioning safe, high quality and sustainable services within available resources.

A Working Group has been established to develop and propose a framework against which the NHS England Board can achieve this assurance and to ensure that the same principles applied to the assurance of clinical commissioning groups and other partners providing healthcare services are also being consistently applied to the assurance of NHS England's commissioning activity.

The working group has engaged a range of internal and external partners and stakeholders and which has led to a single annual assurance cycle being proposed, comprised of a series of quarterly assurance meetings which will be summative in nature. These quarterly meetings will will be framed around six 'assurance domains' that reflect the attributes of a great commissioning function.

The current proposal is for the assurance conversation to be held between area teams and their respective regional team, consistent with the line management arrangements in place within NHS England. However, it is recognised that there are dependencies on other functions within NHS England for area team direct commissioning, including regional and national teams. These should be highlighted through the assurance process and support requirements identified during the discussions.

In addition, there are co-dependencies between area teams, CCGs and other local partners in commissioning high quality care for the same populations. This applies across care pathways and in pursuing improvement in the quality of primary care and necessitate that we develop proposals for mutual assurance. As a first step this framework is published alongside a similar framework for CCG assurance.

Introduction and context

One of NHS England's key roles is to directly commission services in five areas:

- Primary medical care, dental services (including secondary dental), community pharmacy and primary optical services;
- Specialised services;
- Some specific public health screening and immunisation services;
- Services for members of the armed forces; and
- Health and justice services

The commissioning of these services is largely conducted through area teams. It should be noted that area teams are not independent statutory bodies with accountable officers and direct commissioning therefore depends on significant inputs from the whole of NHS England. As a single national commissioning organisation, NHS England set out single operating models for each of these services to set the ambitions for delivering high quality care and to secure consistency of approach to commissioning and delivering improved outcomes. These are the foundations on which the six assurance domains are based. In addition, NHS England proposes to apply the same principles when assuring its own commissioning activity as it would in the assurance of Clinical Commissioning Groups.

As a national commissioning body, NHS England seeks to act as system leader and develop exemplar models of direct commissioning. In developing an assurance framework for direct commissioning, NHS England aims to act in a transparent and collaborative way and challenge itself about quality improvement and the effective use of resources, as NHS England would expect for other parts of the healthcare system.

This framework represents the outline proposal and arrangements for direct commissioning assurance to assess how well direct commissioning functions are performing against their plans to improve services and deliver better outcomes for patients.

The initial establishment of the NHS Commissioning Board in 2011 focused specifically on undertaking development and authorisation of newly established CCGs in order to prepare them to take on their statutory duties from April 2013. Much of the remaining commissioning system was retained within legacy organisations to ensure resilience during transition. This resulted in a phased introduction of area teams into their commissioning roles and as such area teams remain at an earlier stage of their development in 2013/14 than CCGs. In this context, NHS England are proposing that the initial focus for assurance is to establish the baseline across the six assurance domains, including review of evidence, systems and processes within the direct commissioning function, against which future summative rounds of assurance will build on.

The Health and Social Care Act created a more dispersed system that requires a number of commissioning partners, CCGs, NHS England, Local

Authorities and Public Health England, to work collaboratively to commission patient pathways in integrated ways. This has also added complexities in the data flows for these service areas.

NHS England has made a commitment to CCGs and wider stakeholders that it will apply the same level of scrutiny to its own direct commissioning responsibilities as it does for CCG commissioning. To enable this and to reflect the importance of mutual accountability, the framework has been developed and will be published alongside the CCG assurance framework, applying consistent principles in parallel wherever this is practicable and in the interests of patients.

Scope of assurance

Assurance will apply to the entirety of the direct commissioning functions of area teams, reflecting the integral contributions from all, including the local medical, nursing and finance expertise at local level. It will also acknowledge that the regional and central support teams have an important role in direct commissioning that should also be reflected in assurance.

For the purposes of this proposal, assurance is defined as the checking and acting on the assessment findings, across the delivery, capability and development needs of the direct commissioning function of area teams. It is intended to identify areas within the six assurance domains where performance is achieving the required standards as well as where performance is challenged. It is conducted in an adult to adult relationship and with a positive tone, which results in an assessment which assures direct commissioning, but also contributes to on-going ambitions for development.

For the purposes of this framework the assurance function of the NHS England Board is assumed to be delegated to regional teams. During development of the framework alternative models of assurance have been considered, however this model has been chosen for the following reasons:

i) Assurance will be best performed if there is an on-going relationship between the assurer and the assuree
ii) The Board delegation describes oversight of direct commissioning as a regional function – assurance covers that role

The process of assurance by regional teams will need to involve staff from across the regional team, including finance, medical and nursing. The role of leading and co-ordinating the process within the region may be performed either by the Regional Director of Ops & Delivery or the Regional Director of Commissioning, based on local determination.

The assurance process must help to assess how the direct commissioning function can realise its full potential and how other teams within NHS England can support it on that journey. The framework maps out some of the interdependencies between the respective teams and functions within NHS England across the six assurance domains. Undertaking the assurance process will also help to clarify these interdependencies to ensure that these are clearly articulated and understood as part of the assurance and development process for direct commissioning.

The framework sets out the arrangements for the assurance process which NHS England intend to test widely with the direct commissioning colleagues, CCGs and other key stakeholders over the coming months. It builds on a Q2 baseline assurance round during Q3 that will help to establish and embed the processes, systems, behaviours and data on which future assurance will build. It is our expectation that the framework will continue to evolve as the commissioning system continues to develop in 2014/15 and beyond.

Principles of Direct Commissioning Assurance

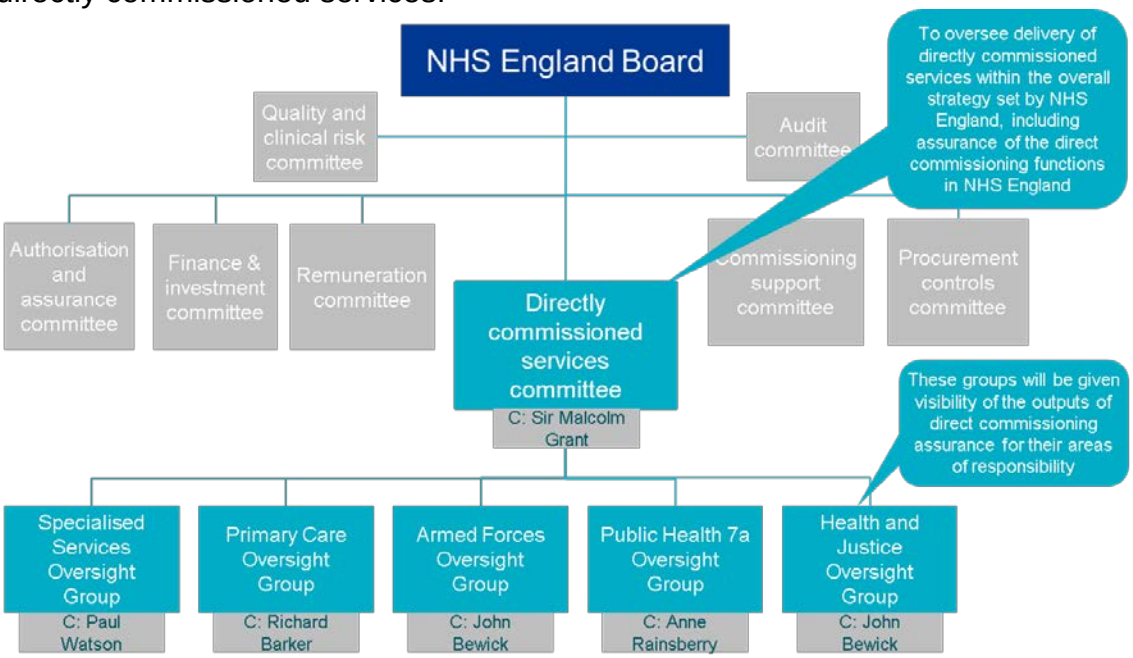
Our engagement to develop this framework for direct commissioning has resulted in the development of a set of principles which should underpin the way the assurance framework is further developed and delivered;

- Assurance should be transparent and demonstrate to partner organisations, to patients and the wider public the effective use of public funds to commission safe and sustainable services. As such an annual assurance report will be published on NHS England's website.
- The framework should assure the effectiveness of the contributions of all of the roles of an area team in delivering the direct commissioning function, not only the commissioners.
- Assurance should be summative and should take place over the year through adult to adult discussions.
- Assurance should reflect the dependencies between the area teams with regional and central support teams in delivering the direct commissioning function.
- The framework should be subject to year on year improvement and set stretching standards that drive improvements in direct commissioning.
- The framework should minimise bureaucracy and additional reporting requirements by drawing on available data and making appropriate use of self-certification.
- The framework should be adaptable and be able to respond to the availability of new data sources.
- The framework should reflect the need for mutual accountability of partner commissioners where patients move through different care settings and focus on scrutinising the cohesion of those pathways.
- The voice of the patient should be central both as a subject of assurance (in terms of patient inclusion in commissioning decision making through domain 2) and as a sense-check to the assurance process itself.
- The framework will be developed and tested with a broad range of commissioning partners.
- The framework should complement CCG assurance and assess direct commissioning functions through the application of consistent principles.
- The framework should be developed and implemented based on the 'ways of working' agreed between NHS Clinical Commissioners (NHSCC) and NHS England.
- The framework should assure equity of access, consistency of offer and equity of outcome.

Governance of Direct Commissioning

Governance of directly commissioned services includes arrangements with a number of other external bodies. The governance arrangements that area teams put in place will interface with these broader governance forums and as such consistent messages relating to delivery and capability of area teams should be received by these groups.

The diagram below sets out the existing governance in place for each of the directly commissioned services:



Mutual Accountability

To reinforce the reciprocal nature of assurance conversations and to reinforce our mutual responsibility for the commissioning of local services and accountability to patients, CCG assurance has been developed with comparable principles and standards. CCG assurance will also be based around the six assurance domains and will involve quarterly meetings to discuss a set of locally agreed areas for discussion.

However, NHS England know that what is important is that practical, mutual assurance takes place at the same time through a unified and coherent process, and that both assurance processes can join together to ensure that commissioners are working in unison to address any concerns around the quality of care across the whole local health economy.

Given the dispersed system of commissioners at local level, and aspects of direct commissioning that NHS England discharges through certain area teams, but not others (e.g. specialised services via 10 area teams) there are aspects of commissioning that straddle the responsibilities of NHS England, CCGs, Public Health England and local government, including social care. For this reason, mutual assurance is an integral principle in the development of

the direct commissioning assurance framework and as such CCGs and other partners will be invited to attend the assurance discussions of their local area team to enable a coherent discussion across local commissioning partners.

Assurance of NHS England's direct commissioning function needs to be considered in the context of the wider commissioning system and considering the interdependence of area teams and CCGs as co-commissioners. The following have been suggested as key elements within the assurance process to enable mutuality and will be tested through the on-going development of the approach :

- Whilst direct commissioning assurance will be led through the regional teams within NHS England, it is crucial to reflect the views of co-commissioners;
- Information and intelligence gained through the CCG assurance conversation regarding the effectiveness of collaboration between CCGs and NHS England should be reflected within the direct commissioning assurance process.
- Wider consultation through a 360° stakeholder survey that considers the local healthcare economy in its entirety (i.e. Local Authorities, Health and Wellbeing Boards, Local HealthWatch) will enrich the intelligence gathered through assurance process;
- Consider including local authority partners within appropriate aspects of direct commissioning assurance;
- The intelligence gained through direct commissioning assurance should be shared with stakeholders to enhance honesty and transparency across the commissioning system;

In designing mutual assurance, NHS England also need to consider interdependencies with local authorities, as commissioners of public health as well as social care services. The model of mutual accountability must be anchored within the local Health and Wellbeing Board (HWB). HWBs play a key role in bringing organisations together for the mutual interest of their population. It is the place where all key commissioners of health and social care services come together alongside other vital stakeholders, to hold each other to account on behalf of local people for the use of public resources and the outcomes they deliver. NHS England will explore with CCGs, local authorities, HWBs and other key stakeholders, including patient and public groups, how we can best develop and integrate this approach to mutual assurance.

Developing the Framework

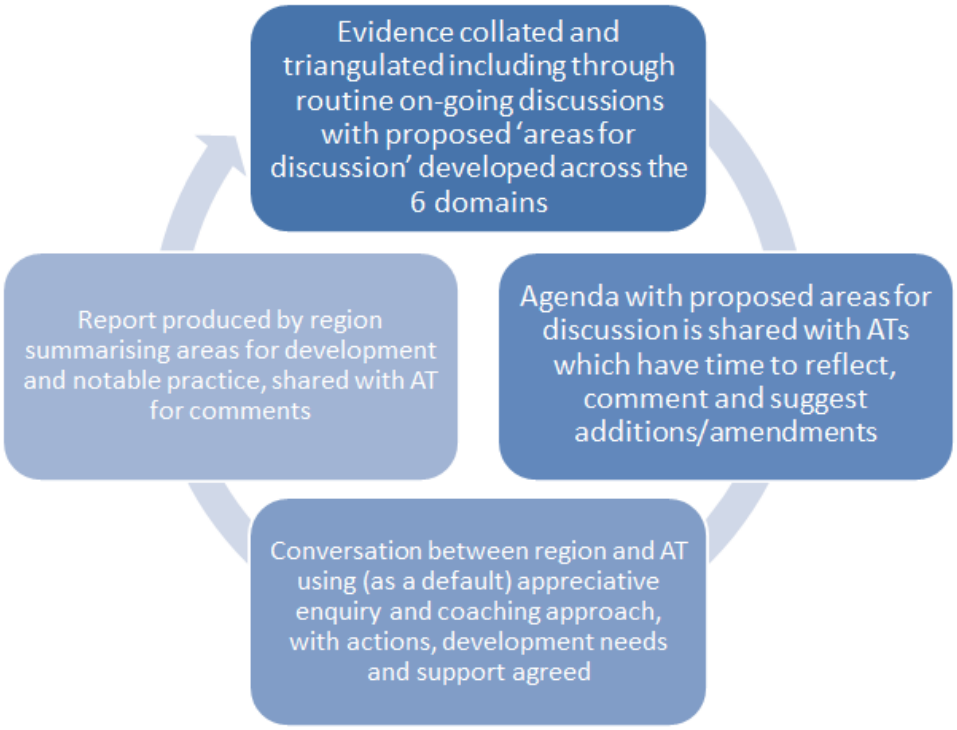
A Direct Commissioning Assurance Working Group was established in June 2013 in order to lead the development of the Assurance Framework for Direct Commissioning. This working group was comprised of cross-directorate representatives from national support centres, regional teams and area teams and specific leads for each of the directly commissioned services. In addition, the working group has held engagement events with area team

commissioners responsible for each of the directly commissioned service areas, operation and delivery leads and CCGs. Business Intelligence representatives have also engaged with their commissioning colleagues to identify sets of key metrics that will be needed to provide evidence into the Direct Commissioning Assurance Framework.

Core Elements of Assurance

The Direct Commissioning Assurance Process

This assurance process will be undertaken through a series of quarterly assurance discussions between the region and the direct commissioning function of the area teams. These will be structured around points where key evidence becomes available and relevant for the stage of the financial year to which the assurance meeting relates. This will culminate in an annual assurance report being published to summarise the assurance position of the direct commissioning function. We will seek to publish this in an accessible and easy to read format that is applicable to patients and the public.



The quarterly assurance discussions will be based on a set of information and indicators across the six assurance domains and will demonstrate how the area team is performing. The sources of evidence will include data from the delivery dashboard, local insight from area teams and wider NHS England functions to assure effective processes, governance and behaviours consistent with the definitions of great commissioning. Some of this information will be publically available, including delivery against the agreed strategic plan, operating plans, NHS Constitution commitments and relevant

Outcomes Frameworks, but much of it will be reviewed on the basis of self-certification by the direct commissioning function of area teams. The indicators of performance information should be based on the priorities for direct commissioners set out as part of the annual planning cycle. Regions will use available performance data as part of the assurance discussions. The quarterly assurance discussion will also assess that the area team is on track financially.

It is anticipated that the assurance approach will also help NHS England to identify themes and priorities to inform and support the further development of direct commissioning functions. This is consistent with the objective of the CCG Assurance Framework to support the development of CCGs.

The quarterly assurance discussions also present an opportunity to assess the actions being taken by direct commissioning functions, often in collaboration with local CCGs, to address concerns about the quality of care delivered by local providers. This must include the assessments of providers by the Care Quality Commission (CQC) and a much greater role for the voice of the patient and other local stakeholders. Complaints data will also be an important component of this wider context view.

NHS England anticipate that carrying out the assurance process will be a key component of the working relationship between regional and area teams, other functions within NHS England and local partners, including CCGs.

Our expectation is that where support needs are identified, the direct commissioning functions will receive much of this from within NHS England, in recognition of the interdependencies between team roles, and that this will be integral to the on-going relationships between teams in the organisation. In addition, shared development between area teams and CCGs will be crucial to the on-going development of the co-commissioning partnership.

As part of the assurance process, NHS England also need to identify the mechanisms by which it would seek to escalate any serious concerns for the attention of the NHS England Board; for example where interdependencies are not being addressed. The assurance framework sets out the basis for such escalation.

The Six Assurance Domains

The structure of the direct commissioning assurance framework is based on the principle of building an assurance process that demonstrates to NHS England's stakeholders that its direct commissioning function is making effective use of public funds to commission safe and sustainable high quality services.

Feedback from engagement events, with a cross-section of NHS England teams and CCGs, has told us that the domains used during the CCG authorisation process were an effective foundation on which to define the characteristics of a great commissioning function for NHS England. These have been further developed based on feedback from these events to more

accurately reflect the specifics of NHS England's commissioning responsibilities including reflecting the structures, processes and governance arrangements set out in the single operating models and developed into the six assurance domains for direct commissioning.

Evidence will be sought and reviewed against each of the proposed six assurance domains as part of the summative assurance conversation:

- **Domain 1:** A strong focus on clinical and multi-professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements
- **Domain 2:** Meaningful engagement with their communities, citizens, patients and carers.
- **Domain 3:** Clear and credible plans with delivery against improved outcomes within financial resources, and are aligned to CCG commissioning plans and local joint health and wellbeing strategies
- **Domain 4**: Robust NHS England governance arrangements are embedded locally, with the capacity and capability to deliver all their duties and responsibilities to effectively commission all the services for which they are responsible.
- **Domain 5:** Collaborative arrangements for commissioning with other direct commissioning functions, CCGs, local authorities and external stakeholders.
- **Domain 6:** Great leadership that contributes to making a real difference to the health, wellbeing and healthcare services of local communities.

Annex A sets out the assurance themes that underpin each domain and will be used to demonstrate assurance against the domain.

It is a key principle of the framework to use published data and indicators that are readily available to develop a delivery dashboard on a quarterly basis, or as applicable, against each of these domains. NHS England will work to ensure that reporting requirements and the impact on area teams is minimised wherever possible and supported through existing data tools.

Where an area team identifies itself as needing improvement against an element of the framework, support should be discussed and agreed with the regional team. Where common themes for support are identified across a number of area teams, peer to peer support as well as support from regional and central support teams in coordinated programmes may be appropriate.

Detailed Process

Q2 Baselining Exercise

During Q3 of 2013/14, the first round of direct commissioning assurance will take place. This quarter's assurance will establish the processes, systems, behaviours and data on which future assurance will build. As such, many of the assurance questions and evidence sources will relate to the key attributes of organisational health rather than the on-going quarterly delivery data and activity. The assurance framework contains suggested evidence in support of the assurance domains and regional teams are advised to use their local insights to seek additional evidence where this may be required to support the assurance conversation. It is expected that the Operations & Delivery function will have a key role in the preliminary assurance round by supporting the direct commissioning function both to complete the self-assessment and ensure that processes and systems are in place as set out within the assurance framework.

Testing the assurance process

The quarterly meetings during 203/14 will, at least partly, be on the basis of assessing self-certification by the area team, reviewed through specific key questions by regional teams, taking into account local context, challenges and the views of CCGs as commissioning partners. Regions are expected to have a conversation with the direct commissioning function of the area team on the basis of:

- Reviewing exceptions identified by the direct commissioning function of the area team
- Reviewing exceptions highlighted as the result of CCG or other feedback
- Local insight or delivery data is used to generate additional key questions for the assurance conversation.

The data that can be collected in advance of the assurance meeting will be populated into a single delivery dashboard, which will provide information for each of the directly commissioned services for which the area team is responsible.

NHS England is considering the options for publication of the results of direct commissioning assurance, with particular reference to local and national accountability. This will include the consideration of the publication of a single assurance outcome report (including relevant dashboard information) on the NHS England website as a record of progress to date.

The further development of the assurance framework will also consider these requirements and the need to generate reports that are specific to individual services. For example, Public Health reports should feed into national governance and oversight arrangements. Furthermore, the quarterly assurance discussions must be linked to the co-commissioning discussions through CCG mutual assurance.

Identifying support needs

A key aspect of the assurance process is to ensure that there is a consistent method of identifying support requirements across the direct commissioning landscape. Each of the teams within NHS England has a role in supporting the effectiveness of direct commissioning.

Whilst the formal role for providing assurance to the NHS England Board has been delegated to regional teams there is an expectation that many other organisations will be invited to input into the assurance process and to support the development of area teams based on the outputs of the assurance conversation.

Support will be offered to all teams as part of the process and will be as broad as the commissioning functions require, calling upon resource from all parts of NHS England and partner organisations, e.g. NHS Improving Quality. For example, NHS England will actively promote initiatives and processes to enable the mutual development of area teams and CCGs in their co-commissioning roles.

In certain circumstances, the assurance framework may identify concerns where the direct commissioning functions of area teams are particularly challenged in delivering their agreed plans and where the broader development offer does not give sufficient scope to deliver the necessary improvements. In these exceptional circumstances the issues will be escalated through the line management arrangements in order to ensure extra scrutiny or support is given as required.

Conclusion

NHS England's single operating model allows for the co-production of key policies and processes with inputs from national, regional and area teams. Direct commissioning assurance is a vital example of where such collaboration is essential. This document represents NHS England's proposal for how direct commissioning assurance will be undertaken.

It sets out an assurance process throughout the year to assess direct commissioning across six assurance domains. The quarterly assurance discussions between area teams' direct commissioning functions and regions will ensure a greater focus on the development and support required to deliver continuous improvement to commissioning practises.

Opportunities for sharing best practice with partner groups and organisations will be central to ensuring that direct commissioning functions are operating at the leading edge of commissioning practice.

Annex: Assurance Domains and associated themes

Domain	Domain Description	Themes
1. A strong focus on clinical and multi-professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements	Direct commissioning functions have strong partnerships with clinicians at local level, through their local professional networks, CCGs, local professional committees, clinical senates and wider clinical and professional groups, to ensure that there is involvement and clinical leadership in making and implementing commissioning and quality improvement plans. Views and input is sought, heard and valued from a range of professionals, including primary and secondary care clinicians and other allied health professionals, including national and regional colleagues for those services where national guidance or specifications are used.	1.1 Quality and safety is demonstrably and systematically at the heart of the Direct Commissioning function's work, including its governance, decision-making, planning and commissioning arrangements
		1.2 The direct commissioning function can demonstrate that there is appropriate local clinical leadership in planning and implementing commissioning and quality improvement. Clinical perspectives shape planning and decision-making at each of the stages of the commissioning cycle and are shown to add value to the cycle
		1.3 The direct commissioning function is engaged in efforts to identify quality and safety issues today through Quality Surveillance Groups (QSGs), include other local commissioners from CCG and local government and local Healthwatch and representative of Monitor and the CQC
2. Meaningful engagement with their communities, citizens, patients and carers	Direct commissioning functions have robust arrangements in place to engage communities, citizens, patients and carers in commissioning decisions that ensure services are responsive, appropriate and consistent and reflect their specific commissioning responsibilities. Engagement is intrinsic to what a direct commissioning function does, often in partnership with CCGs and other area teams.	2.1 Direct commissioning function has sourced, analysed and interpreted the expressed and unmet health and wellbeing needs of all constituent communities and groups within its population.
		2.2 Direct commissioning function has plans in place to identify, engage and communicate with strategic partners and diverse groups and communities and demonstrate examples of this engagement e.g. H&WBBs, CVS, 3rd Sector Acceptable mechanisms for engagement with patients, carers and members of the public is intrinsic to what the direct commissioning function does
		2.3 Direct commissioning function understands NHS England's statutory duties in relation to enabling patients to make choices and to promote the involvement of patients, carers and relatives in decisions about their care and treatment.
		2.4 Direct commissioning function demonstrably and regularly monitors, acts on and shares patient feedback, concerns, complaints and choice, from a range of different sources, particularly in identifying quality and safety issues. The direct commissioning function can demonstrate data systematically feeds into activities for improving quality today and transforming services for tomorrow. Complaints are used to inform improvements in the range and quality of service.
3. Clear and credible plans	Direct commissioning functions have service	3.1 The direct commissioning function has credible plans that will deliver

Domain	Domain Description	Themes
with delivery against improved outcomes within financial resources, and are aligned to CCG commissioning plans and local joint health and wellbeing strategies	delivery plans that set out priorities in order to improve local health outcomes. These plans are supported by detailed financial plans that deliver financial balance and are integrated with their commissioning plans. There are on-going discussions with the relevant fellow commissioners to ensure that care pathways in which they have a shared interest, including primary care and specialised services, are aligned to long-term strategies and plans.	continuous improvements in quality, reductions in inequalities in access to healthcare and healthcare outcomes in line with the national planning guidance for each service which also meet NHS Constitution requirements.
		3.2 The direct commissioning function has credible plans that deliver financial plans that meet the business rules for each direct commissioning area from Everyone Counts.
		3.3 Plans of the direct commissioning function, local CCGs and other commissioners across the health and wellbeing system, constitute a coherent and sustainable plan to meet the needs of local populations.
		3.4 The direct commissioning function plan is aligned to local CCG plans, is consistent with the JHWS and is aligned to local & national priorities. The direct commissioning function plans are aligned with relevant plans commissioning strategies, JHWS, the JSNA and the Pharmaceutical Needs Assessment of local authorities.
		3.5 The direct commissioning function has systems and processes established to translate commissioning plan into contracts and delivery. The direct commissioning function has systems in place to track and manage performance and providers for which it directly commissions, including taking action when required standards are not met and responding to concerns raised about safety, quality or other risk issues.
		3.6 The direct commissioning function is aware of current procurement requirements and is aligned to national strategies for re-procurement.
4. Robust NHS England governance arrangements are embedded locally, with the capacity and capability to deliver all their duties and responsibilities to effectively commission all the services for which they are responsible	NHS England, both nationally (central support unit) and locally (area teams) has appropriately secured the capacity and the capability to deliver excellence in their commissioning responsibilities for span planning, securing and monitoring of the services for which they are responsible. Direct Commissioning Functions have clear governance arrangements with CCGs for the commissioning and quality improvement of primary medical services and specialised services locally.	4.1 NHS England can demonstrate that it has clear governance structures and the capacity and capabilities in place to monitor and support planning and delivery The direct commissioning function has robust and comprehensive assurance arrangements in place
		4.2 NHS England has appropriate systems for safeguarding with clear accountability and has plans to train staff in recognising and reporting safeguarding issues within the services they commission
		4.3 NHS England understands and can evidence how it discharges its responsibility for championing innovation and the adoption of innovation and promoting and using research
		4.4 NHS England can demonstrate that it has sufficient staff resource with the correct range of skills and, where relevant, contracted commissioning support to provide capacity and capability to deliver its full range of commissioning responsibilities, within the constraints of the national staffing framework

Domain	Domain Description	Themes
		4.5 NHS England, nationally and locally, can demonstrate compliance with the public sector Equality Duty
		4.6 Direct Commissioning function have clear governance arrangements with CCGs for the commissioning and quality improvement of primary medical services and specialised services
		4.7 Direct commissioning function have assessed their communications capacity / capability requirements and have plans in place to secure appropriate internal or external capacity and capability required to deliver its commissioning plans
		4.8 The direct commissioning function has assessed its information requirements and planned capacity and capability to deliver those requirements
5. Collaborative arrangements for commissioning with other Direct commissioning functions, CCGs, local authorities and external stakeholders.	Direct commissioning function collaborate and hold mutual assurance with a range of partners including CCGs as well as the local health and wellbeing boards and clinical senates. As partners within health and wellbeing boards, the strategies and plans of direct commissioning function and their partner CCGs, effectively reflect JSNA and JHWS processes, and contribute to delivering improved outcomes for all local people.	5.1 The direct commissioning function can describe its collaboration and formalised governance arrangements with partners that span its commissioning responsibilities and in particular where partners have a shared interest, which includes: • The direct commissioning function's commissioning strategies and plans complement and align to those of local partners • The direct commissioning function can demonstrate that it has engaged and reflected the input of partners in its strategy and commissioning plans. • Improving the quality of services directly commissioned by NHS England • Issues of broader strategy and system leadership to ensure the continuing resilience of health services, emergency preparedness and response
		5.2 Engage with stakeholders in relationship to reconfiguration and consultation.
		5.3 The direct commissioning function can demonstrate how it is collaborating effectively with other Direct commissioning functions, local partners and seeking patient representation in areas where there is co-ordinated commissioning, which reflect the appropriate footprint of the service being commissioned
		5.4 NHS England engage with a wider group of stakeholders, including Monitor, TDA, MOD, NOMS, PHE
		5.5 The direct commissioning function collaborates with local HWB partners of the development of local JSNAs and JHWS, PHE, CQC The direct commissioning function contributes to local Health and Wellbeing processes, engagement and decision making to maximise the benefit of all public investment for a local population to ensure quality for today and transforming services for tomorrow.
		5.6 There is an established plan to undertaking gap analysis in care pathways

Domain	Domain Description	Themes
		5.7 Primary Care strategies are engaging CCGs on collaborative arrangements
6. Great leadership that contributes to making a real difference to the health, wellbeing and healthcare services of local communities	As fellow health and wellbeing leaders, direct commissioning functions have the skills to make significant contributions to ensuring the quality of services today and transforming services for tomorrow for local communities, citizens, patients and carers.	6.1 The direct commissioning function can show how its development plans take account of the development needs of both its local leadership and NHS England more widely, based on an appropriate assessment. The direct commissioning function can demonstrate where it has used clinical involvement in service redesign and quality improvement. The leadership role of Clinical Senates and Strategic Clinical Networks is embedded in Area team and local collaborative commissioning arrangements.
		6.2 The direct commissioning function sets out how it is systematically embedding and promoting an open and transparent culture within its commissioning team and in its engagement with communities, citizens, patients, and the public, as well as other local health and wellbeing leaders, and can give examples of this.
		6.3 The direct commissioning function can show how senior management roles provide adequate capacity and capability to maintain strategic oversight for its direct commissioning and collaborative commissioning partnership roles. The direct commissioning function can describe these processes and explain its reasoning.
		6.4 At local level, the direct commissioning function has set out the vision of NHS England for improving quality and outcomes, including population health and reducing health inequalities.

DRAFT

NHS England

CCG Assurance Framework 2013/14

THE NHS CONSTITUTION
the NHS belongs to us all

CCG Assurance Framework 2013/14

First published:

Prepared by

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Introduction and context

The interim CCG assurance framework[1] (published in May) set out NHS England's initial proposals to ensure that CCGs, following their significant achievements through authorisation, were continuing to meet their ongoing responsibilities to patients and the public. The interim framework set out how quarterly checkpoints would contribute to an annual assessment focussed on broader measures of organisational health with a commitment to testing and co-development over the first half of the year to produce a final framework that was fit for purpose.

The final **CCG assurance framework** is the product of these engagement efforts and reflects views gathered from across the stakeholder community including at convened CCG development events which have allowed us to have detailed discussions with CCGs across the country. The feedback from this engagement has been integral to the development of the final framework and the accompanying **CCG Assurance Engagement Report** sets out in more detail the engagement journey and the feedback received through engagement across the country. An **Area Team Guide** has also been developed and published alongside the assurance framework which sets out in more detail the assurance process itself and identifies the key elements of assurance which are linked to the planning framework and which will be monitored on an in-year basis. The intention is to retain the overarching structure of the assurance process in future years and republish the Area Team Guide to reflect any changes to the planning guidance where appropriate.

The CCG assurance engagement process resulted in some strong messages about the importance of developing a final framework which is more evenly balanced across the year - summative in nature, proportionate in delivery and reinforcing of the developing relationships between CCGs and NHS England Area Teams. There were also strong feelings about the importance of assurance conversations that were genuinely tailored to local needs and flexible in delivery to take account of broad sources of evidence – underpinned by a commitment to support and ongoing development throughout.

As a result, the quarterly checkpoints established through the interim assurance framework will become **quarterly assurance meetings** and will focus across the breadth of the assurance framework. The balanced scorecard will be renamed to reflect its role in the process as a **delivery dashboard** and will be refocused to become a source of intelligence which informs assurance conversations. The delivery dashboard will not guide the outcome of the process or any decisions about intervention – however it will remain a consistent and useful piece of national insight which both CCGs and area teams can use to inform assurance conversations.

[1] http://www.england.nhs.uk/wp-content/uploads/2013/05/ccg-af.pdf

Whilst the CCG assurance engagement has been taking place, the publication of the Keogh review[2] into hospital mortality rates and the Berwick review[3] into patient safety have made important contributions to the national debate about the quality of NHS services. The final CCG assurance framework has been written in the context of these reports – reflecting the need for evidence based enquiry and the fundamental need to better reflect patient and public opinion in assurance conversations and assessment methodologies.

Why assurance?

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. This framework sets out **six broad 'assurance domains'** under which this assessment will be made – allowing for a broad and sophisticated conversation to take place locally which results in an assessment which meets statutory requirements but also contributes to ongoing ambitions for development.

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.

Principles and behaviours

The CCG assurance engagement has resulted in the development of a set of broad principles which should set the benchmark for the way assurance should be delivered.

1. Assurance should be transparent and demonstrate to internal and external stakeholders and the wider public the effective use of public funds to commission safe and sustainable services
2. Assurance is primarily about providing confidence
3. Assurance should build on what CCGs are already doing to hold themselves accountable locally to their communities, members and stakeholders, for both statutory requirements and for national and local priorities
4. Assurance should minimise bureaucracy and additional reporting requirements by drawing on available data and aligning with other regulatory and planning processes – There should be minimal additional paperwork

[2] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
[3] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

5. Assurance should be proportionate and respect the time and priorities of CCGs and area teams
6. Assurance should be summative and take place over the year as on-going, adult to adult conversations
7. The tone, process and outcomes need to help CCGs unlock their potential – there should be no discussion about performance without a discussion about development and vice versa
8. Accountability, learning and development between CCGs and area teams will be integral to the process
9. The framework will be based on a nationally consistent methodology and format whilst allowing room for local context and variation

Beyond these principles, it is also important that assurance is a model for the mature relationships which we aspire to build between NHS England and CCGs. To ensure that this commitment is met, NHS England will undertake a benchmarking exercise which will identify a development programme for area teams to ensure that the same attention is given to the development of our own functions as a commissioning organisation as has been given through authorisation to the development of CCGs. The direct commissioning assurance framework which is published alongside the CCG assurance framework sets out further detail on this commitment and also outlines how we will meet our commitment to deliver equal transparency for our own direct commissioning functions and the timescales for this to happen.

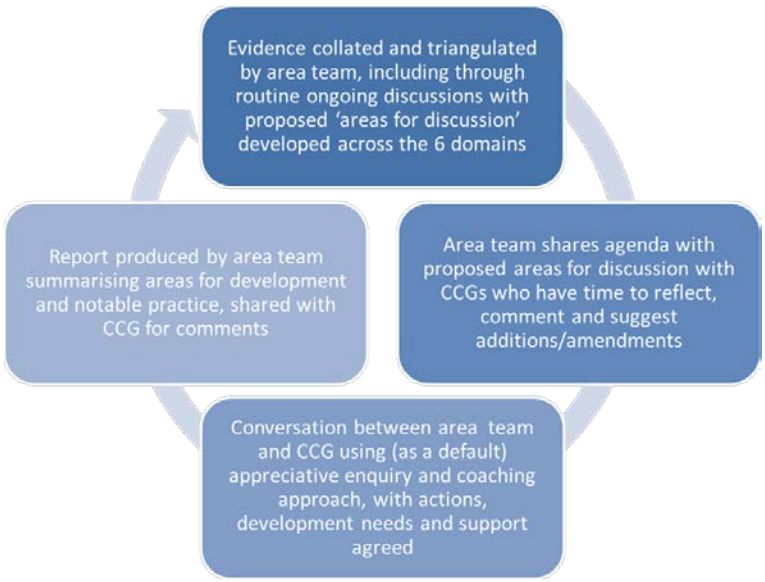
Mutual accountability

To reinforce the reciprocal nature of assurance conversations and to reinforce our mutual responsibility for the commissioning of local services and accountability to patients, direct commissioning assurance has been developed with comparable principles and standards. Direct commissioning assurance will also be based around the six assurance domains and will involve quarterly meetings to discuss a set of locally agreed areas for discussion. The evidence base to feed these meetings needs more development, acknowledging the different positions we are in with the different elements of direct commissioning, compared to that of CCG assurance.

However, we know that what is important is that practical, mutual assurance takes place at the same time through a unified and coherent process, and that both assurance processes can join together to ensure that commissioners are working in unison to address any concerns around the quality of care across the whole local health economy.

The assurance process

Figure 1: The assurance cycle



The final CCG assurance framework recognises that assurance is continuous and takes place through every local interaction. The annual assessment will be the product of these interactions. It will be balanced and summative in nature, with 'no surprises', based on a mature relationship between CCGs and area team. Area teams and CCGs are engaged in a range of discussions around assurance and development throughout the year and the frequency and nature of these will vary dependent on local circumstances. This framework sets out an overall context for assurance and development discussions and describes the formal elements of assurance that will be in common for all CCGs and area teams.

The assurance proposals which were previously described in the interim framework have been significantly refined as a result of CCG engagement. Assurance is now structured around six **assurance domains** which have been jointly developed and agreed with CCGs through engagement. For the first year, assurance and development conversations will continue to take place on a quarterly basis, and will be proportionate and minimally burdensome in both their design and delivery.

The CCG assurance domains reflect the key elements of an effective clinical commissioner which were integral to CCG authorisation.

Figure 2: CCG assurance domains

Domain 1: Are patients receiving clinically commissioned, high quality services?
The CCG consistently demonstrates a strong clinical and multi-professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements to commission safe, high quality and compassionate care for patients.
Domain 2: Are patients and the public actively engaged and involved?
The CCG demonstrates active and meaningful engagement with patients, carers and their communities which is embedded in the way that the CCG does it's work.
Domain 3: Are CCG plans delivering better outcomes for patients?
The CCG is delivering improved outcomes within financial resources, supported by clear and credible plans which are in line with national requirements (including excellent outcomes), and local joint health and wellbeing strategies.
Domain 4: Does the CCG have robust governance arrangements?
The CCG has effective and appropriate constitutional, corporate, clinical and information governance arrangements in place, with the capacity and capability to deliver all its duties and responsibilities, including financial control, as well as effectively commission all the services for which it is responsible.
Domain 5: Are CCGs working in partnership with others?
The CCG has strong collaborative arrangements in place for commissioning with other CCGs, local authorities and NHS England, as well as appropriate external commissioning support services and wider stakeholders including regulators.
Domain 6: Does the CCG have strong and robust leadership?
The CCG has in place great leaders who individually and collectively make a real difference.

The process of CCG authorisation set a static benchmark for safe operation under each of these domains to establish CCGs as statutory organisations. Assurance represents a dynamic process which takes the baseline established through authorisation and tests it against CCG planning and delivery in the content of progressive improvement and development.

For the purposes of assurance, drawing on a rich range of evidence sources, area teams will shape a proposed agenda with **'areas for discussion'** across the six domains. In line with the principle of minimising additional bureaucracy, assurance conversations will be on the basis of **rich and varied sources of existing information and intelligence** – reflecting a balance of national and local data sources - including the published documents which CCGs use to demonstrate assurance to their own governing bodies (an important indicator of robust internal governance arrangements). This means that each assurance meeting will be structured around a nationally consistent framework but with content that is specific to each CCG.

Underpinning the assurance domains are the statutory duties that each CCG has to meet and the need for NHS England to comply with guidance issued by the Secretary of State for Health under 14Z16 or 14Z8 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). CCG governance was a core component of the CCG authorisation assessment and as established statutory bodies, CCGs will use these internal structures to monitor their own delivery against statutory requirements for example towards improving quality, reducing inequalities, obtaining advice and engaging patients and the public. NHS England's assessment of a CCG's statutory compliance will use these internal assurances as the basis for the annual assurance assessment. However, where evidence indicates that these duties are not being met then this should form one of the 'areas for discussion'.

Whilst the development of 'areas for discussion' will be the subject to local discretion, there are a number of areas which should be consistently considered for discussion across the country, including:

- Any performance concerns identified by the quarterly delivery dashboard
- Any evidence to suggest that CCGs are not delivering against their statutory duties in-year should also be considered
- The annually commissioned 360 degree stakeholder survey will give insight into both CCGs and area teams providing another national source of intelligence and insight into the strength of local relationships.

The emphasis of the conversations at each quarter may also change during the year to reflect the stage of the CCG's annual planning and delivery cycle – for example the discussion of the planning process around the quarter 3 assurance conversation. In this way, the assurance process aims to align with the annual functioning of a CCG, complementing and supporting the work being undertaken rather than adding another layer of process.

Quarterly assurance meetings will ensure that the formal assurance discussion is continuous throughout the year, and the evidence from these meetings will contribute to the final annual assessment. Following the first full year of assurance, when CCGs will have developed a track record of delivery, the frequency of assurance meetings could be subject to more local discretion and could be less frequent on the agreement of both CCGs and area teams where the CCG has demonstrated assurance across the assurance domains. Where assurance concerns remain, conversations should continue to take place at a minimum on a quarterly basis and where evidence emerges that the delivery of statutory duties are at risk, it is expected that these would be raised with the CCG, including the reassessment where necessary of the agreed frequency of meetings.

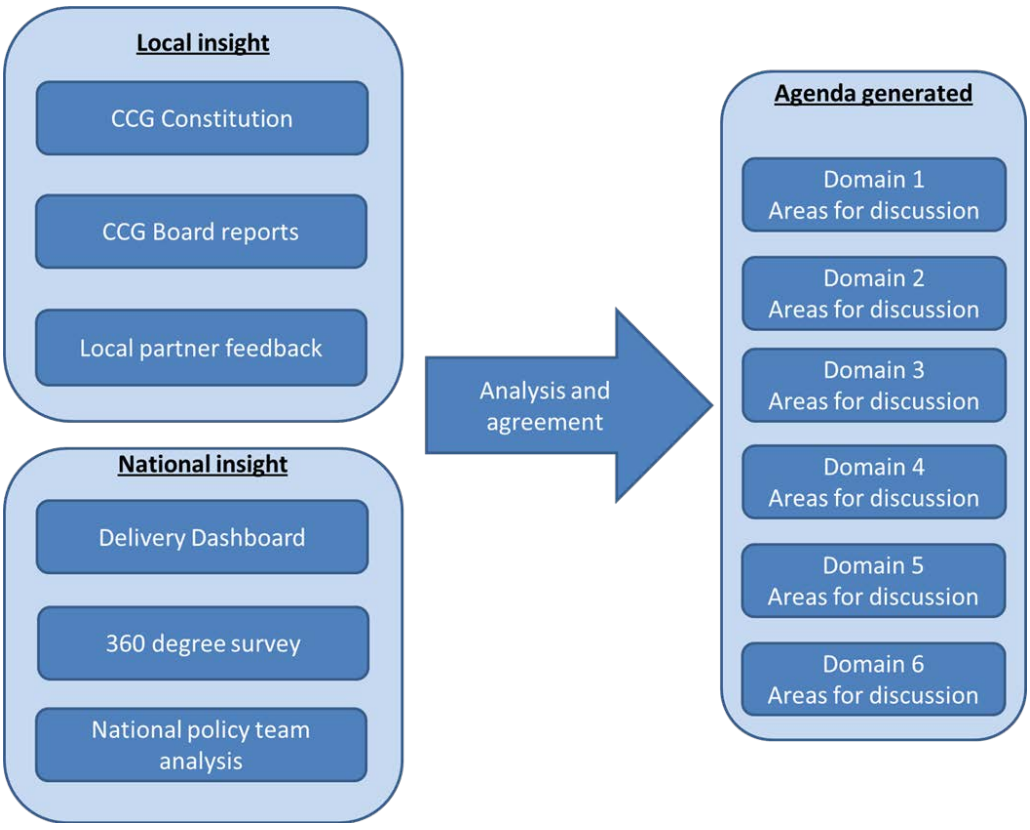
The result of the quarterly assurance conversations will inform the annual assessment and will also encourage discussions about further development or support required. Where concerns remain following assurance conversations, support to address these should be agreed and clear improvement set which should be subject to further monitoring and discussion.

This assurance approach recognises that the concept of support can be broadly drawn on a continuum which ranges from providing information and advice to providing additional expertise and capacity to resolve specific performance concerns. The concept of support includes activity to help CCGs develop as organisations and is not restricted to work to help address quality or performance concerns through assurance. **Development and support should be the default response** and it is only in the exceptional circumstances that development and support are not sufficient that we would expect statutory intervention to take place, in line with the development, support and intervention framework shown at **annex A**. Further detail about the continuum between development and support, and the exceptional exercise of statutory intervention powers is set out in the Area Team Guide.

Possible key sources of evidence

There are a number of key documents that may be used in the development of the 'areas for discussion' that underpin assurance conversations but these will be dependent on local circumstances. The framework is intentionally not prescriptive in this area and area teams and CCGs are encouraged to be creative in the use of robust, reliable and diverse sources of evidence to contribute to a supportively challenging assurance conversation.

Figure 3: Examples of key sources of evidence



National insight

National data flows give a consistent insight into a wide range of performance areas and are an important source of evidence to provide assurance across a number of the domains of assurance. As a general principle, where national insight indicates areas of concern, to ensure consistency of approach these should become areas for discussion in the assurance conversation.

NHS England will continue to produce a quarterly **delivery dashboard** which is aligned to a number of potential 'areas for discussion' under the assurance domains. This dashboard will be based on the balanced scorecard which was proposed under the interim CCG assurance framework but will be further refined to improve content and also to develop better insight into key indicators of good public and patient involvement. If a performance concern is identified through the dashboard, this should be discussed in assurance conversations. In future years, the delivery dashboard will be further amended to reflect revisions to national planning and delivery priorities in line with CCG plans. The revised delivery dashboard is published in the Area Team Guide which is published alongside the CCG Assurance Framework.

National analysis from policy teams will also inform the assurance assessment through routine information and intelligence which can be generated and provided to area teams on a regular basis to highlight variation and use evidence to highlight areas under the planning framework where local performance against the planning framework are presenting a risk to the achievement of the NHS Mandate or the continued delivery of statutory duties.

A nationally commissioned **360 degree stakeholder survey** will also be made available each year to inform the annual assessment, augmenting existing local governance and information about the strength of local stakeholder relationships. The content and core participants for the 360 degree survey will be subject to further engagement with CCGs and area team representatives 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 develop further proposals to continue to develop the survey to generate more specific local insights in agreement with CCGs.

Local insight

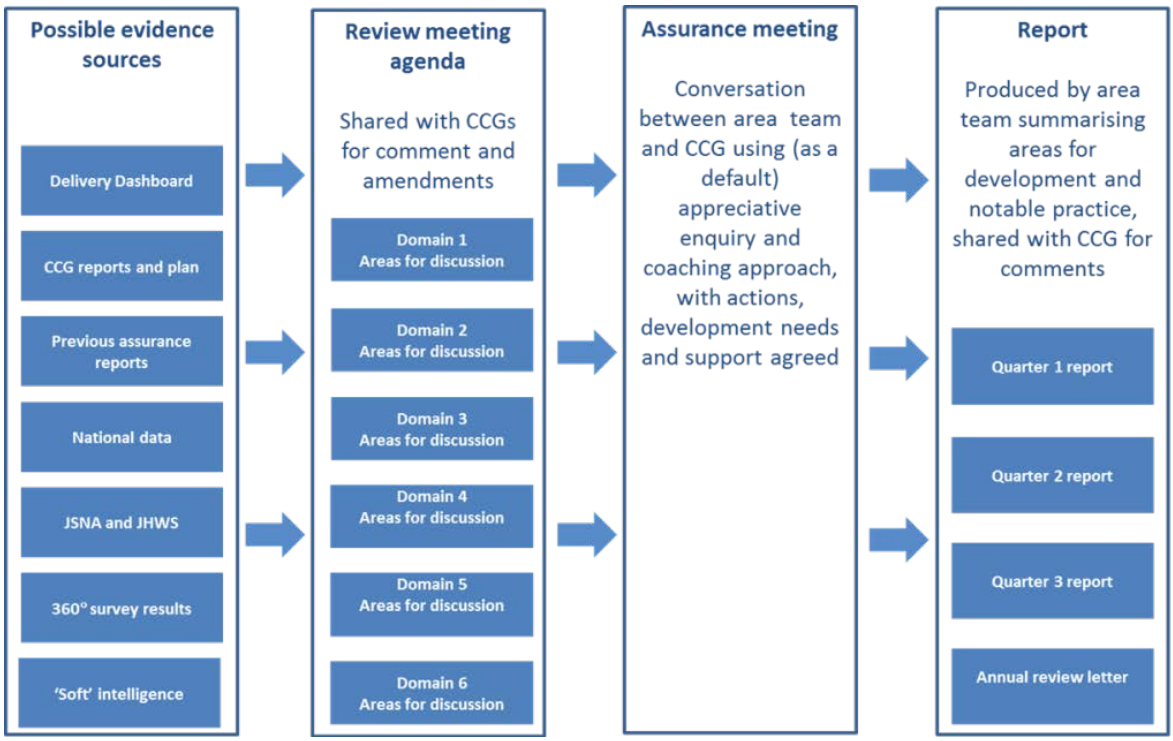
'Areas for discussion' will also be generated from the **information which CCGs produce and make available locally to patients and the public** such as CCG board papers and the CCG constitution - including internal/external audits and financial and strategic plans. Each of these documents demonstrate CCG accountability and contain additional supporting information

which provide insight across the domains of assurance with a particular focus on CCG governance.

Another key source of insight will be intelligence received from local partners and other organisations, such as the Care Quality Commission, the NHS Trust Development Authority and Monitor reviews and reports, plus relevant local Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and insights from quality surveillance groups. Local Healthwatch organisations also play a crucial role in highlighting issues of local concern and opportunities for improving services. This intelligence will also give insight into concerns about delivery and an opportunity to provide constructive challenge to ensure that CCGs are meeting their statutory responsibilities. Key local partners, including local authority and Health and Wellbeing Board members, will also be important contributors to the 360 degree stakeholder survey.

In addition, CCGs also have a statutory obligation on an annual basis to develop and publish an **annual report**. In addition to the explicit areas which CCGs need to include in their annual report as set out in statute, NHS England would expect CCGs to make a formal statement about their delivery against their statutory duties – a list of which is included at **annex B**. This would then form an additional key source of insight to inform assurance conversations following publication.

Figure 4: Overview of the assurance process



Output from assurance

The output of assurance should respect the principle to minimise the bureaucratic impact of the assurance process.

There will be two headline outputs from the assurance assessment which the area team should produce and share with the CCG – a **quarterly report** which contains a *headline assessment* and *summary report* following quarterly assurance conversations and an **annual letter** from the area team to the CCG governing body which summarises the annual assessment.

Within the quarterly 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 (see development, support and intervention framework) and includes references to the information which informed these judgements. 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 improvement trajectories.

The **annual letter** should summarise assurance conversations throughout the year and also identify any agreed improvement required and ambitions for further development. This letter may be supported by annexes, including key evidence on which were used to make assurance judgements.

To ensure transparency in the output of assurance conversations, we would expect that CCGs will want to make these materials available for public review. In addition, to meet statutory requirements, NHS England will publish the results of the annual assessment as required by statute as part of the summary from the Authorisation and Assurance Committee.

Attendance at the quarterly assurance meeting

In recognition that each conversation will be unique and different, the agenda and attendance at the quarterly assurance meeting should be agreed locally however we would expect that attendance should be appropriate for a comprehensive discussion of the agenda. This could include requesting specific expertise where necessary.

A key lesson from the approach taken to the mortality review undertaken by Sir Bruce Keogh was the importance of the involvement of lay people in assessment. To ensure transparency and openness to patients and the public, it has been suggested that public participation is built into CCG assurance meetings. Therefore it is expected that both CCGs and area teams would locally agree proposals to embed lay people and independent scrutiny into their relationships. Options to do this could include, but would not be limited to, inviting a representative from Healthwatch, involving members of the Health and Wellbeing Board, CCGs including their lay members in their

representation at the meetings or accessing local patient engagement arrangements that have been developed by CCGs. This would contribute further evidence to the domains of assurance and NHS England area teams will work locally with CCGs to further develop these proposals. Further work will be done by NHS England to support this lay input into the process, including developing training for lay members to ensure that involvement can be meaningful as a developmental and productive part of assurance conversations.

CCG development and support

Every assurance conversation should be an opportunity to identify further areas for development and for NHS England to support CCGs to continue to meet their own self-determined development needs and continue to pursue excellence in commissioning. The assurance process and its outcomes need to help CCGs unlock their potential – **there should be no conversation about assurance without development** and vice versa.

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. Similarly, each quarterly meeting should be an opportunity for CCGs and area teams to discuss areas for support and development, to inform conversations and CCG ambitions, and develop the relationship between the two over the coming quarter. 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.

As support is on a continuum it is not possible to develop a check list of potential support options because flexibility is required in order to deliver a tailored response. As has been described, support can include every action from providing information and advice to providing additional expertise and capacity to resolve performance concerns. Support should be the default response to any performance challenge. It is not an indication that a CCG is failing and should not be viewed as such. Many of the concerns raised through assurance will have a system wide impact and the response requires both the CCG and NHS England as a direct commissioner to act. Shared problems require shared solutions and agreed support will ensure that NHS England is equally as accountable for agreed improvement. Through 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.

A commitment to ongoing development

NHS England is strongly committed to working collaboratively with CCGs to pursue continuous improvement in clinical commissioning in pursuit of excellence. Throughout the development of the CCG assurance proposals, work has been on going with NHS Commissioning Assembly, their CCG development working group and external partners to develop a strategic framework for CCG development. Based on the views and feedback from CCGs across the country, a number of key areas of work are being pursued to support continued CCG development. These include:

- The identification and presentation of insight into notable practice in clinical commissioning, across the six assurance domain, based on international examples, academic research, and the codified best practice of leading CCGs
- Listening to CCGs and marshalling resources 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
- Making more visible the wider range of support available and encouraging a vibrant, innovative market of support for CCGs to meet their specific needs
- The development of practical offers of real help for CCGs in response to specific identified needs and gaps 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 for their populations.
- Supporting the creation of a national learning network designed around CCG preferences for adopting and spreading learning and innovation

To complement both assurance and development activity, further work will be undertaken in collaboration with CCGs and area teams to test a proposal for a programme of more in depth insight visits. The purpose, costs and benefits will be explored carefully in order to potentially test these proposals through piloting in 2014/15. This insight methodology could also be refined to complement the support offer to assist CCGs and area teams in developing a response to performance concerns but also to identify areas of best practice to support the spread and adoption of learning and innovation.

Development, support and intervention framework

Following each assurance conversation, area teams will make an assessment under each assurance domain on the basis of the evidence presented. These assessments will be individual to each conversation but should be made in

accordance with the development, support and intervention framework set out in more detail at **annex A**. The assessment should also take into account any information which the area team has received as a result of a request for further information or improvement trajectories.

The assessment should be documented in the *summary report* published as supplementary evidence to the *headline assessment* published in the **quarterly report** (see output from assurance below).

Where the CCG can demonstrate that they are continuing to show good performance across the domain, the assessment should be that the domain is '**assured**'.

Where the CCG has quality performance concerns which can be mitigated by mutually agreed support from NHS England, the assessment should be that the domain is '**assured – with support**'.

In both of these circumstances, subject to monitoring of any performance improvement and moderation of whether support is being provided consistently across the country, there should be no further intervention action taken at that time. The assessment of these domains, and the overall assessment of each CCG, will be based on a CCG's capacity and capability as an organisation. Although the environment in which the CCG is operating will be relevant to the CCG's ability to act effectively, this is an assurance process for CCGs as organisations rather than of local health and care systems.

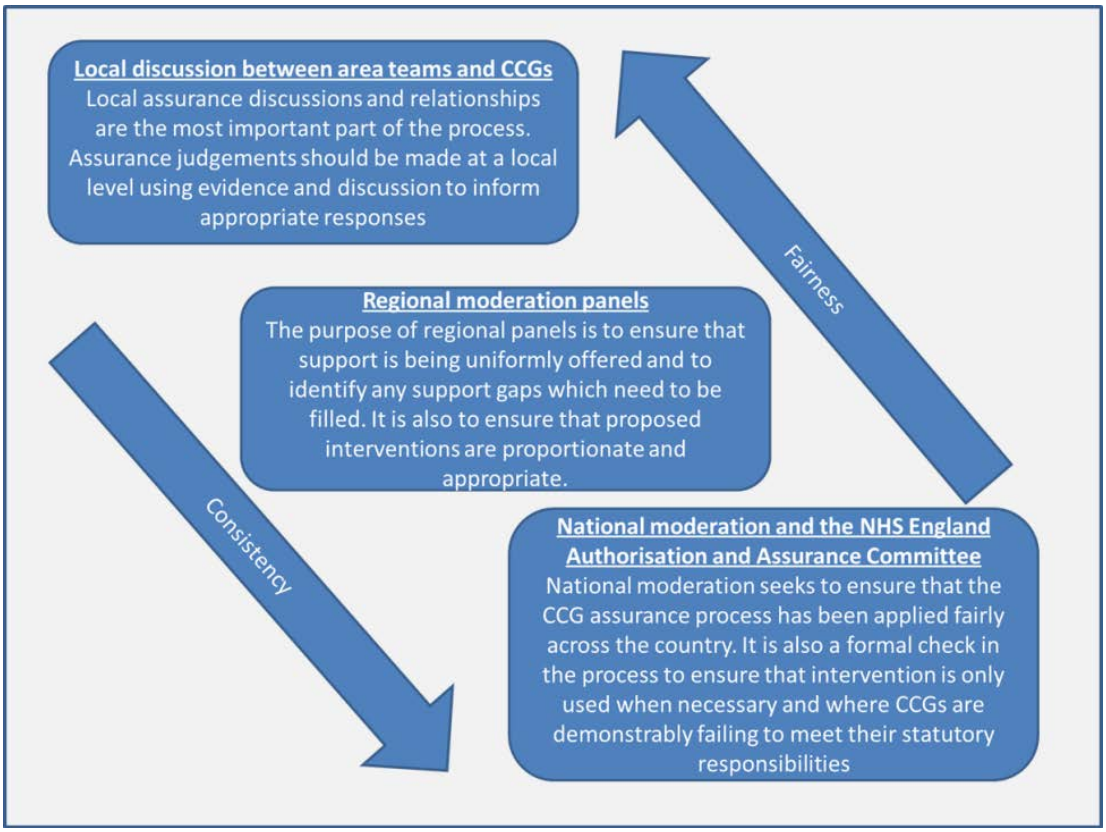
In some circumstances, assurance will identify concerns where CCGs cannot provide evidence that they are capable of giving assurance under the assurance domain, or may have demonstrated over time that support is not sufficient to deliver agreed improvement. Where these serious concerns arise, NHS England has the ability to exercise statutory powers of intervention where it is satisfied that (a) a CCG is failing or (b) is at risk of failing to discharge its functions. In these limited circumstances, the assessment should be that the domain is '**not assured without intervention**' and appropriate intervention action would be proposed.

We expect that statutory intervention powers will only be used rarely and only where NHS England is satisfied that a CCG is failing or is at risk of failing to discharge its functions. The assurance approach should be characterised by a regular dialogue with a focus on development and support.

NHS England will continue to work to develop the application of this framework including the development of a shared understanding of the range of support offers and how these are linked to the assurance discussions, including how an assessment of a CCG would result in it moving from "assured" to "not assured" or a view is taken that NHS England would move from supporting a CCG to an intervention with legal directions.

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

Figure 5: Moderation process

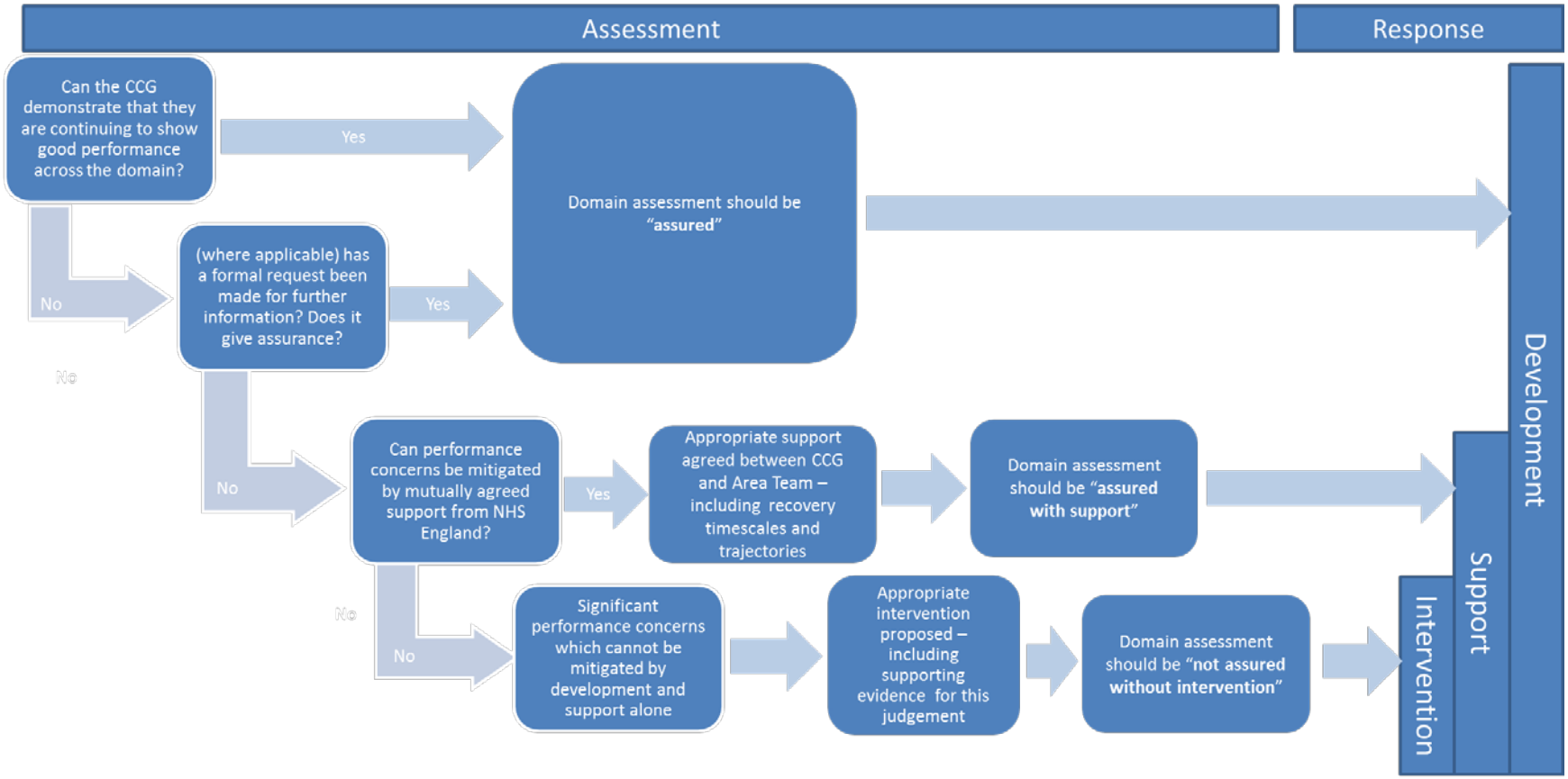


In common with the interim assurance process, appropriate checks and balances will be put in place to ensure that the assurance framework is applied fairly. Support proposals will be discussed at regional level to ensure that they are applied consistently and to identify any gaps in existing support offers to CCGs. Any proposals for intervention will continue to need agreement by the Authorisation and Assurance committee of NHS England.

A continuously evolving process

This CCG assurance framework is the product of a significant engagement exercise and represents a point in time however relationships are continuing to develop and both CCGs and area teams are continuing to evolve over time. This framework will necessarily continue to evolve. It has been developed to provide a framework that is resilient to change but NHS England are committed to ensuring that the process of assurance and the key sources of information which inform it continue to evolve as relationships mature in the spirit of ongoing co-production with CCGs.

Annex A: Development, Support and Intervention Framework



Annex B: CCG Annual Report Requirements

Under section 14Z15 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), CCGs have a duty to prepare an annual report for each financial year on how they have discharged their functions. This report must include in particular:

- How the CCG has exercised its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness;
- How the CCG, when exercising its functions, has had regard to the need to reduce inequalities of access and inequalities of outcomes;
- What arrangements the CCG has made to secure that individuals to whom services are being (or may be) provided are involved at various specified stages, including in planning commissioning arrangements, the development and consideration of proposals for change, and in decisions affecting the operation of commissioning arrangements (where implementation would have an impact on the manner in which services are delivered or the range of services available); and
- How the CCG has reviewed the extent to which it has contributed to the delivery of any joint health and wellbeing strategy.

In addition, CCGs will need to demonstrate how they have met the financial requirements set out under section 223G *et seq* of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

A full list of CCG statutory duties was produced to support the CCG authorisation process. Under section 14Z15(4) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), NHS England can give directions to CCGs as to the form and content of an annual report. In order to promote local accountability, it is not intended to be prescriptive about the form of the report however the annual report will be an important source of local insight to inform the annual assessment of CCGs, particularly regarding compliance with statutory duties – including the publication of financial information. CCGs are therefore expected to include a section on statutory compliance within their annual report which specifically covers how the CCG has:

- Acted with a view to securing that health services are provided in a way which promotes the NHS Constitution, and that it has promoted awareness of the NHS Constitution among patients, staff and members of the public

- Assisted and supported NHS England in discharging its duties relating to securing the continuous improvement in the quality of primary medical services
- Promoted the involvement of patients, their carers and representatives in decisions that relate to the prevention or diagnosis of illness in the patient, or their care and treatment
- Enabled patients to make choices with respect to the aspects of health services provided to them
- Promoted innovation, research, education and training
- Consulted when devising its commissioning plans
- Taken appropriate steps to secure that it is properly prepared for dealing with a relevant emergency
- Cooperated with its Health and Wellbeing Board in relation to the discharge of the Health and Wellbeing Board's functions
- Discharged its functions with regard to the need to safeguard and promote the welfare of children
- Cooperated in relation to the preparation of joint strategic needs assessments

A copy of the annual report should be given to NHS England in advance of the Quarter 4 assurance meeting for the purposes of discussion and to inform the annual assurance assessment.