Interim CCG Assurance Framework

Balanced Scorecard User Guide
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Purpose of this document

This document is intended to provide a comprehensive user guide for the following audiences:

- **Clinical commissioning group (CCG)** users of the Balanced Scorecard (BSC)
- **Area teams (AT)** managing the CCG Quarterly Assurance process; this includes process guidance on the use of the tool and technical guidance on how to amend or develop the tool if required
- **Regional teams (RT)** receiving information about the outcomes of Quarterly Assurance and considering / approving support and recommending intervention proposals
- **National Authorisation and Assurance Sub-committee**, receiving recommendations in relation to interventions proposals

The document has been split into three parts:

1. The **first** refers to positive behaviours required to deliver a model of collaboration and mutual accountability.
2. The **second** refers to the Assurance process and makes reference to the roles of various audiences.
3. The **third** refers to how the ‘Interim CCG Assurance Framework’ policy has been translated into the Balanced Scorecard tool.
Part 1
Delivering a model of collaboration, mutual accountability and positive behaviours

1 Introduction

The joint statement between NHS England and NHS Clinical Commissioners set out how each of us would commit to a different way of working together, based on a common purpose, local leadership and accountability, and honesty and transparency.

To make these statements a reality, we need to embed these values in our behaviours. The process of assurance is a key opportunity to demonstrate that these agreed values are lifted off the page and put into practice.

During our process of engagement across the country with CCGs and area teams we heard some very strong messages and a number of concerns:

- that assurance will become an excuse to revert to the performance management of the past and will undermine the positive relationships that have been built up locally
- that the content of assurance will not give enough flexibility to have the discussions you need to have
- that there will not be a reciprocity of assurance and the mutual accountability of NHS England as a direct commissioner
- that the process will be unduly bureaucratic and burdensome
- that a focus on performance metrics will detract from a wider conversation about quality and a focus on development

It is essential that we demonstrate through assurance conversations that these concerns are not becoming a reality.

1.1 Respecting mutual accountability

Assurance is an integral part of NHS England’s on-going relationship with CCGs and a mainstream part of business as usual. The quarterly checkpoint process should not constrain the ability to have a broader conversation about development and broader areas of local interest and collaboration. From the start it should be clear, through the setting of the agenda, tone and nature of the meetings, that assurance is as much about an assessment of NHS England as a commissioner and key local partner as it is about the
A performance concern should be a shared concern and the response to this should be agreed where appropriate by all parties.

Whilst the realities of the new system have meant that it has not been possible to bring forward a direct commissioning assurance proposal along the same timescales as CCG assurance, NHS England are absolutely committed to publishing a direct commissioning proposal alongside the final CCG Assurance Framework which delivers on our commitment to hold ourselves account to the same level of rigour as CCGs. In addition, CCGs themselves will have an opportunity to contribute to the development of direct commissioning assurance to ensure that this commitment is delivered.

1.2 Setting the agenda and the balanced scorecard domains

The balanced scorecard has been derived to provide a quarterly checkpoint with rigorous and comprehensive national information to inform assurance conversations. The intention is that the scorecard will feed from the existing data that CCGs will use themselves in their own performance assessments. The aggregate result of the quarterly conversations will form a key element of annual assurance – demonstrating clearly that a CCG has delivered against its plan. The domains were designed to answer the following questions:

1. **Are local people getting good quality care?** – To use key quality metrics to assess the CCG’s response to quality concerns in the providers they commission from and to ensure that quality oversight is embedded within the CCG

2. **Are patient rights under the NHS Constitution being promoted?** – To use the core measures which are embedded within the NHS Constitution to ensure that statutory responsibilities are being met and that oversight is in place to recover where performance concerns arise

3. **Are health outcomes improving to local people?** – To use data that CCGs can measure to make an assessment of health outcomes and key local priorities for local people, and progress towards achievement of the quality premium

4. **Are CCGs commissioning services within their financial allocations?** – To use the core measures agreed through CCG plans to ensure that statutory responsibilities are being met and that oversight is in place to recover where performance concerns arise

5. **Are conditions of CCG authorisation being addressed and removed (where relevant)?** – To provide the opportunity to discuss any outstanding conditions of authorisation prior to submission for removal

However the balanced scorecard was only designed to provide points for discussion as part of a broader discussion. It should not dominate or limit the assurance agenda or level of ambition for the purpose of the quarterly checkpoint meetings. We anticipate these will develop locally into much broader conversations, subject to local agreement, including mutual assurance, on-going development needs and local strategic priorities. We would not wish to place any constraints on this in order to make these meetings a valuable
contribution to on-going relationships. We also anticipate that once the annual assessment process is defined it will, wherever possible, be integrated within the quarterly cycle to ensure that assurance is a year round process and not an annual endeavour.

### 1.3 Reducing the burden of bureaucracy

Assurance has been designed to minimise the need to generate information locally. We will base assurance wherever possible on information which CCGs and area teams will already hold to assure themselves of performance and will work wherever possible to facilitate the collation of this information through regional and national teams. We will work in future to constantly refine to process with an aim of continually reducing the impact on the day to day work of CCGs and area teams.

### 1.4 Engaging with development and support requirements

Quarterly assurance should be judged to be a failure if we do not ensure that every conversation is an opportunity to identify areas for development and discuss mutual support options. Development and support should be a key output of the assurance process and the results of development support previously agreed should be appraised through subsequent assurance conversations. The support provided to both area teams and CCGs should be responsive to assurance conversations.

### 1.5 A consistency of approach and respect for the primacy of local relationships

Assurance needs to strike a balance. We need to ensure that NHS England treats each CCG equally but it is important that this does not undermine the primacy of local decisions and local relationships. Where no concerns are identified through the quarterly checkpoint, there should be no barrier to confirming this and making this agreement known to the wider public. If minor concerns are identified through the checkpoint which require support to be put in place, this support should be assured for consistency by RT and it is only on the rare occasions where intervention is proposed that these decisions need to be formally agreed and ratified by the authorisation and assurance committee of NHS England.

### 1.6 Continuous engagement and improvement

Statements of intent are important but we commit to continuing to work with area teams and CCGs to continually reappraise the process and draw broader alignments with other emerging areas such as direct commissioning assurance and CCG development work. A key component of the annual assessment will be a test of whether we are demonstrating through our behaviours that we are delivering against these commitments. We will strive to do more to drive this process to ensure that it is embedded as an important and reciprocal part of the CCG and area team relationship.
Part 2

CCG Assurance Process

2 Introduction to the Interim CCG Assurance process

2.1 Quarterly Assurance Process

NHS England published the ‘CCG Assurance Framework (outline proposals and interim arrangements)’ in May 2013 as a proposal for the assurance of CCGs over Q1 and Q2 2013/14, including a broad outline of the elements of assurance that could be undertaken on an annual basis.

The interim approach will apply for the first six months of 2013/14 with the final approach to be determined following a broad and deep engagement with key stakeholders including the Commissioning Assembly and other stakeholders in the health and care system.

The CCG Assurance Framework will provide a nationally consistent approach to the formal interactions between all CCGs and ATs in order to make an annual assessment of CCG performance. It also provides a framework for NHS England to assess CCG performance and capability.

In order to make a rounded assessment of the performance and capability of each CCG the annual assessment will be informed by a series of quarterly checkpoints between the CCG and their respective AT.

For practical reasons, the quarterly checkpoint will be based around published data which is consistent with a pre-published cut off date and will consist of an assessment about the following domains:

- Is the CCG ensuring that local people are getting good quality of care?
- Is the CCG promoting patient rights as stipulated in the NHS Constitution?
- Is the CCG securing improvement in the health outcomes of local people? (as indicated in Annex A of ‘Everyone Counts: Planning for Patients 2013/14’)
- Is the CCG delivering agreed financial requirements?
- Are conditions of CCG authorisation being addressed and removed (where relevant)?
2.2 Annual Assurance Process

Outputs from the Balance scorecard feed into the annual assessment. The annual assessment will be a senior strategic conversation about achievements to date and future ambition.

3 Guidance on the process

3.1 The Quarterly Checkpoint Process

The Balanced Scorecard will be used to inform the Quarterly Checkpoint process, which will in turn feed into the Annual CCG Assurance process. This guidance sets out the various steps involved in the population through to publication of the Balanced Scorecard on a quarterly basis.

The key emphasis in designing the checkpoint process has been to collect data to inform a rich and helpful dialogue whilst minimising the bureaucratic impact on CCGs and ATs. With this in mind, the scorecard will be generated centrally on the basis of existing published data to ensure a consistent standard of reporting and to maximise the benefits of existing analytical tools. Wherever possible, both the Balanced Scorecard and the monthly data packs produced for CCGs and ATs have been harmonised to reinforce that assurance forms just one part of what we expect to become rich and mature local relationships.

Much of the data in the Balanced Scorecard will be pre-populated, specifically data required for Domains 2-5.

3.2 Overview

Each Domain of the Balanced Scorecard will be populated at different time points during the first 8 weeks following the end of the quarter; this is due to the fact that various sources are feeding the population of the tool. The diagram below shows the data source for each domain:

3.3 Step by step process

The key process steps involved in populating through to publishing the Balanced Scorecard are displayed in the diagram below:
Each step is described in more detail below:

<table>
<thead>
<tr>
<th>Process step</th>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
</table>
| 1: CCG to complete UNIFY 2 self certification template | CCG will be required to complete the UNIFY self-certification template which captures information on:  
- Quality of care provided by the CCG and its local providers  
- Progress against CCG’s local priorities  
- Finance (internal and external audit)  
- CCGs progress against IAPT trajectory  
- Whether CCGs providers are meeting 15% response rate on FFT  

For Quarter 1 only, CCGs will need to list between 5-10 of their main providers (where CCG commissioning constitutes more than 5% of the provider’s income). As a general guide, it is expected that a CCGs main providers only will be listed and only therefore only in exceptional circumstances will more than 5 providers be listed.  

Once completed, the self certification element must be approved by the CCG’s Governing Body.  

Please note: All questions within the UNIFY 2 template must be answered for the file to be successfully uploaded.  

If a CCG requires further UNIFY users to be set up please click here: http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx | CCG |
ATs and Regional Teams to quality assure and populate UNIFY submissions

ATs should access UNIFY to view and verify self-certification return for each of their CCGs. This will involve checking all entries are appropriate e.g. % are given where specified.

ATs should also populate finance data for each of their CCGs to UNIFY. Regional teams will then be asked to verify this information. This will conclude the population and verification of data for Domain 4.

The London Business intelligence team will co-ordinate the population of domains 2, 3 and 5;

- Domains 2 and 3 will be transferred from a data warehouse in the South of England. Each data set will be available at different points in time

- Domain 5 will involve a co-ordination exercise with each of the CCG authorisation leads in each of regions. This will take place following the meeting of the authorisation and assurance sub – committee, once outstanding authorisation conditions have been confirmed.

The London Business intelligence team will bring all this information together to form a final BSC. The BSC will be uploaded to the West Midlands SharePoint.

If an Area Team requires UNIFY users to be set up please click here: http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx

---

### Domain 2 – NHS Constitution

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 data ready to populate BSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Treatment waiting times for non urgent consultant led treatment</td>
<td>19th August</td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>7th August</td>
</tr>
<tr>
<td>A &amp; E waits</td>
<td>6th July</td>
</tr>
<tr>
<td>Cancer patients – 2 week wait</td>
<td>7th August</td>
</tr>
<tr>
<td>Cancer waits – 31 days</td>
<td>7th August</td>
</tr>
<tr>
<td>Cancer waits – 62 days</td>
<td>7th August</td>
</tr>
<tr>
<td>Category A Ambulance calls</td>
<td>5th August</td>
</tr>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>18th July</td>
</tr>
</tbody>
</table>

### Domain 3 – Health Outcomes

1. Preventing people from dying prematurely

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 data ready to populate BSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Measure</td>
<td>Indicators used for Annual Assurance only</td>
</tr>
</tbody>
</table>

2. Enhancing quality of life for people with long term conditions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 data ready to populate BSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT Coverage - performance against plan</td>
<td>Not available for Q1</td>
</tr>
</tbody>
</table>

3. Helping people to recover from ill health or following injury

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 data ready to populate BSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of healthcare associated infection (HCAI) i) MRSA</td>
<td>9th August</td>
</tr>
<tr>
<td>Incidence of healthcare associated infection (HCAI) i) C difficile</td>
<td>9th August</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 data ready to populate BSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>30th July</td>
<td></td>
</tr>
</tbody>
</table>

---
### Process steps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2B: ATs to disseminate BSC</strong></td>
<td>Regional Business Intelligence teams to download each of their CCG’s BSC files from West Midlands SharePoint, and share with Area Teams. Area Teams will disseminate BSC to their respective CCGs.</td>
</tr>
<tr>
<td></td>
<td>The Balanced Scorecard will be published in Excel and will contain 10 sheets:</td>
</tr>
<tr>
<td>1. Overall RAG rating to each Domain, for summary</td>
<td></td>
</tr>
<tr>
<td>2. Reporting guidance, for information</td>
<td></td>
</tr>
<tr>
<td>3. Guide/FAQ, for information</td>
<td></td>
</tr>
<tr>
<td>4. Domain 1, results including RAG</td>
<td></td>
</tr>
<tr>
<td>5. Domain 2, results including RAG</td>
<td></td>
</tr>
<tr>
<td>6. Domain 3, results including RAG</td>
<td></td>
</tr>
<tr>
<td>7. Domain 4, results including RAG</td>
<td></td>
</tr>
<tr>
<td>8. Domain 5, results including RAG</td>
<td></td>
</tr>
<tr>
<td>9. Escalation Framework, for information</td>
<td></td>
</tr>
<tr>
<td>10. Support/Intervention log to record what has been recommended and agreed in relation to each of these</td>
<td></td>
</tr>
<tr>
<td>All Domains, except domain 5 are RAG rated.</td>
<td></td>
</tr>
<tr>
<td>The domains within the framework are not aggregated to produce an overall RAG rating for the CCG.</td>
<td></td>
</tr>
</tbody>
</table>

### Process steps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3A: CCG Quarterly Assurance Meeting to be held</strong></td>
<td>Area teams will conduct a checkpoint meeting with their respective CCGs. The purpose of the meeting is to discuss areas of concern, or emerging risk as highlighted by the Balanced Scorecard. The checkpoint meeting should be supportive and developmental. The nature of the discussion will vary depending on the outcome of the Domains, but will be focussed on providing the CCG with the right level of support to address potential issues in a proactive manner.</td>
</tr>
<tr>
<td></td>
<td>To come to a joint understanding of the appropriate response to a Domain that is Amber – Red or Red rated, Area teams and CCGS will discuss and agree:</td>
</tr>
<tr>
<td>• cause of the problem</td>
<td></td>
</tr>
<tr>
<td>• a plan for action / improvement</td>
<td></td>
</tr>
<tr>
<td>• a timeline for improvement</td>
<td></td>
</tr>
<tr>
<td>• whether support or intervention would be appropriate</td>
<td></td>
</tr>
<tr>
<td>The Area team will develop a short CCG plan, to reflect discussions held at the Checkpoint meeting.</td>
<td></td>
</tr>
</tbody>
</table>
### Process steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3B:</strong> Balanced Scorecards for CCGs with ‘Green’ or ‘Amber-Green’ RAG domains to be formally published locally</td>
<td>For CCGs with only ‘Green’ or ‘Amber-Green’ Domains, the Balanced Scorecard should be published locally, on the CCG’s website as soon as possible after the checkpoint meeting (and wherever possible, no more than 12 weeks after the quarter end)</td>
<td>CCG</td>
</tr>
</tbody>
</table>
| **4:** Regional review to ensure consistency | For CCGs with one or more ‘Amber-Red or Red’ rated Domains, support or intervention agreed at the checkpoint meeting will be discussed at the Regional Assurance Meeting. **Regional Assurance Meeting**  
The purpose of regional assurance meetings is to:  
- Moderate proposals of agreed support, to ensure a fair and consistent approach is being taken across the region  
- Consider effectiveness of existing support, whether to continue, or whether to remove it based on progress towards agreed trajectories for improvement  
- Review requests for intervention as detailed in CCG action plan.  
- Make recommendations for intervention to the NHS England Authorisation and Assurance Committee | Regional Teams |
| **5A:** National approval of escalation at National Authorisation and Assurance committee | All proposals for intervention will be shared with the NHS England Authorisation and Assurance Committee. **National Assurance**  
The purpose of national assurance through the Authorisation and Assurance Committee is to:  
- Review and formally agree decisions as outlined in CCG action plans.  
- Moderate proposals for intervention, to ensure a fair and consistent approach is being taken nationally.  
- Review effectiveness of interventions currently in place, whether to continue, or whether to remove it based on progress towards agreed trajectories for improvement.  
**Following confirmation of outcome** Area teams to send support / intervention information to Regional BI teams, BI teams to save to WM SharePoint  
**London BI team** to update warehouse with information on confirmed intervention and support proposals | National team |
To ensure consistency in application, the following guidance has been developed to help CCGs and ATs identify when to opt for support or intervention and what this entails:

**Support**

Where CCG Assurance **identifies performance concerns** which require support above and beyond broader discussions about CCG Development, NHS England has the statutory powers to provide assistance or support to a CCG. In the majority of cases we expect this to take the form of support conversations where CCGs are supported to address problems and set out plans to improve performance. It is only in exceptional circumstances where we would expect formal intervention powers to be exercised.

The response to any performance concerns is rooted in local relationships and an agreed and supportive approach to improvement. The information below sets out broadly how support conversations should be framed however it is important to note that this information is intentionally high level and is by no means exhaustive. This is to ensure that innovative responses to performance concerns are not constrained by a nationally prescriptive list of support options.

**Types of support**

Where it is agreed that support may be the appropriate way forward, different types of support options could include:

- Providing model document/guidance, with informal advice available if needed
- Making advice/expertise available to the CCG
- Facilitating peer review and partnership with other CCGs
- Creatively collaborating with partner organisations such as NICE and NHS Improving Quality to gain broader professional input into problem solving
- Facilitating conversations with key partner organisations and facilitating best practice modelling
- In limited circumstances, providing specific funding for agreed improvement initiatives

Where a CCG has been subject to **support** on any BSC Domain for more than **two consecutive quarters**, an escalation to intervention should be considered.
Support is expected to be the agreed way forward in the vast majority of cases.

In addition, where performance concerns persist under agreed support, NHS England would expect the level of support to be reassessed.

Intervention

Where CCG Assurance identifies significant performance concerns or where existing development and support have been insufficient to deliver improvements, NHS England has the power to directly intervene in a CCG where there are concerns that a CCG is failing or is at significant risk of failing to discharge its functions.

Types of intervention

Where intervention may be the appropriate way forward, the options could include the Board:

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

Intervention should only be considered as a last resort following attempts to resolve issues locally and through support and it is deemed there is a significant risk of a CCG failing to carry out its functions.

If intervention is deemed appropriate by ATs and CCGs to recover from significant performance concerns, the actions to implement this should not be delayed if they are considered to be effective in supporting the CCG to discharge its functions. It is at the discretion of the AT to escalate this through the appropriate governance structure to gain ad hoc sign-off as opposed to waiting for the next sub-committee.
### 3.4 Timelines

The diagram below shows the timing of the process within each quarter of 2013/14:

<table>
<thead>
<tr>
<th>Task</th>
<th>Est. weeks following end of quarter</th>
<th>Q1</th>
<th>Q2 – tbc Following Q1</th>
<th>Q3 – tbc Following Q1</th>
<th>Q4 – tbc Following Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>London team</strong> to coordinate collection of information on outstanding authorisation conditions</td>
<td>3 weeks</td>
<td>18 July</td>
<td>8 October</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Area teams</strong> to upload finance data for each CCG via</td>
<td>6 weeks</td>
<td>5 August</td>
<td>21 October</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CCG</strong> to upload self certificate information via UNIFY</td>
<td>6 weeks</td>
<td>5 August</td>
<td>21 October</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regional teams</strong> to verify UNIFY finance information for their CCGs</td>
<td>7 weeks</td>
<td>12 August</td>
<td>28 October</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Area team</strong> to verify self certification data uploaded to</td>
<td>7 weeks</td>
<td>12 August</td>
<td>28 October</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>London BI</strong> team to import data relating to Domains 2,3</td>
<td>8 weeks</td>
<td>19 August</td>
<td>18 November</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upload BSC to share point</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Balanced Scorecard available for download</strong></td>
<td>8 weeks</td>
<td>23 August</td>
<td>20 November</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Area teams</strong> to download and disseminate BSC for each of the individual CCGs</td>
<td>9 weeks</td>
<td>26 August</td>
<td>20 November</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Area teams</strong> to conduct quarterly checkpoint meetings</td>
<td>9-10 weeks</td>
<td>26 August</td>
<td>20-29 November</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Area team</strong> to refresh BSC with agreed support / Intervention where appropriate</td>
<td>10 weeks</td>
<td>4 Sept</td>
<td>2 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Duration</td>
<td>Start Date</td>
<td>End Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------</td>
<td>----------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regional teams</strong> to summarise position for each CCG ahead of regional moderation**</td>
<td>10 weeks</td>
<td>6 September</td>
<td>3 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regional moderation panel</strong></td>
<td>11-12 weeks</td>
<td>9-13 September</td>
<td>3-13 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TBC to write report, outlining all regional and area team recommendations for intervention</strong></td>
<td>12 weeks</td>
<td>16 September</td>
<td>16 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assurance and authorisation committee</strong></td>
<td></td>
<td>8 October</td>
<td>16 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Area team</strong> to refresh BSC in light of regional and national moderation, share with Regional BI to who will upload to WM SharePoint**</td>
<td>13 weeks</td>
<td>26-29 September</td>
<td>27 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CCG notified of outcome</strong></td>
<td>13 weeks</td>
<td>30 September</td>
<td>30 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSC published on individual CCG websites</strong></td>
<td>13 weeks</td>
<td>30 September</td>
<td>31 December</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.5 Overview of the Balanced Scorecard

The CCG Assurance BSC will form the basis of the quarterly checkpoint and is designed to represent a holistic assessment of a CCGs performance against core statutory responsibilities across five domains. The BSC will be based on the information which we would expect CCGs to be monitoring and making available to their local population. Where performance concerns are identified under the BSC, support should be discussed and agreed against a consistent national framework. The BSC is designed to minimise the bureaucratic burden on CCGs and ATs – where possible data will be populated automatically on the basis of published national data.

Further information on the BSC Tool can be found in Part 2 of this pack.

3.6 Feedback

Should you have any feedback or queries on the tool itself, please direct them to your AT or email:

<table>
<thead>
<tr>
<th>Region</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Region</td>
<td><a href="mailto:england.londonsubmissions@nhs.net">england.londonsubmissions@nhs.net</a></td>
</tr>
<tr>
<td>South Region</td>
<td><a href="mailto:england.operations-south@nhs.net">england.operations-south@nhs.net</a></td>
</tr>
<tr>
<td>North Region</td>
<td><a href="mailto:england.ccg-north@nhs.net">england.ccg-north@nhs.net</a></td>
</tr>
<tr>
<td>Midlands Region</td>
<td><a href="mailto:gareth.harry@nhs.net">gareth.harry@nhs.net</a></td>
</tr>
</tbody>
</table>
Part 2
Balanced Scorecard (BSC) Tool

4 Data collection

To minimise the burden of data collection associated with the BSC the majority of the data will be extracted from existing, published data sources. Only the CCG UNIFY 2 self-certification element will be provided by the CCG, in preparation for each of the quarterly checkpoints.

The development stage of the CCG Assurance BSC was undertaken with a focus on minimising the burden of data collection. With this in mind, data has been extracted from existing sources (further detail on this can be found within the ‘Reporting’ tab of the BSC Tool).

The process for population of the BSC tabs is shown below:
1. Self certification information uploaded to UNIFY, by CCG

- CCGs to fill in self certification information relating to all of Domain 1, elements of 3 and 4
- CCG Board to sign off self certification information
- CCG to upload self certification information to UNIFY

2. Balanced Score Card finalised, with Area and Regional Team input

- Regional authorisation teams to fill in outstanding conditions template, send to London authorisation team
- Area finance teams upload information relating to Domain 4 (finance) to UNIFY
- Area teams to QA CCGs' self certification upload to UNIFY
- Regional finance teams to ratify UNIFY upload relating to Domain 4
- London Business Intelligence (BI) team to populate domains 2,3, of the BSC from data warehouse in South region
- London BI team to QA Domains 2,3 and finalise BSC
- Regional BI teams download BSC from WM SharePoint, send to Area teams, who will share with CCGs

3. CCG Assurance Meetings held between CCG and Area team

- Area teams to conduct CCG assurance meetings
- CCGs with all Green / Amber Green domains and no support requirement to publish BSC locally
- CCGs with one or more Amber / Red domains discuss appropriate support / intervention
- Area teams to refresh BSC with agreed support / intervention
- CCG to send action plan (outlining agreed support / intervention) to area team

4. Assurance of support proposals and moderation of any proposed intervention

- Support/ intervention proposals for CCGs with one or more Amber / Red domains is discussed at regional level to ensure consistency and fairness in approach
- In exceptional circumstances only, Intervention proposals for CCGs to be reviewed and approved by National Assurance and Authorisation committee
- CCGs with one or more Amber / Red domains to publish BSC locally
- Area teams to send support / intervention information to Regional BI teams, BI teams to save to WM SharePoint
- London BI team to update warehouse with information on confirmed intervention and support proposals

• CCGs to fill in self certification information relating to all of Domain 1, elements of 3 and 4
• CCG Board to sign off self certification information
• CCG to upload self certification information to UNIFY
5 Getting Started with the Balanced Scorecard Tool

It is advisable to print out a copy of this guidance to refer to whilst using the Balanced Scorecard Tool.

5.1 Enabling the workbook to function

Please note: The Balanced Scorecard has been developed using Microsoft Excel 2007 and it functions best when opened using this version of Excel.

Each workbook will be password protected for security purposes. This information will be provided to you initially. Should you want to change your password or have locked your password, please email your region and we will arrange for this to be done.

<table>
<thead>
<tr>
<th>Region</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Region</td>
<td><a href="mailto:england.londonsubmissions@nhs.net">england.londonsubmissions@nhs.net</a></td>
</tr>
<tr>
<td>South Region</td>
<td><a href="mailto:england.operations-south@nhs.net">england.operations-south@nhs.net</a></td>
</tr>
<tr>
<td>North Region</td>
<td><a href="mailto:england.ccg-north@nhs.net">england.ccg-north@nhs.net</a></td>
</tr>
<tr>
<td>Midlands Region</td>
<td><a href="mailto:gareth.harry@nhs.net">gareth.harry@nhs.net</a></td>
</tr>
</tbody>
</table>

It is essential that before proceeding to use the Balanced Scorecard, **active content is enabled**. This is a simple process which can be achieved as follows:

The Balanced Scorecard is predicated on using buttons. To ensure that this functionality works, please also check that all macros are enabled.

This can be done by selecting ‘Developer’ > ‘Macro Settings’ > ‘Enable all macros’.
5.2 Navigating through the Balanced Scorecard

Having completed the macro security check, all the buttons allowing you to navigate through the Balanced Scorecard should be enabled.

There are guides and prompts within various parts of the Balanced Scorecard that inform you on how to work your way through the tool.

5.3 Accessing worksheets within the Balanced Scorecard

As we have limited the need for the CCG to provide extensive data inputs, there are areas within the BSC that will not need to be amended. Therefore the following sheets will be locked:

- BSC Summary
- Guide-FAQ
- Reporting
- Domain 1
- Domain 2 (except for the Future Concerns section)
- Domain 3
- Domain 4
- Domain 5
- Escalation Framework

The following sheets will be available to edit:
5.4 Tool overview

The CCG Assurance BSC is a multi-tabbed Excel based tool which comprises the following sections:

- Domain 2 – only Future Concerns section
- Support
CCG Assurance - Balanced Scorecard User Guide

Balance Scorecard Summary

- The CCG RAG status for each domain, and where appropriate the self-certification status, is captured here. The summary will demonstrate how many indicators have led to the RAG rating.
- This worksheet will also capture the agreed support/intervention that is agreed for each domain.

Self-certification

- The CCG will complete the self-certification worksheet for domain 1, part of domain 3 (local priorities) and part of domain 4 (finance). This will automatically generate the content in the domain worksheets.
- Once completed, the CCG will return the Balanced Scorecard to their AT Delivery Director prior to their assurance meeting.

Domain 1

- This domain will be self-generated through the responses received from CCGs via the self-certification.

Domain 2

- This domain will be populated via the central informatics team prior to sharing with Area Teams and CCGs.

Domain 3

- This domain will be populated via the central informatics team prior to sharing with Area Teams and CCGs.
- Local priorities will be self-generated through the responses received from CCGs via the self-certification.

Domain 4

- This domain will demonstrate the number of outstanding authorisation criteria, by domain
- This domain is not RAG rated

Domain 5

- This worksheet will pull through the CCG RAG status for each Domain and how many indicators have led to the RAG rating
- This will provide the foundation for discussion on what support or intervention the CCG may require or request.
- This is to be completed jointly by ATs and CCGs.
- If all domains are Amber-Green or Green, a CCG can publish the Balance Scorecard on their website, otherwise a CCG needs to wait for either Regional or National Moderation.
In addition, there are a number of supporting tabs that will help all users of the tool. These are described in more detail below:

- **The Guide and FAQ** is there to provide a high-level understanding of what the CCG Assurance process is about and answer some of the common queries (these have been gathered through CCG engagement events).

- **This information is available to provide Area Teams and CCGs an understanding of how indicators have been calculated, especially as some of these are populated by the central informatics team.**

- **The escalation framework is a guide for how Area Teams and CCGs may approach the support/intervention discussions. It demonstrates the flow of conversation that the two parties may engage in based on the RAG rating of domains.**

Each tab is described in detail below.

### 5.5 Balanced Scorecard Summary Page

A screenshot of this tab is shown below:

This summary of the RAG for each of the Domains is shown here and the number of indicators for each Domain that trigger the overall RAG for the Domain, e.g. if the Domain RAG is Amber-Red, this will identify how many indicators have caused this.
The self-certification status, i.e. the UNIFY 2 returns, against each of the relevant domains is also shown in the far right-hand column.

5.6 Self-Certification (UNIFY 2 return)

UNIFY2 is a flexible system for collecting, validating, storing and reporting data. It provides a trusted data store across all data sets including historical data.

To log into UNIFY2: http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

If you do not have an account and need to register for one, this can be done by selecting ‘Request a Unify account’.

If you have an account, you can log in here.

Once CCG’s complete the Excel spread sheet called CCG_SCV1.2.xls, they should log onto the system as above, navigate to ‘Data Collection and Management’.
Then select ‘NON DCT Homepage’

There are two templates that are available on UNIFY 2:

In the Reference row called CCG_AF or CCG Assurance Framework click upload.

Click browse to upload document from your home drive, and then click auto sign off

1. **CCG Assurance Self Certification (CCG_SC)** – These are to be completed by CCGs and signed off by Area Teams. CCGs are asked to use version 1.2.

2. **CCG Assurance - Finance (CCG_AF)** - These are to be completed by Area Teams on behalf of CCGs and signed off by commissioning region. Area Teams will need to impersonate CCGs in turn by clicking on their username on the front page and selecting a CCG.

For more information on UNIFY2, please refer to: Annex 6.2 for an overview.
5.7 Domain 1

Domain 1 Populated version

The data the CCG enters into the UNIFY 2 return will be used to populate the tab as shown below:

CCG Provider Quality

In box 1: A discrete column entry for all providers of the CCG for which the provider receives more than 5% of its income from the CCG. This % figure reflects an existing requirement stipulated in the financial returns, made during the planning and contracting process.

The first time the self certification upload is completed, the CCG will need to list its main providers (that receive more than 5% of their income from the CCG in question). As a general rule, the number of providers will range between 1-5. In exceptional circumstances the number may stretch to 10, depending on
where the CCG is based. CCGs are asked to provide this information in order of their biggest provider first to their smallest (within 5% of their income).

**In box 2:** For each of the questions in box 2, by provider, the following responses apply:
- No
- Yes – Action plan in place
- Yes – No action plan in place
- Yes – Enforcement action

**CCG Governance**

The questions in this section relate to the CCG rather than the CCG’s providers. Each of the questions may have one of the following responses:
- No
- Yes – Action plan in place
- Yes – No action plan in place
- Yes – Enforcement action

NB. The CCG will not be able to amend any data on this page.

**Domain 1 RAG Criteria Guidance**

By clicking on the ‘Domain 1 – RAG Criteria’ a screen tip will appear showing the criteria that apply to the self-certification data in order to derive the overall RAG for the Domain.
## 5.8 Domain 2

### Domain 2 Populated version

**Data for the A&E measure ‘Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department’ takes into account the CCG’s 3 main providers (main providers are defined as those where CCG commissioning constitutes more than 5% of the provider’s income). This will be determined using the return by CCGs on UNIFY 2 listing their main providers for Domain 1.**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Operational Standard</th>
<th>Lower Threshold</th>
<th>2013-14 YTD Performance</th>
<th>2013-14 YTD Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>90%</td>
<td>85%</td>
<td>93.34%</td>
<td>93.34%</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 20 weeks from referral</td>
<td>95%</td>
<td>90%</td>
<td>97.58%</td>
<td>97.58%</td>
</tr>
<tr>
<td>Patients on incomplete non emergency pathways (to start treatment should have been waiting no more than 32 weeks)</td>
<td>92%</td>
<td>87%</td>
<td>95.16%</td>
<td>95.16%</td>
</tr>
<tr>
<td>Number of patients waiting more than 52 weeks</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Diagnostic test waiting times

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013-14 YTD Performance</th>
<th>2013-14 YTD Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Patients waiting 5 weeks or more for a diagnostic test</td>
<td>1%</td>
<td>1.00%</td>
</tr>
</tbody>
</table>

### A&E wait times

| Provider 1: Patients should be admitted, transferred or discharged within 8 hours of their arrival at an A&E department | 95%                  | 90%             | 94.83%                  | 94.83%                  |
| Provider 2: Patients should be admitted, transferred or discharged within 8 hours of their arrival at an A&E department | 95%                  | 90%             | 90.55%                  | 90.55%                  |
| Provider 3: Patients should be admitted, transferred or discharged within 6 hours of their arrival at an A&E department | 95%                  | 90%             | 93.60%                  | 93.60%                  |

### Cancer patients - 2 week wait

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013-14 YTD Performance</th>
<th>2013-14 YTD Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td>Maximum two-week wait for first out-patient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td>Cancer wait - 35 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>91%</td>
</tr>
</tbody>
</table>
Data within Domain 2 of the BSC will be pre-populated for each CCG with nationally available information from a data warehouse within 6 weeks of the end of the Quarter.

Within this Domain, the CCG can identify whether it has any ‘Future Concerns’ on any of the indicators so that it can be addressed as part of the CCG Assurance Meeting. This can be discussed at the checkpoint meeting.

Guidance on how to understand thresholds, numerators, denominators and quarterly performance will be available in the ‘Reporting tab’.

The criteria by which the Domain 2 indicator RAG statuses are determined are shown in a screen tip by clicking on the ‘Domain 2 – Indicator RAG rating’ field.

The overall criteria for generating the RAG status for the Domain are shown in a screen tip when clicking on the ‘Domain 2 – RAG criteria’ field, as illustrated:
5.9 Domain 3
Domain 3 Populated version

5.9.1 Domain 3 - Are health outcomes improving for local people?

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline position</th>
<th>Current QIB performance</th>
<th>Rank</th>
<th>Indicator used qualified</th>
<th>Indicator included in quality framework</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient stays per thousand population</td>
<td>0.8</td>
<td>0.9</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital admissions per thousand population</td>
<td>0.8</td>
<td>0.9</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Support

5.9.2 Domain 3 - Are health outcomes improving for local people?

- Inpatient stays per thousand population
- Hospital admissions per thousand population

Support
Data within Domain 3 of the BSC will be pre-populated for each CCG with nationally available information from a data warehouse within 6 weeks of the end of the Quarter.

The following data will be populated from publically available data stored within the intelligence tool:

- **Baseline position.** This is the measure of value against which the specific indicator will be measured over the year.
- **Indicator value** – this is the current performance of the CCG against this indicator (this might be quarterly or annual depending on the regularity of the respective reporting processes)
- **Unit** – where relevant, what is this against – for example, ‘X per population’
- **Indicator used in quarterly checkpoint** – Yes/No - whether or not this indicator is measured and reviewed at quarterly checkpoint.
- **Indicator included in Quality Premium** – Yes/No - whether or not this indicator is measured and reviewed as part of the Quality Premium.
- **Threshold** – if the indicator is included within the quality premium, what value is required to achieve the Quality Premium.

The local priorities within the domain will be populated through the CCG UNIFY 2 return which will ask whether the CCG is on track to deliver against these priorities.

The criteria by which the Domain 3 RAG status is generated is shown in a screen tip when clicking on the ‘Domain 3 – RAG criteria’ field, as illustrated.

An Overall RAG is calculated for this Domain. The RAG calculation mirrors that of Domain 2.
5.10 Domain 4
Domain 4 Populated version

The data within this domain will be populated by the Area Finance teams and verified by Regional Finance teams. The internal and external audit measure will be captured through the CCG UNIFY 2 return template.

The criteria by which the Domain 4 RAG status is generated is shown in a screen tip when clicking on the ‘Domain 4 – RAG criteria’ field, as illustrated.
5.11 Domain 5

Domain 5 as populated by the Rectification Team

The Rectification Team (RT) responsible for authorisation will provide the London team with verified information which will be used to populate the data in Domain 5 to show the number of outstanding conditions the CCG has against each of the Authorisation Domains. This Domain will only be used during the first full year of CCG Assurance.

This domain will not be RAG rated. Information on the 6 Authorisation Domains can be found below:

The RT responsible for authorisation will provide the London team with verified information which will be used to populate the data in Domain 5 to show the number of outstanding conditions the CCG has against each of the Authorisation Domains. This Domain will only be used during the first full year of CCG Assurance.

This domain will not be RAG rated. Information on the 6 Authorisation Domains can be found below:
<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A strong clinical and multi-professional focus which brings real added value</td>
<td>A great CCG will have a clinical focus perspective threaded through everything it does, resulting in having quality at its heart, and a real focus on outcomes. It will have significant engagement from its constituent practices as well as widespread involvement of all other clinical colleagues; clinicians providing health services locally including secondary care, community and mental health, those providing services to people with learning disabilities, public health experts, as well as social care colleagues. It will communicate a clear vision of the improvements it is seeking to make in the health of the locality, including population health.</td>
</tr>
<tr>
<td>Meaningful engagement with patients, carers and their communities</td>
<td>CCGs need to be able to show they will ensure inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards and local authorities. They should include mechanisms for gaining a broad range of views then analysing and acting on these. It should be evident how the views of individual patients are translated into commissioning decisions and how the voice of each practice population will be sought and acted on. CCGs need to promote shared decision-making with patients, about their care.</td>
</tr>
<tr>
<td>Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes), and local joint health and wellbeing strategies</td>
<td>CCGs should have a credible plan for how they will continue to deliver the local QIPP challenge for their health system, and meet the NHS Constitution requirements. These plans will set out how the CCG will take responsibility for service transformation that will improve outcomes, quality and productivity, whilst reducing unwarranted variation and tackling inequalities, within their financial allocation. They need a track record of delivery and progress against these plans, within whole system working, and contracts in place to ensure future delivery. CCGs will need to demonstrate how they will exercise important functions, such as the need to promote research.</td>
</tr>
<tr>
<td>Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commission all the services for which they are responsible</td>
<td>CCGs need the capacity and capability to carry out their corporate and commissioning responsibilities. This means they must be properly constituted with all the right governance arrangements. They must be able to deliver all their statutory functions, strategic oversight, financial control and probity, as well as driving quality, encouraging innovation and managing risk. They must be committed to and capable of delivering on important agendas included in the NHS Constitution such as equality and diversity, safeguarding and choice. They must have appropriate arrangements for day to day business, e.g. communications. They must also have all the process in place to commission effectively each and every one of those services for which they are responsible, from the early health needs assessment through service design, planning and reconfiguration to procurement, contract monitoring and quality control.</td>
</tr>
<tr>
<td>Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as appropriate external commissioning support</td>
<td>CCGs need robust arrangements for working with other CCGs in order to commission key services across wider geographies and play their part in major service reconfiguration. They also need strong shared leadership with local authorities to develop joint health and wellbeing strategies, and strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care is vital and the ability to secure expert public health advice when this is required.</td>
</tr>
</tbody>
</table>
is needed. They also need to have credible commissioning support arrangements in place to ensure robust commissioning and economies of scale. They need to be able to support the NHS Commissioning Board in its role of commissioner of primary care and work with the Board as a partner to integrate commissioning where appropriate.

Great leaders who individually and collectively can make a real difference

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

5.12 Escalation Framework

The escalation framework that will be applied to CCGs where ‘Amber-Red’ or ‘Red’ thresholds are breached in any of the Domains is set out in the above diagram.

If a CCG with a ‘Green’ or ‘Amber-Green’ RAG rated domain self-refers itself for support, this does not mean that the CCG’s rating changes to an ‘Amber-Red’ or ‘Red’.

5.13 Support
For each 'Red' or 'Amber-Red' Domain identified on the BSC should trigger a support or intervention discussion between the CCG and AT. The Domains and individual indicators triggering the 'Red' or 'Amber-Red' Domain will be identified in this tab. A series of questions will need to be addressed in relation to each indicator:

- Is there a shared understanding of the underlying cause of the problem?
- Has an action plan been agreed?
- Has a trajectory of improvement been agreed?
- Support/Intervention agreed

Where an action plan has been agreed, CCGs will be asked to send this through to their AT as a separate attachment.
6 Annexes

6.1 CCG Assurance Meeting – Agenda Principles

The agenda that is set by the Area Team and CCG for the CCG Assurance Meeting should integrate the following key principles:

- Any ‘Red’ or ‘Amber-Red’ Domains must form part of the agenda and a discussion around support needs should be held.

- The effectiveness of any existing forms of support and/or intervention should be discussed and proposals for revoking or revising previously agreed levels of support should be recorded formally to present back to the Regional Assurance Board.

- Any areas of concern that either a Area Team or CCG have on indicators should be raised at the meeting as a part of a preventative discussion.

- The agenda should build on on going discussions that Area Teams and CCGs should be having on a regular basis.
6.2 Example: CCG Action Plan template

<table>
<thead>
<tr>
<th>CCG PLAN: INSERT CCG NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause of issue</td>
</tr>
<tr>
<td>Domain 1</td>
</tr>
<tr>
<td>Domain 2</td>
</tr>
<tr>
<td>Domain 3</td>
</tr>
<tr>
<td>Domain 4</td>
</tr>
</tbody>
</table>
6.3 Example of Unify2 Finance template

CCG_AF_v1.1.xls

6.4 Example of Unify2 Self Certification

CCG_SC_v1.2.xls

6.5 Unify2 General Overview

Unify2 - General Overview.pdf