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Key issues for Clinical Commissioning Groups

Issue 1

Grant Thornton is appointed external auditor for around 40% of CCGs, giving us excellent insight into the key issues facing CCGs and the solutions being adopted across the country. From meeting with key people, carrying out board presentations and workshops, and attending audit committees, we find that many of the key issues raised and risk faced are common to many CCGs

This briefing paper summarises the main issues and potential implications. It also sets out way we can help you address these areas

Top ten issues

1 **Patient identifiable data** including issues around: access to this data leading to delays in making payments, concerns over data received from acute trusts; and how to tackle overcharging

2 **Deficit budgets** have been set in several CCGs. In many areas this is linked to top-slicing budgets for specialised service commissioning

3 **Future funding formula**, the distance from target analysis and the need for five year financial plans. There are also concerns about proposed changes to the funding formula, that would place more emphasis on age of population and less on deprivation indices

4 **Managing conflict of interest**, from a basic awareness level to more difficult scenarios, where GPs have interests both as commissioners and potential providers of services commissioned by the CCG

5 **Concerns about stability, value for money and quality of Commissioning Support Units** (CSUs) including concerns as to whether CSUs will be able to meet service requirements in relation to CCG final accounts

6 **Better Care Fund and CCGs strategic and operational plans 2014/15 to 2018/19**. Better Care Fund plans agreed with local authorities and health providers need to be submitted by health and wellbeing boards (HWBBs) as a 'first cut' by 14 February 2014, as an integral part of CCGs strategic and operational plans. Revised plans should be approved by HWBBs by 31 March and submitted to NHS England by 4 April 2014. We will be reviewing the development of the joint plans as part of our VfM conclusion work.

7 **CCG internal audit teams without access to the CSU** to undertake financial systems testing. NHS England's internal auditor will provider service auditor reports in respect of the CSU, which both the CCGs internal and external audit can place reliance on. There is still some uncertainty over when these reports will be available, what they will cover and what reliance can be placed on them

8 **Delivery of QIPP schemes**, with some CCGs still yet to identify them at the level required. There is also some desire to see good practice examples of identifying and managing QIPP schemes more successfully

9 **Pharmaceutical companies discounts** if the CCG agrees to prescribe certain drugs. Different approaches are being adopted. One CCG we are aware of has refused to sign up and referred the issues to Local Counter Fraud Services, whereas others are engaging in the process

10 **Strategic review of services in the health sector**. This is a major issue, particularly in London , where all acute trusts are involved in strategic change reviews.

CCG Assurance Framework

CCGs are addressing these issues against the backdrop of the first year of the new CCG assurance framework that was published by NHS England in November 2013.

NHS England is using the assurance framework to assess each CCGs ability to operate effectively to commission safe, high quality and sustainable services. The framework sets out six broad assurance domains:

- Domain 1: Are patients receiving clinically commissioned, high quality services?
- Domain 2: Are patients and the public actively engaged and involved

- Domain 3: Are CCG plans delivering better outcomes for patients?
- Domain 4: Does the CCG have robust governance arrangements?
- Domain 5: Are CCGs working in partnership with others?
- Domain 6: Does the CCG have strong and robust leadership?

The NHS England Local Area Team will produce the following documents from the assurance assessment which will be shared with the CCG:

- a quarterly report containing:
  - a headline assessment as to whether NHS England is 'assured' or 'not assured' on the basis of the assurance domains
  - a summary report; which identifies the assessments made under each domain
- an annual letter from the Area Team to the CCG governing body summarising the annual assessment

One of the key elements of the annual assessment is an agreement between each CCG and NHS England about the CCGs support and development needs

Where the CCG can demonstrate that it is continuing to show good performance across the domain, the assessment will be that the domain is 'assured'

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

In exceptional circumstances, NHS England may identify that a CCG is failing, or at risk of failing, to discharge its functions. In these circumstances, NHS England may make an assessment that the domain is 'not assured' and propose statutory intervention action.

NHS England expects that statutory intervention powers will be used rarely and only where a CCG is failing, to discharge its function. Although the assurance framework is not designed to impose excessive burdens on CCGs, or the NHS England Area Teams, we recognise that assessment and assurance processes can sometimes place time demands on the parties involved that exceed the time available.

At Grant Thornton, we have extensive experience of public sector assessment regimes and providing support and independence to assist with the assurance process if required. We are also able to provide additional advice to assist CCGs resolve issues identified through the assurance process.

Exploring further issues

The following issues are explored in more detail:

- Appendix 1 – conflicts of interest
- Appendix 2 – managing QIIP schemes
- Appendix 3 – commissioning support units

Further bulletins will explore other key issues, but please contact us in the meantime, if you wish to seek assurances on the extent to which the remaining issues apply at your CCG and how well they are being managed.

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Appendix 1

Managing conflicts of interest

While a strong emphasis in 2013 was rightly placed on CCGs achieving successful authorisation, GPs and other members of CCG governing bodies have now turned their attention to the practical issues of embedding good governance into their day-to-day activities. This includes managing the risk area of conflicts of interest.

Why managing conflicts of interest is important

Conflicts of interest for CCGs have received a lot of media attention during the health reform discussions. The Health and Social Care Act places a duty on a CCG to publish its arrangements to manage conflicts of interest. To help with decision making and to protect the interests of everyone involved, it is important that appropriate arrangements are in place early on. Weaknesses in these arrangements could:

- leave commissioning open to abuse
- cause reputational harm, undermining confidence in the decisions and integrity of CCGs
- damage public confidence and the trust between patients and GPs, which can be hard to recover
- prove time consuming, with the CCG likely to suffer from delays and flaws in decision making.

Managing conflicts of interest well will help demonstrate that CCGs are acting fairly, transparently and in the best interests of patients. It will also protect them from perceptions of wrong-doing, particularly where GPs and GP practices are potential providers of CCG commissioned services.

Key issues include:

- clarity of requirements, protocols and responsibilities
- declarations of interest and conduct of meetings
- openness, transparency and efficiency
- demonstrating good governance and value for money.

What needs to be done?

In order to reduce and manage these risks, CCGs require:

- **clear rules and protocols on when and how to record interests** – CCGs need to provide clear guidance on what might constitute a conflict of interest and then have robust processes to ensure that all potential conflicts are identified and reported
- **clear processes to manage potential conflicts which arise** – It is vital that when conflicts of interest are identified these are managed correctly. Where services are being procured from GP practices requires particular attention, so that such decisions pass the tests of public perception and scrutiny. Safeguards are vital, so need to be both robust and clear, but also proportionate and workable in practice. All processes should help empower and protect the people making decisions, rather than acting as a brake on efficiency and good governance. CCGs should be proactive, anticipating and responding to potential conflicts early on.
- **effective service design and procurement** – CCGs will need to invest valuable time in making sure that needs assessments, consultation, service options and design, and commissioning are right for their patients. Avoiding conflicts of interest at each stage will contribute to their success. It will help keep the focus on what is important and ensure that decisions on service design and procurement stand up to public scrutiny.

Progress so far

Our work and interactive workshops with CCGs across the country indicates that while CCG boards are aware of the importance of minimising the risks potential conflicts pose to the organisation, the overall level of awareness is lower in the wider CCG membership. CCGs are addressing this through various means. It is also clear from these workshops that all parties are willing to learn to ensure that individual CCGs are minimising any potential conflict of interest issues.

The workshops elicited several discussions which highlighted early problems in relation to declaration of interests at internal meetings, with specific examples where an attendee should have declared an interest. This was caused by a lack of awareness, or where the agenda had not been properly set. CCGs have responded to this by better forward planning of meetings to anticipate potential conflicts.

Other lessons learnt from the workshops included:

- a realisation that any perceived conflict of interest can be damaging, even if there is no actual wrongdoing
- commissioning decisions affecting the CCG's own GPs need to be taken transparently so there can be no perceived conflict
- the importance of being proactive in agenda planning, and anticipating potential conflicts of interest in specific areas of the CCG's business
- increased sensitivity where the CCG makes a decision to fund improvements on a GP surgery
- the importance of managing carefully perceived conflicts of interest, where GPs are involved in service redesign.

How can we help further?

To assist CCGs with managing conflicts of interest, we offer:

- **workshops for governing bodies** – a very practical way of working through what good governance means in practice and why it really matters. Tailored to each client, it covers the types of conflicts and how best to deal with them. It also includes working through realistic scenarios that the CCG might face.
- **a review of the CCG's arrangements to manage conflicts of interest** – we review the arrangements that the CCG has in place to identify, report and subsequently manage conflicts. The aim is to provide external assurance and support so that this difficult issue is well managed from the outset.

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Appendix 2
Good Practice in Managing QIPP Schemes

To realise significant efficiency improvements in the NHS over the next few years, CCGs will need to focus on the projects that will deliver the required savings. At the same time, as emphasised by the Francis Report, the quality and safety of services must also be maintained and, in many cases, improved.

Managing the process to deliver both high-quality, patient-focussed health services in a more efficient way is a significant challenge and the QIPP programme is designed to help deliver these combined objectives.

This paper shares current intelligence, taken from our review of QIPP schemes, along with practical advice to assist CCGs with their own QIPP agendas.

Sizing the task: the overview

Before getting into the detail of the QIPP development scheme and monitoring, CCGs need to size up the task before the start of the financial year.

Key questions

- What are the clinical gains that the CCG is trying to deliver through QIPP?
- What is the size of the gap between budgeted QIPP and schemes agreed?
- Is the CCG and its governing body agreed on the amount of savings required?
- What contingency plans are in place should QIPP not be delivered in full?
- How will the CCG monitor the delivery of savings and clinical outcomes for each scheme and how regularly? Are these built into agreements with providers with associated Key Performance Indicators?
- How robust are QIPP plans? Are there project managers for each scheme and a defined project plan and timeline? Are the clinicians and local partners fully engaged?
- Is the CCG and its governing body assured that QIPP plans will contribute to patient safety and not impact negatively on clinical quality?

Engaging the local health economy

There are no quick fixes. The best schemes – those which deliver the optimal cost and quality outcomes – tend to be multi-agency, focus on the whole system and take a number of years to yield outcomes. That is because they focus on doing things fundamentally differently.

Consequently, in order to deliver ambitious schemes that meet their objectives, CCGs need to engage with the local health economy and its key stakeholders to develop schemes which are relevant to the local health context. This requires the commitment of both clinical and support staff. In particular, the time to agree any new schemes and consult with local GPs should not be underestimated.

At the heart of creating any successful transformational change programme is the need for effective sponsors often from multiple organisations and including both health and social care organisations. These project champions need to be engaged at an early stage. It is particularly important that clinical sponsors are identified who can act as advocates of the change programme and speak to other clinicians in their own language.

Key sponsors to engage at an early stage for each project

- Overall clinical sponsor
- Overall non-clinical sponsor
- Project managers for each project strand
- Key representatives from each partner organisation

Case study

Feedback from a successful project in the North West supports the centrality of **clinical engagement**. Their three key lessons for engagement were:

1 A little and often approach to communications is better than just one formal launch
2 Identify your advocates – CCG and local medical committee members are very powerful
3 Clinical engagement with the project is vital

Defining the vision

A key task for delivering a successful scheme is to develop a clear, shared vision of the cost and quality improvements that the project will make and the transformation to patient safety and care. This vision needs to be captured and translated into measurable targets.

Most healthcare organisations already have a number of initiatives underway, including local efficiency projects, patient safety and infection control schemes. To achieve whole system change requires these disparate strands of activity to be brought together into a single coherent vision, so it can be seen how they will help the organisation, or the whole health economy, to deliver the overall objectives.

Partners need to be clear about the various problems they are attempting to tackle in order to develop a clear scope for the project. It is also important that CCG QIPP schemes are co-ordinated, where possible, with provider cost improvement plans.

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Key questions

- What is the compelling need for change?
- Have similar transformational projects worked elsewhere?
- How will partners measure the success of outcomes?
- Is there a clear vision of how the project will produce both cost and quality improvements?
- How are services currently organised and what service configuration are we looking to achieve in future? Which organisations will deliver services and in what setting?
- What is the numerically quantified baseline position and what improvement is required?
- What services, people and functions will be included in the project?
- Are there any project parameters or constraints eg statutory targets, patient safety?
- What are the risks?
- What are the likely timelines for the project and which financial years will improvements be delivered in?
- Who are the key players that will lead the project?

Various approaches have been adopted to develop a shared vision, but the most common approach is a workshop with project leads from each sponsor organisation, to articulate what each wants from the project and work through and agree the wider aims and scope for improvement.

Case study

One organisation, in developing its successful care programme, created a **set of core principles** that was agreed by all partners:

- Service redesign must deliver both cost reduction and safe care
- Financial benefits will be shared across all partners
- Each partner will be held to account for the delivery of the agreed changes
- Redesign will be clinically-led across both primary and secondary care
- Service redesign will be a joint process by providers and commissioners
- Each organisation retains its independence

Developing a project plan

Having defined the project's vision and secured stakeholder and clinical engagement, it is essential to translate this into an operational project plan. All the successful schemes we reviewed featured good project management with clear timelines, deliverables and accountability.

Investment-led projects will clearly have a longer lead time, particularly if they involve the implementation of new IT, buildings or equipment. For very large projects, many health organisations make use of a project manager, or project management office to inject the extra formal discipline the project may need to help orchestrate many complex strands.

Whatever the size of project, or route chosen, all schemes should have a sound implementation plan.

Key elements of an implementation plan

- An identified owner
- Clear milestones and accountabilities
- A detailed sub plan for each sponsor organisation
- A steering group to oversee change
- Adequate resourcing
- Clear articulation about the resources needed from each partner
- A communication plan, with an agreed distribution list and frequency of reporting
- A contingency plan and risk management strategy
- Reporting and monitoring arrangements to track progress in relation to project delivery

Implementation and monitoring progress

Implementing a major project and ensuring that it achieves the agreed vision means that improvements need to be sustained and embedded.

To ensure long-term and sustainable change, the partner organisations need to ensure that change is embedded. The CCG plays a key role alongside its partners in ensuing through its monitoring of activity and review of outcomes that the transformation programme continues to deliver improvements.

Key elements for sustaining progress

- Developing processes to deal with teething problems in the early days
- Regular team meetings to reinforce the new processes and systems
- Sharing progress and success
- Monitoring progress
- Visible leadership

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Case study

One scheme we saw established very clear project **management arrangements**, that involved:

- **A QIPP team for each scheme** that included:
  - a commissioning lead
  - a project management lead
- **Monthly meetings** that covered:
  - performance monitoring with regards to activity and savings
  - milestones updates and RAG ratings
  - assess risks of non-delivery of targets
  - agreed actions for team member to report on at next meeting.

What we have seen so far

In planning our 2013/14 audits we have started to review QIPPs at many CCGs. We have found a wide range of approaches to QIPP and its reporting at governing bodies:

- Variation between detailed reporting of QIPPs in financial reports to one-line summaries, or a brief commentary offering limited information. In these examples slippage in schemes is mentioned but without a clear explanation of the reason or its implication. Given the long-term importance of delivering QIPP, it is essential to give governing body members as much information as possible in relation to achieving planned efficiencies. The largest QIPP schemes we reviewed tended to be related to prescribing, with other large initiatives relating to urgent care and better management of referrals by GPs to secondary care.
- Referral gateway schemes can produce some large efficiencies for CCGs. However some CCGs are reporting delays in setting up such arrangements. These delays have related to issues in obtaining information or ensuring there is full agreement from all parties. Where such schemes have been properly developed, results are already being seen. Gateway schemes are preventing unnecessary referrals to secondary care, with appropriate treatment being provided within the primary care environment and are therefore resulting in savings to commissioners.
- Of 12 CCG QIPP reports we looked at during November 2013:
  - 5 were showing slippage at year to date
  - 4 were reporting uncertainty that how the QIPP target would be achieved by the financial year-end
  - non-achievement of QIPP targets was, in most cases, unlikely to result in failure to hit overall financial targets in 2013/14.

How can we help further?

We are able to support you by:

- sharing best practice from our database of successful QIPP schemes
- working alongside you in developing and implementing your QIPPs
- advising on successful governance arrangements to deliver QIPPs
- assisting you deliver effective programme and project management.

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Appendix 3
Commissioning Support Units

The aim of CSUs is to provide the most efficient and cost-effective way of delivering excellent commissioning support activities. Such arrangements will, in turn, allow CCGs to maximise their investment in frontline healthcare services for communities and improving health outcomes.

What we have seen so far

For some support activities, CCGs have chosen to appoint their own internal teams, while others have used CSUs or other sources of commissioning support, such as existing shared service providers.

The feedback we have received from CCGs in relation to satisfaction with the services provided by CSUs has been mixed. It is clear that CSUs can provide a cost-effective way of support service provision, which is important given the level of running cost budgets at CCGs. However, feedback from CCGs, both at meetings and audit committees, has highlighted some initial concerns, for example in relation to the information being provided by the CSU in relation to financial support and insufficient resource being available to support quality within the CCG

Where the relationship has developed well, the CCG and the CSU have facilitated good communications. For example, one CSU proactively organised a telephone conference with its CCGs, the NHS England internal auditor and the external auditors to instigate an informed discussion that meant the CCGs were fully briefed on the assurances they would receive. A senior representative from the CSU then presented a paper at CCG audit committees where further discussion and clarification took place.

We have also seen different models for service delivery by CSUs. This includes a more centralised approach where the CSU team is based in one building, to one where it is permanently based at the CCG. Both methods have their advantages. However, the CCG needs to have a clear performance monitoring and reporting system to ensure it gets the most out of the relationship with the CSU and such monitoring should be built into the signed service level agreement and supported by regular meetings. It is currently unclear how much planned monitoring is taking place.

How can we help further?

We can assist you further in improving your arrangements with the CSU including:

- A review of how the CCG is performance managing its services from the CSU, for example by considering the clarity and content of the Service Level Agreements and how the CCG is ensuring that it is receiving the quantity and quality of service it is paying for.
- A review of whether the services provided by the CSU represent good value for money by considering user satisfaction levels for the services received and comparing costs to other service providers.

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