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Key issues for Clinical Commissioning Groups

Issue 2

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

Top ten issues

1 **Significant financial pressures.** Deficit budgets have been set in several CCGs and many others are facing significant pressures, often citing problems caused by top-slicing of budgets for specialised service commissioning. NHS England is currently working with Monitor and the NHS Trust Development Authority to provide additional project management support to eleven health economies which have been identified as having particular local challenges. It is designed to help groups of commissioners and providers work together to develop integrated five year plans that effectively address the local challenges. NHS England will appoint an external supplier to act as a critical friend to seek to bring together all partners in the health economy and to test whether the organisations are undertaking their long terms strategic planning in the most effective way. Our local work has also identified pockets of financial pressures in many other areas of the country in addition to the 11 most financially challenged. We have set out in Appendix 1 more detail on good practice financial reporting.

2 **Future funbding formular and underlying deficits in future years.** The new commissioner funding formula was designed to be equitable and fair, and help the most underfunding areas in relation to need. It takes into account population growth, deprivation (including a measure specifically aimed at tackling health inequalities) and the impact of an ageing population. Some CCGs think that the formula and allocations do not address local differences in funding levels fast enough. There is also the perception of winners and losers, as there is less emphasis on the age of populations than had been expected. The proposed top-slice of 2014/15 CCG allocations to cover the costs of continuing healthcare provisions retained by NHS England is also a cause for concern by many at CCGs as the accuracy of these estimated provisions is yet to be proved.

3 **Capacity of CCGs.** There are concerns that management capacity is too stretched to deliver important strategic changed programmes, for example the Better Care Fund. The capacity of some audit committees to effectively fufil their governance role has also been questioned

4 **Concerns about the capability, capacity and value for money of Commissioning Support Units (CSUs).** There are doubts over the capability and capacity of many CSUs. There are also concerns over CSU's ability to meet service requirements in relation to CCG final accounts and control issues raised in internal auditors' reports. More detail was set out on CSUs in the last bulletin

5 **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. Initial problems include difficulty in agreeing deflection rates from hospital activity and subsequent inconsistencies between activity assumptions in providers 'plans and CCGs' commissioning intentions. We will be reviewing the development of the joint plans as part of our VfM conclusion work.

6 **First year preparation of CCG financial statements.** There are concerns over CSU's capacity yand capability in some areas to deliver what they are required to for the 2013/14 accounts. Other teething troubles include:

- questions about the process fro approving the accounts
- significant disagreements to resolve from month 9 agreements of balances exercise
- lateness of the final Annual Reporting Guidance (ARG)

We have set out at Appendix 3 more details on issues in relation to annual reports and accounts.

7 **Provider Trusts.** There are concerns around an increasing number of provider trusts' financial stability and quality of care, as well as over performance against contracts

8 **Delivery of QIPP schemes**. Some CCGs are struggling to deliver planned QIIP schemes. There is some desire to see good practice examples of identifying and managing QIPP schemes more successfully. More detail was set out on managing QIPP schemes in the last bulletin

9 **Patient identifiable data.** Many CCGs are still struggling with the inability to access and use patient identifiable data and the impact in terms of being unable in some cases to confirm patient-level activity, and manage provider trusty contracts effectively

10 **Strategic review and redesign of health and social care services**. These are major issues in many areas across the country, as the need for service transformation has become widely acknowledged.

Exploring further issues

The following issues are explored in more detail:

- Appendix 1 – Good practice financial reporting
- Appendix 2 – Better Care Fund
- Appendix 3 – Annual report and accounts – questions for governing body members

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

Good practice financial reporting

Regular finance reports to the CCG governing body are a key component of effective financial management, governance and accountability. Further, their quality is critical in supporting sound decision making. We carried out a review of monthly financial reporting in 24 CCGs across various key financial performance indicators and found a degree of variation.

What we have seen so far

- **Revenue resource limit** – all finance reports showed the current in-year revenue position and made reference to the forecast year end position. Not all finance reports made explicit reference to the RRL and likely outturn against it, while others relegated the performance to the appendix
- **Cash flow forecast** – over half of CCGs did not show the current cash position in their monthly report. It is good practice for CCGs to report the cash flow forecast, even if there are no issues
- **Running costs** – very few CCGs provided detailed reporting with reference to the annual allowance and two CCGs made no reference to running costs. Good practice reports included a table showing running costs and performance against this £25 allowance
- **Better payments practice code (BPPC)** – the BBPC shows the CCG's performance in paying its bills within 30 days. Poor performance against the BPPC could indicate issues with the underlying financial processes. Only half of CCGs reported BPPC performance
- **Risks to achieving financial targets** – good quality reports quantified the risks together with probabilities of the risk occurring and different scenarios considered
- **Actions taken to manage risks** – 42% of reports did not include detail on the actions taken to manage identified risks. For a governing body to assess the effectiveness of the actions taken, finance reports should include the actions being taken to address the identified financial risks
- **Statement of financial position** – only 30% of reports included a statement of financial position. While CCGs generally hold fewer assets and liabilities, the governing body may still find a balance sheet update useful to identify trends and movements in the overall net worth of the CCG. CCGs could consider a quarterly update if a monthly update is not realistic
- **QIPP performance** – almost all (88%) included a section summarising QIPP performance. Good practice financial reports included red-amber-green ratings, demonstrating the progress on delivery of QIPP, and explicit statements demonstrating the link between QIPP delivery and the impact on the overall financial position
- **Reporting style** – a wide variety in the amount and style of narrative is used; some appeared very brief, while others contained significant amounts of narrative. A small proportion (17%) contained no graphical representations of key aspects of financial performance. As governing body members will have varying experience and knowledge of finance, graphical representations can be an accessible way to present financial information

Good practice

Examples of good practice CCG financial reporting included:

- integrated finance, performance and quality reports that clearly demonstrate the links between performance and financial impact
- a user-friendly front page summary aimed towards non-finance members of the governing body
- red-amber-green and 'direction of travel' graphics to illustrate relative performance and trends
- key finance performance indicators which clearly show comparative benchmarks with other CCGs and over time
- a glossary of key terms and acronyms for newer governing body members.

Key questions to ensure financial reporting meets good practice

- Does your financial report set out clearly:
  - the year-end expenditure forecast against the RRL?
  - the cashflow forecast?
  - the statement of financial position?
  - the performance against the running costs target?
  - how the running costs are broken down between the CCG and the Commissioning Support Unit?
  - the performance against the BPPC?
  - the financial risks faced by the CCG and the actions being taken to address them?
- Does your financial report provide you with a clear understanding:
  - of your QIPP performance and the progress made?
  - of the link between QIPP delivery and the impact on the overall financial position?
- Does your financial report provide you with an understandable overview of your financial position?
- Would the governing body welcome training to help them understand the financial reports?

How can we help further?

Where required, we can assist you by reviewing your financial reporting arrangements.

Appendix 2

Better Care Fund

In June 2013, the Government announced that it would transfer £1.1 billion to social care in 2014/15, building up to a £3.8 billion pooled budget in 2015/16. The aim is to ensure that health and social care services work more closely together and stimulate transformation of services to improve health and social care outcomes through integrated care.

The fund should align with the local joint strategic needs assessment and be an integral part of the CCG's five year strategic plan and two year operational plan.

Although the legislation under which funds are pooled is not new, the Better Care Fund (BCF) and supporting requirements are. The time available from introducing the requirements to having plans in place is challenging, limited and comes within the first year of CCGs' existence. The BCF does not bring new additional funds into the health and social care system, rather it typically reallocates funds that were previously allocated to the NHS.

BCF plans must be joint and will include at least one local authority and one CCG. In some areas the arrangements will be more complex than others, and will include a number of local authorities with adult social care responsibilities, a number of CCGs and possibly more than one NHS provider.

The first requirement was for draft plans to be agreed by local HWBBs by 14 February 2014, prior to review by the NHS England Local Area Teams. Final plans should be agreed by the HWBBs and submitted to NHS England by 4 April 2014.

What we have seen so far

Early messages from Grant Thornton's current assessment of local arrangements to establish BCF plans are:

- **HWBB approval** – the draft plans we have seen have been agreed by local HWBBs, as required
- **Scope of plans** – early indications are that the draft plans are very high level strategic plans, which set out the vision and aims up to 2018. However, they tend to lack detail, both financial and operational, as to what is required in practice to meet these aims. There are, however good signs that organisations are developing more detailed plans for the 4 April submission
- **Level of involvement** – The level of involvement of different organisations is varied and most joint plans show good evidence of collaboration between CCGs and local authorities providing social care. Whilst we have seen good examples of where CCGs and local authorities are clearly aware of the need to involve acute providers, evidence of actual involvement and buy-in to date of NHS providers is less apparent. Effective involvement of providers is vital to reach shared understanding of proposed deflection from hospital based activity.

  However, since January 2014 NHS providers' involvement has increased and is being demonstrated through:
  - attendance at, and participation in HWBB discussions
  - the use of existing arrangements, such as urgent care forums to engage providers
  - structured formal consultation with providers
- **Partnership working** – The BCF relies on effective partnership working. The areas where more proactive and innovative approaches are developing tend to be those where existing working relationships are already good and there is evidence of previous close joint planning
- **Funding levels** – The amount of funding included within the BCF varies. Minimum levels have been set for the BCF, but some areas have announced that they intend to include up to the whole of their adult social care budget and increase the amount of contribution from the CCG above the prescribed minimum amount
- **Demonstrating performance improvements** – Initial requirements were that access to BCF allocations would be based on areas demonstrating improvements in performance against national and local metrics. The performance related element of this requirement for 2015/16 has now been relaxed. However, effective planning and performance management against expected outcomes will still be key to achieving the future aims of the BCF, and is needed to help prepare CCGs for the likely future reintroduction of performance related measures. Some local areas are not yet clear how they will monitor performance and have yet to establish key performance indicators

What needs to be done?

In order to reduce and manage the risks relating to the BCF, CCGs need:

- **detailed financial plans** aligned to activity assumptions – CCGs and local authorities need to develop aligned financial and service plans so that it is clear how demand will be managed and met, including how deflected activity from hospitals will be met from community based capacity, and the impact understood
- **robust implementation plans to be in place** – without these, the strategic vision is unlikely to be achieved
- **the involvement of providers** – given the expected significant impact on providers' future plans, it is vital that they are fully involved in the planning process
- **effective performance management based on SMART KPIs** – without this the likelihood of achieving the required outcomes will be slim.

How can we help further?

To assist CCGs in further developing their BCF planning arrangements, we can:

- share our knowledge of good practice and innovative BCF projects
- review the effectiveness of partnership arrangements
- review performance management arrangements.

Appendix 3

Annual report and accounts – Questions for governing body members

CCGs are now nearing the end of their first year and will be producing their first draft annual report and set of accounts in April. In early June 2014 governing bodies will be meeting to approve the annual report and accounts. There will be significant challenges for CCGs and differing levels of input from CSUs.

The annual report and accounts allow CCGs to demonstrate their stewardship of public money. They summarise and report on the CCG's activities during the period up to 31 March. The form and content of the annual report and accounts must meet the requirements of the Department of Health's manual for accounts and is achieved by following NHS England's annual reporting guidance.

A CCG's annual report and accounts must contain:

- an annual report, including a remuneration report
- a statement of the accountable officer's responsibilities
- a governance statement
- a foreword to the accounts, which states the accounts have been prepared as NHS England has directed
- four primary financial statements
- notes to the accounts
- a report and opinion from an independent auditor.

The governing body has an important responsibility to approve the annual report and accounts for submission to NHS England, as well as its wider publication. In approving the annual report and accounts, the members of the governing body confirm that the documents appropriately and comprehensively present the CCG's activity, income and expenditure, and financial position.

How can we help further?

Grant Thornton audit teams work with their CCG audit clients to agree, working paper requirements. And we are always happy to talk through with any governing body members the implications for their CCG of the issues set out in this document.

Grant Thornton has also worked with the HFMA to produce an accounts guide for CCG governing bodies. This is designed to explain and demystify the accounts and financial reporting responsibilities and requirements for non-accountants. We are also running Spring seminars across the country to go through accounting and governance issues facing CCGs with members of their finance teams.

Key questions for governing body members to ask when reviewing the annual report and accounts

- Have you been allowed sufficient time that any questions you may have can be responded to before you have to approve the final annual report and governance statement?
- Are you satisfied that there is a properly resourced plan that will allow accurate completion of the required statements and reports to the appropriate timetable?
- Are the draft annual report and governance statement consistent with your knowledge of the activities of the CCG?
- Do the year-end accounts show a financial position that is consistent with what has been reported to you throughout the year? In particular:
  - the reported performance against the CCG's resource limits. If the CCG has exceeded its target spend do you understand why that is and the resulting consequence?
  - the CCG's running costs against its target
  - the reported percentage of NHS and non-NHS invoices paid within a target number of days. If performance is below 95% do you understand why. (Problems with access to patient identifiable data may result in a number of CCGs failing to make this target this year for NHS invoices.)
- Do the annual report and accounts accurately disclose the CCG's interests and remuneration?
- Varying the accounting policies requires approval by NHS England and can result in very different financial results. Are you satisfied that the accounting policies used are those set by NHS England?
- In this first year of the CCG's accounts, with no comparisons, it may be difficult to gain an initial understanding of the figures within the statement. Do you understand why receivables (money owed to the CCG by a third party at 31 March), payables (money owed by the CCG to a third party at 31 March) and provisions shown in the statement of financial position are at the level reported?