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Key issues for Clinical Commissioning Groups

Issue 3

Our third briefing paper summarises the current key issues facing the sector and the solutions being adopted across the country, drawing on sector insights as the external auditor to around 40% of clinical commissioning groups (CCGs)

Top ten issues

Many of the issues from our last bulletin remain. Co-commissioning of primary care and data quality are new entries and financial pressures have increased in significance

1 **Significant financial pressures.** Nineteen CCGs (9%) reported an overspend against allocation in 2013/14 and a greater number are reporting potential overspends in 2014/15. Unexpected increases in charges for property and top-slices for legacy continuing healthcare are putting additional pressure on CCGs. NHS England is currently working with Monitor and the NHS Trust Development Authority to provide additional project management support to 11 health economies which have been identified as having particular local challenges. It is designed to help groups of commissioners and provider work together to develop integrated five year plans that effectively address local challenges. NHS England has appointed an external supplier to act as a critical friend to bring together all partners in the health economy and to test whether the organisations are undertaking their long-term 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 set out in our second bulletin more detail on good practice financial reporting.

2 **Capacity of CCGs.** CCGs have concerns that management capacity is too stretched to deliver important strategic change programmes. The capacity of some audit committees to effectively fulfil their governance role has also been questioned by some CCGs. In other areas we have noticed issues around the capacity in finance teams, with difficulties in permanently filling senior posts

3 **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. We are increasingly seeing more CCGs bring services in-house, such as business intelligence, and also start to consider and plan how services which are currently being provided by a local CSU will be commissioned in future. More details was set out on CSUs in our first bulletin

4 **Better Care Fund**. 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. New guidance, issued in July 2014, puts a clear focus on the need for CCGs to set target reductions on total emergency admissions, which is linked to the pay-for-performance fund. The guidance also emphasises:

- the continued importance of monitoring and managing against national and local metrics, although no payments will be linked to the metrics
- the requirements to discuss projected non-elective volumes with providers, who in turn will comment on those projections with reference to their own two year plans

Plans need to be resubmitted by 19 September 2014. We reviewed the development of the original joint plans as part of our VfM conclusion work. We have also helped facilitate a research workshop with HfMA West Midlands, and the highlights from this are reported at Appendix 1

5 **Provider Trusts.** There are increasing concerns around a number of provider trusts' financial stability and overall performance against contracts. Concerns have also been raised in relation to the quality of care and performance, such as difficulties achieving the four hour waiting time target for Accident and Emergency. There are also issues surfacing on transferring care, currently provided in an acute setting, into the community, in part from a lack of alternative facilities

in the community. Not surprisingly, these issues are translating into relationships difficulties in some areas.

6 **Delivery of QIIPs schemes.** Some CCGs continue to struggle to deliver planned QIPP schemes. There is some desire to see good practice examples of identifying and managing QIIP schemes more successfully. More details on managing QIPP schemes and ways in which we can assist were set out in our first bulletin.

7 **Data Quality**. Some CCGs have raised concerns about the quality of data they are receiving from trusts they commission from and the difficulties this presents in managing their contracts effectively. More worryingly, there are increasing concerns at CCGs that trusts are engaging in 'gaming' which increases costs at the CCG.

8 **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. Examples of such reviews are the Worcestershire Joint Services Review and the Healthier Together review in Greater Manchester. There are proposed changes to A&E, acute medical and general surgery, including a smaller number of specialist trusts providing emergency and high risk general surgery across Greater Manchester

9 **Co-commissioning of primary healthcare**. NHS England wrote to all CCGs in England with details of how to submit expressions of interest for taking on enhanced powers and responsibilities to co-commission primary care. Applications need to be made in June, and describe the additional powers and responsibilities the CCG would like to assume. They needed to meet a number of tests, including showing they will help advance care integration, raise standards and cut health inequalities in primary care. They also need to demonstrate how they will ensure transparent and fair governance – all in the context of the CCG's five-year plan. We have noted a large difference in expressions of interest, with significant interest in many areas and little in others. Many CCGs we have spoken to have enthusiastically put forward proposals on co-commissioning which fit well with their strategic ambitions.

10 **Governance reviews**. Most CCGs have either carried out, or are considering carrying out, a review of their governance arrangements. Some are completing their reviews in-house, while others have considered the benefits in an external view. Our governance review process offers objectivity, insight and best practice.

First year of preparation of financial accounts

The first year of preparing financial accounts was an important issue at all CCGs in 2013/14. In anticipation of this, we issued a joint publication with the HFMA to help non accountants understand CCG financial statements. Audited accounts were submitted in early June. The preparation was challenging this year, not only because it was a first year, but also because of national issues such as availability of clear guidance. While it was pleasing that no CCG accounts opinions were qualified, 10% of CCGs received a qualified regularity opinion, 18% of CCGs had matters reported regarding their Value for Money conclusions and 11% of CCGs were referred to the Secretary of State, mainly for breaching their Revenue Resource Limit.

Please contact us if you wish to receive a flier providing further detail on our experience from this first year of CCG external audits

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Appendix 1

Better Care Fund research workshop

Background

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 and comes early in 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.

A total of 151 local area BCF plans were agreed by local health and wellbeing boards (HWBs) by 4 April 2014. On the 5 July 2014 the Department of Health announced in a press release that more than 80% of the BCF plans are on course to transform 'out of hospital' services. Linked to this was a requirement to reduce avoidable emergency admissions by 3.5%.

The plans have huge implications for the way in which health and social care will be commissioned and provided in future. For NHS trusts, the plans have identified the intended activity/operational impact, such as a 10% reduction in avoidable emergency admissions and 20% (2 day) reduction in the non-elective length of stay, but have not assessed the financial impact on the Trust.

Learning from the research workshop

Grant Thornton and the HFMA West Midlands branch ran a research workshop to share knowledge on the arrangements being put in place for the Better Care Fund in different health economies.

The workshop included representatives from local authorities, NHS commissioners and providers, as well as members of the Grant Thornton team who had experience in this area.

A range of issues were explored, including:

- governance arrangements
- formal agreements
- risks and risk sharing
- budget hosting arrangements
- provider engagement
- other engagement
- finance issues
- performance management.

The detailed paper of the workshop discussions, published in July 2014, is available from the HfMA website. Our team of experts in the sector are also available to meet with your health and wellbeing board to run through the learning from this event.

Since the workshop, Grant Thornton has undertaken further research and will be releasing a national report on the BCF in Autumn 2014.

While this is a complex area with different views and differing arrangements in place across health economies, there are, however, still significant opportunities to learn from the experiences of others. We have a range of tools to help health and wellbeing board develop their arrangements. These include:

- our board effectiveness self-evaluation tool to review the effectiveness of partnership arrangements and HWBs. This can help track progress over time and also compare with other HWBs
- our relationship survey tool to map the relationships across the partners in the Better Care Fund and identify weaknesses or gaps in relationships that are critical to the success of the plans
- our CEO room that provides dedicated thinking space and a facilitated 1-2-1 discussion with the key partners on the HWB to help them focus on their crucial leadership role
- our health analytics capability to map health determinants and health outcomes to ensure the plan is focussing on initiatives that will make a difference to the local population

What do you need to do now?

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

- develop robust implementation plans based on detailed financial plans
- ensure NHS providers understand the impact, both financial as well as operational. Plans needs to be in place which will first reduce activity and then reduce costs
- evaluate the HWB governance arrangement to ensure that CCGs are able to influence, but also to ensure the HWB is effective and able to add value

- ensure that NHS providers, both acute and specialised such as mental health are engaged in the process
- develop effective performance management based on SMART KPIs which will monitor outcomes and operational delivery.
- assess what further support you need to maximise the effectiveness of the HWB.

Appendix 2

First year audit of CCGs

Introduction

The production of a statement of accounts is one of the main ways that CCGs demonstrate their accountability to stakeholders for the stewardship of considerable sums of public money. Producing and submitting audited accounts on time with an unqualified opinion reflects well on the financial management arrangements of a CCG and provides assurance and accountability to the governing body and external stakeholders, such as the Department of Health and NHS England.

This was the first year that CCGs produced accounts and the fact that all CCGs submitted accounts on time and received an unqualified "true and fair" audit opinion is a very positive outcome.

This paper provides an assessment of the first year of audit and draws out lessons learnt to help improve the process in future. It also references, where necessary, the Audit Commission's report 'Auditing for Accounts-NHS bodies' which is available on the Commission's website.

Key messages on audit of accounts

The timeliness of submissions was excellent. All CCGs met the deadline for submitting their draft and audited accounts to NHS England.

The quality of CCG accounts, when judged by changes to net expenditure, was generally good. CCGs made net adjustments of less than 1% between their draft and audited accounts. There was scope to improve disclosure notes in many CCGs. Auditors at around 18% of CCGs issued an 'other matter' paragraph in their reports in relation to disclosures within the remuneration report relating to pensions benefits of GP senior managers.

Nationally:

- 21 CCGs received a qualified regularity opinion. Of these, 19 were due to breaches of the revenue resource limit
- auditors referred 24 CCGs to the Secretary of State during the year, mainly due to the financial position
- auditors reported matters arising in respect of arrangements for VfM at 38 CCGs (18%). The vast majority of these related to: CCGs breaching their revenue resource limit; setting a budget deficit in 2014/15; concerns over controls only operating for part of the year at the CCG; the CSU supporting the CCG; and where authorisation conditions imposed by NHS England were still in force.

Main issues identified by Grant Thornton

A number of CCGs had not received all the information necessary to allow them to include all the required pension-related benefits for GPs identified as senior managers disclosure in their remuneration report. This resulted in a failure to comply with the annual report requirements set by NHS England and auditors having to report "other matters". The incomplete disclosures were primarily due to relevant information not being received from the NHS Business Services Authority Pensions Division by the submission deadline. The process was further complicated by the late issue of guidance in NHS England's Annual Reporting Guidance(ARG).

We noted errors in several CCGs' remuneration reports caused by a failure to check the figures in these reports. Auditors typically apply a much lower level of materiality to the figures due to the sensitivity of this information. This was resolved by amending the remuneration report within the annual report.

The area which consumed the largest amount of audit effort was auditing NHS contracting payments. This is not surprising given that it typically accounts for a large percentage of CCG expenditure. There was a large difference in the quality of working papers produced by CCGs to support this expenditure. We will share good practice examples with our CCG audit clients as part of the 2014/15 planning process to help reduce the amount of time taken by both CCGs and auditors.

There was some confusion around the accounting treatment for lead commissioning arrangements and how IAS8 (changes in accounting policies) should be applied. We were able to assist several CCGs to get this right in 2013/14.

Many CCG statement of accounts would have benefitted from a high level review and sense check prior to submission. Implementing this would have eliminated some of unnecessary changes we found such as:

- lack of tailoring of the accounts and accounting policies for a particular CCG's circumstances, for example the inclusion of notes and accounting policies on areas such as PFI when there were none
- errors in formatting and reference numbers and missing figures in notes
- figures in notes not casting or agreeing to the main statements.

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Many CCGs told us that some of the guidance from NHS England in the first year was later and less clear than they had hoped for. At a national level, while the audits were on-going we liaised with the Audit Commission and, through the Commission, NHS England, to help facilitate the publication of additional guidance on matters arising. This included the contents of the remuneration report, the financial duties note, continuing care provisions and partly completed spells. We will continue to liaise with the Audit Commission to help identify and suggest further improvements for the 2014/15 audit and will seek to establish direct technical lines of communication with NHS England when the Audit Commission closes in March 2015.

Assisting CCGs in the first year of producing accounts

To help our CCG audit clients to minimise the impact of risks in the first year, we:

- ran regional accounts workshop before the year end
- provided a copy of our guide to CCG accounts published jointly with the HFMA
- discussed technical issues early
- shared information from the Audit Commission and NHS England as we received it
- held regular meetings and shared working paper requirements before the year end.

Planning for 2014/15 accounts

Planning for the preparation of CCGs' 2014/15 financial statements should begin now, starting with a review and assessment of the whole process for 2013/14. To assist with this, we will run final accounts workshops early in 2015 and will continue to work with the HFMA to identify any updates and further support that might help CCGs. We will also issue model working paper requirements based on the experience of what worked both well and less well in the first year.

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