

Key issues for clinical commissioning groups

October 2015 – Our sixth briefing paper summarises the current key issues facing the sector and the solutions being adopted across the country, drawing on sector insight as the external auditor to 35% of the clinical commissioning groups (CCGs)

We have been discussing many issues with our clients recently which fall in to the following three categories:

- 1 **Emerging issues** – which have emerged during 2015 and have risen in importance
- 2 **Stubborn issues** – which have existed from when CCGs were established and have refused to go away
- 3 **Issues on the horizon** – which we are discussing at some clients but are likely to grow in importance in the future

Emerging issues

Co-commissioning of primary healthcare

NHS England gave CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015. This was one of a series of changes set out in the 'NHS five year forward view' and is potentially a key enabler in developing integrated out-of-hospital services based around the needs of local populations. It also potentially drives the development of new models of care such as multispecialty community providers and primary and acute care systems. The document 'Next steps towards primary care co-commissioning' provided three models CCGs could take forward:

- 1 greater involvement in primary care decision-making
- 2 joint commissioning arrangements
- 3 delegated commissioning arrangements.

Sixty-four CCGs were given full approval on their applications for delegation, while a further 87 CCGs have been approved for joint commissioning.

Conflicts of interest will need to be carefully managed and a national framework for conflicts was published as statutory guidance in December 2014.

Where CCGs have taken on additional responsibility we have seen new governance arrangements develop to help minimise the risk from conflicts of interest. One example is the development of primary care commissioning committees as a sub-committee of the governing body, with meetings open to the public. Other CCGs have revisited existing arrangements to ensure they

are sufficiently robust in light of the additional responsibilities.

We have helped CCGs through our conflict of interest workshops which have proven a great way of preparing for ways to deal with this risk.

The challenges we have seen in primary care co-commissioning to date include:

- management capacity due to the need to restructure and build skills and knowledge in the CCG team
- relationships with the membership when the CCG is managing the performance of GPs and resolving any conflicts of interest
- reflecting the inherent risk in primary care budget within financial plans.

New models of delivery

Commissioners have to balance many competing requirements, one of which is the need to fulfil the vision of the 'Five year forward view' and is a core requirement throughout the 2015/16 planning guidance. CCGs were given the opportunity to bid for funding from NHS England to develop and co-design new models of care, creating one of three prototype models.

There was considerable interest with more than 260 organisations applying. In March 2015, NHS England announced 29 vanguard pilots for developing and co-designing new models of care. The different organisations within each pilot need to work more closely, share patient information and remove the need for repeated health assessments. The chosen pilots involved three prototype models:

- 1 **Integrated primary and acute care systems (PACs)** will bring together GP, hospital, community and mental health services. Money will be directed from a joint budget to wherever patients are judged to need it most. One example is the Salford Together Partnership which includes the local CCG, city council and the local acute and mental health foundation trusts. There is also support from the local GP provider consortium
- 2 **Multispecialty community providers (MCPs)** will bring specialist services – such as chemotherapy and



dialysis – out of the hospital and closer to people's homes in parts of the country where this is considered useful for patients. This includes the Vitality Partnership which operates across Birmingham and Sandwell and aims to develop a health and social care system accessible through GP practices

- 3 **Models of enhanced health in care homes** will enable the NHS and councils to work together to provide more healthcare in care homes provide better preventive services in the home.

In May and June two further phases of the programme were announced, inviting expressions of interest from organisations and partnerships across England to become vanguard sites for a further new care model focusing on urgent and emergency care (UEC) and acute care collaboration. The successful pilots were recently announced.

We are currently assisting CCGs in many aspects of this process, including the development of a vision and plan for all the organisations involved as well as a financial model. Organisations are identifying learning points all the time and these include the increasing need for new governance arrangements to be developed. As the vanguard schemes are established there may be a challenge in having two different models of care being commissioned and delivered by the CCG. A further challenge is that the development of the vanguard schemes is taking place at the same time as other major developments, for example devolution.

Governance

It is fair to say this has been a staple issue since the creation of CCGs and most CCGs have carried out some form of review of their governance arrangements typically at the end of their first year. However we have seen this emerge recently as a much more significant issue due in part to the attention afforded it by NHS England and the extension of the 'well led' framework to CCGs. We have consequently seen a large upsurge in CCGs asking for help in this area. Our own governance review process has provided many CCGs with objectivity, insight and best practice. Earlier this year, we published our fourth annual [NHS governance review](#) which summarises our conclusions on the current state of NHS governance and includes good practice from our client base.

Stubborn issues

Financial pressures and underlying deficits in future years

NHS England reported that CCGs underspent allocation by £151m in aggregate, but it was not split evenly across the country. This underspend occurred because £156m of planned spending on continuing healthcare claims that was to be made in 2014/15 was moved to future years and payments to CCGs under the quality premium scheme were £66m lower than planned. If these non-recurrent benefits are excluded, there was a small net overspend in 2014/15 in the CCG sector.

A greater number of CCGs are reporting potential overspends in 2015/16, some of which are significant. However, most CCGs produced a better outturn than budget and the large majority of CCGs (around 80%) are still reporting a balanced position in 2015/16, albeit with a heightened risk than last year.

The picture is still much better than in provider trusts where 47% made a deficit in 2014/15 and 63% are forecasting a deficit in 2015/16. The position is also variable nationally, being worse in the Midlands and Eastern Region and better in London. We set out in our [second bulletin](#) more detail on good practice financial reporting. Many CCGs continue to struggle to deliver planned QIPP schemes. Typically in 2014/15 we have seen around 20% of QIPP schemes remaining undelivered while in some cases QIPP delivery was only achieved through non-recurrent means. This non-delivery is increasing financial pressures in 2015/16.

CCGs have responded to the QIPP challenge by bolstering project management capacity and putting greater emphasis onto the real engagement of clinicians. There is some desire to see good practice examples of identifying and managing QIPP schemes more successfully. Some CCGs have highlighted that QIPP has previously been seen to be a 'finance issue'. A key development this year has been the wider involvement of the CCG as a whole to identify and deliver individual schemes. We have also seen an improvement in project management capacity to deliver schemes. More detail on managing QIPP schemes and ways in which we can assist were set out in our [first bulletin](#).



Capacity and ensuring commissioning support services are high quality and deliver value for money.

The demanding agenda CCGs are managing means that their overall capacity is being stretched. CCGs are therefore investigating options to address this capacity gap by considering using the legislative reform order to create 'mergers' or 'joint committees'.

CCGs report differing experiences with their clinical support units (CSUs). A large number of CCGs are still questioning whether CSUs are providing the services they require at the right price, particularly in relation to support provided in continuing healthcare and business intelligence. Furthermore the lead provider framework announcement in February 2015 has resulted in a number of CCGs having to look for new commissioning support services. We are seeing some CCGs bring services in-house while others are re-negotiating contracts or performing service reviews as they decide what to do next. The lead provider framework developed by NHS England went live from February 2015 and [our fourth bulletin](#) set out details on what CCGs should be doing and how we can help. All CCGs now have to reach a decision on their 'make share buy' options around commissioning support services.

Integration and the Better Care Fund

The challenge remains to make the plans work by building positive working relationships between CCGs and Councils at a local level. We have used our unique position of working with both CCGs and local government to facilitate discussions to assist the process of both building relationships and reviewing plans to manage the transition from existing arrangements to more integrated relationships in a number of areas. The Integrated Personal Commissioning (IPC) programme was set out in October 2014 and went live in April 2015 with the first wave of nine demonstrator sites – such as Tower Hamlets – enabling over 10,000 high-need services users to gain control of their own integrated health and social care budgets.

Accounting for the Better Care Fund could create some fairly complex accounting and governance issues and we will continue to assist you in working through these.

Provider trusts

Concerns continue to grow on the financial stability and performance against contracts of provider trusts. At some trusts very significant deficits are emerging. Not surprisingly, these issues are translating into relationship difficulties in some areas. In addition CCGs are also expressing concerns on the quality of care and performance, such as difficulties achieving the four hour waiting time target for accident and emergency. Many CCGs have raised concerns over the quality of data they receive from the trusts they commission and the uncertainty this presents in managing the contracts.

Issues on the horizon

Devolution

With firm devolution plans in place in nine geographical areas covering a wide range of services, including: health and social care; transport; housing investment; and skills and with more deals to follow, we focus on two of the more advanced devolution areas of Greater Manchester and Cornwall. Both of these 'devolution deals' include health and social care and are therefore of great interest to many CCGs looking to maximise working with local partners.

Greater Manchester – The devolution deal in relation to Health and Social Care within Greater Manchester continues to develop. Health leaders in the region are developing a Strategic Sustainability Plan which will demonstrate how they will deliver improved and sustainable services for Greater Manchester. At the same time the Government has pledged that this will be aligned with the Spending Review process for health and social care. The main advantage of this alignment is that it will enable more certainty to funding levels for health and social care for a longer period than currently known. July also saw the signing of a major agreement to create a single leadership for public health across Greater Manchester, with a real focus on preventative and targeted work to keep the population healthy. A Memorandum of Understanding (MoU) was published between Public Health England, the Association of Greater Manchester CCGs, the Greater Manchester local authorities, NHS England, local NHS Providers and the blue light services within Greater Manchester. The MoU was designed to complement the wider devolution deal and sets out how public health leadership can come together to re-focus the health and social care system towards prevention and early intervention.



Cornwall – In July Cornwall became the first rural authority in the country to be offered a devolution deal. The Cornwall Devolution Deal, which was signed by the Secretary of State for Communities and Local Government; the Leader of Cornwall Council, the Chair of the Cornwall and Isles of Scilly Local Enterprise Partnership and the Chair of NHS Kernow CCG, gives Cornwall greater powers over public sector funding including on health and social care.

The deal sets out that local partners will work with the Government, NHS England and other national partners to co-design a business plan to move towards integration of health and social care across Cornwall and the Isles of Scilly bringing together available local health and social care resources to improve outcomes for the local population. The deal does also highlight that NHS England and local organisations will remain accountable for meeting the full range of statutory duties.

The future of clinical commissioning and collaborative commissioning

How clinical commissioning will look going forward is a key issue. Specialised commissioning and co-commissioning are already impacting on how CCGs operate. New care models are seen as an opportunity to address existing barriers and will change how services are commissioned. The drive to focus on whole pathways of care and outcomes based commissioning aim to transform the way services are provided. All this will change the way services are commissioned and will require CCGs to have the skills, capacity and structures to meet the challenges.

Many CCGs will be involved in changes in specialised commissioning. Currently NHS England is responsible for commissioning 147 specialised health services in England and spending £14 million. These are commissioned by four regions e.g. Midlands and East. The Five Year Forward View talked about specialised providers developing networks of services over an area, integrating services around patients, using innovations such as prime contracting and delegated capitated budgets. For example in cancer, chemotherapy, support and follow up care could take place in local community hospitals or primary care. This process, referred to as collaborative commissioning, should improve patient experience and access to services. These new collaborative arrangements will be co-designed with CCGs but CCGs will be able to choose how much involvement they want in the local sub-regional collaborative committees and are not required to invest additional funding. 2015/16 will be a developmental year and whereas there are plans to transfer funding and services back to CCGs in the next two years, this is only in a few specialities. Over the longer run there will be a move towards population accountability and lay the basis for “place” based on population budgets which will improve financial incentives and reduce demand.

Provision of GP services

Due to the many challenges effecting primary care services including reduced funding, workforce recruitment, CQC inspections and increased demand caused by amongst other things an ageing population with increased multiple morbidities, many GP practices and CCGs are considering whether current structures are appropriate going forward. This has generated an increased interest in new models of working across boundaries as discussed earlier but it has also lead to the creation of GP federations in many areas. Many of these federations have had financial and other support from the host CCG. There has been a merger which has created one particularly large GP practice with over 35 practices in Birmingham. Grant Thornton have been assisting some of the larger practices and federations in many areas of their activities.

Financial accounts in 2014/15

In 2014/15, the deadline for submission of audited accounts was brought forward to 29 May 2015. Despite this the process went very well and all our CCGs submitted both draft and audited accounts by the deadline. However nationally six missed the deadline for submission of audited accounts. The quality of the accounts submitted was a real improvement on previous years. All CCGs received an unqualified opinion on the financial statements.

While it was pleasing that no CCG accounts opinions were qualified, 10% of CCGs received a qualified regularity opinion, 15% of CCGs had received a qualified value for money conclusion and 11% of CCGs were referred to the Secretary of State, mainly for breaching their revenue resource limit. Appendix 1 sets out our experience from this first year of CCG external audits.

HMRC are reviewing all CCGs. Are you compliant?

Over the past 12 months HM Revenue & Customs (HMRC) have carried out sample reviews at CCGs looking at payments made to Governing Body members, Clinical Leads, Practice Representatives and others. Failure to account for tax and national insurance contributions puts CCGs at risk as well as breaching Treasury guidelines. We have been advised by HMRC that, over the next 12-18 months such reviews will be carried out at all CCGs. If you would like some more background information and some initial advice please speak to Peter Minchinton on 01908 359633.



Department of Health/HFMA guidance on auditor panels

The Local Audit and Accountability Act 2014 brought in significant changes to the local public audit regime in England, including replacing centralised arrangements for appointing external auditors to clinical commissioning groups, NHS trusts and local government bodies with a system that allows each body to make its own appointment. The Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 were laid in January 2015 and came into force on 1 April 2015. They aim to ensure that there is appropriate scrutiny and oversight of the health service body's relationship with its external auditor.

On Wednesday 30 September 2015 the Department of Health published guidance – jointly prepared with the HFMA – advising NHS trusts and CCGs on meeting their statutory duties in relation to auditor appointments under the Local Audit and Accountability Act 2014. The guidance confirms that 2017/18 will be the first year for which auditor panels will appoint the external auditor at NHS trusts and CCGs. Some smaller local government bodies will also appoint their external auditor from 1 April 2017 with larger local government bodies appointing from 1 April 2018.

The guidance explains the legal requirements in relation to auditor panels and gives advice on how CCGs can fulfil their responsibilities and summarises the regulations which state that:

- an auditor panel member may receive remuneration
- the quorum is two members or 50% of the membership of the panel (whichever is the greater)
- the auditor panel should advise the health service body on the purchase of non-audit services from the auditor
- an auditor panel must have at least three members, including a chair who is an independent non-executive member of the health service body's governing board/body
- the governing board/body must assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement.

As appointments for 2017/18 must be made by the end of 2016, your auditor panel needs to be in place early in 2016 so that it can fulfil its responsibilities in relation to the procurement and appointment of auditors.

Contacts

Rhiannon Williams

Director, Healthcare Advisory Services
T 0207 728 3267
E rhiannon.e.williams@uk.gt.com

James Cook

Director, National Commissioner Lead
T 0121 232 5343
E james.a.cook@uk.gt.com

Simon Hardman

Public Sector Assurance
(North)
T 0161 234 6379
E simon.hardman@uk.gt.com

Peter Barber

Public Sector Assurance
(South West)
T 0117 305 7897
E peter.a.barber@uk.gt.com

Sarah Ironmonger

Public Sector Assurance
(London and SE)
T 01293 554 072
E sarah.ironmonger@uk.gt.com

Terry Tobin

Public Sector Assurance
(Bulletin Editor)
T 0121 232 5276
E terry.p.tobin@uk.gt.com

Final accounts key issues

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 paper summarises the lessons learnt from the production of the 2014/15 accounts.

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 public money. Producing and submitting audited accounts on time with an unqualified opinion reflects well on their organisation's financial management arrangements and provides assurance to the governing body and external stakeholders, such as the Department of Health and NHS England.

This was the second year that CCGs produced accounts and the fact that 98% of 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 second year of audit and draws out lessons learnt to help improve the process in future.

Key messages on audit of accounts

The timeliness of submissions was very good. All but five CCGs (98%) met the deadline for submitting their audited accounts to NHS England.

The quality of CCG accounts, when judged by changes to net expenditure, was generally good and an improvement on the previous year. There was scope to improve disclosure notes in many CCGs. Auditors at around 3% of CCGs, down from 18% the previous year, 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:

- 10 % of CCGs received a qualified regularity opinion, which was the same percentage as 2013/14. Of these, 19 were due to breaches of the revenue resource limit and one due to an illegal payment between CCGs
- auditors referred 24 CCGs (11%) to the Secretary of State during the year, mainly due to the financial position. This was the same percentage as in 2013/14

- auditors issued non-standard VfM arrangement conclusions at 31 CCGs (15%). The vast majority of these related to CCGs breaching their revenue resource limit or setting deficit budgets for 2015/16. In 2013/14 auditors concluded that there were matters to report at 38 CCGs (18 %).

Main issues

A number of CCGs had not included 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, while some CCGs had not fully understood the guidance produced by NHS England.

We noted errors in several CCGs' remuneration reports caused by a failure to check the figures in these reports such as pay multiple ratios being incorrectly calculated and incorrect salary bands being used. 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 2015/16 planning process to help reduce the amount of time taken by both CCGs and auditors.

We noted a greater value and volume of imbalances from the agreement of balances exercise in 2014/15. This was a reflection of the increased financial pressures which NHS bodies were experiencing. We recommend that CCGs plan to address any imbalances early in 2015/16.



Several CCGs experienced delays in receiving information from local authorities. This was in part due to different reporting timetables in local government. While transactions with local government were not material in 2014/15 at many CCGs, the introduction of the Better Care Fund in 2015/16 will change this and CCGs should be discussing their requirements with local authorities early.

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. However a much greater number of CCGs did tailor their accounts to their own circumstances
- errors in formatting and reference numbers and missing figures in notes
- figures in notes not casting or agreeing to the main statements
- comparative figures for the previous financial year were omitted from several notes such as related parties.
- errors in the way that the financial performance note was presented

Most CCGs told us that the quality of guidance from NHS England was much better than the previous year and this helped the process go more smoothly. At a national level, while the audits were on-going we liaised with the Audit Commission and, through them, NHS England, to help facilitate the publication of additional guidance on matters arising. We will continue to liaise nationally to help identify and suggest further improvements for the 2015/16 audit.

Assisting CCGs to produce accounts

To help our CCG audit clients to minimise the impact of risks in the second 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 2015/16 accounts

Planning for the preparation of CCGs' 2015/16 financial statements should begin now, starting with a review and assessment of the whole process for 2014/15. To assist with this, we will run final accounts workshops early in 2016 and 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 2014/15.

Contact us

Rhiannon Williams

Director, Healthcare Advisory Services
T 0207 728 3267
E Rhiannon.e.williams@uk.gt.com

James Cook

Director, National Commissioner Lead
T 0121 232 5343
E james.a.cook@uk.gt.com

Terry Tobin

Senior Manager, Bulletin Editor
T 0121 232 5276
E terry.p.tobin@uk.gt.com

Peter Barber

Associate Director (South West)
T 0117 305 7897
E peter.a.barber@uk.gt.com

Sarah Ironmonger

Senior Manager (London and SE)
T 0129 355 4072
E sarah.ironmonger@uk.gt.com

Simon Hardman

Manager, Public Sector Assurance
T 0161 234 6379
E simon.hardman@uk.gt.com