Grant Thornton
An instinct for growth™

Key issues for clinical commissioning groups

August 2016 – Our eighth 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 current issues with our clients recently which fall in to the following three categories:

1 **Emerging issues** – which have emerged during 2015/16 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

Our last bulletin set out the several issues in each of these categories which still remain relevant

Emerging issues

- Co-commissioning of primary healthcare
- New models of delivery
- Governance
- Sustainability and transformation plans

Stubborn issues

- Financial pressures and underlying deficits in future years
- Capacity and ensuring commissioning support services are high quality and deliver value for money.
- Integration and the Better Care Fund (BCF)
- Provider trusts

Issues on the horizon

- Devolution
- The future of clinical commissioning and collaborative commissioning
- Health HACKs
- Technology in health care

In the August edition we provide a current update on some of these issues.

The future provision of GP services

There are many significant challenges effecting primary care services including reduced funding, workforce recruitment, CQC inspections and increased demand caused by, among other things, an ageing population with increased multiple morbidities. As a result many GP practices and CCGs are considering whether current structures are appropriate. This has generated an increased interest in new models of working across boundaries such as multispecialty community providers and has also led to the creation of GP federations and 'super practices' in many areas. Many of these federations have had financial and other support from the host CCG.

Our recent round table discussion on the future of primary care shared current thinking and good practice from progressive GP practices and CCGs which are captured in our report 'Primary Concern- shaping the future direction of primary care'. Since then, NHS England (NHSE) has published 'The General Practice Forward View' which has been generally well received by primary care practioners as an important first step to recognising and starting to tackle the serious issues in primary care. We feel the direction set out in the General Practice Forward View also complements the key issues in our paper.

Grant Thornton has assisted some of the larger super practices and federations in developing their arrangements such as business planning and tax management. We are happy to discuss this paper with you or facilitate a local discussion with GP groups.

CCG mergers

At a national level there does not yet appear to be an appetite for formal CCG mergers. However many CCGs are being encouraged to set up shared management teams and innovative structures to tackle the significant issues presented to the newly formed sustainability and transformation area teams.

There are many advantages of shared management structures, including greater capacity and resilience, economies of scale and an enhanced skill base. This move to joint working and shared responsibility will be particularly welcome for those CCGs currently struggling to tackle common significant issues with NHS providers or social services.

However achieving effective joint working will not be easy. There will be a variety of big issues to tackle including the governance structures to put in place in the short-term to medium- term, and people and culture issues with governing bodies, members and employees.

Governance reform is currently at an infancy stage and different health economies are considering different solutions.

Some of the things for CCGs to consider include:

- How best to ensure that board and committee meetings are able to consider the business of more than one CCG in an effective and time efficient way
- How to ensure everyone remains on board with the new strategic direction
- How to develop a culture for the new organisation which takes only the best elements from the existing CCGs.

We hosted a round table discussion in July on this topic and we now plan to publish a summary report to ensure that best practice emerging from this event is shared.

Governance matters

Conflicts of interest

In June 2016 'Managing conflicts of interest: Revised statutory guidance for CCGs' was issued in relation to conflicts of interest. This issue has been periodically re-visited since the introduction of our key issues bulletins.

NHSE issued initial guidance for CCGs in December 2014 which clarified its expectations and in 2015/16 it commissioned an audit of conflicts of interest management at ten CCGs with delegated co-commissioning arrangements. This reviewed how the safeguards set out in the guidance were operating in practice and aimed to identify any areas for improvement and share learning and good practice.

Based on this review, NHSE published draft guidance on their website in March 2016. NHSE has now published a final version of the guidance after considering the outcome of consultation. While the review did find some good practice, the overall view was that there are some measures that could improve arrangements:

- Minimum of 3 lay members on the governing body
- The introduction of a 'guardian' in CCGs
- A robust process for managing breaches should be included within their conflict of interest policy
- Strengthened provisions required around decision making when a member of the governing body or committee are conflicted and also around the management of gifts and hospitality
- An annual audit of conflicts of interest management should be included in their internal audit plan
- The need for CCG employees and governing body members to complete online training on conflicts of interest.

CCGs are increasingly looking for assistance to help them deal with this issue. However there are some measures which CCGs can quickly put in place to strengthen their own arrangements. These include ensuring their registers of interest and hospitality are:

- updated and reviewed regularly
- easily located on the CCGs website
- include all relevant information in a format that meets the requirements and allows transparency.

We recognise this is a complex area and our teams are able to support you in developing your procedures or through training.

Integrated working

A final current governance issue is linked to the developing integration agenda. As health and social care integration gathers pace, new ways of working are developing. We are seeing new organisations develop and some genuine integration in both the provision of health and social care and in the commissioning of that care.

While Section 75 pooled budgets are clearly not new, the size of these pooled budgets have increased. As local authorities and CCGs begin to integrate their commissioning, pooled budgets of over £100m are not uncommon. A concern, therefore is that as new arrangements are being developed, CCGs are unsure of the assurances that they require, particularly given the materiality of the pooled expenditure and in relation to the governance risks. As a result of a perceived lack of added value and delivery some CCGs are reducing the pooling of budgets.

We have recently held workshops with audit committee chairs from a variety of organisations to identify the assurances that CCGs would want to receive where new arrangements are developing. Given the increasing levels of spend in joint commissioning or the development of new provider arrangements it is clearly important for the CCGs to receive some assurances in relation to the governance of the new structures. CCGs, however, may face barriers in obtaining those assurances. Sometimes it is simply an issue of not having the mechanisms in place to liaise with another organisation to discuss 'shared assurance' arrangements or there could be cultural issues that need to be addressed.

Assessment framework

2015/16 final assessment ratings for CCGs were published in 21 July 2016. CCGs were assessed in one of four categories against five components of assurance.
As in previous years, NHSE has updated its improvement and assessment framework for 2016/17. It intends the framework to supply indicators as markers of success where sustainability and transformation plans (STPs) adopt them and the focus of the indicators are on tasks-in-common. The framework has four domains: better health; better care; sustainability; and leadership. It has 60 indicators across 29 areas and the aim is that quarterly dashboards will be available to compare performance between CCGs and STP areas.

It is important that CCGs understand the indicators and how this reflects their performance and their strategic priorities. During 2016/17 a methodology to support the year end assessment will be agreed and CCGs will be categorised as outstanding, good, requires improvement or inadequate. As the methodology is developed, CCGs may want to consider a self-assessment against the categories.

The framework also includes agreed principles regarding behaviours and interactions which fall into three areas: build from a common purpose; local leadership and accountability; and honesty and transparency.

Financial position

The financial position of the NHS continues to be extremely challenging. 2015/16 saw a significant deficit position from the provider sector (a £2.4 billion overspend) with a cumulative CCG overspend against allocation of £16 million. Our experience of auditing local CCGs mirrors that reported by the recent HFMA 'NHS financial temperature check'. CCGs are reporting pressures from acute overperformance, primarily from increases in emergency activity, rising continuing care costs and slippage on QIPP savings.

The impact of the pressures has been mitigated by an increase in allocations to CCGs, lower than planned quality premium payments and in some cases levying fines on providers. As more providers face financial challenges, the 2016/17 contracting agreement process has been protracted with delays in agreeing contracts and in some areas an increase in negotiations reaching arbitration. Pressures are likely to continue to increase during 2016/17 as patient demand continues to grow. There are also a significant number of CCGs that agreed budget plans with unidentified QIPP schemes. In our experience, the risk associated with slippage in delivery of QIPP savings increases where schemes are developed in year. So finalising these plans must be a priority.

Transformation of services is now commonly accepted as the way forward. This can involve the re-design and closer integration of patient pathways and reducing clinical variation. Many CCGs are now investing money earlier in the patient pathway (typically the primary care setting) both to focus more on prevention and also support the management of more people in the community setting. However waiting times and the range of services on offer are increasingly being threatened. At the time of writing, many CCGs are reporting to us that initial activity data is not yet a reliable indicator of year end performance and CCGs expect more realistic forecasts in Autumn 2016. CCGs need to continue their focus on reliable financial forecasts.

Sustainability and transformation plans

Following the publication of the 'FYFV', the NHS-wide published the national priorities for 2016/17 and planning guidance in December 2015. It was relevant to all NHS bodies and set out the longer-term challenges for local systems, together with financial assumptions and business rules.

The 'NHS Mandate for 2016/17' set out the objectives for the NHS as a whole, not just for commissioners with emphasis on planning by place.

All organisations were required to construct and submit two separate but linked plans:

1 **A sustainability and transformation plan by end June 2016** – a five-year plan from October 2016 to March 2021 for the local health and care system. This is a place -based plan for the local population and must reflect local health and well-being strategies

2 **An operational plan for 2016/17 draft by 8 February 2016** – this is organisation specific and forms the first year of the STP

The plans had to address three gaps:

1 Health and well-being
2 Care and quality gap
3 Finance and efficiency

NHSE require each area to set out governance arrangements for agreeing and implementing a plan. This included the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG chief officer.

To access funding in 2016/17 through the Sustainability and Transformation Fund, providers need to meet certain conditions such as delivering an agreed control total in 2016/17, improving access standards and working with commissioners on sustainability and transformation plans which needed to be agreed with NHSE and NHS improvement early in 2016/17.

STPs have generally been welcomed in the CCG community and many CCGs tell us that they can see that the process will provide real benefits through the re-shaping of services and improved collaboration.

The main issues raised with us at this stage are:

- concerns around the governance especially with the larger STP areas
- worries that the severe pressures individual organisations are under to achieve agreed control totals will take precedence over collaboration
- as relationships were often still developing, the required fast pace of change may place great strains on these relationships
- the difficulties in taking the big STP agenda forward while still delivering the 'day job' including hitting control totals and delivering savings schemes.

Final accounts in 2015/16

In 2015/16, the deadline for submission of audited accounts was the 27 May 2016. This was the third year that CCGs have produced accounts. Grant Thornton audit 35% of all CCGs in England and in 2015/2016 this process went well and all our CCGs submitted both draft and audited accounts by the deadline. The quality of the accounts submitted and the supporting working papers were generally of a good standard.

While it was pleasing that no CCG accounts opinions were qualified, 19% of CCGs received a qualified regularity opinion and were referred to the Secretary of State for breaching their revenue resource limit and 15% of CCGs received a qualified VfM conclusion. Appendix 1 sets out our experience from this third year of CCG external audits in more detail.

Contacts

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

James Cook
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.l.ironmonger@uk.gt.com

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

Appendix 1

Lessons from 2015/16 accounts

2015/16 final accounts – key issues at Grant Thornton audits

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 audit opinion reflects well on the financial management arrangements of a CCG and provides assurance to the governing body and external stakeholders, such as the Department of Health (DOH) and NHSE. During 2015/16 new criteria were introduced by the National audit office (NAO) for consideration by auditors when assessing whether CCGs had made proper arrangements to secure economy, efficiency and effectiveness in their use of resources. On completing this work we were required to report only by exception. This was a change from the previous year in which we were required to give a positive conclusion if we were satisfied with a CCGs arrangements.

This paper provides an assessment of the third year of audit of CCGs, of which we audit 32% in England, and draws out lessons learnt to help improve the process in future.

Key messages

The timeliness of submissions of draft accounts for audit was very good with 100% of our clients meeting the audit and VfM arrangement conclusions submission deadline. The draft accounts submitted for audit and the quality of the working papers and documents supporting the balances were generally of a good standard.

Under the NAO Code of Audit Practice we are required to report whether a CCGs financial statements give a true and fair view of the financial position and whether the income and expenditure included in the financial statements has been applied for the purposes intended by parliament (the regularity opinion). We are also required to give an opinion on some elements of the remuneration and staff report and report if we made a referral to the Secretary of state where we had reason to believe that the CCG was about to make, or had made, a decision involving unlawful expenditure (section 30 referral), had issued a public interest report or made written recommendations which should be considered by the CCG and responded to publicly.

For Grant Thornton clients nationally:

- 19% of CCGs (13) received a qualified regularity opinion. (This was an increase on the national picture for 2014/15 where only 10% of CCGs received a qualified regularity opinion.) These qualifications were all due to breaches of the revenue resource limit
- Section 30 referrals were made to the Secretary of State for Health and NHSE for all those CCGs who had qualified regularity opinions. In 2014/15 auditors nationally referred 11% of CCGs (24) to the Secretary of State, mainly due to the financial position
- There was one qualification of the consistency opinion due to inconsistencies between the accounts consolidation template provided to NHSE and the audited financial statements
- We issued non-standard VfM arrangement conclusions at 16% of CCGs (11) increasing from 15% the previous year. In 2015/16 the vast majority of these (eight) were 'except for' conclusions and related to CCGs breaching their revenue resource limit or setting deficit budgets for 2016/17. Adverse VfM conclusions were given to three CCGs and related to weaknesses such as not setting a sustainable budget with sufficient capacity to absorb emerging cost pressures and a lack of a credible financial recovery plan
- In 2014/15 auditors at around 3% of CCGs issued an 'other matter' paragraph in their audit reports in relation to disclosures within the remuneration report relating to pensions benefits of GP senior managers. In 2015/16 there were no 'other matter' paragraphs reported which is an improvement on the previous year

Assisting CCGs in the third year of producing accounts

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

- ran regional accounts workshop before the year end on accounts, annual report, BCF and pooled budgets
- produced tailored benchmarked 2014/15 annual reports for CCGs to assist in their production of the 2015/16 reports
- discussed technical issues early
- shared information from the NAO on the new VfM assessments for 2015/16
- held regular meetings and shared working paper requirements before the year end
- produced national thought leadership publications on the NHS including 'Modelling future care:the NHS under

reconstruction' (March 2016) and 'Partnership working in mental health: Joining up the dots, not picking up the pieces' (April 2016).

Main issues

In 2015/16 the audit of the new arrangements for the BCF and pooled budgets required a large amount of attention. CCGs were required to have agreements in place to operate pooled budgets with local authorities from 1 April 2015. The aim of the BCF was to create a 'single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as a focus of health and care services'.

CCGs and NHS providers have extensive experience of managing various types of healthcare commissioning arrangements, including joint arrangements and the use of pooled budgets. However, the operational arrangements for BCF across the country were varied and in some cases complex, increasing the potential risks of inconsistencies and confusions between members of BCF pooled budgets internally and between commissioners and providers. It was therefore difficult in some cases to identify the appropriate accounting. As a consequence there were risks to both NHSE and the DH consolidated accounts, particularly as transactions and balances within the NHS family may not be consistently treated and recorded.

We found that the arrangements around the BCF were still evolving. In some cases we noted delays in obtaining signed S75 agreements setting out the BCF arrangements between the parties to the agreement. Many of the disclosure amendments requested by auditors also related to the BCF, eg the critical judgements note in the accounting policies needed to be updated to reflect the new arrangements and more detail needed to be provided in the annual governance statement in the annual report on the controls over the BCF. Changes to the initial accounting treatment were also required at some CCGs.

Last year we reported that many CCG statements of account would have benefitted from a high level review and sense check prior to submission to eliminate some of the unnecessary changes we found. In 2015/16, although the disclosure issues reported largely related to new areas of work or late guidance from the DH, there were still some residual issues associated with the remuneration report in particular, such as:

- incorrect use of the inflation factor for pension entitlements
- out of date pension information on board members
- the need to include prior year comparators for pay and pension tables
- incorrect reporting of negative balances for pension benefits
- incorrect banding disclosures and additional wording around CETV figures following late DH guidance

Many CCGs told us that the communication and quality of guidance from NHSE continues to develop and improve. The hard close at Month 9 is a priority for the NHSE and gives comfort over the ability of CCGs and NHSE to deliver year end close. At a national level, while the audits were on-going, we liaised through the Public Sector Audit Appointments (PSAA) with NHSE, to help facilitate the publication of additional guidance on matters arising. We will continue to share our national experieicne to help identify and suggest further improvements for the 2016/17 audit.

Planning for 2016/17 accounts

Planning for the preparation of CCGs' 2016/17 financial statements should begin now, starting with a review and assessment of the whole process from 2015/16. To assist with this, we will run final accounts workshops early in 2017 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 2015/16, and consider the impact of other emerging issues such as the impact of sustainability and transformation footprints and partnerships with local government in bids for devolution.