Grant Thornton

Key issues for clinical commissioning groups

March 2020

Welcome to our latest key issues bulletin for clinical commissioning groups.

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COVID 19

COVID-19 pandemic

At the time of going to print the COVID-19 pandemic is continuing to develop at a very fast pace and we are aware that responding to the health needs of local populations will be the primary focus of clinical commissioning groups (CCGs). We will continue working with and supporting CCGs in whatever ways are necessary and adapting our approach as the situation develops. We have set out below a brief consideration of the impact on CCGs including the impact on the accounts and audit process.

Impact on CCGs

COVID-19 presents the NHS with the greatest challenge it has faced since its creation. The Department of Health and Social Care declared coronavirus as a "level 4 incident" on 30 January 2020 — a move which allows NHS England (NHSE) to take control of all NHS resources across England. NHSE's national team can now direct all health service resources in England through its regional teams, according to NHSE's Emergency Preparedness, Resilience and Response Framework. Directions are now in place for NHSE to take over any function of a CCG as it "deems appropriate for the purpose of directly or indirectly supporting the provision of services by NHS bodies to address coronavirus and coronavirus disease" until the end of the year. This was primarily designed to help NHSE to commission services from independent sector providers. Simon Stevens' letter on 17 March 2020 outlined the urgent next steps for the NHS and the specific priorities for CCGs. This included working with local authority partners to commission additional out-of-hospital care and support capacity, in particular to facilitate step down of patients from secondary care and so free up acute beds; procurement of additional GP out of hours capacity and moving to block contract payments 'on account' for all NHS trusts and foundation trusts for an initial period of 1 April to 31 July 2020. CCG managers and administrative staff are being urged to work at home in line with guidance issued to the general public. They have also been responding to requests from the wider NHS family to support other NHS services whether in a clinical capacity where appropriate or back-filling other functions such as NHS 111. Primary care services have been fundamentally altered to focus on the pandemic and for clinical staff to deal with patients remotely to avoid "face to face" contact wherever possible. Certain requirements on GP practices have been temporarily suspended alongside guarantees that their income will not be affected. All routine CQC inspections of GP practices have been cancelled.

The Chancellor of the Exchequer and NHS England have stressed that financial constraints will not stand in the way of taking immediate action, but the maintenance of financial control and stewardship of public funds whilst making decisions to commit extra resources will remain important during the NHS response. CCGs should therefore be reviewing the resilience of their finance functions and business continuity plans to make sure that the most important elements can continue with significant staff absences and remote working. This will include considering the resilience of your fraud prevention arrangements.

Changes to NHS CCG deadlines and requirements:

Due to the pressures on CCGs in responding to the pandemic, NHSE has announced that the draft CCG accounts deadline will be moved from 24 April to 27 April and the audit deadline moved from 29 May to 25 June. In addition, the implementation of IFRS 16 (leases) has been deferred for one year to 1 April 2021. Given this is a developing situation, there may be further changes to the accounts process for 2019/20 and we will be in regular dialogue with your finance teams over the coming weeks.

Impact on accounts and audit opinions

The following sets out a number of the key issues which finance teams will need to consider as part of the year end closedown.

- Impact on financial health and whether the audited body needs to provide additional disclosures that draw attention to a Material Uncertainty around Going Concern (this could also impact on the VfM conclusion)
- Impact on collectability of debt and assumptions made in bad debt provisions although most CCG debt is within the NHS
- Impact on post-balance sheets events (the consequences of the virus post 31 March 2020 will generally be non-adjusting post balance sheet events but some form of disclosure may be needed)
- Disclosure of impact in annual report
- Disclosure of critical judgements
- Disclosure of material estimation uncertainties
- Impact on the content of the Annual Governance Statement, particularly with regards to risks, controls and mitigation
- Considerations in respect of service continuity and disaster planning arrangements (this could impact on the VfM conclusion)
- Impact on reporting to those charged with governance and signing arrangements due to remote working

Working with you:

Following the Government's announcement on Monday 16th March, we closed our offices for the foreseeable future and your audit team are now working from home. We will therefore be working remotely during the accounts audit and have discussed the logistics of these arrangements with your finance team. Helped by previous experience of operating in an agile manner, to date this has gone very smoothly. Although there are some audit tasks which are best undertaken in person, the majority of the audit will be able to be completed remotely. This is however likely to make the audit process longer. We will work closely with your finance team to make this different way of working as efficient as possible. We acknowledge there may need to be further changes to planned audit timings, due to potential illness within the audit team or the finance team and due to the further developments of COVID-19.

Stubborn issues

Financial Special Measures to Financial Sustainability – the Croydon CCG Story

The difficulty of delivering against increasingly challenging financial targets is at the forefront of most commissioner leadership teams and their boards. For this reason, we thought it may be helpful to share what we observed at NHS Croydon CCG. From being set up on 1 April 2013 the CCG has faced significant financial challenge and has been operating in financial recovery mode. In the first three years, it incurred in-year deficits of £18.2 million in 2013/14, £14.7 million in 2014/15 and £10.8 million in 2015/16. Throughout this time, the CCG continued to address the underlying financial position including delivering £35.5 million Quality Innovation Productivity and Prevention (QIPP).

In 2016/17, NHS England placed the CCG into Financial Special Measures which led the CCG to further strengthen its Programme Management Office (PMO) to oversee all QIPP Schemes. The PMO enabled a clear focus on the identification and delivery of QIPP schemes supported by people who were able to spend an appropriate amount of time dealing with these tasks as opposed to having to fit this in around their day jobs, which clearly reduces the scope available for scheme identification.

In addition to the PMO, a QIPP Operational Board was established which met on a weekly basis to review and oversee progress on the overall delivery of QIPP Schemes during the course of the year. The PMO provided a weekly update on progress to date and any potential risks to the delivery of QIPP schemes where action may need to be taken. The CCG had a cyclical programme where all QIPP schemes are reviewed within each month by the Operational Board. The Operational Board was attended by the Executive Team and the Clinical Chair which enabled both financial and clinical perspectives to be considered in progressing each QIPP scheme.

The CCG delivered a further £14.3 million of QIPP Savings in 2016/17, however the in-year deficit for 2016/17 was £10.8 million.

In 2017/18 there was a change of leadership with the CCG sharing a Chief Officer with a neighbouring CCG. The CCG continued to build and strengthen the governance arrangements which had been implemented in the previous year. The CCG delivered a further £21.2 million of QIPP savings in 2017/18 with an in-year deficit of £13.8 million.

In 2018/19 the CCG was able to set a balanced budget for the first time since its inception and the CCG exited Financial Special Measures in July 2018. A surplus of £1.2 million was achieved in line with the plan alongside delivery of a £27 million QIPP.

Clinical leadership and ownership of the CCG's QIPP programme has been critical to the successful delivery of QIPP. In addition, the joint working on transformational change through the One Croydon Alliance consisting of health and social care partners, primary care, mental health and the voluntary sector in the Croydon health and care system has been critical in successfully managing down non-elective admissions.

Other success factors include a high level of stability within the CCG's Finance Function. There has been continuity at the Chief Finance Officer and Deputy Chief Finance Officer level throughout this period. This has helped ensure a consistency of message and understanding. The CCG also sought additional resource at key times to deliver the business as usual activities enabling core finance team members to keep a focus on QIPP for example obtaining interim support to prepare the financial statements and support the audit process.

Appendix 1 has a checklist of what we think makes for a good savings plan based on what we have seen at CCGs nationally.

Emerging Issues

Final accounts in 2018/19

In 2018/19, Grant Thornton audited 34% of all CCGs in England. We found that the quality of the accounts submitted and the supporting working papers were generally of a good standard. CCGs audited by Grant Thornton all submitted their unaudited and audited accounts by the deadline.

Audit opinions for CCGs have three elements: the statement of accounts; the regulatory opinion; and the value for money (VfM) conclusion. No statements of accounts opinions were qualified. However, 16% received a qualified regulatory opinion for breaching their revenue resource limits and 28% received a qualified VfM conclusion which reflects weaknesses in financial arrangements.

Appendix 2 sets out our national findings and our experience from this sixth year of CCG external audits in more detail.

Accounting Changes in 2019/20

There are no significant changes which take effect this year. The Department of Health has issued some updates to the Group Accounting Manual (GAM) in the form of FAQs, which have been issued in previous years as well. Consideration of the FAQs enable CCGs to ensure they are able to consider any potential impact on their accounts prior to submission. As mentioned earlier, it has just been announced that the implementation of IFRS 16 - Leases will now take effect from the 1 April 2021 and we will discuss the issues as they effect CCGs in the next edition of this bulletin.
Due to the expected impact of COVID-19 the key dates for 2019-20 have been revised. They are now as follows

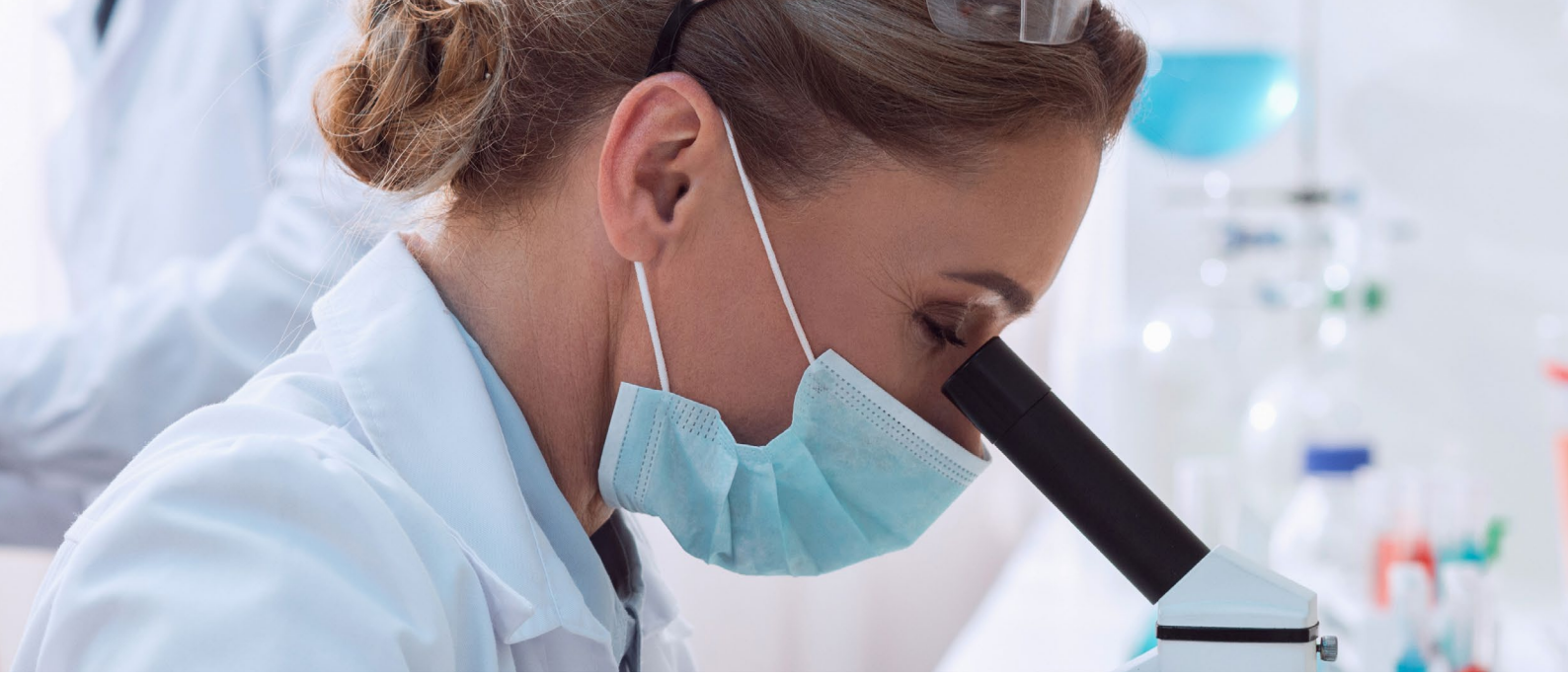
Deadline	Date
Submission of Draft Accounts to External Audit	5pm on Thursday 27th April
Submission of Final Accounts	5pm on Thursday 25th June

We are aware that again NHS England would like to receive the audited Annual Report ahead of this deadline, but we would encourage CCGs to liaise with their external auditors over this as auditors will likely be working to the submission deadline, which is the statutory deadline for the Annual Report alongside the accounts. Clearly these deadlines are subject to revision given the ongoing impact of COVID-19, and Auditors will liaise with Finance Teams should either of these be formally moved.

As in previous years we explored these matters in more depth as part of our Chief Accountant's Workshops which your finance staff attended in January and February.

CCG auditors issue model working paper requirements based on the local experience of what worked well and less well in 2018/19. They will also be considering the impact of other emerging issues such as changes in staff and finance teams as a result of CCG mergers and collaboration, the impact of mergers and shared management on accounts and annual report disclosures and impact of sustainability and transformation footprints and development of integrated care system models and local delivery systems.

If you would like any further information or support in respect of these areas, please contact your audit team.



Issues on the horizon

Lessons from CCG Mergers

In 2017 we published our All Together Now report to share insights and best practice to assist CCGs who were then starting to come together in shared management arrangements. Since then we have seen at close hand some formal mergers take place such as in Birmingham and Bristol in April 2018. A large number of CCG mergers are planned for April 2020 with most of the remaining merging in 2021. This is in response to the need to reduce management costs, create more strategic commissioning and improve system working across the STP.

The CCGs involved in the early mergers were eager to share the lessons they had learned with those who will be merging in the future. Birmingham and Solihull CCG ran an event in April 2019 for other CCGs due to interest expressed.

The CCGs were positive about the early benefits of mergers including improved relationships with providers and partners. The main areas of challenge they faced were:

- engagement with GPs, public and staff
- HR and OD (and developing a common effective culture)
- governance
- finance

The CCGs found the merger process a complex task with many challenges and said it was hard to understate the sheer amount of time taken up. Therefore, it was considered invaluable to obtain outside support be that from NHSE or from specialist firms such as HR, legal, finance, engagement and project management support. Setting up a common senior leadership team including a Chief Executive early was regarded as a "game changer". It was also fundamental to set up a transition program team backed up by strong project management support both pre and post approval. Having an independent Chair was hailed as a successful decision.

It was important to make a genuine commitment to keep all stakeholders involved from an early stage as support is needed from a wide range of people and to offer personalised and regular communication to the most important stakeholders. In doing this it was vital to develop and present a strong "case for change". Dedicated communications and engagement support was enlisted. A particular common feedback from stakeholders was that "place" was a key area and some feared the potential loss of localism from a more distant commissioning body. Therefore this needed to be positively addressed.

In terms of governance, the CCGs saw having a strong grasp of what the legal "dos and don'ts" are as important. One CCG had developed an easy to read companion to the constitution which they thought was very helpful. They considered the constitution to be a key part of the development of shared culture and something that brought all the differences to a head early on. They also wrote the constitution to be as flexible as possible for the future.

Primary care networks and social prescribing

Primary care networks were introduced into the National Health Service in England as part of the NHS Long Term Plan, published in January 2019. The 2019 General Practitioner contract gave the opportunity for GP practices to join networks, each with between 30,000 and 50,000 patients. The stated aim is to create fully integrated community-based health services. Primary care networks have the potential to benefit patients by offering improved access and extending the range of services available to them. We see this change from reactively providing appointments to proactively caring for the people and communities. One aspect primary care networks are tackling currently is social prescribing. Social prescribing involves GPs and other primary healthcare professionals helping patients to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity.

Social prescribing is not a new concept, but it has recently become a much discussed topic, after the NHS Long Term plan announced significant investment into link workers. Health and Social Care Secretary, Matt Hancock, has also announced the development of a Social Prescribing Academy. But many key stakeholders have differing interpretations of what exactly social prescribing is.

Most local authorities (LAs) and CCGs have existing schemes in place, but this newly released funding is an opportunity to take stock of their strategic objectives and align spend accordingly. Less important than ensuring a uniform definition of what social prescribing is, is a clear strategy around key cohorts on whom to focus.

By developing a targeted set of 'prescriptions' for specific groups of people, LAs and CCGs will be better enabled to measure benefits of their social prescribing schemes – financial, abating growth and improving outcomes for the patients involved.

The Local Government Association estimated that we spend around 20 times as much on treating ill health as we do on direct prevention, yet the relative cost effectiveness equation sees a reversal of these proportions – primary prevention is likely to be 24 to 40 times more cost effective than treatment on a lifetime basis. We see social prescribing as a critical component in this prevention agenda and as a result our analysts have reviewed and collated the evidence of multiple social prescribing schemes across the country, in order to quantify the longer term benefits of sustainable interventions on the wider health and social ecosystem.

Generally, there is a lack of tools or systems to support the broader monitoring of the long-term outcomes of effective schemes and interventions. In partnership with the Bromley by Bow Centre the evidence we have gathered is being used to address this and shape strategic interventions which are customised according to patient risk stratification.

We believe that this approach is the start of ensuring a more sustainable view of social prescribing becomes embedded across the system, reinforcing the underlying place-based ethos and personalised care agenda. If you would like to know more, please contact tamsyn.r.flynn@uk.gt.com.

Contact us

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Appendix 1 – Checklist of what makes a good savings plan

Planning

- Proportionate plan/PID/business case, clearly articulating scheme
- Sufficient financial and resource capacity allocated to deliver savings (transformational savings plans often require significant capital and revenue investment up from to deliver long term revenue savings)
- Clear ownership for all elements/stages of the scheme, who is the scheme sponsor/s and lead/s
- Clinical involvement in development of scheme where appropriate
- Non-NHS body (e.g. social care) involvement in the development of the scheme, where appropriate
- Governance, what are the reporting arrangements - Financial savings profiled and supported by detailed financial plans - outcome focused KPI measures that facilitate monitoring of progress
- Time bound with clear milestones facilitating monitoring
- Financially quantified in terms of investments, savings, timing of savings. This should not be just one figure but profiled throughout the year
- Impact of scheme on other partners budgets – consistency between financial plans
- Patient safety and performance impact understood and articulated to stakeholders.
- Consultation on change proportionate and used to inform final decision

Implementation

- Clear ownership and accountability throughout, buy-in from the owners critical
- Ownership at divisional and executive level
- Capacity to implement – savings schemes are part of the day job but proper consideration of the time commitment required is crucial

Monitoring

- Monitoring is based on up to date forecasts to ensure any corrective action can be taken promptly (financial projections should not be more than 1 month old)
- Progress is assessed periodically, both at an executive level and board level
- Progress focuses on outcomes and includes both financial and non-financial KPIs
- Financial information to include realised savings to date and projected year end outturn vs budget
- Costs of implementation are also monitored against budget
- Any assumptions in financial projections are articulated
- Delivery risks captured, RAG ratings and direction of travel ratings applied to focus challenge
- Clear assessment of progress against individual milestones which are ticked off
- Consideration given to speed and timeliness of delivery of milestone
- If slippage or off plan, frequency of monitoring to increase
- Robust, proportionate challenge when slippage identified with clear articulation of actions, by who and by when

Schemes involving partner organisations

- Ensure buy-in and ownership from other partners
- Arrangements provide for confidence over the financial information sourced from third parties

Post implementation

- At the end of each scheme a post implementation review should be undertaken to inform learning for future schemes
- Savings should be used to inform future budgets in that savings area

NHS body wide support for savings

- Consideration to the establishment of a Programme Management Office (PMO) to oversee all savings schemes (to ensure consistency of approach to delivery supported by capacity and advice and shared learning as part of the post implementation review stage)

Appendix 2 – Final accounts in 2018/19

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 large 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 and Social Care (DHSE) and NHS England and NHS Improvement (NHSE/I).

This paper provides an assessment of the sixth year of CCGs accounts, of which we audited 34% in 2018/19. It includes findings from our audit of 68 CCGs undertaken across the country and draws out lessons learnt to help improve the process in future.

Key messages

The timeliness of submission of draft and audited accounts was very good with all CCGs we audit submitting their draft and audited accounts by the deadline. The draft accounts submitted by our clients for audit and the quality of the working papers and supporting documents were generally of a good standard.

Under the NAO Code of Audit Practice, we are required to:

- report on whether a CCG's financial statements give a true and fair view of its financial position
- provide a regularity opinion on whether the income and expenditure included in the financial statements has been applied for the purposes intended by parliament
- provide an opinion on elements of the remuneration and staff report
- report if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

In addition, we are required to make a referral to the Secretary of State where we have 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 publicly responded to.

For CCGs nationally:

- All CCGs audited by Grant Thornton in 2018/19 received an unqualified true and fair view opinion. All CCGs audited by Grant Thornton in 2018/19 received an unqualified true and fair view opinion.
- Section 30 referrals were made to the Secretary of State for Health and NHSE/I for 16% (11) of CCGs audited by Grant Thornton which also resulted in a qualified regularity opinion, reflecting the challenging financial position continuing to face a number of CCGs. These referrals related to breaches of the CCG revenue resource limit during 2018/19 and in some instances also referenced deficit budgets set for 2019/20 which were also likely to result in a breach of the revenue resource limit. There was however a reduction in the level of referrals made since 2017/18 of 45% (35), due in part to the introduction of commissioner sustainability funding (CSR) where CCGs who met their deficit control total were able to access funding and come back to financial balance.
- Emphasis of matter paragraphs highlighting the demise of the organisation and establishment of newly merged organisations were included in the accounts of a number of CCGs where a merger was due to take place from 1 April 2019.
- No going concern material uncertainty disclosures were included in the 2018/19 accounts opinions of any CCGs audited by Grant Thornton.
- Non-standard VfM arrangement conclusions were issued at 28% of CCGs audited by Grant Thornton (19/68), a reduction from 36% in 2017/18 (28/77). In 2018/19, the vast majority of these (14) were 'except for ' conclusions and related to CCGs breaching their revenue resource limit, setting deficit budgets for 2019/20 or budgets which include unidentified savings plans, only achieving control totals agreed through the receipt of non-current funding or savings and only achieving control totals agreed through the receipt of non-current funding or savings and failure to deliver QIPP targets due to lack of developed plans. Except for conclusions were also issued where weak governance arrangements were in place including where 'inadequate' performance ratings had been issued by NHES/I.
- An adverse VfM conclusion was given to five CCGs audited by Grant Thornton in 2018/19 (1 in 2017/18) and related to CCGs being unable to submit a plan which meets NHSE/I control total requirements.

Common errors and problems

Remuneration reports continued to be an issue for some CCGs. Residual issues associated with the remuneration report remaining in 2018/19 included:

- Incorrect calculation of fair pay multiple and average staff numbers
- Shared costs of staff and senior officers not disclosed in line with Department of Health and Social Care GAM
- Where payments are made to a corporate body rather than to individual, the costs to the CCG not disclosed in the remuneration report.
- Report not including all senior managers in post in year including period they were in the role and only remuneration relevant to that period.
- Incorrect banding disclosures for salary and pension costs
- Excluding senior manager's other remuneration, from the same CCG, for a clinical role from the remuneration table.
- Not clearly identifying which sections of the remuneration report was subject to audit

Other common errors and problems identified included:

- Incorrectly accounting for prescriptions issued close to year end as prepayments on the basis that the patient will not have used the drugs by the 31 March. CCGs should recognise the cost of all prescriptions issued in the year as expenditure including accruals for any drugs not paid for at the year end.
- Management's assessment of going concern not being documented in sufficient detail to explain the basis of management's conclusion, common issues include
- The assessment not being proportionate to the financial circumstances
- Not covering 12 months from date of opinion
- Did not consider the magnitude and likelihood of the potential impacts and likelihood of actions to avoid or reduce going concern risks
- Accounting policies and disclosure notes in relation to pooled budgets not meeting the Department of Health and Social Care GAM requirements
- Critical judgements that are not critical to the financial statements
- Material estimation uncertainties that do not meet the definition of material estimation uncertainties.

National findings across audit firms

In January 2019, the Local Audit Code and Guidance team within the NAO published a report 'Local auditor reporting in England 2018' which summarised the main findings reported by local auditors in 2017-18. Following on from this report, the NAO have developed a web-based tool which presents the results of local auditor reporting of local bodies in England in 2017-18 and 2018-19 and enables the public to access the auditor's annual audit letter (AAL). The web-based tool is expected to be released soon with the first release focused on the health sector and bodies that received non-standard auditor reports.

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