

# Key issues for clinical commissioning groups

October 2017

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Our tenth 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 37% of the clinical commissioning groups (CCGs).

Current issues we have been discussing with our clients fall into three categories:

1. **Emerging issues** – are those which have emerged recently and have risen in importance
2. **Stubborn issues** – are those which have known about for some time and have refused to go away
3. **Issues on the horizon** – are those which are likely to grow in importance in the future

Our previous bulletins highlighted several issues in each of these categories which continue to remain relevant.

## Emerging issues

- Sustainability and transformation plans
- New models of delivery (including future GP services)
- Governance (including accounts issues and fraud)
- Co-commissioning of primary healthcare

## 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

- The future of clinical commissioning and collaborative commissioning (including CCG mergers)
- Devolution
- Technology in healthcare
- Brexit

We set out in this bulletin an update on some of these issues.

## Sustainability and transformation plans (STPs)

Across England there are 44 STP (footprint) areas. These footprints are geographic areas that aim to bring together local health and care leaders, organisations and communities to develop local blueprints for improved health, care and finances over the next five years, delivering the NHS Five Year Forward View.

The STPs are an important part of the NHS England's drive to address the challenges facing the NHS. They require NHS and other organisations involved in health and social care to work together on plans to transform services and deliver unprecedented improvements in efficiency. They challenge many of the assumptions on which the Health and Social Care Act 2012 was based, in particular that competition should be used to improve performance of care. STPs are an example of the place-based systems of care in which CCGs collaborate with other NHS organisations and services to address the challenges and improve the health of the populations they serve. STPs have been broadly welcomed as a vehicle for transformation.

As STPs move from the planning stage into strategic partnerships, there remain a number of issues which need further development. Early feedback from practitioners involved in pulling together STPs includes concerns on:

- the governance arrangements, particularly in the larger/more complex STP areas. This includes the transparency and clarity of risk management arrangements and accountability structures
- how individual organisations balance pressures to achieve their control totals against STP area control totals. This includes the balance between meeting statutory financial targets and supporting collaborative achievement of the system control total

- how to manage long-standing system deficits in key organisations
- building trust in key relationships. The maturity of trusted relationships varies within and between STPs, between commissioners and providers, and between NHS and local government organisations
- how current characteristics of business relationships such as contract disputes, penalties and arbitration impact on collaboration
- the role and involvement of local government in driving local solutions.

There is widespread acknowledgement that the forecast gap in NHS funding is widening and ‘doing nothing’ is no longer an option. Whilst there is more to do, the initial focus has been on creating a set of structures and processes to deliver the STPs. Further progress is needed, particularly in developing the culture and behaviours that will underpin the delivery of the plan.

Given the scale of changes required across the various areas of service delivery, radical decisions will need to be made. Savings are not real unless cost reduction is achieved at provision level (eg direct CCG cost like CHC or GP prescribing) and not passed onto other organisations.

#### Early learning points:

- it is essential that regulators are involved in the planning process to ensure targets are agreed. We have recently noted improvements in this area
- problems cannot be fixed in isolation, consideration needs to be given to the wider system impacts
- communication should be regular and in a variety of formats
- change on this scale is not easy so greater understanding of necessary behaviour changes is required.

In recent months, many STPs have appointed key members of staff full time. The transition to having a single Accountable Officer across STPs is continuing to gather momentum, and is firmly supported by NHS England (NHSE).

In July, the NHS revealed its first formal ratings of the 44 STPs across England through the **STP Progress Dashboard**.

The CCGs were rated from ‘needs most improvement’ to ‘outstanding’ across a variety of different rankings. Five STPs were rated as ‘outstanding’ and five as ‘needs most improvement’.

Accountable Care Systems (ACSs) are beginning to gain some traction following Simon Stevens’ announcement in June of eight initial areas. This appears to be the ultimate outcome for all STPs, so they can deliver the joined up care which is much needed. CCGs not included in these pilot areas should consider the potential impact this could have on their STP plans within the existing arrangements to avoid unnecessary change later.

Formal CCG mergers are also remaining very much part of the narrative in this area. Two CCGs in Buckinghamshire, three around Bristol and three in Birmingham are the latest to announce plans to formally merge in 2018.

This is another sign that the NHS is slowly starting to accept formal mergers as a way forward under the STP arrangements, and it is likely that there will be more formal mergers announced over the coming weeks and months.

#### Final accounts in 2016/17

In 2016/17, the deadline for submission of audited accounts was 31 May 2017. We audit 32% of all CCGs in England and in 2016/17 and we found that the quality of the accounts submitted and the supporting working papers were generally of a good standard. Public Sector Audit Appointments (PSAA) reported that all CCGs submitted both draft and audited accounts by the deadline.

While it was pleasing that no CCG accounts opinions were qualified, 28% of CCGs received a qualified regularity opinion and were referred to the Secretary of State for breaching their revenue resource limit. This was a 12% increase from the previous year. In addition, 26% of CCGs received a qualified VfM conclusion compared to 12% in 2015/16. The majority of these relate to CCG finances and reflect the increasing financial pressure on the sector. Appendix 1 sets out national findings and our experience from this fourth year of CCG external audits in more detail.

#### Financial position

The financial position of the NHS continues to be extremely challenging. 2016/17 saw a significant deficit position in the provider sector (a £791 million deficit before provisions and other adjustments) with a cumulative CCG overspend against an allocation of £556 million. The NHS England Annual Report and Accounts describes ‘2016/17 as a year of unprecedented challenges for NHS Commissioners’.

The creation of the risk reserve placed significant pressure on the commissioning system. This required an increase in the level of savings commissioners needed to make, from an average of 2.2% of allocations in 2015/16 to 3.0% in 2016/17 plans. Further pressures included a £190 million increase in Department of Health set rates for funded nursing care.

CCGs delivered £2 billion of efficiencies in 2016/17 compared to £1.5 billion the previous year. The majority of CCGs delivered their financial position, however 85 CCGs reported operating overspends totalling £607 million, leading to the aggregate overspend of £556 million. This outturn included £17 million of underspends by 24 CCGs and a £34 million underspend of the quality premium budget.

CCGs are likely to face one of their most financially challenging years to date in 2017/18. Across our audits CCGs are reporting increasing financial pressures. These are arising from numerous sources including underachievement of savings plans, rising continuing healthcare costs, increased demand for services and increases in emergency care activity.

Our own experience mirrors that reported by July's HFMA 'NHS financial temperature check'. HFMA reported that:

- 28% of CCG Finance Directors are forecasting an in year deficit position in 2017/18, with 16% forecasting a deficit in 2018/19
- CCGs planned QIPP as a percentage of income is expected to grow to 3.9% in 2017/18, with 46% of CCGs having savings plans that are in excess of 4% of their income
- STPs remain at an early stage of development and 77% of CCG Finance Directors report that they are 'not confident' or 'not very confident' that their STP has the ability to deliver a plan to help close the funding gap by 2021.

Transformation of services is now commonly accepted as the way forward, with the redesign and closer integration of patient pathways and reduction of clinical variation. Many CCGs are now investing money earlier in the patient pathway (typically the primary care setting) to focus on prevention and support the management of more people in the community setting. CCGs are also increasingly looking at reducing procedures with 'limited clinical value'.

Similar financial pressures are being felt in the provider sector and both CCGs and providers are under pressure to achieve their control totals. There are some risks to this and we are seeing signs that both CCGs and providers are cooperating less and are focusing more on enforcement of contracts. This is making working in STP and the establishment of joint, long term redesign of care systems more difficult.

### The future provision of GP services

There are many significant challenges affecting primary care services. These include reduced funding, workforce recruitment, CQC inspections and increased demand primarily caused by 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 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 round table discussion last year 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](#)'. The direction set out in the General Practice Forward View also complements the key findings in our paper. Since our report was issued, we have noticed an increase in the number of GPs investigating the option of a GP 'super practice', and further detail has emerged on MCP proposals such as in Dudley.

Grant Thornton has assisted some of the largest super practices and federations in developing their arrangements such as business planning and tax management. Further detail about our experience in this area is set out in Appendix 2.

### CCG fraud

The battle against fraud in the NHS came into focus during September with the report by the City of London Police's Economic Crime Academy on NHS Protect. The review considered a number of investigated cases as well as individual interviews and focus groups with intelligence and investigations staff. The report made 21 recommendations, the key conclusion being that there is a significant under-reporting of frauds within the NHS, which leads to under-detection and therefore financial loss for the NHS. The report also referred to concerns in relation to the role of the Local Counter-Fraud Specialists, including the lack of investment at some NHS organisations and the need for more directive control from NHS Protect.

The NHS Counter Fraud Authority, which began in shadow form in April 2017, will be established in the autumn as an independent special health authority to replace NHS Protect. This comes at a time when full time employees in NHS Protect reduced by 12.5%, its budget reduced by 0.5m (between 15/16 and 16/17), and its in-house training function was withdrawn.

Despite these findings and changes, it is evident that there have been a number of successful investigations. In the December key issues bulletin, we highlighted the case of a lead commissioner for mental health and learning disability being found guilty of fraud, where he used his position to authorise fake payments to two companies set up in his name.

A few months later another fraud case relating to mental health and a CCG was reported. The case related to the then Senior Commissioning Manager for Mental Health and the Clinical Lead for Mental Health at Sandwell and West Birmingham CCG. Both were trustees for the 'Primary Care Mental Health and Education' (PRIMHE) charity. Towards the end of 2012, as the predecessor PCT was nearing its end, commissioners could apply for 'Innovations' funding for schemes that improved service quality. However, due to winter pressures, the funding was ended. The Senior Commissioning Manager and Clinical Lead, knowing that the scheme had ended, submitted an invoice for £153,600 to the CCG in the name of PRIMHE. The invoice was paid in error and, as trustees, they were able to transfer 95% of the money in to a bank account under their control. The fraud was identified after a colleague raised their suspicions with senior staff.

Both individuals were well connected and respected health professionals, however this case indicates the importance of reporting issues where such suspicions arise. The Accountable Officer at the CCG highlighted how they acted swiftly once the matter was raised by the internal whistleblower. The case clearly demonstrates the need for organisations to ensure appropriate whistleblowing arrangements are in place and are fully understood by all staff members to help detect such fraud.

We have a wealth of experience in reviewing an organisation's governance arrangements, including those relating to fraud. If you would like any further information about how we can help, please get in touch.

## Procurement - Virgin Care

Given the continuing pressures on NHS finances, it is fully understandable that CCGs are looking at a range of different ways to deliver and procure services, many of which are being driven by the STPs. Some of these methods are relatively new to large parts of the NHS. It is critical that procurement processes comply with the relevant regulations to ensure that the NHS is not at risk from subsequent legal claims, as has been the case in Surrey in recent months.

Virgin Care is currently proceeding with legal action against NHS England, Surrey County Council and six Surrey CCGs over what it views as an unfair procurement process for the delivery of £82m of Children's Services in Surrey over the next three years. Virgin Care has stated serious concerns over the procurement process which ultimately led to the contract being awarded to a different provider. Virgin Care provides a significant amount of NHS services across the country, with over 400 contracts in place across the whole of the NHS and considerable contracts wins in recent years.

This case highlights the importance of ensuring clear and transparent procurement processes are in place when CCGs and other bodies are looking to award contracts outside of the routes which have been followed historically. Where CCGs do not feel that they have the relevant expertise internally to be able to procure complex contracts, external support for the procurement process should be obtained to reduce the risk of the decision being open to future legal implications.

## Benchmarking annual reports

Each year, as part of our work with audit clients, we complete a benchmarking review of the organisation's annual report. The review is well received and helps CCGs identify potential areas for further development. We will shortly commence the review of 2016/17 annual reports. The exercise will give CCGs insight on the areas where they are ahead of the pack in the disclosures made, or where improvements may be made. The annual report plays a significant role in communicating how CCGs are responding to challenges, such as the unprecedented financial and operational issues, and allows organisations to demonstrate how they are adding value.

Given that we are about to embark on our research for the benchmarking of 2016/17 annual reports and the issues previously considered remain relevant, we felt that now is a good time to reflect on our findings from the 2015/16 review. Our detailed findings are set out in Appendix 3.

In a future key issues bulletin, we will reflect on the annual progress and highlight ways the annual report can be developed further.

## CCG mergers

At a national level there is a growing appetite for formal CCG mergers. Several are now in the formal process of application with a view to commencing as a new statutory body on 1 April 2018. The vast majority of CCGs have already 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 skills base. This move to joint working and shared responsibility will be particularly welcome for those CCGs currently struggling to tackle common issues with NHS providers or social services.

However achieving effective joint working will not be easy. Key issues to address include the governance structures put in place in the short-term to medium-term, and people and culture issues amongst governing bodies, members and employees.

Governance reform is currently at an infancy stage and the different solutions being considered by CCGs include:

- ensuring that board and committee meetings are considering the business of more than one CCG in an effective and time-efficient manner
- ensuring everyone remains engaged with the new strategic direction
- developing a culture for the new organisation which takes only the best elements from the existing CCGs
- enabling effective governance challenges from individual CCGs, balancing statutory responsibilities against system priorities.

We hosted a round table discussion on this topic and published an [All Together Now](#) report to share our insight on best practice.

# Appendix One - Final Accounts in 2016/17

## 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 (DH) and NHSE.

This paper provides an assessment of the fourth year of CCGs audit accounts, of which we audited over 32% in 2015/16. It includes findings from the PSAA report 'Summary - Results of auditors' work 2016/17: NHS bodies' 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 meeting 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.

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 publically responded to.

For CCGs nationally:

- 28% of CCGs (59) received a qualified regularity opinion, reflecting the challenging financial position facing many CCGs. This was an increase on the national level for 2015/16 where 16% (33) of CCGs received a qualified regularity opinion. These qualifications were due to breaches of the revenue resource
- Section 30 referrals were made to the Secretary of State for Health and NHSE for all those CCGs who had qualified regularity opinions. In 2015/16 auditors referred 16% of CCGs (33) to the Secretary of State, predominantly due to the financial position
- An 'emphasis of matter'<sup>1</sup> paragraph was issued at Northumberland CCG, which highlighted uncertainty that may cast doubt on the CCG's ability to continue because of the level of cumulative deficit and QIPP savings required. Another emphasis of matter paragraph was issued at Coastal West Sussex CCG to reflect four unresolved data validation and reconciliation differences between the CCG and its principal provider trust in relation to the CCG's expenditure.

At the time of the audit the case was progressing to formal mediation and no provision had been included in the accounts to reflect any potential liability. No emphasis of matter paragraphs were issued in 2015/16

- Non-standard<sup>2</sup> VfM arrangement conclusions were issued at 26% of CCGs (54), an increase in 10% (28) from the previous year. In 2016/17, the vast majority of these (46) were 'except for'<sup>3</sup> conclusions and related to CCGs breaching their revenue resource limit or setting deficit budgets for 2017/18. Adverse<sup>4</sup> VfM conclusions were given to eight CCGs (six in 2015/16) and related to weaknesses such as not setting a sustainable budget with sufficient capacity to absorb emerging cost pressures, a lack of a credible financial recovery plan and governance weaknesses identified within S.75 agreements with local government bodies
- 1% of CCGs (3) included an 'other matters'<sup>5</sup> paragraph in their 2016 audit reports in relation to disclosures within the remuneration report relating to pensions benefits of senior managers. This is consistent with 2015/16 where 1% of CCGs (3) included an 'other matters' paragraph in their audit report.

## Assisting CCGs in the fourth year of producing accounts

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

- ran regional accounts workshop before the year end
- produced tailored benchmarked 2015/16 annual reports for CCGs to assist in the production of the 2016/17 reports
- discussed technical issues early with individual CCGs
- held regular meetings and shared working paper requirements before the year end.

## Main issues with remuneration reports

Remuneration reports continued to be an issue for some CCGs. Residual issues associated with the remuneration report remaining in 2016, particularly:

- changes made by officers after submission of accounts and annual report for audit
- incorrect comparators
- additional disclosure required in relation to staff numbers
- average staff numbers incorrectly included lay members
- incorrectly included joint funding provided by another body within the staff costs of a senior officer
- incorrect banding disclosures for salary and pension costs.

## Planning for 2017/18 accounts

Planning for the preparation of CCGs' 2017/18 financial statements should begin now, starting with a review and assessment of the whole process from 2016/17. To assist with this, we will:

- run final accounts workshops early in 2018
- continue to work with the HFMA to identify any updates and further support that might help CCGs
- issue model working paper requirements based on the experience of what work well and less well in 2016/17
- consider 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 sustainability and transformation footprints and development of Accountable Care system models.

## Appendix 2 – Future sustainability of primary care

We set out our views on the future direction of primary care in our 2016 ‘Primary Concern’ report. The position and direction set out has been confirmed by many other commentators and mirrors the NHS England’s GP Forward View. In our report we discussed the many pressures currently facing primary care such as patient demand, GP shortages and decreasing practice profitability.

The current arrangements for delivering primary care are unsustainable in the medium-term, meaning that significant numbers of GPs face the prospect of going out of business. Practitioners must focus on either generating additional income or reducing expenditure. Whilst options are available to increase income such as bidding for contracts to provide services which were previously supplied by local NHS trusts, reducing expenditure appears to be the most realistic option.

We argue that GPs need to consider collaboration with other practices such as a federation, super practice or similar alternative delivery structures. Federations however have not generally proven to be successful and can be hindered by taxation rules, therefore GPs may look to increase personal earnings by creating new, larger practices with their peers. These will help achieve scale and thereby cut costs in areas such as practice management back office functions, preparation for regulatory inspections, clinical negligence insurance, locum GP costs and accountancy. This will also enable practitioners to cover additional sessions at linked surgeries to avoid locum GP hire costs, improving GP work-life balance by removing some of the pressures associated with managing a smaller practice and increasing resilience within the service.

Careful consideration is needed regarding reward structures to ensure individual surgeries within the organisation are fairly remunerated, reflecting the amount of business they bring in. A potential solution to this is individual profit centres for member surgeries. There are many different forms of super practices in operation, some of which are decentralised and give the previous GP practices considerable autonomy. For example, in some models, the previous individual practices can choose to recruit and retain their own staff and retain profits made after making a contribution for any central services provided by the new GP super practice.

GPs may also have the option of working with a local NHS trust as a salaried GP as opposed to exposing themselves to the financial risk and administrative burden of sole or small practices. This has the added benefit of enabling trusts to more effectively manage patient pathways.

We believe it is in the long-term interest of CCGs to assist GPs in their area in moving towards the delivery of primary care at scale if the crisis in primary care is not resolved. Secondary healthcare budgets in turn are likely to continue to overspend. There are significant costs of a CCG dealing with a practice which has closed, not only financially but in terms of reputational damage and inconvenience for patients. It is not surprising that we have seen many CCGs proactively seeking solutions in this area which often includes financial support.

With the advent of accountable care systems, it will be essential for groups of smaller GP practices to come together to provide services.

Some of the options open to GP practices include:

- stay as you are but innovate
- form a super-partnership
- join an existing super-partnership
- multiple smaller partnerships/mergers
- GP provider company to tender for more business
- federation
- GP provider company to tender for more business
- take-over by acute or community trust.

We are finding that more GPs are now considering the option of forming a super partnership, perhaps having first been in a federation.

Some key questions that CCGs can ask themselves in this area include:

- what concerns do you have about GP shortages?
- how close are some of your GP practices to financial collapse?
- what sort of financial and other concerns do GPs have?
- how are the GPs responding?
- how is your CCG responding?
- what discussions are you having with the GPs about making primary care more resilient?
- are any of the local NHS trusts interested in taking over GP services?

### How we can help?

We have been working alongside groups of GPs as they develop into super practices, such as Our Health Partnership in Birmingham which is the largest super practice in the country. It currently has 187 partners (and 50 salaried GPs) covering 340,000 patients. The work we have done has involved providing support in setting up the super company, starting with assessing the business case (ie what savings are to be made), reviewing current practice accounts, project management and assistance on the many tax and VAT issues. We are happy to discuss potential options with groups of GPs and share our insight and experience.

## Appendix 3 - Benchmarking annual reports

Annual reports are required to be fair, balanced and understandable. These requirements are increasingly being met. When benchmarking 2015/16 annual reports, we considered three key areas which are contributing to the transformation of services:

- leadership, people and culture
- governing integration
- stakeholder engagement & empowerment.

### Leadership, people and culture

We found that only a few organisations reported on the steps taken to ensure that a risk-aware patient-led culture operates and is embedded. System-wide leadership plays a significant role in moving forward collaborative local health economy agendas, however only one in three organisations reported progress on such leadership. Evaluating the effectiveness of the governing body and communicating the outcomes remains a cornerstone of good governance, though question marks remained on the transparency of such evaluations. We anticipated an increase in disclosures related to accelerating innovation and new ways of delivering care, however there was a reduction in such reporting.

Reporting on strategic risk in annual reports around financial and operational performance has increased. Such increases are to be expected given the current climate that organisations are operating within. However, there was an unexpected reduction in the reporting of strategic risks around partnership and collaborative working.

### Governing integration

The importance of collaboration and integration is clear given sector operational risks and financial challenges. Reporting on the development of shared integrated care governance was disclosed to some degree, with 45% of reports making reference to links with local government but only 20% on arrangements with the third sector. Progress around the integration of health and social care was reported at 84% of CCGs. Going forward we expect to see further commentary on new emerging models of care in annual reports. We found that there was less reporting on prevention and its priority than in previous annual reports. For example, the sufficient partner input to support prevention initiatives was unmentioned in many disclosures.

### Stakeholder engagement and empowerment

We saw innovative stakeholder engagement examples in 58% of reports, however only 32% included empowerment examples. Stakeholder empowerment is an important part of realising step change in the care system and we expect to see an increase in such examples in future years. Reporting on serious clinical incidents improved between 2014/15 and 2015/16, though clear reporting on complaints reduced slightly over the same period.

Annual reports remained lengthy documents. The average length of CCGs' annual reports was 116 pages, a reduction of one page between 2014/15 and 2015/16, despite the average length of governance statements rising by two pages. The quality of disclosure on collective and individual board evaluation remained poor and emphasised the need for greater transparency about the performance of leaders.

If you would like more information on our annual report benchmarking reviews, please contact your Engagement Lead or Engagement Manager.

<sup>1</sup> Auditors may add an 'emphasis of matter' paragraph after their opinion. This draws the attention of users of the accounts to a matter, or matters presented or disclosed in the accounts, which are of such importance that they are fundamental to users' understanding of the accounts. This does not affect the auditor's opinion on the accounts.

<sup>2</sup> A Vfm conclusion other than unqualified is known as 'non-standard'

<sup>3</sup> A 'Except for' Vfm Conclusion is given where the auditor has identified one or more weaknesses that are sufficiently significant in their professional judgement to warrant reporting, but are limited to specific issues or areas. In such circumstances the auditor may conclude that the body does have proper arrangements in place, 'except for...' the issue concerned.

<sup>4</sup> Adverse Vfm Conclusion is given where the auditor concludes that the weaknesses in arrangements that they have identified are either so significant in terms of their impact, or so numerous in terms of the number of different aspects of proper arrangements affected, that they are unable to satisfy themselves that the body has proper arrangements in place to secure value for money.

<sup>5</sup> NHS auditors are also required to report on two 'other matters' contained within the NHS accounts. These include ensuring that:

- the annual report is consistent with the financial statements
- the specified elements of the remuneration and staff report subject to audit have been prepared in accordance with the relevant guidance.

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