

Contributing to the debate on NHS finance
September 2011

Governance: managing a corporate organisation

Governance arrangements for commissioning groups as statutory bodies

Foreword

The Healthcare Financial Management Association (HFMA) is the representative body for NHS finance professionals. With a 60-year history, it has a long track record in issuing authoritative guidance, delivering training and helping to spread best practice in financial management.

Good financial management is the responsibility of all staff and fundamental to delivering high-quality healthcare. The need to have a sound underlying approach to finance, financial management and governance will be increasingly important as the new structure for the NHS set out in the Health and Social Care Bill is introduced during a time of financial constraint in the public sector.

This briefing, the fourth in the series, is designed to help GP practices prepare for the challenges ahead. As statutory bodies, clinical commissioning groups will assume significant responsibilities in terms of governance and accountability for taxpayers' money. They will need to be able to show that this public money is used well and for its intended purpose.

This means more than producing financial accounts once a year. As statutory public bodies, clinical commissioning groups will also be required to justify on an ongoing basis that they are using public money wisely and effectively and that they are operating in a certain way.

To be able to demonstrate they are operating with such strong principles, clinical commissioning groups will need to have systems in place that make clear who is responsible for what, and how and by whom decisions are taken. These systems, known as the governance framework, cover all aspects of how an organisation operates.

This briefing looks at tools that clinical commissioning groups may find helpful in ensuring they meet their statutory responsibilities and operate in the public interest.

The HFMA is active at a national and local level in raising awareness of how NHS finance works, influencing policy development and raising the skill base of those involved in financial management. We support NHS organisations and individuals in improving financial management through periods of change, and plan to release further briefings as the transition to the new NHS gathers pace.

We trust you will find this briefing helpful and would be delighted to hear your feedback. We would also welcome any suggestions you may have for ways in which we might support your practice and the development of clinical commissioning groups.

John Yarnold, chair of the HFMA Governance and Audit Committee

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Overview

The government is planning to put GPs at the heart of the NHS, with direct responsibility for a large part of the NHS budget. As this is taxpayers' money it comes with strings attached – namely that there is an absolute requirement to demonstrate that it is used well and for its intended purpose.

Clinical commissioning groups will be responsible for how they spend these funds and the decisions they make and will need to demonstrate absolute probity in all they do.

This means more than producing financial accounts once a year: as public bodies, commissioning groups will also be required to justify on an ongoing basis that they are using public money wisely and effectively and that they are operating openly and transparently.

To be able to do this, commissioning groups will need to have systems in place that make clear who is responsible for what, and how and by whom decisions are taken. Collectively, these systems are known as the governance framework and they cover all aspects of how an organisation operates.

Governance is concerned with how an organisation is run – how it structures itself, how it is led, how it is held to account and how it justifies its actions or decisions. It also means that good governance is the responsibility of all members of staff, not just those in leadership roles.

This briefing looks at the arrangements commissioning groups may need to establish to ensure they avoid failure, can meet their statutory responsibilities and operate in the public interest. It considers where their accountabilities may lie and what can be learnt from existing NHS organisations and the way in which they fulfil their own accountability requirements. It looks at:

- Governance standards and what happens when things go wrong
- What it means to be accountable
- What accountability might look like for commissioning groups
- Key roles and responsibilities
- The practical implications.

The briefing is not intended to be exhaustive in its coverage nor does it aim to set out a standard approach that all groups should follow. Instead,

it focuses on tried and tested tools that commissioning groups may find helpful as they establish their own approach to effective governance and take on their new roles and responsibilities.

Introduction

Public sector organisations need to operate in line with the legislation that establishes them and be held to account for delivering their aims and objectives, justifying to a wide range of people and organisations the actions taken and decisions made – did the organisation do what it said it would in an appropriate way and what were the consequences if it didn't?

Increasingly, the public and media make use of freedom of information legislation to hold those in public office and public sector organisations to account, often with dramatic and well publicised consequences.

In any organisation (in whichever sector), you need to be clear about your aims and ambitions and how best to achieve them. This means getting the right culture and structure in place and the right people involved to deliver those aims.

You can't manage an organisation effectively and achieve what you want to without thinking through your vision, strategic objectives, governance and management structures and values. Unless you do this, stakeholders – those with an interest in the organisation and its actions – cannot be sure that their interests are being safeguarded, that the organisation is well managed and that the objectives will be met.



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Governance failures

There is a level of expectation from the general public about how a public sector organisation will 'behave'. When the governance systems and structures aren't in place or break down, there can be catastrophic and very public consequences directly affecting patients, as well as damaging the reputation and viability of the organisation concerned.

There have been a number of high profile and well documented failures in the NHS, including:

- Bristol Royal Infirmary and Royal Liverpool Children's (Alder Hey) inquiries in 2001
- The Shipman crimes of 2003/04
- Healthcare Commission's reports into Stoke Mandeville hospital (2006), Maidstone and Tunbridge Wells NHS Trust (2007) and Mid-Staffordshire NHS Foundation Trust (2009).

To find out more about some of these cases and the links to governance arrangements see box below.

Some of the investigations into such lapses have also underlined the need for governance policies, procedures and structures to be comprehensive – too often, processes that appear adequate on paper, do not operate in practice.

In these cases and others in the NHS a clear linkage can be drawn between the clinical shortcomings and the governance failings that allowed them to continue uncorrected, emphasising that effective governance must cover all that an organisation does and involve every member of staff. Such failures also drive home to those responsible for the organisation and achieving its aims just how wide ranging their responsibilities and accountabilities can be.

Being accountable

All public sector organisations, be they health, local authority, police or education, are expected to show their stakeholders that they are using taxpayers' money wisely and well – showing good judgment and being accountable for its use.

In the private sector shareholders are the key concern in accountability terms, but in the public sector organisations need to meet a number of statutory responsibilities as well as build public and stakeholder confidence.

It is important therefore that commissioning groups are able to identify who they are accountable to, what they need to deliver, how they will go about demonstrating they have done so and what the sanctions may be if they fail. As statutory organisations, commissioning groups will have a wide range of things they need to deliver, including key duties required by law.

They will also need to demonstrate to different stakeholders that service provision and public resources are in safe hands, and that they have met their objectives and standards. This will influence the governance structures and processes they need to establish.

Commissioning groups will also have a wide range of accountabilities to the public and to parliament through the NHS Commissioning Board (NHSCB). You can see these relationships in the diagram above right.

How everything will work together under the future structure is not yet clear, but this briefing will follow through the different accountabilities commissioning groups are likely to have, identify where statutory responsibilities are involved and link them to the arrangements that can help to fulfil them, drawing on the experience that already exists in the NHS.

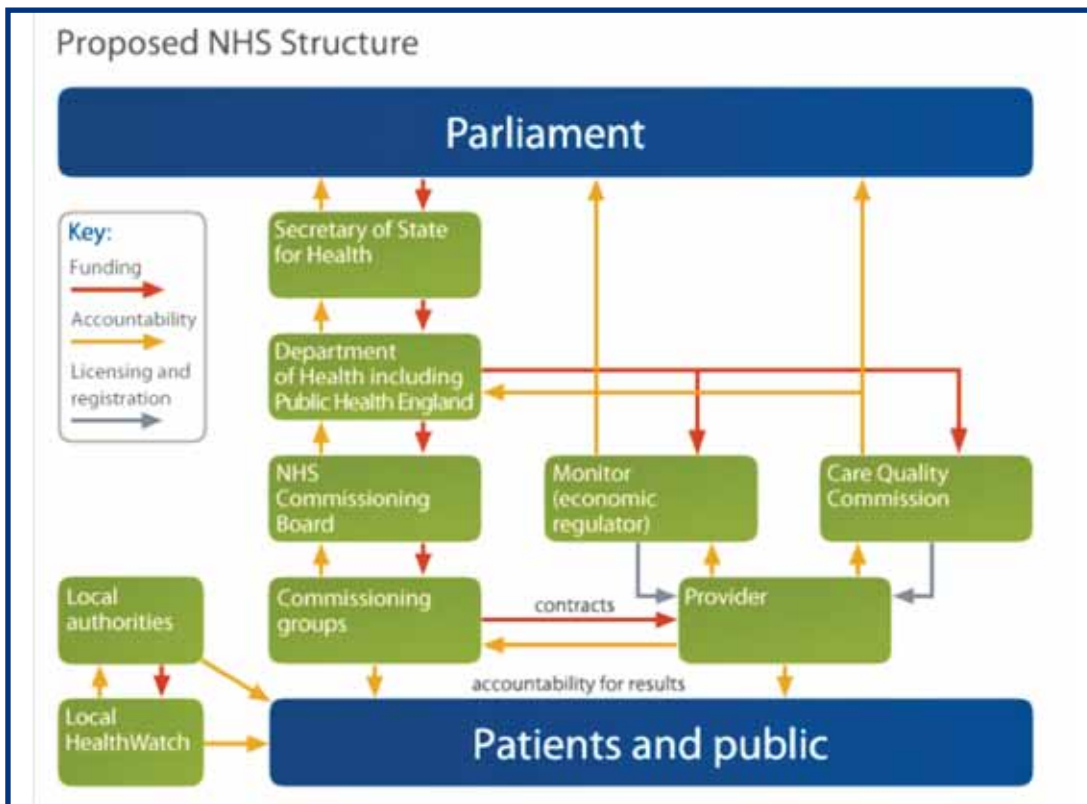
GAPS IN GOVERNANCE ARRANGEMENTS

The 2001 inquiry into the treatment of very sick children at the Bristol Royal Infirmary found a number of significant governance failings including:

- Unsafe arrangements for caring for the children
- No requirement for consultants to keep their skills and knowledge up to date
- No agreed standards of care
- No openness about clinical performance
- No systematic mechanism for monitoring the clinical performance of healthcare professionals or hospitals.

A number of significant gaps in governance processes also enabled Dr Harold Shipman to continue to murder his patients over a long period of time without detection. The numerous inquiries into his practice highlighted, among other issues, the need to share information about complaints and concerns raised that should then be systematically investigated, and the importance of establishing strong governance processes and culture.

The Healthcare Commission's 2009 investigation into Mid-Staffordshire NHS Foundation Trust (where multiple management failures led to high mortality rates) found that the trust, which was seeking to make financial savings in order to apply for foundation trust status, appeared to 'have lost sight of its real priorities'. The initial report by Robert Francis QC on Mid-Staffordshire (2010) revealed that deficiencies in staffing and governance extended over a period of more than five years and yet remained un-remedied by those responsible.



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- Exerting influence to shape the wider healthcare agenda

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What might accountability look like for a clinical commissioning group?

It is important to bear in mind when establishing governance structures that they need to suit local circumstances and – as one of the standards in the Treasury guidance document *Managing public money* says– ‘avoid over-defining detail and imposing undue compliance costs, either on its own staff or on its customers and stakeholders’.

In other words, while the governance framework needs to be sound and ‘fit for purpose’, it should do only what is absolutely necessary and no more.

Governance context

From the diagram above, it can be seen that a commissioning group will have a primary ‘upwards’ accountability to parliament via the new NHSCB, subject to parliamentary approval of the Health and Social Care Bill 2011. However, as part of the wider NHS, there are a number of wider duties that commissioning groups will need to deliver and we’ll examine these first, as they provide the context within which the groups will operate.

The NHS Constitution

In January 2010, the first ever NHS Constitution came into effect, placing all providers and commissioners of NHS care under a statutory duty – something they must do – to have regard to the

Constitution in all their decisions and actions. As the Department of Health website states: ‘This means the Constitution, its pledges, principles, values and responsibilities need to be fully embedded and ingrained into everything the NHS does.’

The coalition government has made clear that it will ‘uphold and reinforce the NHS Constitution, which all providers and commissioners will be obliged to have regard to in carrying out their

NHS CONSTITUTION

The NHS Constitution contains the following seven key principles:

- The NHS provides a comprehensive service, available to all.
- Access to NHS services is based on clinical need, not an individual’s ability to pay.
- The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on the patient experience.
- NHS services must reflect the needs and preferences of patients, their families and their carers.
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
- The NHS is committed to providing best value for taxpayers’ money and the most cost-effective, fair and sustainable use of finite resources.
- The NHS is accountable to the public, communities and patients that it serves.

functions.' Consequently, commissioning groups will be required to 'take active steps to promote' the NHS Constitution, which means abiding by its seven key principles (see box previous page).

Public sector principles

The Department has specified that each commissioning group must have in place a constitution of its own – a set of fundamental principles according to which it is governed. To find out more about how these organisational constitutions work, see box below.

Culture and values

The Department's March 2011 publication *The functions of GP commissioning consortia* identifies the need for commissioning groups to develop their constitutions in line with the seven principles of conduct in public life identified by the Nolan Committee (later, the Committee on Standards in Public Life) in 1995, namely:

- **Selflessness:** Holders of public office should act solely in terms of the public interest.
- **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity:** In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take.

- **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

HM Treasury's guidance document, *Managing public money* also sets out the standards it expects all public services to deliver – these overlap with the Nolan principles:

- Honesty
- Fairness
- Impartiality
- Integrity
- Openness
- Transparency
- Accountability
- Objectivity
- Accuracy
- Reliability...

...carried out...

- In the spirit of, as well as to the letter of, the law
- In the public interest
- To high ethical standards
- Achieving value for money.

Together, these standards provide a 'blueprint' for the underlying culture and values of any public sector organisation and should underpin all that a commissioning group does and how it operates.

As part of the authorisation process for commissioning groups, the NHSCB will assess governance arrangements and ensure they are consistent with the Nolan principles and are 'accountable and transparent'.

Acting lawfully

As a statutory public sector body, a commissioning group must act within the law and never beyond its legal powers or ultra vires. This will include compliance with equalities duties, meeting the requirements of the Employment Rights Act, the Freedom of Information Act, health and safety legislation and many others.

The functions of GP commissioning consortia identifies key acts of parliament that will be of particular interest as commissioning groups develop their constitutions and governance arrangements in the coming months.

HOW ORGANISATIONAL CONSTITUTIONS WORK

As well as setting out its name and the commissioning group's constituent practices, the constitution must also specify how the commissioning group will carry out its functions and how it will make decisions.

An example of how this may work already exists in the NHS as foundation trusts have constitutions and all NHS trusts and primary care trusts have standing orders in place that perform a similar function.

Constitutions and standing orders translate an organisation's statutory powers into a series of practical rules designed to protect the interests of the organisation, its staff and 'customers' and are similar to the articles of association of a private sector company.

Accountability to the NHS Commissioning Board

The primary upward accountability for each commissioning group will be to parliament through the NHSCB, which is a statutory relationship. It is the NHSCB that will approve an application to establish a commissioning group and allocate its funding in due course. Each commissioning group will then be accountable to the NHSCB for the delivery of core duties in relation to finance and quality outcomes. Although the detailed mechanisms for this are still to be finalised, a number of key features are already known.

Finance outcomes

Commissioning groups will operate with resource limits, a key mechanism for controlling finances within the NHS. You can find out more about these limits and how they work from the box below.

As the NHSCB will have its own statutory responsibility to stay within the available resources, it will require commissioning groups to remain within their own individual resource limits.

To demonstrate delivery against resource limits, spending is likely to be closely monitored throughout the year, with commissioning groups needing to provide both financial and other information to the local teams of the NHSCB as required. This may entail the submission of primarily financial information at the end of a month or quarter to a specified timescale.

Each commissioning group will need systems and processes in place to ensure the right information is collected on a regular and timely basis, checked for accuracy and 'signed off' by the organisation. This is likely to require a level of technical and informatics support that may not currently be in place.

Another way in which delivery of this duty will be demonstrated is through the preparation of year end annual accounts for commissioning resources, which are submitted to the NHSCB, again in a prescribed format and to a specified timescale. This will facilitate the production of the accounts for the NHS as a whole and enable them to be laid before parliament before the summer recess.

These are requirements in which PCTs are well versed, providing monthly, quarterly and year end returns to their strategic health authorities and

they will be able to offer support to commissioning groups as they become established.

Quality outcomes

The role of the NHSCB will be to work with commissioning groups to 'use the commissioning budget... to secure the best possible health outcomes for patients and communities'. Consequently, commissioning groups will have a statutory duty to secure the continuous improvement in the quality of services for patients.

This is currently a duty placed on PCTs and will involve commissioning groups arranging for the provision of services that 'aim to secure improvements in physical and mental health, or in the prevention, diagnosis and treatment of illness'. This will be achieved and measured through the Commissioning Outcomes Framework based on a number of quality standards for particular service areas. Both the reduction of inequalities in healthcare and the achievement of continuous improvement through effective commissioning will be rewarded through financial incentives and a quality premium, although the details of how this will work are not yet clear.

The delivery of improved health of a population and improvements in healthcare are also areas where PCTs have been required to deliver, most notably through World Class Commissioning. This was introduced by the Labour government in 2007 and involved SHAs assessing PCTs' progress against key indicators and commissioning competencies as part of an annual process to examine the extent to which a PCT had achieved better health outcomes.

Intervention

The responsibility for performance against financial and other objectives means the NHSCB may need to intervene in the event of a commissioning



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RESOURCE LIMITS

The revenue resource limit is the total funding allocated for revenue or day-to-day spending and will be set for each commissioning group by the NHSCB each year. Under the current system, strategic health authorities (SHAs) and PCTs have resource limits within which they must stay as part of the annual statutory performance targets for these bodies. Performance against the target is reported in the annual report and accounts. A similar limit applies to capital expenditure – spending on land, buildings and equipment – and commissioning groups will also be required to ensure that such spending does not exceed this limit.

group failing to deliver their statutory duties over a period of time or if there is a significant risk that this may happen. To that end, the Health and Social Care Bill 2011 provides the NHSCB with a range of measures ranging from requiring additional monitoring and action plans to (as a last resort) dissolving a commissioning group itself.

Accountable officer

The key link between the commissioning group and the NHSCB – and vital to ensuring the sound stewardship of public funds – is the accountable officer. This is a formal and specified role that already exists throughout the public sector.

Although the coalition government has not set out detailed requirements for commissioning groups it stated in its white paper *Liberating the NHS – commissioning for patients*: 'We intend consortia, once established, will be statutory bodies, with powers and responsibilities set out through primary and secondary legislation. By that time, each consortium would need to have chosen its own accountable officer and chief financial officer.'

This requirement has since been confirmed and expanded in *The functions of GP commissioning consortia – a working document*. One person will be able to hold this important role for more than one commissioning group and can be an existing member or employee within the commissioning group concerned, or someone new to the organisation(s). In NHS organisations the accountable officer role is normally fulfilled by the chief executive officer.

The accountable officer will be accountable both to the NHSCB and within the commissioning group. The way in which accountability may stretch from the accountable officer upwards to parliament is shown in the diagram below.

The accountable officer will be selected by the commissioning group itself but formally appointed by the NHSCB at the time of authorisation. As with other NHS organisations, accountable officers' responsibilities are likely to be set out in a memorandum by the Department. They will include the requirement to appear before the Committee of Public Accounts to give evidence of their and their organisation's performance as requested.

The accountable officer is responsible for ensuring compliance with statutory obligations. Broadly, these can be thought of in terms of:

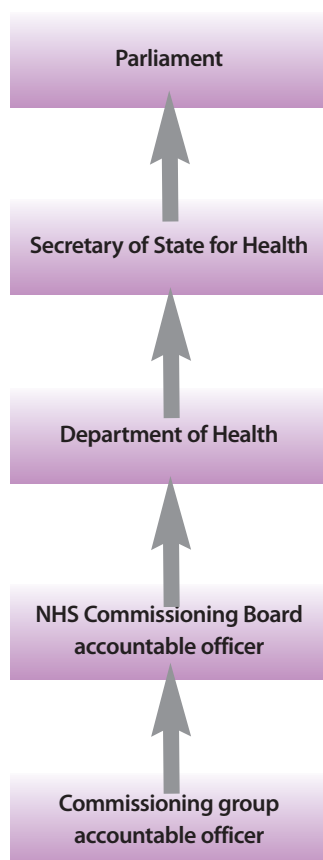
- Improving the quality of services through effective commissioning
- Finance
- Information.

The accountable officer will have a key duty to ensure that the commissioning group is securing continuous improvements in outcomes for patients, notably in terms of the effectiveness of the treatments received, the safety of the services commissioned and the overall quality of the patient experience.

It is important that all organisations spending public money are able to account fully and transparently for their use of public funds and the role of the accountable officer is key to this in ensuring that the organisation:

- Operates effectively, economically and with probity
- Makes good use of its resources
- Keeps proper accounts.

ACCOUNTABILITY HIERARCHY



This important overarching requirement is also noted as a general statutory duty for commissioning groups as public bodies and is widely recognised as underpinning the governance arrangements of all public sector organisations.

How might a commissioning group organise itself?

To support the delivery of these duties, the accountable officer will need to ensure that the commissioning group works in partnership with other organisations and that proper governance structures and systems are put in place to cascade responsibilities through the organisation itself. We'll look at both these areas in turn.

External partnerships

No part of the NHS works in isolation. It is complex and multi-layered and commissioning groups will need to take account of and work with a large number of partners in their area to deliver their objectives and duties, some of which will be joint responsibilities with one or more organisation(s).

Next we'll examine some of these key external partnerships and responsibilities, as well as some of the difficult questions that such relationships pose.

Working with the wider health economy

When established, commissioning groups will have a formal duty to co-operate with other NHS bodies. This will include providers of healthcare, PCTs and associated clusters (until they are formally abolished), and other commissioning groups.

They will need to consult on commissioning plans with the new clinical senates, which will be hosted by the NHSCB and provide 'expert advice on how to best make patient care operate effectively in each area of the country', as well as working with clinical networks both new and existing (also hosted by the NHSCB). There will also be relationships with other bodies such as local drug and alcohol teams and public health services to consider.

To fulfil their own duty to ensure continuous improvement and that commissioning arrangements are properly in place, commissioning groups will be required to use standard contracts for healthcare services. Use of these contracts combined with regular discussions with providers will give confidence to accountable officers that providers are meeting their contractual obligations in terms of service quality and patient activity. To find out more



about how standard contracts already work in the NHS, see box below.

The Department is developing a legally binding commercial contract for use by commissioning groups when they assume full responsibility for commissioning healthcare services.

Commissioning groups will also need to work closely with their local PCTs during the transition period to help pave the way for the new regime. Until commissioning groups assume their new legal responsibilities and while PCTs remain statutorily accountable as commissioners of healthcare, they have formed clusters by geographical area in order to smooth the transition to the new structure.

A number of strategic health authorities have implemented 'accountability agreements' between clusters and shadow clinical commissioning groups.

STANDARD NHS CONTRACT

A standard NHS contract is used for agreements between PCTs and all providers of NHS-funded services. In the current financial year (2011/12) the contract applies to NHS trusts, foundation trusts, independent sector providers, charitable and voluntary organisations and social enterprises.

The standard contracts cover mental health and learning disability services, ambulance services, acute hospital, community services and care homes. The Department produces contract documentation and guidance each year and requires contracts to be signed before the start of the financial year. Any disputes must be resolved swiftly with outstanding problems dealt with via mediation and ultimately formal adjudication.



These agreements set out in broad terms how resources may be allocated to clinical commissioning groups and what they will deliver as the transition progresses.

Working with other commissioning groups

Commissioning groups will have multiple relationships but should also bear in mind the operational challenges that providers of healthcare will face. At present, a provider will have key contracts with a small number of PCTs, which will account for the majority of its income from treating patients.

For example, University Hospitals Coventry and Warwickshire NHS Trust provides a large part of its healthcare services to the patients of NHS Coventry and NHS Warwickshire. These two contracts account for about 75% of its annual income. The move to commissioning groups could significantly increase the numbers of organisations with which a provider holds contracting discussions. It is also likely to lead to requests for a range of patient pathways for individual services in line with different commissioners' requirements.

This may be further complicated by the need to

agree pathways and contracts between all organisations to a timetable set out by the NHSCB.

Commissioning groups will need to be able to work with and on behalf of other groups where collaboration may provide an efficient solution for the health economy as a whole. Each commissioning group will need to understand what other local groups are proposing so that a joined up solution for patients and individual providers is achieved.

Each commissioning group will need to decide what approach best suits its local circumstances, but options include entering into contracts jointly with one another, or a single commissioning group acting on behalf of others.

This 'lead commissioning' model is already used by PCTs and involves them negotiating a contract with a service provider on behalf of a pre-agreed group of PCTs. The contract is then 'performance managed' across all member PCTs.

Working with local authorities

Although NHS organisations have always been expected to engage with their local community,



Each group will need to understand what other local groups are proposing so that a joined up solution is achieved

JOINT STRATEGIC NEEDS ASSESSMENT

The joint strategic needs assessment (JSNA) was introduced following the 2006 white paper *Our health, our care, our say*, which identified a need for there to be regular assessments of the health and wellbeing status of local populations so that meaningful objectives for local services could be established.

JSNAs are designed to 'identify the current and future health and wellbeing needs of a local population' and are a statutory requirement for PCTs and upper tier local authorities.

Under the current regime, JSNAs feed into PCTs' planning processes. In particular, they help PCTs develop and refine their:

- Strategic direction
- Priorities and targets for improving health and social care outcomes and reducing health inequalities
- Operational plans
- Service and financial plans.

Commissioning groups will have a duty to contribute to the JSNA. Commissioning plans will need to be in line with local health and wellbeing strategies and the JSNAs.



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the coalition government envisages a much wider role for local authorities in the future, most notably in securing improvements in healthcare for their local populations.

Established within local authorities, health and wellbeing boards (HWBs) will lead the joint strategic needs assessment (at present this a joint responsibility between local authorities and PCTs), which will inform healthcare commissioning. To find out more about the joint strategic needs assessment, see box above.

Although the detailed arrangements are still unknown, it is anticipated this approach will provide strategic co-ordination to commissioning of NHS services, social care and health improvement. Commissioning group members will be core members of HWBs once established and the boards themselves will have a formal role in the authorisation of a new commissioning group.

It is clear that commissioning groups and local authorities will form new partnerships for joint decision-making in order to improve the health outcomes of their local population. This may take the form of joint working arrangements and

service provision or a more formal pooled fund. Whatever form such arrangements take, it is likely that commissioning groups will be subject to review by their local authority, as with any NHS organisation under the current structure.

This oversight role is exercised through the local authority health overview and scrutiny committee (HOSC). This is a statutory committee comprised of locally elected councillors whose role is to review, scrutinise and report on NHS services and organisations. The HOSC is also responsible for overseeing the local authority's role in the promotion of health and wellbeing.

Health organisations are often invited to attend these formal meetings to answer questions on key issues, including their financial health and operational plans or to undertake formal consultation with the committee members. This is one of the ways in which commissioning groups are likely to be held accountable by the general public and local stakeholders.

Working with patients and HealthWatch

Individual GP practices have a clear and long established relationship with their patients.

RISK RATINGS

Monitor has established a risk-based approach to regulation outlined in its Compliance Framework. Assessments of risk in a number of key areas are used to determine the level and depth of monitoring that an FT is subject to. Monitor focuses on two risk areas – finance and governance.

A financial scorecard is used to generate a finance risk rating (FRR). It looks at five ratios within four criteria – for each ratio a score of one to five is awarded with one indicating a high risk of a significant breach of the terms of authorisation and five a low risk with no financial regulatory concerns.

An FT is rated in each of these metrics and then, using weightings, an overall aggregate FRR is produced. This is a whole number from one to five, where 1 indicates a high risk of financial instability and 5 a low risk.

A scoring system is also used to assess governance risk levels and a graduated 'traffic light' rating is linked to those scores. For example, if an FT achieves a green rating it indicates that there are 'no material concerns' – it is a low risk – while a red rating signifies that there is 'likely or actual significant breach of authorisation' – it is a high risk.

The scoring system takes into consideration the registration requirements of the CQC: if conditions are attached to an FT's registration, the governance risk rating is adversely affected.

However, it will be crucial to a commissioning group's success to establish good links with the members of its constituent practices and the local population. Public and patient involvement will be critical and to that end, commissioning groups will have statutory duties placed on them in order to ensure they involve these key stakeholders where necessary, notably in terms of service availability and the way in which those services are delivered.

Commissioning groups will be required to set out in their commissioning plans how the public and patients will be involved in commissioning decisions.

This important relationship will be strengthened by working with HealthWatch, which will be developed from existing Local Involvement Networks (LINKs). This will involve a representative membership of different healthcare users, including carers, one of whom will sit on the health and wellbeing board.

HealthWatch services will be contracted by local authorities with the aim of promoting patient and public involvement and seeking views on local health and social care services. Although commissioning groups will not be accountable formally to their local HealthWatch, they will undoubtedly have to think about how best to interact with this service.

Working with regulators and the information they provide

There are two key regulators with which commissioning groups will become familiar. Monitor, currently the independent regulator of foundation trusts, and the Care Quality Commission (CQC). Each has a distinct but complementary role in relation to providers of healthcare services in the proposed structure of the NHS.

The Health and Social Care Bill expands Monitor's current role into that of regulator for the health and social care sectors, with a core duty to protect and promote patients' interests. Monitor will be responsible for licensing all providers of NHS-funded care in England, including existing foundation trusts, private and voluntary sector providers, in a regime that will replace the existing system for authorising foundation trusts.

In carrying out this licensing role, Monitor will be required to co-operate with the CQC, which will continue to be responsible for registering providers against 'essential levels of safety and quality'. If licence conditions are breached, Monitor will be able to order the situation to be rectified and fine the provider if necessary. Monitor and the CQC are to establish a single integrated process of licensing and registration.

Commissioning groups will only be able to place contracts for the provision of healthcare services with an appropriately licensed provider. Commissioning groups will also need to understand and refer to the risk ratings applied by Monitor to providers with whom they consider placing contracts in order to secure the best services possible for their patients.

At the moment, all foundation trusts have both financial and governance risk ratings, which give an indication of whether they are well run on behalf of patients and taxpayers. To find out more about how these ratings work, see box above left.

A commissioning group may prefer to place a contract for service provision with its local hospital. However, if this hospital currently has an amber-red governance rating the commissioning group may ultimately consider placing the contract with a different provider. Although further away, this second provider may be rated green for governance and therefore offer a greater level of

assurance to commissioners that their patients will receive high quality care.

As part of the regulation of healthcare providers a commissioning group may be required to provide information to either Monitor or the CQC during the course of an investigation. Once established, commissioning groups will also be consulted when a local hospital trust is seeking to attain foundation status. This will be particularly important as the NHS moves to the position where all current NHS provider trusts are foundation trusts.

Commissioning groups will be asked for their views and assumptions around the number of patients to be treated by the provider as well as to outline their support (or otherwise) for the foundation trust application.

Internal governance framework

For a public sector body to meet its statutory obligations, demonstrate accountability and avoid conflicts of interest within and between it and other organisations, it needs to have in place sound systems, processes and controls – all of which form part of the overall governance framework.

This will be particularly important for GPs, who will want to avoid any conflicts of interest between commissioning and providing services. In this respect, the importance of sound mechanisms for and transparency of commissioning group decision-making cannot be over-stressed.

This will be helped by the NHSCB taking on the responsibility for directly commissioning GP and other primary medical services, but there will still be the need for commissioning groups to have their own robust internal arrangements.

The internal governance framework should enable the accountable officer to demonstrate that the required accountabilities are being met. Existing NHS organisations have a number of key features within their governance arrangements that help them achieve their objectives and minimise conflicts of interest. We'll look at each in turn and how they might apply to a commissioning group.

Management structure

While keeping in mind the running cost allowance that a commissioning group will receive as part of its funding and the need to use available resources

wisely, each group will need to agree a management structure. The Department has not specified what this needs to look like – rightly, that is for each group to decide.

It is worth noting that within the NHS, the responsibilities of a chief finance officer are complex and varied, ranging from statutory duties relating to accountability, governance and probity; 'traditional' treasurer activities; corporate strategic management and day-to-day operational management.

Two key elements of these responsibilities, which support the accountable officer in discharging their duties, are:

- The production of the annual report and accounts, which are independently audited by the external auditors
- Developing and maintaining an effective and comprehensive system of internal financial control. This is a system to assess and manage financial risks and ensure business continuity.

In determining their management structure, commissioning groups will also have to consider the linkages with constituent practices and allow for soliciting views, seeking agreement and the holding of practices to account for their individual performance so that the group stays on track overall and meets all its responsibilities.

The board

NHS organisations all currently operate with a pre-eminent governing body that takes corporate responsibility for the strategies and actions of the organisation and is accountable to the public and parliament. This governing body or board sets the strategy and objectives for the organisation, monitors their achievement, and looks for potential problems and risks that might prevent them achieving those objectives. The board also expects to receive assurances that things are working as they should do.

This overall responsibility was clearly set out by the National Leadership Council's report *The healthy NHS board: principles for good governance*, following the failings and subsequent reviews of Mid Staffordshire NHS Foundation Trust. It says: 'The purpose of NHS boards is to govern effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands.'



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BOARD STRUCTURE

The board of a public sector body takes corporate responsibility for the strategies and actions of the organisation and is accountable to the public and parliament.

It is normally comprised of the chief officer of the organisation, who is the accountable officer, a number of executive and non-executive directors, including the chief finance officer.

To support the robustness of this arrangement, foundation trusts are required to appoint non-executive directors to at least half of the seats on their board of directors.

Similarly, each board of an NHS trust can have a maximum of 12 directors excluding the chair – up to seven non-executive members (although the majority have five) and no more than five executive directors.

The board brings together in a decision-making forum the executive directors and the non-executive directors (NEDs) of the organisation and is separate from the day-to-day management structure. The board is led by an independent, non-executive chair. While foundation trusts appoint their own non-executive directors and chair, for PCTs and NHS trusts these posts are currently appointed by the NHS Appointments Commission.

NEDs play an important role by providing independence, challenge and a breadth of experience to the board. By balancing the views of the executive directors, NEDs ensure that power is not concentrated in a few hands such that no individual or small group of individuals can dominate the board's decision making. To find out how boards in some NHS organisations are made up, see box above.

ROLE OF INTERNAL AUDITORS

At present, all NHS bodies are required to have an internal audit service. This service has two aspects – assurance and consultancy. The first provides an independent and objective opinion to the accountable officer, board and audit committee on the extent to which risk management, control and governance arrangements support the aims of the organisation.

The second provides an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance.

Internal auditors develop and deliver a risk-based audit plan targeting their work in areas of greatest risk. These will include financial systems, processes and controls but also wider systems within the organisation. For example, an NHS trust may have a strong and well documented staff appraisal system but if no one follows it, it is unlikely that the organisation will get the best out of its workforce.

The coalition government has stated that each commissioning group will need to operate with 'a governing body with decision-making powers'. This governing body will have independent membership via at least two lay members (equivalent to NEDs), as well as further clinical representation through one registered nurse and one doctor who is a secondary care specialist.

The two lay members will be key appointments with specific responsibilities. One will have a lead role in patient and public involvement, while the other will oversee key elements of the governance arrangements including audit. In addition, one of the lay members will undertake the role of chair or the deputy chair.

The governing body will also be required to hold its meetings in public and publish the minutes of those meetings. These arrangements are beginning to be tested by a number of pathfinder groups.

Audit committee and the auditors

At present, every NHS organisation (including foundation trusts) must have an audit committee that reports to the board. This committee's distinctive characteristic is that it comprises only NEDs – and the chair of the organisation should not be a member. The chief executive officer and all other executive directors will attend whenever they are invited and provide assurances and explanations to the committee when it is discussing matters within their areas of responsibility.

The audit committee will receive regular reports from internal and external auditors as a means of obtaining independent confirmation that all is well with the way in which the organisation is working. On that basis, the audit committee is able to provide assurance to the board in relation to the systems operating and that adequate controls are in place. To find out more about the role of internal auditors, see box left.

As things stand, there has been no reference to a requirement for commissioning groups to have an audit committee or an internal audit service. However, establishing some form of audit or scrutiny committee is generally accepted as essential in order to provide for proper oversight, ensure good governance across the organisation and help the board to focus on strategic issues while discharging its duty to keep proper accounts and have them audited annually. New

commissioning groups will need to consider allowing for these functions when planning how to use their management cost allowance.

Internal control and assurance frameworks

The purpose of an internal control system is to minimise the risk of an organisation not achieving its objectives. For a commissioning group, the key strategic objective is likely to be described in terms of 'Securing the best value and quality of care for the population they serve whilst also promoting health and well being'.

This will involve balancing a consideration of costs, making the most of the money spent and making sure services meet the needs of patients in terms of being clinically effective, safe and delivering a good patient experience through working closely with a number of partners including local authorities and Public Health England.

To ensure that a commissioning group achieves this goal, it may find it beneficial to use a structured approach to identifying objectives, risks, problem areas, and outcomes and measuring their impact on patients. In the NHS this structure is currently provided by an 'assurance framework' or 'board assurance framework' underpinned by a risk management system.

An assurance framework is a means of recording the key processes used to manage the organisation and demonstrate that they are working. When processes are not working, action plans can be implemented to correct the situation. To find out more about assurance frameworks, see box right.

Once identified, any risks to the commissioning group's objectives can be mitigated through well designed controls or contingency plans or alternatively the risks might be transferred – for example, through contractual arrangements.

Other options to deal with risks include stopping the activity concerned or taking a positive decision to accept and tolerate the risk. In reality organisations seek to manage most routine risks through appropriate systems of internal controls. However, even with the best designed control system there is no assurance that risks will be avoided or minimised if the controls are not operating in practice as they were designed.

It is vital therefore that there is some evidence for the commissioning group's board that key risks to

the organisation are being managed in line with the board's expectations and 'risk appetite'. Each commissioning group will need assurances that the services it procures are safe, effective and represent best value for money.

It could do this by setting up a complex and costly inspection service or it could seek to place reliance on its partners' internal control systems and seek assurance through sample checks as well as via reviews by external regulators and inspectors.

As noted above, internal audit could play a key role in providing assurances over key risks. The internal audit work plan can reflect any concerns or areas identified as posing a high risk within the commissioning group.

Risk management framework

The assurance framework described above needs to be underpinned by an effective approach to risk management in order for the board to identify which are the strategic risks faced by the organisation and which objectives those risks are linked to. In essence, risk management is about being aware of potential problems, thinking through what effect they could have and planning ahead to prevent the worst-case scenario. It focuses the organisation on anticipating and forecasting risks together with the processes and actions needed to minimise them.

BOARD ASSURANCE FRAMEWORKS

The board assurance framework in an NHS organisation provides a simple but comprehensive method for the effective and focused management of the principal risks to meeting strategic objectives. Although a commissioning group may not be required to have a full board assurance framework, it will need to have robust arrangements in place which identify as a minimum:

- Its principal objectives linked to its business plan
- Key risks to achieving those objectives
- Key controls in place to manage the risks identified
- Independent assurances that controls are operating as designed, risks are being managed and objectives delivered
- Gaps in assurance
- Gaps in control
- Action plans to address the gaps identified.

The assurance framework should in turn be used to inform the board's core agenda: it should focus attention on the biggest risks and how those risks are to be minimised so that objectives are not compromised.

SFIs AND SORD

SFIs set out the organisation's detailed financial procedures and responsibilities and are designed to ensure that NHS organisations account fully and openly for all that they do. They cover areas such as the role of audit, budgets, budgetary control and monitoring, how long an organisation should keep records, the processes for contracting for goods and services.

SFIs are particularly important for decision makers and budget holders as stewards of public money. If for example, an organisation would like to ask a number of companies to compete to supply a particular product or service, it is important that the process is fair, open and objective. If the tendering process is rigorous and follows a strict set of rules reflecting the value of spending involved, the organisation will achieve the best possible outcome.

The scheme of delegation is a detailed listing of who the board empowers to take actions or make decisions on its behalf. It also shows which decisions can only be taken by the board. It ensures that decisions are made at the right level within an organisation.

Each commissioning group should consider having these in place if it is to ensure that it has a sound system of internal control which will minimise financial and other risks.

It is impossible to guarantee that nothing will ever go wrong, however it is possible to be aware of key risks and then plan to reduce or minimise the threat they pose to the organisation achieving its aims. Good risk management also allows for the taking of risks, where they are controlled and result in the safe development, growth and change of an organisation.

Not everything always works as it should and a key benefit of a good risk management system is that it should give early warnings of when things are starting to go wrong so that action can be taken. Effective risk management also allows for serious incidents to be raised and reported throughout the organisation so that problems can be addressed and lessons learned.

This is best supported by a culture of openness and transparency that enables staff to raise concerns about patient safety or the conduct of other members of staff without fear for their own role or reputation.

As part of this it is important that the organisation has arrangements in place to deal with any concerns or complaints and also to allow for 'whistle blowing' where necessary.

Business rules

All organisations, be they public or private sector have business rules, which can be both informal

and formal. Business rules protect staff by giving them a framework within which to carry out their duties and also provide consistency of approach to the way matters of business are conducted.

The need for effective business rules has been highlighted recently by the Bribery Act 2010, which came into effect on 1 July 2011. This requires organisations to have adequate procedures in place to prevent bribery taking place as they can be prosecuted for the failure to prevent a bribe being paid on the organisation's behalf, for example when placing a contract for a major service or investment.

For NHS bodies, business rules are set out in the organisation's standing orders (SOs). They provide a comprehensive framework for carrying out activities such as how to go about calling an annual general meeting or how many non-executive directors sit on the board. SOs are a critical element in the governance framework as they provide the link to an organisation's statutory powers and translate these powers into a series of practical rules designed to protect the interests of both the organisation and its staff. In many ways SOs are similar to the memorandum and articles of association of a company. For FTs, SOs form part of their constitution.

SOs are underpinned by standing financial instructions (SFIs) and a scheme of reservation and delegation (SORD). To find out more about these, see box above left.

Taken together, SOs and SFIs protect staff by ensuring that officers use the organisation's resources in line with the appropriate level of responsibility and accountability. They are normally supported by detailed finance, human resources and corporate policies.

Statement on internal control

Having the right governance framework in place is so important that the accountable officer has a statutory requirement to produce a statement on internal control (SIC) also known as an annual governance statement. The SIC is a comprehensive statement documenting the effectiveness of the system of internal control and demonstrating that the accountable officer is doing his or her reasonable best to minimise and manage the risks to the organisation obtaining its objectives. It forms part of the annual accounts and is signed by the accountable officer.

Conflicts of interest

In all the relationships described above, commissioning groups will need to avoid conflicts of interest that arise when a person or organisation has a relationship or is involved in something elsewhere which may influence their decision-making. It is particularly important in terms of the public sector as the existence of a conflict of interest may influence how taxpayers' money is spent or how a decision is made.

For example, consider a chief executive officer of an NHS trust who is married to the director of a small IT company. If the hospital then invites tenders for an IT supplier for a replacement to one of its IT applications and the company concerned submits a tender, a conflict of interest exists.

If this went unrecognised and the contract was awarded to that IT company, the contracting process and the decision made could be called into question.

To counter the risk of conflicts arising, NHS organisations maintain a register of interests – subject to external audit review, which details any such relationships and any business interests held by the members of its board. Board members are also required to disclose any such interests at the end of the financial year by completing a

disclosure form as part of the organisation's annual accounts process. It can be difficult for detailed scrutiny to be applied and a register can be limited as it is also dependent on the co-operation of those required to complete it.

So what happens if everyone is pretty much conflicted all of the time – how do decisions get made and how do suppliers and providers of goods and services believe that they have had a fair shot?

At its most fundamental level, the solution is to always act with the public sector principles in mind and underpinning all decisions made and actions taken. The chief executive officer and the chief finance officer need to ensure that all staff are aware of and comply with the organisation's business rules, which as a minimum should outline the need for the declaration of interests, including a register of individuals' interests and a framework for the resolution of conflicts within and between organisations.

NHS organisations also make use of 'local counter fraud specialists' who focus on preventing and detecting fraud within the NHS – commissioning groups may also be expected to make use of this service. Above all, NHS organisations need to be open to scrutiny and be able to demonstrate that the principles outlined have been upheld.





What evidence is there of accountability?

Information that is publicly available

All NHS organisations produce an annual report and accounts. Together these documents form one of the key ways in which they discharge their responsibility to the taxpayer for the resources they have used during the year.

The annual report and accounts are normally made available both through an organisation's website and in hard copy on request. It is presented at the annual general meeting, at which executive directors are available in person to answer questions from members of the public.

As well as financial information, you can find out details of how the organisation has operated, the number of patients treated, the improvements in healthcare made, even the size of its carbon footprint! It also contains information relating to the money paid to the directors of the organisation (set by the remuneration committee).

During the year organisations also routinely make information about their monthly board meetings available via their websites, including the minutes of the meetings and this will be a requirement for commissioning groups.

Commissioning groups will also need to publish the details of their contracts with health service

providers. For existing FTs, Monitor makes financial and governance risk rating information available on its website. Similarly, information about providers of health and social care services is available from the CQC.

The Freedom of Information Act 2000 currently applies to most public authorities including the NHS and PCTs and GPs are already involved in meeting its requirements as providers of primary healthcare services. Given that commissioning groups will be statutory public sector organisations, they will also have a duty to meet the act's requirements.

In addition to the information that must be made available as a result of freedom of information requests, the coalition government launched an initiative in 2010 to make spending by public bodies more transparent. As a result, the Department, SHAs, PCTs and NHS trusts (foundation and non-foundation) are required to publish on a monthly basis all items of expenditure over £25,000.

Although this requirement doesn't relate to staff expenses, all other expenditure data is included. This information is available on www.data.gov.uk for each NHS organisation. As a result, decisions made and transactions recorded are subject to public scrutiny and available in the public domain.

Meetings held in public

Many meetings of NHS organisations have to take place in public – including the annual general meeting – as well as the local authority health overview and scrutiny committee. All NHS organisations also have two parts to their board meetings: one is held in private, but one can be attended by members of staff and the public.

The dates and relevant papers must be published well in advance to give members of the public the opportunity to attend. As with an NHS organisation, the governing body of commissioning groups will be required to meet in public.

Public and patient involvement

NHS organisations regularly seek feedback from patients and the public. Both commissioners and providers of healthcare services routinely make information available to, and seek the views of, particular patient groups, as well as the wider population when reviewing and developing healthcare services.

For example, NHS Northamptonshire operates Northamptonshire Pulse, a membership scheme to encourage the regular involvement of the local population in its decision-making process. It uses a series of electronic newsletters as well as specific events to seek the views of and feedback to local people.

Commissioning groups will need to consider how they might involve all stakeholders and best seek input from their local public.

Organisational culture

Although harder to define and less tangible than the examples outlined above, the culture of an organisation and the way in which it operates should be one of openness and transparency where staff and patients feel able to raise concerns, confident that they will be taken seriously.

If the public sector principles outlined earlier are adhered to, public sector organisations will be better able to demonstrate transparency in decision-making while meeting their wider public sector obligations.

Conclusion

Clinicians will be keen to reduce the level of bureaucracy to the absolute minimum when establishing new commissioning groups, and will rightly look to minimise infrastructure and back office costs. However, there is a danger that if the approach adopted is too pared down, governance

arrangements will not be sufficiently robust or comprehensive to provide them with a solid foundation. As a result, their ability to achieve their objectives will be compromised from the outset.

To guard against the risk of governance failure, a commissioning group will need a framework in place that:

- Extends through all levels of the organisation and across all activities
- Provides assurance throughout the organisation
- Provides early warnings if things are going wrong
- Demonstrates that things are working as they should
- Ensures that the commissioning group is operating in line with:
 - Public service values
 - The NHS Constitution
 - Statutory (legal) responsibilities.

This is a significant challenge. However, the good news is that there are lots of examples in the NHS already, as well as good practice guidance and advice.

You can find out more about governance and how it works in the NHS through the HFMA's publication *Integrated Governance: a guide to risk and joining up the NHS reforms*. The HFMA also has an e-learning module you may find helpful, *Introduction to governance in the NHS*. To download, please go to www.hfma.org.uk ■

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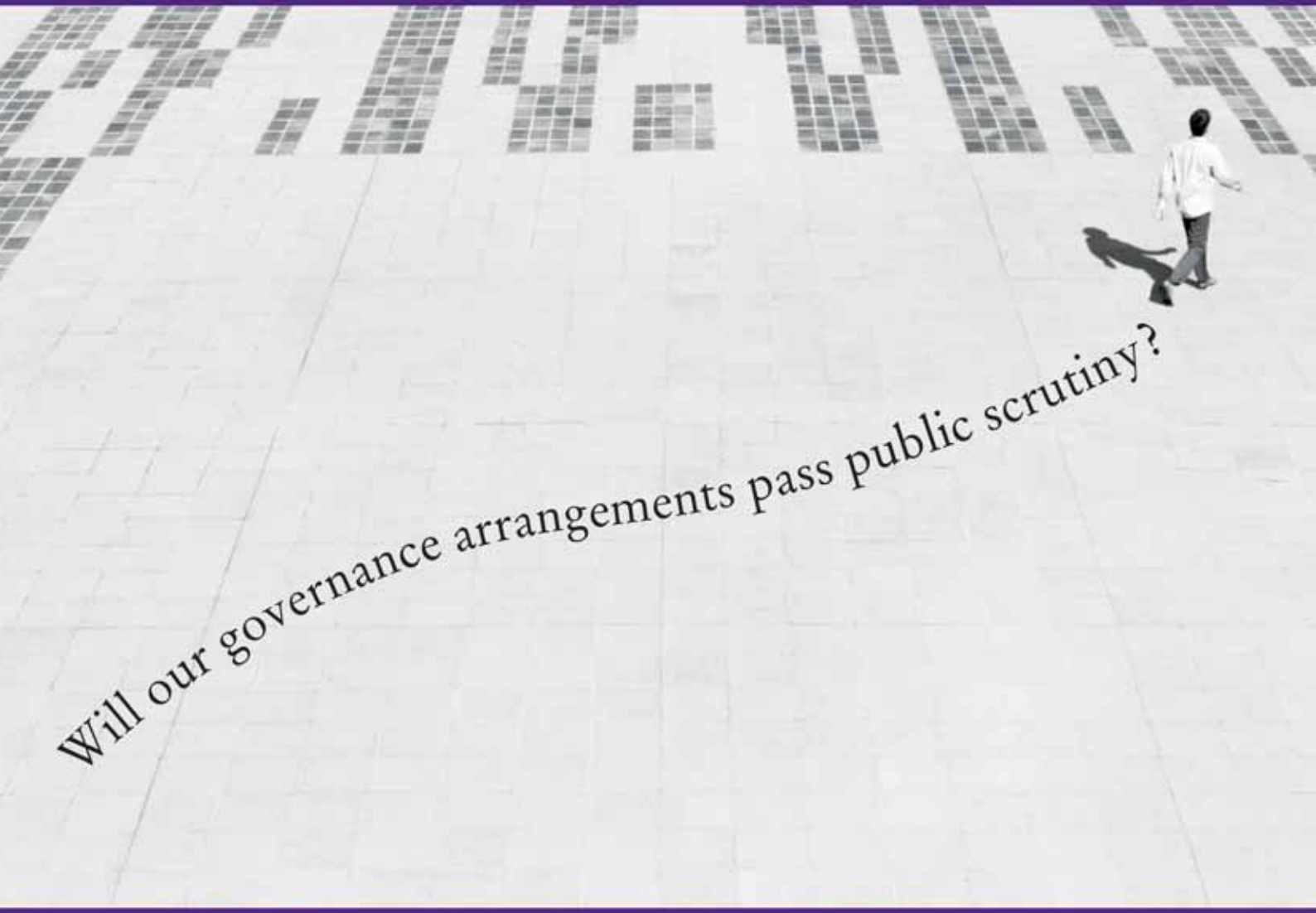
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