Merton Clinical Commissioning Group
Annual Report and Annual Accounts
2013-14
Right care, right place, right time, right outcome
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1. Member Practices’ Introduction

1.1 The changes in the way the NHS is run have brought both opportunities and challenges to those of us working in primary care. We believe that in Merton we have risen to the challenge with energy and rigour, and embraced our role in commissioning. We are pleased to be in a position to put our patients first in the design and purchasing of health care locally.

1.2 As local GPs, we work with the officers and management team of the clinical commissioning group to make a real difference in the healthcare available to our patients. We are grouped in three localities: East Merton, Raynes Park and West Merton, meeting regularly at locality level and also at a Merton-wide level at the Practice Leads Forum. These are regular, well attended meetings where GPs are positively engaged and actively contributing to our work.

1.3 Each locality is led by a GP who has been nominated by their colleagues, to sit on Merton CCG’s executive management team. The Practice Leads Forum plays an important role in enabling practices, through their practice leads, to shape the CCG’s priorities advising and influencing the Governing Body. As a network of practices we are able to suggest ideas and offer an evaluation on issues arising from and relating to commissioning strategies and operating plans, e.g.

1.4 In addition, the Clinical Reference Group (CRG) provides leadership in the design and clinical scrutiny of the CCG’s plans. The CRG membership is made up of GP clinical and nurse leads for the CCG’s different clinical workstreams, for example mental health or end of life care.

1.5 The CCG is committed to engaging the membership and holds regular events for all member practices. The last event in October 2013 brought together 70 GPs, Practice Nurses and Practice Managers from the member practices with the CCG’s executive team and Governing Body members. This was a well-received and informative event.

1.6 Over the course of the year, as members of Merton Clinical Commissioning Group, we have contributed to the development of commissioning intentions, reviewed referral pathways to support a reduction in emergency admissions, and designed schemes to ensure patient experience is better, particularly in primary care. We know there is a lot more work to do and we are keen to be part of this change.

1.7 One of our key in year developments has been the start of bringing primary and social care together more closely across our three localities. This is a major step forward to integrating care for our patients. Using risk stratification tools we can identify patients who are at risk of being admitted to hospital and work to support them to stay well. We now undertake multidisciplinary meetings across primary, community and social care in our practices. This is enabling us to review these patients and to identify ways of supporting them better in the community with dedicated key workers and care plans. This will deliver positive outcomes for patients, particularly those living with long terms conditions.
1.8 As member practices we recently undertook a CCG 360° stakeholder survey. This allows stakeholders to provide feedback on working relationships with CCGs. The results from the survey provide a valuable tool for all CCGs to be able to evaluate their progress and inform their organisational decisions.

1.9 The survey carried out in February 2014, provides feedback from 80% of member practices, and a good overall response from other stakeholders and partners. The detailed feedback contains comments and quantitative measures. Compared to 2012 responses, the CCG performs better in 4 areas and worse in none (from 7 questions asked in both years). We perform better than other CCGs nationally and across South London in 3 areas and worse in 1 (from 24 questions asked by all CCGs).

1.10 The CCG will now work through the feedback in more detail and identify areas for improvement. One area the CCG should improve is the communication of what they have changed in response to feedback received. The South London CSU department has agreed to identify a plan for improvement in this area. The report will be used to support the CCG’s organisational development plans for 2014/15.

1.11 Looking back at our first year we are pleased with our achievements and how that by working together we can continue to improve health services for the people who live and work in Merton in the future.

Dr Karen Worthington
Locality Lead GP, East Merton

Dr Sion Gibby
Locality Lead GP, Raynes Park

Dr Tim Hodgson
Locality Lead GP, West Merton

On behalf of the 25 Merton CCG member practices
2. Strategic Report

2.1 Foreword

2.2 We are delighted to publish our first annual report as Merton Clinical Commissioning Group. We have come a long way in our first year as a fully established clinically-led organisation, particularly in understanding the needs of our local population and making a difference for our patients.

2.3 We are pleased to have set up a new organisation from scratch which has grasped the challenges of developing better care, out of hospital. We have been working closely with the London Borough of Merton for some time now on a range of activities which will deliver greater integration of services across health and social care. In 2013-14 we made plans to move significant funding and activity from hospitals into the community and social care arena as part of the national Better Care Fund initiative. We have also been working closely with Merton’s Health and Wellbeing Board who have been very supportive of our approach to working across organisations to meet the health needs of the local population.

2.4 We are particularly encouraged by how well our members have engaged and contributed to these achievements, especially at a time of great challenge in primary care, and across the NHS as a whole. We recognise the current demands on our practices and their staff and are extremely grateful that they have embraced their role in commissioning.

2.5 As described in our Member Practices’ Introduction, we are passionate about realising the potential of clinically-led commissioning and during 2013-14 we have put in place an organisational structure which puts local clinicians at the heart of our decision making.

2.6 We have started to align community nursing, social care staff and General Practitioners in ‘teams around the patient’. We have made good progress engaging with our local voluntary sector partners and Merton Healthwatch.

2.7 We were authorised on 1st April 2013 as Merton Clinical Commissioning Group, with one condition in relation to safeguarding systems. This condition was resolved by July 2013 and we were fully authorised with no conditions. Starting the year with one condition was a positive start and we have made good progress since.

2.8 We use a blend of clinical and managerial skill to ensure that we commission in a way that is better than and different from what has gone before. We have good clinical engagement and input from partners and are looking to strengthen this further in the future. We are working closely with our public health colleagues to capture ideas for population health improvement, combine these with local and national priorities, and involve key partners and stakeholders to develop commissioning plans that have broad consensus. With a leaner and more fluid
structure, we aim to be faster at converting good ideas into reality. We thank the Merton CCG team for their hard work and determination to make real change for patients during 2013/14.

2.9 We cannot shy away from the quality and sustainability challenge we face in our area of London, which is focusing our efforts on how we secure the long term future for the local health and care economy. This means we must transform the way the system works. We know this will not be easy but we will continue to be open and transparent in how we work. We will strive to achieve consensus for clinical change and couple clinical priorities with local democracy, working with the local authority to ensure our population has confidence in our commissioning decisions. For instance, we are working across South West London to develop our 5-year strategic commissioning plan to create a clinically and financially sustainable local health system which delivers the best care and outcomes for our patients. We are engaging with all our stakeholders on these plans.

2.10 We hope you enjoy reading about the start of our journey as a truly clinically-led organisation, where we are making a real difference to the people of Merton. We would like to thank you all for your continued interest and support.

Dr Howard Freeman
Chairman

Eleanor Brown
Chief Officer
2.11 **Overview**

2.12 **A new health and care system**

2.13 On 1 April 2013, NHS Merton CCG became the new organisation responsible for commissioning (planning and buying), healthcare services for everyone in the borough.

2.14 We are made up of 25 GP practices in Merton, led by a Governing Body including:
- three Merton GPs – one of whom is the Governing Body chair;
- an independent nurse;
- a hospital doctor;
- the Director of Public Health from Merton Council;
- two lay members who are not clinicians – one with an expertise in financial oversight, and the other who brings great experience of the voluntary sector and local community organisations;
- Chief Officer; and
- Chief Finance Officer

2.15 We believe that GPs, nurses, hospital doctors, pharmacists, other healthcare professionals and patients are the best people to know if a service can really improve care. This means our work is clinically-led, with input from our local population.

2.16 While we are not responsible for commissioning primary care services (these include GP, pharmacy, optometry and dentist services) nor specialist services (for example very complex mental health care or heart surgery), we are working very closely with NHS England to ensure a ‘joined up’ approach across the new health system.

2.17 Merton Council now takes the lead on commissioning ‘public health’, which includes health improvement and protection services such as obesity programmes, sexual health promotion and mental illness prevention. Local authorities are now responsible for providing population health advice, information and expertise to CCGs to support them in buying health services which improve population health and reduce inequalities. More detailed information about their role can be found on the [Merton Council website](#).

2.18 **Our vision**

2.19 Our vision is to improve the health outcomes for the population of Merton by commissioning services tailored to the needs of individual patients whilst addressing the diverse health needs of the population.

2.20 Our guiding principle is that everyone in Merton should be able to receive the care they need, at the right time, in the right place and from the right healthcare professionals, bringing the right results for each individual patient. To do this, we
are looking carefully at the kinds of services that people in Merton need: both now and in the future.

2.21 We aim to improve patient experiences and health outcomes in a financially and clinically sustainable way by achieving best value and acting with a view to ensuring that health services are provided in a way which promotes the NHS Constitution. We also commit to:
- Putting patients first
- Delivering high quality care
- Working together with our providers
- Providing system leadership
- Preventing problems (ill health)
- Taking action promptly

2.22 **Merton’s health need**

2.23 Overall Merton’s population\(^1\) is comparatively healthy and life expectancy exceeds the national and regional average for both men and women. However there are some notable inequalities within the borough.

2.24 Merton’s population is growing. We have an increasing and high birth rate and at the same time an ageing population. The young and the old have more complex health needs.

2.25 Merton has a resident population of approximately 211,000\(^2\). There have been significant changes to the demographics of the population in Merton over the past decade, most noticeably the birth rate, which has increased by 40% since 2002. The population is set to increase by over 21% by 2021. This has significant implications for the planning and delivery of local health and care services.

2.26 Local communities have become more diverse over the last ten years, and it is estimated that overall 49% of the population are from Black and Asian Minority Ethnic groups and non-British White communities, with emerging new Polish and Tamil communities in the borough.

2.27 Overall Merton health outcomes are among the best in London, and largely in line with the England average, for example life expectancy for men is 80.7 years and for women is 84.6 years. However, there are stark differences between different areas and life expectancy is nearly 9 years lower for men and 13 years lower for women in the most deprived areas in east Merton than the least deprived areas in the west of the borough.

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\(^1\) Data on Merton’s health need taken from Joint Strategic Needs Assessment for Merton 2013

\(^2\) Taken from results of 2011 Census
2.28 Health provision landscape

2.29 Significant health and social care providers we work with include:
- 25 member GP practices
- Sutton & Merton Community Services (part of the Royal Marsden NHS Foundation Trust)
- Acute Hospitals including; St George’s Healthcare NHS Trust, Epsom and St Helier University Hospital NHS Trust, Croydon University Hospital and Kingston Hospital NHS Foundation Trust,
- a number of specialist hospitals in London and elsewhere, including The Royal Marsden NHS Foundation Trust and Royal Brompton and Harefield NHS Foundation Trust
- South West London and St George's NHS Trust for mental health services
- A range of independent and voluntary sector providers, such as residential and nursing homes, local hospices
- Other health service professionals such as pharmacists and optometrists
- Local authorities, in particular, Merton Council
- Healthwatch Merton

Figure 1: South West London map and the seven providers engaged with Merton commissioners
2.30 In order to commission services that will support a reduction in health inequalities and meet the health needs of the population, we work collaboratively with other south west London CCGs and the South London Commissioning Support Unit.

2.31 **How we operate**

2.32 We have strong clinical input via the work of our three localities, our Practice Leads Forum, the Practice Nurse Forum and our Clinical Reference Group. This provides us with a closer connection to our communities who now have more influence than ever over how their local health services support them.

2.33 We now have in place a strong executive leadership team bringing a wealth of experience from clinical practice, both as NHS service providers and as commissioners.

2.34 Over the course of the year we have been reviewing our capacity and capability to deliver the transformational changes we needed in the future to secure the long term sustainability of the local health and care system. We know that the input of clinicians into our decision making is a great strength to us, and over the year we have increasingly enabled our clinicians to take on more leadership across increased clinical areas. We now have 13 clinical staff working with the CCG on a sessional basis.

2.35 We have also seen closer partnership working with Merton Council, resulting in more emphasis on preventing illness and helping people stay independent in older age or with a disability. We share the same geographical boundaries as our borough council which means we have a better chance of impact locally and improving everyone’s long term health and wellbeing.

2.36 All CCGs have a cap on running costs of £25 per head of population. As a comparatively small CCG based on registered population, we have a streamlined in-house team of 32 staff (28 WTE – whole time equivalent). We buy in some support functions, such as human resources (HR), information technology (IT), transactional finance and communications from the South London Commissioning Support Unit (SLCSU), particularly in instances where there are economies of scale from accessing a larger pool of expertise and knowledge. This support complements our in-house capacity and capability, and is under constant review to ensure we receive high quality services and best value for money.

2.37 **Our strategy for 2013-14**

2.38 Merton CCG’s strategy was set out in the following documents:

- Merton Integrated Strategy and Operating Plan (ISOP) 2013/14 – 2014/15
- Merton Health & Wellbeing Strategy 2013/14
- Financial Plan - Setting out finance and activity over the next three years to support the ISOP
2.39 These plans are all on our website.

2.40 The strategies and plans were developed following membership events in June 2012 and March 2013, and took into account previous plans and strategies from Sutton and Merton Primary Care Trust as well as analysis of needs across South West London, including:

- Better Services, Better Value Review 2012
- NHS South West London - Sutton & Merton Operating Plan 2012/13

2.41 The strategic goals for 2013/14 were to:

- Ensure people in Merton are able to access the care they need from the right care professionals in the right setting, at the right time, with the right outcomes
- Right services - Commission evidence-based, clinically effective innovations in health care services to meet the diverse needs of our communities and reduce the gap in outcomes.
- Right setting - Commission models of care that ensure the right care professional delivers services in the most efficient, effective and convenient setting, closer to or within patients’ homes.
- Right time - Commission a system of care that is efficient and responsive to the needs of patients.
- Right outcomes - Patients are at the heart of everything we do and their experiences and expectations will shape the use of our resources and the way health care is provided.

2.42 Merton CCG worked with the members to identify emerging priorities for 2013/2014 as follows:

- Long Term Conditions – to develop an integrated model of health and social care.
- Mental Health and Learning Disabilities – improvement in the way these services are commissioned
- End of Life Care – service improvements will be built upon in this area.
- Urgent Care/Unscheduled Care – services will be redesigned through local and national initiatives.
- Planned Care – lessons learnt from previous plans and initiatives will be implemented as appropriate.
- Maternity and Newborn – collaborative commissioning with public health and NHS England will be adopted to improve quality.
- Children and Young People – a systematic quality review of services will be carried out.
- Staying Healthy and Prevention – working in partnership to commission high quality prevention focused services.

2.43 Further refinements of these priorities were developed over the year with our Clinical Reference Group (CRG) and through the localities.
Financial Review and Performance

Financial Review

The financial reporting requirement of CCGs is determined by NHS England with the approval of HM Treasury. Based on the Treasury’s Government Financial Reporting Manual (FReM), Merton CCG is required to prepare their financial statements based on International Financial Reporting Standards (IFRS).

2013-14 has been a challenging year for Commissioners mainly due to the disaggregation of Primary Care Trust (PCT) budgets. Merton and Sutton CCGs were created by the disaggregation of Sutton and Merton PCT. This in itself has brought challenges during the year as funding splits for Sutton community learning disability service was revisited during the year. In addition to the local disaggregation in 2013-14, PCT services were nationally disaggregated to several Commissioners, which have not been cost neutral to Merton CCG including:

- Primary Care commissioning to NHS England
- Public Health services to Local Authorities
- Specialist services to NHS England
- Primary Care Trust properties to NHS Property Service

Due to the large volume and value of Sutton and Merton disaggregation, there were errors made in the allocation splits, which could not be resolved in-year and resulted in Merton CCG having less to spend on commissioned services compared to the needs of our population.

Significant work was undertaken on 2013/14 specialised commissioning allocations across London which resulted in three allocation adjustments totalling £8.4m in year from Merton CCG to ensure allocation and expenditure match specialised services. This work was not fully completed until March 2014, hence further adjustments are expected in quarter 1 of 2014-15. There is a lack of clarity on property costs, which in 2013-14 was based on funding allocated to CCGs to ensure it was cost neutral, with a view to actuals being charged in 2014-15.

The disaggregation also had to be applied to balance sheet items between the various organisations taking responsibility for services. The majority of services have been attributed to the appropriate commissioners, however the 2012-13 provision relating to continuing care restitution payments has remained with NHS England in 2013-14 and will continue to be met by NHS England in 2014-15 and 2015-16 by top slicing CCG allocations to meet these payments.

Financial Performance

2013-14 has been a challenging year for Merton CCG for reasons outlined above. However, we have delivered on our financial duties:
• Achieving 1% (£2.1 million) surplus by managing revenue expenditure within resource limits
• Managing the CCG functions within the running cost allocation. Running costs budget was under spent by £0.3m
• Delivering our QIPP (Quality, Innovation, Productivity and Prevention) target – we underachieved this by £1.1m (15% below target).

2.53 Merton CCG also has an obligation to ensure all valid invoices are paid within 30 days of the due date or within 30 days of receipt of a valid invoice whichever is later. Overall Merton CCG achieved 91% in terms of number of invoices and 98% in terms of value of invoices. The expected target is 95% which has been achieved in the latter part of the year.

2.54 **Revenue Expenditure**

2.55 The CCG receives a revenue budget from NHS England. This is in the form of a revenue resource limit imposed on the CCG, as to the amount of revenue expenditure the CCG can incur, but not in line with the needs of the population. NHS England also calculate the level of funding that CCGs should require based on size of population, age, deprivation of area and mortality of the population. Calculations for 2013-14 show that Merton CCG is 7.8% below the target funding (known as distance from target) required to meet the needs of our population. This gap will be addressed in future years.

2.56 In 2013-14 Merton CCG had a delegated budget of £207m with which to purchase healthcare for our population. Revenue spending includes items such as commissioning of acute services, mental health, community services and primary care prescribing on behalf of the population.

**Chart 1: below shows the breakdown of spend for 2013-14**
2.57 Delivery of 1% surplus represents a strong performance in our first year, but there is no room for complacency as the national pressure to deliver significant level of efficiency savings continues for the next 5 years.

2.58 The surplus position is due to the efforts of member practices and staff in delivering their contribution to the CCG’s objectives. This is a firm foundation from which to deliver the future, however we did not deliver the planned activity reductions in our QIPP programme. This shortfall was partially off-set by savings in management costs, which is a one-off benefit that cannot be relied upon in future years and under spends in other commissioning budgets.

2.59 In addition the acute services budget overspent in 2013-14, which was offset by under spending on other non-acute budgets and utilisation of contingency reserves including the 2% non-recurrent budget.

2.60 Acute spend totalling 61% of Merton CCGs total expenditure paid for the following activity;

Table 1: total acute spend (£) broken down by activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>2013-14 Forecast</th>
<th>Outturn</th>
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<tbody>
<tr>
<td>A&amp;E attendances</td>
<td>64,359</td>
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<tr>
<td>Non-elective excl maternity admissions</td>
<td>14,726</td>
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<tr>
<td>Daycases admissions</td>
<td>13,262</td>
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<tr>
<td>Elective admissions</td>
<td>12,128</td>
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<tr>
<td>Maternity admissions</td>
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<td>GP referred 1st Outpatient attendances</td>
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<tr>
<td>All Other 1st Outpatient attendances</td>
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<tr>
<td>Follow-up outpatient attendances</td>
<td>120,460</td>
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<tr>
<td>Outpatient procedures</td>
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<tr>
<td>Critical Care days</td>
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<tr>
<td>Bed days</td>
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2.61 The activity figures above are based on eleven months performance as full year final activity details will not be available until June 2014. In addition to the above activity money is spent on non-activity related items such as drugs, medical devices, patient transport and paying providers for improvement in quality standards.

2.62 QIPP (Quality, Innovation, Productivity and Prevention)

2.63 The QIPP programme is about improving quality and innovation, so that every pound spent brings maximum benefit and quality of care to patients. The NHS needs to achieve up to £30 billion of efficiency savings by 2025, which will be reinvested back into frontline care for patients. Merton CCG’s QIPP target for
2013-14 was £7.5m, of which £6.4m was delivered; an under achievement of £1.1m (15%) of the planned target.

2.64 The year-end position is a culmination of some projects not achieving the target under the long-terms conditions and urgent care schemes and schemes that did not start in-year. A detailed review of the schemes has identified the following:

- Planning assumptions were optimistic and in some cases incorrect with little detail on how performance would be monitored
- Plans with Providers have slipped from planned timescales resulting in slippage on some schemes or non-delivery in 2013-14
- Over ambitious schemes to be delivered by Merton CCG.

2.65 On a positive note schemes such as reduction in medicine use and acute challenges have exceeded plan. New mitigating schemes totalling £0.6m such as mental health placements, ambulance alternative pathways and ECG price reductions have been identified in-year to mitigate some of the under-performance.

<table>
<thead>
<tr>
<th>BY QIPP CATEGORY</th>
<th>Gross Savings Planned YTD (£000)</th>
<th>Actual YTD (£000)</th>
<th>variance YTD (£000)</th>
<th>Gross Savings POT (£000)</th>
<th>Costs POT (£000)</th>
<th>Planed YTD (£000)</th>
<th>Actual YTD (£000)</th>
<th>Variance YTD (£000)</th>
<th>Costs POT (£000)</th>
<th>Variance (£000)</th>
<th>Variance (£000)</th>
<th>NET POT RAG RATED (£000)</th>
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Table 2: Merton CCG’s QIPP plan for 2013-14

2.66 Although the financial QIPP target has not been achieved we are proud of schemes such as the Community Prevention of Admission Team (CPAT). This scheme is the proactive management of patients in the community, identified through risk profiling which started on 1st October 2013. We also launched the Expert Patient Programme with 24 participants completing the courses. These schemes have been slow to take-off this year however the Membership have led on the design of these services and believe the required efficiencies will be delivered in 2014-15.

2.67 The QIPP agenda continues to be driven by the CCG with both strong clinical and management leadership to ensure process improvement, redesign and a clear programme management system.
2.68 **Delivering our priorities in 2013-14**

We agreed a set of priorities for 2013-14 which we believed would make a real difference to the quality of care in Merton. Many of these initiatives aimed to tackle the most common conditions which affect local people and their quality of life.

1. **Long term conditions**: developing an integrated model of health and social care; risk stratification; Co-ordinate My Care; and a multidisciplinary team approach to case review

2.70 **What we did**

2.71 **Integrated Care**

2.72 There has been a history of working with the London Borough of Merton, since the publication of the new coalition Government’s plans for health in 2010. This included an early collaborative arrangement of GPs involved in the (then) local practice-based commissioning groups, the local authority, public health, and other partners. This collaboration developed into the current One Merton Group and the Health and Wellbeing Board.

2.73 In February 2013, we confirmed a shared commitment to explore integrated working with London Borough of Merton and all provider health partners. The focus was on older people with long-term conditions and the aims were to improve patient and carer experience, reduce non-elective hospital admissions, reduce length of stay in hospitals, and reduce admissions to care homes.

2.74 An Integration Project Board was formed to deliver these objectives. It has met monthly since March 2013 and has initiated work in the following areas:

- The formation of three locality teams in Merton, consisting of social care, primary care and community health staff, with the aim of providing person-centred integrated case management
- Resolution of the problems that prevent health and social care staff sharing patient information with each other
- A shared financial and performance framework to underpin the locality model
- Work with our staff to promote any required changes in practice and culture.

2.75 Key developments to our services over coming years to achieve seamless care, delivered by a truly integrated health and social care system will include:

- Person-centred care where our community-based services focus on delivering an expanded service to older adults and vulnerable adults such as the frail elderly, focusing on reablement and independence, as well as prevention of escalation
• A service offer to individuals with mental health conditions including dementia, focused on delivering a joined-up health and social care package, and prevention of escalation where possible.

2.76 During 2013-14 we have drawn up plans for how we will use the Better Care Fund (BCF) as a vehicle to achieve our ambition of a truly integrated care system in Merton. The BCF provides a framework for joint initiatives to become appropriate, integrated services with a suitable funding structure and outcomes to support them. Overall the BCF is an opportunity jointly to address the greatest health and social care challenges in Merton, in alliance with our Health and Wellbeing Board and other stakeholders, community services, acute service and mental health providers, third sector providers and, most importantly, our service users.

2.77 **Case study – Mrs Jones**

2.78 Mrs Jones is an 83-year-old retired schoolteacher who lives alone and has no relatives living locally. She has had COPD for the past 10 years and has increasing problems with breathlessness and mobility. Over the weekend she develops a cough and fever and then has a fall whilst feeding her cat. She calls the London Ambulance Service who take her to St George’s Accident and Emergency department where she has a full geriatric assessment. This reveals that she has no fractures and access to her GP records helps the team identify that she is suffering from an exacerbation of COPD causing confusion and reduced mobility. This requires treatment with antibiotics and steroids and means she will be less able to look after herself for a period of time. It is agreed that hospital admission is not needed. However Mrs Jones does not feel confident or safe to return home alone. The “in reach” team arrange for her to spend a couple of nights in a “step down” bed under the care of the locality based multi-disciplinary team. She is introduced to the community nurse who will act as her key worker and together they agree a care plan. This includes support from the voluntary sector to ensure her home is warm when she returns and provide domestic support until she is well enough to do this herself. A clinical management plan, aimed to reduce exacerbations and identify any deterioration early, is developed with the help of her GP. Once Mrs Jones is feeling better in her own home the voluntary sector continues to support her by introducing her to an exercise class for older people which helps her maintain her fitness and her mobility and where she makes some new friends.

2.79 **Community Prevention of Admissions Team**

2.80 In Merton during 2012-13, over £7 million was spent on admissions for conditions that would normally be amenable to home based care representing 2889 potential avoidable admissions. The Community Prevention of Admission Team (CPAT) was launched on 1 October 2013, to ensure that patients could be supported at home where clinically appropriate. The team comprises nurses and therapists who

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3 Taken from Merton CCG 2014-2016 Operating Plan and Commissioning Intentions, 1 March 2014
provide rapid integrated assessment with health and social care partners to support the reduction of inappropriate emergency admissions. This service covers both Merton and Sutton and in the first six weeks saw 67 patients of whom 42 were from Merton, 36 being managed in their own home. The table below shows the number of patients supported by the CPAT team each month since the service started, and we have undertaken 3 audits to assess whom might otherwise have been admitted to A&E without appropriate home-based support. From the random sample undertaken, actual admissions prevented ranged from 18-29%, with an overall rate of 22%.

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<th>Table 3: referrals to CPAT since service launched</th>
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2.81 **Managing patients with long term conditions better, closer to home**

2.82 The lack of consistent joined up care in the community has rendered patients with long term conditions, particularly the complex frail elderly, vulnerable to exacerbations of their condition resulting in a higher numbers of admissions, length of stay and delayed discharges. Person-centred coordinated care and support is key to improving outcomes for these individuals.

2.83 Risk stratification tools allow clinicians to identify patients at high risk of future hospitalisation. These patients then have an allocated key worker, who ensures care planning is person centred and a common care plan is implemented across organisations.

2.84 All practices in Merton have agreed to use the risk stratification tool and are beginning to have multi-disciplinary meetings to agree clinical and social support plans for patients who are deemed to be high risk.

*Patient consultation with nurse at Wimbledon Village Surgery © www.andybarker.com all rights reserved*
2. **Urgent Care**: integration of urgent care centres at St George’s and St Helier Hospitals; NHS111 and out-of-hours services

2.85 **What we did**

2.86 **Urgent Care Centres**

2.87 Urgent care centres were integrated with Accident and Emergency (A&E) Departments at St Helier Hospital, Carshalton and St George’s Hospital, Tooting in 2011 and 2012. They provide a front door to A&E and other services to support better use of health services.

2.88 At these urgent care centres, patients are seen by a nurse who will undertake the initial clinical triage and make a decision as to where to appropriately refer the patient this might be to A&E, or the urgent care centre, GP or pharmacist. A dedicated ‘navigator’ then assists patients with their onward referral.

2.89 Emergency cases, brought in by ambulances or ‘blue lights’, will access A&E straight away.

2.90 Over the course of the year we have worked closely with the Trusts and other commissioners to establish the effectiveness and impact of this service. As a result we have established the correct level of care provided in these facilities and used information from the providers to redesign the urgent care pathways to stop unnecessary hospital attendances.

2.91 **NHS 111 and Out of Hours**

2.92 NHS 111 was introduced across England in 2013 to provide a single point of access for patients requiring urgent care, not an emergency.

2.93 As a result of the decision by NHS Direct in 2013 to withdraw from their contract to provide NHS 111 services for NHS Merton CCG and NHS Sutton CCG, both CCGs undertook a procurement to identify an alternative provider. This was the first procurement we had undertaken as a CCG.

2.94 At the same time, we went through a procurement exercise to procure a concurrent contract to deliver GP Out-Of-Hours services.

2.95 Following a successful procurement process and mobilisation, NHS 111 and Out-Of-Hours services went live with a new provider, Harmoni, on 12 November 2013.

2.96 Since the service has gone live we have had excellent performance across both contracts and feel that we have strengthened the clinical ownership of this service by setting up a specific clinical quality assurance meeting to review the quality of the service.
2.97 Reducing pressure on local A&E departments

2.98 In January we launched a communications and engagement campaign designed to raise awareness of the range of health services in the borough and encourage people to only use Accident and Emergency (A&E) departments in life threatening situations.

2.99 Eye-catching, seven-foot tall yellow figures took over local landmarks and appeared on billboards, bus advertising, in health centres and other public buildings across the borough. The figures highlighted quicker and easier local alternatives to A&E where people can receive expert advice and treatment including: self-care at home, pharmacists, their GP and urgent care centres. Neighbouring CCGs also ran the campaign increasing opportunities for recognition and impact of the visuals and messages as people travel in and around local areas, as well as providing a more cost effective way to deliver the activity.

Chief Officer, Eleanor Brown, launches the Not Always A&E campaign in Wimbledon, January 2014

2.100 Talking to our patients about the health services available in a broad range of community settings is an important part of our ongoing work to keep people out of hospital wherever possible and provide treatment closer to home – ensuring services stay safe and sustainable.

2.101 An evaluation of the campaign’s impact took place in March/April 2014 involving face-to-face street interviews with people across south London. Top line evaluation results show:
• Unprompted awareness of publicity about A&E was 43% - this rose to 45% when people were shown a campaign leaflet
• 76% of Merton respondents recalled messages that A&E is for real emergencies
• 70% of people said it was fairly likely or very likely that the campaign will change how they think about and use A&E and other health services in the future

3. Mental Health and Learning Disabilities: accessible early intervention and prevention; treating people with dignity and respect

2.102 What we did

2.103 Improving Access to Psychological Therapies (IAPT)

2.104 Improving Access to Psychological Therapies is an NHS programme rolling out locally based services offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders.

2.105 For Merton patients we commission an IAPT service from South West London and St George’s Mental Health Trust; Sutton and Merton IAPT. We are pleased to report that there are good service satisfaction rates expressed by referring GPs and service users.

2.106 Sutton and Merton IAPT also won a South London Innovation Award in October 2013. The South London Membership Council awarded a total of £80,000 for a joint partnership approach to healthcare education and training, with a bid from St Christopher’s.

2.107 The award will support the delivery of The Sutton and Merton IAPT Strategy: ‘Long-term conditions healthcare training strategy’. The aim is to equip GP practice and other physical healthcare staff to deliver ‘Cognitive Behavioural Therapy–informed psycho-educational courses’ for patients with long-term conditions who are not significantly depressed or anxious (e.g. sub-clinical) but who could benefit from a preventative intervention.

2.108 The strategy includes the role of a Long Term Conditions Trainer who will identify a "dedicated expert" from each practice and work with them to set up a programme of educational courses for patients. In this way, nominated GP practice and health care staff will be fully supported so that they develop the confidence and enthusiasm to deliver educational courses to patients beyond the life of the project thus embedding this approach throughout Sutton and Merton.

2.109 Dementia Hub and moving memory clinics closer to home

2.110 Working in partnership with the London Borough of Merton, plans were put in place during the year to open a new Dementia Hub in Mitcham and to relocate the current memory clinics from St George’s.
2.111 The Dementia Hub that has opened in Mitcham in April 2014. It is the first one of its type in the country that has been designed especially for people with a diagnosis of dementia and their carers and loved ones.

2.112 The old Cumberland day centre was totally transformed into a dementia friendly hub for service users, carers, professionals and anyone seeking information or support can visit the centre Monday to Friday from 9am to 6pm.

2.113 The inside has been opened up into a beautiful light area with many coloured rooms where people can go for information from social services about benefits or sign posting. The rooms, furniture and wall art is in line with the King’s Fund guidelines, the walls being adorned with images of the seasons and nature.

2.114 There is a sensory garden that is planted with herbs and has a soft rippling fountain that is overlooked by benches. In addition there is a large garden where users are able to wander around safely. The flowers beds are planted to aid seasonal orientation.

2.115 The memory clinics will now be held in an environment which is non-clinical and non-institutional.

4. Planned Care: closer to home; review of referral pathways; and Patient Navigation Project

2.116 What we did

2.117 Bringing care closer to home @The Nelson Local Care Centre

2.118 In March 2013 construction began to develop the first of our local care centres in Merton. Good progress has been made on the construction of the new building which is due to open by Spring 2015. Once complete, the Nelson Local Care
Centre, on the previous Nelson Hospital site, will be a spacious and modern environment allowing more people to be seen, diagnosed and treated closer to home.

2.119 The Nelson will provide GP services, outpatient appointments, minor surgery and procedures, X-ray, ultrasound and blood tests, physiotherapy, pharmacy services, a variety of community services and support services for people living with long-term conditions.

2.120 Our vision for The Nelson is to improve the range and quality of health and social care services available locally. In particular, we want to bring services closer to the local community and reduce trips to hospital, improving accessible and convenient services for our patients.

2.121 **Mitcham Local Care Centre**

2.122 A proposal for a new local healthcare facility within Mitcham is being taken forward by the East Merton Locality involving local clinicians, patients and users. During 2013-14 work has begun to create the strategic outline business case based on the outcomes of a Health Needs Assessment (HNA) for Merton. This will ensure that the service strategy is designed around the health needs of the population, that the models of care are designed around the patient and that the national outcomes are delivered through locally focused accessible services.

2.123 By providing these local services, tailored to the needs of the population, it is anticipated that this will not only improve the treatment of ill health but will better promote activities that prevent ill health by helping people with lifestyle choices. This is particularly pertinent for residents of East Merton, who demonstrate a significantly lower life expectancy than their counterparts in West Merton.
5. Children and Young people: strong focus on safeguarding

2.124 What we did

2.125 We supported Merton MASH (Multi-Agency Safeguarding Hub) by funding a health navigator for the health economy and commissioned Sutton and Merton Community Services (SMCS), to provide this role. The Merton MASH co-locates a range of agencies, including police, local authority children’s social care, education, probation and health staff, to share information and spot emerging problems early, potentially preventing serious incidents to children and families. In Merton a qualified Health Visitor has been appointed who is working on behalf of all health providers to ensure that appropriate health information is shared, with consent, to enable the best outcome decision to be made for the families. The turnaround time for child protection cases judged as high or complex needs has reduced since the start of the MASH, improving outcomes for children and making them safer.

2.126 Safeguarding Children

2.127 CCGs have a duty to improve the health of the whole population which includes safeguarding and promoting the welfare of children, young people and vulnerable adults. Working with local authorities and other partner agencies we ensure that services delivered to vulnerable people are actively managed.

2.128 We have arrangements in place for ensuring that all staff working with children, or adults who are parents within the services the CCG commissions, are able to keep them safe. This includes ensuring safeguarding supervision and training is in place so that vulnerable children are identified early and timely intervention occurs.

2.129 We have Governing Body leads for safeguarding children and safeguarding adults, and a designated nurse and designated doctor who take the strategic professional lead for safeguarding children across the local health economy.

2.130 We also work closely with our partner agencies e.g. social services, police, education, housing and the voluntary sector to share information and initiatives that protect children and review cases when children or vulnerable adults have been seriously harmed or have died through abuse and/or neglect.

2.131 We are members of both the Merton Local Safeguarding Children Board and Adult Safeguarding Board. These are multi-agency statutory partnerships tasked with improving outcomes for children and vulnerable adults, monitoring and holding to account all public and private organisations in terms of their safeguarding arrangements.

2.132 You can see our declaration outlining our commitments and responsibilities for protecting and safeguarding children and young people on our website.
2.133 We are pleased to say we are meeting our statutory responsibilities in relation to safeguarding children. Developments this year include:

2.134 **Requirements following Savile allegations (Yewtree Report)**

2.135 On the 12th November 2012, Sir David Nicholson, the then NHS Chief Executive, wrote to the Chief Executives of all NHS Trusts and NHS Foundation Trusts regarding the allegations of abuse by Jimmy Savile. The Department of Health sought assurance that all existing NHS procedures are robust.

2.136 MCCG has received written assurance from all the main acute, community and mental health providers regarding their processes which includes their approach to celebrities as well as paid employees.

2.137 **Inspection**

2.138 The Ofsted and Care Quality Commission (CQC) integrated inspection of safeguarding children and looked after children’s (LAC) services took place in January 2012 and was reported in the 2011/2012 Sutton and Merton PCT Annual Board Report. The health service contribution to safeguarding children and looked after children was judged as ‘good’. The Merton action plan formed as a result has been regularly and routinely monitored via the Safeguarding Children Executive Group (pre-CCG) and Merton Safeguarding Children Board. The recommendations which remain in progress relate to improving the completion of the health assessments for looked after children within the statutory timescale.

2.139 **Serious Case Review (SCR)**

2.140 A 12-year-old girl was reported missing from her grandmother’s house where she had been staying for a visit. Her body was discovered, hidden in the loft of her grandmother’s home in Croydon on the 10th August 2012. Her grandmother’s partner was charged and convicted of her murder. The SCR found that her death could not have been predicted.

2.141 While good practice was identified in the report, key learning points were also identified for staff and have been implemented, for example the need for training and awareness to recognise the potential risks of prolific cannabis use within the home.

2.142 This review was completed during the transition period between PCT and CCG. The recommendations and actions have been completed and continued vigilance is being applied so that high standards of practice are maintained.
6. **Staying Healthy and Prevention**: work with partners to commission high quality health improvement services focused on prevention and targeting health inequalities

**What we did**

2.143 We identified that diagnosis rates for **Chronic Obstructive Pulmonary Disease (COPD)** were below those expected. This implied that patients were not seeking help, or that doctors and nurses were not identifying the condition early enough. It is known that early diagnosis can provide opportunities to support patients and relieve the distressing symptoms earlier. During 2013/14, we worked with general practices to identify the ‘hidden’ patients by asking them to carry out a series of tests on patients who smoke. The results have been positive, with an overall increase of the COPD register by 59 patients.

2.144 **Health Checks**

2.145 The CCG GP members have taken on board the health prevention message and by working through the localities and practices we have now met our health checks target and signposted patients where appropriately to our LiveWell and Stop Smoking Services.

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Patient having blood pressure checked at Grand Drive Surgery, Raynes Park
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2.146 **Expert Patients Programme**

2.147 The Expert Patients Programme (EPP) is a free, six-week self-management education course for adults living with any long-term health condition(s), or for carers of those living with a long-term health condition(s). The course is designed to promote and build people’s confidence and self-management skills, empowering them to take control of their health and improve their quality of life. The programme has proven to be a success with participants reporting that course has a very positive impact on their health and well being, and has stimulated some participants to train as trainers for future classes.

2.148 The EPP has received continued funding from Merton CCG, which will enable more courses to be delivered, and allow the programme to continue to work with health and social care professionals, raise awareness and reach out to those communities who have a higher risk of long term conditions.

2.149 **Childhood immunisation**

2.150 We have worked closely with GPs to improve childhood immunisations rates and uptake, however, the data will not be available to review before the annual report is published.

*Childhood immunisations at Grand Drive Surgery, Raynes Park*  © www.andybarker.com all rights reserved
7. Maternity and Newborn: improve quality and service productivity

2.151 **What we did**

2.152 Merton CCG, through the Director of Quality, has been an active member of the South West London Maternity Network, which brings commissioners and midwives, obstetricians, paediatricians and lay members together to improve services for women and babies before, during and after birth. Through the year, the network has led the following developments:

- Creation of a South West London dashboard, so that maternity units can compare their performance on, for example, Caesarian section rates. This allows providers and commissioners to identify and share good practice.
- Implementation of clinical pathways for innovation – for example there is now a cross London ‘fetal fibronectin’ pathway (this is a substance which can be used to predict preterm labour). This test can make a significant improvement to women’s experience, by providing a clearer prediction of preterm labour, thus avoiding unnecessary hospital admissions, and reassurance to women that labour is not imminent (or more certainty for women who are about to go into preterm labour).
- A review of the midwifery support worker role. This is a new role which has developed to support midwives in many hospitals. The review examined the recruitment, training and practice of the support workers and made several recommendations to ensure these roles are supported more consistently.
- The well-established neonatal network has also continued to meet, to ensure good practice is shared between units and that policies for transfer of babies, for example, are clinically safe.

2.153 **Children’s centres review**

2.154 The Public Health team at the London Borough of Merton, together with the Merton Council Early Years team, have undertaken a review of the Children’s Centres in Merton to see how health teams (midwives, health visitors, GPs) work with their education and social care colleagues, and whether coordination could be improved. The review demonstrated some very good practice, and underlined the benefits of a range of staff working in an integrated way to support young children and families. The report has made some recommendations, which will be implemented in 2014/15.

8. End of Life Care: increase uptake of Co-ordinate My Care

2.155 **What we did**

2.156 **End of life care in Merton**

2.157 End of life care remains an important area of work with use of the Co-ordinate My Care register helping patients to be cared for and die in their preferred place.
2.158 Information from the Health and Social Care Information Centre shows that in Merton the percentage of deaths in a patient’s "normal place of residence" increased from 34.8% in April 2013 to 41.6% in December 2013.

It is likely that the contributory factors for this are increasing use of Co-ordinate My Care, an Electronic Palliative Care Co-ordination System (EPACCS) and a change in the way the Community Services End of Life Care nurses are working.

2.159 Co-ordinate My Care

2.160 1205 Merton patients had a Co-ordinate My Care record in March 2014 which represents 42.6% of the population who might be expected to die in the next 12 months. Of the patients who expressed a preference regarding place of death 70.9% achieved either their first or second choice and of these, in March 2014, 18% died in hospital compared with 54% nationally.

2.161 Community End of Life Care nurses

2.162 During 2013 this team changed their way of working and began to work specifically with nursing homes. Their work includes training and support for care home staff as well as seeing patients to help with advance care planning and assessment and management of symptoms, so patients can die in the nursing home, if this is their wish and is appropriate for them, and are not transferred to hospital unnecessarily during their last days of life. Preliminary figures suggest an increase in deaths in care homes, especially in the Raynes Park locality which may be related to this.

2.163 Our ambitions for 2014-16

2.164 We are working across Merton’s health and social care economy to be clear about how the system will achieve sustainable services and financial performance whilst delivering quality and productivity improvements.

2.165 Our two-year operating plan 2014-16 outlines our vision for the Merton system over the next 24 months. We have developed this vision with member practices via our three localities, our membership and our local population supported by Healthwatch Merton and local community groups. Our aims and ambition are built on the Joint Strategic Needs Assessment (JSNA) which has resulted in jointly agreed priorities with Merton’s Health and Wellbeing Board. We have engaged with many patients, health and social care professionals, the voluntary sector and other stakeholders to hear their views as to our plans and priorities.
2.166 We know there are specific underlying challenges in our local health economy that we must address over the next two years and into the future, which means delivering a robust strategy for providing health care out of hospital:

- Managing the increased needs of our frail older population, which is set to double by 2018
- Building robust and effective community services to bring care closer to home safely and effectively
- Addressing the financial challenge and potential quality and safety risks in the future
- Continuing movement towards greater service integration and building high quality community services
- Reducing variation of practice across all providers
- Ensuring greater patient and public engagement in all our work
- Securing and commissioning better communication between services and clinicians
- Ensuring equity of access and continuity of care for all patients but particularly those with complex and long term conditions
- Developing a configuration of acute services which ensures sustainability and affordability
- Securing both quality and value from existing services, and where this is not happening, addressing this through service improvement or decommissioning
- Commissioning for outcomes in a number of priority areas
- Ensuring that we use technology and IT as accelerators of change.
2.167 Engagement

2.168 Listening as never before

2.169 Involvement and feedback from patients, carers and the public is crucial if we are to achieve our aims. We want people in Merton to have a voice and to be able to influence how we plan and improve healthcare services. This is a key part of our commitment to openness in all our work, and supports the principles set out in the NHS Constitution and our commitment in our quality strategy to ‘listen as never before’.

2.170 Engage Merton

2.171 We held our first major stakeholder event, Engage Merton, on 16 October 2013. Fifty-seven people from 12 organisations and groups attended. The aim of the event was to discuss with the local population the commissioning plan for 2014-16; sharing information, listening to local people’s views, raising awareness about Call to Action, and how we continuously improve our engagement with patients and the local populations.

Local residents, Governing Body members and Merton CCG staff in conversation at Engage Merton event, October 2013

2.172 Event feedback was that an overwhelming number of participants felt that they had a good understanding of our Commissioning Intentions; that their voice has been heard; and would recommend the event to others.

2.173 You said: we did
2.174 Using valuable feedback from our Engage Merton event, we have reviewed and set priorities, formed our commissioning plans for 2014-15 and an engagement implementation plan for 2013-15.

2.175 The feedback has shaped our Communications and Engagement Implementation plan for 2013-15 which focuses more on Patient Participation Groups (PPGs), carers and partnership working.

2.176 Engaging with patients and the public

2.177 We are working with those practices who have active Patient Participation Groups (PPGs) to develop PPGs in all our practices, as a platform for listening and engagement. We have undertaken an audit of practices PPGs and identified practices who need developmental support.

2.178 We continue to explore ways of improving and strengthening our involvement and engagement. We support and attend a wide variety of existing patients, carers and community groups and fora to communicate and engage with patients, public, carers and their communities to ensure their involvement in the commissioning, planning, designing, improvement and monitoring of health services for local people. For example, we held a simulation event with patients, carers and professionals to look at our model for integration of services in Merton. We have more work to do to capture feedback and inputs from these groups in a systematic way and ensure we are identifying any gaps.

2.179 The quality and sustainability challenge – Call to Action

2.180 Call to Action is a national initiative to stimulate debate in local communities, amongst patients, health care professionals and commissioners, about how best to deliver healthcare services in the face of the future challenges of a funding deficit and growing demand for services. It is predicted that there will be a shortfall of approximately £38 billion in the NHS in terms of service provision over the next ten years.

2.181 National aims for Call to Action include:

- Building a common understanding about the need to renew our vision of the health and social care services, particularly to meet the challenges of the future
- Giving NHS stakeholders (patients, clinicians, commissioners, etc.) an opportunity to tell us how to maintain current NHS values in the face of future pressures
- Gathering ideas and solutions to develop both the CCG’s 2-year operating plan and 5-year strategic commissioning plan.

2.182 In Merton, engagement activities for Call to Action complemented our existing engagement and strategic planning. The feedback has been fed into our 2-year
operating plan and is being fed into our 5-year strategic commissioning plan. Call to Action feedback will also shape the national vision, identifying what NHS England should do to drive service change.

2.183 Approximately 200 people have been reached by Merton’s Call to Action through 15 engagement events, an online survey, and community and voluntary organisations’ distribution list.

2.184 We are publishing a full report on the feedback received from Call to Action, which includes the following themes:

- Increase in integration and collaboration between health and social care, and hospital and community services to improve outcomes and experience for patients
- Greater focus on prevention, awareness raising, health campaigns, training and education on specific conditions
- Need to improve health and well-being by promoting exercise and healthy lifestyles
- Improving patient information and advice on local services
- Investing in the workforce to prepare for the changes within the NHS
- Greater use of technology.
2.185 **Working in partnership**

2.186 **The Health and Wellbeing Board**

2.187 The Health and Wellbeing Board is an example of the way NHS Merton CCG work in partnership with Merton Council and the voluntary and community sector. It is a strategic forum that brings together elected representatives with local commissioners and providers of health services, to advise support, challenge and direct the development of local health care services.

2.188 Merton CCG’s members on the Health and Wellbeing Board include Chair, Chief Officer, Director of Commissioning and Planning and a GP member.

2.189 It is a vital way for us to unite, to share expertise, local knowledge and work towards creating better health and well-being for the people of Merton.

2.190 Health and Wellbeing Boards play a key role in developing a Joint Strategic Needs Assessment (JSNA) and a Health and Wellbeing Strategy for their local authority area. The Joint Strategic Needs Assessment (JSNA) provides a picture of health and wellbeing for Merton. It provides a basis of sound evidence for the planning and commissioning of local services.

2.191 The JSNA is accessible on line at: www.mertonjsna.org.uk. It draws out the most important challenges to our residents.

2.192 The central focus of the latest Merton Health and Wellbeing Strategy is to encourage a more joined up approach to health and wellbeing. It is concerned with promoting the health of the whole population of Merton and highlights significant inequalities which require targeted actions.

2.193 Four priority themes have been developed with reference to the Joint Strategic Needs Assessment and existing strategic priorities. Each of the four priority themes has given milestones, indicators and success measures, frequency of reporting and a specified lead for each action, as described in Table 4 below.
Table 4: Health and Wellbeing Board’s four priorities and outcomes

2.194 The vision and priorities of the Health and Wellbeing Strategy have been broadly welcomed and members of the Health and Wellbeing Board want to see details of how the planned outcomes are to be delivered. Each priority theme lead has drafted a Delivery Plan which sets out how the Health and Wellbeing Strategy will be implemented over the next two years. Merton CCG is the lead for priority three – enabling people to manage their own health and wellbeing as independently as possible.

2.195 Better Care Fund

2.196 The Better Care Fund (BCF) – previously referred to as the Integration Transformation Fund – was announced in June 2013 with the aim of encouraging
closer working between local authorities and CCGs and changing local services so that people receive more seamless care and support in community settings.

2.197 The BCF will provide protection for social care services and support local transformation of services so that more people are supported in the community receiving integrated health and social care services. The BCF plan aligns with the needs of the population as identified in Merton’s Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

2.198 The four key areas of ambition for the BCF are:

- Reducing (growth of) Emergency Admissions
- Reducing Length of Hospital Stay
- Reducing Permanent Admissions to Care Homes
- Improving Service User & Carer Experience

2.199 The BCF plan and the implementation of the service changes and schemes, forms the core of MCCG’s two-year operational plan, as follows:

1. Older and Vulnerable Adults
2. Mental Health
3. Keeping Healthy and Well
4. Early Detection and Management
5. Urgent Care
6. Children and Maternity

2.200 The fund for Merton is £12,198k as from 2015/16. This funding is already in the system, either through existing Local Authority grants or our commissioning budget.

2.201 The Health and Wellbeing Board has overseen the plan for the fund in Merton. In the past when we have taken a joint approach to planning health and social care services we have seen particular success for people with learning disabilities and children. The new plan looks to create similar arrangements for older people and residents with mental ill health.

2.202 Areas of planned spend for the fund are outlined below:

- Integrated locality teams - including more community nurses, new dementia nurses, expert patient programme courses, telehealth, and end of life care;
• Seven day working - a range of social care and health staff will be deployed on the basis of seven days a week and extended hours into evenings;
• Prevention of admissions - including geriatrician sessions, continuation of the pilot Community Prevention of Admissions Team, rapid response teams in Emergency Departments in St Georges and St Helier, psycho-geriatrician sessions, and investment in the Ageing Well prevention programme;
• Community beds and rehabilitation - including a remodelled health and broader rehabilitation service, step-up and step-down beds, intensive rehabilitation into St Georges, a scheme in St Helier to prevent admissions;
• Protecting and modernising social care. This includes funding for care packages, funding for Merton Independent Living and Re-ablement Service (MILES), and funding for implementation of the Care Bill;
• Developing personal health and social care budgets;
• Investing in integration infrastructure including project management costs and solutions for data sharing;
• Carers breaks and night nurses to support carers;
• Disabled Facilities Grant. Central government grant now routed through this Fund; and
• Social Care Grant – a central government grant now routed through this Fund.
2.203 A five-year plan for healthcare in south west London

2.204 Clinicians have been highlighting for several years that the way in which we deliver services in the NHS needs to change. There is a broad clinical consensus on this point and reports from the Academy of Royal Colleges, NHS Confederation, the King’s Fund and NHS England have all highlighted the need for change.

2.205 We face a number of challenges in the years ahead:

- The population is ageing and up to a third of people are living with long term conditions, meaning we need to provide more and better care out of hospital and closer to where people live.
- We need health and social care services to work better together – nationally, the Better Care Fund has been set up to achieve this and means money is being moved from CCG budgets for hospital care to local community services as described previously.
- None of our hospitals meets all the minimum safety and quality standards set out by clinicians based on Royal College guidance – the London Quality Standards – and there is a variation in the quality of care between different hospitals and different times of the day, week and year.
- Hospitals are expected to provide seven-day services with the required level of consultant cover at all times, but we do not currently provide this in south west London and there are not enough consultants available to do so across our four acute hospitals.
- The NHS is unlikely to be given extra money in the foreseeable future, yet the costs of providing healthcare are rising much faster than the rate of inflation, meaning we face significant financial challenges.
- We need to reshape mental health services so that they achieve the highest possible standards and are focused primarily in the community.
- We need to ensure that primary care and other community-based services meet the highest possible standards.
- We need to do more to prevent people becoming ill and to provide better information to patients about where to get help when.

2.206 In February 2014 the six south west London CCGs’ Chairs and NHS England, who commission specialised and primary care services in south west London, agreed to work together to develop a five-year strategy for the local NHS. This programme replaces the Better Services Better Value (BSBV) programme which the CCGs inherited. The strategy will address the same issues as those highlighted by BSBV, but has been widened to look at the whole health system, including primary care, community services and mental health. Recently, (April 2014) all CCG Governing Bodies have agreed to work together under the umbrella name of South West London Collaborative Commissioning.

2.207 The 5-year draft strategy will be submitted to NHS England’s London Regional Team on 20th June 2014. The CCGs will work closely with patients, carers and the public, local provider Trusts, local clinicians and local authorities on the detail of
the strategy and we hope to agree a plan that the whole of the local NHS and HWBB can own jointly.

2.208 Our focus on improving quality

2.209 The final report of the Francis Public Inquiry into the failings at Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. It made 290 recommendations related to the identification of early warning signs, culture, governance, the roles and responsibilities of organisations and agencies including providers, commissioners and regulators.

2.210 On 3rd April 2013, the Government published an interim response to the report, ‘Patients First and Foremost’. It set out a statement of common purpose and reaffirmed the commitment to the values of the NHS as set out in the Constitution.

2.211 As commissioners, we take our role in monitoring the quality and safety of healthcare services we purchase for our patients extremely seriously. Therefore, we have dedicated substantial time, at Executive Team and Governing Body level, to consider the Francis Report and recommendations, and also the recommendations from the Winterbourne View Report. The result of these discussions has significantly influenced our Quality Strategy and work plan, which is regularly updated and reviewed by our Quality Committee.

2.212 Quality strategy

2.213 Our quality strategy has four key quality goals:

- As commissioners, to seek assurance that all NHS funded providers from whom we commission services, provide care which meets Care Quality Commission (CQC) and other e.g. National Institute of Health and Clinical Excellence (NICE) quality standards and outcomes
- As the system leader for health, to drive for continuous improvement in quality outcomes across the locality, improving standards of healthcare to match or exceed the best in London
- To work with our local authority and other partners to promote health and prevent ill health for Merton residents, through our Health and Wellbeing Strategy
- To work with our partners to ensure children and vulnerable adults are protected from harm and live in safe and health environments, through the local Adult Safeguarding and Children Safeguarding Boards.

2.214 Our quality strategy ensures that as commissioners we continuously improve quality by:

- Setting and demanding increasingly ambitious standards
- Using contractual levers to improve quality
- Facilitating system wide solutions to intractable complex problems
2.215 We will continuously assure quality by:

- Monitoring performance against agreed standards and outcomes
- Gaining assurance that the services commissioned meet quality standards
- Providing assurance to other regulators and system leaders as required.

2.216 **Quality assurance**

2.217 We continuously review the quality of care given at our main NHS providers via Clinical Quality Review Groups and a programme of regular Clinical Quality Committee meetings. As Merton does not have an acute trust within the borough, the CQRG meetings are chaired by a clinician of the ‘host’ CCG, Merton CCG is represented by our relevant GP clinical locality lead in our role as an ‘associate’ commissioner. We are the host CCG for Sutton and Merton Community Services (Royal Marsden Hospital) and lead the CQRG for this contract.

2.218 In 2014/15 we aim to roll out our quality assurance programme further to cover intermediate care, continuing care, nursing and residential homes and smaller providers.

2.219 We scrutinise a range of quantitative and qualitative data and performance measures at our monthly Clinical Quality Committee, a sub-committee of the Governing Body. Our integrated quality and performance report provides a more in-depth picture of the quality of care provided to Merton patients by our main providers.

2.220 **Quality premium**

2.221 The quality premium is paid to CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs.

2.222 The 2013-14 measures cover a combination of national and local priorities. To receive 100% of the quality premium we have to deliver on our local priorities, national targets and aspects of the constitutional pledges (A&E, cancer two week wait and subsequent treatment, Referral to Treatment 18 week compliance and Ambulance response times). We also have to ensure we meet our financial plan for 2013-14. Where a CCG does not deliver the identified patient rights and pledges on waiting times, a reduction of 25 per cent for each relevant NHS Constitution measure will be made to the quality premium payment.

2.223 The four national measures, all of which are based on measures in the NHS Outcomes Framework, are:

- Reducing potential years of lives lost through amenable mortality (12.5 % of quality premium)
• Reducing avoidable emergency admissions (25 % of quality premium)
• Ensuring roll-out of the Friends and Family Test and improving patient experience of hospital services (12.5 % of quality premium)
• Preventing healthcare associated infections (12.5 % of quality premium)
• Three local priorities, which have been agreed by the Health and Wellbeing Board and with NHS England.

2.224 In addition we have three local priorities, which have been agreed by the Merton Health and Wellbeing Board and with NHS England as follows:

• Reablement: development of a new reablement pathway to support recovery and independence after illness or injury. This was linked to integrated services and reduction of avoidable admissions
• Chronic Obstructive Pulmonary Disease (COPD): Reduce premature mortality from COPD by better diagnosis and treatment; reduce the gap between the recorded and expected prevalence by 10% by improving the ratio of recorded: expected prevalence from 0.4 to 0.44 as a CCG overall by coding review, recurrent admissions on register and increased screening of smokers
• Immunisations: Increase immunisation uptake by 4% on 2 year age group immunisations.

Table 5: Are health outcomes improving for local people?

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Quality Premium</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>In Year proxy: NHS Health Checks</td>
<td>57.5%</td>
<td>G</td>
</tr>
<tr>
<td>In-Year proxy: Smoking Cessation</td>
<td>115222</td>
<td>R</td>
</tr>
<tr>
<td>In-Year proxy: Emergency admissions for liver disease</td>
<td>30</td>
<td>A</td>
</tr>
<tr>
<td>In-Year proxy: Bowel cancer Screening</td>
<td>48%</td>
<td>R</td>
</tr>
<tr>
<td>In-Year proxy: Breast cancer Screening</td>
<td>66%</td>
<td>R</td>
</tr>
<tr>
<td>In-Year proxy: Cervical cancer Screening</td>
<td>76%</td>
<td>R</td>
</tr>
</tbody>
</table>

| Enhancing quality of life for people with long term conditions             | 25.0%           |     |
| In-Year proxy: No of people accessing expert patient programmes           | 51              | G   |
| In-Year proxy: patient education programmes/groups (DESMOND activity?)   | 546             | G   |
| *Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) | 1,049          | G   |
| *Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s | 117             | R   |

| Helping people to recover from episodes of ill health or following injury |                 |     |
| Emergency admissions for acute conditions that should not usually require hospital admission | 1,644          | R   |
| Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) | 157            | R   |

| Ensuring that people have a positive experience of care                   | 12.5%           |     |
| Friends and family test: Are providers meeting 15% response rate?        |                 | G   |
| St.George’s combined FFT Score                                            |                 | G   |
| Epsom & St. Heller’s combined FFT Score                                   |                 | G   |
| Royal Marsden combined FFT Score                                          |                 | G   |

| Treating and caring for people in a safe environment and protecting them from avoidable harm | 12.5% |     |
| Incidence of healthcare associated infection (HCAI) i) MRSA              | 2     | R   |
| Incidence of healthcare associated infection (HCAI) ii) C.difficile      | 27    | G   |

Local Priorities
1.) **Reablement:** New pathway to support recovery and independence after illness or injury. Linked to integrated services and reduction of admissions. 12.5% 34 G

2.) **COPD:** Reduce premature mortality from COPD by better diagnosis and treatment; reduce the gap between recorded and expected prevalence by 10% from 0.4 to 0.44% as a CCG overall total moving the 11 practices towards the target by coding review, recurrent admissions on register and increased screening of smokers 12.5% 0.44 G

3.) **Immunisation 2013/14**
   - Increasing immunisation uptake by 4% on: DTaP/IPV/HiB (90.2% at Q3 12/13)
   - MMR (82.8% at Q3 12/13) and
   - PCV (89.3% at Q3 12/13). 12.5% TBC TBC TBC

2.225 We have had a good first year on the performance of our quality premium by delivering on the majority of our targets. We have achieved our constitutional pledges and those indicators can be seen in table 5. We unfortunately did not achieve our zero target of MRSA, we had two incidences of MRSA during the year. These cases have been reviewed in-year through the clinical quality review groups and actions agreed by the provider organisations where appropriate. We are actively working to improve our performance on targets that were not achieved within 2013/14.

2.226 On reviewing our health outcomes Merton does not perform as well as it could in screening for cancer and smoking cessation. As part of the new clinical delivery teams, we have created a new team that are solely responsible for Keeping Healthy and Well. This team has a strong Public Health presence. Within this area, we have asked for a robust action and implementation plan for Cancer Services and smoking cessation services. We expect to sign off this plan at our Clinical Reference Group in July 2014.

2.227 We have a clear programme of work in 2014/15, associated with investments to assist in reducing unnecessary emergency admission and attendances. Our Better Care Fund plans are all focused on achieving this reduction and the programmes have started to deliver real changes. We have also reconfigured out community teams to be based on our locality model. It is expected that through the co-ordination of better care in the community, we will see a reduction in avoidable admissions.

2.228 We have put an extensive amount of effort into achieving the immunisations priority and as yet do not have the data to report on our achievement against this target.

2.229 Notification of Quality Premium awards will be made in Quarter 3 2014/15. Assessment of the CCG’s position with respect to the four national quality premium measures will be carried out by the national support centre. At the time of writing this report, Merton CCG reported achievement of the local priorities for COPD and reablement. Further work was required to validate the data quality of the immunisations local priority.
2.230 Commissioning for Quality and Innovation (CQUIN)

2.231 The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of local care providers’ income to the achievement of local quality improvement goals and better outcomes for patients.

2.232 This approach involves setting national and local quality goals and targets. For 2013-14 these were:

2.233 National CQUINS:

- NHS Safety Thermometer – Submit a complete survey to the information centre.
- Dementia – Report on monthly audit.
- VTE Root Cause Analysis – RCA initiated for 90% of HAT, 70% of RCA completed with consultant report. (Payment not received for VTE CQUIN due to failure of VTE assessment).
- End of Life Ongoing Education – Description of education programme and course content.
- End of Life Extension of CMC or equivalent – Provide agreed data on CMC patients and number of patients placed on CMC.
- Alcohol Misuse – Targeted screening of inpatients.
- Alcohol Misuse – Development of improvement programme.
- Alcohol Misuse – 60% of all relevant information communicated to GPs.
- Smoking cessation – Recruitment of 2 WTE CNS.
- Maternity Midwife ratio – Achieve a ratio of 1:2
- Maternity supernumerary midwife cover 24hrs, 7 days – 96% cover
- Maternity Consultant Cover – 98 hours per week cover for Q2
- COPD Development of the tiered model – Agree the clinical parameters for the tiered model
- COPD Admissions – Identify the % who have respiratory specialist input and the % under care of respiratory specialist
- Oncology - 90% of patients with suspected malignancy not requiring admission offered appointment in Fast Track clinic within one week.
- Oncology – Maintain 95% inpatients reviewed by AOS within one working day.
- Paediatric Services – Introduction of photo documentation into assessment workflow.
- Paediatric Services Consultant Cover – Cover 9am-9pm, 7 days a week.
- Medicines Management Homecare – Strategy Document developed and agreed.
- Medicines Management Insulin and GLP – Non-analogue insulin as a % of all insulin is more than 11%.
- GP Communication discharge letters – 90% of A&E letters within 48 hours, 90% of discharge summaries within 48hrs.
- GP Communication Quality of letters – Agree template for A&E, Outpatient and Inpatient discharge letters.
- Dermatology Service Redesign – Provide clinical attendance for monthly service spec meeting.
- Diabetes Development of tiered model – Present plan & commence delivery.
• Diabetes Development of tiered model – Review uptake of DESMOND, DAFNE and BERTIE. Identify baseline of attended within 10 days and appointment within 14 days. Agree planned increase on baseline. Also ensure 70% of patients are referred.
• VTE Assessment – Achieve 95.33% of patients having risk assessment (94.3% actual).
• Alcohol Misuse – 92% of patients screened positively within 1 working day.
• Smoking Cessation – 168 smokers attending as inpatients are supported. 420 smokers attending as outpatients are supported

2.234 Community CQUINs:

• NHS Safety Thermometer – as above
• Community Minimum Data Set – Q2 Data flow to HSIC started
• Multidisciplinary Team – 90% attendance by core MDT staff.
• Multidisciplinary Team – 90% attendance by Community Specialist Nurses
• Diabetes Development of tiered model – as above
• COPD Integration – as above

2.235 Quality Accounts

2.236 A Quality Account is a report about the quality of services by an NHS healthcare provider. Reports are published annually by each of our NHS providers, and are available to the public through the NHS Choices website.

2.237 Quality Accounts are an important way for NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

2.238 The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

2.239 Clinical Commissioning Groups are asked to comment on these accounts. Across South West London it was agreed that all CCG comments would be coordinated by each ‘host’ CCG. Merton CCG sent its comments on the acute Trusts to the host CCG. Merton CCG, in turn, coordinated comments for The Royal Marsden, (which hosts the Sutton and Merton Community Services) quality account. This quality account mostly covered the acute services of The Royal Marsden Hospital, which is not commissioned by Merton CCG, so the CCG commented on the aspects which related to community care. We agreed the priorities which they set out for 2013-14 including improvements in pressure ulcer care and immunisations. The coordinated comments from the host and associate CCGs were all ‘signed off’ and published in the relevant provider’s quality account.

2.240 Quality accounts for our main NHS providers can be found on the trust websites:
- Sutton and Merton Community Services
- Epsom and St Helier University Hospitals NHS Trust
2.241 Protecting vulnerable adults

2.242 We are committed to working with local stakeholders to protect adults at risk. According to the No Secrets government guidance (DH, 2000), local authorities have the lead role in coordinating work to safeguard adults. In 2013/14 the Local Authority also took on responsibility for all cases involving Deprivation of Liberty Safeguards from the previous Sutton and Merton Primary Care Trust. The CCG is responsible for ensuring that health providers play their part in the multi-agency team which delivers the adult safeguarding procedures. Merton CCG have a Governing Body Lead for safeguarding adults.

2.243 The procedures aim to make sure that the needs and interests of adults at risk are always respected and upheld including:

- the human rights of adults at risk are respected and upheld;
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse; and
- all decisions and actions are taken in line with the Mental Capacity Act 2005.

2.244 The local partnership is led through the ‘Vulnerable Adults Safeguarding Team’ (VAST) which involves a variety of agencies, coordinated by the London Borough of Merton.

2.245 Notable areas of action over the last year have been to create a hoarding policy and protocol so that all staff, from any agency, which supports people with hoarding behaviours, follow common risk assessments and action plans.

2.246 The VAST team also supported a serious case review, (involving an elderly gentleman who died following significant self-neglect), through an action learning approach which explored themes of mental capacity and non-engagement with services.

2.247 Performance Review

2.248 Merton CCG measures the organisation’s performance against three of the measureable rights and pledges described in the NHS Constitution Handbook (March 2013):

- People’s right to access certain services commissioned by NHS bodies within maximum waiting times;
- Government pledges on waiting times; and
- CCGs responsibility to secure continuous improvements in the quality of services provided to individuals.
2.249 **Table 6 Performance against 2013/14 indicators at year end**

2.250 **Are patient rights under the NHS Constitution being promoted?**

<table>
<thead>
<tr>
<th>Monthly Indicators</th>
<th>At 2013/14 Year End</th>
<th>Year to Date</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CB_A15: Healthcare acquired infection (YTD) (MRSA)</td>
<td>2</td>
<td>R</td>
<td>0</td>
</tr>
<tr>
<td>CB_A16: Healthcare acquired infection (YTD) (C- Difficile)</td>
<td>27</td>
<td>G</td>
<td>33</td>
</tr>
</tbody>
</table>

2.251 We are pleased to have met national targets for the NHS Constitutional rights of 18 weeks referral to treatment for non-urgent treatments and 2 week wait for GP referral where cancer is suspected.

2.252 We have also met the majority of constitutional pledges, only narrowly missing the target of diagnostics waits by 0.09%. At the time of publication, national guidance regarding the attribution of A&E performance was not yet published; however,
applying the Everyone Counts 13/14 technical guidance suggests that the CCG met the A&E 4 hour wait target.

2.253 **Sustainability**

2.254 In order to promote sustainability MCCG have worked in the following way:

- During our first year of operation, we have occupied two modern, shared-use office buildings with other NHS tenants, and have worked with the landlords to ensure the buildings are energy efficient, for example we recycle waste and encourage staff to reduce the use of energy (lighting, power etc.)
- Our staff are encouraged to use public transport for their travel to and from home and for business travel. To this extent, we have ensured that our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. A sustainability policy will be finalised during 2014/15, which will reflect our role as an organisation employing fewer than 50 staff, as well as our role as a commissioner of services.

2.255 Understanding these challenges and developing plans to achieve improved health and wellbeing and continued delivery of high quality care is the essence of sustainable development. In order to achieve this it is important that our plans factor in:

- The environmental impact of the health and care system
- How the health and care system can adapt and react to climate change, including preparing and responding to extreme events
- How the local NHS, public health and social care system can maximise every opportunity to improve economic, social and environmental sustainability.

2.256 **Sustainability at the heart of the Nelson Local Care Centre**

2.257 The design of the Nelson aims to minimise the impact of the new building on the surrounding and global environment.

2.258 During 2013/14 the project team have been working to agreed principles to set the sustainability agenda and the building is intended to provide a landmark in terms of its environmental credentials. These principles include:

- Integrating with the local neighbourhood and enhancing the local environment
- Provide sustainable transport options for all building users
- Deliver cleaner, greener and safer external spaces that are rich in biodiversity
- Use energy and water efficiently and maximise the use of renewable and natural resources
- Provide flexibility and adaptability to meet changing service needs (short and long term)
- Reduce pollution and waste during both the construction and operation phases of the building.
2.259 The Nelson will also result in approximately 50% reduction in carbon emissions compared to the previous estate.

2.260 **Equality (annual report and Equality Delivery System)**

2.261 We have published our Equality and Diversity report, which is available on our [website](#).

2.262 In 2011, the Department of Health introduced a new tool for monitoring equality outcomes called the Equality Delivery System (EDS). This year we made significant progress in assessing a baseline for our position regarding equalities.

2.263 The EDS gives NHS organisations an opportunity to improve fairness in service commissioning and performance evaluation for the benefit of the whole community – patients, carers and staff. It also enhances collaboration with local stakeholders and interest groups by enable the analysis of service commissioning, provision and performance which leads to clearer identification of equality objectives and ensures compliance with statutory equality obligations.

2.264 The EDS enables us to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity.
- Fostering of good relations between individuals and communities.

2.265 The strengths and gaps highlighted through the EDS have helped us to understand where we need to focus attention in order to improve equalities performance within all our functions. These are reflected in our Equality Objectives and Action Plan.

2.266 As commissioners of services, we recognise that we must account both for our own organisational equality performance and also that of the providers of services that we commission. The results of the EDS baseline assessment and feedback from patient groups highlighted the work that we need to do with our provider organisations around equality and diversity.

2.267 When making decisions about the services to be commissioned we ensure that equality and diversity intelligence informs our decisions by routinely using the Joint Strategic Needs Assessment (JSNA) and by carrying out Equality Analysis. We have prepared commissioning plans which look carefully at population needs based on demographics, health inequalities and access to services. At the heart of these strategies is the objective to reduce health inequalities, improve outcomes for patients ensuring services are accessible and responsive to patients.

2.269 Developments during 2013/14 included:

2.270 **Leadership**

2.271 Our Independent Nurse Member has taken over the role of Clinical Equality and Diversity (E&D) Lead. This role will provide scrutiny, clinical input and support to the Director of Quality, who has operational responsibility for Equality and Diversity in Merton CCG. An Equality and Diversity Group has also been established, chaired by the Director of Quality, with representatives from Public Health, Commissioning and Patient and Public Engagement.

2.272 **Partnership working to tackle health inequalities**

2.273 In 2013/14 we continued to work closely with London Borough of Merton, particularly with their work around health and wellbeing. This includes tackling health inequalities through a number of public health initiatives including:

- Refreshing the Joint Strategic Needs Assessment
- Ongoing implementation of the LiveWell scheme, a free health improvement service available to anyone aged 16 or over who is registered with a GP
- A healthy lifestyle programme
- Supporting rollout of NHS Health Checks
- The development of the business case for an East Merton (Mitcham) Local Care Centre and a model of care that delivers services closer to home.

2.274 We commission a Bi-lingual Health Advocacy Service to provide navigation, signposting and liaison support to the largest ethnic minority groups in the borough, covering Tamil, Polish and Urdu-speaking communities. We reviewed how this service is working, and during early 2014/15 the service will move under the umbrella of LiveWell so that it is better aligned to deliver health improvement for our local minority ethnic communities.

2.275 **Commissioning for Equality**

2.276 Three commissioning priorities were identified for assessment using the NHS England Equality Delivery System framework: Mental Health – reviewing the Improving Access to Psychological Therapies (IAPT) service; Older People – looking at Older People’s services in a community setting and; Children and Young People – focusing on Child and Adolescent Health Services (CAMHS).

2.277 **Expert Patients Programme**

2.278 Self-management is an important part of the Long Term Conditions (LTC) strategy. As previously described, we have been successful in rolling out a 6-week self-management education course for those with a long term condition or a carer of someone with an LTC. One of the programme’s aims has been to encourage minority groups to participate and this has been successful.
2.279 **Equality Analysis (previously Equality Impact Assessments)**

2.280 Equality Analysis forms part of our commissioning cycle and is considered during the redesign of a service or policy to ensure that the needs of our community groups are being met. Equality Analysis is integrated into the commissioning process enabling commissioners to assess impacts and inform decision making.

2.281 **Our staff**

2.282 **Communicating and engaging**

2.283 There are a number of ways we have communicated and engaged with our staff during 2013/14 including:

- A SWL CCG Staff Partnership Forum where managers and staff from the 6 SWL CCGs meet to discuss and consult on issues. This is co-chaired by the Merton CCG Chief Officer.
- CCG organisational development events have been held throughout the year for Governing Body members, Management Team and staff.
- There are regular team meetings between the staff and Executive Management Team.
- We participated in the NHS Staff Survey that South London CSU is coordinating as part of their HR Service offer. The results have provided us with the opportunity to build up a picture of staff experience and use for future comparison and monitoring of change over time, and to identify variations between staff groups. All permanent members of staff were eligible to participate between 27th January and 9th March 2014. Our response rate was 72%. The results will be communicated to staff and an action plan developed with a staff focus throughout the first quarter of 2014/15.

2.284 **Training and development**

Merton CCG staff in a team meeting
2.285 There is a statutory and mandatory training policy in place and reporting procedures for staff to undertake training which is provided both on line via e-learning from Skills for Health and in house. Training is reported back to the CCG.

2.286 All staff have regular 1:1s and have appraisals, objectives and PDPs in place.

2.287 **Equalities for staff**

2.288 Our Equal Opportunities and Managing Diversity Policy promotes a working environment in which all parties and procedures relating to recruitment, selection, training, promotion and employment are free from unfair discrimination, ensuring that no employee or prospective employee is discriminated against, whether directly or indirectly on the grounds of:

- gender
- marital status
- race
- colour
- ethnic or national origin
- nationality
- disability
- age
- sexual orientation
- religion or belief
- responsibility for dependants
- trade union membership
- HIV status
- or any other condition or requirement which cannot be shown to be justifiable.

2.289 All HR policies are assessed to ensure there is no detriment to any of the equality protected characteristics in line with the Equality Act 2010.

2.290 **Information on the gender of staff**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Members and Governing Body</th>
<th>Very Senior Managers (VSM)</th>
<th>Employees of the CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M  F</td>
<td>M  F</td>
<td>M  F</td>
</tr>
<tr>
<td>Merton</td>
<td>4  6</td>
<td>0  1</td>
<td>4  27</td>
</tr>
</tbody>
</table>
Eleanor Brown

Signed:
Accountable Officer
5 June 2014
3. Members’ report

3.1 Details of our Membership

3.2 Our 25 member practices are grouped into three localities supported by a central team covering commissioning, quality, finance, medicines management and primary care support. Each locality is led by a nominated GP clinical lead, who are members of the Clinical Quality Reference Group (CQRG) for their relevant major acute provider, as well as the CCG’s Executive Management Team and Clinical Reference Group.

3.3 This is integral to how we ensure that all decisions have clinical review, input and challenge. In addition we have created a Clinical Reference Group (CRG) made up of primary care clinicians including GPs and the nurse lead to further enhance our clinical decision making on wider transformational and system wide change.

1. East Merton

3.4 The locality GP lead is Dr Karen Worthington.

3.5 There are nine member practices:
   - Central Medical Practice
   - Cricket Green Medical Practice
   - Figges Marsh Surgery
   - Graham Road Surgery
   - Ravensbury Park Medical Centre
   - Rowans Surgery
   - Tamworth House
   - Wide Way Surgery
   - Wilson Health Centre

3.6 Achievements in 2013-14:

3.7 We have seen closer working between practices over the course of the year with a focus on public health and addressing the health inequalities specific to our part of the borough. For instance, we have engaged with Merton’s Multi-Agency Safeguarding Hub to deliver improved communication and closer working in children’s safeguarding. We also continue to support the health advocacy service and are engaged in the development of the service for the future.

3.7 There is enthusiasm and commitment to drive forward a transformation of healthcare in Mitcham and work continues on an East Merton model of care that will meet the needs of our communities.

3.8 We continue to work towards supporting patients better closer to home, particularly those living with long term conditions. We have been rolling out the risk stratification tool; all practices are now using it and holding multi-
disciplinary meetings to review the care of individual patients. We also have three practices working together to improve care of residents in Eltandia Hall Care centre, holding regular meetings between the care home and practice representatives, and delivered shared arrangements for respite unit.

2. Raynes Park

3.9 The locality GP lead is Dr Sion Gibby

3.10 There are eight member practices:
- Cannon Hill Lane Medical
- Church Lane Practice
- Francis Grove Surgery
- Grand Drive Surgery
- James O’Riordan Surgery
- Lambton Road Medical Practice
- Morden Hall Medical
- Stonecot Surgery

3.11 Achievements in 2013-14:

3.12 Across our locality, practices are piloting a federated model of working, which enables us to collaborate in areas of mutual benefit to achieve better outcomes for our patients and best value.

3.13 We are testing out how a GP federation allows our practices to stay independent and build on this strength, while ensuring we have the scale to ensure primary care can compete for contracts and practices are better supported to address local workload or recruitment issues. We believe it balances our need for scale with our desire to remain local.

3.14 We are fortunate to have The Nelson Local Care Centre in our locality. You will have read earlier that this redevelopment is well on the way. The opportunity to transform care out of hospital is an exciting prospect. GP members across Merton have been engaged in determining the model of care,
design of the building and service specifications for the services operating at The Nelson. When the new healthcare facility opens next year it will help us deliver our ambitions to bring care closer to home for many of our patients.

3. West Merton

3.15 The locality GP lead is Dr Tim Hodgson

3.16 There are eight member practices:
Alexandra Road Surgery
Colliers Wood
Merton Medical Practice
Mitcham Medical Practice
Princes Road Surgery
River House Practice
Vineyard Hill Practice
Wimbledon Village

3.17 Achievements in 2013-14:

3.18 The eight practices in West Merton have grasped the opportunity to work together with both hands. We have been exploring closer working relationships across the practices, and how the future of general practice may look including federation. We have forged new relationships with the senior clinicians and management of St George’s Hospital, and strive to improve quality for our patients. Many of the GP practices will enjoy the benefits of the new Nelson Local Care Centre and have been contributing to the creation of new clinical care pathways. We continue to support the direction of travel of the CCG with regard to integration, and have benefited from creating new links with the Local Authority, especially the locality social worker and her team.

3.19 At the beginning of this year West Merton practices introduced testing kits to help diagnose patients with suspected Deep Vein Thrombosis. Having this testing kit to hand in surgeries will not only save lives but could also reduce the
number of patients having to go to Accident and Emergency for investigation. We already have an example where a patient’s life has been saved as a result of the testing kits.

3.20 **Governing Body**

3.21 The Governing Body oversees the delivery of the CCG’s commissioning plan, set and lead the strategy for the CCG and are accountable for the delivery of our functions as a statutory body. There are three GPs on our Governing Body including our Clinical GP Chair.

![Merton CCG Governing Body](https://www.andybarker.com)

3.22 The membership of our Governing Body:

- Dr Howard Freeman – Chair
- Eleanor Brown – Chief Officer
- Cynthia Cardozo – Chief Finance Officer (from 8 August 2013)
- Dr Kay Eilbert – Director of Public Health, London Borough of Merton
- Adam Doyle – Director of Commissioning and Planning (from 8 July 2013)
- Peter Derrick – Lay Member, Chair of the Audit Committee and Vice Chair
- Clare Gummett – Lay Member, Patient and Public Involvement
- Mary Clarke – Independent Nurse Member
- Dr Andrew Murray – GP Clinical Governing Body Member (from 1 June 2013)
- Dr Caroline Chill – GP Clinical Governing Body Member (from 17 October 2013)
- Professor Stephen Powis – Secondary Care Consultant
- David Avis – Interim Chief Finance Officer (from 13 May 2013 – 31 May 2013)
- Karen McKinley – Chief Finance Officer (until 28 April 2013)
• Dr Geoffrey Hollier – GP Clinical Governing Body Member (from 1 April 2013 – 19 July 2013)

3.23 The clinicians are well placed to lead NHS commissioning because they talk to and treat patients every day. Having local clinicians working together with patients to plan and manage health services means that we can focus more on the quality and clinical effectiveness of care than ever before.

3.24 You can find out more about the functions of the Governing Body in the Merton Clinical Commissioning Group Constitution.

3.25 **Practice Leads Forum**

3.26 The Practice Leads Forum meets on alternate months (alternating with the locality meetings) to receive an update from the EMT and CRG on the development of the CCG strategy and participate in service redesign and network good practice.

### Practice Leads Forum

3.27 Membership:

<table>
<thead>
<tr>
<th>Member GP Practice</th>
<th>Practice Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Alexandra Rd H85656</td>
<td>Dr Mayura Mahadevan</td>
</tr>
<tr>
<td>2 Cannon Hill Lane H85016</td>
<td>Dr Graham Mason</td>
</tr>
<tr>
<td>3 Central Medical H85070</td>
<td>Dr Elizabeth Higham</td>
</tr>
<tr>
<td>4 Church Lane H85020</td>
<td>Dr Shweta Singh</td>
</tr>
<tr>
<td>5 Colliers Wood H85649</td>
<td>Dr Saqib Ayub</td>
</tr>
<tr>
<td>6 Cricket Green H85038</td>
<td>Dr Andrew Otley</td>
</tr>
</tbody>
</table>
Table 8: Merton CCG Member Practices and Practice Leads names

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Doctor Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figges Marsh H85090</td>
<td>Dr Abdullah Zakaria</td>
</tr>
<tr>
<td>Francis Grove H85026</td>
<td>Dr Simon Vickers</td>
</tr>
<tr>
<td>Graham Road H85078</td>
<td>Dr Raghu Lall</td>
</tr>
<tr>
<td>Grand Drive H85101</td>
<td>Dr Sion Gibby</td>
</tr>
<tr>
<td>James O’Riordan H85072</td>
<td>Dr Jerome Jephcott</td>
</tr>
<tr>
<td>Lampton Road H85051</td>
<td>Dr Naz Dhalla</td>
</tr>
<tr>
<td>Merton Medical Practice H85634</td>
<td>Dr Rafik Taibjee</td>
</tr>
<tr>
<td>Mitcham Medical H85024</td>
<td>Dr Naem Khan</td>
</tr>
<tr>
<td>Morden Hall Medical Centre H85037</td>
<td>Dr Naheed Ahmad</td>
</tr>
<tr>
<td>Princes Rd H85028</td>
<td>Dr Ladan Sharifi</td>
</tr>
<tr>
<td>Ravensbury Park H85110</td>
<td>Dr Titus Keyamo</td>
</tr>
<tr>
<td>Riverhouse H85092</td>
<td>Dr Naveed Baig</td>
</tr>
<tr>
<td>Rowans H85035</td>
<td>Dr Karen Worthington</td>
</tr>
<tr>
<td>Stonecot H85076</td>
<td>Dr Vasa Gnanapragasam</td>
</tr>
<tr>
<td>Tamworth House H85033</td>
<td>Dr Geoff Hollier</td>
</tr>
<tr>
<td>Vineyard Hill Rd H85112</td>
<td>Dr Rob Jones</td>
</tr>
<tr>
<td>Wide Way H85029</td>
<td>Dr Sayanthan Ganesaratnam</td>
</tr>
<tr>
<td>Wilson Health Centre Y02968</td>
<td>Dr Anirban Gupta</td>
</tr>
<tr>
<td>Wimbledon H85027</td>
<td>Dr Tim Hodgson</td>
</tr>
</tbody>
</table>

3.28 Audit and Governance Committee Membership:

3.29 Full details about Merton CCG’s Audit and Governance Committees and Membership can be found in the Governance Section on page 70

3.30 Pension liabilities

3.31 This can be found under the financial notes 4.5 to the Annual Accounts.

3.32 Sickness absence data for CCG staff

3.33 This can be found under note 4.3 in the Annual Accounts.

3.34 South London CSU’s provide our HR support and the HR Business Partner and has worked closely with managers to ensure that sickness absence cases are managed in a timely way and in accordance with the CCGs Sickness Absence policy.
3.35 An Occupational Health (OH) service is available to provide professional medical advice to the CCG. Staff can access OH for a self-referral and can access the OH Counselling service.

3.36 We also have access to an Employee Assistance Programme which is provided by Right Management, which offers unlimited confidential access to emotional and practical support, including legal and financial advice.

3.37 **External audit**

3.38 The appointment of external auditors on behalf of NHS Merton CCG was undertaken by the Audit Commission. Ernst and Young LLP were initially appointed with effect from 1 April 2013, however, owing to a potential conflict of interest, the Audit Commission consulted with NHS Merton CCG and appointed Grant Thornton as the external auditors in September 2013. The appointment was made under section 3 of the Audit Commission Act 1998 and covers the audit of the accounts for 2013/14 to 2016/17.

3.39 The external audit fees for 2013/14 amount to £84,000. The fee covers the audit of the financial statements and work carried out to reach a conclusion on the economy, efficiency and effectiveness in the CCG’s use of resources. No further work in addition to the statutory audit and services carried out in relation to the statutory audit has been carried out by Grant Thornton in 2013/14.

3.40 **Disclosure of “Serious Untoward Incidents” – Information Governance**

3.41 Our Governance Statement on page 81 outlines our policy relating to incidents involving data loss or confidentiality breaches.

3.42 **Cost Allocation and setting of charges for information**

3.43 We certify that Merton Clinical Commissioning Group has complied with HM Treasury’s guidance on cost allocation and the setting of charges for information.

3.44 **Principles for Remedy**

3.45 **Complaints**

3.46 We encourage feedback, positive and negative, so that we can act to improve services based directly on the concerns of patients and the public. During 2013/14, there were 47 formal complaints, compared with 175 in 2012/13. The reduction may be attributed to handing over responsibility for all primary care and specialist commissioning complaints to NHS England on 1 April 2013. Prior to April 2013, Sutton and Merton PCTs were a single organisation, so the figures for 2012/13 reflect the numbers across both boroughs and for all services.
3.47 Of the 47 complaints, three were legacy complaints that were received initially within the 2012/13 period. Six of the complainants whose complaint related to primary care were offered information and guidance to enable them to contact NHS England. Of the remaining complaints received during 2013/14, four related directly to treatment and care provided by a hospital and four related to community services; and we worked in collaboration with these organisations to resolve the complaint. There were also two complaints related to mental health services and a further two complaints which were redirected to the local authority. The final 26 complaints related directly to us and the main themes from these were regarding access and eligibility for services, for example individual funding requests and access to IVF. There were also a small number of complaints relating to the proposed downgrade of St Helier Hospital under the then Better Service Better Value plan.

3.48 The investigations into complaints about us have resulted in changes and learning, for example:

- Complaint regarding an educational and non-educational needs assessment for a child who had, as a consequence not received the care required. We facilitated a re-assessment of the case and the funding for care was granted as a result. (This complaint also led to a review of how we commission care for children with complex health needs)
- We received an Ombudsman letter proposing to investigate a complaint about our handling of a relative’s transfer to a care home and the handling of the complaint. We reinvestigated the complaint and a conclusion was reached that enabled lessons to be learned about the process and systems for care home transfers
- The complaints in relation to commissioning IVF services led to a review of this important area of support to patients with assisted conception infertility issues.

3.49 Complaints about care – following the Ombudsman’s principles

3.50 The Health Service Ombudsman is responsible for handling complaints from the public that relate to maladministration and has set out the six principles which underpin this work as follows:

- Get it right
- Be customer focused
- Be open and accountable
- Act fairly and proportionately
- Put things right
- Seek continuous improvement

3.51 We continue to work hard to meet the standards set within these principles, working closely with partner agencies such as Healthwatch, NHS Trusts and NHS England to ensure robust services which reflect the principles of being open and
enabling continuous improvement to meet the needs of residents within the borough.

3.52 **Patient Advice and Liaison Service**

3.53 We provide a Patient Advice and Liaison Service (PALS) to deal with information requests, issues and concerns raised by patients and members of the public.

3.54 In addition to the complaints received, there have been 108 PALS enquiries received in 2013/14. This is a tenfold reduction on the previous year (1,234 enquiries) but cannot be compared, as the health system has changed so radically (as described above under ‘Complaints’).

3.55 Of the 108 PALS queries, 48 were specifically related to the Better Services Better Value report. The PALS office worked with us and local representatives, such as MPs, to ensure the concerns of the public and patients have been heard relating to hospital services in SWL and, in particular, one of the options in the report to downgrade St Helier Hospital. The BSBV programme ceased running in February 2014.

3.56 The PALS office works closely with us and our directly commissioned services to ensure that concerns are dealt with promptly and services are improved.

3.57 **Employee consultation**

3.58 Organisational Change is managed in accordance with the principles and procedures contained within the CCG’s Organisational Change Policy. The CCG also informally communicates and consults with employees via a monthly newsletter and regular staff and team meetings.

3.59 **Disabled employees**

3.60 Disabled employees are protected under the “protected characteristics” of the Equality Act 2010, one of which is disability. The CCGs Equal Opportunities and Managing Diversity Policy confirms that the CCG will ensure that the requirements and reasonable adjustments necessary for employees with disabilities are taken into account during their employment and that people with disabilities are not discriminated against on the ground of their disability at any stage of the recruitment process or in their employment with the CCG.

3.61 The CCG’s Sickness Absence Policy confirms that where an employee becomes disabled as a result of sickness, the CCG will make any necessary reasonable adjustments, as required, and in accordance with the Equality Act to enable the employee to return to work. The types of adjustments may include adjustments to work base, working hours, redeploying the employee to another suitable position and providing any necessary equipment to assist the employee to perform their role.
3.62 Emergency preparedness, resilience and response

3.63 Merton CCG is a Tier 2 responder in any major incident or emergency, which means we may be called to help NHS England who takes the lead on any major incidents in London. We discharge this responsibility via a formal arrangement with South London Commissioning Support Unit. Merton CCG Directors take their part in the SW London CCG Directors on call rota and have all received training in their roles if a major incident was to occur.

3.64 We certify that Merton Clinical Commissioning Group has a business continuity plan in place, which is compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The Clinical Commissioning Group has reviewed this Business Continuity Plan during the year, in light of our new Tier 2 responsibilities, and has agreed a programme of regularly testing this plan, the results of which will be reported to the Governing Body.

3.65 Statement as to Disclosure to Auditors

3.66 Each individual who is a member of the Governing Body at the time of the Members’ Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group’s external auditor is unaware; and
- That the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the clinical commissioning group’s auditor is aware of that information.

Eleanor Brown

Signed:

Accountable Officer:

5 June 2014
4. Remuneration Report

4.1 The Remuneration Committee comprises of four members and has met on three occasions during the past year. Chair of the committee is Peter Derrick. A full list of members, their roles and the number of meetings each attended is below.

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Role</th>
<th>Date joined committee</th>
<th>Date left committee (if applicable)</th>
<th>No of committee meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Derrick</td>
<td>Lay member for Audit and Governance</td>
<td>01.04.13</td>
<td>NA</td>
<td>3</td>
</tr>
<tr>
<td>Mary Clarke</td>
<td>Independent Nurse Member</td>
<td>01.04.13</td>
<td>NA</td>
<td>3</td>
</tr>
<tr>
<td>Clare Gummett</td>
<td>Lay member for PPI</td>
<td>01.04.13</td>
<td>NA</td>
<td>3</td>
</tr>
<tr>
<td>Howard Freeman</td>
<td>Clinical Chair</td>
<td>01.04.13</td>
<td>NA</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 9: Remuneration Committee members

4.2 In addition to the members listed above, the following individuals provided the committee with services which was material to the committee’s deliberations.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona Stirling (employee of South London Commissioning Support Unit (SLCSU))</td>
<td>Human Resources Manager</td>
<td>Advice</td>
</tr>
<tr>
<td>Eleanor Brown</td>
<td>Chief Officer</td>
<td>Advice</td>
</tr>
<tr>
<td>Cynthia Cardozo</td>
<td>Chief Finance Officer</td>
<td>Advice</td>
</tr>
</tbody>
</table>

Table 10: Individuals support Remuneration Committee

4.3 Remuneration Policy

4.4 The Committee’s deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.

4.5 NHS Merton CCG will be using the national pay and remuneration guidelines for the coming financial year.

4.6 Senior Managers’ Performance Related Pay

4.7 Merton CCG does not have a policy of performance related pay for senior managers.

4.8 Senior Managers’ Service contracts

4.9 All senior managers’ at Merton CCG follow the national pay and remuneration guidelines.

4.10 Table 11: Senior Managers’ Salaries and Allowances (subject to audit)
<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees (bands of £5,000)</th>
<th>Taxable Benefits (rounded to the nearest £00)</th>
<th>Annual Performance Related Bonuses (bands of £5,000)</th>
<th>Long-term Performance Related bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>TOTAL (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Avis – Interim Chief Finance Officer from 13th May to 31st May 2013</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10-15</td>
</tr>
<tr>
<td>Eleanor Brown – Chief Officer</td>
<td>105-110</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>52.5-55</td>
<td>155-160</td>
</tr>
<tr>
<td>Cynthia Cardozo – Chief Finance Officer from 8th August 2013</td>
<td>55-60</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>52.5-55</td>
<td>110-115</td>
</tr>
<tr>
<td>Dr Carrie Chill – 3 roles, Primary Care Lead, Clinical Lead for End of Life Care (both full-year) and Member of Governing Body from 17th October 2013</td>
<td>45-50</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>167.5-170</td>
<td>215-220</td>
</tr>
<tr>
<td>Mary Clarke – Independent Nurse</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>5-10</td>
</tr>
<tr>
<td>Peter Derrick – Lay person with responsibility for finance and governance</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10-15</td>
</tr>
<tr>
<td>Adam Doyle – Director of Commissioning and Planning from 8th July 2013</td>
<td>75-80</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15-17.5</td>
<td>90-95</td>
</tr>
<tr>
<td>Dr. Howard Freeman – Chair</td>
<td>70-75</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>70-75</td>
</tr>
<tr>
<td>Name</td>
<td>Position/Role</td>
<td>Amount (000)</td>
<td>Benefits</td>
<td>On-Secondment</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>----------</td>
<td>---------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Clare Gummett</td>
<td>Lay person with responsibility for patient and public involvement</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Jenny Kay</td>
<td>Director of Quality</td>
<td>105-110</td>
<td>0</td>
<td>0</td>
<td>On secondment with Merton CCG</td>
<td></td>
</tr>
<tr>
<td>Dr Geoffrey Hollier</td>
<td>GP Governing Body member from 1st April – 19th July 2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Karen McKinley</td>
<td>Chief Finance Officer until 28th April 2013</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>70-72.5</td>
<td></td>
</tr>
<tr>
<td>Dr Andrew Murray</td>
<td>2 roles – Clinical lead (full-year) and Governing Body member from 1st June 2013</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Professor Stephen Powis</td>
<td>Secondary Care Consultant</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Note 1 – Payment is made to a corporate body and includes employer’s on-costs such as national insurance and super-annuation contributions.

4.11 NHS organisations are required to disclose the pension benefits for those persons disclosed as senior managers of the organisation, where the clinical commissioning group has made a direct contribution to a pension scheme. Due to the nature of clinical commissioning groups, some GPs have served as office holders of NHS Merton CCG. However, for GPs who work under a contract for services with the CCG, they are not considered to hold a pensionable post and so no pension disclosure is required. From 1 April 2013, NHS England became the employing agency for all types of GPs and pensions contributions have been made by NHS England rather than the CCG. The CCG has made no direct GP payments to NHS Pensions Agency for GP pension contributions.
### Table 12: Senior Managers’ Pension Benefits (subject to audit)

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at aged 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2013</th>
<th>Cash Equivalent Transfer Value at 31 March 2014</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Employer’s contribution to partnership pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleanor Brown – Chief Officer</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
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<tr>
<td>Cynthia Cardozo – Chief Finance Officer</td>
<td>0 – 2.5</td>
<td>5 – 7.5</td>
<td>30 – 35</td>
<td>90 – 95</td>
<td>499</td>
<td>563</td>
<td>53</td>
<td>0</td>
</tr>
<tr>
<td>Dr Carrie Chill – Primary Care, Clinical Support and Governing Body member</td>
<td>5 – 7.5</td>
<td>20 – 22.5</td>
<td>10 – 15</td>
<td>40 – 45</td>
<td>138</td>
<td>291</td>
<td>149</td>
<td>0</td>
</tr>
<tr>
<td>Adam Doyle – Director of Commissioning and Planning</td>
<td>0 – 2.5</td>
<td>0 – 5</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td></td>
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<tr>
<td>Jenny Kay – Director of Quality</td>
<td>On secondment with Merton CCG</td>
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<tr>
<td>Karen McKinley – Chief Finance Officer</td>
<td>2.5 – 5</td>
<td>7.5 – 10</td>
<td>15 – 20</td>
<td>55 – 60</td>
<td>228</td>
<td>280</td>
<td>47</td>
<td>0</td>
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</tbody>
</table>

#### 4.12 Pay Multiples

#### 4.13 Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation’s workforce.

#### 4.14 The banded remuneration of the highest paid director in the financial year 2013/14 was £105-110k. This was 3.3 times the median remuneration of the workforce, which was £33k.

#### 4.15 In 2013/14, no other employee received remuneration in excess of the highest paid member of the Governing Body.
4.16 For the purposes of calculating pay multiples, remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

4.17 Off-payroll Engagements

4.18 Merton CCG had three off-payroll engagements in the financial year to 31 March 2014.

<table>
<thead>
<tr>
<th>Table 13: Off-payroll engagements</th>
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</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>-----------------------------------</td>
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<tr>
<td>Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year</td>
</tr>
<tr>
<td>Number of individuals that have been deemed “Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements)</td>
</tr>
</tbody>
</table>

**Eleanor Brown**

Signed:
Accountable Officer
5 June 2014
5. Statement of Accountable Officer’s Responsibilities

5.1 The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group (CCG) shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Eleanor Brown to be the Accountable Officer of Merton CCG.

5.2 The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the CCG’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the CCG Accountable Officer Appointment Letter.

5.3 Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of their net expenditure, changes in taxpayers’ equity and cash flows for the financial year.

5.4 In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgments and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

5.5 To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my CCG Accountable Officer Appointment Letter.

Eleanor Brown

Signed:
Accountable Officer
5 June 2014
6. Governance Statement

6.1 Introduction and Context

6.2 The CCG was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

6.3 The CCG operated in shadow form prior to 1 April 2013, to allow for the completion of the licensing process and the establishment of function, systems and processes prior to CCGs taking on their full powers.

6.4 We were authorised on 1st April 2013 as Merton Clinical Commissioning Group, with one condition in relation to safeguarding systems. This condition was resolved by July 2013 and we were fully authorised with no conditions. Starting the year with one condition was a positive start and we have made good progress since.

6.5 Scope of Responsibility

6.6 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am professionally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my CCG Accountable Officer Appointment Letter.

6.7 I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

6.8 Compliance with the Corporate Governance Code

6.9 We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

6.10 The Clinical Commissioning Group Governance Framework

6.11 The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

6.12 The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

6.13 Merton CCG’s constitution sets out the principles and methods that the CCG adheres to in delivering our role and functions. It describes how the Governing Body operates, confirms matters reserved for Board decision, and other areas
where certain powers of the Board are delegated within the organisation. It sets out key processes for decision-making, including arrangements for securing transparency in the decision-making of the CCG and the governing body; and the arrangements for discharging our duties with regard to registers of interest and managing conflicts of interest.

6.14 The CCG intends to review these arrangements each year to ensure we remain fit for purpose, enabling the organisation to do everything within our power to support the commissioning of excellent NHS services for Merton residents.

6.15 **Committee Structure**

![Merton CCG Committee Structure Diagram]

6.16 The Governing Body undertakes a proportion of their work through sub-committees. Each sub-committee has a set of terms of reference, which have been formally adopted by the Governing Body. The approved minutes of the sub-committees are presented to the Governing Body meetings, together with a verbal summary on any meetings that have occurred, but for which approved minutes are not yet available.
6.17 Governing Body

6.18 The Governing Body oversees the delivery of the CCG’s commissioning plan, set and lead the strategy for the CCG and are accountable for the delivery of Merton CCGs functions as a statutory body. They monitor performance against objectives, provide effective financial stewardship and ensure high standards of corporate governance are achieved. There are three GPs on the Governing Body including the Clinical GP Chair.

6.19 The membership of our Governing Body:

- Dr Howard Freeman – Chair
- Eleanor Brown – Chief Officer
- Cynthia Cardozo – Chief Finance Officer (from 8 August 2013)
- Dr Kay Eilbert – Director of Public Health, London Borough of Merton
- Adam Doyle – Director of Commissioning and Planning (from 8 July 2013)
- Peter Derrick – Lay Member, Chair of the Audit Committee and Vice Chair
- Clare Gummett – Lay Member, Patient and Public Involvement
- Mary Clarke – Independent Nurse Member
- Dr Andrew Murray – GP Clinical Governing Body Member (from 1 June 2013)
- Dr Caroline Chill – GP Clinical Governing Body Member (from 17 October 2013)
- Professor Stephen Powis – Secondary Care Consultant
- David Avis – Interim Chief Finance Officer (from 13 May 2013 – 31 May 2013)
- Karen McKinley – Chief Finance Officer (until 28 April 2013)
- Dr Geoffrey Hollier – GP Clinical Governing Body Member (from 1 April 2013 – 19 July 2013)

6.20 The clinicians are well placed to lead NHS commissioning because they talk to and treat patients every day. Having local clinicians working together with patients to plan and manage health services means that the organisation can focus more on the quality and clinical effectiveness of care than ever before.

6.21 In the first year of operation, the Governing Body’s main priority has been to govern effectively and in doing so build patient, public and stakeholder confidence that healthcare services commissioned by Merton CCG are in safe hands. This has been achieved by concentrating on the following areas:

- Quality and safety of health services
- Investment of resources that deliver the best possible health outcomes for patients in Merton undertaken as part of the approved internal audit plan for 2013/14.
6.22 The attendance of members at the Governing Body meeting is detailed below:

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<thead>
<tr>
<th>Name</th>
<th>Apr S</th>
<th>May GB</th>
<th>Jun S</th>
<th>Jul GB</th>
<th>Aug No Meeting</th>
<th>Sep GB</th>
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<td>Prof. Stephen Powis</td>
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GB = full meeting  S = Seminar

6.23 **Merton Clinical Quality Committee (MCQC)**

6.24 The MCQC has met monthly throughout the year, with the remit of providing assurance to the Governing Body that commissioned services are being delivered in a high quality and safe manner. The MCQC has been vital in ensuring that quality sits at the heart of everything the CCG does which is reflected in the audit of Quality Governance undertaken as part of the approved internal audit plan for 2013/14.

6.25 Good practice identified during the audit included:

- Findings from recent reports including Francis, Keogh and Berwick are embedded within the CCG Quality Strategy and disaggregated across 24 workstreams, with assigned CCG leads and timescales for implementation.
- An annual forward planner agreed at the beginning of the year which ensures that non standing items such as external reviews and one off exercises are considered by the committee in a timely manner.
- Presentation to the Governing Body by the Clinical Quality Committee of “quality” items outside the standing performance reports, recent examples include winter planning and safeguarding of children.

6.26 The committee delivers its objectives by:

- continuously reviewing the quality of care given at main NHS providers via Clinical Quality Review Groups (CQRG) and ensuring action plans are in place. As Merton does not have an acute trust within the borough, the acute CQRG
meetings are chaired by a clinician of the 'host' CCG, Merton CCG is represented by our relevant GP locality clinical lead in our role as an 'associate' commissioner. Merton CCG hosts Sutton and Merton Community Services (Royal Marsden Hospital) and leads the CQRG for this contract and is chaired by Dr A. Murray, one of our GP Governing Board members

- scrutinising a range of quantitative and qualitative data and performance measures to manage risk appropriately and having robust mechanisms in place to effectively address clinical governance issues
- reviewing and scrutinising the integrated quality and performance report, which provides a more in-depth picture of the quality of care provided to Merton patients by the main providers and is also presented to the Governing Body as part of the balanced score card
- having oversight of the process and compliance issues concerning Serious Incidents (SIs); Central Alert Systems (CAS); National Reporting; and being informed of all Never Events and informing the Governing Body of any escalation or sensitive issues in good time
- receiving and reviewing reports relating to Safeguarding Adults and Children including Serious Case Reviews
- receiving and scrutinising independent investigation reports relating to patient safety issues and agree publication plans
- ensuring a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern
- overseeing and promoting the general duty to improve the quality of primary care so as to improve the quality of services

6.27 Membership and attendance of the committee is as follows:

Table 15: Clinical Quality Committee 2013/14 attendance, meetings take place monthly

<table>
<thead>
<tr>
<th>Name</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<tr>
<td>Mary Clarke</td>
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<td>Adam Doyle</td>
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<td>Dr Sion Gibby</td>
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<td>Dr Tim Hodgson</td>
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Present | Apols | Prior to appointment/after departure

6.28 Audit and Governance Committee

6.28 The Audit and Governance Committee has met quarterly during the year and provides the Governing Body with a means of independent and objective review of
financial and corporate governance, assurance processes and risk management across the whole of the CCG’s activities (clinical and non-clinical).

6.29 The committee delivers their objectives by:

- overseeing internal and external audit services;
- reviewing the external and internal audit plan;
- reviewing the annual statutory accounts, before they are presented to the Governing body to determine their completeness, objectivity, integrity and accuracy;
- reviewing financial and information systems, monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
- providing oversight of the establishment and maintenance through the Board Assurance Framework of an effective system of assurance on risk management and internal control across Merton CCG’s activities that supports achievement of objectives;
- monitoring compliance with Prime Financial Policies and Scheme of Delegation;
- obtaining assurance that Merton CCG has adequate arrangements in place for countering fraud and reviewing outcomes of counter fraud work;
- reviewing schedules of losses and compensations and tender waivers;

6.30 The committee is composed entirely of Non-executive members as detailed in the attendance below:

Table 16: Audit and Governance Committee Meeting attendance 2013/14, meetings take place on a quarterly basis

<table>
<thead>
<tr>
<th>Name</th>
<th>Jun</th>
<th>Sep</th>
<th>Dec</th>
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<td>Mary Clarke</td>
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<td>Prof. Stephen Powis</td>
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6.31 The committee’s main activities through the year have been:

- planning and monitoring the delivery of the internal audit plan for the year;
- receiving the Head of Internal Audit Opinion on the system of internal control;
- the re-tender of the Internal Audit and Counter Fraud contracts;
- receiving and considering the counter fraud work plan and performance;
- reviewing and approving counter fraud and prime financial policies;
- reviewing and making recommendations on the corporate risk register and the Board Assurance Framework;
• receiving an assessment from the internal auditors of the South London Commissioning Support Unit (SL CSU) on the financial risks for Merton CCG associated with the financial services provided by SL CSU.

6.32 **Finance Committee**

6.33 The Finance Committee was established by the Governing Body to scrutinise financial planning and performance for Merton CCG, review areas of concern and report to the Governing Body as appropriate. It works alongside the Audit and Governance Committee to ensure financial probity in the CCG.

6.34 The Committee delivers their objective by;

• keeping under review strategic and operational financial plans and the current and forecast financial position of the CCG;
• overseeing the arrangements in place for the allocation of resources and the scrutiny of all expenditure. This includes actual and forecast expenditure and activity on commissioning contracts;
• reviewing the financial report to be presented to the Governing Body, incorporating financial performance against budget, financial risk analysis, forecasts and robustness of underlying assumptions;
• receiving and reviewing a monthly report on the progress of the QIPP plan;
• Reviewing, scrutinising and recommending business cases to the Governing Body;
• reviewing and approving tender waivers or seeking tenders from firms not on approved lists and ensure these are reported to the Audit and Governance Committee;
• reviewing and scrutinising the financial strategy and financial plans for future years.

6.35 Membership of the committee and attendance is detailed below:

**Table 17: Finance Committee attendance 2013/14, meetings take place monthly**

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<td>David Avis</td>
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**Present** | **Apols** | **Prior to appointment/after departure**
6.36 **Charitable Funds Committee (CFC)**

6.37 On 1 April 2013, the management of the Sutton and Merton Primary Care Trust Charitable Funds was transferred to Sutton CCG to act as the Corporate Trustee of the transferred Charitable Funds. Sutton CCG has established a Charitable Funds Committee which includes members of Merton CCG as trustees.

6.38 The Sutton and Merton Charitable Funds Committee (The Committee) oversees the management, administration and accounting arrangements for funds held by Sutton CCG for charitable purposes.

6.39 The funds at 31 March 2013 had a value of £1.744 million per the audited accounts 2012/13.

6.40 **Merton CCG Attendees at Charitable Funds Committee – Formed December 2013**

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Feb</th>
<th>Mar</th>
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<tbody>
<tr>
<td>Peter Derrick</td>
<td>Present</td>
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<td>Prior to appointment/after departure</td>
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<tr>
<td>Clare Gummett</td>
<td>Present</td>
<td>Apols</td>
<td>Prior to appointment/after departure</td>
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</tbody>
</table>

6.41 **Remuneration Committee**

6.42 During 2013/14, the Remuneration Committee’s primary aim has been oversight of remuneration and terms of service for the Governing Body, including the CO and CFO and Directors.

6.43 The objectives of the committee are to make recommendations to the Governing Body on determinations about remuneration and conditions of service for:

- Governing Body Members
- Executive Directors
- Allowances under any pension scheme it might establish as an alternative to the NHS pension scheme
- Reviewing the performance of the Chief Officer and other senior team members and determining annual salary awards, if appropriate.

6.44 The committee delivers it objective by setting all aspects of salary for the Chief Officer, Chief Finance officer, executive directors, the Lay members of the Governing Body and Clinical Leads of the organisation.

6.45 Membership and attendance of the committee is as follows:
Table 19: Remuneration and Nominations Committee attendance 2013/14, meetings take place bi-annually

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th></th>
<th>Sep</th>
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<th>Mar</th>
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<tr>
<td>Mary Clarke</td>
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<td>Peter Derrick</td>
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<td>Prior to appointment/after departure</td>
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6.46 Assessment of effectiveness

6.47 Following Merton CCG’s authorisation site visit, the CCG was commended in a number of areas:

- clinical engagement and clinical leadership,
- the strength of the CCG’s partnerships and credibility with key stakeholders,
- the organisation’s demonstrated capacity and capability for delivering change and meeting statutory responsibilities.

6.48 One remaining evidence gap, however, was for the governing body to undergo a skills audit. The CCG with the assistance of an external consultancy company developed an online self-assessment tool designed to plug this evidence gap and to ensure the CCG’s leadership fulfilled their potential in the first year.

6.49 Completion of the self-assessment tool by Governing Body members and members of the Clinical Reference Group, helped to determine the organisational development needs for the governing body collectively as a leadership team, as well as for individual leaders and informed the development and delivery of the CCG’s Organisational Development plan in 2013/14.

6.50 Going forward, the tool has been updated, but with many of the questions staying the same in order to track progress from 2013/14. A new section looks specifically at the effectiveness of the committees, and another section asks about thoughts on how well the governing body is functioning.

6.51 The self-assessment tool will be undertaken in early April, which will be reported in aggregate and discussed at a CGG Seminar on 24 April 2014. Combined, the self-assessments will identify priorities and a revised plan for the governing body’s development. Individual results will be provided to each person separately and in confidence, with a short discussion between the OD consultant and the individual to agree a personal development plan.

6.52 The Clinical Commissioning Group Risk Management Framework

6.53 Merton CCG has developed a comprehensive risk management framework which identifies specific risks, responsibilities and mitigating actions at both a strategic and operational level, and then through various Committees and reports (e.g. the
Audit Committee and Clinical Quality Committee and the Corporate Risk Register) escalate the most important of these to the Governing Body via the Board Assurance Framework.

6.54 At a strategic level, the Governing Body determines the CCG’s overall risk appetite which enables a consistent approach when developing operational policies and provides assurance to the Governing Body and management that objectives are pursued within reasonable risk limits.

6.55 The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across all organisational activities, both clinical and non-clinical, which support the achievement of the CCG’s objectives.

6.56 All directors, as part of the Executive Management Team and Governing Body, have a responsibility for identifying and managing strategic risks for the organisation. Additionally, the executive directors are accountable for managing operational risks associated with their areas of responsibility. Each Director is responsible for ensuring that the Assurance Framework reflects key risks, controls and assurances related to strategic objectives, and that these are reviewed regularly.

6.66 The Board Assurance Framework (BAF) provides a comprehensive method for effective and focused management of the principal risks that arise in meeting the CCG’s objectives and ensures that the CCG Governing Body:

- is confident that the organisation’s principal objectives can be achieved
- has a process in place for identifying, minimising and prioritising risks that may prevent the achievement of principal objectives
- ensures strategic controls are in place to manage those risks
- is satisfied with the assurance received that these controls are effective and risks are managed appropriately

6.67 During the year, the reporting of the board assurance framework has been developed to more accurately reflect the improvement in mitigating the likelihood of strategic risks being realised. Plans to further develop the assurance framework in 2014/15 are underway to enhance the assurance provided to the Governing Body for delivery of the CCG objectives (Figure ).
At an operational level, supported by South London Commissioning Support Unit (SLCSU), the Executive Management Team (EMT) reviews all risks to the organisation each month by subject (i.e. Quality, Finance and Commissioning) on a rotating basis. This ensures that risks are effectively identified, assessed, managed and monitored and provides assurance and tracking of effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.
6.69 Risk appetites are determined by individual risk owners and moderated by the Executive Management Team during the monthly review of the BAF. The Audit Committee and Governing Body approve the BAF at each meeting including the risk appetite scores. Controls mechanisms have been chosen according to best practice and previous management approaches applied in managing similar risks within historical PCT organisations.

6.70 The risk controls in place, enable the CCG to determine whether the risks are being managed effectively through:

- Policies/guidelines
- Education and training
- Equipment
- Staff Competency
- Induction programme
- and any other measures deemed necessary

6.71 Risk Assessments are carried out by all services/departments to identify the significant risks arising out of all CCG activities; and their potential to cause injury, litigation, damage to the environment or property, or result in delays or impact upon reputation. Risks associated with the following are assessed and recorded on the corporate risk register:

- Strategic and business plan targets
- Adverse incidents and near misses
- Complaints
- Claims
- New projects
- Research and trials
- Environmental risk including Health & Safety Risks
- Fire safety
- Security
- Red Risks from the directorate risk registers

6.72 Quality and Safeguarding leads meet regularly with the Risk Manager to ensure, risks are captured, controls documented and implemented and mitigating actions followed up. Quality and safety risks are monitored by the Clinical Quality Committee and risks of sufficient severity are escalated as required to the Assurance Framework.

6.73 Incident reporting processes have been communicated to all staff via briefings and information on the CCG file sharing structures. A non-clinical incident reporting policy has been implemented and processes to ensure learning from incident reports is captured and fed into the risk management process.

6.74 As a CCG, patients and the public have been involved in the design and oversight of our commissioning strategies, which are designed to address the strategic risks of the organisation. An example would be the Engage Merton event which enabled
the CCG to hear a variety of stakeholder views including risk, in developing our 2-year operating plan.

6.75 **The Clinical Commissioning Group Internal Control Framework**

6.76 A system of internal control is the set of processes and procedures within the CCG to ensure it delivers the policies, aims and objectives of the organisation. It is designed to identify and prioritise the risks, to evaluate the likelihood and the impact should they be realised, and to manage them efficiently, effectively and economically.

6.77 The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

6.78 **Information Governance**

6.79 The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

6.80 We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

6.81 We recognise that information governance is part of risk management. We are therefore committed to ensuring that we meet the required compliance standards of the IG Toolkit to ensure the secure and confidential handling of all personally identifiable data.

6.82 There is a formal process for co-ordinating the self-assessment against the IG requirements, supported by IG experts. This assessment is then independently audited to ensure assurance that sufficient evidence is in place to support the attainment levels assigned by the CCG.

6.83 Each year a comprehensive IG action plan is agreed and implementations monitored by the IG Steering Group to ensure any gaps are identified and improvements made. The action plan has an emphasis on ensuring that staff complete the mandated modules of the IG e-learning programme and raising the importance of security and confidentiality in accordance with the Care Records Guarantee.

6.84 In 2013/14 we worked with the SLCU to achieve Level 2 of the IG toolkit, which is
There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme is being established to fully embed an information risk culture throughout the organisation.

**Reported Information Governance Incidents**

- There were no serious incidents (categorised as 3-5) reported by NHS Merton CCG during 2013/14
- There were no minor incidents (categorised as 1-2) reported by NHS Merton CCG during 2013/14

**Pension Obligations**

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

**Equality, Diversity & Human Rights Obligations**

Control measures are in place to ensure that Merton CCG complies with the required public sector equality duty set out in the Equality Act 2010. The CCG has a clearly defined workplan which is overseen and monitored by the internal Equality and Diversity Group. The group comprises of leads from relevant functions, including Governing Body members. The Director lead for the Equality and Diversity programme is Director of Quality and monthly meetings are established with the E&D lead to progress the work areas.

**Sustainable Development Obligations**

The CCG is required to report progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure that Merton CCG complies with our obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.
Risk Assessment in Relation to Governance, Risk Management & Internal Control

As a new organisation, established on 1st April 2013, all the risks to the CCG, including those inherited from the former PCT organisations were identified and managed within the year using risk management database software. Workshops were held at the beginning of the year to identify key risks and to identify and implement controls. As expected, many of the risks facing the new organisation were rated high, as controls were un-tested, there was no historical assurance and a level of uncertainty in the new health landscape. During the year, the appointment of specialist staff, the implementation of policies, mandatory training, and in year guidance together with clarity about potential cost pressures means that the CCG was able to mitigate these risks to more tolerable levels.

The CCG has established an effective organisational structure with clear lines of authority and accountability which guards against inappropriate decision making and delegation of authorities and enables the CCG to meet statutory duties and follow best practice guidelines. Clinicians and management work in partnership through the commissioning cycle adding value and delivering outcomes to ensure the procurement of quality services and supplies that are tailored to local needs and deliver sustainable outcomes and value for money.

The establishment of both the Audit and Governance Committee and Finance Committee provide the Governing Body with assurance over the wide range of business risks. For example, the Finance Committee has served to provide an overview of financial activity and a sound understanding of costs, performance and achieving efficiencies through reliable and timely financial reporting that met the needs of internal users, stakeholders and local people.

Risk Management and Counter Fraud have been proactively managed by the Audit Committee, approving and implementing a number of policies, systems and processes to ensure best practice operationally and that the CCG is legally compliant before dissemination to staff. Each committee oversees risks relating to their area of responsibility, for example quality and clinical risks are reviewed by Merton Clinical Quality Committee.

At March 2014, the risks to the CCG with the highest residual score were:
- delivery of QIPP programmes; and
- achieving financial balance

These risks were successfully mitigated against in 2013/14 but remain an ongoing risk.

The CCG has recently refreshed our strategic objectives and corporate objectives are being set for each directorate. The Board Assurance Framework will be recast against the refreshed priorities and reported to the Audit and Governance Committee and Governing Body in May 2014.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

The Executive Management Team has met formally fortnightly to monitor the performance against all of the CCGs delivery plans. This includes ensuring that
projects and programmes are delivering cost effective services and optimal benefits to our patient population.

6.106 In addition, the Finance Committee has taken ownership of the management of financial risks and the CCG Audit Committee has taken an independent view of the CCG’s financial management. The Audit Committee is attended by our colleagues from Internal Audit and External Audit and reports to the Governing Body.

6.107 The CCG under-achieved our QIPP target in 2013-14 by £1.1m. The plan was to deliver a net QIPP of £7.5m, 3.6% of our closing revenue resource allocation. The internal audit review on QIPP also highlighted some weaknesses in the planning of QIPP schemes as well as the monitoring of these schemes. The under-achievement of the QIPP plan was mainly due to:

- planning assumptions that were optimistic and in some cases incorrect with little detail on how performance would be monitored
- plans with Providers slipping from planned timescales resulting in slippage on some schemes or non-delivery in 2013-14 and
- over-ambitious schemes to be delivered by Merton CCG.

6.108 On a positive note new mitigating schemes were identified in-year to reduce the gap and the internal governance of how QIPP is being delivered was strengthened.

6.109 Merton CCG acknowledges the challenges to our 2013-14 QIPP and building on our learning have revised and strengthened our processes to include the following:

- The QIPP performance is discussed on a monthly basis at the Executive Management Meetings, which has clinical representation from the three clinical locality leads and Public Health.
- A monthly QIPP Project Delivery Group chaired by the Chief Finance Officer, was set-up to further strengthen the governance of the QIPP programme of work as well as oversee the development of the QIPP plan in 2014/15.
- The Clinical Reference Group, receives a monthly report on QIPP performance and has been actively involved in recommending QIPP schemes for 2014-15 and will continue to identify schemes during the year.

6.110 Review of the Effectiveness of Governance, Risk Management & Internal Control

6.111 As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

6.112 Capacity to Handle Risk

6.113 To develop our capacity to manage risk a workshop was held with Governing Body members at the beginning of the year to describe and review the CCG’s risk management processes.
6.114 All of our key risks have been “owned” by a senior manager who is responsible for ensuring that controls are effectively implemented and appropriate actions are taken.

6.115 Our risk owners are supported by a Corporate Affairs lead at South London CSU, and provided with monthly support to review the risks and mitigation plans. Training has been provided to staff at all levels in risk management processes and in how to use the CCG’s risk management software.

6.116 **Review of Effectiveness**

6.117 My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

6.118 The *Board Assurance Framework* provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving our principles objectives have been reviewed.

6.119 The Governing Body and Audit Committee have provided regular feedback on the completeness and effectiveness of our systems of internal control via their comments and feedback on the completeness of the Board Assurance Framework. During the year gaps in assurance were identified and rectified.

6.120 In addition to this I can confirm:

- The CCG demonstrates their commitment to maintaining an awareness of the level of risk around corporate objectives by discussing the Board Assurance Framework update at meetings of the Governing Body.
- The CCG has an established Risk Management policy that outlines how risks should be scored in terms of likelihood and impact (consequence) and the Corporate Risk Register and Board Assurance Framework show the controls/assurance the CCG has obtained against each risk.
- Appropriate training is provided to staff, tailored to reflect their involvement in the risk management process including one-on-one sessions with risk owners.
- The Conflicts of Interests policy (currently being refreshed) sets out what is expected of CCG employees and members. Conflicts of interest are declared as appropriate at the start of each Governing Body or sub-committee meeting to help ensure the CCG is operating transparently in all business dealings. The policy is also updated annually to ensure it is complying with good practice.
- The CCG is able to demonstrate that their membership structure, required number of meetings and quorum for each committee is consistent with NHS England guidance.
- There is a good balance between allowing the Governing Body and sub-committees to fulfill their scrutiny roles and their decision-making responsibilities with agendas giving priority to those items which require a decision.
### Internal Audit

Following completion of the planned audit work for the financial year 2013/14 for the Merton CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG’s system of risk management, governance and internal control. Below is a summary of progress against the internal audit plan:

<table>
<thead>
<tr>
<th>Audit</th>
<th>Link to risk or rationale for coverage</th>
<th>Opinion</th>
<th>Actions Agreed (by priority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance (1.13/14)</td>
<td>Inadequate governance arrangements resulting in inability to meet statutory duties and delivery of objectives which could damage to the CCG’s reputation.</td>
<td>Amber/Green</td>
<td>0 2 0</td>
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<tr>
<td>Board Assurance Framework (2.13/14)</td>
<td>Inadequate board assurance framework resulting in ineffective risk management.</td>
<td>Not applicable as advisory review</td>
<td>1 3 1</td>
</tr>
<tr>
<td>Financial Feeder Systems (3.13/14)</td>
<td>To provide assurance for External Audit.</td>
<td>Green</td>
<td>0 1 2</td>
</tr>
<tr>
<td>Payroll Feeder System (4.13/14)</td>
<td>To provide assurance for External Audit.</td>
<td>Amber/Green</td>
<td>0 3 1</td>
</tr>
<tr>
<td>Quality, Innovation, Productivity and Prevention (5.13/14)</td>
<td>The CCG will not achieve financial balance for the year ending 2013/14.</td>
<td>Amber/Red</td>
<td>0 5 2</td>
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<tr>
<td>Remuneration of Members (6.13/14)</td>
<td>Failure to ensure transparency of payments made to members could cause reputational damage and result in the CCGs not receiving value for money.</td>
<td>Green</td>
<td>0 0 0</td>
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<td>Quality Governance (7.13/14)</td>
<td>Failure to commission healthcare services that meet the five quality domains:</td>
<td>Amber/Green</td>
<td>0 1 2</td>
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<tr>
<td>- Preventing people from dying prematurely</td>
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<td>- Enhancing quality of life for people with long term conditions</td>
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<td>- Helping people to recover from episodes of ill health or following injury</td>
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<td>- Ensuring that people have a positive experience of care</td>
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<tr>
<td>- Caring for people in a safe environment and protecting them from avoidable harm</td>
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<td>Contract Monitoring - Commissioning Support Unit (8.13/14)</td>
<td>Failure to hold the CSU to account will impact on the services commissioned and achievement of the organisational objectives</td>
<td>Amber/Green</td>
<td>0 2 1</td>
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</table>

**TOTAL**: 1 17 9

6.123 Overall internal audit received assurance on a sound system of internal control. However, there are some assurances on the QIPP audit.
6.124 From the review of the QIPP flash reports in October 2013, internal audit noted that four of the five projects reviewed were RAG rated as Red, with a recovery plan in place to manage and mitigate further reductions in the savings target.

6.125 The following tables highlight the number and categories of recommendations made by our auditors on the QIPP audit.

<table>
<thead>
<tr>
<th>Recommendations made during this audit:</th>
<th>Priority</th>
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</thead>
<tbody>
<tr>
<td>Our recommendations address the design and application of the control framework as follows:</td>
<td></td>
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<tr>
<td>Design of control framework</td>
<td>High: 0</td>
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<td></td>
<td>Medium: 1</td>
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<td></td>
<td>Low: 0</td>
</tr>
<tr>
<td>Application of control framework</td>
<td>High: 2</td>
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<tr>
<td></td>
<td>Medium: 4</td>
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<tr>
<td></td>
<td>Low: 0</td>
</tr>
<tr>
<td>Total</td>
<td>High: 0</td>
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<tr>
<td></td>
<td>Medium: 3</td>
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<td></td>
<td>Low: 2</td>
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6.126 These recommendations have been addressed during the year and also as part of the planning for 2014-15 QIPP plans.

6.127 Head of Internal Audit opinion on the effectiveness of the system of internal control at Merton Clinical Commissioning Group for the year ended 31 March 2014

6.128 Roles and responsibilities

6.129 The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

6.130 The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

6.131 The organisation’s Assurance Framework is one of the key mechanisms that the Accountable Officer can use to support their AGS.
6.132 In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes (i.e. the organisation’s system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

6.133 The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

6.134 **The Head of Internal Audit (HOIA) Opinion**

6.135 The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body’s own assessment of the effectiveness of the organisation’s system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS.

Based on the work undertaken in 2013/14, **significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weaknesses (within the QIPP/Cost Improvement Programmes below) have been identified, as follows:

We have not issued any RED rated reports during the course of the year but did identify one report where we could only provide some assurance (Amber/Red opinion). That area pertained to QIPP/Cost Improvement Programmes.

For QIPP/Cost Improvement Programmes we highlighted concerns with some projects that the estimated net savings are in place but there were no assumptions described in the Project Initiation Documents for how the clinical leads have arrived at the saving figures. The robustness of the monitoring processes also needed strengthening. An action plan has been agreed and we confirmed that the majority of recommendations have been implemented.

6.136 **Issues Judged Relevant to the Preparation of the Annual Governance Statement**

6.137 Based on the work we have undertaken on the Group’s system on internal control we do not consider that within these areas there are any issues that need to be
flagged as significant internal control issues within the AGS. However, the CCG may wish to consider whether any other information should be considered for inclusion in the Annual Governance Statement.

6.138 The basis of the Opinion

6.139 The basis for forming my opinion is as follows:

6.140 An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

6.141 An assessment of the range of individual opinions arising from our work reported throughout the year. This assessment had taken account of the relative materiality of these areas and management’s progress in addressing control weaknesses; and

6.142 Any reliance that is being placed upon third party assurances.

6.143 Information Supporting the Opinion

6.144 The commentary below provides the context for my opinion and together with the opinion should be read in its entirety.

6.145 We carried out a review of the Assurance Framework in January 2014 and reviewed the design of the Assurance Framework. It was evident throughout our review that a great deal of work has been completed on the Board Assurance Framework with good progress made. The general framework and format of the BAF appears robust and sufficient. However we identified a number of areas below which the CCG may wish to consider in developing the document and associated processes further.

6.146 General findings were as follows:

6.147 Our review identified instances where controls are in place to mitigate the impact or likelihood or a risk to the CCG, but according to the BAF this did not appear to be impacting on the residual risk score which remained identical to the inherent risk score;

6.148 The risk target score for some risks appeared to be subjective and to require review for appropriateness; and

6.149 The wording of the controls, actions and assurances identified should include greater detail to provide the Board with more clarity and detail and ultimately assurance.

6.150 Overall we found the systems to have improved during the course of the year with the support provided from the CSU. We were satisfied that there was an appropriate assurance framework in place during the course of the year.

6.151 The range of individual opinions arising from our work that have been reported throughout the year

6.152 The internal audit plan was driven by the CCG’s key risks as identified by management and was further driven by the need to review key financial systems to
ensure that continued External Audit reliance is placed upon the work of Internal Audit. Discussions were also held with the Chief Finance Officer during the year to ensure that any key emerging risks for the CCG were included in the plan.

6.154 A summary of internal audit work undertaken, and the resulting opinions, is provided at Appendix A. At Appendix B we provide more detail on the key internal audit findings which have informed our annual opinion.

6.155 We issued an advisory based report on the Board Assurance Framework, and of the seven assurance based reports we issued during the year, two opinions were ‘Green Rated’, four “Amber/Green rated” and one “Amber/Red rated”. We have not issued any RED rated reports.

6.156 Common Weaknesses

6.157 There have been no common weaknesses identified throughout our reviews.

6.158 Acceptance of Recommendations

6.159 We made a total of 27 recommendations; of which one was high, 17 were medium and 9 were low. These recommendations were made during the year within the seven final reports issued to date. All our recommendations in respect of our 2013/2014 work have been accepted by management, with the exception of one low priority recommendation on the QIPP review whereby the QIPP scheme approval process did not specifically mention the CSU, although their support and provision of information is implied and utilised in all stages of the QIPP process which mitigates this risk. The recommendations made have either been implemented or are in the process if implementation.

6.160 Reliance Placed Upon Work of Other Assurance Providers

6.161 In forming our opinion we have not placed any direct reliance on other assurance providers. However we have liaised with LCFS and External Audit as appropriate. The Service Auditor Report for the CSU which should be prepared by the CSU’s Internal Auditors has not been received at the time of writing this Annual Report and therefore we do not have formal assurance over the controls in operation at the CSU. A Service Auditors report was provided by the auditors for the National Shared Business Services. No significant issues were identified.

Nick Atkinson
Head of Internal Audit
Baker Tilly
6.162 **Data Quality**

6.163 In line with the need to know principles set out in the Caldicott 2 Information Governance Review Report, the CCG ensures that information presented to the Governing Body and other governance forums does not identify individuals and is fully anonymised.

6.164 Senior Management diligently reviews information to be set out in governance and decision making information prior to consideration and presentation to the relevant governance forums.

6.165 The quality of information that the Governing Body and other governance forums receive to consider and direct decision making is also assured through the service level specification arrangements with the South London Commissioning Support Unit and the use of contractual arrangements with the commissioned providers.

6.166 **Business Critical Models**

6.167 The key business critical models on which the Governing Body relies are (i) in-year financial forecasts, (ii) medium term financial planning and (iii) financial evaluation and forecasting of quality led savings schemes. These models are the responsibility of the Chief Finance Officer and operated by the Financial Management & Planning Team and the QIPP Programme Management Office. The governance of these models is delegated from the Governing Body to the Finance Committee. Quality assurance on these models has been sought, and received, by (i) expert external review and (ii) the internal audit programme.

6.168 The supplier of our ICT and BI functions is South London CSU. Business critical models in use within ICT are subject to a number of quality assurance processes which link into the overall framework and management commitment to quality. There is transparency and management oversight over models and data sources used to make business critical and strategic decisions, with scrutiny within the IG and IAG senior management committees (through which customer CCGs receive assurance). In addition a governance process is implemented whereby an internal peer review process is supported by robust document control, ownership and accountability. Data inputs and outputs are regularly validated, with senior management responsible for an overall ‘sense check’ before decisions are approved.

6.169 Business critical models in use within BI include processes which supports the identification and maintenance of a list of all business critical models and a schedule for periodic review. Qualified and experienced personnel exercise professional scepticism over the outputs from key models and organisational use of data. These processes are subject to review by internal Audit, who review management information data and process owners, and external audit whose work covers the quality assurance processes of financial models.

6.170 **Data Security**

6.171 We have submitted a satisfactory level of compliance with the information governance toolkit assessment.
6.172 The CCG has experienced no Serious Untoward Incidents relating to data security breaches.

6.173 **Discharge of Statutory Functions**

6.174 During establishment, the arrangements put in place by the CCG and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation.

6.175 In light of the Harris Review, Merton CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

6.176 Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of Merton CCG’s statutory duties.

6.177 **Conclusion**

6.178 I can confirm that no significant internal control issues have been identified.

Eleanor Brown

Signed:

Accountable Officer

5 June 2014
7. Annual Accounts 2013-14

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>2013-14 £000</th>
</tr>
</thead>
</table>

**Administration Costs and Programme Expenditure**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>2,087</td>
</tr>
<tr>
<td>Other costs</td>
<td>229,858</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>(27,085)</td>
</tr>
<tr>
<td><strong>Net operating costs before interest</strong></td>
<td>204,860</td>
</tr>
<tr>
<td>Other (gains)/losses</td>
<td>46</td>
</tr>
<tr>
<td><strong>Net operating costs for the financial year</strong></td>
<td>204,906</td>
</tr>
<tr>
<td><strong>Net (gain)/loss on transfers by absorption</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Net operating costs for the financial year including absorption transfers</strong></td>
<td>204,906</td>
</tr>
</tbody>
</table>

**Of which:**

**Administration Costs**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>1,417</td>
</tr>
<tr>
<td>Other costs</td>
<td>3,474</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>(187)</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td>4,704</td>
</tr>
</tbody>
</table>

**Programme Expenditure**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>670</td>
</tr>
<tr>
<td>Other costs</td>
<td>226,384</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>(26,898)</td>
</tr>
<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td>200,156</td>
</tr>
</tbody>
</table>

**Other Comprehensive Net Expenditure**

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant &amp; equipment</td>
<td>-</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
</tr>
<tr>
<td><strong>Reclassification Adjustments</strong></td>
<td>-</td>
</tr>
<tr>
<td>On disposal of available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total comprehensive net expenditure for the year</strong></td>
<td>204,906</td>
</tr>
</tbody>
</table>

Merton Clinical Commissioning Group Annual Report and Annual Accounts 2013-14
NHS Merton CCG was established on 1 April 2013 under the Health and Social Care Act 2012. No comparatives are reported as this is the first year of operation of the organisation. NHS Merton CCG achieved its statutory financial performance targets as detailed in note 22.

**Statement of financial position as at 31 March 2014**

<table>
<thead>
<tr>
<th>Note</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>4,479</td>
</tr>
<tr>
<td>11</td>
<td>173</td>
</tr>
<tr>
<td>12</td>
<td>(14,983)</td>
</tr>
<tr>
<td>13</td>
<td>(48)</td>
</tr>
<tr>
<td></td>
<td>(15,031)</td>
</tr>
<tr>
<td></td>
<td>(10,347)</td>
</tr>
<tr>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>(271)</td>
</tr>
<tr>
<td></td>
<td>(271)</td>
</tr>
<tr>
<td></td>
<td>(10,618)</td>
</tr>
<tr>
<td></td>
<td>(10,618)</td>
</tr>
</tbody>
</table>

31 March 2014
The notes on pages 98 to 126 form part of this statement.

The Financial Statements on pages 94 to 126 were approved by the Governing Body on 29th May 2014 and signed on its behalf by:

Eleanor Brown
Chief Accountable Officer

### Statement of Changes in Taxpayers’ Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>General fund</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

#### Changes in taxpayers’ equity for 2013-14

<table>
<thead>
<tr>
<th>Description</th>
<th>General fund</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted CCG balance at 1 April 2013</strong></td>
<td>46</td>
<td>46</td>
</tr>
</tbody>
</table>

#### Changes in CCG taxpayers’ equity for 2013-14

<table>
<thead>
<tr>
<th>Description</th>
<th>General fund</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating costs for the financial year</td>
<td>(204,906)</td>
<td>(204,906)</td>
</tr>
<tr>
<td><strong>Net Recognised CCG Expenditure for the Financial Year</strong></td>
<td>(204,860)</td>
<td>(204,860)</td>
</tr>
<tr>
<td>Net funding</td>
<td>194,242</td>
<td>194,242</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>(10,618)</td>
<td>(10,618)</td>
</tr>
</tbody>
</table>
## Statement of Cash Flows for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>2013-14 £000</th>
</tr>
</thead>
</table>

### Cash Flows from Operating Activities

- **Net operating costs for the financial year**: (204,906)
- **Depreciation and amortisation**: 9 -
- **(Increase)/decrease in trade & other receivables**: 10 (4,479)
- **Increase/(decrease) in trade & other payables**: 12 14,983
- **Provisions utilised**: 13 -
- **Increase/(decrease) in provisions**: 13 319

**Net Cash Inflow (Outflow) from Operating Activities**: (194,083)

### Cash Flows from Investing Activities

- **(Payments) for property, plant and equipment**: 9 (32)
- **(Gain)/ Loss on disposal of property, plant and equipment assets other than by sale**: 9 46

**Net Cash Inflow (Outflow) from Investing Activities**: 14

**Net Cash Inflow (Outflow) before Financing**: (194,069)

### Cash Flows from Financing Activities

- **Net funding received**: 194,242

**Net Cash Inflow (Outflow) from Financing Activities**: 194,242

### Net Increase (Decrease) in Cash & Cash Equivalents

- **Net Increase (Decrease) in Cash & Cash Equivalents**: 11 173

**Cash & Cash Equivalents at the Beginning of the Financial Year**: -

- **Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies**: -

**Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year**: 173
Notes to the financial statements

1. **Accounting Policies**

   NHS England has directed that the Financial Statements of clinical commissioning groups shall meet the accounting requirements of the Manual for Accounts, which shall be agreed with the Department of Health. Consequently, the following Financial Statements have been prepared in accordance with the Manual for Accounts 2013-14 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

   In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 **Going concern**

   These accounts have been prepared on the going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by the inclusion of financial provision for that service in published documents.

   Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the Financial Statements are prepared on the going concern basis.

1.2 **Accounting convention**

   These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.
1.3 **Acquisitions and discontinued operations**

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 **Movement of assets within the Department of Health Group**

"Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than in the Statement of Comprehensive Net Expenditure."

1.5 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and
- The clinical commissioning group’s share of the income from the pooled budget activities.
If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group’s share of any liabilities incurred jointly; and
- The clinical commissioning group’s share of the expenses jointly incurred.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of NHS Merton CCG’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying NHS Merton CCG’s accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

NHS Merton CCG have created a provision for impairment. Also, the accounting arrangements for balances transferred from predecessor PCTs (“legacy balances”) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. However, the CCG has received new legacy claims in 2013-14 relating to 2011-12. The CCG has created a provision for the claims as the liability will sit with the CCG. The impact of the provision is disclosed in note 13.

1.6.2 Key sources of estimation uncertainty

The following are the key estimations that management has made in the process of applying NHS Merton CCG’s accounting policies that have the most significant effect on the amounts recognised in the Financial Statements:

NHS Merton CCG do not believe that 30% of the amount receivable from London Borough of Merton will be received.
NHS Merton CCG believe that 35% of the continuing care claims received will be successful. It is assumed 15% will be settled within one year and the remaining in more than one but less than five years.

1.7 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred. Where the CCG hosts services and recharges other organisations, the recharges are also recognised as operating revenue.

1.8 Employee Benefits

1.8.1 Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the Financial Statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time NHS Merton CCG commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
1.10 Property, plant and equipment

1.10.1 Recognition

Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to NHS Merton CCG;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

NHS Merton CCG does not own any land or buildings. On the dissolution of the former Sutton & Merton Primary Care Trust, all land and buildings were transferred to NHS Property Services Limited.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

1.10.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which NHS Merton CCG expects to obtain economic benefits or service potential from the asset. This is specific to NHS Merton CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, NHS Merton CCG checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but is capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHS Merton CCG's cash management.

1.13 Provisions
Provisions are recognised when NHS Merton CCG has a present legal or constructive obligation as a result of a past event, it is probable that NHS Merton CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.14 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the CCG pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with NHS Merton CCG. The total value of clinical negligence provisions carried by the NHSLA on behalf of the CCG is disclosed at note 13.

1.15 Non-clinical risk pooling
NHS Merton CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which NHS Merton CCG pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of NHS Merton CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of NHS Merton CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.17 **Financial assets**

Financial assets are recognised when NHS Merton CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The only financial assets held are loans and receivables.

1.17.1 **Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, NHS Merton CCG assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what
the amortised cost would have been had the impairment not been recognised.

1.18 Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when NHS Merton CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.19 Value Added Tax
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore, subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Merton CCG not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Joint operations
Joint operations are activities undertaken by NHS Merton CCG in conjunction with one or more other parties but which are not performed through a separate entity. NHS Merton CCG records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.22 Accounting Standards that have been issued but have not yet been adopted
"The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation"

2. Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>181</td>
<td>111</td>
<td>70</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other revenue</td>
<td>26,904</td>
<td>76</td>
<td>26,828</td>
</tr>
<tr>
<td>Total other operating revenue</td>
<td>27,085</td>
<td>187</td>
<td>26,898</td>
</tr>
</tbody>
</table>

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Programme revenue is revenue received that is directly attributable to the provision of healthcare or healthcare services.

Programme revenue relates to:
- hosting Community Services Contract - 81%;
- section 75 non-pooled agreement with local borough council for Genito-Urinary Medicine services - 7%;
- hosting South West London Cancer Network - 4%; and
- other services - 8%.
Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3. Revenue

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total £000</td>
<td>Admin £000</td>
<td>Programme £000</td>
</tr>
<tr>
<td>From rendering of services</td>
<td>(27,085)</td>
<td>(187)</td>
<td>(26,898)</td>
</tr>
<tr>
<td>From sale of goods</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>(27,085)</td>
<td>(187)</td>
<td>(26,898)</td>
</tr>
</tbody>
</table>

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.
4. Employee benefits and staff numbers

**4.1.1 Employee benefits**

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Total</th>
<th>Total Permanent Employees</th>
<th>Other</th>
<th>Total Permanent Employees</th>
<th>Other</th>
<th>Total Programme Permanent Employees</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>1,751</td>
<td>1,354</td>
<td>397</td>
<td>1,178</td>
<td>921</td>
<td>257</td>
<td>573</td>
</tr>
<tr>
<td>Social security costs</td>
<td>130</td>
<td>130</td>
<td>-</td>
<td>93</td>
<td>93</td>
<td>-</td>
<td>37</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>206</td>
<td>206</td>
<td>-</td>
<td>146</td>
<td>146</td>
<td>-</td>
<td>60</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>2,087</td>
<td>1,690</td>
<td>397</td>
<td>1,417</td>
<td>1,160</td>
<td>257</td>
<td>670</td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits (note 4.1.2)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>2,087</td>
<td>1,690</td>
<td>397</td>
<td>1,417</td>
<td>1,160</td>
<td>257</td>
<td>670</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>2,087</td>
<td>1,690</td>
<td>397</td>
<td>1,417</td>
<td>1,160</td>
<td>257</td>
<td>670</td>
</tr>
</tbody>
</table>
4.1.2. Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th>Employee Benefits - Revenue</th>
<th>2013-14</th>
<th>Permanent Employees</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

4.2 Average number of people employed

<table>
<thead>
<tr>
<th>2013-14</th>
<th>Permanently employed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>26</td>
</tr>
</tbody>
</table>

Of the above:
Number of whole time equivalent people engaged on capital projects
- - -

Other average number of people employed has been calculated using average number of hours worked over a full year, this covers 13 individuals at different grades.

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th>2013-14</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>24</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>25</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>1</td>
</tr>
</tbody>
</table>

Number of persons retired early on ill health grounds -
Total additional Pensions liabilities accrued in the year -

Ill health retirement costs are met by the NHS Pension Scheme

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.
4.4 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th>2013-14</th>
<th>Compulsory redundancies</th>
<th>Other agreed departures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>£</td>
<td>Number</td>
<td>£</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Departures where special payments have been made

<table>
<thead>
<tr>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>-</td>
</tr>
</tbody>
</table>

Analysis of Other Agreed Departures

<table>
<thead>
<tr>
<th>Other agreed departures</th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, this valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme’s liabilities.

"The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015."

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on
4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

- The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

- Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

- Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

- For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Net Expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

- Members can purchase additional service in the Scheme and contribute to money purchase AVCs run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.
## 5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Total £000</th>
<th>2013-14 Admin £000</th>
<th>2013-14 Programme £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>1,859</td>
<td>1,189</td>
<td>670</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>228</td>
<td>228</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>2,087</td>
<td>1,417</td>
<td>670</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>3,663</td>
<td>2,239</td>
<td>1,424</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>47,150</td>
<td>-</td>
<td>47,150</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>132,153</td>
<td>-</td>
<td>132,153</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>11</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>16,572</td>
<td>132</td>
<td>16,440</td>
</tr>
<tr>
<td>Chair and lay membership body and governing body members</td>
<td>215</td>
<td>215</td>
<td>-</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>1,717</td>
<td>191</td>
<td>1,526</td>
</tr>
<tr>
<td>Establishment</td>
<td>210</td>
<td>83</td>
<td>127</td>
</tr>
<tr>
<td>Transport</td>
<td>15</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Premises</td>
<td>2,339</td>
<td>283</td>
<td>2,056</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>338</td>
<td>-</td>
<td>338</td>
</tr>
<tr>
<td>Audit fees</td>
<td>84</td>
<td>84</td>
<td>-</td>
</tr>
<tr>
<td>Internal audit services</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>22,701</td>
<td>-</td>
<td>22,701</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>1,784</td>
<td>-</td>
<td>1,784</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>429</td>
<td>168</td>
<td>261</td>
</tr>
<tr>
<td>Education and training</td>
<td>158</td>
<td>74</td>
<td>84</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>319</td>
<td>-</td>
<td>319</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>229,858</td>
<td>3,474</td>
<td>226,384</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>231,945</td>
<td>4,891</td>
<td>227,054</td>
</tr>
</tbody>
</table>

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

Programme revenue is revenue received that is directly attributable to the provision of healthcare or healthcare services.
6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-NHS Payables</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>5,213</td>
<td>15,156</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>4,773</td>
<td>14,029</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>91.56%</td>
<td>92.56%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Payables</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>1,960</td>
<td>182,843</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>1,764</td>
<td>180,421</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>90.00%</td>
<td>98.68%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

<table>
<thead>
<tr>
<th>Amounts included in finance costs from claims made under this legislation</th>
<th>2013-14</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain/(loss) on disposal of property, plant and equipment assets other than by sale</td>
<td>2013-14</td>
<td>£000</td>
</tr>
</tbody>
</table>

7. Other gains and losses
8. Operating Leases

8.1 As lessee
The payment below reflects NHS Property Services Ltd charges for the financial year 2013-14 which have been passed on to providers. There is an ongoing dispute on £1,427k with NHS Property Services Ltd which is reflected in Note 2. £627k of the amount below relates to property owned and managed by NHS Property Services Ltd.

While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include minimum lease payments for these arrangements.

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Land £000</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>-</td>
<td>2,331</td>
<td>-</td>
<td>2,331</td>
</tr>
<tr>
<td>Contingent rents</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-lease payments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>2,331</td>
<td>-</td>
<td>2,331</td>
</tr>
</tbody>
</table>

9. Property, plant and equipment

<table>
<thead>
<tr>
<th>2013-14</th>
<th>Assets under construction and payment on account £000</th>
<th>Information technology £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 1 April 2013</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>-</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Adjusted Cost or valuation at 1 April 2013</td>
<td>-</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Addition of assets under construction and payments on account</td>
<td>32</td>
<td>-</td>
<td>32</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>-</td>
<td>(46)</td>
<td>(46)</td>
</tr>
<tr>
<td>At 31 March 2014</td>
<td>32</td>
<td>-</td>
<td>32</td>
</tr>
<tr>
<td>Depreciation 1 April 2013</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adjusted depreciation 1 April 2013</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>At 31 March 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2014</td>
<td>32</td>
<td>-</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purchased</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at 31 March 2014</td>
<td>32</td>
<td>-</td>
<td>32</td>
</tr>
</tbody>
</table>

**Asset financing:**

<table>
<thead>
<tr>
<th>Owned</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at 31 March 2014</td>
<td>32</td>
<td>-</td>
<td>32</td>
</tr>
</tbody>
</table>

### 9.1 Additions to assets under construction

<table>
<thead>
<tr>
<th>2013-14</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information technology</td>
<td>24</td>
</tr>
<tr>
<td>Furniture &amp; fittings</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
</tr>
</tbody>
</table>

### 9.2 Economic lives

<table>
<thead>
<tr>
<th>Minimum Life (years)</th>
<th>Maximum Life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information technology</td>
<td>-</td>
</tr>
<tr>
<td>Furniture &amp; fittings</td>
<td>-</td>
</tr>
</tbody>
</table>
10. Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>822</td>
<td>-</td>
</tr>
<tr>
<td>NHS receivables: Capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>350</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>3,604</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS receivables: Capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>(338)</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>41</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,479</strong></td>
<td><strong>-</strong></td>
</tr>
<tr>
<td><strong>Total current and non current</strong></td>
<td><strong>4,479</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

Included above:
- Prepaid pensions contributions

The great majority of trade is with NHS organisations and local authorities. As NHS organisations and local authorities are ultimately funded by Government no credit scoring of them is considered necessary. Concentration of credit risk is limited due to the fact that the customer base is large and composed of unrelated/government bodies. Due to this, the Governing Body believes that there is no future risk provision required in excess of the normal provision for doubtful receivables.

10.1 Receivables past their due date but not impaired 2013-14 £000

<table>
<thead>
<tr>
<th></th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>1,443</td>
</tr>
<tr>
<td>By three to six months</td>
<td>170</td>
</tr>
<tr>
<td>By more than six months</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,613</strong></td>
</tr>
</tbody>
</table>

10.2 Provision for impairment of receivables 2013-14 £000

<table>
<thead>
<tr>
<th></th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2013</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted balance at 1 April 2013</strong></td>
<td>-</td>
</tr>
<tr>
<td>Amounts written off during the year</td>
<td>-</td>
</tr>
<tr>
<td>Amounts recovered during the year</td>
<td>-</td>
</tr>
</tbody>
</table>
(Increase) decrease in receivables impaired \( \hspace{1cm} (338) \)
Transfer (to) from other public sector body \[ \hspace{1cm} - \]

**Balance at 31 March 2014** \[ \hspace{1cm} (338) \]

2013-14

Receivables are provided against at the following rates:
NHS debt \[ \hspace{1cm} - \]
London Borough of Merton \[ \hspace{1cm} 30\% \]

## 11. Cash and cash equivalents

<table>
<thead>
<tr>
<th>2013-14</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
</tr>
<tr>
<td>Net change in year</td>
<td>173</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>173</td>
</tr>
</tbody>
</table>

**Made up of:**

- Cash with the Government Banking Service \[172\]
- Cash with Commercial banks \[-\]
- Cash in hand \[1\]
- Current investments \[-\]

**Cash and cash equivalents as in statement of financial position** \[173\]

- Bank overdraft: Government Banking Service \[-\]
- Bank overdraft: Commercial banks \[-\]

**Total bank overdrafts** \[-\]

**Balance at 31 March 2014** \[173\]
### 12. Trade and other payables

<table>
<thead>
<tr>
<th>Current 2013-14</th>
<th>Non-current 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
</tr>
</tbody>
</table>

- Interest payable  -  -
- NHS payables: revenue  (2,750)  -
- NHS payables: capital  -  -
- NHS accruals and deferred income  (3,817)  -
- Non-NHS payables: revenue  (4,460)  -
- Non-NHS payables: capital  -  -
- Non-NHS accruals and deferred income  (3,811)  -
- Social security costs  (26)  -
- VAT  -  -
- Tax  (33)  -
- Payments received on account  -  -
- Other payables  (86)  -
- **Total**  (14,983)  -

**Total payables (current and non-current)**  (14,983)

No liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years are included above.

Other payables include £34k outstanding pension contributions at 31 March 2014.
13 Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing care</td>
<td>48</td>
<td>271</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>271</td>
</tr>
</tbody>
</table>

Total current and non-current

<table>
<thead>
<tr>
<th>Continuing Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>-</td>
</tr>
<tr>
<td>Adjusted balance at 1 April 2013</td>
<td>-</td>
</tr>
</tbody>
</table>

Arising during the year 319 319
Utilised during the year - -

Balance at 31 March 2014 319 319

Expected timing of cash flows:
Within one year 48 48
Between one and five years 271 271
After five years - -

Balance at 31 March 2014 319 319

The new provision for continuing care relates to 2011/12 claims that had not been included in the former Sutton and Merton Primary Care Trust provision for the financial year ending 31 March 2013. Hence, these did not form part of the provision transferred to NHS England. The basis of the new continuing care provision is 18 claims at an estimated cost of £800 per week with an assumption that 35% of the claims submitted will be successful. It is assumed 15% will be settled within one year and the remaining in more than one but less than five years.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £2,175k.

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them.
£nil is included in the provisions of the NHS Litigation Authority as at 31 March 2014 in respect of clinical negligence liabilities of the clinical commissioning group.

14. Commitments

14.1 Capital commitments

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>3,141</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,141</strong></td>
</tr>
</tbody>
</table>

The capital commitment relates to NHS Merton CCG’s contribution towards IT costs at the Nelson Local Care Centre. The Nelson Local Care Centre is funded and owned by Community Health Partnerships Ltd.

15. Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group’s standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group’s internal auditors.

15.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The clinical commissioning group has no overseas operations. The clinical commissioning group therefore has low exposure to currency rate fluctuations.
15.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the clinical commissioning group’s revenue comes from parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

15.2 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>Loans and Receivables</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>822</td>
<td>822</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>3,603</td>
<td>3,603</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>173</td>
<td>173</td>
</tr>
<tr>
<td>Total at 31 March 2014</td>
<td></td>
<td>4,599</td>
</tr>
</tbody>
</table>

15.3 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14</td>
<td>2013-14</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>6,567</td>
<td>6,567</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>8,271</td>
<td>8,271</td>
</tr>
<tr>
<td>Total at 31 March 2014</td>
<td></td>
<td>14,838</td>
</tr>
</tbody>
</table>
16. Operating segments
The clinical commissioning group considers it has only one segment: commissioning of healthcare services.

17. Pooled budgets
The clinical commissioning group had entered into a pooled budget with London Borough of Merton. The pool is hosted by London Borough of Merton.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for Integrated Community Equipment Services.

The clinical commissioning group’s share of the expenditure handled by the pooled budget in the financial year was:

<table>
<thead>
<tr>
<th></th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td>231</td>
</tr>
</tbody>
</table>

18. Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables</th>
<th>Non-current Receivables</th>
<th>Current Payables</th>
<th>Non-current Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Central Government bodies</td>
<td>41</td>
<td>-</td>
<td>59</td>
<td>-</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS bodies outside the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Group</td>
<td>887</td>
<td>-</td>
<td>3,523</td>
<td>-</td>
</tr>
<tr>
<td>NHS Trusts and Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trusts</td>
<td>285</td>
<td>-</td>
<td>3,044</td>
<td>-</td>
</tr>
<tr>
<td>Total of balances with NHS</td>
<td>1,172</td>
<td>-</td>
<td>6,567</td>
<td>-</td>
</tr>
<tr>
<td>bodies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public corporations and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trading funds</td>
<td>3,266</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bodies external to Government</td>
<td>-</td>
<td>-</td>
<td>8,357</td>
<td>-</td>
</tr>
<tr>
<td>Total balances at 31 March 2014</td>
<td></td>
<td></td>
<td>4,479</td>
<td>14,983</td>
</tr>
</tbody>
</table>

Merton Clinical Commissioning Group Annual Report and Annual Accounts 2013-14
page 124/126
19. Related party transactions

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Payments to Related Party</th>
<th>Receipts from Related Party</th>
<th>Amounts owed to Related Party</th>
<th>Amounts due from Related Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Andrew Murray (Personal Medical Services Contract)</td>
<td>55</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

Dr Andrew Murray is a GP member of the Governing Body. The payments above are Dr Andrew Murray’s practice’s share of Local Enhanced Services payments made to the Church Lane Practice as per the Personal Medical Services Contract.

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with London Borough of Merton and London Borough of Sutton.

20. Events after the end of the reporting period

There are no events after the end of the reporting period which will have a material effect on the financial statements of the clinical commissioning group.

21. Losses and special payments

21.1 Losses

The total number of clinical commissioning group losses and special payments cases, and their total value, was as follows:
£46k relates to legacy IT equipment from Sutton & Merton Primary Care Trust which could not be physically verified. The full transferred cost of the equipment has been written off and reported as a loss in 13/14.

22. Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended).

The clinical commissioning group’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th>Duty</th>
<th>National Health Service Act Section</th>
<th>2013-14 Target £’000</th>
<th>2013-14 Performance £’000</th>
<th>Variance £’000</th>
<th>Duty Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>223H(1)</td>
<td>(233,926)</td>
<td>(231,620)</td>
<td>2,306</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>223I(2)</td>
<td>(258)</td>
<td>(32)</td>
<td>226</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>223I(3)</td>
<td>(206,986)</td>
<td>(204,906)</td>
<td>2,080</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>223J(1)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>223J(2)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>223J(3)</td>
<td>(4,960)</td>
<td>(4,704)</td>
<td>256</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF NHS MERTON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Merton Clinical Commissioning Group for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes
- the section on pay multiples and related narrative notes.

This report is made solely to the members of NHS Merton Clinical Commissioning Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)’s members and the CCG as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of the Accountable Officer and auditors

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the CCG; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report which comprises the member practices’ introduction, strategic report, members’ report, remuneration report, statements by the accountable officer and the governance statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Merton Clinical Commissioning Group as at 31 March 2014 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.
Opinion on other matters
In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception
We report to you if:

- in our opinion the governance statement does not reflect compliance with NHS England’s Guidance;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement; and
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG.

As a result, we have concluded that there are no matters to report.

Certificate
We certify that we have completed the audit of the accounts of NHS Merton Clinical Commissioning Group in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

SIGNED

Susan M Exton

Director for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

6 June 2014