“Right care, right place, right time, right outcome”

Merton CCG 2014/2016 Operating Plan and Commissioning Intentions

All enquiries to Adam Doyle, Director of Commissioning and Planning

01 April 2014

Final Version (1.17)
Foreword

This is the first Merton Clinical Commissioning Group 2 Year Operating Plan and Commissioning Intentions and signals the direction of travel for service improvement. The plan will form part of our 5 Year Strategic Plan which is being developed with other commissioners including local Clinical Commissioning Group’s, NHS England and the local authority. This Operating Plan and Commissioning Intentions from Merton CCG, notify all relevant stakeholders and service providers of the priorities for 2014/16.

The Operating Plan will be delivered by the CCG in partnership with the Local Authority & Public Health (London Borough of Merton), with support from the South London Commissioning Support Unit and the Voluntary Sector.

Merton CCG has worked through the commissioning cycle with our patient’s clinicians and members, to identify the emerging priorities for 2014/16, based on the Joint Strategic Needs Assessment and other intelligence.

Our Six Key Delivery Areas are

- Older and Vulnerable Adults
- Mental Health
- Children and Maternity Services
- Keeping Healthy and Well
- Early Detection and Management
- Urgent Care

Our Operating Plan and Commissioning Intentions describe the priorities and actions we will deliver during 2014/2016 and outlines the platform for delivery of continuous commissioning improvement in subsequent years. This is an iterative document subject to active review as national and local policy emerges and areas of delegated accountability are assigned. We look forward to working with our population and colleagues across the health and social care economy to continue to deliver high quality care. We have developed a Plan on a Page for Merton CCG that can be used in a variety of ways to ensure key stakeholders are aware of our plans.

Signed

Dr Howard Freeman  
Clinical Chair

Eleanor Brown  
Chief Officer
## Merton CCG – Right Care, Right Time, Right Place, Right Outcome

### Key Strategic Projects
- Integration, Call to Action, Merton Better Healthcare Closer to Home, Out of Hospital Strategy

### Context and scale of the challenge
- One CCG with 25 member practices covering the same area as Merton Local Authority
- Financially challenged health and social care system due to historical low levels of funding and increasing demands on services
- Inequality gap between wealthiest and poorest wards which is increasing. East Merton is significantly more deprived and the model of care needs to reflect a younger population.
- The 2014/15 CCG budget is around £216 million per year and needs to deliver within budget
- Merton – population 199,693 | 3 Acute Trusts | 1 Local Authority | 1 Mental Health Trust | 1 Community Services

### Health and Wellbeing Priorities
- Giving every child a healthy start
- Enabling people to manage their own health and wellbeing as independently as possible
- Improving wellbeing, resilience and connectedness

### CCG Organisational Development Priorities
- Develop strong clinical leadership and wide clinical engagement
- Ensuring continuous improvement in quality services we commission alongside primary care
- Implement transformational service change to the health and social care system to enable the CCG to meet its objectives. Develop true partnerships between the CCG, Local authority and all our partners.
- Succession planning of clinical leaders and managers

### Patient Involvement and Quality
- Building strong clinical engagement from constituent GP practices
- Develop PPGs and a Patient Reference Group
- Promoting and advancing equality through our work on the Equality Delivery System
- Focus on hard and soft intelligence
- Review smaller contracts
- Jointly construct a quality framework with the Local Authority

### Our Six Priority Areas

#### Older and Vulnerable Adults
- To focus our work on integration to ensure older people have access to seamless services
- To increase our numbers of patients on the Falls Pathway and link in an osteoporosis pathway
- To be the London leader for the numbers of people who receive end of life care in their preferred place
- To review and update the dementia strategy for Merton
- To continue to review our learning disability services
- To ensure we respond to the needs of carers and young carers

#### Mental Health
- To redesign and re-commission IAPT and associated services (i.e. bereavement)
- To work with South West London and St Georges Mental health Trust, to ensure that patients receive appropriate inpatient care
- To ensure our patients are treated in a holistic manner so that there is a sense of parity to their care
- To increase the numbers of patients who are treated with Mental Health conditions in the community through outreach
- To work with Military Health to ensure that veterans have access to all tiers of Mental Health care

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#### Children's and Maternity
- To work more with young children to ensure we listen and respond to their needs and improve their health outcomes
- To review and develop our service for children who are looked after or require safeguarding
- To work towards more integrated Children’s Services ensuring that services are commissioned as jointly as possible
- To focus on transition as a key area to ensure children with complex needs move seamlessly into adult services
- To further work with the Maternity Networks to improve the choice of community antenatal care
- To review the way we can offer IVF services

#### Urgent Care
- To ensure a whole system approach focusing on the patient journey and experience, and clinical outcomes
- To embed the 111 and OOH services and look at new solutions for these services
- To join up system surveillance within Merton for all urgent care services
- To develop the community prevention and response service
- To work with SWL acute host Urgent Care Boards

#### Early Detection and Management
- To review cardiac, diabetes, respiratory and gynaecological pathways and transfer appropriate care to the community
- To ensure we reduce any wide variation in the level of hospital attendances for certain services, we take an active role to ensure that patients have equal access to healthcare
- To work with Public Health and Primary Care to ensure suitable solutions for encouraging exercise are in place
- To include healthy person checks where possible

#### Enhanced Commissioning through
- Working closely with patients and clinicians to design services
- Use of the Equality Delivery System as a robust platform for meeting the needs of Merton
- Working with CSU, CCG and NHSE colleagues to ensure decisions evidence based
- Integration of services through our commissioning

#### We will deliver
- The NHS Constitution for people in Merton
- The NHS Outcomes Framework
- The Social Care Outcomes Framework
- Public Health Outcomes Framework
- Innovation by turning good ideas into services to benefit patients

#### Primary Care Support and Improvement
- We are aware that primary care colleagues are working within a challenged health system and therefore
- We will work with primary colleagues to help them to find solutions to the increasing pressures they are managing
- We will work up innovative models of care with Primary Care Services at the centre (i.e. East Merton Model of Care within 2014/15)
- We will use education and workforce as platforms for pathway changes and service redesign

#### Key Risks and mitigations
- An ageing population who are living longer often with more than one long term condition - integration
- Rising emergency admissions – urgent care surveillance
- Being able to make the efficiency savings required – increased rigour with QIPP
- NHS new systems – work in collaboration with new and existing partners
Contents

Foreword ........................................................................................................... 2
1 Context .............................................................................................................. 8
  1.1 Introduction/Overview ........................................................................... 8
  1.2 Aims and Ambition ............................................................................... 8
  1.3 NHS Planning Guidance ...................................................................... 9
  1.4 NHS Operating Framework for 2014/15 ............................................. 10
  1.5 NHS Outcomes Framework ................................................................. 10
  1.6 Equality Objectives ............................................................................. 10
  1.7 Delivery over 5 years .......................................................................... 11
2 Merton CCG ................................................................................................. 11
  2.1 Clinical Leadership ............................................................................. 11
  2.2 Health and Wellbeing ........................................................................ 12
  2.3 A Call to Action .................................................................................. 13
  2.4 Better Services Better Value (BSBV) .................................................. 14
  2.5 Better Care Fund (BCF) ...................................................................... 15
  Figure 1: ..................................................................................................... 17
3 Commissioning Intentions ........................................................................... 18
  3.1 Transforming services and the way we work .................................... 18
  3.2 What are Commissioning Intentions? ................................................. 18
  Figure 2: South West London locality map and the seven providers engaged with Merton commissioner ............................................................... 19
  Figure 3 – Spend across Care Sector, Merton CCG (2013/14) ............ 20
  3.3 The health of people in Merton ............................................................ 20
  3.4 Commissioning patient centred services .......................................... 21
  3.5 Our Plans for Patient Involvement (PPI) ............................................. 22
  3.6 Promoting integrated care through joint working ............................ 22
  3.7 Moving care closer to home .............................................................. 23
  3.8 Addressing Health Inequalities in Merton ........................................ 24
  Figure 4 – Life Expectancy in Merton ....................................................... 24
4 Delivery ......................................................................................................... 25
  4.1 Areas of responsibility ....................................................................... 25
  4.2 CCG Programme Work streams ......................................................... 26
  4.3 Older and Vulnerable Adults ............................................................... 26
  4.4 Mental Health ..................................................................................... 30
  4.5 Children and Maternity Services ....................................................... 31
  4.6 Keeping Healthy and Well ................................................................. 35
  4.7 Early Detection and Management ...................................................... 36
4.8 Urgent Care ................................................................. 40
4.9 Summary of Commissioning Intentions and Delivery .......................... 41
5 Quality ........................................................................... 42
  5.1 Quality focus .............................................................. 42
  5.2 Assessment of Providers ............................................... 43
  5.3 Quality Premium .......................................................... 44
  5.4 CQUINs ....................................................................... 44
    Table 1: National CQUINs .............................................. 45
    Table 2: Continuing CQUINs ........................................... 45
    Table 3: New Local CQUINs ........................................... 46
6 Performance Monitoring and Delivery .................................................. 46
  6.1 Progress against 2013/14 indicators .................................. 46
  6.2 Outcomes ambitions for 2014/15 .................................. 47
    Figure 5 ........................................................................ 47
    Figure 6 ........................................................................ 48
    Figure 7 ........................................................................ 49
    Figure 8 ........................................................................ 50
    Figure 9 ........................................................................ 51
7 Financial Strategy and Financial Plan 2014/2016 .................................. 52
  7.1 2013/14 Financial Plan and Performance .......................... 52
  7.2 Financial Strategy ......................................................... 53
  7.3 Planning Guidance ....................................................... 54
  7.4 Allocations ................................................................. 54
    Table 4 – Allocation breakdown .................................... 55
  7.5 Running Costs ............................................................. 56
  7.6 Better Care Fund Allocation and Guidance ..................... 56
    Table 5 – BCF ............................................................... 57
  7.7 2014/15 National Tariff ............................................... 58
    Table 6 – Tariff assumptions ........................................ 58
  7.8 Two year financial plan ................................................ 59
    Table 7 - Business rules ................................................. 59
    Table 8 – Local planning assumptions .......................... 59
    Table 9 – High level Financial Plan ............................... 60
  7.9 Expenditure ............................................................... 60
  7.10 Cost Pressures ........................................................... 60
    Table 10 – Cost Pressures ............................................. 60
  7.11 Investments .............................................................. 60
    Table 11 – Investments ................................................ 61
    Table 12 – Non-recurrent reserve ................................. 61
  7.12 Better Care Fund Plan ................................................ 62
Table 13 – Breakdown of BCF ................................................................. 62
7.13 QIPP Plans and management ......................................................... 62
Table 14 – QIPP schemes ..................................................................... 64
7.14 Acute Activity Plans .................................................................... 64
Table 15 - Activity plan ....................................................................... 65
Table 16 – Capital Plan ........................................................................ 67
7.15 Statement of Financial Position (SoFP) .......................................... 67
Table 17 ............................................................................................. 68
7.16 Cash Plans ................................................................................... 68
7.17 Risks and contingency .................................................................. 68
Table 18 – Risks and mitigations ........................................................... 68
7.18 Conclusion ................................................................................... 69
8. Summary .......................................................................................... 69
Appendix A – Plan on a Page 2014/16 ................................................... 71
Appendix B ......................................................................................... 72
1. Purpose .......................................................................................... 72
2. Programme Structure and Organisation .......................................... 72
3. Outline Vision Statement ............................................................... 73
4. Leadership and Stakeholder Management ...................................... 74
5. Benefits Realisation ....................................................................... 75
6. Blueprint Design and Delivery ......................................................... 76
7. Planning and Control ..................................................................... 77
8. Business Case ................................................................................ 77
9. Risk and Issue Management ............................................................ 78
10. Quality ........................................................................................... 78
11. Transformational Flow ................................................................... 79
Appendix B1: Strategic Out-Of-Hospital Programme; Structure and Roles ........................................................................ 80
Appendix B2: Benefits Realisation Plan ................................................ 81
Appendix B3: Stakeholder Management .............................................. 82
Appendix B4: High Level Programme Plan 2014/16 ......................... 83
Appendix B5: Forward Meetings Schedule (Incomplete – assuming SD Board held fortnightly on a Monday) ................................................. 84
Appendix B6: Sample Programme Risk Register ................................ 85
Appendix B7: Sample Issues Log ......................................................... 86
Appendix B8: Highlight Reporting Template ........................................ 87
Appendix C – Performance of Constitutional rights and pledges ........ 89
Appendix D – CCG Outcomes Indicators ............................................. 90
Abbreviations .................................................................................... 91
References .......................................................................................... 93
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1 Context

1.1 Introduction/Overview
Merton Clinical Commissioning Group’s (CCG’s) Operational Plan for 2014/16 outlines the next 24 months of commissioning across Merton, describing our aims and ambitions and how we are working across the health system to improve quality and drive efficiency. The Operating Plan begins by articulating the next phase of changes required within the Merton healthcare system and how the commitments made to implement our vision are being translated into programmes of work.

The operating plan describes our major programmes of work, highlighting ‘what’ we are doing and ‘how’ we plan to do it amidst a national context of profound financial challenge. Being clear about our financial position, our underlying activity assumptions and risks allows us to demonstrate the level of ambition we are aspiring to when planning service change, redesign and increased efficiency savings for the Merton healthcare system.

We have worked with our local providers to outline the main elements of this operational plan and ensuring we are strategically aligned. Additionally we have held a number of system wide meetings involving the public, primary care, acute and community providers, social care and the London Ambulance Service to discuss and align commissioning intentions.

We are working together as a 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.

1.2 Aims and Ambition
The operating plan articulates Merton CCG’s vision for what the Merton system will look like over the next two years. This vision has been developed with member practices through our three Localities. Our aims and ambition are built on the Joint Strategic Needs Assessment (JSNA), jointly agreed priorities with the Merton Health and Wellbeing Board (HWBB), patients, health and social care professionals, the voluntary sector and other stakeholders.

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 and in particular the requirement to deliver a robust Out of Hospital Strategy including:

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

The clinical case for change demonstrated within the Better Services Better Value Programme (BSBV) and now the South West London Commissioning Collaborative alongside the Merton Better Healthcare Closer to Home Programme (MBHCH) also provides us with a unique platform to deliver our Out of Hospital Strategy.

1.3 NHS Planning Guidance  
In October 2013 the NHS Chief Executive wrote to commissioners outlining the planning approach for the NHS over the next 5 years, including:

“Strategic and operational plans – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time.”

Merton CCG received national Business Planning Guidance in mid-December 2013 to define the structure and content of the two year operating plan. The likely requirement for longer term strategic plans was signalled in NHS England’s “A Call To Action” document published in July 2013. This describes anticipated “…future pressures that threaten to overwhelm the NHS and identifies some key challenges which can only be tackled by doing things differently within the following set of requirements:

- How can we improve the quality of NHS care?
- How can we meet everyone’s healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

The initial draft of the 5 Year Strategic Plan is due to be submitted to NHS England by April 2014, with the final version submitted in June 2014. NHS England has asked that the CCG agrees with neighbouring CCGs the footprint in which the five year plans will be written. Merton CCG has agreed to be part of the Strategic Planning Unit of South West London which includes Merton, Wandsworth, Kingston, Richmond, Sutton and Croydon CCGs, and NHSE for Specialist Commissioning and Primary Care services.
1.4 NHS Operating Framework for 2014/15
This was received in December 2014 and includes detailed planning guidance, changes to measures, and details of CCGs' financial allocations. The Commissioning Intentions contained within the Operating Plan were written at a point in time and have been reviewed and revised as additional national planning guidance was received. They cover the key aspects of the CCGs' commissioning responsibilities, and informed the initial stages of the contracting round for 2014/15.

1.5 NHS Outcomes Framework
Merton CCG adopted the principles of the NHS Outcomes Framework for the development of the organisation’s commissioning intentions. To deliver the NHS Constitution rights and pledges, the CCG is working to:

- Prevent people from dying prematurely
- Enhance the quality of life for people with long-term conditions
- Help people to recover from ill health or injury
- Ensure that people have a positive experience of care
- Ensure that people are treated and cared for in a safe environment and protected from avoidable harm

Delivering these outcomes is dependent on alignment with both the Adult Social Care and Public Health Outcomes Frameworks\(^\text{iv}\) and requires partnerships with our fellow commissioners of services for Merton’s population.

The Outcomes Framework is supported by a Clinical Commissioning Outcomes Indicator Set which allows us to benchmark our performance, assuring we are continually improving the quality of services. Measuring and evaluating information on health outcomes and the programmes of work which support them is key to driving quality improvements. In 2013/14 Merton CCG made a good start to deliver the targets and our CCG Balanced Scorecard monitors our progress towards delivering the NHS Constitutional pledges and improving health outcomes for our local population.

We recognise that to improve health outcomes requires forward planning, effective mobilisation and continual monitoring of relevant metrics.

1.6 Equality Objectives
Merton CCG has adopted the following Equality Objectives and these run throughout our work programmes outlined in this Operating Plan:

- To improve the capture and analysis of relevant population, workforce and patient information broken down by protected characteristic as required by the Equality Act to identify and address inequalities
- To improve access to specific information and communication requirements; to ensure patients are kept fully informed and asked about their communication needs, so that reasonable needs can be met
• To identify specific key performance indicators for commissioning areas to improve health outcomes for protected groups

• To improve access to services by involving and listening to patients from all protected characteristics; targeting those people whose voices may not usually be heard by NHS organisations

• To ensure considerations of Equality, Diversity and Human Rights are included in mainstream processes through the use of Equality Analysis

• To ensure that Merton CCG is supported to take the Equality, Diversity and Human Rights agenda forward using the Equality Delivery System (EDS)

Our focus for 2014/15 is to assess and develop the following commissioning priorities through EDS; Mental Health, Older People and Children’s services.

1.7 Delivery over 5 years
The focus for the planning process with full agreement from the Governing Body has been to deliver a robust and credible plan.

Savings in through Quality, Innovation, Productivity and Prevention (QIPP) (2013/14) have been adjusted for implementation time and confidence in delivery in 2014/16. Merton CCG is committed to our decision to concentrating on wider transformational service redesign to deliver a financially sustainable health system over 2 years, rather than having unrealistic annual activity reduction targets.

Merton CCG will receive total of 4.92% in 2014/15, consisting of 2.29% for population growth and 2.63% for growth, which is linked to pace of change associated with distance from target. In 2015/16 Merton will receive 4.49% increased allocation, which is based on estimated population growth of 2.16% and 2.33% linked to bringing us closer to target. The 2015/16 allocation is indicative and is expected to be updated before April 2015.

Key elements of our plans to deliver over the next two years are the shift to commissioning for outcomes and ensuring greater integration. Plans for these changes are covered in more detail in later sections of this plan.

2 Merton CCG

2.1 Clinical Leadership
Merton CCG is a clinically-led membership organisation made up of twenty five general practice teams across the Borough of Merton, grouped into three Localities supported by central teams covering commissioning, quality and finance. The Localities have been working hard to develop, and ensure they link their local priorities into the wider organisational strategy. Each Locality is led by a Locality Clinical Lead who attends the relevant Clinical Quality Reference Group for our major acute providers. The Locality Clinical Leads are also an integral part of the Executive Management Team to ensure that all decisions have clinical review, input and challenge. Every member practice is represented in a locality by their chosen general
practice lead. The CRG made up of primary care clinicians further enhances and advises clinical decision making relating to service redesign and quality.

In 2014/16, the localities will have an operational plan to ensure that all programmes of work are supported by the CCG and all practices are able to sign up to delivering their contribution to the plans.

Locality plans will be finalised once the overall OP is agreed and Locality apportionment of projects discussed and agreed. We are by definition a membership organisation and use our locality structures to ensure the membership have a direct link into the organisation.

The Locality specific projects are equally supported by the central programmes of work which ensure economies of scale for contracting and strategic alignment across the Borough. The six central Programme Work streams build on proposals from, and are working closely with Localities to develop a clear Borough wide framework for these service areas. Each Locality will then own and tailor elements of the overarching strategies to fit with their local patient needs.

Every Programme work stream has an appointed Clinical Director and each has a clear area of focus as follows:

1. Clinical Director for Urgent Care
2. Clinical Director for Mental Health
3. Clinical Director for Children and Maternity
4. Clinical Director for Keeping Fit and Healthy
5. Clinical Director for Early Detection
6. Clinical Director for Older and Vulnerable Adults

We have also created two further roles to ensure we have a full clinical complement of advice and support. They are

1. Clinical Director for Acute and Community Care
2. Clinical Director for Dementia and Diabetes

2.2 Health and Wellbeing

To improve the overall health and wellbeing of the residents of the borough, Health and Wellbeing Boards (HWBB) have been created to deliver strategic and local leadership. The work of the HWBBs are central to informing and performance managing the commissioning and outcomes of health and social care services in Merton and has a core role in encouraging joined-up services across the NHS, social care, public health and other local partners.

Merton HWBB’s full statutory responsibilities have now been in place since April 2013 and a Shadow HWBB has been working in Merton since 2011. The Merton HWBB brings together the Council, Merton Clinical Commissioning Group, Health Watch and the voluntary and community sector with a shared focus on improving the health and wellbeing in Merton.

Merton’s first Health and Wellbeing Strategy has been developed at a time of substantial change, significant challenges and real opportunity. The shift of Public Health to the local authority provides new opportunities to tackle
health inequalities and make a real difference to people’s lives. The Merton Health and Wellbeing Strategy has been developed to take advantage of these opportunities and takes a broad view of health to address the wider determinants of good health and wellbeing.

The jointly written HWB strategy mirrors the CCG strategy to treat as many people as possible out of hospital and to promote independence, and is informed specifically by the local needs identified in the JSNA. The Health and Wellbeing Strategy also links closely to the Merton Community Plan. The Health and Wellbeing Strategy continues to inform the commissioning of health and social care services in Merton and will provide the focus for the partnership working of Merton HWBB in determining its core areas of influence.

There are four priority areas of the Health and Wellbeing Strategy that Merton CCG are actively involved in:

Priority 1 Giving every child a healthy start
Priority 2 Supporting people to improve their health and wellbeing
Priority 3 Enabling people to manage their own health and wellbeing as independently as possible
Priority 4 Improving wellbeing, resilience and connectedness

In addition, Merton CCG co-ordinates the third priority; Enabling people to manage their own health and wellbeing as independently as possible.

2.3 A Call to Action
People in Merton are being given the opportunity to have their say on the future of the NHS by taking part in an honest and open debate called Call to Action.

We know that the population of our borough is growing. We also know that people are living longer than they have in the past. Meanwhile medical technology continues to advance as new or improved treatments and medicines are made available to patients. This means that there is more demand than ever on NHS services, and this demand is continuing to increase. At the same time we know that the funds available to spend on health services will not be able to keep pace with this rise in demand.

Merton CCG is inviting local people to take part in the national debate about how health services can be best delivered now and in the years ahead. In order to continue to have a high quality health service in line with the London Quality Standards we must make significant changes over the next few years. We will do this by working with patients to develop more innovative ways of providing some services outside of hospitals and act to ensure the services patients use are better co-ordinated.

We are working with the public to inform them of the local pressures that the NHS faces:
• An ageing population, with the number of residents aged 85 and over up 41% by 2021
• As a result of the ageing population, the number of people suffering from dementia, diabetes and other long-term conditions is increasing
• There are also expected future pressures on health care services from increasing numbers of young people (up by 20% by 2021) and the health risks within this group, particularly obesity and smoking
• Difference in health outcomes between the East and the West of the borough

Engagement with local residents on plans to improve services outside of hospitals has taken place and our Call to Action dialogue is helping us to shape our two-year operating plan and five-year strategic plan. In order to develop our plans further we are talking to local people about how we can help people stay healthy and self-manage their health conditions more effectively.

• Health & Wellbeing Board
• Merton Healthwatch/PPI Engagement Event
• MCCG Members’ Event – 9 October 2013
• Governing Body Seminar
• Merton Integrated Project Board

We have also provided an accessible Call to Action questionnaire on our website that is open until 31 March 2014.

In addition to an online Call to Action survey, we have been talking to local residents at various forums and meetings, some of which include HWBB, Merton Healthwatch events, Merton Residents Health Forum, Merton Seniors Forum.

2.4 Better Services Better Value (BSBV)
The BSBV programme of work has now concluded however the clinical case for change within BSBV still exists.

As General Practitioner (GP) leaders of the local NHS, we have a unique opportunity to work together to transform services for our patients in south west London. We must tackle the variation in quality across all local health services and we know we can only do this by working together.

Our services are inter-dependent and the challenges we face cross borough boundaries. We need closer working between our hospitals and between the hospitals, GPs, community and mental health services if we are to improve quality for everyone in south west London and make the local NHS sustainable. We do not believe it would be possible to achieve the scale of change that is needed by working independently at borough level. We will work with our local authorities, HWBB, mental health trusts, primary and community care providers, local hospitals, patients and neighbouring CCGs to achieve substantial and lasting improvements in our health services.
We will therefore be recommending to our CCG boards that the six CCGs and NHS England, who commission specialist services in south west London, work jointly to develop new strategies for local health services. We do not propose to continue with our BSBV programme or to consult on the options that emerged from it, which have now been withdrawn. But we do know that we need to continue to work together to drive up the quality of local health services in a way that is acceptable to our patients. There are no easy answers and we know change will be needed.

We agree that all future hospital services should be commissioned against the London Quality Standards – which are the minimum safety standards developed by senior clinicians, based on Royal College guidance – and that all hospitals must provide seven-day, consultant-led services. We know this will not be easy – as there are not enough senior and experienced doctors, the hospitals will have to work together to achieve this. We also expect our hospitals to comply fully with the recommendations set out in the national review of urgent and emergency care by Sir Bruce Keogh and to be financially sustainable.

As commissioners of specialist services in south west London, NHS England will work with us as part of a strategic planning group to develop long term, sustainable improvements for patients.

Should the outcome of our discussions mean major service change at any of our trusts – which we think is likely, given the difficulty of meeting the London Quality Standards across four hospitals – then proposals would of course be subject to public consultation. Most recently Merton CCG has been working with the other CCG’s in south west London and NHSE to form the South West London Commissioning Collaborative for developing the 5 year plan for Merton.

The collaborative is focusing on the following key areas and Merton CCG’s two year operating plan mirrors the strategic themes for South West London. The strategic themes are as follows:

- Children’s Care
- Integration
- Maternity
- Mental Health
- Planned Care
- Primary Care
- Specialised Services
- Urgent Care

2.5 Better Care Fund (BCF)
The BCF is a national initiative which introduces a pooled budget between NHS Clinical Commissioning Groups and Local Authorities to provide an opportunity to transform local services so that people are provided with better integrated care and support. It was previously referred to as the Integration Transformation Fund, and re-named the Better Care Fund in December 2013.

The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. It
provides an opportunity to improve the lives of some of the most vulnerable people in our population, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. However, as the funding is mainly a transfer of revenue from the Merton CCG’s allocation, and existing capital from LBM’s allocation, into the pooled budget, the Better Care Fund could be viewed as not being new money but a new way of agreeing and stimulating service transformation between health and social care.

The BCF will support the aim of providing people with the right care, in the right place, at the right time and with the right outcome, including through a significant expansion of care in community settings, instead of in hospital or care homes. The drive behind the BCF is focused on adults, in particular older people.

We do see the BCF as a key part of our overall strategy as demonstrated in the diagram below
In Merton, it provides the opportunity to develop the existing Merton Integration Project which began in 2013. A partnership of the CCG, LBM, trusts and voluntary sector, it aims to develop integrated care between social and health care. The Merton project is focused on two phases of individuals’ care:

- A proactive phase, including the identification of high risk individuals, allocation of a key worker, person-centred planning and a common care plan across organisations, development of integrated locality teams and multi-disciplinary review meetings.
- A reactive phase, developing improved responses to short term crises and exacerbation of conditions, including rapidly available alternatives to hospital admission, supported hospital discharge, rehabilitation, intermediate care, reablement, and increasing the integration of these health and social care responses.

In 2014/15 the Fund will consist primarily of the existing Section 256 transfer of funds from the CCG allocation to the Council, used to fund social care that benefits health, plus an initial increase to begin progress. The main BCF has a wider brief, and comes into operation in 2015/16.

The BCF has the following aims, and progress will be measured nationally against metrics for each of these aims:

- Increase patient and service-user experience
- Reduce avoidable emergency admissions to hospital
- Reduce delayed transfer of care from hospital
- Demonstrate the effectiveness of reablement
- Reduce permanent admissions to residential and nursing homes
A locally agreed metric on reablement will be added to the above list. In 2015/16 25% (£3.3m) of the BCF is subject to a performance assessment, based on metrics for the above elements, together with progress on 7-day working, data sharing, joint assessments with an accountable professional, and protection for adult social care services.

It has been clarified that should the planned level of achievement not be reached, money will not be clawed back in 2015/16. Instead, a previously agreed contingency plan will be put into operation if the performance is above 70% of the level of the levels of ambition set out in the plan. If performance falls below 70%, a recovery plan may be required. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be coordinated by NHS England, with the support of the Local Government Association (LGA). A final version of the plan will be agreed by the Council and CCG Board, and taken to the HWBB for agreement at its meeting on 25 March 2014, for submission on 4th April 2014.

The full BCF document can be found on our website.

### 3 Commissioning Intentions

#### 3.1 Transforming services and the way we work

2014/15 is the second year of the health service reforms. Merton CCG will build on the progress of having local clinical ownership of the Quality, Improvement, Productivity and Prevention challenge (QIPP) and especially to ensure sustainable implementation of the clinical changes needed to ensure wider service and financial sustainability.

To improve health outcomes across the five domains within limited resources, we have to update the way health services are delivered. We need to work to speed up our commitment to deliver more care closer to home. Merton CCG is well equipped to meet this aim which has been a clinical focus and legacy from previous commissioning organisations and aligns with increased national impetus.

#### 3.2 What are Commissioning Intentions?

The purpose of this section is to inform all the stakeholders of health services for Merton CCG’s population of the commissioning priorities for the next two years. The commissioning intentions are in effect the CCG’s annual plans for the next two years outlining which areas we have prioritised for improvement, the changes we wish to make and how we will look to transact those changes.

Merton CCG is the co-ordinating commissioner for the Community Services contracts with The Royal Marsden NHS Foundation Trust, who host Sutton and Merton Community Services (SMCS). We are also a significant associate commissioner in the contracts with:

- St George’s Healthcare NHS Trust
- Epsom and St Helier University Hospital NHS Trust
Our CCG also holds contracts with a range of hospice, voluntary and independent sector providers. Table 1 shows the spend across each care sector.

Primary medical care, dental, pharmacy and optometry services will be contracted for our population through the NHS England. Public health services are contracted by the London Borough of Merton or Public Health England.
3.3 The health of people in Merton

- **Joint Strategic Needs Assessment (JSNA)**

Our Commissioning Intentions are informed by the 2013/14 JSNA, which sets out a big picture for commissioning partners, to agree key priorities for improving the health and wellbeing of all our communities at the same time as reducing health inequalities. The JSNA provides the rationale and evidence base for the Joint Health and Wellbeing Strategy, and underpins Merton CCG’s commissioning intentions. The health and wellbeing of Merton’s population is closely defined by the characteristics which make Merton a unique borough.

Merton continues to be “healthy” in comparison with much of London, but within the borough there are unacceptably wide differences in life expectancy and death rates for some of the major causes of death—cancer, heart disease and respiratory disease. These inequalities are reflected in key predictors of health and wellbeing such as obesity prevalence, smoking prevalence and teenage conceptions. Strong partnerships and innovative ways of working are central to improving health and reducing inequalities. The east of the borough experiences higher levels of social and economic deprivation, which contrasts the resulting poorer health outcomes in the East. The JSNA is an assessment of the health and wellbeing of the people of Merton. Locally, the JSNA programme is led by the Merton Public Health team, and involves partner organisations, such as the local NHS, local authority, and voluntary and third sector organisations.
• Place

Merton is suburban in character, and has significant amounts of green space, with over 60 parks and open spaces. 18% of the borough area is open space, compared to a 10% London average. The health and wellbeing of Merton’s population is closely defined by the characteristics which make Merton a unique borough. While Merton generally performs well on health indicators overall, the east of the borough experiences higher levels of social and economic deprivation, which result in significant differences in life expectancy and mortality between and within electoral wards in Merton.

• People

Merton is part of one of the world’s largest cities. The 2011 Census identified a resident population of 199,693. The age profile in Merton is atypical to outer London Boroughs currently. There is a very high proportion of young working age adults, and a smaller proportion of older people. There are around 3,500 new births each year, a 40% increase since 2002. By 2021 it is expected that there will be a 20% increase in children born each year. The population is predicted to increase in size through increasing birth rates and migration, and will remain relatively young compared to the national profile and more in line with what is expected in London. However, there is an expected increase of the very elderly population that is more in line with the national profile.

Approximately 35% of the population are from Black, Asian and Minority Ethnic (BAME) communities. An additional 16% of the population are from non-British White communities (mainly South African, Polish and Irish). Combined, 51% of Merton’s population are from diverse communities.

In 2012, Merton continued to be healthy in comparison with much of London, but within the borough there are unacceptably wide differences in life expectancy and death rates for some of the major causes of death. A man born in Ravensbury ward can expect to live 71.6 years, while a man born in Wimbledon 84.8 years – a difference of 9 years and no change from 2005/09. A woman born in Figges March can expect to live 79.5 years and one born in Hillside 92 years, a difference of 13 years and 2 years more than in 2005/09.

3.4 Commissioning patient centred services

Merton CCG aims to ensure “the right service, at the right time, from the right person with the right outcome”. Outcomes based commissioning, increased integration of services and the movement of care closer to home all testify to our commitment to put the patient first; each transformation seeks to increase the quality of services and commission around service user needs. We are taking the key message of “No decision about me without me”, traditionally applied to shared patient-clinician decision making in frontline health services and applying it to our commissioning approach. Our communication and engagement strategy identifies our way forward.

At all our Merton events we are taking time to speak to patients, patient representatives, and support groups. By taking the time to listen to first-
hand accounts of using services we commission Merton CCG has gained a unique insight into the needs and wishes of the residents of Merton. We have also used our internal and external meeting structures to gather opinion about services to ensure we have a rounded view on the approach we need to take. This has given us some of the detail for plans to change specific services.

Key to our drive for commissioning patient centred services is having the ability to monitor how health services are doing through the use of the Friends and Family Test (FFT), patient complaints and other intelligence which align with local initiatives to measure and act on patient experience feedback.

In practice our patient-centred services will continue to increase opportunities for service users to maintain or regain independence allowing them to choose their care from a wide range of quality and qualified providers supported by clinicians.

3.5 Our Plans for Patient Involvement (PPI)

PPI Objectives

In our quality and communications and engagement strategies we state our ambition to ‘listen as never before’. This means we need to do things differently, and work in new ways to hear from our population and engage them in a meaningful discussion about local healthcare.

We are:

- Building strong clinical engagement from constituent GP practices, and wider local professional groups to gather clinical insights which have a tangible impact and add value to the commissioning process
- Using the success of those practices which have active Patient Participation Groups (PPGs) to develop PPGs in all our practices, as a platform for engagement and listening
- Developing a Patient Reference Group (PRG) which brings together the PPGs and supports / steers their activities
- Using existing groups and systems to engage with patients, public, carers and their communities to ensure their systematic involvement in the commissioning, planning, designing, improvement and monitoring of health services for local people
- Building public and stakeholder confidence in our CCG and its leadership by making better use of engagement, consultation and patient experience data to improve health services and the patients experience of health services
- Promoting and advancing equality through our work on the EDS

3.6 Promoting integrated care through joint working

Integration is built on collaborative working, shared decision making and jointly defined priorities. We recognise that in order to make the best use of available and limited resources we need to integrate across the health system. Our JSNA and Health and Wellbeing Strategy are mechanisms for effective partnership working. In planning for 2014/16 we have worked with
the HWBB, Local Authority and patient representative groups to ensure our local priorities are appropriately aligned.

Integrated care is a key lever to commission for outcomes. From direct NHS health care services through to social care and voluntary services, which can provide additional on-going support for recovery and management, every service provider will be expected to work together to improve overall health outcomes of service users. Shared accountability will facilitate integration to produce improved outcomes.

We are keen to drive forward integrated care, giving explicit consideration to ways we can increase joint working. We will ensure that our plans for the BCF are robust and meet the needs of our population. Further thought will also be given to the establishment of pooled budgets for:

- Mental Health
- Learning Disabilities
- Children’s Services

Pooled budgets will be a priority for the Merton CCG in 2014/15 as a way to reflect and commission for local needs.

3.7 Moving care closer to home
Merton CCG aims to keep people out of hospital when care can be provided in other settings such as the community. As part of MBHCH programme, we are developing care outside a hospital setting.

Our Primary Care and multidisciplinary assessment unit at the Nelson Local Care Centre opens in April 2015 and the MBHCH Programme are actively seeking to ensure that the new model delivers fully integrated care. In order to ensure that the people of Merton have full access to excellent facilities, we are assessing a new model of care in East Merton and working with the HWBB to ensure that healthcare needs of our most deprived area within the Borough are taken into account.

We know we must do better at commissioning our intermediate care facilities and we will commission an improved model to reduce admissions to acute care settings and facilitate the discharge and return home of patients following admission to an acute trust.

We will review and develop further our new 111 provider to improve a single point of access into the healthcare system. This service will be patient-centric using consistent means of assessment allowing us to direct patients to the appropriate care setting, preventing unnecessary visits and waits at Accident & Emergency (A&E) by promoting the availability of other options and care settings. The notion of “The Right Care, Right Place, Right Time, and Right Outcome” will rely on the increased provision of out of hours and community services.

We will link these changes into ensuring that we support and develop Primary Care to further enable practices to deliver a robust service model. One of our localities is a London pilot for looking at a federated model of general practice. Merton CCG is committed to support other localities to look at new models of care in general practice.
This work will be implemented through the Merton CCG clinical leadership structure. The Clinical Reference Group (CRG) which is made up of GPs, nurses and senior managers, will continue to be the focus point within Merton CCG to ensure that all programmes of work are implemented in a robust fashion. Each theme is championed by a Clinical Director who is responsible for delivering the required changes.

3.8 Addressing Health Inequalities in Merton
The Joint Strategic Needs Assessment shows that overall health outcomes in Merton are good compared to London and England. There are however significant inequalities in health outcomes. The maps below show the differences in life expectancy between the east and the west of the borough. The darker shaded areas represent those areas with the shorter life expectancy.

Figure 4 – Life Expectancy in Merton

Public Health and Merton CCG then agreed to work together to address the health care inequalities in the East. A health needs assessment of health for East Merton residents completed in January 2014 found that for the biggest killers in Merton (coronary heart disease, cancer and respiratory diseases)

- They are more frequent in poorer people
- They can be prevented. All are related to lifestyle factors such as smoking, obesity, lack of physical activity, an unhealthy diet and excessive alcohol consumption
- Primary care has a key role in preventing and treating them

The needs assessment therefore recommended:

- Improvements should be made in early detection and management of long-term conditions in primary care, especially in East Merton
• A new local healthcare centre in East Merton should contribute to health improvement in that locality. Its purpose might include accommodating services moving from elsewhere, housing novel services to complement what exists now, providing the public with an accessible point of contact for a range of local services and acting as a focus for quality improvement initiatives in primary care
• The CCG should consider new models of service provision that involve more care being provided in community settings and less at hospital sites, including intermediate care for people with diabetes for example

A task and finish group, led by representatives from GP practices in the East Merton locality, includes the MCCG, the Council and Public Health colleagues. The group will develop a model of care that ensures disease is detected early when it can be cured or managed closest to home. Work will be two fold – over the next year the task and finish group will develop a new Model of Care. At the same time, a strategic operating case for the development of a local health care centre in Mitcham is under development for consideration by the Department of Health. This process should be completed by April 2015, when, if approved work can begin on the centre.

4 Delivery

4.1 Areas of responsibility
Merton CCG has the responsibility for commissioning the following range of services:

• Urgent and emergency health care
• Planned health services
• Community health services
• NHS Continuing Care
• Mental health services including psychological and substance misuse
• Maternity and newborn health services (excluding neonatal services)
• Children’s health services – physical and mental health
• Primary care prescribing

The list below summarises the services that Merton CCG does not have the responsibility for commissioning and identifies the responsible organisation:

• NHS England commission core primary care contracts e.g. core GP practice services, dentists, optometrists, community pharmacists
• NHS England commission health visiting
• Merton local authority commissions school nursing
• Merton local authority commissions health promotion and prevention services
4.2 CCG Programme Work streams
As stated previously we have developed key areas to deliver our vision, each is clinically-led with robust project management methodology applied to each work stream including:

- Older and Vulnerable Adults
- Mental Health
- Children and Maternity Services
- Keeping Healthy and Well
- Early Detection and Management
- Urgent Care

4.3 Older and Vulnerable Adults
The JSNA is projecting that between 2011 and 2021, Merton’s over 65 population will increase by 20.9% (4,900 individuals), over 75s increase by 20.8%, and over 85 by 40.8% (1,300 individuals). Older People live predominantly in the Wimbledon Village, St. Helier, Merton Park and Lower Morden. The more deprived older people are predominantly in Abbey ward. In the population of retirement age (over 65 years for men and over 60 years for women), around 83% in Merton are estimated to be from White ethnic groups, and a health needs assessment has been undertaken and we are currently establishing the appropriate services for the East of the borough.

‘In Merton there is an expected increase of the very elderly population that is more in line with the national profile’…. ‘As people are living longer they are more likely to develop long term conditions. These conditions are likely to become increasingly complex as people age, requiring additional support either in peoples own homes or in residential or nursing accommodation if preventative services (primary and secondary) are not in place early to avoid this.’

JSNA, 2013

Clearly demands on services for these age groups are set to increase and plans for service delivery need to match this. In line with our vision and commitment we have undertaken a review of admissions to establish new models of care closer to home to reduce admissions to hospital. One such initiative is the Community Prevention of Admission Team (CPAT) where a patient can have rapid access to community services if they require assistance. Whilst only going live since October 2013, it has already yielded promising results on average of 50 referrals per month and as such we aim to build on this service over the coming years. This stream of work also dovetails neatly into our Urgent Care stream (see 4.8).

4.3.1 Integration
Whilst there are services available in the community to support people to manage their long term conditions and help prevent hospital admissions, these are not comprehensive or joined up, information sharing is limited. They are not always straightforward to access or able to offer a rapid response and are not as well-known as emergency departments. As a
result in Merton during 2012/13, over £7 million was spent on admissions for ambulatory care sensitive conditions and acute conditions not normally admitted, representing 2889 potentially avoidable admissions. For these acute conditions, the most significant age groups are aged 75 and over. For chronic conditions, the most significant activity is those aged 65 and over. There are slightly more females admitted for acute conditions (56%) but an even split within chronic admissions. The ethnic split of this activity is 48% ‘White British’, ‘Any Other White Background’ is the next highest at 10% and ‘Any Other Asian Background’ at 6%. Services that appear to be working well include: Rapid Response Team at St Helier and START team at St George’s in terms of reducing unnecessary hospital admissions. There is positive feedback from clinicians regarding the community rehabilitation team, although the performance data for all services supporting this group of patients could be strengthened.

A whole system approach has been developed to focus the model of care needed to deliver ‘integrated’ services. This approach includes access to support for primary prevention (to focus on improving lifestyles and improving uptake of early intervention and prevention services), and to enhance community and primary care. Merton CCG will work with NHSE to examine the 2014/16 contract for Primary Care Services to ensure we link our aspirations with those of NHSE. We have reviewed NHSEs plan on a page and have used this tool to shape our strategic direction; See Appendix A.

**4.3.2 Podiatry**

With effect from April 2014 Merton CCG has commissioned podiatry services from organisations that met the Any Qualified Provider status. Specialised and extended scope podiatry services outside the brief of the any qualified provider (AQP) exercise will continue to be commissioned in line with the current provision. Due to patient and stakeholder feedback, podiatry services are currently under review and will be recommissioned in line with best practice and patient need.

**4.3.3 Intermediate Care**

Merton CCG together with Sutton CCG jointly commissions with Sutton CCG a range of intermediate care beds and is currently in the process of reviewing these arrangements. It is expected that the review will conclude in January 2014 and services redesigned by 1st April 2014, implemented by 1st October 2014.

**4.3.4 Falls**

Merton CCG will continue to ensure that falls services meet the needs of the population, by understanding how to reduce falls, provide a multifaceted falls prevention programme including home exercise programmes; medication review; assessment of balance, gait, and blood pressure; and addressing environmental risk factors. Handrails can produce a 60% reduction in falls; among those with low impact fractures, treatment for
osteoporosis reduces the chance of further fracture. Services are in place to achieve this and a review is required to:

- To maximise capacity within existing falls services to scope the need for increased capacity
- To work with LBM and link with Mascot and Telecare initiatives to support use of aids (e.g. handrails) and monitoring people at risk of falls
- To increase the profile of osteoporosis treatment and establish a robust pathway
- To link overall falls prevention to quality premium MDTs and older people’s services
- To incorporate into the BCF for 2014/15

4.3.5 End of Life Care

Building on the vision of our End of Life Care (EOLC) Strategy: A good end to life, Merton CCG aims to be the leading CCG in London for delivering high quality EOLC. Merton CCG has increased the number of patients dying in their preferred place of care through the introduction of rapid discharge pathways for patients wishing to die at home and the integration of care packages across all providers place of care and death the number of EOLC patients who die in hospital has significantly decreased.

On average, 1,210 people (0.6% of the local population) die in Merton each year (2008/10, ONS); 67% of these deaths are people aged 75 or over, and 38% are people aged 85 or over (2008/10, ONS). Merton has a lower percentage of older people than the national average; Merton’s increase in the older population is lower than the national average (JSNA). It is therefore expected that the crude death rate will stay relatively static at 0.6% – based on the current registered GP population of 216,000 there will be approximately 1,300 deaths each year. Up to 74% of people say they would prefer to die at home (NICE QS13). On average, people have 3.5 admissions to hospital in their last year of life, spending almost 30 days in hospital (NICE QS13). Traditionally, EOLC services have been orientated towards cancer care, however, only 26.6% of deaths in Merton have cancer as an underlying cause. 31.8% of Merton deaths are attributable to respiratory disease (2008/10, ONS). 13.6% of deaths are attributable to cardiovascular disease (2008/10, ONS).

Considerable investment and effort has been made in EOLC services for residents of Merton, as part of the implementation of the Sutton & Merton End of Life Care Strategy: A Good End to Life.

A good end to life can only be facilitated through excellent communications between the patient and the various care providers, and within a health economy which includes appropriate levels of support in the community.

In 2013/14 Merton CCG provides funding for the following specific community EOLC services:

- Specialist Community End of Life Nursing Services (this service has recently been reconfigured to provide specific support to Nursing
Homes and their patients, in addition to community nurses and local GP Practices)
- Hospital palliative care specialist services to support fast track discharge to community services (five local hospitals)
- Hospices (four local hospices), including a Hospice at Home service
- Marie Curie nursing services (planned and reactive)

Based on the available data, Merton CCG will make better use of:
- Hospice at Home services provided by local Hospices
- A responsive nursing service provided by Marie Curie
- Encourage more social care provision through the BCF

There may be also an imbalance between the use of Trinity Hospice by Merton patients and the apportioned funding (£80K plus an additional portion of the £241K provided to the Hospice by the six local CCGs). Specific intentions for 2014/16 include:
- Increased use of the Co-ordinate my Care (CMC) EPaCCS
- Increased capacity in hospice and home-based services for Merton patients
- Increased education of Nursing Home and Care Home staff in Merton
- Improved access to, and integration of, services including

• 4.3.6 People with Learning Disabilities (PLD)

“Valuing People Now” 2009 states that all people with learning disabilities should get the healthcare and the support they need to live healthy lives. Good health begins with promoting well-being and preventing ill-health, healthy active lifestyles have to be the starting point for all. Following Winterbourne View, Merton CCG is working with a number of providers to ensure that PLD have access to the full range of healthcare services including dentistry, screening, sexual health, maternity, health visiting, primary care, hospital care, mental health care and EOLC. We aim to ensure that people with learning disabilities can take greater control of their health and well-being.

The key areas of focus are as follows:
- Achieving full inclusion of people with learning disabilities in our mainstream work to reduce health inequalities
- Ensuring high quality in line with evidence-based specialist health services

• 4.3.7 Carers

Merton CCG is working in partnership with LBM to review the carer strategy for Merton in line with recommendations from the national carer’s strategy,
Recognised, Valued and Supported: Next Steps for the Carer Strategy (Department of Health 2010) and Carers at the Heart of 21st-Century Families and Communities (Department of Health 2008). Carer consultations will be an essential element in the following areas:

- Early Intervention and Carer Assessments
- Respite/breaks/one off payments
- Support and recognition from GP and health agencies
- Recognition
- Third Sector Support
- Young Carer

This is in line with the Health and Wellbeing Strategy\textsuperscript{vii}.

4.4 Mental Health

Merton CCG and the four other local CCGs, have agreed that Kingston CCG act as the lead commissioner for collaborative mental health commissioning.

Merton CCG has commissioned Merton Public Health to undertake a Mental Health Needs Review and it is expected the outcomes of this review will be known in April 2014. As such there will be a revision to the commissioning intentions once the outcome of the review is known. Merton CCG is committed to improved access and outcomes within primary and community care settings with the aim of refocusing services towards prevention and early intervention, continued improvement of access into treatment for individuals who have a dual diagnosis (with a focus on mental health and substance misuse). We will also ensure that the pathways for physical and mental health are brought much more closely together. This will encompass holistic care to ensure there is a sense of parity between physical and mental health.

- Improving Access to Psychological Therapies (IAPT)

Merton CCG will clinically review the IAPT Service with a view to conducting a procurement process for this service in 2014/15. Other work needs to be progressed to ensure that our primary care model of Mental Health is delivered by the local Mental Health Trust.

- In-patient Care

In-patient capacity is a key area of focus and Merton CCG, in partnership with Kingston CCG, will work with South West London and St George’s NHS Trust to support the implementation of their estates strategy when agreed, agree a SWL strategic approach to deliver future Tier 4 services and reinvestment opportunities for a cohesive community approach. Work will continue in 2014/15 to review the use of inpatient beds to ensure the following:
• Patients are cared for in the community wherever possible
• Length of stay and emergency readmission rates are reduced
• Improvements in the care pathway, discharge and transfer arrangements

Merton CCG is committed to ensuring that we introduce increased community rehabilitation services to better support people in their own homes and to create an improved step-down and out-reach rehabilitation for patients into the community through supported living accommodation. Our commissioning approach must be in parallel with LBM and the recent issues highlighted with the proposed closure of Norfolk Lodge will be addressed.

Merton CCG has made significant progress in the management of out of area specialist placements. We aim to reduce the level of activity within tertiary and specialist services by management and review of secondary care pathways, improved contracting, review and repatriation to local services if clinically appropriate. This will include the review of Attention Deficit Hyperactivity Disorder (ADHD) services.

Merton CCG will ensure there is improved access to mental health services for veterans and their families by raising awareness in primary and secondary sectors and ensuring appropriate referral to London Veterans Mental Health Service is made. This will be done in collaboration with NHS England as commissioner for Military Health.

Merton CCG is committed to the review of Older Persons Community Mental Health Services with a particular focus on patients who have cognitive impairment.

4.5 Children and Maternity Services
Merton CCG is committed to ensuring that it improves health outcomes for all children. The priorities we are focusing on directly link to Priority 1 of the Merton HWBB Strategy.

We will review services for children with a disability with a view to integrated commissioning in health, the local authority and the voluntary sector by June 2014. With the implementation of CCG’s the new statutory duties of the Children and Families Bill, it is important that Merton CCG takes an active role in health commissioning for children. The introduction of a single Education, Health and Social Care (EHC) Plan replacing the current Statement of Special Educational Needs and a joint assessment process is also an important milestone to be achieved from September 2014.

• Engagement with Children, Young People and their families

It is important that we know the views of young children, young people and their families and we will expect providers to demonstrate how they have listened to the voice of children and young people and how this will improve their health outcomes. We will use existing networks (provider liaison and young carers groups) to make sure the services we design meet their needs and expectations.
• Development of a patient pathway approach

Merton CCG aims to develop a patient pathway approach, which sets out questions that those using health services may ask for each pathway step, and a broader life course approach, to help identify indicators important at particular life stage(s) such as conception through pregnancy to birth, the early years, mid-childhood, to teenagers and young adults.

• Looked After Children and Young People with inequalities in outcomes

We will ensure sufficient clinical expertise and leadership for looked after children is commissioned, including from a designated doctor and nurse for children who are “looked after” to receive timely health assessments. We will specifically recognise care leavers in early adulthood (aged 18–25) as well as looked after children, including a requirement that health teams provide a focus on this group.

• Integration and Partnership

As part of the needs to ensure that children have access to integrated care, Merton CCG will review the commissioning arrangements for all services with the aim to:

- Join up services and commissioning ensuring that children, young people and parents provide information once, records are not lost or duplicated, individuals and their needs do not fall between gaps, and resources are focused on the same outcomes
- Review the basis for Multi-Systemic Therapy and ensure that families have robust access to this service and to deliver this within 2014/15. The CCG will fund LBM for a pilot to deliver an integrated model that will be reviewed in a year
- To review the process for children’s continuing care

• Children’s Universal Services (Health Visiting, School Nursing)

As part of the Health and Social Care Act, school nursing is now commissioned by Public Health and Heath Visiting is commissioned by NHS England for 2014/16. We will support commissioning of services which:

- Build on the integration of children’s community health universal services with the Local Authority
- Realise the benefits of integrated working and further improving the working relationships between local authority (social work teams, children’s centres and early years) with health services and third sector organisations
- Continue to build on the established Family Nurse Partnership (FNP) scheme
• Meet the needs of vulnerable groups, including those in need of safeguarding as identified in the JSNA
• Work with NHSE to ensure the transfer of commissioning to the local authority occurs in a seamless fashion
• Work with NHSE to ensure the smooth transfer of commissioning to Public Health in 2014/15

• **Children’s Specialist Community Services (Community Paediatricians and Paediatric Therapies)**

During 2014/16 Merton CCG will:

• Review 5 pathways for services, and ensure that as part of the new commissioning landscape, Community Paediatrics and Therapies are linked appropriately into existing universal services
• Ensure that providers continue to support and fully engage in joint agency working and pathway development as appropriate
• Deliver against key outcomes and targets including 18 week referral to treatment times and to address waiting list pressures identified within these services
• Ensure that all providers review all services and ensure close working relationships between universal and specialist children’s services
• Establish integrated pathways for Speech and Language Therapy and Autism services

• **Transition**

Transition from Children’s to Adult Services has become an important issue in recent years. The National Service Framework for Children, Young People and Maternity Services highlighted the importance of ensuring safe and effective transition throughout children’s services and also dedicates a standard to growing up into adulthood.

In Merton, once a child reaches 14 years of age, the Transition Process begins; the child, family and relevant professionals involved in the care of the child begin to plan the care arrangements for the future. For children with complex health needs in Merton, the Home Care Team at Epsom and St Helier University Hospitals Trust is involved to determine the package of care to meet assessed health needs, creating health care plans and case management.

In October 2013, a Care Quality Commission (CQC) review was undertaken regarding Transition arrangements within Merton. Merton CCG is now taking the lead in embedding the health aspects of transition into a seamless process ensuring that, for each child entering transition there will be a named health professional for each child to ensure the child, family and carer receive joined up high quality care.

• **Reducing avoidable secondary care activity**
We have seen within our urgent care system a significant rise in the number of children attending A&E and need to ensure that we offer robust alternatives to children and families. Therefore we aim to:

- Review the paediatric urgent care/A&E pathway as part of the urgent care stream of work
- Work with primary and secondary care to further develop referral pathways for advice and guidance
- Utilise the health advocacy team and community groups to support specific populations within primary care
- Increase Educational Resources for Children and Families relating to Common Childhood Illnesses;
  - Develop a booklet for families with Children (0-5 years) with advice on management of common childhood illnesses designed to empower families to use services appropriately and avoid unnecessary hospital activity.

- **Child and Adolescent Mental Health Services (CAMHS)**

Merton CCG aims to refresh the CAMHS strategy in collaboration with the local authority to:

- Improve access and understanding of CAMHS services across Merton
- Reduce Tier 4 placements and improve timeliness of responses to emergency and urgent mental health issues through the tier based service model of early intervention and prevention approaches
- Ensure the jointly commissioned CAMHS Development Worker posts are focussed to support lower tier emotional health and well-being needs across the county
- Ensure clarity is established with the respective roles of primary care and South West London St Georges Mental Health Trust
- Review the eating disorders service

- **Maternity**

We will continue working across London and South West London as part of the Maternity Strategic Network.

- To address issues of maternal obesity, maternal age (both teenagers and older mothers), smoking during pregnancy, breastfeeding, low birth weight, maternal mental health and screening for infectious diseases
- To continuing the implementation of choice relating to maternity care. Commissioners will seek assurance that there is evidence of access to all types of intrapartum care; homebirth, midwife led environments (freestanding or alongside units), obstetric led environments; evidence of a range of models of antenatal and postnatal care including individual and group sessions, in and out of hours availability; and promotion of normal birth through reduced rates of caesarean section
• To review payment by results guidance relating to maternity service pathway bundles. Providers will need to be able to estimate the proportions of women falling into each of the case mix categories and commissioners will compare this against national benchmarks and local data on needs and demographics. Commissioners will require providers to engage with the process of calculating local case mix proportions using the national template
• Review the service against the London Quality Standard’s (LQS) and commission services to ensure the LQS are achieved

• Assisted Conception
Merton CCG has been an outlier within 2014/15 regarding the lack of commissioning for In vitro fertilization (IVF). We have allocated resources to deliver ensure we can deliver a level of IVF that meets some of the NICE guidance. This is currently being worked through with our clinicians in preparation for 2014/15.

4.6 Keeping Healthy and Well
As a CCG we aim to ensure that all services we commission, deliver care that has sustainable and lasting benefit to our community. Public Health supports Merton CCG to assess need. We will ensure through contracting negotiations and when we develop new services that all providers can demonstrate that they play an active role in improving the health of the local population. We will ensure that all service specifications have a greater focus on prevention and will work with providers to focus on:

- Musculoskeletal disorders
- Diet
- Exercise
- Obesity
- Alcohol
- Smoking Cessation

Our strategic programme can be found in Appendix B.

• Musculoskeletal (MSK) Services
In 2012/13, Sutton and Merton Primary Care Trust spent over £11 million on Merton admissions under the Healthcare Resource Group (HRG) Musculoskeletal System; 1461 admissions, costing £3.6 million, were recorded as emergency admissions; £7.5 million was spent on 2114 elective admissions (55% of these admissions were women). There is significant activity for all ages, although emergency admissions increase for those aged 75 and over.

The rate of hip fractures in people aged 65+ is significantly lower in Merton (357 per 100,000) compared to England (451 per 100,000), and is the fourth lowest rate of all London boroughs. For over 80 year olds the rate is much higher (1,109 per 100,000) as would be expected, but again this rate
is significantly lower than the England average. However, this is expected to increase by 40% by 2018.

Trauma and Orthopaedic outpatient appointments were 21,268 in 2012/13, 37% of which were first appointments costing £1.1 million, with £1.2 million spent on follow ups.

**Key Actions:**

We will therefore redesign our MSK pathway and work with our existing provider through investment to provide a much more responsive service to our patients.

- **Dietetics and Obesity**

The recent Call to Action: Commissioning for Prevention advocates commissioning for prevention as one potentially transformative change that CCGs can make. Evidence suggests prevention programmes can be important enablers for improving resident’s quality of life and reducing acute activity over the medium term. Specifically, the CCG will work closely with Merton Public Health to ensure that every opportunity is grasped to help people stay healthy and will include:

- Promoting NHS health checks among member practices
- Training frontline staff to provide brief messages about lifestyles and signpost to relevant services
- Developing clear pathways for Tiers 1 – 4 obesity services, with particular reference to Tier 3 for Merton CCG, including an exercise prescription service and Livewell service
- Creating a Clinical Director role for Keeping Healthy and Well and making prevention part of the work of all our Clinical Directors
- Embedding prevention in the forthcoming reconfiguration of health care services especially in the East of the borough

**4.7 Early Detection and Management**

Set against the background of Merton CCGs plans for integrated care and Out of Hospital services, which support patients with all long term conditions, the CCG will:

- Decrease the gap between the expected prevalence and recorded prevalence of Long Term Conditions in Merton
- Improve the health outcomes for people who have been diagnosed with a Long Term Condition
- Increase the provision of healthcare in the community for people who have been diagnosed with a Long Term Condition
- Reduce inequalities in the identification of, treatment and services for people with a Long Term Condition
- Support people with a Long Term Condition to maintain their quality of life through being better able to manage their own care
In 2014/15/16 the CCG will concentrate on delivering these improvements for patients with Diabetes, Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD) and Cancer.

Comparison of recorded prevalence (based on GP Registers) of various long term conditions compared with modelled expected prevalence suggests that a significant proportion of the population in Merton who are likely to have a long term condition have yet to be identified, for example:

- An estimated 2376 people have undiagnosed Diabetes
- An estimated 3175 people have undiagnosed CHD
- An estimated 4428 people have undiagnosed COPD

The most recent JSNA (Dec 2013) highlights that:

- The level of recorded diabetes in GP practices across Merton ranges from under 2% to nearly 10%
- The rate of premature death (deaths under 75 years) from CHD in Merton is the highest in South West London and is also higher than England so we will ensure that we have a robust cardiac pathway with a clear work stream that relates to prevention
- The mortality rate from respiratory disease in people under 75 years in Merton is lower than the national average. Our plans to increase respiratory care in the community will aim to address this issue

Merton CCG is aware that there are issues related to access and targeted healthcare for those in most need. There is a wide variation in the level of hospital admissions for COPD by geography in Merton, with higher admission rates in the eastern wards of the Borough.

Overall Merton is generally in line with or slightly below regional and national averages in terms of mortality for COPD for women but substantially lower in recent years for men. (JSNA, Dec 2013)

Although no detailed breakdown of data for diabetes is available for Merton, based on national data:

- People from BAME groups are up to six times more likely to develop diabetes
- Complications of diabetes such as heart disease, stroke and kidney damage are three and a half times higher in lower socio-economic groups
- Women with diabetes tend to receive poorer care than men

Although no detailed breakdown of data for CHD is available for Merton, based on national data:

- There is lower achievement of cholesterol lowering in deprived geographical areas and in areas with a large minority ethnic population
• Women with heart disease are less likely to receive effective primary care interventions than men
• People of South Asian origin are 50% more likely to die prematurely from CHD than the general population

Key actions:
• Target interventions on specific populations
• Utilise the health advocacy workers to ensure communities are able to work with their community re prevention
• To ensure that our health advocacy services are utilized in a more robust fashion
• To continue to work in partnership with colleagues on the as part of the HWBB to enable the reduction of inequalities within healthcare

• Long Term Conditions

In 2014/15 Merton CCG will address the needs of people with diabetes, CHD or COPD by improving the identification of disease, as follows:

• Working with LBM Public Health to support promotional activities to encourage ‘at risk’ patient groups to come forward for screening
• Supporting GP Practices with a large gap between recorded and expected prevalence to identify patients for proactive screening.
• Supporting GP Practices across Merton to proactively screen patients at risk of COPD

Reviewing existing pathways, in conjunction with patients and local GP providers, in order to identify:

• Gaps in service provision (geographic or other)
• Barriers to access which may result in unintended inequalities (ethnicity, gender etc.)
• Potential improvements (such as provision of greater diagnostic services out of hospital and access by GP Practices to Consultant support for complex patients)
• Opportunities for a ‘one stop shop’ to streamline services for patients

Increase provision of Community based services across Merton (ensuring equity of access), including:

• Expanding the locations of Diabetes community services (including multi-disciplinary clinics and Patient Education)
• Increasing the provision of Pulmonary Rehabilitation classes for patients diagnosed with COPD
• Increasing the provision of Cardiac Rehabilitation services for patients with CHD
Deliver an Expert Patient Programme in accessible locations across Merton, to support people to stay well and maintain their independence and evaluate at the end of the year. Expected outcomes to be monitored are:

- Increase in capacity and utilisation of Community and Primary Care based diagnostic services (as reported by hospital service providers)
- Fewer A&E attendances for CHD or Respiratory conditions (as reported by hospital service providers)
- Improved patient and carer experience (measures to be identified as a priority)

**Cancer**

Merton CCG will commission cancer services to improve outcomes for patients. All cancer services will be compliant with the relevant Improving Outcomes Guidance (IOG), including pathology testing of haematological malignancy, liver metastases, cancer of unknown primary origin and psychological support services, with compliance measured via the Cancer Peer Review process against the Manual for Cancer Services. Performance against the Cancer Waiting Times Operating Standards will be achieved through the following ways:

- Community Services and The Royal Marsden NHS Foundation Trust Support for cancer patients will be provided within the community in order to meet their assessed survivorship and rehabilitation needs
- New models of follow up for cancer patients based on risk stratification, with an associated reduction in hospital follow ups achieved
- Each patient completing an acute phase of treatment for cancer will be offered an individualised plan for follow up, including access to a supported self-management programme, and have their assessment and end of treatment summary provided
- Ensure that we use the Macmillan funded GP clinical lead to enhance increased screening uptake across Merton

**Diagnostics**

We work with our member practices to ensure that there is direct access to enabling diagnostic pathway changes to occur. This will enhance both patient experience and quality, and enable the CCG to ensure that only appropriate conditions are referred to secondary care.

**Medicines Management**

- We will ensure the medicines aspects and implications of any services commissioned are considered to ensure value for money, impartiality of access, quality and patient safety
- A robust primary care prescribing review will be delivered to improve primary care prescribing to improve safety, and quality as well as
optimise efficiency and effectiveness and ultimately deliver targeted savings

- Investment in additional pharmacist resource to specifically focussing on patients in care homes to reduce medicines related harm, improving patients' wellbeing and avoid hospital admissions
- Investment will be made in a dietician focussing on prescribing of oral nutrition supplements to reduce waste, inappropriate prescribing and improve efficiency and effectiveness
- The existing minor ailment scheme (currently commissioned by NHSE) in community pharmacies will be launched. This scheme provides an alternative to a GP appointment for an agreed set of common conditions, freeing capacity in GP surgeries and A&E for patients needing those services
- In collaboration with other CCGs in SW London and the Commissioning Support Unit (CSU), checks and systems to ensure safety, appropriate transfer of prescribing and value for money from medicines prescribed in secondary care will continue to be developed and implemented
- We also aim to work more closely with NHS England and the Local Pharmaceutical Committee to ensure out mutual aim are realised

4.8 Urgent Care
Merton CCG will improve immediate and emergency care across the health system to ensure patients get the right care, at the right time, in the right place, with the right outcome – be that primary care, community, ambulance or acute care. The commissioning of high quality and accessible urgent care services for our residents and visiting population continues to be an important priority for Merton CCG.

In recent years there has been increasing pressure placed on urgent care systems as patients seek greater assurance regarding their condition and more rapid responses from services.

Urgent Care should not be considered as a stand-alone, discrete service but embedded within patient pathways to ensure a joined up approach to care. A number of new developments have marked the start of this journey, including:

- The development and opening of the Urgent Care Centre (UCC) on site at St Helier Hospital
- The closure and integration of the Tooting Walk-In-Centre (TWiC) at St George’s Hospital with the newly developed UCC
- The introduction of a local GP-led / Walk-in Centre in Mitcham
- A 111 single point of access service alongside a new provider for our Out of Hours Service (OOH) for Merton

Evidence suggests that as attendance at A&E departments continue to rise, a significant proportion could be more appropriately dealt with by Primary and Community Services. This would result in better utilisation of specialist A&E skills and enable more effective relationships being developed between the patient and primary care in managing their condition. Learning
from past experience and supporting evidence, we need to underpin the services we have invested in and develop an urgent care strategy which:

- Takes a whole system approach centring on the patient journey and experience
- Ensure that urgent care services are easier to navigate for patients as well as clinicians, utilising the single point of access to deliver this (111)
- Involve patients in supporting the urgent care model, development and implementation of the strategy
- To work across south West London to ensure that all urgent care working groups are sited on the same aims and join up services as smoothly as possible
- Ensure the OOH service is integrated with Urgent Care provision

Urgent Care is a key priority for neighbouring CCGs and we are active members of both Wandsworth and Sutton Urgent Care Working Groups (UCWG). There is also close alignment to the Merton HWBB Strategy with a priority of long term conditions and Merton Integration Project.

There has been a historic under-funding in community care and are aware of short falls in quality as a result. We aim to redress this balance by investing in Community Nursing and Rehabilitation Services over the next two years. We aim to do this in a systematic way that supports the integration programme and delivers real quality gains within the community. Our current provider of Community Services has proposed an appropriate change in nursing leadership and we are fully supportive of the model which will help to:

- Reduce growth in A&E activity ensuring sufficient A&E capacity for injuries and emergencies that require A&E services
- Develop admission avoidance services to ensure that at times of urgent need, when clinically correct, patients are supported in the community
- Develop practice care for frail elderly people with long term conditions to prevent the need for non-elective and emergency admissions
- Ensure that the services have robust access to efficient Information Technology

4.9 Summary of Commissioning Intentions and Delivery
The clinical leaders and executive team within Merton CCG know that there is a real challenge ahead and are ready to improve services within Merton. Our plan on a page Appendix A summarises our commissioning intentions and two year operational plan.
5 Quality

5.1 Quality focus
Merton CCG’s quality strategy contains four key quality goals:

- As commissioners, to seek assurance that all NHS funded providers, from whom we commission services, provide care which meets CQC and other (e.g. NICE) quality standards and outcomes
- As the system leader for health, to drive for continuous improvement in quality and 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 Well Being Strategy
- To work with our partners to ensure children and vulnerable adults are protected from harm and live in safe and healthy environments, through the Local Adult and Child Safeguarding Boards

Merton CCG defines quality as follows, and care can be regarded as high quality if it is:

- Safe – patients and service users suffer no avoidable harm
- Effective – evidence based and in line with best practice
- With a positive patient experience – patients are treated with respect and dignity

This definition of quality, first seen in ‘High Quality Care for All’ (2008) is now enshrined in legislation through the Health and Social Care Act 2012\textsuperscript{x}.

The NHS Outcomes Framework has developed this definition further into five quality domains. These domains capture the breadth of ambitions that the NHS should be striving to deliver for patients as follows:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

In addition, any review of quality must include an assessment of organisational culture and leadership, as it is so critical to success in delivering quality of patient care. Unhealthy cultures can lead to service failure and poorer outcomes\textsuperscript{x}.

The CCG’s 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

In addition, 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

The commissioning intentions stated herein Section 4 build on these quality goals and set out our ambitions in relation to the services we deliver and the developments we plan for the next year.

5.2 Assessment of Providers

Merton CCG has a programme of quality assurance whereby it reviews the care given at its main NHS providers, through our GPs who are members of their local ‘Clinical Quality Review Groups’ (The CQRGs are clinically led committees which review quality of care within each provider) are chaired by a clinician of the ‘host’ CCG, and attended by GPs and other members of the associate CCGs.

The CCG also receives information about all its providers from a range of sources at the Merton Clinical Quality Committee, a sub-committee of the Governing Body. Merton CCG is responsible for hosting the SMCS Contract and CQRG with the aim to improve the responsiveness and performance of a variety of community based services, such as district nursing and therapy support.

During 2014/15, we aim to develop this quality assurance programme to ensure scrutiny of the quality of care given by all our providers, including intermediate care, continuing care, nursing and residential homes and our smaller providers.

One of the lessons from the Francis report into the failings of Mid Staffordshire NHS Foundation Trust was that the regulatory and commissioning agencies did not share information about providers in a helpful way. To this end, the Director of Quality and Chief Officer attend the monthly NHS England (London South) Quality Surveillance Group which is charged with sharing information and intelligence across the various agencies and regulatory bodies supporting NHS services in South London.

The CCG’s integrated quality and performance report provides a more in depth picture of the quality of care provided to Merton residents, by our main providers, and includes both ‘hard’ and ‘soft’ measures of quality, e.g. Stakeholder feedback or GP concerns.
5.3 Quality Premium
The ‘quality premium’ is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

- To reduce potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15%)
- To improve access to psychological therapies (15%)
- To reduce avoidable emergency admissions (25%)
- To address issues identified in the 2013/14 FFT, supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15%)
- To improve the reporting of medication-related safety incidents based on a locally selected measure (15 per cent of quality premium)
- A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15%)

All of the measures, except avoidable emergency admissions, include the ability for CCGs and local partners to set either partially or fully the level of improvement to be achieved. These, together with the additional local measure, should be agreed by individual CCGs with their HWBB and with the relevant NHSE area team.

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. (This is in addition to a CCG’s main financial allocation for 2014/15 and in addition to its running costs allowance.)

Regulations set out that quality premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities.

Merton CCG monitors progress of delivery of the Quality Premium indicators is part of the CCG’s Balanced Scorecard. The CCGs outcomes ambitions for 2014/15 and beyond, including those captured by the Quality Premium are set out in Section 6.2.

5.4 CQUINs
The key aim of the Commissioning for Quality and Innovation (CQUIN) framework is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management. This approach encompasses a system of setting national and local quality goals and targets, which if successfully achieved will bring financial rewards to the provider, which may constitute up to 2.5% the total contract value.
The CCG has worked with the CSU and neighbouring CCGs to agree CQUINs for its local Trusts for 2014/15.

There are four national CQUIN goals for 2014/15, which are:

- FFT
- Improvement against the NHS Safety Thermometer (excluding VTE), particularly pressure sores;
- Improving dementia care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR); and
- Venous Thromboembolism (VTE) – 95% of patients being risk assessed and achievement of a locally agreed goal for the number of VTE admissions that are reviewed through root cause analysis.

In addition, Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS set out that from April 2013 compliance with high impact innovations would become a prequalification requirement for CQUIN. Below are the current CQUINs and progress against them for the 2014/15 contracting round.

### Table 1: National CQUINs

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Latest Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Friend Test</td>
<td>Nationally set. Value can change but currently set at national percentage unless further discussions take place.</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>Trust wants to discuss the measurement of pressure ulcers to measure using local data flows rather than the national ones.</td>
</tr>
<tr>
<td>Dementia</td>
<td>Nationally set. Value can change but currently set at national percentage unless further discussions take place.</td>
</tr>
</tbody>
</table>

### Table 2: Continuing CQUINs

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Latest Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Communications</td>
<td>Continue to measure discharge letter against timescales. Also continue to measure the quality of the discharge letters.</td>
</tr>
<tr>
<td></td>
<td>It was agreed we would scope out if patients could leave their appointment with their next appointment in hand.</td>
</tr>
<tr>
<td></td>
<td>Outpatient summaries should be extended to cover all services.</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>£100k of this area is ring-fenced due to staff being employed using this money.</td>
</tr>
<tr>
<td></td>
<td>Commissioners are looking to move to percentages as a measurement, although Local Authority requires numbers as well. A further stretch target will be introduced.</td>
</tr>
<tr>
<td>Paediatric Consultant</td>
<td>Consultant cover is funded using this money. The cover is to address previous safety issues that have now being resolved.</td>
</tr>
</tbody>
</table>
Cover

The group are happy to continue this as per 13/14.

Maternity

Commissioners want to use CQUINs to bridge the gap between the Trust expenditure in Maternity and income from the introduction of the new pathway tariff.

End of Life Care

The group believe this should continue to be a CQUIN.

The Trust need to put suggestions to the commissioners on what to continue as a CQUIN.

Table 3: New Local CQUINs

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Latest Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of the Elderly</td>
<td>Agreement on developing the discharge package. Further work to be done on how the community services support this. KPI's need to be developed with Community providers to ensure a 4 hour response time to communicate with the discharging team.</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Bundle of care to be designed by the clinical team as part of the pathway work. Cohorting of patient in Acute setting. Rapid response needed for Acute team. Response required within 4 hours. Trust to see if 8-8, 7 days a week is possible. Discussion was held about whether this could be bigger than just Heart Failure nurses.</td>
</tr>
<tr>
<td>TB</td>
<td>It was agreed that tariff pays for normal patients but St. Georges Healthcare NHS Trust have more complex patients who they believe are more expensive than tariff.</td>
</tr>
<tr>
<td>COPD</td>
<td>It was agreed that we could add COPD into next year’s CQUIN due to not achieving this year. The CQUIN will fund a pilot of the COPD service.</td>
</tr>
<tr>
<td>Elective Integrated Pathways</td>
<td>Merton will include the COPD pilot into their area. The cardiology pathway needs further work for Merton and needs to link with Merton’s community provider</td>
</tr>
</tbody>
</table>

6 Performance Monitoring and Delivery

6.1 Progress against 2013/14 indicators

Merton CCG currently monitors the organisations performance against three of the measurable rights and pledges described in the NHS Constitution handbook (March 2013):

1. People’s right to access certain services commissioned by NHS bodies within maximum waiting times
2. Government pledges on waiting times and
3. CCGs responsibility to secure continuous improvements in the quality of services provided to individuals.

As at month 8, the CCG is on track to deliver against all the constitutional waiting time rights and pledges, see Appendix C. Merton residents use the A&E department of St. Georges Healthcare NHS Trust and Epsom and St. Helier NHS Trust and therefore their performance informs whether the CCG delivers this constitutional pledge. Currently the year to date performance of these trusts is:

- St. Georges NHS Trust: 94.6%
- Epsom and St. Helier NHS Trust: 95.4%

6.2 Outcomes ambitions for 2014/15

The CCG outcomes indicators contribute to the overarching aims of the five domains in the NHS Outcomes Framework. Merton CCG has used the Indicators to set thresholds or levels of ambition for improving health outcomes of Merton’s population in order to drive improvement.

In setting the levels of ambition for the outcomes indicators, the CCG has used the levels of NHSE Ambition Atlas to consider historic trends of the published indicators, as well as how Merton CCG compared to other CCGs nationally. For those indicators where the CCG is incentivized to drive specific levels of improvement by the CCG Quality Premium (section 5.3), Merton CCG has committed to achieving those levels in 2014/15.

- **EA1: Quality Premium indicator - Reducing potential years of lives lost through causes considered amenable to healthcare and including addressing locally agreed priorities for reducing premature mortality**

From 2009 to 2010 there was an increase in the number of years of life lost of 7.36%, however from 2010 to 2011 this decreased by 4.3%. Merton CCG performed well on this indicator in 2011, ranked in the second quintile nationally.

**Figure 5**

![Graph showing outcomes for Merton CCG](image)

Using the Health and Social Care Information Centre (HSCIC) figures for the directly standardised rate of deaths and the directly standardised rates
of potential years of life lost as guides, it is estimated that all females living in Merton in 2012 who died from one of the causes considered amenable to healthcare, died approximately 21 years prematurely. For males in 2012, the figure was about 23 years.

By aiming to reduce the years of potential life lost (PYLL) by 3.2%, as incentivised through the Quality Premium, we are aiming that women dying of causes considered to causes considered amenable to healthcare live 7 months longer and men 5 months longer by the end of the 2014/15. Ultimately, by the end of 2018/19, we aim for women dying from these causes will live 4.5 years longer and men closer to 5 years.

- **EA2: Improving the health-related quality of life for people with long-term conditions**

From 2011 to 2012 the number of Merton people with a long term condition who reported that they had a good average health status improved by 1.2%.

In 2012 Merton CCG was ranked in the best quintile nationally for this indicator.

**Figure 6**

It is estimated that, of approximately 1,507 patients in Merton with one or more Long Term Conditions (LTC), 1,153 feel supported to manage their condition. Merton CCG has set an ambition to be ranked the best performing CCG for this indicator by 2018/19. The CCG are aiming for 8 more people with LTCs who respond to the GP survey to feel supported to manage their condition, which would be 38 more people by 2018/19.

- **EA3: Quality Premium indicator - For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16**

The Quality Premium incentivises the CCG to achieve IAPT access levels of at least 15% of the population expected to have anxiety or depression disorders by 31 March 2015. Currently, Sutton and Merton IAPT services is contracted to achieve a 13% coverage rate. This contract is due for renewal in October 2014, when a 15% coverage rate will be contracted for.
Achieving the 15% coverage target in 2014/15 will mean a total of 3,219 people will receive treatment for psychological therapy, which is equivalent to 62 Merton residents per week. This means that 357 more people (3,576) will receive treatment in 2015/16; equivalent to about 69 people per week.

• **EA4: Quality Premium indicator - Ambition for reducing emergency admissions**

Over the past three years, the number of emergency admissions for those groups of conditions that are classified as chronic ambulatory care sensitive conditions, asthma, diabetes and epilepsy in under 19s, acute conditions that should not usually require hospitalisation and emergency admissions for children with lower respiratory tract has increased between 3% - 5% annually. Between 2010 and 2013 this growth equated to an additional 432 avoidable admissions. Despite this increase, in 2012/13 Merton CCG was ranked in the second best quintile nationally for this indicator.

**Figure 7**

![Chart showing emergency admissions]

The Quality Premium incentivises CCG to halt the growth of these admissions. In aiming for a 0% increase, the CCG is aiming to prevent the forecast growth of 133 additional avoidable emergency admissions in 2014/15, which over the course of 5 years would account for an additional 939 additional avoidable admissions.

• **EA5: Increasing the proportion of people having a positive experience of hospital care**

In 2012, Merton CCG was ranked at the higher end of the second quintile for this indicator.
Merton CCG intends to reduce the rate of Inpatients reporting their hospital care as ‘poor’ from 142 to 135, which is equivalent to a 2% reduction from the baseline by 2014/15 and 7% reduction from the baseline by 2018/19.

Across the 3 main acute hospitals commissioned by Merton CCG 1065 patients gave responses to the 2012 inpatient survey. Should the same number of patients respond in to the next survey, Merton aims for 16 more patients to report a positive experience of hospital care by 2014/15, increasing to 75 more patients by 2018/19.

- **EA6: Quality Premium indicator - Commitment to meeting the nationally set objective of the FFT in 2014/15 and 2015/16**

Merton CCG is committed to addressing issues identified in the 2013/14 FFT, supporting roll out of FFT in 2014/15 and showing improvement in the net promote score for our main acute trusts.

As part of the 2014/15 contracting round, Merton CCG will ensure plans are agreed with St. Georges NHS Trust, Epsom and St. Helier Trust and Kingston Hospital Foundation Trust with specified actions and milestones for addressing the issues that are identified from the 2013/14 FFT results, particularly where they highlight issues which relate to poor care. These plans will be monitored through the individual trust CQRGs.

The CCG will ensure that our providers have robust plans in place to meet the national roll-out schedule of FFT by December 2014.

- **EA7: Ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community**

Based on the 2012 CQC survey, Merton was ranked in the worst performing quintile nationally for this indicator.
Using the weighted GP Patient Survey data for Merton CCG published in December 2013 it is estimated that 354 people reported very or fairly poor experience or care outside of hospital. Merton CCG aims to improve to be ranked at the lowest end of the forth quintile by 2014/15. Achieving this outcome ambition would mean that 19 more people will be reporting positive experience of care outside of hospital, increasing to 96 more people in 2018/19.

- **EA9: Quality Premium Indicator** - Improving the reporting of medication-related safety incidents in a locally selected measure
  
  A 10% increased reporting between Q4 2013/14 and Q4 2014/15 of medication errors has been agreed by Epsom & St. Helier NHS Trust.

- **Quality Premium Local Priority**: Increasing the number of patients from Black and Minority Ethnic (BME) groups using Psychological Therapies
  
  It is forecast that of the 70,084 people from BME groups registered with Merton GPs, currently 1800 access psychological therapies.

  Merton CCG aims to increase the number of patients from BME groups using psychological therapies by 2.5% in 2014/15. This will equate to 45 more patients from BME groups using Psychological Therapies

- **EAS1: Ambition for improving the dementia diagnosis rate in 2014/15 and 2015/16**

  According to 2013 GP Quality and Outcomes Framework (QOF) data, Merton CCG currently has a dementia diagnosis rate of 47%. (Primary Care Web Tool)

  Reaching the national ambition of a 67% diagnosis rate by March 2015 is not considered by the CCG to be possible due to two reasons: Dementia Prevalence is forecast to increase annually. Additionally, when people who have been diagnosed with dementia die, GP’s dementia registers decrease.

  Although challenging, the more achievable ambition that Merton CCG have set is to achieve a 57% dementia diagnosis rate by 2014/15 increasing to 67% in 2015/16. This translates to an additional 200 people added to GP
• **EAS2: Ambition for improving the IAPT recovery rate**

As per national guidance, Merton CCG is committed to improving the recovery following talking therapies to 50% by March 2015.

Achieving this ambition will mean an additional 317 people will recover after having completed psychological therapy treatment, which equates to about an additional 26 people moving to recovery each month. By 2015/16 this number will increase to about 31 additional people reaching recovery each month.

• **EAS5: Number of C. Difficile infections in 2014/15.**

Considering the forecast growth in population, the CCG aims to maintain the current threshold of 24 C. Difficile infections for 2014/15.


The financial strategy will be informed by the current financial position of the CCG, the financial climate that surrounds the organisation, the allocations and planning guidance issued in December 2013 and the assumptions the CCG is making for the two year operating plan to deliver our strategy.

#### 7.1 2013/14 Financial Plan and Performance

The current financial year is not without challenge and this will in turn present the CCG with further challenges moving forward. Higher than planned growth in activity within secondary care, specifically at the CCGs three main acute providers has meant mitigation plans have had to be instigated.

In 2013/14 the CCG planned to deliver a surplus of £2.1m, which is to be delivered by a QIPP net programme of £7.5m. The plan includes 0.5% contingency reserves (£1m) and 2% non-recurrent reserves (£4.2m).

Merton CCGs current resource allocation excluding running costs is £201m; this includes non-recurrent allocations of £2.2m. Therefore, the recurrent allocation is £199m. This includes the final adjustments relating to specialised commissioning, which results in an overall deduction of £46.7m from CCG allocation.

Merton CCG expects to deliver the planned surplus of £2.1m and £6.7m of QIPP (89% of target) in 2013/14. Acute over performance to date is £5.4m and has been mitigated by utilisation of contract and contingency reserves and most of the non recurrent funding, including the 1% risk pool reserve approved by SWL Finance Review Group.

Non acute services are forecast to under-perform by £0.8m this year, an in year QIPP scheme on mental health placements has been successful and accounts for most of the non acute under-performance.
The running cost allocation for the CCG is £5m based on £25 per head of population per year. Running costs is expected to be in line with plan at the end of the financial year.

7.2 Financial Strategy
The overriding financial strategy for Merton CCG is to ensure a long term sustainable financial position which ensures the CCGs overall objectives around patient care for our population can be achieved.

This strategy can only be achieved through sensible and realistic financial planning, a measured approach to risk and long term view of the local health system, which will at times mean difficult financial decisions have to be taken.

To deliver the above, strong financial governance and reporting, is pivotal, along with a strong culture of accountability around our financial decisions. With this in mind, the following set of financial principles will be core to this approach:

- Realistic and accurate planning - robust, well worked plans that create changes in systems behaviour, our financial plans and budget must reflect what we believe, will actually happen.
- Investments will be assessed against specific criteria to ensure they deliver value for money and are in line with Merton CCGs strategic objectives over 5 years and or nationally mandated objectives.
- Recurrent costs will be met with recurrent funds unless strong, robust plans exist to alter the nature of the costs and spend. This approach will ensure that as a CCG we tackle and solve the real challenges presented to us.
- Quality, Innovation, Productivity and Prevention schemes (QIPP) are key to delivering the level of efficiency required. A realistic and robust approach to QIPP that ensures plans are centred around pathway changes that bring about the required, real recurrent financial savings and benefits are essential.
- Continued investment will only be achievable if efficiency savings are created through service reviews, redesign over and above that which is required to deliver financial balance.
- Resources are prioritised to deliver the CCG’s strategic objective in line with our commissioning intentions.
- GP Practices, local clinicians and managers continue to work together to deliver focused change and improvement for patients within the financial resources.
- A measured approach to risk - Merton CCG and the local health economy face some significant challenges around modernising and integrating health and social care under the Better Care Fund and Merton’s Out of Hospital Strategy which will require some level of risk taking. Through the financial strategy and corporate governance the CCG will ensure these are measured, anticipated and mitigated where possible.

As part of its overall strategy, the CCG recognises there needs to be fundamental changes to pathways of care to ensure a sustainable health
economy moving forward. It is anticipated that the financial plan above, through its level of investment and QIPP, reflects the strategic investment needed to deliver changes to patient pathways along with an approach to reduce current inefficiencies in the system and deliver greater productivity.

7.3 Planning Guidance
In December 2013 NHS England published ‘Everyone counts – Planning for Patients 2014/15 to 2018/19’. This document recognises that the NHS faces an unprecedented level of future pressure driven by an ageing population, increases in long-term conditions and rising costs and public expectations all within a challenging financial environment. The document notes that in order to respond to these challenges all parties in the NHS have to change and to develop and implement bold and transformational long-term strategies and service plans. Full integration between the NHS and local government through the Better Care Fund (BCF) is seen as the solution which will take time to implement.

Improving Outcomes is required to be at the heart of the strategic and operational planning process. CCGs are required to develop plans, which combine transparency with detailed patient and public participation (Call to Action). The five domains under the NHS Outcome framework have been translated into seven specific and measurable ambitions for which progress on critical indicators of success can be tracked. The seven specific ambitions are:

- Securing additional years of life for the people of England with treatable mental and physical health conditions;
- Improving the health related quality of life of the 15 million+ people with one or more long term condition, including mental health condition;
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;
- Increasing the proportion of older people living independently at home following discharge from hospital;
- Increasing the number of people with mental and physical conditions having a positive experience of hospital care;
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community;
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

7.4 Allocations
NHS England published 2 year allocations covering 2014/15 and 2015/16 on 19th December 2013, following approval on the allocation methodology by the NHS England Board at its meeting in December.

In summary the Board agreed the following;

- That the revised methodology for allocating funds to CCGs is approved. This is based on CCG registered population as reported
on NHS IT systems downloaded in October 2013. Projections on the registered population for 2014/15 and 2015/16 are based on the ONS population projections used for Local Authorities. The methodology not only takes into account population quantum, it also looks at age and market forces factor. The funding formula establishes the ‘target’ financial allocation for each CCG, which is compared to the actual funding received in 2013/14 (month 6 recurring allocation); the difference between this and the target is known as the ‘distance from target’. The distance from target is used to drive the pace of change, which in turn generates the growth percentages for the allocations in 2014/15 and 2015/16.

- That in moving to the revised allocation formula all CCGs would receive a minimum uplift of 2.14% in 2014/15 and 1.7% in 2015/16, with those CCGs most under target receiving additional increase above this level.
- That an adjustment for health inequalities of 10% should be applied.
- That the metrics used to make the adjustment should be SMR<75, weighted in a similar way to the local authority public health grant formula.
- That in line with previous guidance known as Integration Transformation Fund (ITF), the funds would transfer in 2015/16 to form the ‘Better Care Fund’ (BCF).

The table below summarises the allocations for Merton CCG:

Table 4 – Allocation breakdown

<table>
<thead>
<tr>
<th>Estimated registered population</th>
<th>Allocation per head</th>
<th>Budget allocation</th>
<th>Growth Uplift</th>
<th>Growth Allocation</th>
<th>Population Growth</th>
<th>Population allocation</th>
<th>Total increased allocation</th>
<th>Total Growth</th>
<th>Distance from target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline 2013-14</td>
<td>217,050</td>
<td>915</td>
<td>198,689</td>
<td>-7.75%</td>
<td>2,29%</td>
<td>5,226</td>
<td>4,550</td>
<td>9,776</td>
<td>-7.75%</td>
</tr>
<tr>
<td>2014-15</td>
<td>221,876</td>
<td>940</td>
<td>208,458</td>
<td>2.63%</td>
<td>2.29%</td>
<td>4,550</td>
<td>9,776</td>
<td>4.92%</td>
<td>-7.67%</td>
</tr>
<tr>
<td>2015-16</td>
<td>226,559</td>
<td>961</td>
<td>217,810</td>
<td>2.33%</td>
<td>2.16%</td>
<td>4,503</td>
<td>9,360</td>
<td>4.49%</td>
<td>-6.66%</td>
</tr>
<tr>
<td>Increase over 2 years</td>
<td>9,509</td>
<td>19,121</td>
<td>10,083</td>
<td>9,053</td>
<td>19,136</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above shows that Merton CCG will receive a total of 4.92% in 2014/15, consisting of 2.29% for population growth and 2.63% for growth, which is linked to pace of change associated with distance from target. In 2015/16 Merton will receive 4.49% increased allocation, which is based on estimated population growth of 2.16% and 2.33% linked to getting us closer to target. The 2015/16 allocation is indicative and is expected to be updated before April 2015.

The allocations paper presented to the NHSE Board highlighted the following assumptions, some of which need further clarity;

- Payment of provisions relating to continuing healthcare is within the 2014/15 funding envelope for CCGs. In February 2014 NHS England have stated that all CCGs will contribute to a risk-sharing pool, by payment of an amount proportional to the size of their 14/15 allocations. The contributions made will be held by NHS England in a
ring-fenced account to be used only for legacy provision payments. For Merton CCG this equates to £810k.

- Depreciation is included in the allocation, even though many CCGs do not have capital.
- Allocations for all CCGs will be top-sliced for Overseas Visitors in 2014/15.
- Pension costs increase in 2015/16 has been included within the allocation.
- The planning guidance states that CCGs are expected to provide additional funding to commission additional services which GP practices, individually or collectively have identified will further support the accountable GP in improving quality of care for older people (transformation and reducing avoidable admissions). The funding should be around £5 per head of population of each practice. Clarification has been sought from NHS England on the funding source.

7.5 Running Costs
The running cost allocation (RCA) for 2014/15 has increased marginally by £32K, resulting in a reduction from £25 per head of population to £24.71 per head of population.

Taking account of population growth, the RCA per head for 2015/16 is estimated at £22.07.

RCAs have been set on the basis of a constrained population which is ‘unweighted’. This is unlike the programme allocations which has the traditional determinants of population need (e.g. age / sex /deprivation) that form the basis of ‘weighted’ populations.

The starting point for the calculation of RCAs is the number of registrations with CCG’s member GP practices to ensure that the distribution of running costs takes account of cross-boundary patient flows. The total registered population is mapped to the relevant local authority area of residence to calculate the total sum of practice populations resident in a local authority. This is compared to the ONS projection (minus military personnel) and a scaling factor calculated for each local authority area. These scaling factors are then applied to each CCG’s registrations resident in each local authority area to produce a constrained population for each CCG.

7.6 Better Care Fund Allocation and Guidance
The Better Care Fund allocation adjustment in 2015/16 for Merton CCG is £11.3m. In addition £0.9m will transfer to the Better Care Fund from Local Authority making the minimum amount expected in the Better Care Fund to be £12.2m. The make up of the funding is as follows;
The S256 funding currently sits with NHS England (£2.7m in 2013/14, increased by £0.6m in 2014/15; total £3.3m) and is paid directly to Local Authority. This will continue in 2014/15, but will transfer to Merton CCG in 2015/16.

The BCF guidance states that 25% (£3.2m) of the fund will be paid in 2015/16 on the basis of the delivery of national and local metrics and six national conditions. The national conditions are:

- Plans to be agreed jointly
- Protections for social care services (rather than spending) with the definition determined locally
- Seven day working in social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on NSH Number, plans and targets for reducing A&E attendances and emergency admissions
- Joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional
- Agreement on consequential impacts of changes in the acute sector

The national outcome metrics are:

- Reducing admissions to residential and care homes (aged 65 and over);
- Effectiveness of reablement (aged 65 and over) - proportion of older people who were still at home 91 days after discharge from hospital into rehabilitation services;
- Avoiding delayed transfers of care (attributable to either NHS or Social Care);
- Reduce avoidable emergency admissions;
- Patient/service user experience used to improve services.

In addition to the 5 national metrics the CCG and LA need to agree on one local metric to measure performance on the effectiveness of the BCF.

In 2015/16 The Better Care Fund revenue stream will be allocated initially to CCGs, where it will be put into pooled budgets under Section 75 with joint governance arrangements between CCGs and LA. A condition of accessing...
the money in the BCF is that CCGs and local authorities must agree plans on the spend of the fund through the local Health and Wellbeing Board.

### 7.7 2014/15 National Tariff

The National Tariff for 2014/15 was jointly published by NHS England and Monitor on 17th December 2013. There are some minor changes to the structure of the tariff; overall the tariff prices are generally the 2013/14 prices rolled forward and adjusted for inflation and efficiency. The net effect for the two years is shown below:

#### Table 6 – Tariff assumptions

<table>
<thead>
<tr>
<th>Description</th>
<th>Type</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Provider Efficiency (-%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>-4.00%</td>
<td>-4.00%</td>
<td></td>
</tr>
<tr>
<td>Non Acute</td>
<td>-4.00%</td>
<td>-4.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Inflation (+%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>2.50%</td>
<td>2.90%</td>
<td></td>
</tr>
<tr>
<td>Non Acute</td>
<td>2.20%</td>
<td>2.90%</td>
<td></td>
</tr>
</tbody>
</table>

The difference between the acute and non-acute deflator takes into account funding for acute providers to implement the recommendations from the Francis and Keogh reports. NHS England and Monitor are currently developing a medium term pricing strategy for 2015/16 and beyond.

The threshold for emergency admissions, where Providers are paid at 30% for activity above 2008/09 baseline still applies in 2014/15. The balance of 70% is to be invested in demand management schemes which are to be published on CCGs website and shared with all relevant stakeholders. Where it can be demonstrated that there has been a significant change in non-elective admissions since 2008/09, Monitor and NHS England confirm that a joint review between provider and commissioner is to be undertaken involving both the provider(s) and the commissioner(s). Following a review, baseline adjustments must be made where there have been material changes in the pattern of demand for or supply of emergency care in a local health economy, or when material changes are planned for 2014/15. Baseline values (specified in £s) should then be updated to account for material changes that the affected provider cannot directly control.

Commissioning for Quality and Innovation (CQUIN) scheme will continue to be in place for 2014/15, where Providers will be able to earn up to 2.5% of the annual contract outturn excluding high cost drugs and devices that are excluded from national tariff.

Monitor’s guidance on national tariff 2014/15 encourages local variation of tariff prices where it is in the best interest of patients and promotes transparency and accountability. Providers and Commissioners must engage constructively with each other when trying to reach local agreements. In addition to local variation, the 2012 Act also allows for local modifications to nationally determined prices (that is national prices after the application of all relevant national variations) in cases where the services in question are uneconomic at those prices. Providers and commissioners can
agree a local modification or in limited circumstances a Provider can apply to Monitor for a local modification where the commissioner does not agree.

7.8 Two year financial plan
The Financial Plan is based on the business rules and assumptions given in the NHSE planning guidance. Table 4 below highlights the business rules for income and expenditure that have been used for the financial plan.

**Table 7 - Business rules**

<table>
<thead>
<tr>
<th>Planning Assumptions</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency (%)</td>
<td>0.50%</td>
<td>0.50%</td>
</tr>
<tr>
<td>Non-Recurent Headroom (%)</td>
<td>2.50%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Surplus</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
</tbody>
</table>

CCGs are required to deliver a 1% surplus in the first two years. In 2014/15 CCGs are required to create a transformation reserve of 1% to pump prime integration and transformation services that form part of the BCF. Non-recurrent reserves are set at 1.5% and contingency reserve at 0.5% in 2014/15. The non-recurrent reserve drops to 1% in 2015/16 as the assumption is that the BCF will have a significant impact on CCGs. Contingency reserve stays at 0.5%.

Table below highlights the local assumptions based on historical trends that have been used in the financial plans over the two years.

**Table 8 – Local planning assumptions**

<table>
<thead>
<tr>
<th>Demographic Growth (+/- %)</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Demographic Growth (+/- %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>1.60%</td>
<td>1.40%</td>
</tr>
<tr>
<td>CHC</td>
<td>1.60%</td>
<td>1.40%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3.00%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Other Non Acute</td>
<td>1.60%</td>
<td>1.40%</td>
</tr>
</tbody>
</table>

Based on the assumptions presented above the table below shows the planned resource allocation and spend to deliver the 1% surplus required each year.
Table 9 – High level Financial Plan

<table>
<thead>
<tr>
<th>£ 000</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent</td>
<td>203,649</td>
<td>214,170</td>
<td>226,502</td>
</tr>
<tr>
<td>Non-Recurrent</td>
<td>2,892</td>
<td>2,081</td>
<td>2,163</td>
</tr>
<tr>
<td>Total</td>
<td>206,541</td>
<td>216,251</td>
<td>228,665</td>
</tr>
</tbody>
</table>

Income and Expenditure

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>126,604</td>
<td>126,004</td>
<td>124,954</td>
</tr>
<tr>
<td>Mental Health</td>
<td>19,918</td>
<td>20,624</td>
<td>20,819</td>
</tr>
<tr>
<td>Community</td>
<td>16,677</td>
<td>19,838</td>
<td>31,480</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>7,676</td>
<td>8,004</td>
<td>8,117</td>
</tr>
<tr>
<td>Primary Care</td>
<td>25,854</td>
<td>26,677</td>
<td>27,470</td>
</tr>
<tr>
<td>Other Programme</td>
<td>2,997</td>
<td>6,868</td>
<td>7,846</td>
</tr>
<tr>
<td>Total Programme Costs</td>
<td>197,724</td>
<td>208,015</td>
<td>220,686</td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Running Costs</td>
<td>4,737</td>
<td>4,992</td>
<td>4,544</td>
</tr>
<tr>
<td>Contingency</td>
<td></td>
<td>1,081</td>
<td>1,148</td>
</tr>
<tr>
<td>Total Costs</td>
<td>204,461</td>
<td>214,088</td>
<td>226,378</td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(Deficit) Cumulative</td>
<td>2,080</td>
<td>2,163</td>
<td>2,287</td>
</tr>
</tbody>
</table>

7.9 Expenditure

In the absence of agreed contracts with our acute providers, the planned expenditure for 2014/15 starts with the 2013/14 forecast outturn position as at month 9, using the following assumptions for tariff and growth.

7.10 Cost Pressures

The forecast outturn position includes the recurrent acute over-performance for 2013/14 and any cost pressures reflected in the reported 2013/14 position as detailed in table 7 below.

Table 10 – Cost Pressures

<table>
<thead>
<tr>
<th>Cost Pressures</th>
<th>14/15 £'000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childrens continuing care</td>
<td>60</td>
</tr>
<tr>
<td>End of life care - discharge co-ordinators</td>
<td>27</td>
</tr>
<tr>
<td>SLAM</td>
<td>197</td>
</tr>
<tr>
<td>Norfolk Lodge</td>
<td>334</td>
</tr>
<tr>
<td>Mainstreaming of alcohol services - St Georges</td>
<td>25</td>
</tr>
<tr>
<td>Out of Hours service</td>
<td>277</td>
</tr>
<tr>
<td>Marie Stopes</td>
<td>59</td>
</tr>
<tr>
<td>BPAS (ToPs)</td>
<td>68</td>
</tr>
<tr>
<td>SK:N dermatology laser treatment</td>
<td>1</td>
</tr>
<tr>
<td>DEXA scanning (St Anthony’s)</td>
<td>17</td>
</tr>
<tr>
<td>Recruitment to special schools health teams (Perseid)</td>
<td>159</td>
</tr>
<tr>
<td>Acute contract outturn</td>
<td>5,000</td>
</tr>
<tr>
<td>Total Cost Pressures funded</td>
<td>6,223</td>
</tr>
</tbody>
</table>

The total amount of cost pressures funded recurrently in 2014/15 is £6.2m.

7.11 Investments

Service developments/investments have been identified by Commissioning Managers in consultation with clinical leads during January and February 2014. The process for agreeing the prioritisation on investments using a scoring sheet agreed by the Finance Committee in January 2014 has been completed. The results are detailed in table 8. As the current position on provider contracts is not clear, Executive Management Team agreed to the top 6 priorities proceeding from 1st April, with a view to revisiting the
remainder in-year. The prioritisation process and outcomes was shared with the Clinical Reference Group and Practice leads to ensure the priorities reflected a truly local clinical view.

Table 11 – Investments

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Score</th>
<th>2014-15 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology Out of hospital</td>
<td>1014.85</td>
<td>58</td>
<td>259</td>
</tr>
<tr>
<td>MSK</td>
<td>969.32</td>
<td>137</td>
<td>200</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>943.09</td>
<td>2,041</td>
<td>1,081</td>
</tr>
<tr>
<td>IVF</td>
<td>914</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td>Dementia Screening / memory Clinics</td>
<td>873.45</td>
<td>153</td>
<td>0</td>
</tr>
<tr>
<td>Bereavement services</td>
<td>858.71</td>
<td>86</td>
<td>0</td>
</tr>
<tr>
<td>ESH cancer nurse team leader</td>
<td>857.29</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Children’s Service – Improving Transition</td>
<td>809.51</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>SUN Project</td>
<td>791.68</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Eclipse software</td>
<td>767</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Prevention of Alcohol Misuse in Primary Care</td>
<td>738.39</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>630.45</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3,805</td>
<td>1,540</td>
</tr>
</tbody>
</table>

The total amount approved over 2 years is £4.8m (split as 2014/15 £3.3m and 2015/16 £1.5m). It should be noted that although investment into IVF has been prioritised. There are a range of options on IVF services that need to be considered and agreed by Merton CCG that best suits Merton’s population and financial affordability. Work on this is currently taking place.

As part of the Business rules, a 2.5% non-recurrent reserve (£5.2m) is to be created of which 1% is to be used on transformation relating to the Better Care Fund. The 1% transformation fund will be carried forward recurrently in 2015/16 along with additional investment of £1.1m. The plan in 2014/15 for this reserve is as follows:

Table 12 – Non-recurrent reserve

<table>
<thead>
<tr>
<th>Scheme</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Fund</td>
<td>2,041</td>
</tr>
<tr>
<td>2013-14 Repayment to SWL Risk Pool</td>
<td>200</td>
</tr>
<tr>
<td>Payment to Sutton CCG for CLD</td>
<td>600</td>
</tr>
<tr>
<td>SWL collaboration</td>
<td>500</td>
</tr>
<tr>
<td>Top-slice for CHC legacy payments</td>
<td>810</td>
</tr>
<tr>
<td>SWL Risk Pool</td>
<td>1,081</td>
</tr>
<tr>
<td><strong>Total Non-recurrent commitment</strong></td>
<td>5,232</td>
</tr>
</tbody>
</table>

The above plan fully utilises the non-recurrent reserve in 2014/15. The repayment of £0.6m borrowed in 2013/14 from the SWL Risk pool will be
paid across 2 years; £0.2m in 2014/15 and the balance in 2015/16. The £0.6m payment to Sutton CCG relates to an agreement that Merton CCG will pay a final contribution in 2014/15 towards the Community Learning disability team. The CHC legacy payment is a risk share contribution mandated by NHS England to pay legacy continuing care provision invoices in 2014/15. NHS England has stated that the funding has been included in the allocations for CCGs.

There is a key risk to the delivery of the required 1% surplus; as at the time of writing this plan about 16% of the proposed acute contract value for 2014/15 had not yet been agreed.

7.12 Better Care Fund Plan

The CCG and LA have worked together to plan for services within the £12.2m pooled fund that will have the greatest outcome for patients and on the BCF metrics (outcomes) and national conditions to be delivered. In order to ensure that maximum benefit is gained the CCG and LA will start the schemes in 2014/15 as detailed in the table below.

Table 13 – Breakdown of BCF

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Seven day working</td>
<td>240</td>
<td>110</td>
<td>350</td>
<td>500</td>
<td>240</td>
<td>740</td>
</tr>
<tr>
<td>Prevention of Admission</td>
<td>0</td>
<td>943</td>
<td>943</td>
<td>80</td>
<td>1,107</td>
<td>1,187</td>
</tr>
<tr>
<td>Community beds and rehabiliation</td>
<td>200</td>
<td>2,288</td>
<td>2,488</td>
<td>200</td>
<td>2,707</td>
<td>2,907</td>
</tr>
<tr>
<td>Protecting and Modernising Social Care</td>
<td>1,877</td>
<td>0</td>
<td>1,877</td>
<td>3,577</td>
<td>0</td>
<td>3,577</td>
</tr>
<tr>
<td>Developing personal health and care budgets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>400</td>
<td>0</td>
<td>400</td>
</tr>
<tr>
<td>Investing into integration infrastructure</td>
<td>167</td>
<td>167</td>
<td>333</td>
<td>182</td>
<td>182</td>
<td>363</td>
</tr>
<tr>
<td>Carers breaks</td>
<td>0</td>
<td>551</td>
<td>551</td>
<td>0</td>
<td>551</td>
<td>551</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>3,054</strong></td>
<td><strong>4,664</strong></td>
<td><strong>7,718</strong></td>
<td><strong>5,509</strong></td>
<td><strong>5,745</strong></td>
<td><strong>11,254</strong></td>
</tr>
<tr>
<td>Disabled Facilities &amp; Social Care Capital grants</td>
<td>944</td>
<td>0</td>
<td>944</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total BCF</strong></td>
<td><strong>3,054</strong></td>
<td><strong>4,664</strong></td>
<td><strong>7,718</strong></td>
<td><strong>6,453</strong></td>
<td><strong>5,745</strong></td>
<td><strong>12,198</strong></td>
</tr>
<tr>
<td><strong>New investment</strong></td>
<td><strong>2,455</strong></td>
<td><strong>1,081</strong></td>
<td><strong>3,536</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The revenue fund is £11.3m which consists of £7.8m existing costs and £3.5m new investments.

These schemes are expected to deliver reduction in acute activity and release money which would be reinvested in the pool in 2015/16. A risk share of 50:50 has been agreed by the CCG and LA on an amount equivalent to half of the new investment (£1.6m) so that the monies can be repriorled or redirected to make an impact on the metrics, where they are not being achieved.

7.13 QIPP Plans and management

The QIPP schemes currently being finalised and implemented will align with the CCGs Commissioning Intentions and are focused on the following main areas:
• **Urgent Care and intermediate care**
  - Long Term Conditions and Case Management; through improving the management of long term conditions using risk stratification, care planning and better use of community specialist and existing service partners.
  - Prevention of admissions to Secondary care; this scheme started in October 2013.
  - Community prevention of admission team within community services seeing all urgent referrals for assessment to the appropriate setting.
  - More co-ordinated working with acute hospital and social care to reduce excess bed days and ensure prompt discharge.

• **Planned Care and diagnostics**
  - Prevention and early diagnosis; this involves working closely with Public Health to promote health checks and updating GPs regarding early diagnosis.
  - Utilisation of demand management activities; reducing GP referrals into acute hospitals by finding other alternative pathways in the community.
  - Redesign and lower cost delivery; finding ways of achieving the same or better outcomes for patients for less cost by redesigning and reorganising the way in which services are delivered and/or delivering services in a lower cost setting.

• **Prescribing**
  - Identifying cost effective solutions to prescribing in primary care e.g. the use of generic products, prescribing for an appropriate time period and reducing wastage.

• **Transactional schemes**
  - The plan assumes that the forecast outturn position will be inflated with demographic and non-demographic growth as detailed in table 5. QIPP will be delivered through the BCF and planned care schemes, hence growth has not been included within most of the non-local contracts; maintaining 2013/14 activity levels. The amount used in the QIPP plan has been risk abated to 80%.
  - Acute challenges - This relates mainly to KPIs in planned contract figures within the acute contracts which is based on historic performance. The planned amount for QIPP has been risk abated to 75%
  - Continuing care and mental health placements is based on a cost reduction per bed day.
  - CSU recharges and accommodation has yet to be worked up in detail for 2015/16.

The table below summarises net QIPP schemes.
Table 14– QIPP schemes

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Intermediate Care</td>
<td>620</td>
<td>91</td>
</tr>
<tr>
<td>Planned Care and diagnostics</td>
<td>367</td>
<td>-213</td>
</tr>
<tr>
<td>Prescribing</td>
<td>455</td>
<td>500</td>
</tr>
<tr>
<td>Curtailing growth</td>
<td>3,137</td>
<td>3,088</td>
</tr>
<tr>
<td>Acute challenges</td>
<td>1,406</td>
<td>1,406</td>
</tr>
<tr>
<td>Continuing Care placements</td>
<td>173</td>
<td>167</td>
</tr>
<tr>
<td>Mental Health Placements</td>
<td>400</td>
<td>318</td>
</tr>
<tr>
<td>CSU recharge/accommodation</td>
<td></td>
<td>480</td>
</tr>
<tr>
<td>Total QIPP</td>
<td>6,558</td>
<td>5,837</td>
</tr>
</tbody>
</table>

To ensure robust and recurrent delivery of QIPP the CCG will continue to have a QIPP delivery team that meets monthly, involve the Clinical Reference Group on assessing the viability and quality impact on QIPP schemes and report monthly to the Executive Management Team and the Finance Committee.

7.14 Acute Activity Plans

Based on the assumptions above the table below gives the activity plans for the next two years along with the anticipated forecast outturn for 2013/14.
## Table 15 - Activity plan

Merton CCG QIPP Finance and Activity Modelling

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E attendances</td>
<td>64,359</td>
<td>66,805</td>
<td>69,143</td>
<td>71,563</td>
<td>74,068</td>
<td>76,660</td>
</tr>
<tr>
<td>Non-elective excl maternity</td>
<td>14,726</td>
<td>15,286</td>
<td>15,821</td>
<td>16,375</td>
<td>16,948</td>
<td>17,541</td>
</tr>
<tr>
<td>Non-elective QMH</td>
<td>2,690</td>
<td>2,792</td>
<td>2,890</td>
<td>2,991</td>
<td>3,096</td>
<td>3,204</td>
</tr>
<tr>
<td>Daycases</td>
<td>13,262</td>
<td>13,766</td>
<td>14,248</td>
<td>14,747</td>
<td>15,263</td>
<td>15,797</td>
</tr>
<tr>
<td>Elective admissions</td>
<td>12,128</td>
<td>12,588</td>
<td>13,029</td>
<td>13,485</td>
<td>13,957</td>
<td>14,446</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>7,202</td>
<td>7,476</td>
<td>7,738</td>
<td>8,008</td>
<td>8,289</td>
<td>8,579</td>
</tr>
<tr>
<td>GP referred 1st Outpatient attendances</td>
<td>35,099</td>
<td>36,433</td>
<td>37,708</td>
<td>39,028</td>
<td>40,394</td>
<td>41,807</td>
</tr>
<tr>
<td>All Other 1st Outpatient attendances</td>
<td>22,664</td>
<td>23,525</td>
<td>24,348</td>
<td>25,200</td>
<td>26,082</td>
<td>26,995</td>
</tr>
<tr>
<td>Follow-up attendances</td>
<td>120,460</td>
<td>125,038</td>
<td>129,414</td>
<td>133,944</td>
<td>138,632</td>
<td>143,484</td>
</tr>
<tr>
<td>Outpatient procedures</td>
<td>23,940</td>
<td>24,850</td>
<td>25,719</td>
<td>26,620</td>
<td>27,551</td>
<td>28,516</td>
</tr>
<tr>
<td>Critical Care</td>
<td>4,306</td>
<td>4,470</td>
<td>4,626</td>
<td>4,788</td>
<td>4,956</td>
<td>5,129</td>
</tr>
<tr>
<td>XSBD</td>
<td>12,730</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Shifts - total</th>
<th>2013/14 Baseline</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Total</th>
<th>% of baseline year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E attendances</td>
<td>64,359</td>
<td>1,287</td>
<td>1,350</td>
<td>1,350</td>
<td>1,287</td>
<td>2,081</td>
<td>7,355</td>
<td>11.4%</td>
</tr>
<tr>
<td>Non-elective excl maternity</td>
<td>14,726</td>
<td>851</td>
<td>531</td>
<td>500</td>
<td>435</td>
<td>615</td>
<td>2,932</td>
<td>19.9%</td>
</tr>
<tr>
<td>Non-elective QMH</td>
<td>2,690</td>
<td>15,286</td>
<td>2,890</td>
<td>2,991</td>
<td>3,096</td>
<td>3,204</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>Daycases</td>
<td>13,262</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>Elective admissions</td>
<td>12,128</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>64,359</td>
<td>65,541</td>
<td>66,504</td>
<td>67,501</td>
<td>68,598</td>
<td>68,939</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective excl maternity</td>
<td>14,726</td>
<td>14,440</td>
<td>14,419</td>
<td>14,428</td>
<td>14,502</td>
<td>14,399</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective QMH</td>
<td>2,690</td>
<td>2,793</td>
<td>2,892</td>
<td>2,994</td>
<td>3,100</td>
<td>3,209</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>13,262</td>
<td>13,771</td>
<td>14,257</td>
<td>14,760</td>
<td>15,301</td>
<td>15,821</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective admissions</td>
<td>12,128</td>
<td>12,593</td>
<td>13,037</td>
<td>13,497</td>
<td>13,974</td>
<td>14,467</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>7,202</td>
<td>7,478</td>
<td>7,742</td>
<td>8,016</td>
<td>8,299</td>
<td>8,592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP referred 1st</td>
<td>35,099</td>
<td>34,236</td>
<td>28,090</td>
<td>23,693</td>
<td>23,717</td>
<td>19,820</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient attendances</td>
<td>22,664</td>
<td>23,199</td>
<td>20,788</td>
<td>20,114</td>
<td>10,114</td>
<td>14,096</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other 1st Outpatient attendances</td>
<td>120,460</td>
<td>7,655</td>
<td>21,075</td>
<td>18,176</td>
<td>2,468</td>
<td>65,307</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up attendances</td>
<td>120,460</td>
<td>7,655</td>
<td>21,075</td>
<td>18,176</td>
<td>2,468</td>
<td>65,307</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient procedures</td>
<td>23,940</td>
<td>1,075</td>
<td>4,061</td>
<td>3,615</td>
<td>14,096</td>
<td>14,096</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td>4,306</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XSBD</td>
<td>12,730</td>
<td>367</td>
<td>497</td>
<td>267</td>
<td>267</td>
<td>1,667</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maternity admissions                          7,202
GP referred 1st Outpatient attendances
All Other 1st Outpatient attendances
Follow-up attendances
Outpatient procedures
Critical Care
XSBD

Non-elective excl maternity
Non-elective QMH
Daycases
Elective admissions
Maternity admissions
GP referred 1st Outpatient attendances
All Other 1st Outpatient attendances
Follow-up attendances
Outpatient procedures
Critical Care
XSBD
The plans reflect agreed contract activity with our three main local providers, following agreed adjustments for growth, developments and QIPP.

Performance against the plan will be monitored on a monthly basis, with action plans to work with providers to ensure the plan is delivered.

**Capital plans**

In December 2013 CCGs were asked to submit capital plans for 5 years in consultation with all stakeholders i.e. Primary Care, NHS Property Services and NHS England. The capital plan submitted is detailed in table 12;

**Table 16 – Capital Plan**

<table>
<thead>
<tr>
<th>Planned Capital Expenditure</th>
<th>2014/15 Value £'000s</th>
<th>2015/16 Value £'000s</th>
<th>2016/17 Value £'000s</th>
<th>2017/18 Value £'000s</th>
<th>2018/19 Value £'000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Infrastructure</td>
<td>143</td>
<td>143</td>
<td>143</td>
<td>143</td>
<td>143</td>
</tr>
<tr>
<td>Assistive Technology</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Medicine on the move</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
</tr>
<tr>
<td>Patient Access to GP Records</td>
<td>104</td>
<td>104</td>
<td>104</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>Community Based Mobile Working</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Nelson Local Care Centre</td>
<td>619</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nelson Local Care Centre ICT Implementation</td>
<td>943</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hardware replacement for CCG headquarters</td>
<td>160</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,395</strong></td>
<td><strong>673</strong></td>
<td><strong>673</strong></td>
<td><strong>673</strong></td>
<td><strong>673</strong></td>
</tr>
</tbody>
</table>

In 2014/15 the costs (£1.7m) associated with the Nelson local care centre and hardware replacement for CCG headquarters will fall under the CCG. The remaining £0.7m sits under NHS England Primary Care in 2014/15 and on an on-going basis.

Merton CCG is currently working on a strategic outline case for a local care centre in East Merton, which it is hoped will result in an outline business case by the end of 2014/15. Approval for the case and will be sought from NHS England.

**7.15 Statement of Financial Position (SoFP)**

It is assumed that the current forecast position for 2013/14 will continue in 2014/15.
Although a capital plan has been submitted for the next five years, Merton CCG has not received approval to-date hence the balance sheet consequences have not been reflected in the plan.

### 7.16 Cash Plans

The cash plan is in line with the revenue resource allocation for each year excluding primary care prescription costs which are paid directly by the Prescription Pricing Authority. The CCG will always aim to manage its working capital with the utmost efficiency to meet the Better Payment Practice Code, therefore no significant swings would affect the cash plan are predicted.

### 7.17 Risks and contingency

The main risks and mitigations are detailed below:

<table>
<thead>
<tr>
<th>Table 18 – Risks and mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial Risk</strong></td>
</tr>
<tr>
<td>Acute contracts will over spend</td>
</tr>
<tr>
<td>QIPP schemes will not deliver</td>
</tr>
</tbody>
</table>
project plans, broken down to measurable areas and realistic savings targets. Process in place to identify other schemes to come on line in year (if there is slippage on existing schemes). Investment funding not to be fully allocated.

| Curtailing growth | Work to be done with Commissioning managers and clinical leads to ensure existing schemes deliver at 2013/14 levels. On-going work on QIPP to find in-year schemes | High |
| Planned surplus for 2013/14 will not be delivered | Dependent on year-end position with the two largest local providers. | Medium |
| Resource allocation top-sliced above current plans | Review guidance as well as identify QIPP schemes in-year to bridge the gap | Medium |

Merton CCG will maintain a 0.5% contingency reserve of £1.1m in all years. At present there is also a reserve of £1.5m to mitigate against acute SLA negotiation risks for 2014/15 and future years. If this is uncommitted after all contracts are agreed, this reserve will be available for further investments.

If an upside scenario occurs, any additional flexibility will look to be re-invested rather than increasing the level of reserves significantly. As the financial position during the year becomes clearer the reserves could also be utilised during the year.

In addition to the above, the CCG is also a member of a risk pooling scheme which effectively shares risk across South West London CCGs where a CCG is in financial difficulty. This arrangement is 1% of the CCG’s expenditure and acts as a further mitigation mechanism to the key risks Merton CCG faces. This amount is part of the non-recurrent reserves set aside each year.

7.18 Conclusion
The financial plan demonstrates that the CCG is in recurrent balance over the five year period and has planned contingencies to manage risk and deliver the anticipated statutory financial duties.

The CCG needs to remain focused on the value for money, productivity, service redesign and innovation to meet the continued financial challenges that are faced over the five years.

Financial balance will remain a key objective for the NHS and it is essential that financial awareness, ownership and accountability remain central in the CCG’s objectives, plans and culture.

8. Summary
In summary, Merton CCG has created this exciting and innovative 2 Year Operating Plan and we are confident that we are well placed to deliver our strategic ambition and ensure that we constantly challenge ourselves, manage effectively within our resource allocation, to ensure that people
receive the right care, at the right place, at the right time, with the right outcome.
### Appendix A – Plan on a Page 2014/16

**Merton CCG – Right Care, Right Time, Right Place, Right Outcome**

**Merton – population 199,693 | 3 Acute Trusts | 1 Local Authority | 1 Mental Health Trust | 1 Community Services**

### Key Strategic Projects

**Integration, Call to Action, Merton Better Healthcare Closer to Home, Out of Hospital Strategy**

### Context and scale of the challenge

- **One CCG with 25 member practices covering the same area as Merton Local Authority**
- **Financially challenged health and social care system due to historical low levels of funding and increasing demands on services**
- **Inequality gap between wealthiest and poorest wards – which is increasing. East Merton is significantly more deprived and the model of care needs to reflect a younger population.**
- **The 2014/15 CCG budget is around £216 million per year and needs to deliver within budget**

<table>
<thead>
<tr>
<th>Health and Wellbeing Priorities</th>
<th>CCG Organisational Development Priorities</th>
<th>Patient Involvement and Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving every child a healthy start</td>
<td>Implement transformational service change to the health and social care system to enable the CCG to meet its objectives</td>
<td>Build strong clinical engagement from constituent GP practices</td>
</tr>
<tr>
<td>Supporting people to improve their health and wellbeing</td>
<td>Develop strong clinical leadership and wide clinical engagement</td>
<td>Develop PPGs and a Patient Reference Group</td>
</tr>
<tr>
<td>Enabling people to manage their own health and wellbeing as independently as possible</td>
<td>Ensuring continuous improvement in quality services we commission alongside primary care</td>
<td>Promoting and advancing equality through our work on the Equality Delivery System</td>
</tr>
<tr>
<td>Improving wellbeing, resilience and connectedness</td>
<td></td>
<td>Focus on hard and soft intelligence</td>
</tr>
</tbody>
</table>

### Our Six Priority Areas

#### Health and Wellbeing Priorities

**Older and Vulnerable Adults**
- To focus our work on integration to ensure older people have access to seamless services
- To increase our numbers of patients on the Falls Pathway and link in an osteoporosis pathway
- To be the London leader for the numbers of people who receive end of life care in their preferred place
- To review and update the dementia strategy for Merton
- To continue to review our learning disability services
- To ensure we respond to the needs of carers and young carers

**Mental Health**
- To redesign and re-commission IAPT and associated services (i.e. bereavement)
- To work with South West London and St Georges Mental Health Trust, to ensure that patients receive appropriate inpatient care
- To ensure our patients are treated in a holistic manner so that there is a sense of parity to their care
- To increase the numbers of patients who are treated with Mental Health conditions in the community through outreach
- To work with Military Health to ensure that veterans have access to all tiers of Mental Health care

**Urgent Care**
- To ensure a whole system approach focusing on the patient journey and experience, and clinical outcomes
- To embed the 111 and OOH services and look at new solutions for these services
- To join up system surveillance within Merton for all urgent care services
- To develop the community prevention and response service
- To work with SWL acute host Urgent Care Boards

**Early Detection and Management**
- To review cardiac, diabetes, respiratory and gynaecological pathways and transfer appropriate care to the community
- To ensure we reduce any wide variation in the level of hospital attendances for certain services, we take an active role to ensure that patients have equal access to healthcare
- To work with Public Health and Primary Care to ensure suitable solutions for encouraging exercise are in place
- To include healthy person checks where possible

#### Better Care Fund

- We will use the BCF to deliver the following aspirations for patients:
  - Reducing (growth of) emergency admissions
  - Reducing length of hospital stay
  - Reducing permanent admissions to care homes
  - Improving service user and carer experience

#### Enhanced Commissioning through

**We will deliver**

- Working closely with patients and clinicians to design services
- Use of the Equality Delivery System as a robust platform for meeting the needs of Merton
- Working with CSU, CCG and NHSE colleagues to ensure decisions evidence based
- Integration of services through our commissioning

**Key Risks and mitigations**

- An ageing population who are living longer often with more than one long-term condition - integration
- Rising emergency admissions – urgent care surveillance
- Being able to make the efficiency savings required – increased rigour with QIPP
- NHS new systems – work in collaboration with new and existing partners

- We are aware that primary care colleagues are working within a challenged health system and therefore we will work with primary colleagues to help them to find solutions to the increasing pressures they are managing
- We will work to develop innovative models of care with Primary Care Services at the centre (i.e. East Merton Model of Care within 2014/15)
- We will use education and workforce as platforms for pathway changes and service redesign

#### Primary Care Support and Improvement

<table>
<thead>
<tr>
<th>The NHS Constitution for people in Merton</th>
<th>The NHS Outcomes Framework</th>
<th>The Social Care Outcomes Framework</th>
<th>Public Health Outcomes Framework</th>
<th>Innovation by turning good ideas into services to benefit patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working closely with patients and clinicians to design services</td>
<td>Use of the Equality Delivery System as a robust platform for meeting the needs of Merton</td>
<td>Working with CSU, CCG and NHSE colleagues to ensure decisions evidence based</td>
<td>Integration of services through our commissioning</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Strategic Out-of-Hospital Programme 2014/2016

Programme Brief

1. Purpose
The programme to deliver Merton Clinical Commissioning Group’s strategic commissioning intentions has been formally constituted to ensure that the emerging priorities for 2014/16, based on the JSNA and other intelligence, and is delivered in an entirely structured manner.

This programme brief sets out the structures, purpose, outcomes and benefits that the programme is expected to deliver and is the document that initiates the work once it has been signed off by the Strategic Delivery Board.

The ultimate goal of a programme is to realise outcomes and benefits of strategic relevance, i.e. measurable improvement resulting from an outcome and perceived as an advantage by one or more stakeholders.

To achieve this, the programme is designed to coordinate, direct and oversee the implementation of a set of related projects and activities in order to deliver outcomes and benefits related to the organisation’s strategic objectives.

2. Programme Structure and Organisation
The overall programme will be managed by a Strategic Delivery Board operating six ‘Priority Areas’ managed by a Clinical Lead and a Commissioning Manager, that will, in turn, manage a portfolio of projects, reviews, redesigns and implementations.

The CCG’s Operating Plan and Commissioning Intentions document separately describes the priorities and actions to be delivered during 2014/2016 and outlines the platform for delivery of continuous commissioning improvement in subsequent years. The programme is the means by which the following agreed priority areas within the Operating Plan for 2014/16 are delivered:

- Older and Vulnerable Adults
- Mental Health
- Children and Maternity Services
- Keeping Healthy and Well
• Early Detection and Management
• Urgent Care

The structure of the programme to meet the deliverable outcomes of the priority areas is set out in Appendix B1 to this programme brief. The programme will be run according to the principles of the ‘Managing Successful Programmes’ methodology and the projects will be run according to the ‘Prince 2’ methodology.

Due to the size of the programme and the resources available to manage it at Merton CCG, the functions of a project board for any project within the programme will be fulfilled by the Strategic Delivery Board but each project will have its own Project Delivery Team to deliver the specific outputs of the project.

Additionally, components of the methodologies may be scaled to ensure that they serve the needs of the programme rather than the programme being driven by the constraints of the methodologies.

The Strategic Delivery Board performs important functions in terms of governance and management for the programme, as follows:

• Governance
  o Provides transparent links into the Executive Management Team and the Governing Body, as the CCG’s senior decision-making bodies.
  o Oversees the programme plan, project portfolio and interdependencies.

• Management
  o Acts as a focus for all clinical activity
  o Approves programme budget decisions, in line with delegated authority
  o Manages programme level risks and issues.
  o Provides the mandate to set up, close and suspend individual projects of the programme
  o Approves the communications strategy and plan.
  o Delegates authority as appropriate, for example to project teams.

3. Outline Vision Statement
The vision for delivering this programme is drawn from the Merton CCG Operating Plan for 2014/16 and is as follows:

“Ensuring the right service, at right time, from the right person with the right outcome for users of health services within Merton.”

The programme must remain focused at all times on delivering outcomes and benefits that meet the aims of the vision statement.

Operating Plan 2014/16
Page 73/93
With health service reforms allowing greater local control over decision-making, Merton CCG is continuing to build on the progress of having local clinical ownership of the Quality, Improvement, Productivity and Prevention challenge (QIPP) and especially understanding the clinical changes needed to ensure wider service and financial sustainability.

4. Leadership and Stakeholder Management

The programme must manage relationships with the ranges of stakeholders who have an interest in the programme and provides the leadership required to direct, influence and motivate others towards the desired outcome.

A stakeholder relationship diagram is attached to this Programme Brief at Appendix B3, which compares the various stakeholders and their interests in the programme.

The programme will also develop a Communications Plan to ensure appropriate engagement, including identifying messages, audiences, timings, channels and feedback processes.

Within the programme, the following specific roles are defined:

- **Senior Responsible Officer (SRO)**

  The SRO is responsible for ensuring that the project or programme meets its overall objectives and delivers its projected benefits. The SRO owns the overall business change and ensures that the change maintains its business focus, has clear authority and that the context, including risk, is actively managed.

  The SRO in this programme is Adam Doyle, Director of Commissioning and Planning for Merton CCG.

- **Business Change Manager (BCM)**

  The BCM is responsible for integrating the outputs from the projects into the operational environment and consequently generating the expected benefits. Realizing the benefits identifies three distinct sets of activities which comprise this process, as follows:

  - Managing pre-transition, incorporating the analysis, preparation and planning for the business change
  - Managing transition, incorporating all of the activities involved in the handover and integration of the outputs into the business environment
  - Managing post-transition, including the measurement of progress and the benefits.

  The role of BCM in this programme is fulfilled by Caroline Farrar, Deputy Director of Commissioning and Planning for Merton CCG, with effect from 1 April 2014.
• **Programme Manager**

The Programme Manager is an inward facing role responsible for detailed planning and tracking of delivery of the programme’s outputs and benefits.

The programme manager is responsible for the coordination and management of the projects. This is achieved through the process known as delivering the capability. The programme manager will deliver the blueprint using this management process.

During the establishment of the programme, this role is being fulfilled in an interim capacity by James Corrigan but a longer-term appointment will be made once the programme is up-and-running.

• **Programme Assurance**

Programme Assurance is a systematic approach to measure the likelihood of success of a program and proposing improvements that will ensure success.

Within the context of this programme, it is used to review and assess programme performance and to ensure that risks are managed appropriately.

Programme assurance will ensure that the clinical and patient outcomes and benefits are delivered by the programme and it will be fulfilled by the Clinical Leads within the three Locality Teams.

• **Programme Office**

The administrative roles of the Programme Office will be coordinated by Victoria Calvert, PA to the Director of Commissioning and Planning.

5. **Benefits Realisation**

The purpose of a Benefits Realisation Plan is to identify, define, track and optimise the realisation of benefits (and dis-benefits).

The most easily managed benefits are tangible, measurable and, ideally, definable in financial terms. However, some benefits might be intangible (known as ‘soft’ benefits) in that they are difficult to substantiate – proxy measures might be necessary to provide some evidence of realisation (e.g. a reduction in the number/type of calls to a Help Line might be used as a proxy indicator for the improved customer appeal or usability of a website).

An outline Benefits Map is attached at Appendix B2 to show how benefits relate to each other and to the programme outputs and business changes that will enable them to be achieved. The dependency relationships in a Benefits Map show how project outputs ultimately lead to the achievement of strategic objectives.

Management of the Benefits Map is the responsibility of the Business Change Manager within the programme, who will identify and quantify
benefits and ensure that transition plans are designed and executed so that the enabling capability and culture is properly embedded into business operations.

An assessment of the anticipated benefits is essential for determination of the initial and continuing justification of a programme. Financial benefits will form part of the Investment Appraisal in the Business Case and will be used during and after the programme to measure the advantage gained and the value for money achieved.

The Benefits Map has been developed in response to the specific underlying challenges in Merton’s local health economy that the Operating Plan identified must be addressed to deliver a robust Out of Hospital Strategy including:

1. Managing increased demand for services from our frail older population
2. Addressing the financial challenge and potential quality and safety risks this could bring in the future
3. Building robust and effective community services to bring care closer to home safely and effectively
4. Developing a configuration of acute services which with an overall reduced ‘footprint’ ensures sustainability and affordability
5. Continuing our path toward greater service integration and continuing to build high quality community services
6. Ensuring greater patient and public engagement in all of our work
7. Reducing variation of practice across hospital sites and services
8. Securing and commissioning better communication between services and clinicians
9. Ensuring equity of access and continuity of care services for all patients but particularly those with complex and long-term conditions
10. Securing both quality and value from existing services and, where this is not happening, addressing this through service improvement or decommissioning
11. Beginning to commission for outcomes in a number of priority areas
12. Ensuring that we use technology and IT as accelerators of change

6. Blueprint Design and Delivery
The Operating Plan for 2014/16 functions as the ‘Blueprint’ for delivering the Strategic Out-of-Hospital Programme for 2014/16. It sets out the operational capability that will need to be put in place to enable the required outcomes and benefits. The Blueprint comprises the current, intermediate and target end state of the key aspects of the business operations of not only Merton CCG but also all stakeholders that must change for benefits to be realised.
7. Planning and Control
Planning and control is integral to any programme to ensure that a clear management and control regime exists. The full Programme Plan will cover key programme level events and controls including:

1. The division of the programme into tranches, each of which delivers a step change in capability and some associated benefits.
2. Governance activities (e.g. end of Tranche Reviews), i.e. how learning from each activity is applied to the overall management of other projects and reviews.
3. Project milestones (start, finish, key events).
4. Project output delivery.

A single-page, high level programme plan is attached at Appendix B4 but the ultimate programme plan will be significantly more detailed and will ensure that interdependencies, key transition activities and milestones, communications, benefits management activities, quality management activities and assurance activities are all co-ordinated for the benefit of the overall programme and the CCG and its stakeholders.

An outline Forward Meetings Schedule is attached at Appendix B5 to illustrate how the programme will be structured to deliver outcomes to specific meetings for consideration, review and decision.

8. Business Case
The Operating Plan and this Programme are Merton CCG’s response to the communication to Commissioners from the NHS Chief Executive in October 2013 outlining the planning approach for the NHS over the next 5 years, including:

“Strategic and operational plans – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time.”

The programme also responds to the likely requirement for longer term strategic plans, as signalled in NHS England’s “A Call To Action” document published in July 2013. This describes anticipated “…future pressures that threaten to overwhelm the NHS and identifies some key challenges which can only be tackled by doing things differently within the following set of requirements:

- How can we improve the quality of NHS care?
- How can we meet everyone’s healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

The 5 Year Strategic Plan initial draft is due to be submitted to NHS England by April 2014, with final versions submitted in June 2014.
England has asked that the CCG agrees with neighbouring CCGs the footprint in which the five year plans will be written. Merton CCG has agreed to plan as part of the Strategic Planning Unit of South West London which includes Merton, Wandsworth, Kingston, Richmond, Sutton and Croydon, and NHSE for Specialist Commissioning and Primary Care services.

9. Risk and Issue Management
Programmes are managed in an uncertain environment and risks will be identified throughout the duration of the programme. This governance theme covers the identification, management and escalation of risks and issues.

At a programme level, the risk process is applied to both threats and opportunities: threats have a negative impact on the programme outcomes whilst opportunities have a positive or advantageous impact. The programme’s approach to the management of risk should be derived as far as possible from the corporate approach.

A sample of the programme Risk Register is attached at Appendix B6.

Issue resolution is closely linked to change control and provides a formal approach to the treatment of changes. A programme strategy must be established to provide guidelines for the management of issues because it is impossible to plan a programme that will not be subject to change requests and issues. As with risks, the programme’s approach should take into account any relevant corporate approach.

A sample of the programme Issues Log is attached at Appendix B7

10. Quality
Programme-level Quality Management refers to the need to satisfy the stakeholders’ requirements by meeting their expectations and offering the best opportunity to realize the planned benefits.

Quality management activities will be undertaken throughout the duration of the programme to confirm that the people, processes and outputs will meet and continue to meet the stakeholders’ expectations. This will enable stakeholders to be assured that the planned benefits have the best chance of being realised.

The programme will review the development of the following:

- Quality Management Strategy: to define the approach to managing quality across the programme e.g. what will be subject to quality assurance/audit/review/control, responsibilities for quality management, standards and regulations, interfaces with corporate and other relevant quality management systems.
- Quality Management Plan: the timetable and arrangements for implementing the quality management strategy.
11. Transformational Flow

‘Transformational flow’ describes a series of six processes which guide the programme management team through the programme. Each process details the management activities that are required to be undertaken at each step of the programme.

The transformational flow is designed to ensure that the team gathers information and makes decisions at the appropriate point in the programme’s lifecycle. Some of these processes are designed to be undertaken sequentially; for example, “identifying a programme” is completed before defining a programme. Others may be undertaken in parallel; for example, “managing the tranches”, “delivering the capability” and “realizing the benefits” will all have considerable overlap during many of the tranches.

As stated in Section 3 above, the programme will be managed according to a modified version of the ‘Managing Successful Programmes’ methodology and will adopt the following six processes to managing the programme:

- Identifying a programme.
- Defining a programme.
- Managing the tranches.
- Delivering the capability.
- Realising the benefits.
- Closing the programme.
### Appendix B2: Benefits Realisation Plan

<table>
<thead>
<tr>
<th>Benefit</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Managing increased demand from frail older people</td>
<td>Memory Clinic</td>
<td>Increased takeup of service after reconfiguration</td>
<td>Q1 2015-16</td>
</tr>
<tr>
<td>2. Meeting financial challenge &amp; managing quality and safety risks</td>
<td>Falls Prevention</td>
<td>Admissions reduced by redesigned pathway</td>
<td>Q1 2015-16</td>
</tr>
<tr>
<td>3. Community services delivering care closer to home</td>
<td>Podiatry</td>
<td>Service Redesign Savings</td>
<td>Q1 2015-16</td>
</tr>
<tr>
<td>4. Sustainable and affordable acute services with a reduced footprint</td>
<td>MSK Redesign and Procurement</td>
<td>Reduction in costs and improved access</td>
<td>Q1 2015-16</td>
</tr>
<tr>
<td>5. Service integration and building quality community services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Greater public and patient engagement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Reducing variation of practice across sites and services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Better communication between services and divisions</td>
<td></td>
<td></td>
<td>Integration of Mental Health Services</td>
</tr>
<tr>
<td>9. Equal access and continuity of care esp LTCs and complex needs</td>
<td></td>
<td></td>
<td>Integration of Children’s Services</td>
</tr>
<tr>
<td>10. Quality &amp; value from existing assets, improvement and decommissioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Commissioning &amp; Outcomes in priority areas</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12. Using technology and IT as accelerators of change</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**
- Baseline Measurement
- Measurement against Baseline
- Financial Benefit
- Non-Financial Benefit

**Legend**
- Related to specific project or review in Programme Plan
- Refers to specific project or review in Programme Plan
Appendix B3: Stakeholder Management

The wider healthcare community includes acute trusts, community services, private providers and any other providers.

Patients will contribute to various of the individual projects within the programme but are not directly represented on the programme.

NHS England and other CCGs will be kept informed through established channels.

Many of the projects within the programme are focused on integration with Merton Council so there will be a strong interdependency between the CCG and LB Merton. The SRO and Programme Manager will ensure that programme-level communications are maintained where appropriate.

The EMT and the Governing Body will manage the majority of formal communications with external stakeholders through established communications, although the programme will also be responsible for appropriate liaison, as necessary.

Locality Teams play a significant role in the delivery of the programme, as they provide the clinical assurance to the programme and ensure that the outcomes remain focused on clinical priorities. Locality teams also liaise regularly with other Merton GPs.

The programme provides leadership and direction to the portfolio of projects and reviews that it controls. While representatives from external stakeholders are fully engaged with the projects, the programme remains largely internally focused, with assurance provided from the locality team clinical leads.

GP's will be involved both through the Locality Teams and through established communications with the Governing Body. Individual GP's may also be invited to work with project teams.
## Appendix B4: High Level Programme Plan 2014/16

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
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<tbody>
<tr>
<td>Priority Area 1: Older and Vulnerable Adults</td>
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<tr>
<td>1.1</td>
<td>REHAB REVIEW</td>
<td>BASELINE</td>
<td>DEVELOP PROPOSALS</td>
</tr>
<tr>
<td>1.2</td>
<td>REVIEW STRATEGY</td>
<td>PETER MAC TAPLE</td>
<td>INTERMEDIATE CARE REVIEW</td>
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<tr>
<td>1.3</td>
<td>Podiatry Review</td>
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<td>1.4</td>
<td>Falls Review</td>
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<td>2.1</td>
<td>IAPT REVIEW</td>
<td>BASELINE</td>
<td>DEVELOP PROPOSALS</td>
</tr>
<tr>
<td>2.2</td>
<td>RECOMMISSION MEMORY CLINIC</td>
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<tr>
<td>2.3</td>
<td>SCOPE INTEGRATION WITH MERON</td>
<td>IMPLEMENTATION OF INTEGRATION WITH LB MERTON MH SERVICES</td>
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<td>Priority Area 2: Mental Health</td>
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<td>3.1</td>
<td>CHILDERN'S SVC REVIEW</td>
<td>DEVELOP PROPOSALS</td>
<td>IMPLEMENTATION OF NEW MODEL</td>
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<td>3.2</td>
<td>CONTINUING CARE REVIEW</td>
<td>DEVELOP PROPOSALS</td>
<td>IMPLEMENTATION OF NEW MODEL</td>
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<td>3.3</td>
<td>SCOPE INTEGRATION WITH MERON</td>
<td>IMPLEMENTATION OF INTEGRATION WITH LB MERTON CHILDREN'S SERVICES</td>
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<tr>
<td>Priority Area 3: Children and Maternity Services</td>
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<td>4.1</td>
<td>MSK REVIEW</td>
<td>PROCUREMENT</td>
<td>IMPLEMENTATION</td>
</tr>
<tr>
<td>4.2</td>
<td>REVIEW PUBLIC HEALTH</td>
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<td>COMMUNICATION EXERCISE</td>
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<td>Priority Area 4: Keeping Healthy and Well</td>
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<tr>
<td>5.1</td>
<td>DIAGNOSTICS REVIEW</td>
<td>DEVELOP PROPOSALS</td>
<td>IMPLEMENTATION OF NEW DIAGNOSTICS MODEL</td>
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<td>5.2</td>
<td>CARDIOLOGY PATHWAY REVIEW</td>
<td>DEVELOP PROPOSALS</td>
<td>IMPLEMENTATION OF NEW CARDIOLOGY PATHWAY</td>
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<td>5.3</td>
<td>UROLOGY PATHWAY REVIEW</td>
<td>DEVELOP PROPOSALS</td>
<td>IMPLEMENTATION OF NEW UROLOGY PATHWAY</td>
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<td>5.4</td>
<td>DIABETES HDF COMMUNICATION</td>
<td>MONITORING REFERRAL PATTERNS</td>
<td>PATHWAY REVIEW</td>
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<td>5.5</td>
<td>SURVEILLANCE MODE</td>
<td>IMPLEMENT NEW MODE</td>
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<td>5.6</td>
<td>ADOPT MERON WITH THS ENGLAND S/COM</td>
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<td>Key</td>
<td>Refers to specific project or phase in Programme Plan.</td>
<td>BASELINE PHASE</td>
<td>PROCUREMENT PHASE</td>
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<td></td>
<td>Significant decision points</td>
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</table>
### Appendix B5: Forward Meetings Schedule (Incomplete – assuming SD Board held fortnightly on a Monday)

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
<th>Papers Due</th>
<th>Scheduled Business</th>
<th>Programme Decision Points</th>
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<tbody>
<tr>
<td>12/02/14</td>
<td>Executive Mgt Team</td>
<td>07/02/14</td>
<td>Initial review of Programme Brief and Development</td>
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</tr>
<tr>
<td></td>
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<tr>
<td>03/03/14</td>
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<td>4.1 MSK Procurement Initial Documentation Review Update</td>
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<td>5.1 Diagnostics Review Update</td>
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<td>5.7 Urology Redesign Review Update</td>
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<td>17/03/14</td>
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<td>1.2 Agree to proceed with EoL Strategy</td>
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<td>4.1 Final MSK review and proposals</td>
<td>4.1 Agree to proceed with MSK Procurement</td>
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<td>09/04/14</td>
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<td>04/04/14</td>
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<td>Agreement to proceed with MSK Procurement</td>
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<td></td>
<td>2.1 Review scoping integration with LB Merton – MH Services.</td>
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<td>25/04/14</td>
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<td>5.5 Commence GP Communication on Cancer Pathway</td>
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<tr>
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<td>02/05/14</td>
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<td>11/06/14</td>
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<td>Progress review from all active projects and reviews</td>
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</table>
## Appendix B6: Sample Programme Risk Register

|-----|----------------|-------|------|---------------------|---------------|---------------------|------------------------------------------|---------------------|--------------|-------------------------------------------------|
| 1   | 23/01/14       | SRO (AD) | Loss to project of key staff. | Medium        | High           | Unable to complete key tasks | SRO ensuring staff are aware of commitments and are not overburdened with other work before committing to projects or reviews. | Low                | High         | Triggers
Reports of absence, or diversion of staff to other work
Actions
Identify alternative resources in case of unexpected absence. Investigate whether extra resources could either be involved or shadow any work dependent on a single member of staff. Ensure complete records of work are available at any point. |
### Appendix B7: Sample Issues Log

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue Type</th>
<th>Date Raised</th>
<th>Raised by</th>
<th>Issue Report author</th>
<th>Issue description</th>
<th>Priority</th>
<th>Severity</th>
<th>Status</th>
<th>Closure date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Problem/Concern</td>
<td>23/01/14</td>
<td>J Corrigan</td>
<td>J Corrigan</td>
<td>Clinical Leads identified as not having enough time to commit to the reviews. Replacements identified and briefed. Issue closed.</td>
<td>2</td>
<td>Medium</td>
<td>Closed</td>
<td>23/01/14</td>
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1 Highlight Summary

<table>
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<tr>
<th>Reporting Period:</th>
<th>13 March – 3 April 2014</th>
<th>Overall Programme Status</th>
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</thead>
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<tr>
<td>Programme Manager:</td>
<td>James Corrigan</td>
<td>ON TARGET</td>
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<tr>
<td>SRO:</td>
<td>Adam Doyle</td>
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</table>

2 Progress during the reporting period

The following outcomes were agreed for delivery at the previous meeting of the EMT on 7 March 2014 (these outcomes were detailed in the ‘Programme Brief’ Document that was agreed at the previous meeting). Reference numbers refer to the relevant projects or reviews.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Action</th>
<th>Achieved</th>
<th>Reasons/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Final MSK review and proposals</td>
<td>Yes</td>
<td>Review proposals and recommendation submitted to EMT.</td>
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<tr>
<td>5.2</td>
<td>Progress Report on Cardiology Pathway</td>
<td>Yes</td>
<td>Progress report submitted to EMT</td>
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<tr>
<td>5.5</td>
<td>Commence GP Communication on Cancer Pathway</td>
<td>No – delay not critical</td>
<td>Start held up by staff absence. Will commence on 14/04/13</td>
</tr>
</tbody>
</table>

3. Targets for the next reporting period

The following outcomes have been agreed for reporting to the next EMT meeting on 7 May 2014 and were set out in the Project Brief. Reference numbers refer to the relevant projects or reviews. Please refer back to the Programme Brief for outcomes to be delivered to other EMT meetings.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Deliverable</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Proposals to proceed to procurement for MSK</td>
<td>07/05/13</td>
</tr>
<tr>
<td>6.1</td>
<td>Options appraisal for Surveillance Reporting</td>
<td>07/05/13</td>
</tr>
</tbody>
</table>

4. Summary of principal risks

Risks are listed which have both a ‘medium’ or ‘high’ likelihood of happening, a ‘medium’ or ‘high’ impact on the programme and are categorised as ‘near’ rather than ‘far’. There are eight ‘open’ risks on the programme risk register but none is rated at medium or higher in both likelihood and impact, due to strong project controls.
5 Summary of principal issues

Issues are factors that are already happening and that can lead to the programme failing to deliver its outcomes within the agreed time, quality and budget. There are no currently open issues.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk and Impact</th>
<th>Lik’h’d</th>
<th>Impact</th>
<th>Mitigation</th>
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6 Overall Summary

The programme remains on schedule with all projects and reviews managed appropriately. There are no programme-level risks or issues to report.

7 Acceptance

The SRO and the Programme Manager sign the file copy of the highlight report.

Project Manager Date: 2 April 2014

Project Executive Date: 2 April 2014
## Appendix C – Performance of Constitutional rights and pledges

### Monthly Indicators

| CB_B1 | RTT 18 week compliance, admitted patients | 92.5% | G | 90.0% |
| CB_B2 | RTT 18 week compliance, non admitted patients | 97.3% | G | 95.0% |
| CB_B3 | RTT 18 week compliance, incomplete pathways | 94.0% | G | 92.0% |
| CB_B4 | Diagnostic test waiting times | 99.38% | G | 99.90% |
| CB_B5 | A and E 4 hour waiting time compliance | 95.0% | G | 90.0% |
| CB_B6 | All cancer two week waits | 97.5% | G | 93.0% |
| CB_B7 | Breast symptoms (cancer not initially suspected) | 97.3% | G | 92.0% |
| CB_B9 | Cancer subsequent treatment 31 days, surgery | 94.7% | G | 94.0% |
| CB_B10 | Cancer subsequent treatment 31 days, drug | 100.0% | G | 96.0% |
| CB_B11 | Cancer subsequent treatment 31 days, radiotherapy | 98.9% | G | 94.0% |
| CB_B12 | Cancer first treatment 62 days, GP referral | 83.2% | G | 85.0% |
| CB_B13 | Cancer first treatment 62 days, screening referral | 100.0% | G | 90.0% |
| CB_B15_01 | Ambulance category A (Red 1) 8 minute response | 76.5% | G | 75.0% |
| CB_B15_02 | Ambulance category A (Red 2) 8 minute response | 73.9% | A | 75.0% |
| CB_B16 | Ambulance category A 19 minute transportation time | 97.8% | G | 95.0% |

### Quarterly Indicators

| CB_B6 | All cancer two week waits | 97.2% | G | 93.0% |
| CB_B7 | Breast symptoms (cancer not initially suspected) | 97.3% | G | 93.0% |
| CB_B9 | Cancer first definitive treatment in 31 days | 98.9% | G | 96.0% |
| CB_B10 | Cancer subsequent treatment 31 days, surgery | 98.3% | G | 94.0% |
| CB_B11 | Cancer subsequent treatment 31 days, drug | 100.0% | G | 96.0% |
| CB_B12 | Cancer first treatment 62 days, GP referral | 82.5% | A | 85.0% |
| CB_B13 | Cancer first treatment 62 days, screening referral | 100.0% | G | 90.0% |
| CB_B19 | Care programme approach follow up in 7 days | 97.1% | G | 95.0% |

**Last Updated:** 17-Dec-2013 09.56

Produced by the South London CSU Business Intelligence Team. For any queries please contact us at slcsu.performance@nhs.net
### Preventing people from dying prematurely

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Quality Premium</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Quarter 1</th>
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<tr>
<td><strong>In Year proxy: NHS Health Checks</strong></td>
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### Enhancing quality of life for people with long term conditions

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<th>Quarter 1</th>
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<tbody>
<tr>
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<td><strong>In Year proxy: patient education programmes/groups (DESIGN2 activity)</strong></td>
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</table>

### Treating and caring for people in a safe environment and protecting them from avoidable harm

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<thead>
<tr>
<th>Indicator</th>
<th>Quality Premium</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<tbody>
<tr>
<td><strong>In Year proxy: Number of people accessing expert patient programmes</strong></td>
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<td><strong>In Year proxy: Medical education programmes (DESIGN2 activity)</strong></td>
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</table>

### CCG Outcomes Indicators

1. **Preventing people from dying prematurely**

   - In Year proxy: NHS Health Checks
   - Under 75 mortality rate from respiratory disease
   - Under 75 mortality rate from liver disease
   - Under 75 mortality rate from cancer

2. **Enhancing quality of life for people with long term conditions**

   - In Year proxy: No of people accessing expert patient programmes
   - In Year proxy: Medical education programmes (DESIGN2 activity)
   - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

3. **Enabling quality of life for people with long term conditions**

   - Proportion of people feeling supported to manage their condition
   - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

4. **Helping people to recover from episodes of ill health or following injury**

   - Emergency admissions for acute conditions that should not usually require hospital admission
   - Emergency readmissions within 30 days of discharge from hospital
   - Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)

5. **Ensuring that people have a positive experience of care**

   - Friends and family test: Are providers meeting 15% response rate?

6. **Reducing the risk of hospital infection**

   - Incidence of healthcare associated infection (HCAI): MRSA
   - Incidence of healthcare associated infection (HCAI): C.difficile

7. **Local Priorities**

   - Reablement: New pathway to support recovery and independence after illness or injury
   - 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
   - Immunisation: Increasing immunisation uptake by 4% on DTaP/IPV/HiB (86.3% at Q3 12/13)
   - MMR (82.8% at Q3 12/13)
   - PCV (89.3% at Q3 12/13)

**Project initiation**

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**Project development**

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References

i  http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm

ii  http://www.bsbv.swlondon.nhs.uk/


v  http://www.local.gov.uk/health/-/journal_content/56/10180/3510973/ARTICLE

vi  http://www.merton.gov.uk/democratic_services/w-agendas/w-scrutinyreports/915a.pdf


viii  PHE Health Needs Assessment Toolkit, Dec 2012 data

ix  http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

x  (Francis, 2013, Winterbourne View 2012, Keogh, 2013, Berwick, 2013)