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Chair’s Introduction

Welcome to the Annual Report and Accounts of NHS Merton Clinical Commissioning Group (CCG) for 2016/17. All NHS organisations are required to publish an annual report and financial accounts at the end of each financial year. This report provides an overview of the CCG’s work between 1 April 2016 and 31 March 2017.

The report is made up of three parts. The first section contains details of our performance for the year with the second section ‘the Accountability Report’ covering details of governance and risk. The third is the financial accounts for the CCG for the financial year.

As a publicly accountable body, the CCG is committed to being transparent with its staff, partners, patients and the public. The CCG held eight governing body meetings in public, a Members’ Annual General Meeting (AGM), a public AGM and a number of Public and Patient Involvement (PPI) events in 2016/17 (including stalls at Mitcham Carnival and Wimbledon Fair) and attended over 40 community and voluntary group meetings as part of our ‘choose wisely’ engagement this spring.

2016/17 has been a challenging year for the CCG and for the NHS as a whole as we have sought to improve patient care and live within our financial means. Regrettably the CCG began 2016/17 in financial recovery and this has meant we have needed to focus considerable attention on turning that situation around. Unfortunately, we face an even greater challenge in 2017-18 both as an individual CCG and as a South West London health system. Merton’s agreed plan with NHS England is for a return to financial balance in 2017/18. It requires the CCG to deliver savings programmes of around £14million, almost double our current year’s saving target of £7.3m.

Across South West London providers and commissioners are facing similar financial and transformational challenges. That is why we took the decision to work together as a South West London health and care system to resolve these issues collectively. The whole of the NHS in South West London is now working together and with local councils to develop a ‘sustainability and transformation plan’ (STP) that sets out how we could transform health and care services, so that local people receive the high quality care they rightfully expect, now and in years to come. The draft plan – called our Five Year Forward Plan and endorsed by all the Boards and Governing Bodies of NHS organisations in SW London – has now been published.
and we are discussing the ideas it contains with our local communities. As part of this initiative, independently-facilitated Health and Care Forums have been held in five of the six local boroughs, with the final event scheduled to be in Merton on 29 June 2017. Further events will be held in the autumn.

In November 2016, the CCG governing bodies agreed to introduce a new operating model in South West London to strengthen collaborative commissioning arrangements and to consolidate leadership and accountability arrangements. This will put us in the best possible position to deliver, at pace, our five year plan. Those new arrangements formally started in April 2017. Sarah Blow is now in post as the South West London Accountable Officer and James Blythe has been appointed as Managing Director for the Merton and Wandsworth Local Delivery Unit (LDU).

2017/18 will see the CCG having to make some very tough choices but it is also a year where I hope we will see an improvement in access to and in increased consistency of high quality GP services for patients across the borough. The CCG is committed to transforming primary care (which includes general practice) and much of our work over the next two years will focus in this area.

One of the strongest features of the CCG is the strength of its primary care membership. GPs and practice staff bring their knowledge and understanding of patient experiences, local services and the health needs of the community to help to shape services in Merton. This expertise is a key enabler to help deliver the CCG’s commissioning plans. Throughout this year the primary care community has worked increasingly collaboratively and cohesively and has both supported the CCG while providing appropriate challenge in the consideration of innovative and significantly different delivery models of health and care.

There are many reasons to be optimistic for the future including the redevelopment of the Wilson Hospital site into a state of the art health and wellbeing centre, increasing integration between different health providers and with social care and public health. We are also pleased to see continual improvements to our mental health services - our talking therapies service is now delivering our best ever results (with 56% of people feeling better), a Recovery Cafe opened in April 2017 and South West London and St George’s Mental Health Trust achieved a CQC inspection rating of ‘Good’ following its inspection in 2016.
Local people are proud of their NHS and they have a passion for the services it provides. In 2017/18 we will continue to collaborate with all our local stakeholders to deliver new and efficient ways of working and stay on course to deliver our five year plan while we protect, and where possible, enhance the quality and safety of services.

Finally I would like to say a very big thank you to Dr Carrie Chill whose term of office comes to an end on 31st March both as one of our Governing Body GPs and as the Clinical Director for Unplanned Care. Carrie has been instrumental in the CCG developing its falls prevention service, the Holistic Assessment Rapid Investigation Service (HARI) and our End of Life Care Strategy and will be greatly missed. I would also like to thank Adam Doyle for his tremendous support as my Chief Officer and Karen Parsons who filled the role on an interim basis after his departure to NHS Brighton and Hove CCG in November and all our staff for their continuing professionalism, dedication and commitment.

Dr Andrew Murray, Chair NHS Merton CCG
Member Practices’ Introduction

Welcome to our 2016/17 Annual Report for Merton Clinical Commissioning Group.

Our CCG is made up of two localities, each of which has a GP clinical lead nominated by their colleagues to sit on Merton CCG’s executive management team.

This year, Dr Karen Worthington became Clinical Director for Primary Care Transformation and has had a very positive influence on the CCG’s overall primary care strategy. In addition, for the first time the CCG recruited two dedicated Locality Partnership Managers and had unprecedented engagement with our membership, including two rounds of clinically-led individual practice visits and the first Protected Learning Time (PLT) education event to be held for all Merton practice staff.

Dr Karen Worthington (East Merton Locality Lead) and Dr Tim Hodgson (West Merton Locality Lead) provide their perspectives on the year and the achievements of the membership:

Membership Engagement

The CCG meets formally with members on a monthly basis, either at the Merton-wide Practice Leads’ Forum and Practice Managers’ Forum, or at East and West locality-based meetings.

Our locality meetings focus on the varied and diverse needs of the local population, and this year included the opportunity for all our GPs to visit Merton’s Dementia Hub; the Holistic Assessment Rapid Investigation (HARI) Service and Merton Enhanced Rapid Intervention Team (MERIT) Service both based at The Nelson Health Centre. Keynote speakers included the new providers of Merton’s IAPT (Improving Access to Psychological Therapy) Service and MSK (Musculoskeletal) Service; Health visiting teams; the CCG’s Macmillan GP; as well as regular slots for Public Health speakers, and our Merton CCG Pharmacy team.

Our bi-monthly Practice Leads Forums continue to enable local clinicians shape local health service changes and CCG’s priorities. The Forums offer the opportunity for members to suggest ideas and offer medical advice.
This year, our GP Federation, Merton Health, has worked with commissioners to develop a number of initiatives which will continue into the new financial year.

**Key Areas of Focus**

- **Practice Variation Scheme** – involving two rounds of 24 dedicated clinically focussed visits exploring reasons for variation in first outpatient referrals and pathology testing across Merton;
- **Delegated Commissioning** – the CCG took on the responsibility of primary care contracts from NHS England from April 2016;
- **Introducing Kinesis** – cloud based system of GP to consultant communication to ensure patients have the best care in the most appropriate setting;
- **Improving awareness** – visiting community based services and encouraging referrals to reduce pressure on our overstretched acute providers;
- **Improving relationships** with stakeholders and other partners such as Public Health;
- **Social Prescribing pilot** – a joint project with Merton CCG, Public Health and Merton Voluntary Services Council (MVSC);
- **Health Help Now App** – members have continued to encourage use of the HHN App across the borough;
- **Improving GP Information Technology and Estates** through take-up of NHS England funding opportunities;
- **Working closely with other CCG partners** in urgent and planned care to improve services for our local population;
- **Access** – national and local research and patient feedback has demonstrated an urgent need to improve people’s access to GP appointments in Merton. We have secured £1m in funding from NHS England to help us do this. This is in addition to Merton’s own increased investment in primary care. We have developed a new Extending Access Local Incentive Scheme for Practices which will support our GP membership to boost the number of appointments available and the hours at which they are offered. In response to requests from patients, practices will be offering some same day slots dedicated for use by children. Some of the funding will deliver an improved skill mix thus providing greater choice of healthcare professionals for patients. The children’s appointments will also include advice during these consultations about appropriate use of services for urgent care, and self-care for parents on behalf of their children. In addition, the CCG is planning two local hubs in the east and west of Merton, covering 100% of Merton’s registered population. As a result appointments will be available within
Merton 8am-8pm, seven days per week. The hubs will provide access to nursing at the weekends for those who need wound care.

The above gives you a flavour of our work for Merton in 2016/17. We’ve achieved a great deal but there is still work to be done with our membership and in our primary care team to improve the health outcomes for all our residents in challenging times.

Dr Tim Hodgson, West Merton Locality Lead
Dr Karen Worthington, East Merton Locality Lead
Sarah Blow, Accountable Officer for Merton from 27 Feb 2017

Sarah is Accountable Officer for the South West London Alliance which is the result of five CCGs in south west London having chosen to work collectively to maximise health outcomes for local populations

25 May 2017
Performance Overview

This section provides an overview of our work and performance, including financial performance during 2016/17. It also includes key partners we work with and includes a short summary of the key issues, challenges - and opportunities - we’ve faced over the year.

About Merton CCG

Merton CCG is a membership organisation which comprises 24 GP practices in 2016/17. We are responsible for planning, buying and monitoring (commissioning) health care services for the people who are registered with a GP, live or work in the borough of Merton. We work through our GP membership and Governing Body.

We work with NHS services such as hospitals, pharmacies and dentists, Merton Council and local community groups to improve health and wellbeing and to make sure local people have access to the healthcare services they need.

In 2016/17 we were responsible for spending £275m on hospital, primary care and community health services for our patients, in a way which ensures that good quality and the most effective services are available to them. All CCGs have a cap on running costs based on per head of population. In 2016/17 this was £4,425k for Merton CCG.

During 2016/17 the CCG was not responsible for commissioning pharmacy, optometry and dentistry services - nor specialist services, such as very complex mental health care or heart surgery. These are commissioned by NHS England.

In 2016/17 we took on delegated responsibility from NHS England for GP services. This means that as a CCG we can influence more effectively the care provided by the GPs in Merton.

To ensure that the services we commission are of a high-quality we advocate:

- **strong clinical leadership** ensuring that local healthcare, meets the needs of our patients
- **value for money** providing high-quality care by ensuring effective and efficient use of resources
• equality treating our staff and patients equitably and ensuring that services address inequality
• partnership and collaboration delivering high-quality services to achieve the best possible outcomes
• honesty and integrity working openly with the public, our patients and all other stakeholders to build a mutual level of trust and understanding, and doing what we say we will do
• openness and transparency being open about what can and cannot be done, and being accountable for the decisions made; and
• Listening and involving listening to what people tell us about their needs and experiences, and involving them in finding solutions.

We have strong clinical input via the work of our two localities, our Practice Leads Forum, Practice Nurse Forum and our Clinical Reference Group (CRG) and Clinical Cabinet. Our developing Patient Engagement Group (PEG) helps us connect and engage with our local communities and groups, providing one of the ways in which patients and the public have more influence over how local health services support them.

Our Constitution (available to download from our website) sets out the way we operate. The Governing Body of Merton CCG ensures that the CCG works effectively, efficiently and economically and follows the CCG’s principles of good governance.

The Governing Body in 2016/2017 comprised:

• Three Merton GPs – one of whom is the Governing Body chair
• An independent nurse
• A hospital doctor
• The Director of Public Health from Merton Council
• Two lay members who are not clinicians – one with an expertise in financial oversight, and the other who brings great experience of the voluntary sector and local community organisations
• Chief Officer; and
• Chief Finance Officer
During 2016/17 the Governing Body also included the Director of Quality, Director of Transformation, Director of Performance and the Director of Commissioning Operations. These positions are, however, without voting rights.

As a comparatively small CCG based on our registered population, we have a streamlined in-house team and buy in some support functions where we can achieve economies of scale from access to a larger pool of expertise and knowledge. We buy in human resources (HR), information technology (IT), governance and information governance, equality and diversity, contract support and communications/patient engagement services from South East Commissioning Support Unit (SECSU). This support complements our in-house capacity and capability, and is under constant review to ensure we receive high-quality services and best value for money.

**Merton CCG Corporate Objectives 2016/17**

Merton agreed seven key corporate objectives for 2016/17

1. Optimise planning and delivery by effectively informing, engaging and consulting with member practices, local partners and the public.
2. Meet constitutional and statutory standards and quality and performance outcomes while recognising the requirements of the CCG financial strategy.
3. Develop and agree with all stakeholders a Merton integrated model of care (e.g. alliance, joint structures) across health and social care, to include self-care, care coordination and care in the right setting, and have in place a robust integrated model of care in the following services by 2017/18: Primary care and Community Services; Primary care and social care
4. Develop a three year financial recovery plan to achieve financial balance, meeting annual financial control targets and quality and performance standards.
5. Support South West London collaborative working for effective short term provider management and support, and long term sustainable services.
6. Develop a service commissioning strategy that fully utilises the capabilities and capacity of all providers including delegated primary care commissioning.
7. Develop a high performing CCG organisation by supporting staff and staff development and maintaining the necessary infrastructure to perform.
Working with others

The CCG believes that GPs, nurses, hospital doctors, pharmacists, other healthcare professionals and patients are the best people to know if a service can really improve care. This means its work is clinically-led, with vital input from local people. The CCG is committed to working collaboratively with a range of partners across the wider health and social care system, including our local authority and voluntary organisations, to develop the Whole Merton vision and strategy. As a membership organisation the CCG worked closely with its 24 GP practices over the year. We have also worked with Merton Health GP Federation.

Chief Pharmacist Sedina Agama gets her flu jab

Merton Health GP Federation

Merton’s primary care strategy developed during 2016/17 included a commitment to continue to work with the local GP Federation to improve services to patients. The Federation have been involved in the development of our strategy. Merton CCG holds regular meetings with them to support their development and during 2016/17 has supported the development of a local Referral Facilitation Centre (RFC). This will help to ensure patients receive the right care, in the right place, at the right time and with the right outcome.
Merton Council

The CCG works with Merton Council as a key strategic partner to develop and put in place the right commissioning and leadership arrangements to support the ‘Whole Merton’ approach. We are jointly placing a greater emphasis on preventing illness and helping people stay independent in older age or with a disability. We share geographical boundaries with our borough council which means we can make a strong impact and improve everyone’s long term health and wellbeing.

i) Public Health

Merton Council takes the lead on commissioning ‘public health’ services and shares information and expertise with the CCG to support us in buying services which improve population health and reduce inequalities. More detailed information about the Council’s public health role can be found here: [http://www.merton.gov.uk/health-social-care/publichealth.htm](http://www.merton.gov.uk/health-social-care/publichealth.htm)

Merton CCG is working closely with public health colleagues to ensure that our jointly published Health and Wellbeing Strategy focuses on support for patients and staff, in line with NICE guidance, to tackle smoking, alcohol over-consumption and obesity.

ii) Merton Health and Wellbeing Board

Health and wellbeing boards (HWBs) are designed to deliver strategic, local leadership. The work of the HWB is central to the commissioning of health and social care services in Merton and encourages joined-up services across the NHS, social care, public health and other local partners. The HWB brings together Merton Council, Merton Clinical Commissioning Group, Healthwatch and the voluntary and community sector with a shared focus on improving health and wellbeing in Merton, tackling health inequalities and concentrating on prevention.

Merton CCG is represented on the Health and Wellbeing Board (HWB) which considers matters relating to the provision of public health services and the commissioning of adult social services and children's services across health and social care and the impact of these on the health and wellbeing of the local population.

The Joint Health and Wellbeing Strategy (JHWS) sets out our approach to improving the health and wellbeing of everyone in Merton and reducing health inequalities between communities. It is available on Merton Council’s [website](http://www.merton.gov.uk).
The CCG’s work to develop a new East Merton model of health and wellbeing and a new health facility in Mitcham (in the east of the borough) is being taken forward jointly with Merton Council and the project is overseen by the Merton Council’s Health and Wellbeing Board, chaired by Cllr Tobin Byers. Community engagement on the initiative took place throughout 2016 and in the summer the Chair of the CCG, the Director of Public Health, Merton Healthwatch and other members of the Health and Wellbeing Board held a series of community conversations with a wide range of local people about their hopes for the services and the chosen site.

The Merton Health and Wellbeing Strategy 2015/18 sets out the way the Health and Wellbeing Board will work in partnership to improve health and reduce inequalities across the borough. All commissioners of health, health care and social care services use this strategy to inform commissioning plans, along with the Joint Strategic Needs Assessment, which defines the health and wellbeing of our residents.
Cllr Tobin Byers, Chair Merton Health and Wellbeing Board:

“As Chair of the Health and Wellbeing Board since May 2016, I have nothing but praise for the CCG's involvement in it. The Chair of the CCG plays a key role in each meeting, dedicating the time to prepare beforehand to ensure we get the most out of it. The Chair and Chief Officer also played an active role in a series of community conversations that took place over the summer, which I thought was really impressive given the other demands on both of their time. A lot of the work we are doing on the board requires close working between the council and CCG, notably social prescribing, childhood obesity and the Wilson development, and I believe we are doing good work on all three as a result of the relationship that has been established.”

iii) Healthier Communities and Older People Overview and Scrutiny Panel

The CCG has also worked with Merton Council's Healthier Communities and Older People Overview and Scrutiny Panel (HOSC) in 2016/17 on our proposals to improve local GP access and create two new GP hubs for the borough. The Chair, Dr Andrew Murray and East Merton locality Lead Dr Karen Worthington addressed the full committee in February 2017 and in March 2017 the Director of Financial Recovery, Andrew Moore and GP Clinical Director for Planned Care Dr Vasa Gnanapragasam attended a HOSC to discuss a number of proposed changes to services and prescriptions in Merton.
Healthy London Partnership

Healthy London Partnership is the collective name for all London CCGs working together to support the delivery of better health across London. Merton CCG, along with every other London CCG and NHS England (London), has made a commitment through Healthy London Partnership to unite and support the transformation of health and care in London. Our partners include the Greater London Authority, Public Health England, London Councils and Health Education England and through the Partnership we are working to deliver changes that are best done ‘once for London’. Collectively we believe it is possible to achieve a healthier, more liveable global city by 2020, by delivering on the ambitions set out in Better Health for London: Next Steps and the national NHS Five Year Forward View.

Highlights this year include:

• A year-long engagement with Londoners on childhood obesity, called the Great Weight Debate, which reached over half a million Londoners on social media, saw 3,900 people fill in our survey, nearly 2,000 people attended roadshows during October half term and culminated in 60 teenagers working through the issues at a Hackathon in January 2017 at City Hall.
• London’s young people helped us design and launch a mobile health website and app called NHS Go that gives them targeted health information plus health advice and signposts to services – approx. 30,000 people are now using NHS Go.

Healthy London Partnership on behalf of London CCGs has also led on the collaboration that saw all 32 CCGs, all 33 borough councils, the Mayor of London, NHS England and Public Health England sign the London Health and Care Collaborative Agreement. Together with the London Devolution Agreement, this paves the way for central government and national bodies to devolve powers and funding to the London system to enable local and London-wide transformation.
Merton’s Health Needs

Merton has a resident population of approximately 211,000 which is set to increase by over 21 per cent by 2021. A significant feature of Merton’s population is the changing age profile, with an increasing and high birth rate alongside an ageing population. The young and the old have more complex health needs.

Merton has developed a falls prevention service, supports a local dementia hub and is a partner in the Dementia Alliance to make Merton Dementia Friendly, an Older People’s Memory Clinic and a Holistic Assessment and Rapid Investigation Service to better support the needs of the older population. The latter has been widened to support a broader age group of people with complex needs and also offers diabetic eye screening.

Overall, Merton’s population is comparatively healthy and life expectancy is higher than the national and London average for both men and women. Life expectancy for men is 80.7 years and for women 84.6 years. However, there are stark differences between different areas of the borough and life expectancy is significantly lower in the most deprived areas in East Merton than the least deprived areas in the west of the borough.
In general, East Merton is younger and poorer, with greater ethnic diversity and relatively lower levels of education and training qualifications than West Merton.

Premature mortality (deaths under 75 years) is very strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts. If East Merton had the same death rate as West Merton, it would see 113 fewer deaths each year – an 18 per cent reduction on its 640 deaths each year. Of the 113 deaths, 81 are under 75 years.

Local communities have become more diverse over the last 10 years; an estimated overall 49 per cent of the population are from Black, Asian and minority ethnic groups and non-British white communities, with emerging new Polish and Tamil communities in the borough. During 2016/17 the CCG has increased its engagement with minority ethnic groups to ensure it understands their experience of healthcare and their health and wellbeing needs.

These changes and differences have significant implications for the planning and delivery of local health and care services. A key focus for Merton in 2016/17 has been the development of the east Merton model of health and wellbeing and a social prescribing pilot to help to address these inequalities.

The JSNA process and commissioning cycle
The main causes of ill health and premature deaths in Merton are cancer and circulatory disease (including coronary heart disease and stroke). Known risk factors (unhealthy diet, smoking, lack of physical activity, and alcohol) account for around 40% of total ill health. Consequently changing patterns of unhealthy behaviour must be an important focus.

The CCG has also worked collaboratively with Merton Council’s Public Health team to support initiatives to tackle childhood obesity encouraged people to make healthier lifestyle choices (check their blood pressure, to stop smoking and to take the ‘One You’ test). The CCG is also actively working with local community groups to improve diabetes awareness and diagnosis and to develop better service user involvement to improve clinical outcomes for patients with diabetes.

Data on Merton’s health needs are taken from the Joint Needs Assessment [http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm](http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm)

**Key Issues and risks in 2016/17**

**Risk Management**

The CCG’s Assurance Framework identifies and prioritises the main risks to delivery and mitigating actions during 2016/17. This has enabled the Executive Management Team to focus on key strategic priorities and risks built up from the various assurance and escalation processes that are in place within the CCG.

The CCG has developed a comprehensive risk management framework which is designed to identify specific risks, responsibilities and mitigating actions at both a strategic and operational level within the organisation. Through various committees and reports, CCG staff can escalate the most important of these to the Executive Management Team and via the Corporate Risk Register to the Governing Body.

The key risks that we have been focussing on during 2016/17 are:

- Financial recovery and ensuring QIPP schemes make savings and improvements
- Turning around the performance of the continuing care service
- The risk to finding high-quality sustainable solutions for healthcare in south west London
- Transforming primary care
- Significant performance risks from St George’s NHS Foundation Trust
The South West London health economy and Five Year Forward Plan

This year, we have worked hard to build closer working relationships with our partner south west London CCGs through commissioning services together through the South West London Collaborative Commissioning (SWLCC), now known as SWL NHS. In particular we have put in place arrangements for shared committees and senior management to achieve our plans.

Following publication of the NHS Five Year Forward View, each NHS region in England was required to publish a Sustainability and Transformation Plan (STP) for the next five years. These plans are intended to meet the clinical, staffing and financial challenges facing the NHS by coming up with a long term plan to ensure that services are safe, high quality and sustainable. Our STP – the South West London Five Year Forward Plan – covers the boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

It is the product of unprecedented collaboration between all parts of the local NHS - hospital consultants, doctors, nurses, therapists, hospitals, mental health trusts, pharmacists and commissioners – working with our colleagues in local councils. There are a number of challenges the NHS needs to address, including increased demand for health services due to an ageing population, quality of care, getting the right staff and the state of some of our buildings. The costs of providing our services are rising far more quickly than the money we get from central government each year. While the financial and staffing challenges are significant, there is compelling evidence that if we spend our money differently, we can get services that are both better and more affordable.

What does the STP propose?

The STP is not a detailed blueprint for the next five years. At this stage, it is a draft document containing a number of ideas and proposals, which are at different stages of development. Taken together, we think they will lead to a number of improvements for patients.

These include:

- It will be easier to see a GP. We are investing in primary care services. We want to make more appointments available between 8am and 8pm and to free up GP time by making better use of other clinicians such as nurses and pharmacists. Our GPs are already working together in local federations and will be able to play a bigger role in coordinating their patients’ care.
- More care will be available in your community. We are setting up ‘locality teams’ in each area to work together in supporting patients. These teams will be made up of your local...
GPs, nurses, pharmacists, social care staff, mental health and other health professionals, working closely with local hospitals. They will support people to look after themselves and stay well.

- It will be easier to get treatment in your local health centre, at a local clinic or at home, as we will be putting more resources into your local communities. You will get better advice and support from NHS and social care staff to look after yourself and your loved ones. We will be launching an improved 111 telephone helpline to provide medical advice and guide you to the right local service. We will make more use of smartphone apps, Skype calls and telephone health advice for those who don’t need to visit their GP.

- We will support patients who have long-term conditions like diabetes, dementia, asthma or a heart condition and their carers – helping them to understand and monitor their condition and when and where they should seek help. ‘Care navigators’ will increasingly support you to find your way around the NHS and make sure you only have to provide the same information once. We will run public health campaigns across south west London, helping people to live healthier lives.

- Your mental and physical health will be treated together. We know that mental and physical health are closely linked but are too often treated separately. A key part of our plan is to join up mental and physical health services. People with mental health problems can also expect to be helped sooner, before their condition gets worse and they end up in crisis at A&E or admitted to a mental health hospital when they do not need to be.

- By reducing the need for so many people to go to hospital and developing clinical networks between hospitals and other services, we will be able to deliver high quality hospital care more quickly for those who need it.

- Buildings where health services are delivered will be safer for patients and suitable for 21st century healthcare.

- As a first step, we are asking Local Transformation Boards in each area (Croydon, Sutton, Merton/Wandsworth and Richmond/Kingston) to develop clinical models for their area - how many community hubs we need, what services we can provide in the community and what services each of the hospitals should offer. This will identify those services that cut across the four sub-regions and need to be considered at south west London level. Out of this, we will arrive at a model of care for the region which is based on each area’s needs, rather than trying to come up with a south west London ‘top down’ solution.
There are a number of other ideas and proposals being put forward. You can read our Five Year Forward Plan online at http://www.swlccgs.nhs.uk/our-plan/our-plan-for-south-west-london/

**How to get involved**

It is important to remember that this is a draft plan, with emerging ideas at different stages of development. We would welcome your comments and queries and we will ensure these are taken into account as our plans develop. We have been talking to people in Merton and across south west London for several years, and will continue to do so as our plans develop.

During 2016/17, we worked with local Healthwatch teams in each borough to speak to 88 grassroots community groups, so we could discuss the issues with people the NHS does not always succeed in talking to about its services. This included people with physical and learning, disabilities, children and young people, older people, black and minority ethnic communities, mental health service users, LGBT communities, faith groups, homeless people, carers, Gypsy, Roma and Travellers, asylum seekers and several others. In Merton over a dozen such events took place allowing us to hear the views of local people from across the borough. We have also arranged a public forum in each of the six south west London boroughs and we will look to repeat these in future.

**Capacity and Resilience**

The CCG has undergone a period of significant senior staff change during 2016/17 and enters 2017/18 in transition to a new local delivery unit (LDU) with Wandsworth CCG. The CCG has sought to ensure that full use is made of corporate briefings and record management systems to mitigate the risk of knowledge loss.

Wherever possible, handover periods and careful prioritisation of work has also been used to mitigate the risks during periods of staff transition. The use of interim staff has helped ensure progress is made in key projects and the move to the new LDU will further support the CCG’s resilience and will increase its capacity to deliver at pace.
Commissioning Highlights of the Year

Children’s Services

The CCG continues to engage and work collaboratively with local and sector-wide providers of children’s services. There are a range of valuable multi-agency meetings and partnership boards which support improved integration and the development of care pathways and service models.

The CCG has valued opportunities to hear the voices of children, young people and families. One example is the ‘Healthfest’ event which took place on 15th November; this was a day of health related activities planned and facilitated by young Healthwatch Merton volunteers and members of Merton Youth Parliament. The CCG’s Clinical Chair met young people to hear their views and experiences.

The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all safeguarding concerns regarding children and young people in Merton. This year progress has been made in terms of improved integration between MASH and local services to ensure that pathways are as efficient and seamless as possible.

At the ‘One Merton’ Meeting in November 2016, the CCG agreed to a trial period of operating an integrated Children and Young People’s commissioning team made up of council and CCG commissioners to be hosted by the council under the Director of Public Health.

Merging the functions will:

- Allow a joint approach to planning and commissioning to reduce silo working and duplication
- Ensure safeguarding principles and practices are inbuilt in every piece of commissioning
- Maximise the quality of services for children and their families and focussing on joint outcomes
- Enable clearer and integrated processes for engaging with children and families to inform commissioning
- Create opportunities to join and combine approaches to prevention
- Promote added and best value for money and ensuring best use of available resources
• Provide clear lines of accountability and links to the Joint Strategic Needs Assessment (JSNA) and other in depth needs assessments to inform commissioning decisions
• Act in line with the Government’s focus on better health outcomes for children.

To date the CCG and council have worked collaboratively to commission new community children’s services, develop an education, health and care assessment function in the SENDIS team and formulate a CAMHS transformation plan. The intention is that the integrated children’s commissioning team will further develop this partnership working.

WISH
The CCG also provides a small grant to the WISH Centre (WISH). WISH Merton supports young people ages 12-18 years who self-harm or who have experienced sexual violence, exploitation and abuse. They provide medium to longer term open ended therapy for young people through their Safe 2 Speak counselling service, and can see young people in schools in Merton or at their centre in Morden.

Right Care Best Setting (RCBS)
Right Care Best Setting represents the unplanned care part of the South West London Sustainability and Transformation Plans (STP) and has five priority areas:

• Integrated locality teams
• Intermediate care and crisis response
• Ambulatory Emergency Care
• Final year-of-life care planning
• Maximising care homes schemes – including learning from the Sutton Vanguard

In Merton this work is being taken forward with Wandsworth CCG and will continue under the LDU. The aim is to bring together existing community services to provide comprehensive integrated care and support to transform, streamline and modernise the way care is provided in Merton. It focuses on ensuring that patients can access services to prevent a hospital
admission or attendance, coordination of care across agencies to stop duplication and improve communication.

Merton CCG has set up a group with representation from primary care, social care, voluntary sector and community service to take this work forward. The teams will build on existing community based health and social care services to bring together “locality teams” to work together to respond to population needs.

There will be a particular focus on support for adults with complex health and social care needs, including those with long term conditions. The aim is to proactively support this group of people to maintain their independence in their own homes for as long as possible, without the need for hospital visits.

Proactive Support for Complex Patients
In June 2016, Merton CCG commissioned Merton Health (the local GP Federation) to lead a multi-agency pilot to support people with complex health and social care support needs using an e Frailty Index to identify patients having moderate or severe frailty. This was piloted in four practices, using case managers and care navigators recruited by Community London Community Health (CLCH).

The pilot aims were to:
- Identify across Merton the number of people in each practice identified as having mild, moderate or severe frailty;
- Scope what resources are required to support people with complex health and social care needs;
- Test the usability of the tool and generate learning from the multi-agency pilot that would help determine the most effective way to roll out the service across Merton.

The pilot has concluded and a report has been prepared. The CCG is now evaluating the findings and identifying next steps to ensure this vulnerable group receives the best support possible.

New Out of Hours and 111 Provider
In the autumn the CCG, along with other SW London CCGs, mobilised a new provider for its 111 and ‘out of hours’ service. There was patient representation from Merton during the
development of the specification and throughout the tender process to help to ensure that patients’ voices guided service development and choices. Merton’s Patient Engagement Group inputted into service requirements.

111 call handler helps to deliver Mitcham baby safely over the phone

A 111 call handler successfully helped deliver a Mitcham couple’s baby girl over the phone after receiving a call from a woman in labour. Simon Williams, who is based in the Vocare 111 call centre, received the call from Mrs Shafin Jahan after she went into labour with her second child.

Mr Williams immediately called an ambulance and with the help of a 111 nurse who was on hand to assist if needed, he guided Ms Jahan and her partner Mr Hameed Siddiqui through the successful delivery of their baby over the phone. The ambulance arrived soon after and found, mother and baby cuddled up and doing well.

Following the birth, 111 call handler Mr Williams met the couple and the baby girl he helped bring into the world. He said: “Ms Jahan phoned us for help and while we requested an ambulance we quickly realised there was no time to wait as the woman was already in advanced stages of labour. My training and experience meant that I knew exactly what to do and felt confident advising Ms Jahan. It is my job to help people with medical problems all day, every day, and some of them have much more complex needs but for some reason, this call felt particularly special. I felt a real sense of pride after the call.”

Ms Jahan said: “Simon clearly guided us through the whole process and had a really calming influence that made me feel safe and happy the whole way through. We are so grateful for all his help and meeting him has meant that we have been able to thank him in person. We are delighted.”

Photo courtesy of the Hexham Courant

Falls prevention

A Merton Falls Prevention Steering Group with multi-professional and multi-organisational representation continued to meet in 2016/17 to drive forward our Falls Prevention Strategy and Action Plan for 2015-2018. This group is coordinated by Public Health at the London Borough of Merton.
The London Ambulance Service continues to refer directly to the Community Falls Prevention Service. On average, the falls prevention service receives 20 referrals per month. This enables people who do not need hospital admission to remain independent in the community.

Screening has taken place to improve the identification of patients who are at risk of falls to get the best treatment and support.

In 2016/17, Merton was awarded funds to work with the Fire service to develop the ‘*Fire well and Safe*’ project which brings together Merton Council, the CCG, the voluntary sector and emergency services to identify people at risk of falls. The Fire and Rescue Service has a long and successful history of prevention and early intervention as it goes into people’s homes at times when a health or social care need may not have been identified. By working in partnership with other organisations, their expertise, experience and resources can contribute to the wider health and wellbeing agenda. The *Fire Well and Safe* funding will allow two staff to help people stay safe and well in their homes and in their neighbourhoods by identifying people and families who are at risk of accident or ill health. This is an exciting project which will develop further during 2017/18.

**Enhanced Musculoskeletal and Physiotherapy Service**

In April 2016 a new community services contract was introduced which built on the patient pathway drawn up in 2015 for musculoskeletal and physiotherapy services. This contract includes a ‘fast triage’ service for all patients with an MSK-related condition providing an early assessment and management plan. Since this service was started there has been a reduction in patients using hospital based MSK related services. A new self-referral service will launch on 1 April 2017.

**Patients comment on the new Musculoskeletal and Physiotherapy Service:**

“The post knee replacement service received was excellent. Appointments ran on time, professional physiotherapy team and the Nelson Centre a very pleasant centre to visit. Good parking. I have two replacement knees that have good range of movement and 12 weeks after 2nd knee op I am pain free. Nothing but praise for the service.”

“Friendly, professional and helpful. Really helped me with my back problems. I was feeling so low being in constant pain. The physiotherapist reassured me and helped a lot.”
Dementia
A dementia diagnosis rate in excess of 70% has been sustained during 2016/17. In March 2017 the diagnosis rate was 71.1%

A dedicated Memory Assessment Service with a new approach was introduced by South West London St George’s Mental Health NHS Trust in April 2016. Benefits of the new model include shorter waiting times, joint care planning and a greater focus on supporting people to live well and independently.

The Community Dementia Service (introduced in 2015/16) is continuing to evolve. Nurses have a vital role in the care planning, delivery and coordination for individuals with dementia and adopt a holistic approach to ensure their physical and mental health needs are met.

The CCG continues to support and promote the local Dementia Hub in Mitcham and works with Merton Council and local voluntary groups to help make Merton more dementia aware and dementia friendly.

End of Life Care
The Sutton and Merton End of Life Care Network met throughout 2016/17 to help provide oversight of new service developments. The Network brings together representatives from local providers of end of life care services (including hospices, hospitals and community services) and commissioners to explore issues which span organisational boundaries in order for solutions to be collectively established and taken forward. Patients are represented at this forum to ensure their voices guide service developments and changes.

Progress has been made in terms of the delivery of the Merton CCG End of Life Care Strategy 2014 – 2019. Various important developments within the Implementation Plan 2014-2017, structured around the NICE (2011) Quality Standard for End of Life Care, have been achieved. This plan now needs to be refreshed and updated, to look at development and actions.

This also ties in with the work of the STP around End of Life care and is a priority area for work in 2017/18.
Mental health

Mental Health Urgent Care

i. The Lotus Suite was opened at the Springfield Hospital site in November 2016. This new service has introduced a new way of working with south west London residents experiencing a mental health crisis. Where people experiencing a mental health crisis present at south west London Accident and Emergency Departments (A&E), or are identified by the police and other emergency services, the Lotus Suite can offer a more appropriate setting than A&E for (longer) assessments that might be appropriate to people in mental health crisis. There is an agreed plan to reduce the bed stock in south west London, from the extraordinarily high levels seen in 2015/2016, and in line with the ambition for improved mental health services set out in the Five Year Forward View for Mental Health.

ii. Two new Crisis Cafés (in Wimbledon Chase and Tooting) were commissioned to support people with mental health crises. Both were opened in early April 2017, with the intention of increasing the choice of support available to people experiencing mental health crises. In other areas, Crisis Cafés have reduced psychiatric hospital admissions, and the number of patients detained under the Mental Health Act (1983). South West London commissioners expect these pilot services will bring similar benefits to this area.

iii. Psychiatric Liaison Services - The Five Year Forward View for Mental Health has set standards for improvements to psychiatric liaison services in England. Psychiatric liaison services provide critical frontline support to patients in crisis who attend the A&E departments, and to patients in acute hospitals who may also have mental health problems. South west London commissioners are poised to meet the new standards for psychiatric liaison services ahead of the time scales set by the Five Year Forward View for Mental Health / NHS England. Merton CCG, alongside Wandsworth CCG, has provided new investment for the Psychiatric Liaison team that operates at SW London St George’s Hospital in Tooting. The new money will raise the service’s standard to the new Core 24 Service Standard. The team will be able to provide a 24 hour per day, seven days per week, service to working age, and older adult patients who present in A&E, or who are in beds at St George’s Hospital. All patients who need the service will be seen more quickly, and acute staff will benefit from new training and the advice that can be made available to them / provided by the increased mental health expertise in the hospital. Commissioners expect to see that the time people with mental health
problems spend in beds, while in St George’s Hospital receiving treatment for physical health problems, is reduced as a result.

iv. The Merton Psychiatric Street Service became operational in late June 2016. The graph (below) shows a downward trend in the number of people detained under Section 136 of the Mental Health Act (1983) over four financial years in part due to the introduction of a sector wide Street Triage service.

IAPT (Improving access to psychological therapies)

Our new talking therapies service was designed in conjunction with service users and 2016/17 was its first full year of operation. Despite some early recruitment challenges they have achieved two of the three targets and delivered the best performance Merton has ever had in this area. It is no surprise therefore, that patient satisfaction for the service is at around 96% and recovery rates are now at a high level reaching 56%. In 2016/17 Merton CCG achieved 9.03% against the IAPT access rate. There is still work to be done to ensure that more people who would benefit from the service access the services on offer and to ensure the CCG achieves all three targets in 2017/18. As part of that the CCG will be working with the provider to help promote the service to boost the number of people benefitting from the service.
In September a new online therapy website was added to the options available.

This online option enables people in Merton to register for help and support with a range of mental health issues including anxiety, depression and stress. The new website, in partnership with SilverCloud, allows users to access a wide range of packages to help them improve their mental health at their own pace and at any time and location that is convenient. A practitioner provides continuous support and checks-in regularly with clients to make sure they are benefiting from the online therapy.

Patient Story:

Clare, 50, came to Thinkaction miapt Merton after finding out about the service from a local group she had started to attend, Focus for One.

“I was definitely having a breakdown. I had lost my job, and the job centre was giving me nothing but hassle, which really made me anxious and stressed. Then I was also losing my home, which really pushed me into a depression. It climaxed and became too much.”

Clare wasn’t sure where to turn to and before she saw a leaflet advertising the service, she had no idea what sort of help was available to her. Clare self-referred to miapt, thinking she might be suffering from depression.

“I thought it was leading to depression. I had it before. I noticed the symptoms this time round but I didn’t know what to do. When you’re in that kind of depression your mind is not your own. Logically, you’d be thinking differently. But when you’re in that state, nothing really makes sense.”

Clare spoke to Hannah at miapt for a number of talking therapy sessions on the phone.

“The first thing I noticed,” Clare says, “was Hannah’s voice. I found that she was talking to me in a relaxed way, which enabled me to come forward with more things and talk.”

Through their sessions on the phone, Hannah and Clare found a common ground talking about photography. This was something Clare had wanted to do a long time ago but had never had the opportunity to pursue. Hannah discussed with Clare that a balance of activities can help reduce depression.
After the third or fourth session, Clare realised that she wanted to take up photography again. She joined a photography club and finds photography, ‘relaxing, almost meditative.’ “It was something I would always like to do but I’ve never had time to do it. From that, I’m really eager to go forward even now. And it is something that does get me outside on a down day. Before Hannah and I mentioned it, on the really bad days I couldn’t see the point of even stepping out the door, let alone taking pictures.”

Hannah also helped Clare focus on small achievements, like housework to help her get through the day if she couldn’t leave the house. This is a Cognitive Behavioural Therapy tool known as Behavioural Activation. Over time a person gradually builds up their activity levels to regain motivation and increase energy levels which are often affected when someone is suffering from depression.

“Your mind and your body are two separate things,” said Clare, “and usually they work together and they act together. But when you’re in that depressive place, your head is telling you ‘you must do this’ but your body is saying, ‘I just haven’t got the energy for this, I don’t want to know’. So you’re working against yourself, not in harmony. The photography came after talking a couple of times. The first few times I would say 'I've done a little housework today' which I wouldn't think was very much but Hannah said that this is an achievement on its own (at that point in time). It was important to hear this; it encouraged me to do a little bit more in the house, when I couldn't get out the house. So even on the really bad days when I couldn't get out the front door, the day still had purpose and a small achievement.”

After working together to find ways she could cope, Clare also found the Five Minute Rule (a tool to help you start tasks) very useful. “The five minute rule became very handy - that really helped me to get calmer in my thoughts and move forward. It was a very useful technique for me. I still use it today. I noticed the change of wanting to do more, having a desire just to do more things, whether that's in the house or otherwise, about two sessions from the end. Maybe after the fourth session my mind just altered itself, it began to want to do things, anything!”

Although she was nervous about the sessions ending, Clare felt she had developed enough tools and self-care techniques to tackle her illness on her own. “I'm one of those people, before this happened to me, who wouldn't even ask my friends for help. People say 'you should speak to people' and you just don't hear it. When you're strongly independent and you've been that way for a long time, it isn't as simple as 'go and talk to a friend' there's a barrier you have to get past.

“Now I'm doing ok. I'm going ahead with the photography. It's almost like a therapy. It's a different head space. But without Hannah digging in and finding out what I wanted to do, which I couldn't see myself, I don't know where I would be.”

Planned care

Planned care is a commissioning priority for the CCG, especially in the context of our recovery plan for the national targets around Referral to Treatment and the 18 week target. During 2016/17 we have worked closely with our CCG partners and alongside our provider NHS hospital trusts to identify future service improvements. Seven specialty areas have been agreed as priorities for review. They include: dermatology, ENT, diabetes, musculoskeletal, neurology, diagnostics and multi-morbidity services.
Alongside this we have been working with our GP Practices to understand and standardise existing areas of variation, improve education and training. We are also reviewing all potential innovations, including technology, how we flexibly use our existing workforce, and sharing of our estate for one-stop-shop/hub service delivery.

**Nelson Health Centre**

The [Nelson Health Centre](#) has gone from strength to strength during 2016/17 and now offers a wide range of diagnostic, outpatient, community health and community mental health services for Merton residents. The building also hosts a GP practice and community pharmacy. The long anticipated café opened its doors in early 2017 and has already proved a popular addition to the building. The West Merton GP Access Hub is due to begin operating from the site in May 2017 complementing the East Merton GP Access Hub which opened on 1 April 2017.

Lord Walpole, President of the Nelson Society, formally dedicated the Nelson Health Centre in May 2016. The ceremony included the unveiling of a plaque to commemorate the official opening of the centre in April last year, which is named in honour of the naval hero Lord Nelson. Lord Walpole was joined by local Wimbledon MP Stephen Hammond, who spoke of the benefits the award-winning centre is bringing to Merton residents.

**Speaking at the dedication ceremony** Community Health Partnerships’ Chief Executive Dr Sue O’Connell said:

“We are delighted that the Centre is fulfilling its important role in bringing integrated primary care to the community.”
Cancer
In 2016/17 the CCG has been working to deliver the Cancer Action Plan developed in collaboration with Public Health Merton. The CCG is also joining with neighbouring CCGs and our local acute hospitals to improve the prostate cancer care pathway. Together with providers the CCG is working to support early diagnosis and ensure accuracy of data to ensure delivery of the national cancer targets.

A pilot project was introduced in primary care to increase bowel cancer screening uptake, called the ACE (Accelerated, Coordinated and Evaluated) Programme. This was funded by NHS England and an evaluation is now being carried out to inform our cancer strategy in 2017/18. The CCG supported bowel cancer awareness month in 2016 and will again in 2017.

Throughout the year the Macmillan GP has been visiting GP practices in Merton to ensure and promote recent revisions to NICE cancer guidelines to support early detection. The CCG organised a Cancer education event for GPs, featuring informative presentations from a number of hospital specialists; which was well received and a similar event is planned for 2017/18.

Continuing Healthcare
The CCG’s CHC provider was transferred to Central London Community Healthcare NHS Trust (CLCH) in July 2016. The CCG was aware that the service needed reviewing and significant improvements made to ensure it followed national best practice going forward. The CCG has invested considerable time and resources into improving both the decision-making and the speed of decision making in the service ensuring it is fit for purpose.

As part of that work Merton CCG and Merton Council developed a new, patient-centred service to ensure equitable access for everyone. Development of the continuing healthcare (CHC) operational policy (which covers the CCG’s obligations to provide care for people who meet the criteria for NHS continuing healthcare) was an important piece of work for the CCG in 2016/17. This policy covers both those with a ‘primary health need’ and those who are referred nearing the end of their life with a Fast Track application.

There is no pre-set criteria for receiving CHC funding. Eligibility is the professional opinion of the Multi-disciplinary Team (MDT). It is based on the gathering of health and social information
which the MDT, through the use of a Decision Support Tool, can identify if the patient has a ‘primary health need’. Right of appeal is covered within the policy.

Following the launch of the Operational Policy 21% of fast tracks have been returned to the referrer due to incorrect completion. With this scrutiny the proportion of CHC referrals coming through the fast track has decreased from 65% (July 16) to 35% (December ‘16) which is in line with the wider London position.

Appointments to senior posts within the team have been made and the team is currently experiencing a period of stability to ensure progress is maintained. The backlog of reviews carried over from the previous provider has also now been completed.

Transforming Primary Care
Along with many other CCGs in South West London, in April 2016 Merton CCG took over delegated commissioning of GP contracts from NHS England. A significant amount of work has been undertaken jointly with our NHS England since April, along with the establishing a new Primary Care Commissioning Committee and Operations Group, to implement the new successful way of working. Primary Care Commissioning Committee meetings are held in public and details given on the CCG’s website.

Developing a GP Forward View
During 2016/17 the CCG has been working closely with other SWL colleagues to respond to the GP Five Year Forward View. Merton CCG GP Forward View plan was submitted to NHSE in December 2016. Management and clinical leads have been assigned to the eight work streams within the plan. Where possible the delivery schemes will align to Wandsworth CCG and SWL Sustainability and Transformation Plans (STP). There is on-going engagement to communicate the key points of the plan to the GP membership.

Primary Care Strategy
The Merton CCG Primary Care Strategy was approved by the Governing Body in July 2016 and includes plans for:

- Improving GP access;
- Estates and Information Technology development;
- Workforce development;
• Practice Variation – Reducing variation in quality;
• Development of Social Prescribing;
• Supporting the development of a Merton Health (local GP Federation) and multi-speciality community provider (MCP);
• Development of a locality structure.

**Improved GP access**

Currently our GP practices work in two well established localities (east and west) and during 2016/17 the CCG developed a plan to offer seven day access to primary care across Merton in 2017/18 and up to 50,000 more GP appointments. Merton GP practices already offer more than 1 million consultations per year. Despite this the need to further improve access to primary care has been requested by patients and also identified as a priority by our member practices.

Our access initiatives will be resourced via national NHS GP Forward View funding, bringing £1 million of extra funding into Merton for the provision of this service over the next two years. The plan, developed by the CCG working with local practices, the Federation and based on feedback from Merton residents over the past two years has three components:

i. **Extended Access**
   This will boost capacity both during core surgery hours from 8am to 6.30pm Monday to Friday and also during extended hours which is before 8am Monday to Friday, 6.30pm to 8pm Monday to Friday, and on Saturday mornings in some practices. In response to requests from patients we will be providing more dedicated children’s slots and also including some advice during these consultations about appropriate use of services for urgent care, and self-care for parents on behalf of their children.

ii. **Two Primary Care Hubs**
   There will be one hub in the east of the borough and one in the west. The hubs will offer extended access Monday to Friday until 5pm - 9pm and on Saturdays 8am-8pm, with the one in the east also open Sundays 8am -8pm and also bank holidays. Initially the hubs will offer same day access only with plans to offer both same day and routine care from October 2017. The hubs will also provide access to nursing at the weekends from April 1st, for those who need wound care.
iii. **A Quality Improvement Scheme**
This will be developed with our GP practices in 2017/18 and will focus on the quality aspects of access.
Good patient experience is not just about capacity which is why our scheme will include a focus on the needs of carers, telephony improvements, training receptionists to better meet the needs of the homeless, including identifying the hidden homeless, and the primary care needs of frequent attendees to our local emergency departments.

**Estates**
The CCG continues to support practices to improve services and premises in line with our primary care strategy. Alongside three successful 2016/17 Estates and Technology Transformation Fund applications, a number of practices were also successful in their London Improvement Grant applications. Successful schemes range from upgrading internal doors to a new loft extension.

**New models for primary care – Federation and MCPs**
The CCG and appointed clinical lead worked closely with the newly formed GP Federation, *Merton Health*, in 2016/17 and will continue this positive work in 2017/18. The Federation has delivered a Frailty Index Scheme for the CCG and are working to deliver a Referral Facilitation Centre (RFC) pilot to launch in May 2017.

**GP Referral Support – Pathway Redesign**
Throughout 2016/17, the CCG has worked to refine and develop a DXS system (previously the Outpatient Navigation Programme). The system allows for locally developed pathways, local and national guidance, patient leaflets and referral forms to be uploaded centrally onto a system that integrates directly with general practice clinical systems, thereby providing general practice with a robust library of content to aid clinical decisions about the best course of action for a patient. It also contains Merton’s complete Directory of Services which provides GPs with visibility of all local services both within and outside of an acute hospital setting.

**GP Online Services**
‘GP Online Services’ is an NHS England programme designed to offer patients the ability to access parts of their patient record, to book GP appointments and order repeat
prescriptions. During 2016/17 we supported all practices which have this capability to put it into operation and have worked with practices to ensure as many appointments as possible are made available for online booking.

South West London CCGs ran a joint ‘Patient Online ‘project to support greater usage. Over a nine month period the results were as follows:

- Patients registered for online services – 50 per cent increase in October 2015 baseline figure
- Appointments available online - Recommended minimum 70 per cent of routine pre-bookable appointments or 40 per cent overall appointments
- Online appointment transactions (booking and cancelling appointments) - 50 per cent increase in October 2015 baseline figures
- Online repeat prescription requests - 50 per cent increase in October 2015 baseline figures

Better use of technology

1. Consistent Referrals Processes

The CCG is in the process of introducing a new programme that monitors, and controls the flow of referrals to our local acute providers, reduces inappropriate
referral to secondary care and provides a quality and education component for our GPs. It also allows GPs to help their patients make more informed choices about possible treatments and where they may wish to be seen. The programme will ensure all our patients, whichever practice they use, will have access to the most appropriate service to meet their clinical need. The system will help ensure a more consistent approach is taken across Merton for all GP referrals. The programme does not include the cancer two week wait or other urgent referrals. The CCG will pilot the programme with four GP practices in April 2017. If successful, full roll out across all our GP Practices will begin in May 2017.

2. ‘Kinesis’
Working with our neighbouring CCGs we have commissioned and implemented ‘Kinesis’ within our GP Practices. Kinesis is widely available at two of our local Acute Trusts (St. George’s and Epsom & St. Helier) which serve the majority of our patients. Kinesis directly links our GPs to local hospital specialists for rapid access to expert clinical advice to reduce unnecessary referrals meaning patients make fewer unnecessary trips to the hospital.

Social Prescribing Pilot
Social Prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with non-medical referral options that can operate alongside existing treatments to improve health and well-being.

Merton Health and Wellbeing Board gave approval for a one year pilot to develop and evaluate a service model for social prescribing in Merton. The aim is to improve the health and wellbeing of patients by providing access to non-medical support that increases self-help, self-management, social engagement and healthy behaviours and prevents ill health. The Clinical Commissioning Group (CCG) and Merton Council’s Public Health are now working with local voluntary and community groups to provide this pilot service in the east of the borough.

The Project Coordinator started in January 2017 and is based in two health centres in Mitcham (Tamworth House and Wide Way) in order to develop and establish strong working relationships with the GPs. The Social Prescribing Steering Group has membership from public health, Merton CCG primary care commissioning and lay
representation, general practice, MVSC, Health Watch and SW London Health Innovation Network (HIN).

The funding of the pilot is £80,000 (Merton Partnership Grant (LBM) (£50k), Public Health (£10k) and CCG (£20k). In addition a £25,000 evaluation budget has been provided by the South London Health Innovation Network.

The overall aim of the pilot is to develop and evaluate a service model for social prescribing in Merton that:

- Improves the health and wellbeing of residents through access to non-medical support that addresses their needs and promotes self-help, social engagement and resilience;
- Reduces avoidable attendances in general practice and A&E attendances;
- Establishes an effective collaborative pathway between primary care and other statutory services and voluntary and community organisations;
- Establishes a locality care network to support the learning from the pilot evaluation, related initiatives and wider service transformation;
- Demonstrates how statutory and voluntary organisations can establish sustainable service models within financial constraints, including use of social investment funding.

Evaluation of the pilot will feed into the development of future models of care for the East Merton population and information is being collected on the patient journey, referrals and A&E attendances. Depending on outcomes there are plans to extend the project out to other East Merton practices.

A database of local community resources is also being built as part of the project. There is also a care navigator as part of the Holistic and Rapid Investigation (HARI) service for patients with complex needs on the Nelson site, directing patients and carers to relevant local voluntary sector organisations.

The Social Prescribing scheme is expected to feature strongly within the East Merton Model of Health and Wellbeing which will harness the local community resources on the community campus part of the site.
East Merton Model of Health and Wellbeing: Wilson Hospital Redevelopment

A Clinical Director and Senior Responsible Officer have been appointed to oversee the project and the project board have also interviewed and recruited a dedicated project manager.

The Community Health Partnerships Investment Committee has approved the scheme to be constructed as a new project to South London Health Partnership (LIFTCo) on the Wilson Hospital site. The affordability analysis has also been completed. The next steps will be to appoint the building design team and technical experts and to commence the initial site feasibility prior to starting the design development of the new facility.

The first phase of community conversations has been completed and information is being gathered to see what can be learned and built on.

A more detailed steering group has now being set up and a workshop was held at the beginning of March 2017 to discuss the development of the health service model.

Plans for 2017/18 include further community conversations and increased local participation in discussions around both the look and feel for the new facility as well as the services offered. With Merton Council the CCG will co-host a tent at Mitcham Carnival (in East Merton) in June 2017 to share the latest news on the project and to seek local input and feedback on the plans as they stand.

Primary Care - Practice Variation QIPP Scheme – Phase 1&2
Phase 1 - Analysis conducted by the CCG and reported on in 2014/2015 showed that Merton CCG had the eighth-highest rate in London, and the second highest in South West London
(Better Care Better Value analysis) with a high number of first outpatient referrals adding to key pressures. Eight top specialities were identified with a focus on managing variation in referral activity and identifying and sharing best practice.

The scheme began in Oct/Nov 2015 and was further developed by Merton CCG’s East and West Locality Leads and Partnership Managers who visited individual practices throughout May/June 2016 to explore the reasons for referrals with completion of a clinical audit and peer to peer discussion. Analysis of first and follow-up GP referred outpatient activity; on a month-by-month comparison from 2014/2015 to 2015/2016 has showed a consistent reduction in activity and outpatient acute costs in the months subsequent to the completion of the visits. This is a change in the usual trend of expected activity shown here:

![Number of new OPAs in Target 8 Specialities - position to date](image)

Phase 2 – This scheme is still operational with a focus on variation in Pathology testing activity in Merton; and access to same day GP services to further improve patient experience in line with the GP Forward View.

A number of important enablers have been identified as a result of the practice variation visit QIPP scheme such as: education and training opportunities for clinical and non-clinical staff;
wider awareness of alternative services available to patients, and improved engagement between the CCG and its membership.

Performance Summary

The CCG has had significant staff turnover during 2016/17 at all levels but has worked hard to deliver service improvement and the constitutional standards. Alongside this the CCG has ensured it achieved its agreed financial control total for the year and delivered its ambitious QIPP savings plan.

In 2016/17 Merton CCG embarked on a significant initiative to engage with primary care and work with providers in a more effective way. The CCG has rolled out a number of programmes aimed at reducing unnecessary and avoidable A&E attendances, including promotion of the free flu vaccination campaign for at risk groups and the award winning ‘NHS Health Help Now’ website and phone app. Commissioners are also working to support discharges for patients who are ready to leave hospital, to free-up beds. Merton CCG is working closely with Merton Council to ensure discharges are both timely and safe. IAPT has delivered two of the three constitutional targets and work is planned by the provider and the CCG for the first part of 17/18 to ensure stronger take-up of the service from key groups of residents.

There is more to be done in relation to cancer. We know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. We have had some good performance over the year but there are still areas for improvement. Poor coding of cancer stage at diagnosis impacts on the ability to assess how well services are performing against this national target. Merton CCG is working with all our providers to improve data.

The CCG has put in place a number of measures to tackle injuries due to falls and there is identifiable good work being done in this area. Nonetheless the CCG has been reported as a national outlier for injuries related to falls. The CCG is currently investigating if the higher reported rate of falls is due to more diligent reporting by our providers, or a real failure of our falls assessment service. This indicator has been selected as a QP (Quality Premium) measure for 2017/18 reporting period in order to prioritise this area. The CCG has engaged with our community provider falls assessment service to review the effectiveness of the service. Additionally the CCG will commission a data audit to benchmark the thresholds for reporting injuries related from falls.
Elective admissions are reducing. Merton CCG feel assured that this is a positive change, in part due to our work to mitigate demand on acute hospitals and we are assured that this variance is due to actual activity rather than data.

We are aware however of a serious issue with St Georges FT Hospital Trust resulting in a significant admitted backlog, and we have observed an increase in inpatient and day-case run-rates which is reassuring that the backlog is being cleared. We also working with St George’s NHS Foundation Trust to ensure that patients are encouraged, if appropriate, to consider options other than St George’s NHS Foundation Trust to ensure timely treatment and to give the Trust the capacity to turnaround its performance.

In 2016/17 Merton CCG has observed an overall downturn in outpatient activity at all three of our main acute providers. While we are conscious that acute data quality is not perfect, we are confident that the vast majority of this variance against plan is real reduction in activity, and that this positive change is in part due to our work with primary care. We are also conscious that the issues declared by St George’s FT Hospital resulting in a backlog of patients waiting to be seen may be driving some of the underperformance against plan in outpatient activity. With Wandsworth CCG we are working closely with the Trust to ensure patient safety and to help the Trust to turn its performance around.

**Finance**

2016/17 continued to be a challenging year for the CCG. The CCG started the year in financial recovery and in a break even position. In year, the CCG over spent by £0.6m but achieved its financial plan as agreed with NHS England.

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs’ 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, the CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2.7m. This additional surplus has been offset against other cost pressures from the current financial year resulting in a reported surplus of £2.1m.
The acute sector, continuing health care and prescribing costs all had significant growth rates predicted and in order to keep spend within plan, the CCG achieved the biggest QIPP requirement in its history.

The CCG’s acute position was dominated by St George’s NHS FT. While there was some over performance in year, a strong performance on QIPP has resulted in this being lower than feared. In addition, we are aware of significant reporting issues with the trust which principally have affected its ability to manage its referral to treat (RTT) pathway. There is growing evidence that this has brought about a back log in treatment which will impact on the CCG’s acute position in future years but especially in 2017/18.

Continuing health care continued to experience significant growth finishing the year 12% higher than 2015/16.

Looking ahead to 2017/18, the CCG has been taken out of financial recovery by NHS England. The CCG has planned to meet an in year break even position but this will require greater still levels of QIPP to be developed and implemented in year.

**Better Care Fund**

The Better Care Fund (BCF) seeks to drive the transformation of local services to ensure that people receive better and more integrated care and support. Merton’s BCF Plan for 2016/17 sought to build on the work already undertaken and strengthen the relationships and collaboration between multiple providers in Merton with a focus on the following key areas:

1. Reducing (growth of) emergency admissions
2. Reducing length of hospital stay
3. Reducing permanent admissions to care homes
4. Improving service user & carer experience

**Better Care Fund ambitions**

The pooled budget to support the delivery of this totalled £12.57m in 2016/17 and was signed off by Merton’s Health and Wellbeing Board and approved by NHS England in July 2016.

During 2016/17, the BCF supported consolidation of a range of services and supported the development of relationships with existing services and the new services being delivered by
the new community services provider, Central London Community Health. This has included an increase in the workforce to support people in their own homes and in particular to support rapid response services in the community to reduce unnecessary emergency admissions to hospital and support referral pathways from hospital seven days per week.

Community health and social care services have been working towards co-location which is expected to be achieved before the end of the financial year, paving the way for greater integration of services within 2017/18.

A case finding pilot project was led by Merton’s GP Federation with partners, including newly appointed case managers and existing health liaison social workers looking at proactive support to those who may have frailty. Plans are being developed to enable this to be rolled out across Merton.

**BCF Performance**

There are challenges to meeting the Health and Wellbeing Board targets for non-elective admissions for 2016/17. Year-end data for 2016/17 is not yet available. However latest data available for Quarter 3 shows performance is 3.7% higher than 2016/17 plans, although the quarterly growth from target has continued to decrease over the three quarters.

![BCF non-elective admissions 2016/17 Actual v Target with 2015/16 Actual & 2014/15 Actual](image)

**BCF performance**

Reablement services provide personal care and help with daily living activities. This is usually in the service user’s home, and they are offered to people with disabilities and those who are frail or recovering from an illness or injury. They are intended to encourage service users to
develop the confidence and skills to carry out these activities themselves and continue to live at home.

The service is on track to exceed our target for the number of people offered reablement. Data for effectiveness of reablement will not be published until later in 2017. We are also on track to meet the target for permanent admissions of older people to residential and nursing care homes. Whilst there are continued challenges with ensuring the most-timely discharges from hospital, Merton are on track to meet the targets set for 2016/17.

Health and Wellbeing Board Metrics

<table>
<thead>
<tr>
<th>Health and Wellbeing Board Metrics</th>
<th>2016/17 target</th>
<th>YTD</th>
<th>RAG Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</td>
<td>&lt;421.7</td>
<td>(Q3) 2016/17 292.7</td>
<td>GREEN</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)</td>
<td>85.7%</td>
<td>Data available November 2017</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of older people (65 and over) who were offered a Reablement or Intermediate care service - (clients Reablement services started per month)</td>
<td>334</td>
<td>(Q2) 259</td>
<td>GREEN</td>
</tr>
<tr>
<td>Rate of delayed transfers of care from hospital per 100,000 population</td>
<td>2799</td>
<td>(Q3) 2056</td>
<td>GREEN</td>
</tr>
<tr>
<td>Social care-related quality of life (User Survey) Enhancing quality of life for people with care and support needs.</td>
<td>18.8</td>
<td>Data available November 2017</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Health and Wellbeing Board Metrics

QIPP

QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver, while making efficiency savings that can be reinvested into the NHS.

The Health and Social Care Act (2012) outlines the Government’s commitment to ensuring that QIPP supports the NHS to make efficiency savings, which are reinvested back into the service
to improve the quality of care. The QIPP programme improves quality and innovation, so that every pound spent brings maximum benefit and quality of care to patients. In order to meet the NHS forecast spend on health care, the service needs to achieve up to £30 billion of efficiency savings by 2025, which will be reinvested back into frontline care for patients.

As part of this programme each NHS organisation is required to deliver QIPP savings year on year to contribute towards this overall savings target.

NHS Merton CCG’s QIPP target for 2016/17 was £7.3million and the CCG’s actual year end savings delivery stood at 99% i.e. £7.258m (a variance of just £38,000).

Delivering transformational change in 2016/17 has been challenging and the need to deliver financial savings required the introduction of several non-recurrent transactional schemes. Nationally and locally there continues to be an even greater challenge going forward to keep the NHS sustainable.

We are also working collaboratively across South West London and are part of the South West London Sustainable Transformation Plan (STP). This will provide a platform for sharing best practice and maximising the opportunities of different organisations working together to benefit patient outcomes.

**Effectiveness of Commissioned Services**

Merton CCG continues to work with the other CCGs in South West London to design and commission effective services which are based on the needs of the population of Merton and south west London as a whole. We are agreed that under the STP we will commission services for the wider population where possible to make sure there is consistency in the services being offered across the patch.

We continue to review commissioned services to ensure we offer an equitable, open and transparent process that realises the benefits for patients, meets their clinical needs and ensures the resources are used in the most efficient manner possible.

As part of this work the six CCGs began to review and develop a number of clinical policies which set thresholds for some treatments and do not fund other treatments except in very limited and exceptional circumstances (e.g. many cosmetic procedures). This included:

- Supporting patients to be more surgery ready and looking at prescriptions for gluten free foods;
multivitamins; and ‘self-care medications’ such as paracetamol.

All CCGs should periodically review the services they commission in light of new evidence, technology change and finances.

Merton CCG’s Governing Body asked for an initial period of public engagement to discuss these savings ideas with local people before making a decision on how to proceed. This work was to assist the CCG formulate its proposals including suggestions for appropriate safeguards and/or exempted groups. The engagement took place in February and March 2017 with over 40 community and voluntary groups reached.

Other future QIPP plans are either directly coming from the STP or very closely aligned with its core principles. For more information on our future plans, please see our Operational Plan which is available on the CCG’s website.

**Merton’s QIPP**

Delivery of Merton’s QIPP plan is managed through a Programme Management Office (PMO). To support this, the CCG introduced a dedicated Director of Financial Recovery in 2016/17 (shared jointly with Richmond CCG, also in financial recovery) and a Head of PMO to work with project leads and stakeholders to develop deliverable plans.

In 2016/17, the CCG developed a robust activity and financial analysis process for our QIPP programme, enabling both detailed planning and strong monitoring processes. Progress on QIPP programme delivery was monitored through the Savings Delivery Group and the Financial Recovery Group.

A member of the CCG Executive oversaw each scheme to ensure milestones were met and any blocks to delivery quickly addressed. Each scheme had a dedicated clinical lead, working with project managers on implementation. All schemes were reviewed at regular intervals with the programme leads and then by exception at the Finance Recovery Group. QIPP delivery is reviewed by the Finance Committee as part of the monthly finance reporting. The CCG now has a rolling QIPP planning process rather than an annual QIPP cycle, with schemes initiated throughout the year.
The financial position of these programmes is outlined in the QIPP table below:

<table>
<thead>
<tr>
<th>QIPP 2016/17</th>
<th>Full Year Plan</th>
<th>Full Year NET QIPP Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gross Annual Plan</td>
<td>Total Investment</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Acute Portfolio</td>
<td>£3,398</td>
<td>£50</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>£1,234</td>
<td>-</td>
</tr>
<tr>
<td>Placements</td>
<td>£381</td>
<td>£262</td>
</tr>
<tr>
<td>Referral Facilitation</td>
<td>£169</td>
<td>£221</td>
</tr>
<tr>
<td>Premises Rationalisation</td>
<td>£314</td>
<td>-</td>
</tr>
<tr>
<td>Corporate Efficiencies</td>
<td>£359</td>
<td>-</td>
</tr>
<tr>
<td>Urgent &amp; Immediate Care</td>
<td>£1,402</td>
<td>£279</td>
</tr>
<tr>
<td><strong>Total QIPP</strong></td>
<td><strong>£7,258</strong></td>
<td><strong>£812</strong></td>
</tr>
</tbody>
</table>

QIPP financial position 2016/17

Some of the QIPP schemes implemented in 2016/17 are highlighted below:

**Practice Standardisation**
- Practice variation (Clinical Audits) - The scheme included clinical visits to Primary Care to review referral patterns. The scheme has provided functional improvements with a significant lower number of inappropriate referrals being sent to the acute sector.
- KINESIS – This information management process will allow Primary Care to link into hospital consultants and allow clinicians to discuss individual patients without the need for the patient to be seen in the hospital environment and also speed up the treatment function.
- Direct Access Pathology – The scheme has reduced the number of inappropriate test result requests and reduced the duplication test requests.

**Planned Care Services**
- Musculoskeletal Services – The service is provided within a community setting allowing patients to be treated in the community rather than the acute hospital and receive support earlier. The service comprises a single point of access for all community MSK and physiotherapy (non-domiciliary) referrals and a fast triage service for all patients presenting with an MSK-related condition. Services, including group activity, are now available in a far wider range of community locations than previously.
- Nelson utilisation – The project allows diagnostic and other outpatient specialist services to be delivered from a community based centre within Merton.
The costs of the service are lower than those charged at the acute hospital by an average of 10%. Patients reported high levels of satisfaction with the service.

**Transactional**
- Counting and coding - this scheme reviewed the transactional processes with acute contract reconciliation. Review of operational transactional reconciliation has indicated a tightening against the business rules and hence improving transactional processes.
- Financial Policy and Procedures – This scheme reviewed financial processes both within contract and out of contract. The review implemented a system wide accountability benefit that streamlined savings over various contracts.
- Primary Care Estates – This scheme has provided reduced rates on primary care premises which has then be used to underpin direct patient services.

**Medicines Management**
- Medicines Management Utilisation – This is a long standing and established programme with four main strands delivered by the medicine management team:
  - Primary Care - consists of a review of medication changes and an individual records review.
  - Scriptswitch – reviews options for alternative less expensive medicines providing the same outcome.
  - Care homes reviews – to review medicines usage for patients on polypharmacy.
  - Nutrition – review of supplements.
  - Cross-SW London work to look at prescription of gluten free products, vitamins and self-care medicines

**Unplanned Care**
- Complex Patients – This scheme aligns community and social care services with a view to keeping people well at home and avoiding or minimising the time admitted to hospital. The service builds on an enhanced community services model with development of :
  - Holistic Assessment and Rapid Investigation Assessment (HARI),
  - Merton Enhanced Rapid Intervention Team (MERIT) - Community preventing admission team and responds within two hours in hospital or at home
  - Case management identifying frail elderly patients.
• Queen Mary’s Hospital - The scheme aims to support better value community based bed rehabilitation for elderly patients which supports the CCG strategy of caring for patients closer to home and delivering value for money rehabilitation.

Continuing Health Care
• A new provider from July 2016 has made a safe transfer of care and improved governance and quality of care by consistent application the national framework. This has also improved data quality to forecast accurate reflection on spend. This project allowed a review spend and ensured a more robust decision making process so that high cost cases and personal health budgets are managed within the framework.

Performance Analysis
This section provides an overall explanation of how Merton CCG has discharged its functions.

How we manage performance

Merton CCG is committed to ensuring that NHS care is provided safely and to the highest quality possible for all patients. The CCG measures performance and quality standards based upon the national CCG Assurance Framework 2016/17, which focuses on key constitutional pledges for patients, as well as the Improving the Health of our Local Population programme we developed to define local health priorities for Merton.

In an environment where NHS organisations across the country have experienced unprecedented growth in demand for NHS care with a tighter limit on resources, the CCG has worked hard to maintain and improve the performance and quality of care for Merton patients by setting firm expectations of standards with our healthcare providers.

The CCG Governing Body has ultimate responsibility for making the final decisions and ensuring the CCG is performing as it should. It is accountable to NHS England and to member practices, as well as to the public. The CCG conducted a full external review of its effectiveness in the spring of 2016 and has scheduled an internal assessment for April 2017.
Performance Management Improvements in 2016/17

We have made performance management and improvement a priority and have put in additional assurance measures this year, including appointing a Director of Performance to our Governing Body, developing a new suite of business intelligence reports to monitor performance and quality, and developing our Performance Delivery Group as a sub-committee of our Clinical Quality Committee.

We report performance and quality standards each month to our Governing Body and hold monthly meetings with our key acute, mental health and community care providers to review performance. Where we feel closer intervention is required, we meet providers more frequently to work with them to ensure performance improvement plans are effective. We designed a new performance management strategy to balance robust and effective provider management with longer term transformation plans to deliver sustainable good performance.

Performance is monitored and measured through the Clinical Quality Reporting Committee. The committee scrutinises performance for Merton CCG and reviews areas of concern and reports to the Governing Body as appropriate.

Clinical Quality Reporting Committee

The Clinical Quality Reporting Committee is chaired by the Governing Body Lay Member, Patient and Public Engagement Lead. The duties of the Committee are as follows:

- To seek assurance that Merton CCG commissioned services are being delivered in a high-quality, safe manner, including against criteria set by the Care Quality Commission, Monitor and other regulatory bodies.
- To oversee the performance of Merton CCG commissioned services, taking into account performance against Key Performance Indicators and the NHS and Public Health Outcomes Frameworks, with a focus on areas rated Red or where there has been deterioration in performance.
- Challenge, scrutinise and ensure that exception reports, action plans and risk assessments submitted by the Commissioning Support Service (or body that undertakes the function), Joint Commissioning Unit, Locality Commissioning Groups and subgroups include robust mitigating actions and controls that would effectively address identified risk.
- To review information including staff survey data, patient experience surveys, PALS queries and complaints to identify potential risks and issues.
- To have oversight of the process and compliance issues concerning Serious Incidents (SIs); Central Alert Systems (CAS); National Reporting; and being informed of all Never Events and informing the Governing Body of any escalation or sensitive issues in good time.
- To approve the CCG quarterly and annual complaints report.
- To receive and review reports relating to Safeguarding Adults and Children including Serious Case Reviews to provide assurance. All Statutory Safeguarding Reports to be formally approved by the CCG Governing Body.
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans
- ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern
- provide assurance that Merton CCG commissioned services, and jointly commissioned services are being delivered in a high-quality and safe manner, ensuring that quality sits at the heart of everything the CCG does
- to oversee and be assured that providers of commissioned services and jointly commissioned services manage risk appropriately and have robust mechanisms in place to effectively address clinical governance issues.
- To ensure that the patient is at the heart of everything we do. To receive and review the Statutory Obligation to Involve Annual Report, prior to formal approval by the CCG Governing Body.
- To receive and review quarterly and annual Equality and Diversity reports to provide assurance to the Governing Body. Statutory reports to be formally approved by the CCG Governing Body.
CLCH Community Services: Merton Cardio Respiratory Service (Respiratory Nurse Specialist (RNS)) patient story heard at Clinical Quality Committee

The Respiratory Team were asked to see a 65 year old patient by her District Nurse after she had numerous hospital admissions.

The RNS took the time to listen to the patient’s concerns and to explain the treatment choices available. The patient appreciated the shared-decision making approach and as a result now feels more in control with an increased understanding of what is wrong and is doing some homework about warning signs.

The RNS wrote up the feedback to share with colleagues and to help embed best practice including the importance of involving patients in co-creating their written action plans and making sure information is explained clearly and in ways they can understand. It also demonstrated the benefits to patients of clinicians working across traditional boundaries and clinical teams in order to give patients the best care. This patient was on the District Nurse caseload but referred to the Respiratory Team.

The patient said: “I have had lung problems for as long as I can remember. When I was a child I had asthma, everybody in my family has asthma. Now I have a lung condition. I’m sick of being in and out of hospital.

Last time I was really poorly, I had sepsis and was in ITU for ages. They said I had pneumonia. The hospital gave me a leaflet. I didn’t know that there was anything I could do to stop myself getting worse. The written plan seems like a good idea and will help stop my daughters worrying. I’m happy because I don’t want to be bothering my daughters for everything. I’m looking forward to making my own cup of tea again!”

How we measure performance

The CCG measures its own performance as well as the performance of all the providers we commission services from. Our performance as a clinical commissioning group is monitored by NHS England through the CCG Improvement and Assessment Framework which assesses us against four domains:

- Better Health
The CCG is given an annual assessment rating against the Improvement and Assessment Framework based upon performance against 60 KPIs covering Quality, Constitutional Targets, Effective Leadership and Commissioning and Financial Sustainability. We anticipate our 2016/17 assessment results to be published in June 2017.

We also measure and monitor quality and performance metrics with all our health service providers, framed around the NHS Constitution and local quality measures. The CCG Performance and Information team reviews performance metrics alongside commissioning and contracting managers on a regular basis. These metrics are combined with local intelligence and information to produce a monthly Quality and Performance report, presented to our Clinical Quality Committee, and our CCG Assurance Report which we present to our Governing Body and publish on our website: March 2017 Merton CCG Assurance Report

The format of the report has changed to highlight areas to note by exception and concern across the health economy. Root causes relating to issues of concern regarding performance are distilled with the mitigating actions detailed. Additionally gaps in assurance, if any, are also detailed.

The Quality and Performance report provides:

- An update on CCG and related providers’ operational performance against national and locally agreed standards. This includes 18 weeks RTT, cancer waits, A&E waits and ambulance handover times, delayed transfers of care
- Detailed information on underachieving indicators including trends and direction of travel are included where there are measurable thresholds.
- Provider quality and safety issues are also covered in the report. The key areas highlighted are Southern Health Report and associated recommendations and Serious Incidents. These are presented in trend charts and tables with commentary and actions for areas of concern to improve the focus on quality in the report.
## 2016/17 Performance Analysis

The NHS Constitution includes a set of pledges which the NHS is committed to achieve. The Constitution states that while these ‘are not legally binding, and cannot be guaranteed for everyone all of the time, they express an ambition to improve’. In our role as commissioner of health services, Merton CCG works closely with service providers; assessing how well they are performing against these standards, and identifying where improvements need to be made.

The table below summarises the end year position against each of the Constitution standards.

In summary, at time of reporting, more of these constitutional standards are being achieved in Merton compared to the position at the end of 2015/16.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015/16 End of Year Position</th>
<th>2016/17 Year to date position (Month 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT 18 weeks (admitted patients)</td>
<td>80.6%</td>
<td>78.9%*</td>
</tr>
<tr>
<td>RTT 18 weeks (non admitted patients)</td>
<td>92.3%</td>
<td>92.2%*</td>
</tr>
<tr>
<td>RTT 18 weeks (incomplete pathways)</td>
<td>90.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Diagnostic tests waiting time</td>
<td>98.9%</td>
<td>98.6%</td>
</tr>
<tr>
<td>A and E waiting times</td>
<td>91.8%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Cancer two weeks</td>
<td>91.1%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Breast symptoms two weeks</td>
<td>95.2%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Cancer first definitive treatment 31 days</td>
<td>97.3%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, surgery</td>
<td>99.1%</td>
<td>97.3%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, drug</td>
<td>100.0%</td>
<td>99.6%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, radiotherapy</td>
<td>97.1%</td>
<td>98.6%</td>
</tr>
<tr>
<td>Cancer composite, 62 days first treatment plus rare cancers</td>
<td>89.7%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, Screening</td>
<td>88.7%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, Consultant upgrade</td>
<td>88.2%</td>
<td>85.7%*</td>
</tr>
<tr>
<td>Ambulance Red 1 - 8 minute response</td>
<td>68.1%</td>
<td>80.7%</td>
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<tr>
<td>Ambulance Red 2 - 8 minute response</td>
<td>63.7%</td>
<td>79.5%</td>
</tr>
<tr>
<td>Ambulance Red 19 minute transportation</td>
<td>93.4%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>RTT 52 weeks (incomplete pathways)</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>MRSA (PIR Assigned)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>C Difficile</td>
<td>24</td>
<td>25</td>
</tr>
</tbody>
</table>

*Metric is no longer assessed nationally
Key highlights are:

- There has been a reduction in the number of mixed-sex accommodation breaches
- We have continued to deliver the majority of cancer waiting time standards
- A&E 4-hour wait performance has improved
- London Ambulance response times in Merton have improved significantly, all three response targets are being met and Merton now has the best LAS performance in London

**Referral to Treatment**

The CCG’s main provider, St George’s, took the decision to suspend national RTT reporting in June 2016, due to significant concerns about the quality of data. An extensive programme of waiting list validation is under way. The task of validating these records is a major logistical challenge and at the time of writing there is no timetable for completion of the work, or for St. George’s to recommence national RTT reporting.

St. George’s Hospital is implementing an Outpatient Transformation Programme to improve the patient experience of booking appointments including through the call centre and improve the efficient organisation of outpatient clinics to create more capacity.

St. George’s has established a Clinical Harm Review Group to ensure that a rigorous process of reviewing whether any patients who have experienced long waits is in place which the CCG participates in together with NHS England and NHS Improvement and other CCGs.

The CCG has robust processes in place to monitor the contracts we have in place with the Trust and we have taken a number of actions to increase our oversight. These include having a dedicated Chief of Commissioning Operations to focus on St George’s; making funding available to provide support with operational redesign at the trust; a series of clinical summits where trust and commissioner clinicians reviewed pathways to improve access; and significant work with regulators, in particular NHS Improvement, on enhanced governance and agreed improvement plans at the trust.

The CCG has been supporting our GPs with giving information to patients when making a choice of where to be referred for hospital care.

On a broader scale, the CCG has been working closely with neighbouring CCGs to reduce the demand for planned care to a more sustainable level.
The RTT performance issues emphasise the importance of ensuring that, where appropriate, clinical pathways are designed to provide out-of-hospital options which are convenient to access for patients. This is a key objective of the Sustainability and Transformation Plan.

**A&E Waiting Times**

Despite not achieving the 95% target throughout the year, St. George's has performed well against the agreed performance trajectory and has ranked as one of the best performing Trusts in London through the 2016/17 winter. Our local A&E Delivery Board has a number of schemes in place to improve streaming of patients at the front door, provide targeted support for patients who most frequently call 999, and improve flow and discharge.

**Waiting Times for Cancer Treatment**

There are eight government pledges on waiting times for patients with, or suspected to have, cancer.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015/16 End of Year Position</th>
<th>2016/17 Year to date position (Month 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer two weeks</td>
<td>91.1%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Breast symptoms two weeks</td>
<td>95.2%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Cancer first definitive treatment 31 days</td>
<td>97.3%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, surgery</td>
<td>99.1%</td>
<td>97.3%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, drug</td>
<td>100.0%</td>
<td>99.6%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, radiotherapy</td>
<td>97.1%</td>
<td>98.6%</td>
</tr>
<tr>
<td>Cancer composite, 62 days first treatment plus rare cancers</td>
<td>89.7%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, Screening</td>
<td>88.7%</td>
<td>95.6%</td>
</tr>
</tbody>
</table>

At time of reporting, seven of the eight standards are being met and in several months this year all eight standards were met. This is an overall improvement from last year and is the result of continuous efforts lead by the Southwest London Senior Leadership Forum (SLF) to deliver sustainable good results around cancer performance.

The remaining challenges are around patients who are transferred between different providers when they are already close to breaching the waiting time limit. Commissioners are addressing this issue with providers at regional level to ensure these patients are transferred earlier in their treatment pathway.
Ambulance response times London Ambulance Service NHS Trust (LAS)

The London Ambulance Service has been working hard over the last year to improve the quality of its services and the speed of its response times. The Trust was placed in the special measures regime in response to a recommendation from the Care Quality Commission (CQC) following an inspection in June 2015. As part of this move, the NHS Trust Development Authority (now part of NHS Improvement) put in place a wide-ranging package to support LAS to deliver rapid improvements to Londoners.

The effects of this improvement plan are now being seen, and all ambulance response times are now consistently delivered in Merton. In fact for the majority of 2016/17, Merton CCG has had the best LAS performance in London. Merton CCG is grateful for the hard work being done by LAS and will continue to support the service with its improvement plans.

Mixed-sex accommodation breaches

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except ‘where it is in the overall best interest of the patient’. There has been only one incident of this standard for Merton CCG patients where this ambition was not achieved. This is a reduction in the number of incidents compared with last year. Each breach is investigated by the relevant Clinical Quality Review Group (CQRG). Patients are advised of the issues at the time of the breach.

Infection Prevention and Control

The NHS is committed to reducing the incidence of avoidable harm, including infections from Methicillin-resistant Staphylococcus aureus (MRSA) & Clostridium Difficile (C Difficile). As part of this, infection control has been a high priority for all NHS providers, and each case of MRSA or C Difficile is investigated and reviewed at the relevant provider Clinical Quality Review Group. At time of writing there has been only one case of MRSA for Merton CCG patients, and 25 cases of C Difficile.

Quality Premiums – Improving Health Outcomes

The Quality Premium (QP) scheme is about rewarding clinical commissioning groups (CCGs) for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services. The 2016/17 scheme has been designed to support the delivery of
the major priorities for the NHS, as well as local priorities identified for Merton. The CCG Improvement and Assessment Framework is the mechanism by which progress is monitored; therefore the national QP indicators are aligned with those in the CCG Improvement and Assessment Framework. By taking this approach, the scheme focuses on those things already identified as critical to delivering the vision.

### 2016/17 Quality Premium Performance Measures

<table>
<thead>
<tr>
<th>National / Local</th>
<th>Description</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>National measure 1</td>
<td>Cancer Diagnosed at an Early Stage</td>
<td>60.0%</td>
</tr>
<tr>
<td>National measure 2</td>
<td>Overall Experience of Making a GP Appointment</td>
<td>85.0%</td>
</tr>
<tr>
<td>National measure 3</td>
<td>Increase the Proportion of GP Referrals Made by eReferrals</td>
<td>80.0%</td>
</tr>
<tr>
<td>National measure 4</td>
<td>Antimicrobial Resistance (AMR) Improving Antibiotic Prescribing in Primary Care.</td>
<td>Part a) 4%+ reduction on 2013/14 OR [=] England 2013/14: 1.161 items per STAR-PU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part b) to be equal to or lower than 10%, OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- to reduce by 20% from each CCG's 2014/15 value</td>
</tr>
<tr>
<td>Local Measure 1</td>
<td>Increase proportion of Merton patients aged 60+ who have completed a FOB Bowel Cancer Screen</td>
<td>55.0%</td>
</tr>
<tr>
<td>Local Measure 2</td>
<td>Number of Patients who have experienced a Myocardial Infarction in the previous 6 months who have accessed community based cardiac rehabilitation services.</td>
<td>&gt;0</td>
</tr>
<tr>
<td>Local Measure 3</td>
<td>Increase Usage of Coordinate My Care for end-of-life patients</td>
<td>10% annual increase (356 patients)</td>
</tr>
</tbody>
</table>

The outcomes of the 2016/17 Quality Premium will be finalised in June 2017.
Financial Performance

How we Measure Financial Performance

Financial performance for Merton CCG is scrutinised by the finance committee which reviews areas of concern and reports to the Governing Body at every meeting. The finance committee works alongside the audit and governance committee. A full financial governance review undertaken early in 2016 was implemented during 2016/17 ensuring the governance arrangements used by the CCG were fit for purpose.

The finance committee delivers its objectives by:

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

Funding for Merton CCG patients

The CCG is almost entirely funded by a central allocation by NHS England based upon a weighted capitation funding formula which adjusts funding per head of population registered with our GP practices to reflect local age and need profiles. The funding formula establishes a target level of funding.
The table below describes the funding levels and compares them to the distance from target (DfT).

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Baseline Allocation £m</th>
<th>DfT %</th>
<th>London DfT %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>230.6</td>
<td>1.34</td>
<td>2.72</td>
</tr>
<tr>
<td>2016/17</td>
<td>237.6</td>
<td>0.02</td>
<td>1.93</td>
</tr>
</tbody>
</table>

In 2016/17, the CCG, like London CCGs generally, has moved closer to its target allocation being just 0.02% above target. The same trend can be seen across London although there is a marked disparity at an individual CCG level where some CCGs have DfT % variances above 30%.

How did the CCG plan to invest this growth?

As takes place every year, the CCG was required to submit an operating plan to NHS England detailing how it proposed to deploy its resources to achieve the delivery of key constitutional standards. A key aspect of this process was ensuring that the CCG procured sufficient growth in activity from the portfolio of hospitals that it contracts with to deliver healthcare for our population. In order to ensure that contracted activity reflected changes to the size and age profile of the population and other anticipated trends in healthcare, the CCG increased its planned activity across the portfolio of contracts by 2.7%.

The financial impact of this growth was partly tempered by the fact that the Department of Health required hospitals and other service providers to deliver nationally mandated efficiency improvements. Therefore, the planned cost of investing in activity growth at £5.7m was lower than would have been the case had these efficiency improvements not been incorporated into the cost of services that we buy.

The most significant deployment of funding that the CCG made in 2016/2017 was to invest in the development of care out of hospital and in particular the Better Care Fund (BCF). The BCF is a key enabler to the CCG’s strategy of promoting greater integration between health and social care to improve outcomes for our population.
A key focus of the BCF programme is reducing non-elective admissions to hospitals. A key target of this investment in the BCF was to support the delivery of the QIPP programme worth £1.1m through reducing non-elective admissions and to support investment in mental healthcare issues to improve access to these services for our patients.

Other significant investments that the CCG made in 2016/2017 included:

- further investment in continuing healthcare service to focus more on the appropriate work required of the service (£0.4m).
- increased investment in community services to keep people well at home (£0.9m).
- investment in the provision of community musculoskeletal and outpatient physiotherapy services to Connect Physical Health Limited (£3.3m).
- investment in Integrated and Urgent Care to allow the service to integrate across the south west London STP (£1.7m).
- investment in Mental Health services including a Crisis Café, Street Triage, and Psychiatric Decision Unit (£0.3m).

Overall financial performance

The financial performance of the CCG each year is assessed externally by a range of financial duties and targets. For the second year running, the CCG was unable to achieve a 1 per cent surplus target as per NHS business rules in 2016/2017. However, the CCG did achieve its in year planned deficit of £0.6m (prior to deployment of the 1% non-recurrent reserve).

Continued pressure was experienced in the acute sector which over performed by £1.5m. However, this level was better than had been expected earlier in the financial year. There was also over performance in continuing healthcare by £1.0m and corporate and estates by £1.1m. However these were offset by under performance in non-acute, prescribing and reserves adjustments.

All other statutory and non-statutorily targets were successfully met. This includes the delivery of a significant efficiency programme which has resulted in £6.4m of net QIPP savings being achieved.
Expenditure

Total expenditure in 2016/17 was £276m. After allowing for £32.0m on primary care, spend was £244m. This compares to £238.9m in 2015/16. Acute spend accounted for 50% of total spend. Primary Care budgets were devolved to the CCG from April 2016. An analysis of how the CCG spent its resources in 2016/17 is set out below:

Merton CCG 2016/17 Expenditure Analysis by Programme £m

- **£139, 50%** (Acute)
- **£32, 12%**
- **£24, 9%**
- **£29, 11%**
- **£12, 4%**
- **£4, 1%**
- **£11, 4%**
- **£2, 1%**

Revenue

Outside of the main funding allocation from NHS England the CCG attracts very low levels of income. The most material element relates to the recharging of other commissioners for services that are hosted by the CCG of which the main example is community services of which £4.5M is charged to the London Borough of Merton.

Capital investment

The CCG incurred no capital expenditure in 2016/17.

Better Payment Practice Code

The Better Payment Practice Code requires the CCGs to aim to pay 95 per cent of undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later. In 2016/17 the CCG maintained its performance from previous years and paid 99.1 per cent by value and 98.2 per cent by number of invoices within the required timescale.
There were no claims for interest payable under the Late Payment of Commercial debts (Interest) Act 1999.

**Accounting policies**

The financial reporting requirement of CCGs is determined by NHS England with the approval of HM Treasury. In accordance with the Treasury’s Government Financial Reporting Manual, Merton CCG is required to prepare their financial statements based on International Financial Reporting Standards (IFRS). There are no changes to the accounting policies from the prior year.

**External auditors**

The CCG’s External Auditors for the 2016/17 financial year were Grant Thornton LLP. Their fees amounted to £52K which was for services provided to conduct the statutory audit.

**Managing our risks**

Full details of the CCG’s approach to risk management can be found in the Annual Governance Statement section of this report.

**Pension liabilities**

Information on how pension liabilities are treated and relevant pension schemes can be found in the remuneration report.

**Financial outlook**

The CCG was successful in achieving its in year control total of a £0.6m deficit for 2016/17 despite growing demand in acute hospital activity. The CCG did not achieve its business rule of maintaining a 1% cumulative surplus despite the adjustment for the release of the 1% non-recurrent reserve in to its position.

Looking forward to 2017/18, the CCG is required to achieve an in-year break even position. This is part of a south west London CCG requirement to achieve an in year surplus of £4.6m. There is a risk therefore, that the CCG could be asked to financially contribute further to meet the wider health system target should the constituent South West London CCGs not achieve their respective targets. This risk is particularly high in two South West London CCGs.
The 2017/18 plan also requires a gross (of investment) £14.1m QIPP contribution. Whilst the CCG has identified the entire sum as part of its medium term planning, the figure does represent a materially more significant ask than in previous years being nearly double the 2016/17 requirement.

This position is further compounded by a number of significant changes in national policy which have been notified by the Department of Health.

These include:

- a change in the way that the funding formula affects Merton CCG. In previous years the CCG has been underfunded by as much as 4.8%. In 2016/17, however, the CCG was virtually on parity at +0.02% over funded although this does reduce to a slight under funding position of -0.43% by 2018/19. The result of this is that the CCG will continue to receive less growth funding as it now receives the appropriate level of funding according to the formula.
- as in 2016/17, NHS providers are required to deliver significant efficiency improvements, which have reduced the cost of contracted services to the CCG. In 2017/2018 the CCG financial plan has assumed provider growth of 2.8% and an efficiency factor of 2% which means the CCG has assumed a net inflator of 0.8%.
- a continuing requirement for the CCG to ensure that half of one per cent of its funding is uncommitted and available for nonrecurring investment.

Moving in to 2018/19, the financial outlook appears more promising. The CCG has a requirement to hit a 0.5% cumulative surplus by March 2019 which in turn requires a £2.0m in year surplus in 2018/19 to achieve a cumulative surplus of £1.4m by March 2019.

In turn, achievement of this position requires a gross QIPP in 2018/19 of £6.6m (net of investment £4.0m). These levels are clearly significantly reduced from the 2017/18 peak and are more similar to QIPP achievements in 2016/17 and 2015/16.

**CCG Assurance Framework**

In March 2015, a new CCG Assurance Framework was published by NHS England to take into account the considerable changes which have taken place in the NHS environment since CCGs were authorised in 2013.
The new framework acknowledged that CCGs had different starting positions, with different populations and challenges and requiring different leadership responses. Assurance covers the overall delivery of a CCG and takes place continuously throughout the year, rather than as a one-off inspection. The framework is used by NHS England to determine whether CCGs are meeting their statutory duties (the things they must do) and appropriately exercising their key statutory powers (the things they have the freedom to do). We expect our rating in June 17.

**Sustainable Development**

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long-term, even in the context of rising cost of natural resources.

The CCG is committed to sustainability and to reducing our carbon footprint. We achieve this by working closely with our landlord and suppliers to improve utilisation and functionality in all areas of the business and day-to-day operations.

We recognise the importance of sustainability and continue to develop our environmental strategy to meet the requirements of the Climate Change Act and to reduce our carbon footprint.

**Estates**

120 The Broadway, Wimbledon, where we are based, is managed by NHS Property Services. The CCG is one several tenants of the building and we work with the landlord to ensure we comply with environmental requirements and best practice in relation to recycling and energy consumption. Waste and recycling points are available.

The CCG commissions services from the Nelson Health Centre, a Community Health Partnerships building. The building is designed to reduce carbon emissions by 50% in comparison to the building previously on the site. In addition it offers cycle parking and easy public transport access to help encourage more sustainable transport usage.

**Paper free at point of care**

The CCG is working hard to improve its performance in relation to ‘paper-free’ at the point of care. As at January 2017, the percentage usage of electronic prescribing in Merton practices
ranged from 89%, down to 17%; the overall average percentage use was 47%. There is a 2016/17 target for 80% of repeat prescriptions to be issued electronically. The CCG has a known issue with use of the e-referral system. As at December 2016 CCG Merton scored 12.2% utilisation rate which remains considerably below the London average of 36%. The South West London Performance Group chaired by CCG Merton is actively monitoring performance and we are contacting CCGs achieving best practice to identify and cascade any lessons learnt.

**CCG paper free**

The CCG is also reducing its reliance on paper by reducing the amount of printing it requests and encouraging senior managers and Governing Body members to use tablets and laptops during meetings.

**Improving Quality**

*This section explains how the CCG has discharged its duty under Section 14R of the National Health Service Act 2006 (as amended) to improve the quality of services.*

Merton CCG has sought to secure continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis and treatment of illness. Nationally, the NHS quality agenda sets out the three key elements for high-quality care: effective and safe care, and care that provides as positive an experience for patients as possible. These three elements for high-quality care are fundamental to the CCG and everything the organisation does.

The CCG aims to continuously raise the quality of services it commissions via robust monitoring of contracts with local providers. As well as monitoring performance of contracts, the CCG also obtains updates regarding the quality and safety of services via an alert system and through visits, both announced and unannounced, to services. It also ensures the patient experience is considered and their voice heard at every Clinical Quality Committee meetings through patient stories. The Patient Engagement Group meeting notes are also seen at the Clinical Quality Committee as well, ensuring the patient voice is a thread through the committee process.
Each meeting of the Clinical Quality Committee has a specific focus allowing for in-depth discussion of a particular service. The Clinical Quality Committee is chaired by the Governing Body Lay Member, Patient and Public Engagement Lead. This ensures there is clear sight of all emerging issues and that any concerns raised can be swiftly investigated and assurance provided. The Clinical Quality Committee identifies any emerging concerns and investigates these and will raise a challenge/assurance to the Governing Body as necessary. The remit and further details about the Clinical Quality Committee can be found on page 48.

**Alerts**

All 24 GP practices in Merton, as well as care homes, have access to a Quality Alert Management System (QAMS) to help them easily raise quality issues, for investigation by the CCG. The system allows GPs to raise concerns – and also praise providers that have provided a good service. Common themes for the alerts in 2016/17 included ‘communication’, ‘referral/appointment issues’ and concerns regarding the ‘standard of care’. Alerts that are classified as ‘high’ or ‘severe’ risks are sent for investigation with the providers. As with safety incidents, these alerts are also reviewed by the Merton Clinical Quality Committee.

**Patient Stories: Expert Patient Programme (EPP)**

Steve Bowman, also a member of Merton’s Patient Engagement Group (PEG), attended the meeting in October to share his views on his experience of the EPP. Patient stories feature at Quality Committee meetings. This session allowed the CCG to focus on how it could best help people manage their conditions.

**Visits**

The CCG has undertaken a range of both announced and unannounced visits to assure itself on the quality of services and the patient experience. For example:

i. **Kingston Hospital**

   Following the Care Quality Commission’s inspection of Kingston Hospital NHS Foundation Trust Hospital, and its report indicating “Requires Improvement” particularly in A&E, medical care, older people’s care, the CCG Governing Body Lay Member (PPI) along with the Head of Quality made an announced visit to the Trust in July. They visited A&E, Maternity and the Older People’s Unit. It had been a particularly quiet day for A&E and maternity, so it was not possible to get a true feel for them, but both had been impressed by the staff and services on these wards.
which they fed back to the CCG. However, the Lay Member and the Head of Quality, felt the older people’s unit was a little cluttered and noisy. They were assured to hear that there were plans to build a new state of the art ward in the near future. In addition the Trust’s Director of Nursing will attend the August Quality Committee meeting to answer questions from the Committee.

ii. Mental Health Assessment and Recovery Teams
The Lay Member (PPI) and the Head of Quality visited the Mental Health Assessment and Recovery teams on an announced visit during the year and were able to report back to the CCG that they were impressed by the team leaders and the team’s commitment and thoroughness.

Contract monitoring
i. Continuing Healthcare
With the appointment of the new community provider, the CCG took the opportunity to address the operational, financial and governance issues with the service. The CCG took the decision to invest in additional resource to tackle both the backlog of reviews and also to ensure that going forward there was a robust and equitable process that met national guidelines. This has been a significant piece of work for the CCG and is only now, at the end of the financial year starting to show results. The CCG’s Director of Quality led much of the work liaising closely with the Commissioning Team, local authority and new provider. Assurance reports were presented on a regular basis to the Merton Clinical Quality Committee and also the CCG’s Governing Body.

ii. Out of Hours (OOH)/111
In the autumn of 2016 the CCG, along with its South West London partner CCGs transitioned its OOH/111 service from one provider to another. The process was closely monitored by the Merton Clinical Quality Committee.

iii. Referral to Treatment
A key measure of the 2016/17 CCG Improvement and Assessment Framework was for patients to be waiting 18 weeks or less from referral to hospital treatment for elective care. The target for this is 92% and, historically, the CCG has narrowly failed to meet this. A key factor in this has been a significant underperformance at St George’s Hospital. The Trust is committed to turning this around and the Clinical Quality Committee has been monitoring its progress. The Director of Quality has been active in the Clinical Harm Review Group with NHSE and NHSi and other
CCGs. We have robust processes in place to monitor the contracts we have in place with the trust and we have taken a number of actions to increase our oversight. These include a series of clinical summits where trust and commissioner clinicians reviewed pathways to improve access and significant work with regulators, in particular NHS Improvement, on enhanced governance and agreed improvement plans at the trust. On a broader scale, Merton is also working closely with neighbouring CCGs, NHSE and NHSI to reduce the demand for planned care to a more sustainable level. One of the main concerns was to ensure patients on the waiting lists were being supported.

iv. **100 Day Cancer Waiting Time Breaches**

The CCG was concerned that the 100 day breaches had occurred over a considerable length of time. Although assurances had been given that this matter was being monitored, this was not sufficient and concerns remained that patients’ care and treatment were being affected by these breaches. The Director of Quality put Contract Performance Reporting in place and the Clinical Quality Committee monitored this closely.

The CCG Clinical Quality Committee also regularly reviews complaints and PALS to identify themes and potential issues.

**Complaints and PALS**

Openness and transparency is a high priority for NHS Merton Clinical Commissioning Group (CCG). The CCG is committed to providing access to information and support to their community.

The [Patient Advice and Liaison Service](#) (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers. You can find your nearest PALS office on the NHS Choices website or you can also ask your GP surgery, hospital or phone NHS 111 for details of your nearest PALS.

The graphs (overleaf) the complaints and PALS received by Merton CCG for the years 2015/16 and 2016/17.
Overall there has been a 33% reduction in complaints compared to 2015/16.

Overall there has been a 24% increase in PALS compared to 2015/2016.

The table below highlights the number of complaints, whether the CCG was required to respond and if the complaint originated from an MP.

<table>
<thead>
<tr>
<th>Numbers Received</th>
<th>1 Quarter</th>
<th>2 Quarter</th>
<th>3 Quarter</th>
<th>4 Quarter</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCG related</td>
<td>CCG not related</td>
<td>CCG and related</td>
<td>CCG related</td>
<td>CCG not related</td>
</tr>
<tr>
<td>Complaint</td>
<td>6</td>
<td>13</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>MP Complaint</td>
<td>1</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>PALS</td>
<td>16</td>
<td>9</td>
<td>0</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>MP PALS</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>23</td>
<td>0</td>
<td>15</td>
<td>22</td>
</tr>
</tbody>
</table>

The target for acknowledging a complaint or PALS enquiry is three days. For the collective 28 complaints and PALS received, the average time to acknowledge a complaint or PALS was less than two days. The average time to acknowledge a complaint was less than three days, the average time to acknowledge a PALS case was less than two days.

The CCG seeks to respond to a complaint within 25 days. In 2016/17 there was one case (where the CCG was the lead responder) that exceeded the 25 day response timescale. The complaint was about the time taken to arrange Continuing Healthcare funding. The CCG was awaiting information from relevant providers.
Parliamentary Health Services Ombudsman (PHSO) Decisions

The PHSO make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations. They do this fairly and without taking sides. Their service is free. Further information is available on their website: https://www.ombudsman.org.uk/

<table>
<thead>
<tr>
<th>Merton PHSO cases in 16/17</th>
<th>One - currently open with PHSO, no result or indication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One – upheld. Recommendations made and followed by CCG</td>
</tr>
<tr>
<td></td>
<td>One – PHSO decided not to investigate</td>
</tr>
</tbody>
</table>

In the one case concluded during 2016/17 the Ombudsman made recommendations that the CCG apologise to the complainant and acknowledge their failings. They also asked the CCG to undertake a retrospective continuing healthcare (CHC) review. An apology letter was been sent to the complainant and the CCG has commissioned a CHC retrospective review.

Patient Feedback Themes

A large proportion of complaints and correspondence this year has arisen from matters relating to continuing healthcare - primarily concerns around eligibility for funding and the quality of care provided by the service.

In addition the CCG received a number of complaints as a result of the decision not to provide a GP service and walk-in facility from portacabins on the Wilson Hospital site in Mitcham. There were three PALS cases which related to this.

Merton CCG worked with NHS England on the arrangements for the list dispersal and when responding to registered patients concerns. The CCG arranged four drop-in sessions for people to ask questions and as a result of feedback at the first session arranged for further information including maps, transport links and a FAQ to be available both online and at the sessions. The Chair of the CCG along with the East Merton Locality lead Dr Karen Worthington also arranged and attended an evening meeting with local residents to answer questions in person and to reassure people about the alternative arrangements being made and the long-term plans for the site. Feedback from that meeting indicated a particular concern around access to GP appointments for young children. As a result the CCG ensured its plans took that
into account and some of the extra GP appointments being created are now specifically allocated to children.

All complaints relating to primary care were redirected to NHS England as the appropriate body; other complaints were redirected to the appropriate trust or provider.

**Public and Patient Involvement**

This section explains how the CCG has discharged its duty under Section 14Z2 of the NHS Act 2006 (as amended) to involve the public in commissioning (planning, decision-making and proposals for change that will impact on individual or groups and how health services are provided to them).

**Vision for Engagement**

Merton CCG is committed to making sure that patient engagement and experience are at the heart of its work and to understand what matters to patients, their relatives and carers so that appropriate and effective patient-centred services are commissioned.

The Lay Member for Patient and Public Involvement (PPI) is a key member of the Equality and Diversity Group and attends local forums and meetings to ensure the Governing Body hears the voice of patients and local people. All papers that come to the board for review or sign off have to provide evidence to demonstrate that equality-related risks have been assessed and where the patient voice was heard, and the influence it has had. Patients and local people are welcome to attend board meetings which are held in public and there can be opportunities for questions. During 2016/17 several patient stories were shared at the meeting to ensure the patient voice was heard. In November 2016 Merton patient and PEG member Steve Bowman gave his experience of the Expert Patient Programme. His story is on our website.

The Lay Member PPI has regular meetings with both the Chief Officer and the Director of Quality and Governance which gives the opportunity for any questions or concerns to be raised directly. In addition CCG staff and representatives are active within the community often giving talks and seeking feedback during meetings and presentations. The Chair, for example, has given talks to various groups including Age UK. Merton’s AGM is another way the CCG seeks to ensure the patient voice is heard and fed into commissioning and service improvement decisions.
Our most recent Patient and Public Involvement Report (for 2015/16) which provides detailed information on our PPI activities is available on our website. The report presents information and evidence which demonstrates how we are meeting our statutory duties under 14Z2 of the Health and Social Care Act 2012 (as amended).

- In 2016/17 we have continued to ensure that the patient voice is heard as we have sought to develop and implement our financial recovery plans and the development of our primary care strategy.
- The CCG has invested considerable time and resource in 2016/17 to develop its Patient Engagement Group.
- Supporting patients make informed choices has also been a focus for 2016/17 with the CCG promoting cancer awareness, Health Help Now and supporting Merton Council promote one You.
- We have maintained patient representation on key committees including those for effective commissioned services, IFR and Medicines Management.
- As work on the STP work stream groups has developed the CCG has ensured these and other patient involvement opportunities have been cascaded widely to ensure strong Merton representation.

**Patient Engagement Group**

In 2016/17 the Patient Engagement Group met eight times. Items discussed included the primary care strategy, financial recovery plans including issues around surgery readiness and clinical thresholds, changes to prescriptions, Health Help Now, patient online (now GP online services) and planned care changes emerging from the development of the STP.

Discussions have been robust and members feel able to ask challenging questions of those presenting at meetings. Timeliness of information and requests for comment going to the group still needs work - and due to the pace of some changes will continue to present a challenge for the CCG and partner organisations.

In its first full year of operation the Group has taken time to review its initial terms of reference and to select a Vice Chair from within its membership to support the Chair in the oversight of the group. Work is on-going to help ensure membership of the group is both accessible and relevant.
The CCG has helped PEG members identify suitable training and development opportunities and to take part in training courses and workshops. This has included the NHS England led programme for London lay representatives which several members attended.

The CCG is grateful to the support individual PEG representatives give to reviewing leaflets, booklets and other materials to ensure they are easy to understand and appropriately designed. Some PEG members also provide a strong link back to their own GP practices. Currently 11 practices are represented in this way and the CCG is working on developing this across all practices.

At the March 2017 meeting Merton Centre for Independent Living gave a presentation on their membership’s experiences of local healthcare - good and bad. This was warmly received and PEG has agreed that going forward similar such sessions should become a regular feature.

**Digital engagement**
The CCG continue to build its use of digital channels as a means of communicating and engaging with patients and the public during 2016/17. The website acts as a source of information and engagement for patients, the public and all local stakeholders. See [www.mertonccg.nhs.uk](http://www.mertonccg.nhs.uk)

People visiting the website can send feedback using a form via the ‘Get Involved’ page, find out about opportunities to get involved in local health services, or the results of consultations and engagement.

The ‘Get involved’ pages have had 5996 visits over the course of the year. The website also offers visitors the option to directly email the Chair and the Chief Officer. This enables the questions and concerns of local people to be clearly visible to the senior leadership team and to ensure questions go to the right people for answer and that local concerns and issues are given clear visibility within the organisation.

The ‘contact us’ page had 13,448 visits from April 2016 to March 2017. Overall the website has had 132,186 page views. By far the most visited page was about the Nelson Health Centre which received 28,744 visits. In comparison the homepage received 15,838.

Merton CCG also uses social media including Twitter and Facebook. Tweets cover a wide range of topics and include re-tweets of partner organisations posts.
It is also used to respond to queries and comments. During 2016/2017 the CCG has grown its digital channels particularly Twitter. By the end of March 2017, the CCG was just shy of 4000 followers on its @NHSMertonccg Twitter account. The CCG does not receive a huge number of questions or feedback via social media. Questions asked in 2016/17 have included requests around how to make a complaint about poor patient experience, GP access and plans to redevelop the Wilson Hospital site. A few people have posted positive feedback about the Nelson Health Centre and we also received a number of questions and requests for further information regarding our engagement ‘Choosing wisely for Merton’.

The CCG uses their social media accounts to help promote local health and care initiatives, events and job opportunities by partner organisations. This can include re-tweeting public meeting dates, calls for patient participation or helping to raise awareness of local initiatives such as help for victims of domestic violence or hate crime. In this way Merton seeks to show support across the broadest spectrum of health and well-being locally.

Follow us @NHSMertonCCG

**Meeting the Collective Duty**

*This section explains how the CCG has ensured public involvement and consultation in commissioning processes and decisions, which include involvement of the public, patients and carers in: commissioning activities, planning of proposed changes to services monitoring, insight and evaluation.*

‘All the fun of the fair’

Collective engagement activity in the first half of 2016/17 focused on two set-piece public engagement events over the not-so hot summer when the CCG hosted tents at both Mitcham Carnival in the east of the borough and also, for the first time, at Wimbledon Fair in the west the following weekend. The CCG asked local people about their recent experience of local healthcare services including their experience of using local community pharmacies and primary care services. The CCG ensured local health partners promote healthier lifestyles, oral hygiene for children, its Expert Patient Programme, the website app Health Help Now and MIAPT, our free talking therapies service. (Pictured opposite)
'Choose Wisely'

During 2016/17 the CCG worked hard to find QIPP savings of £7.3m. Pressures on expenditure will continue to increase in 2017/18 and it's expected that the CCG will need to find at least another £14m of savings to bring the CCG back into financial balance and provide for cost increases and greater patient demand in 2017/18.

To ensure that we live within our means in future and that everyone in Merton has equal access to operations; and that only treatments which offer value to our population are commissioned the CCG decided to consider developing a number of clinical policies which set thresholds for some treatments and do not fund other treatments except in very limited and exceptional circumstances.

All CCGs should periodically review the services they commission in light of new evidence, technology change and finances.

The CCG’s Governing Body asked for an initial period of public engagement to discuss these ideas and options with local people before making a decision on how to proceed.

Engagement ran through February and March 2017 and the CCG took part in over 40 local community, civic and voluntary group meetings and events and almost a thousand booklets were sent out. The CCG promoted the engagement online and through posters distributed to GP practices, libraries, children’s centre and community pharmacies.
‘The Fruity Fridays’, a playgroup run by the Polish Families Association (pictured above), had their say in the discussions.

The CCG attended meetings across the borough in Wimbledon, Raynes Park, Mitcham, Morden and Colliers Wood. The CCG also met with groups from local Tamil and Polish communities, a local LGBT group, older people, carers, people with mental illnesses, people with young children and people from different faiths.

Happy Family Day Club Tamil Elders at the St Helier Community Centre (Pictured Above) took part in the consultation.
Meeting the individual duty

This section explains how Merton CCG has promoted the involvement of patients and carers in decisions which relate to their care or treatment, including diagnosis, care planning, treatment and care management. This duty requires CCGs and commissioners to ensure that the services commissioned promote involvement of patients in their own care, including: personalised care planning, shared decision making, self-care and self-management support information with targeted support.

‘Champions of Self-management’
Merton CCG’s ‘Champions of Self-Management’ Conference in early October promoted the CCG’s free ‘Expert Patients Programme’ and proved popular with over 120 local people attending the free event in Wimbledon. CCG Chair Dr Andrew Murray opened the conference which aimed to encourage people living with long term conditions and those who support them, to adopt or improve their self-management approach. The event also sought to raise awareness of self-management and the audience included patients, carers and health and social care professionals and students from across Merton. The day also included presentations and Health Hub Market stalls from different organisations committed to making a difference to people living with long-term conditions.
Merton’s Expert Patient Programme

The Expert Patients Programme (EPP) is a free self-management education course which supports adults in Merton living with one or more long-term health condition. The EPP offers participants the opportunity to develop techniques to better self-manage their condition, increase their confidence, and improve their quality of life. More details on EPP are on our website.

The staff running Merton’s Expert Patient Programme left in early 2016/17 and the CCG took the opportunity to review the way the programme worked and to identify options for a new approach. The CCG took the decision to develop a joint team with Wandsworth CCG.

In November 2016 the new joint Merton and Wandsworth EPP self-management team organised a course at the Shree Ghanapathy Temple in Wimbledon. Ten of twelve attendees completed the course and subsequently received certificates.
Feedback via the end of course questionnaire included:
“The EPP course really empowered me to take responsibility for my health, helped me to make action plans, increase my exercise time and made me aware of the importance of ME time”.

At the end of January, a new EPP manager was appointed to focus on Merton and is now in post to lead on the dissemination of EPP courses in 2017/18. The team are also appointing a new EPP navigator. There is a target of six courses to be run across Merton for the next financial year. Work is already underway to identify people to take part.

**Expert Patient Steve Bowman tells his story**

I decided to attend the ‘Living Well’ Expert Patient Programme because I suffer from Type 2 diabetes and wanted to get some professional advice and meet other people with similar conditions. Type 2 diabetes has been in my family for generations so it didn’t come as shock when I was diagnosed with it. As well as being a patient I am also a carer for my sister who suffers so severely from diabetes that she lost her big toe to the condition. I spend several days a week checking in on her and taking her to and from hospital appointments.

The course was enlightening and very well organised. Around 12 patients attended. Part of each session consisted of a meditation exercise which I thought was a very good idea. It helped me and the others on the course relax and get into the right mind set for the rest of the session. There were also unusual and imaginative elements of the session, for example, being asked to close our eyes, think of a flavour and imagine we can taste that flavour. I also received a booklet full of information on chronic illnesses and help that is available. I found it invaluable and still dip into it from time to time.

I made some good friends on the course. I thought it was important not to lose touch after the course finished and to keep the support system going I arranged a fortnightly coffee morning with a few of the other patients on the course. I’m still in touch with one other patient which I don’t think is too bad two years on! I wholeheartedly recommend the course to anyone suffering from a chronic illness. It not only helped me be in better control of my illness but also to be a better carer for my sister.
Personalisation and Personal Health Budgets
As a CCG we are committed to continue to offer patients all the choice they require in regards to the care they receive. We do this by ensuring wherever possible that patients and their representatives/family are fully involved in MDT assessments and care planning. During 2016/17 the CCG commissioned external providers to support the infrastructure surrounding the implementation of PHBs and began work with local groups and the local authority to help roll out the offer in 2017/18.

Self-care and self-management
Health Help Now: Merton CCG launched Health Help Now (app and website) in late March 2016 and the public involvement in its local development is highlighted in the 2015/16 Patient and Public Involvement Report. Health Help Now (HHN) is helping Merton residents avoid unnecessary queues and get them to the right place for treatment faster. Health Help Now also has advice and information sections on lifestyle and well-being services and information about Merton Council and local community health and well-being services. Promotion of the website and app has been undertaken throughout 2016/17 through the CCG’s own channels and GP practices as well as at Merton’s big summer fairs. We have also used Facebook, Twitter and Merton Mumsnet to support take-up.

Alongside Health Help Now the CCG was active throughout 2016/17 in helping to inform the local populations of other healthcare resources (such as pharmacists, GP online services and NHS 111) and encouraging them to use NHS services wisely – particularly over bank holidays and long festive periods.
This included supporting ‘Self-Care’ and ‘Ask your pharmacist’ weeks in the autumn. In the autumn the CCG also actively promoted the flu jab to at risk groups and the national ‘stay well this winter’ campaign. CCG staff also took part and a number agreed to be photographed having their flu jab to help encourage others.

The CCG has promoted a greater local awareness of the signs of cervical, bowel, ovarian, bladder and kidney cancer and the benefits of regular screening throughout the year.

During 2016/17 the CCG also worked with Merton Council to encourage local people to take part in the ‘One You’ campaign and to download the available free tools to help them take better care of themselves. The CCG also worked with the Council to promote the Great Weight Debate (led by Healthy London Partnerships) and to consider healthier lifestyle choices to reduce the incidence of obesity, COPD and diabetes.
GP Surveys
During 2016/17 the CCG has been developing its Primary Care Strategy and information from GP surveys has helped to shape how the CCG intends to deliver better integrated local care. The data also helps to inform the CCG of where local practices need help to better meet local need. It is also used continually in discussions with GPs around patient satisfaction and access. Improving access is a key element of the CCG Primary Care Strategy and an area where local people have clearly stated they want to see improvement. Feedback from the survey helped the CCG refine its plans to improve GP access.

End of Life Care
End of Life Care is one of the most important aspects of providing and commissioning care for Merton CCG and the promoting and delivering the CCG’s Strategy (published on the CCG website in October 2015) has remained a priority in 2016/17. As part of Merton’s on-going implementation of its End of Life Care Strategy the CCG continues to have patient representation at Sutton and Merton CCG’s joint End of Life Care Network. The Network is also attended by clinical leads from local acute trusts, community service providers, hospices and primary care.
The network allows:

- Patient experience to be heard by clinicians and service providers to inform service improvement and developments and guide future commissioning strategy;
- Discussion of issues which span organisational boundaries in order for solutions to be collectively established and taken forward; and sharing of best practice from across the local health and care sector.

In September 2016 Governing Body member Dr Caroline Chill gave a presentation at a Kings Fund seminar on ‘How we made end of life care a priority in Merton’ and the wider learning from the event was brought back to the CCG to be shared with both clinicians and commissioners.

**South West London Collaborative Commissioning Engagement**

The South West London NHS and the six SW CCGs have been running a pioneering programme of grassroots engagement since spring 2016. This has involved talking to groups the NHS does not usually reach about issues facing local health services and their views on emerging proposals. The programme was funded by an NHS England grant and run in partnership with our local Healthwatch organisations.

Funding to Healthwatch organisations allowed us to capitalise on their extensive community connections with local grassroots organisations as well as strengthen our own relationship with them as key stakeholders in health and care. The unique element of this project is the benefit each stakeholder gained from the exercise.

Healthwatch organisations were able to strengthen their relationships and raise awareness of their work, while local organisations could run an activity their local community enjoyed. These helped build community cohesion and reduce social isolation. In addition, the local NHS, including Merton CCG has had meaningful conversations with local people whom they might not otherwise have reached (such as a local social anxiety community self-help group (SACI), about their experiences of services. Capturing the contact details of people who attended the events allows us to maintain an on-going dialogue and we intend to go back to some of the groups in future.

Overall through the initiative 88 events have taken place and the six CCGs have had in-depth conversations with over 1600 people from ‘seldom heard’ communities by the end of March 2017. This includes over 60 local meetings with groups with protected characteristics.
This includes more than 5000 individuals across a number of groups including BAME
groups, older people, Roma, faith groups, LGBT organisations, and people with physical
disabilities, learning disabilities, refugees and asylum seekers, homeless people, people with
mental health conditions, children and young people, carers, people with long term conditions
and people from areas of economic and social deprivation.

The CCGs have agreed to support the project for another year to build momentum.

Further information about SWLCC available from www.swlccgs.nhs.uk/

South West London Collaborative Commissioning Patient and Public Steering Group (PPESG) in 2016/17

To ensure that there is effective lay involvement and public and patient engagement in the
SWL Collaborative Commissioning programme a steering group comprising patient and public
lay representatives from each of the six CCGs, the six local Healthwatch organisations and the
voluntary sector within each of the six CCG areas was set up. The group met every six to eight
weeks during 2016/17
During 2016/17, the Group shared information about the case for change, the development of the STP proposals and opportunities to get involved via Patient and Public Engagement Steering Group networks and social media and continued to update key stakeholders such as local MPs on developments with the programme. The programme also worked with providers and Health and Wellbeing Boards to consider the next steps.

Reducing Health Inequality

This section explains how the CCG has discharged its duty under Section 14T of the National Health Service Act 2006 (as amended) to have regard to the need to reduce inequalities.

Equality and Diversity

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

Within our vision is the commitment and recognition that equality and human rights must be central to the way we plan and operate as a public body, an employer and a commissioner of healthcare services.

We understand and recognise that:

- people can experience inequalities, discrimination, harassment and other barriers;
- patients should be at the centre of our decision making, and in partnership we can deliver high quality, accessible services that tackle inequalities and respond to personal needs; and
- an environment of dignity, tolerance and mutual respect should be created, maintained and experienced by all our patients, staff and members.

The Equality Act 2010 places a requirement on the CCG, as a public body, to demonstrate how we are:

- eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act
- advancing equality of opportunity between people who share a relevant protected characteristic and people who do not share it
• fostering good relations between people who share a relevant protected characteristic and those who do not share it
• being transparent about how we are responding to the Equality Duty

We are required to publish relevant, proportionate information showing compliance annually. As commissioners we are determined to carry out these duties and go beyond requirements wherever possible.

Equality, diversity and inclusion are central to our vision, strategic direction and organisational development plans for a 'Whole Merton', where services are designed to meet the needs of the population and individuals and families. In delivering our vision to secure the best possible services for people in Merton and be an employer of choice, we will strive to embed equality and diversity in all key aspects of our commissioning and procurement cycles and employment practices.

In 2016/17 we published a refreshed vision Statement on Equality and Diversity (May 2016).

Merton CCG Equality and Diversity Vision Statement May 2016.pdf

The PSED consists of general and specific duties for public authorities to meet under the Equality Act 2010, as set out above. Merton CCG publishes information annually to show how we are doing this.


Equality Objectives
Merton CCG has legal duties to publish Equality Objectives every four years under the Equality Act 2010. You can view our Equality Objectives report for 2013-17.

Equality Analysis
All projects are required to complete an Equality Analysis before being implemented. This is to ensure that the project has considered the impact it will have on those communities it affects. We have developed a system to ensure that all documents and the healthcare services we commission in Merton complete assessments at the right time.
Equality Delivery System

The Equality Delivery System (EDS) is a performance improvement tool developed by NHS England to help organisations such as Merton CCG deliver better outcomes for patients and communities and improve the working environment for staff.

A comprehensive work plan to reduce inequalities

In 2016/17, Merton CCG delivered a comprehensive work plan to reduce inequalities, which included completing equality analyses (EA) on the following QIPP schemes:

- Referral Management Centre PID
- Direct Access Pathology
- MSK
- Nelson Utilisations
- Practice variation
- Prescribing
- Complex Patients
- Continuing Healthcare
- QMH Referrals
- Medicines Optimisation
- Prescribing Software

Merton CCG completed an Equality Analysis on the following:

- The Female Genital Mutilation Strategy in collaboration with Merton Safeguarding Children Board.
- Safeguarding Adults at Risk Policy
- Evaluation of Gluten-free products from the NHS

Merton CCG implemented the refreshed Equality Delivery System (EDS2) as part of its programme to reduce inequalities, through a review of the following commissioning priorities for Goals 1 and 2:

- Translation and Interpretation Services at GP Surgeries
- Complex Depression and Anxiety Service
The assessment of these services in terms of equality and diversity was undertaken at a public event on 9th June 2016, attended by 30 people, including carers, service users, the voluntary sector, providers, CCG staff and Governing Body members.

The workshop graded each priority and identified areas for improvement which have been carried forward into the commissioning monitoring framework for the services reviewed.

Key outcomes have included:

- To ensure optimal use of the Translation and Interpretation Services, the CCG’s locality team organised a briefing session for practice managers in August 2017 (following the EDS2 public event), where the provider, Central and North West London NHS Trust gave information and addressed queries on the full range of services that had been commissioned for use at GP surgeries. This included information on how to book interpreters (face-to-face and telephonic), quality assurance standards adopted, availability of interpreters to be co-located at GP surgeries with a high demand for some languages on agreed terms, teleconference and video conference facilities (for people requesting sign language interpretation) and availability of specialist interpreters (such as interpreters trained on trauma, displacement and sexual health). The service will be reviewed as planned in April 2017 to assess access, usage and satisfaction rates.

- For the Complex Depression and Anxiety Service, following the EDS2 event, the following changes have been introduced: Patient data is now being disaggregated by protected characteristics with regards to Serious Incidents, complaints and clinical outcomes. In addition the service is now gathering information to understand reasons for patients dropping out.

The assessment of Goal 3 and Outcome 4.3 (which focus on staff experiences) took place at a staff workshop held in October 2016. It was attended by a cross-section of staff from a range of teams, job types and population groups.

Key outcomes aimed at minimising inequalities have included:

- Promoting the employee assistance helpline internally to ensure all staff are aware and have the correct information on accessing it.
- Promoting the staff policies around flexible working and access to HR leads for information and support on any employment related issue, such as recruitment.
The staff survey provides opportunity for employees to express concerns around pressures and tensions within the workplace.

As part of its work on Goal 4 of the EDS2, also known as 'Inclusive Leadership, the CCG’s Governing Body participated in training on equality and diversity and decision-making in December 2016. To ensure independent validation of evidence related this goal, this year, the CCG worked with the equality and diversity lead from London Borough of Merton to identify areas for improvement. Their feedback is being used to strengthen governance processes related to equality and diversity in decision-making.

The EDS2 Report and Action Plan for 2016-17 has been published on the CCG’s Equality and Diversity section of the website.

To address health inequality strategically, Merton CCG is an active participant in key partnerships including: Merton Health and Well-being Board and the South West London Commissioning Collaborative (including the SWL Collaborative patient and public engagement and clinical design programmes). It has participated in the development of Merton Borough’s Joint Strategic Needs Assessment, which provides an overview of the health and well-being of residents in the borough.

The CCG also arranges the Equality and Diversity Steering Group (EDG), which includes representatives from the CCG’s Governing Body, commissioning and patient and public involvement teams and Merton’s Council’s Public Health Team. The EDG oversees the implementation of the CCG’s equality and diversity work plan and makes recommendations for strategic decisions related to addressing inequality.

Detail on Merton CCG’s progress on delivering its general equality duty can be found in its annual public sector equality duty report for the period January to December 2016, which is available on the following link:

**Priorities for 2017/18 include:**

- To ensure providers co-operate with the CCG in providing information on their employment practices and outcomes related to protected groups.
- Services are able to demonstrate improvements relevant to protected groups.
- The CCG continues to be transparent and accountable to its staff, patients and local population in its practices and decision-making processes.
- Objectives are set to test change and improvements annually.
Workforce Race Equality Standard (WRES)

The CCG currently uses the NHS Standard Conditions of Contract with all providers, which includes specific clauses on equality and diversity. Since April 2016, the standard conditions of contract it is mandatory for providers holding contracts over £200,000 to publish (and communicate to the CCG) their Workforce Race Equality Standard metrics and implement the EDS.

Merton CCG has published an internal report on the WRES for the period 2016/17, which was approved by the Clinical Quality Committee and has developed a provider assurance framework whereby key providers report progress against their WRES metrics annually. The WRES Action Plan has been integrated with the EDS2 Action Plan for the year, and was published by March 31, 2017.

The CCG also works closely with the London Borough of Merton Public Health team to address health inequalities. For more details check pages 20-25 of Merton’s Public Sector Equality Duty Report Jan-Dec 2016
Other Performance Targets

Safeguarding Children, Young People and Adults at risk of abuse and neglect

Merton Clinical Commissioning Group (MCCG) is committed to protecting and safeguarding children, young people and adults at risk of abuse and neglect. The safety and welfare of children, young people and adults at risk who come into contact with our services either directly or indirectly is paramount and all staff have a responsibility to ensure that best practice is followed, including compliance with statutory requirements.

MCCG is fully engaged in the work of the Merton Local Safeguarding Children Board and Merton Safeguarding Adult Board. MCCG as a commissioner of health services is fully compliant with the Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2015.

Expectations of healthcare providers are clearly outlined within Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2015 and are embedded within all contracts. These also apply to those services commissioned by healthcare provider organisations. The CCG ensures that organisations commissioned to provide healthcare services have systems in place that safeguard children, young people and adults at risk in line with section 11 of the Children Act 2004 and Care Act 2014. This includes clear accessible policy and procedures, safer recruitment, training and governance systems, which are monitored by Merton CCG, Head of Quality and Adult Safeguarding and the Designated Nurse Safeguarding Children and Children Looked After through performance reporting frameworks.

Merton CCG meets statutory requirements in regard to safer recruitment practices. Disclosure and Barring Service (DBS) checks are undertaken for new staff and repeated every three years for existing staff. These functions and duties are managed through the Merton CCG HR function which is commissioned through the NHS South East Commissioning Support Unit (SECSU).

The CCG ensures all staff complete relevant safeguarding training at a level appropriate to their role and this training is regularly reviewed and updated. Our position with regard to training of staff as of December 2016 is as follows:

- Safeguarding Children: Level 1 (all staff) 80%
• Safeguarding Adults: Level 1 (all staff)  93%

All safeguarding professionals requiring level 4 and above safeguarding training have accessed training; 100%.

The CCG has hosted training events for Primary Care in 2016/17:
• 6th July 2016 – safeguarding children Level 3
• 18th November 2016 – safeguarding children level 3 / safeguarding adults level 2
• 9th March 2017 – Working with families, young people and children at risk of radicalisation / WRAP PREVENT

Events have been well attended by GPs and practice staff and positively evaluated.

The CCG has an annual assurance statement of safeguarding children arrangements which is published on the CCG website. Both the Safeguarding Adults and Safeguarding Children Policies have been reviewed and ratified by the Governing Body. The Governing Body also receives an annual report on both Safeguarding Adults and Safeguarding Children. These are on the CCG’s website.

The CCG has actively supporting Prevent and has also supported Merton Council’s initiative on domestic abuse, providing funding towards the materials to support a local awareness raising campaign around ‘No More’.

Transforming Care

We have worked with providers to ensure the recommendations made in ‘Transforming Care: A national response to Winterbourne View Hospital’ are implemented. We will continue to eliminate inappropriate hospital placements for people with learning disabilities and autism, and people in NHS-funded care who have a mental health condition or challenging behaviour.
Sarah Blow, Accountable Officer for Merton from 27 Feb 2017

Sarah is Accountable Officer for the South West London Alliance which is the result of five CCGs in south west London having chosen to work collectively to maximise health outcomes for local populations

25 May 2017
Corporate Governance Report

Members Report

Details of Membership

For the year ending 31 March 2017 the CCG had 24 member practices reorganised into two localities.

Each locality is led by a nominated GP clinical lead, who is a member of the Clinical Quality Reference Group (CQRG) for their relevant major acute provider, as well as the CCG’s Executive Management Team and Clinical Reference Group. This is integral to how we ensure that all decisions have clinical review, input and challenge. In addition, a Clinical Reference Group (CRG) made up of primary care clinicians including GPs and nurses, further enhances our clinical decision making on wider transformational and system-wide change.

East Merton: Locality Lead is Dr Karen Worthington

There are nine member practices:
- Cricket Green Medical Practice
- Figges Marsh Surgery
- Mitcham Family Practice
- Mitcham Medical Practice
- Ravensbury Park Medical Centre
- Rowans Surgery
- Tamworth House
- Wide Way Surgery
- Wilson Health Centre (closed 31/3/17)

West Merton – The Locality and Clinical lead is Dr Tim Hodgson

There are 15 member practices:
- Alexandra Road Surgery
- Colliers Wood
- Merton Medical Practice
- Princes Road Surgery
- River House Practice
- Vineyard Hill Practice
- Wimbledon Village
- Nelson Medical Centre
- Lambton Road Medical Practice
- Francis Grove Surgery
• Grand Drive Surgery
• James O’Riordan Surgery
• Morden Hall Practice
• Stonecot Surgery
• Central Medical Practice

**Merton CCG Member Practices**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandra Surgery</td>
<td>39 Alexandra Road, Wimbledon SW19 7JZ</td>
</tr>
<tr>
<td>Francis Grove Surgery</td>
<td>Francis Grove Surgery</td>
</tr>
<tr>
<td>Grand Drive Surgery</td>
<td>Grand Drive Surgery</td>
</tr>
<tr>
<td>James O’Riordan Medical Centre</td>
<td>70 Stonecot Hill, Sutton SM3 9HE</td>
</tr>
<tr>
<td>Lambton Road Medical Practice</td>
<td>1 Lambton Road, Raynes Park, SW20 0LW</td>
</tr>
<tr>
<td>Morden Hall Medical Centre</td>
<td>256 Morden Hall Road, London SW19 3DA</td>
</tr>
<tr>
<td>The Nelson Medical Practice</td>
<td>220 Kingston Road, London SW20 8DA</td>
</tr>
<tr>
<td>Princes Road Surgery</td>
<td>51 Princes Road, Wimbledon, SW19 8RA</td>
</tr>
<tr>
<td>Stonecot Surgery</td>
<td>115 Epsom Road, Sutton SM3 9EY</td>
</tr>
<tr>
<td>Vineyard Hill Road Surgery</td>
<td>67 Vineyard Hill Road, Wimbledon SW19 7JL</td>
</tr>
<tr>
<td>Wimbledon Village Surgery</td>
<td>35A High Street, Wimbledon SW19 5BY</td>
</tr>
<tr>
<td>Central Medical Centre</td>
<td>42-46 Central Road, Morden SM4 5RT</td>
</tr>
<tr>
<td>Merton Medical Centre</td>
<td>12-17 Abbey Parade, Merton High Street SW19 1DG</td>
</tr>
<tr>
<td>Colliers Wood Surgery</td>
<td>58 High Street, Colliers Wood, SW19 2BY</td>
</tr>
<tr>
<td>Figges Marsh Surgery</td>
<td>182 London Road, Mitcham CR4 3LD</td>
</tr>
<tr>
<td>Mitcham Family Practice</td>
<td>55 Mortimer Road, Mitcham, CR4 3HW</td>
</tr>
<tr>
<td>Ravensbury Park Medical Centre</td>
<td>Ravensbury Lane, Morden Road, Mitcham CR4 4DQ</td>
</tr>
<tr>
<td>The Rowans Surgery</td>
<td>1 Windermere Road, Streatham SW16 5HF</td>
</tr>
<tr>
<td>Tamworth House Medical Centre</td>
<td>341 Tamworth Lane, Mitcham CR4 1DL</td>
</tr>
<tr>
<td>Cricket Green Surgery</td>
<td>75-79 Miles Road, Mitcham CR4 3DA</td>
</tr>
<tr>
<td>Mitcham Medical Practice</td>
<td>81 Haslemere Ave, Mitcham CR4 3PR</td>
</tr>
<tr>
<td>Riverhouse Surgery</td>
<td>East Road, Wimbledon, SW19 1YG</td>
</tr>
<tr>
<td>Wide Way Surgery</td>
<td>15 Wide Way, Mitcham CR4 1BP</td>
</tr>
<tr>
<td>Wilson Health Centre</td>
<td>Cranmer Rd, Mitcham CR4 4TP</td>
</tr>
</tbody>
</table>

**Governing Body**

The Governing Body oversees the delivery of the CCG’s commissioning plan, sets and leads the strategy for the CCG and is accountable for the delivery of our functions as a statutory body. There are three GPs on our Governing Body including our Clinical GP Chair.
The membership of our Governing body as at 31 March 2017 was:

- Dr Andrew Murray, Chair
- Sarah Blow, Accountable Officer
- Chris Moreton, Acting Director of Finance
- Dr Dagmar Zeuner, Director of Public Health
- Peter Derrick, Lay Member, Chair of the Audit Committee and Vice Chair
- Clare Gummett, Lay Member, Patient and Public Involvement
- Sally Thomson, Independent Nurse Member from 13/8/15 to 1/7/16 then Julie Hall from 1/9/16
- Dr Tim Hodgson, GP Clinical Governing Body Member
- Dr Caroline Chill, GP Clinical Governing Body Member
- Professor Stephen Powis, Secondary Care Consultant
- Chris Clark, Director of Performance (appointed 1/10/16)

Register of Interests

The Register of interests for Merton CCG is published online on the CCG website.

Personal data related incidents

There have been no Serious Incidents Information Governance issues requiring reporting to the Information Commissioner’s Office for Merton CCG.

Statement of Disclosure to Auditors

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

- so far as the member is aware, there is no relevant audit information of which the CCG’s auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG’s auditor is aware of it.

Modern Slavery Act

Merton CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.
Statement of Accountable Officer’s Responsibilities

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:
Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

Make judgements and estimates on a reasonable basis;

State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,

Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG’s auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Sarah Blow, Accountable Officer for Merton from 27 Feb 2017

Sarah is Accountable Officer for the South West London Alliance which is the result of five CCGs in south west London having chosen to work collectively to maximise health outcomes for local populations
NHS England Core Standards for EPRR

Merton CCG is a tier 2 responder in any major incident or emergency, which means we may be called to help NHS England who takes the lead on any major incidents in London. We discharge this responsibility via a formal arrangement with South London Commissioning Support Unit. Merton CCG chief officer and directors take their part in the SW London CCG Directors on call rota.

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Information Governance and Freedom of Information

NHS South East CSU coordinates Freedom of Information requests received by Merton CCG. The CCG complies with its statutory duty to respond to requests for information. During the 2016/17 financial year, the CCG received 268 requests under the Freedom of Information Act 2000 (FOIA 2000), of which 252 were completed within the statutory 20 working days.

We have processes for the reporting and investigation of information governance incidents. This year there were no reportable information governance incidents; which are categorised as those reaching level 2 or more using the Health and Social Care Information Centre Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation.

In 2016/17 the CCG’s Information Governance Toolkit score achieved 97% compliance and it is forecast achieve the same level of compliance for the submission for 2017/18.

Governance Statement

Introduction and context

Merton CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG’s general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in
particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

**Scope of responsibility**

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

**Governance arrangements and effectiveness**

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The CCG are required to undertake a Governing Body effectiveness review each year. This year the decision was taken to undertake this internally, as a full governance review was carried out last year by Capsticks LLP. A self-assessment questionnaire was completed by Governing Body members and nine responses were received. The responses received, particularly those relating to the performance of Governing Body members both individually and collectively, were on the whole positive. There was more variation in the responses where questions related to procedural arrangements and constitutional matters. This may suggest that the frequency of changing Governing Body members resulted in members not being made adequately aware of the processes in place, during their induction period. Overall all of the respondents stated that the Governing Body operates effectively either all of, or most of the time.
**UK Corporate Governance Code**

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

**Discharge of Statutory Functions**

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

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

**Risk management arrangements and effectiveness**

Merton CCG has developed a comprehensive risk management framework which identifies specific risks, responsibilities and mitigating actions at both a strategic and operational level, and then through various committees and reports (e.g. the audit committee and clinical quality committee and the corporate risk register) escalates the most important of these to the Governing Body via the Board Assurance Framework.

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

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

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

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

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

The reporting of the Board Assurance Framework accurately reflects the management of the current risks facing the CCG. The Board Assurance Framework is regularly reviewed to ensure it is in line with the risk management needs of the CCG. The March 2017 BAF can be viewed on the CCG website as part of the Governing Body papers. An example risk from the framework is shown overleaf (p108).

At an operational level, supported by South East Commissioning Support Unit (SECSU), the executive management team (EMT) reviews all risks to the organisation on a cyclical basis. This ensures that risks are effectively identified, assessed, managed and monitored and provides assurance and tracking of effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

Risk appetites are determined by individual risk owners and moderated by the executive management team during the monthly review of the BAF. The audit committee and Governing Body approve the BAF periodically, as set out in the constitution, including the risk appetite scores. Control mechanisms have been chosen according to best practice and management approaches agreed as appropriate by risk leads.
Objective 2: Meet constitutional and statutory standards and quality and performance outcomes while recognising the requirements of the CCG financial strategy.

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Director Lead: Director of Quality &amp; Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial: 5x3 = 15</td>
<td>Date last reviewed: December 2016</td>
</tr>
<tr>
<td>Current: 5 x 1 = 5</td>
<td></td>
</tr>
<tr>
<td>Tolerance: 3 x 1 = 3</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale for current scoring:**
- CCG has a tier 2 role in terms of major incidents, likelihood low, impact high.
- NHSE and providers have a well developed and tested system
- Internal plans and assurance systems need to be tested

**Rationale for acceptable rating and target date for achievement:**
- As above

**Controls** (what are we doing currently about the risk):
- Gain assurance from providers in conjunction with NHS England as part of overall assessment
- Rated as having 'substantial level of assurance' by NHSE
- Liaison with NHSE and attendance at emergency planning meetings
- On call system for CCGs
- Self-assessed CCG position re emergency planning
- EPRR policy approved by GB to replace Business Continuity policy - Nov 2016
- Pandemic Flu Plan approved by GB - May 2015

**Assurance/evidence** (How do we know if things we are doing are having an impact?)
- Business continuity plan – agreed by ELT and GB Nov 2016
- NHSE assurance report
- Attendance record
- Executive director on call rota
- Substantial assurance from NHSE peer review
- Business continuity risk register - reviewed monthly
- Revised business continuity plan (EMT Sept 16)

**Gaps in controls** (what additional assurances should we seek?)

**Further actions required:**
- Review recommendations from SMT business continuity exercise (31/01/2017)
- Unannounced cascade test (31/01/2017)
The risk controls in place, enable the CCG to determine whether the risks are being managed effectively through:

- policies/guidelines
- education and training
- equipment
- staff competency
- induction programme
- any other measures deemed necessary.

Risk assessments are carried out by all services/departments to identify the significant risks arising out of all CCG activities; and their potential to cause injury, litigation, damage to the environment or property, or result in delays or impact upon reputation.

Risks associated with the following are assessed and recorded on the corporate risk register:

- strategic and business plan targets
- adverse incidents and near misses
- complaints
- claims
- new projects
- research and trials
- environmental risk including health and safety risks
- fire safety
- security
- red risks from the directorate risk registers
- quality and safeguarding leads meet regularly with the risk manager to ensure, risks are captured, controls documented and implemented and mitigating actions followed up.

Quality and safety risks are monitored by the Clinical Quality Committee and risks of sufficient severity are escalated as required to the assurance framework.

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

The public has been involved in the design and oversight of our commissioning strategies, which are designed to address the strategic risks of the organisation. An example would be the ‘Choose Wisely’ campaign.

The CCG needs to find £14m of savings in 2017/18 to bring the CCG back into financial balance and provide for cost increases and greater patient demand. To ensure that we live within our means in future and that everyone in Merton has equal access to operations; and that only treatments which offer value to our population are commissioned in 2016/17 the CCG began to consider developing a number of clinical policies which set thresholds for some treatments and do not fund other treatments except in very limited and exceptional circumstances. All CCGs should periodically review the services they commission in light of new evidence, technology change and finances. Responsible disinvestment is as important as investment in new services in order to provide the best possible health outcomes for local people.

The CCG’s Governing Body asked for an initial period of public engagement to discuss these ideas and options with local people before making a decision on how to proceed.

Engagement ran through February and March 2017 and the CCG ran an online and paper survey, took part in over 40 local meetings and events, place posters and leaflets in pharmacies, libraries, GP practices and children’s centres across the borough. Almost a thousand booklets were distributed in total. A report was compiled and went to the Governing Body as part of its consideration of next steps in March 2017.

**Capacity to Handle Risk**

The responsibilities of Directors and committees are set out in the CCG Constitution and the accompanying Scheme of Delegation, as well as the governance reporting lines. Timely and accurate information, to assess risk and ensure compliance with the CCGs statutory obligations, is submitted in line with the CCGs annual plan of committee work. The Governing Body has rigorous oversight of the performance of the CCG, via formal Governing Body meetings, seminars, assurance from committees and audits.
Governance structure 2016/17

Committee Structure

The Governing Body undertakes a proportion of its work through committees.

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

Governing Body

The Governing Body oversees the delivery of the CCG’s commissioning plan, sets and leads the strategy for the CCG and is accountable for the delivery of Merton CCG’s functions as a statutory body. It monitors performance against objectives, provides effective financial stewardship and ensures high standards of corporate governance are achieved. There are three GPs on the Governing Body, including the Clinical GP Chair.
### Membership of the Governing Body

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voting Members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Andrew Murray</td>
<td>Clinical Chair</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Andrew Moore</td>
<td>Chief Officer (Interim)</td>
<td>Feb 17</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Karen Parsons</td>
<td>Chief Officer (Interim)</td>
<td>Oct 16</td>
<td>Jan 17</td>
</tr>
<tr>
<td>Adam Doyle</td>
<td>Chief Officer</td>
<td>Apr 16</td>
<td>Oct 17</td>
</tr>
<tr>
<td>Sarah Blow</td>
<td>Accountable Officer</td>
<td>Feb 17</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Dr Carrie Chill</td>
<td>GP Member</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Dr Tim Hodgson</td>
<td>GP Member</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Peter Derrick</td>
<td>Lay Member: Audit and Finance /Vice Chair</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Clare Gummett</td>
<td>Lay Member: Patient &amp; Public Engagement Lead</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Julie Hall</td>
<td>Independent Nurse Member</td>
<td>Jul 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Sally Thompson</td>
<td>Independent Nurse Member</td>
<td>Apr 16</td>
<td>Apr 16</td>
</tr>
<tr>
<td>Chris Moreton</td>
<td>Chief Finance Officer (Interim)</td>
<td>Jan 17</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Andrew Hyslop</td>
<td>Chief Finance Officer (Interim)</td>
<td>Apr 16</td>
<td>Jan 17</td>
</tr>
<tr>
<td>Prof. Stephen Powis</td>
<td>Secondary Care Consultant</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Dr Dagmar Zeuner</td>
<td>Director of Public Health, LBM</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td><strong>Non-Voting Members</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cynthia Cardozo</td>
<td>Director of Transformation</td>
<td>Apr 16</td>
<td>Jul 16</td>
</tr>
<tr>
<td>Andrew Moore</td>
<td>Programme Director of Financial Recovery and Acting Director of Commissioning Operations</td>
<td>Sep 16</td>
<td>Jan 17</td>
</tr>
<tr>
<td>Chris Clark</td>
<td>Director of Performance, Planning and Informatics (Interim)</td>
<td>Nov 16</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Lynn Street</td>
<td>Director of Quality and Governance</td>
<td>Apr 16</td>
<td>Dec 16</td>
</tr>
<tr>
<td>Liam Williams</td>
<td>Director of Commissioning Operations (Interim)</td>
<td>Oct 16</td>
<td>Jan 17</td>
</tr>
<tr>
<td>Amanda Bland</td>
<td>Deputy Director of Quality</td>
<td>Jan 17</td>
<td>Mar 17</td>
</tr>
<tr>
<td>Dr M Jarzembowski</td>
<td>Chair, Local Medical Committee</td>
<td>Apr 16</td>
<td>Mar 17</td>
</tr>
</tbody>
</table>
The clinicians are well placed to lead NHS commissioning because they talk to and treat patients every day. Having local clinicians working together with patients to plan and manage health services mean that the organisation can focus more on the quality and clinical effectiveness of care than ever before.

Merton CCG Governing Body has now been in operation for four years, and has been able to build on the achievements of the first year since authorisation as a CCG. Their main areas of focus for the year have been: financial recovery, performance and quality matters.

**Governing Body meeting attendance 2016/17**

<table>
<thead>
<tr>
<th>GOVERNING BODY ATTENDANCE 2016/17</th>
<th>GB = Full meeting</th>
<th>S = Seminar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Carrie Chill</td>
<td></td>
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<tr>
<td>Peter Derrick</td>
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<tr>
<td>Adam Doyle</td>
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<td>Karen Parsons</td>
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<td>Andrew Moore</td>
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<td>Dr Andrew Murray</td>
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<tr>
<td>Prof S Powis</td>
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<tr>
<td>Lynn Street</td>
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<tr>
<td>Dr M Jarzemowski</td>
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<tr>
<td>Cynthia Cardozo</td>
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<tr>
<td>Sue Hillyard</td>
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<td>Karen Parsons</td>
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<tr>
<td>Liam Williams</td>
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<tr>
<td>Chris Clark</td>
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<tr>
<td>Andrew Moore</td>
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</table>

**Merton Clinical Quality Committee (MCQC)**

The MCQC has met monthly throughout the year, with the remit of providing assurance to the Governing Body that commissioned services are being delivered in a high-quality and safe manner. The MCQC has been vital in ensuring that quality sits at the heart of everything the CCG does.
The committee delivers it objectives by:

- reviewing the quality of care given at main NHS providers via clinical quality review groups (CQRG) and ensuring action plans are in place. As Merton does not have an acute trust within the borough, the acute CQRG meetings are chaired by a clinician of the ‘host’ CCG, Merton CCG is represented by our relevant GP locality clinical lead in our role as an ‘associate’ commissioner.

- monitoring the Central London Community Healthcare NHS Trust (CLCH) community services contract which is overseen through the CQRG.

- scrutinising a range of quantitative and qualitative data and performance measures to manage risk appropriately and having robust mechanisms in place to effectively address clinical governance issues.

- reviewing and scrutinising the integrated quality and performance report, which provides a more in-depth picture of the quality of care provided to Merton patients by the main providers and is also presented to the Governing Body as part of the balanced scorecard.

- having oversight of the process and compliance issues concerning serious incidents (SIs); central alert systems (CAS); national reporting; and being informed of all ‘never events’ and informing the Governing Body of any escalation or sensitive issues in good time.

- reviewing reports relating to safeguarding adults and children including serious case reviews.

- receiving and scrutinising independent investigation reports relating to patient safety issues and agree publication plans.

- ensuring a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.

- over-seeing and promoting the general duty to improve the quality of primary care so as to improve the quality of services.
Membership and attendance of the committee is as follows:

Chair: Clare Gummett

Each month the committee has a key focus. Over the year this has included: patient experience, safety (including infection control) and quality concerns at our acute trusts, mental health services including SW London St Georges and IAPT (including the impact on patients waiting for long times), Continuing Healthcare and Community Services (CLCH) - a six month review.

The Clinical Transformation Committee

The Clinical Transformation Committee has not met or been constituted during 2016/17. Its work has been covered by the other committees of the Governing Body. However it remains a committee of the Governing Body according to the CCG Constitution and may be reconstituted if required at a future date.

Audit and Governance Committee

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

The committee delivers their objectives by:

- overseeing internal and external audit services
- reviewing the external and internal audit plan
■ review the annual statutory accounts, before they are presented to the Governing Body to determine their completeness, objectivity, integrity and accuracy

■ reviewing financial and information systems, monitoring the integrity of the financial statements and reviewing significant financial reporting judgments

■ providing oversight of the establishment and maintenance through the Board Assurance Framework of an effective system of assurance on risk management and internal control across Merton CCG’s activities that supports achievement of objectives

■ monitoring compliance with Prime Financial Policies and Scheme of Delegation

■ obtaining assurance that Merton CCG has adequate arrangements in place for countering fraud and reviewing outcomes of counter fraud work

■ reviewing schedules of losses and compensations and tender waivers.

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

Chair: Peter Derrick

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<tr>
<th>AUDIT &amp; GOVERNANCE COMMITTEE ATTENDANCE 2015/17</th>
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<tr>
<td>Quarterly</td>
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<td>Peter Derrick</td>
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The committee’s main activities through the year have been focused on: financial controls, procurement, corporate risks, board assurance and the external audit report. The committee also looked at issues around continuing healthcare and tender waivers.

**Finance Committee**

The finance committee was established by the Governing Body to scrutinise financial planning and performance for Merton CCG, review areas of concern and report to the Governing Body as appropriate. It works alongside the audit and governance committee to ensure financial probity in the CCG.
The committee delivers their objective by:

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

Membership and attendance of the committee is as follows:

Chair: Peter Derrick

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The committee’s main activities through the year have been focused on: the CCG’s financial position and recovery plans and trajectory, QIPP delivery, commissioning intentions and particular projects such as referral management and the Wilson walk-in service.
Remuneration and Nominations Committee

During 2016/2017, the remuneration committee’s primary aims have been:

- Director/Chair remuneration
- Pay controls

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

- Governing Body members
- executive directors
- allowances under any pension scheme it might establish as an alternative to the NHS pension scheme
- reviewing the performance of the Chief Officer and other senior team members and determining annual salary awards, if appropriate.

The committee delivers its objective by setting all aspects of salary for the Chief Officer, Chief Finance Officer, executive directors, and lay members of the Governing Body and clinical leads of the organisation.

Membership and attendance of the committee is as follows:

Chair: Peter Derrick

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<th>Present</th>
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Executive Management Team

The Executive Management Team has met throughout the year. It is the operational group, whose purpose is to fulfil the responsibilities of the CCG and to enable the development and delivery of corporate direction.

The committee delivers their objectives by:

- appraising and leading the debate on strategic issues facing the CCG and provide expert advice to the Governing Body
- appraising how these issues should be managed and led within the organisation
- considering corporate issues relating to national policy and local priorities, and agreeing leadership responsibility and arrangements for delivery as appropriate
- overseeing overall operational management of the CCG
- ensuring that EMT actions are defined and timescale for delivery and reporting is agreed
- ensuring business of the CCG is conducted in accordance with Standing Orders (SOs) and Standing Financial Instructions (SFIs)
- establishing and reviewing the assurance framework for the CCG to ensure that risks are assessed and managed
- appraising priorities and risks across directorates and organisations and identifying options for resolution/mitigation including the Commissioning Support Unit
- appraising and monitoring performance of the CCG corporately in accordance with Key Performance Indicators and the NHS Outcomes Framework
- identifying key actions and timescales arising from performance appraisal
- identifying and implementing remedial plans as appropriate to address variances in performance, health outcomes and inequalities
- preparing and reviewing plans in respect of the application and delivery of available financial resources, developing budgets for approval by the Governing Body and scrutinising expenditure

The committees' main activities in 2016/17 have been wide ranging and have covered the CCG’s financial position, corporate and operational risks as well as commissioning activity, strategy development and membership feedback.
Membership and attendance of the committee is as follows:

Chair: Chief Officer

Primary Care Commissioning Committee

NHS Merton CCG has assumed delegated responsibility from NHS England to commission GP primary care services. The Primary Care Commissioning Committee has been established in accordance with statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Merton, under the delegated authority from NHS England. The functions of the Committee are undertaken in the context of a desire to promote increased commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The primary care commissioning committee meets bi-monthly (generally on the same day as our Governing Body meetings) and the meetings are held in public.

It is a committee comprising representatives of the following organisations:

- Merton CCG
- NHS England
- Merton Local Authority
- LMC
- Healthwatch
Membership and attendance of the committee is as follows:

Chair: Clare Gummett

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The committee’s main activities in 2016/17 have focused on: delegated commissioning, service provision, development of the primary care strategy and matters around GP access and improving patient experience.

**Risk Assessment**

The CCG has seven overarching corporate objectives in place, which provide direction and coherence for the work of the CCG as a whole. Directorate objectives have been set in line with these. All board assurance framework risks are aligned with the relevant corporate objective, as agreed by risk leads. This ensures that the Governing Body has oversight of risks which directly impact the achievement of these objectives. These seven objectives have been reviewed during 2016/2017 to reflect the current key objectives which the CCG is seeking to achieve.

The CCG has established an effective organisational structure with clear lines of authority and accountability which guards against inappropriate decision-making and delegation of authorities and enables the CCG to meet statutory duties and follow best practice guidelines. Clinicians and management work in partnership through the commissioning cycle, adding value and delivering outcomes to ensure the procurement of quality services and supplies that are tailored to local needs and deliver sustainable outcomes and value for money.
The establishment of both the audit and governance committee and finance committee provide the Governing Body with assurance over the wide range of business risks. For example, the finance committee has served to provide an overview of financial activity and a sound understanding of costs, performance and achieving efficiencies through reliable and timely financial reporting that meet the needs of internal users, stakeholders and local people.

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

At March 2017, the risks to the CCG with the highest residual scores were:

- 962 Financial and clinical challenges across South West London require organisations to alter current ways of working
- 1029 Transformation programme may not deliver £10m QIPP
- 1030 Stakeholder buy-in to the transformation programme
- 961 If there is a lack of collaboration between SWL CCGs and providers then high quality sustainable solutions may not be determined for healthcare in South West London
- 938 Potential over performance of acute contracts
- 960 If internal and external factors are not managed well, this may impact upon staff morale and staff retention at Merton CCG

Other sources of assurance

*Internal Control Framework*

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.
Annual audit of conflicts of interest management
The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The audit now forms part of the CCGs annual cycle of business for audit, and is reported on at the Audit and Governance Committee periodically.

The annual internal audit of conflicts of interest management for 2016/17 took place in March 2017. The audit concluded that “Taking account of the issues identified, the board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied”. However, the audit identified issues that needed to be addressed in order to ensure that the control framework remained effective in managing the identified risk(s).

The audit identified three ‘Medium’ and three ‘Low’ priority management actions in relation to the design and application of the control framework to progress the CCG to full compliance. An action plan against these areas will be reviewed by the Audit and Governance Committee on 5th June 2017.

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

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

The quality of information that the Governing Body and other governance forums receive to consider and direct decision making is also assured through the service level specification arrangements with the South East Commissioning Support Unit and the use of contractual arrangements with the commissioned providers. The Governing Body and Membership Body are satisfied that the quality of data provided to them is of a good standard.

Information Governance
The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical
commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.

We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure all staff are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation of serious incidents.

We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks. A comprehensive information governance action plan is agreed at the beginning of each year, and implementation is monitored by the IG steering group, chaired by the SIRO, to ensure any gaps are identified and improvements made. The action plan has an emphasis on ensuring that staff complete the mandated modules of the IG e-learning programme and raises the importance of security and confidentiality, in accordance with the Care Records Guarantee.

During this year we worked with our IG expert service, South East Commissioning Support Unit, to achieve level 2 compliance in the IG toolkit for all applicable measures, which is in line with the expected standard. In all bar one area we exceeded level 2 compliance and achieved level 3 compliance. We have processes for the reporting and investigation of information breaches. This year, reported information breaches were:

- nil serious incidents (categorised as 3–5)
- nil minor incidents (categorised as 1–2)

We continue to develop our information risk assessment and management procedures and programmes to fully embed an appreciation of information risk in the culture of the CCG, and will continue in our diligence during the coming year.

**Business Critical Models**

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

The suppliers of our information and computer technology (ICT) and business intelligence (BI) functions are North East London CSU and South East CSU respectively. Business critical models in use within ICT are subject to a number of quality assurance processes which link into the overall framework and management commitment to quality.

There is transparency and management oversight over models and data sources used to make business critical and strategic decisions, with scrutiny within the IG and IAG senior management committees (through which Merton CCG receives assurance). In addition, a governance process is implemented whereby an internal peer review process is supported by robust document control, ownership and accountability.

Data inputs and outputs are regularly validated, with senior management responsible for an overall ‘sense check’ before decisions are approved. Business critical models in use within BI include processes which supports the identification and maintenance of a list of all business critical models and a schedule for periodic review.

Qualified and experienced personnel exercise professional scepticism over the outputs from key models and organisational use of data. These processes are subject to review by internal auditors, who review management information data and process owners, and external auditors, whose work covers the quality assurance processes of financial models.

Third party assurances
The CCG has not relied on any third party providers for assurance, outside of audit.

Control Issues
No significant control issues have been identified during 2016/17

Review of economy, efficiency & effectiveness of the use of resources
The Executive Management Team monitors the performance against all of the CCGs delivery plans monthly. This includes ensuring that projects and programmes are delivering cost effective services and optimal benefits to our patient population. The executive management team also meets monthly to discuss and review strategic programmes and to make recommendations to the Governing Body.
The finance committee has ownership of the management of financial risks and the CCG audit and governance committee takes an independent view of the CCG’s financial management (detailed below). The audit and governance committee is attended by our colleagues from internal audit and external audit and reports to the Governing Body.

Merton CCG’s QIPP target for 2016/2017 was £7.3m. Actual achievement was £7.258m. There were some minor variances to target (totalling £38,000). QIPP performance continues to be discussed at the executive management team meetings. These meetings have clinical representation from the two clinical locality leads. Performance and identification of new schemes is also reviewed and discussed on a weekly basis at the QIPP delivery group. This meeting is chaired by the Chief Finance Officer.

**Delegation of functions**

The CCG has not delegated any functions externally. Internal delegation is detailed in the Scheme of Delegation, which is reviewed regularly. Compliance is monitored through reporting to the Audit and Governance Committee, the annual audit cycle and review of terms of reference of Governing Body committees to assess their on-going suitability.

**Counter fraud arrangements**

Merton CCG contracts Fraud Services through an Accredited Counter Fraud Specialist (ACFS) engaged via a contract with RSM UK Tax and Accounting Limited. RSM also provide Internal Audit services to the CCG. As well as receiving an annual report from the ACFS the CCG receives quarterly Counter Fraud Progress Reports which is monitored against the Counter Fraud plan agreed by the Audit and Governance Committee.

The Chief Financial Officer is the Executive Board member who has responsibility for proactively tackling fraud, bribery and corruption. There has been no NHS Protect Quality Assurance Inspection during the year and hence there have been no recommendations from NHS Protect on which the CCG should take action during 2016/17.
Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group’s system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Factors and findings which have informed our opinion

Based on the work undertaken in 2016/17 there is a generally sound system of internal control, designed to meet the CCG’s objectives, and controls are generally being applied consistently.

We have provided either a substantial or reasonable level of assurance for all areas reviewed, where an assurance opinion was required. However, we have issued one report relating to GP Overpayment which noted several issues where action was needed to strengthen the control framework to manage identified risks.

Due to the review being of an advisory nature we were not required to provide a level of assurance that the controls to manage risks are suitably designed and consistently applied; however a number of control weaknesses were identified which resulted in an overpayment and which were brought to our attention by management at the CCG. These included making non-purchase order payments against fixed term contracts where the use of purchase orders as a primary control could have served as a check against making additional payments. There also appeared to be lack of budget holder challenge before approving invoices for payment. In addition, there was no evidence from either the CCG or the Practice to clarify and confirm the contract end date for one contract.

We have agreed clear action plans to address the issues raised and will continue to follow up any outstanding actions during 2017/18 and report to the Audit Committee.

Further issues relevant to this opinion

We have considered the findings of the Service Auditor reports and bridging letter covering all twelve months of 2016/17 carried out by the internal auditors of NHS England, where services are provided to the CCG from South East Commissioning Support Unit (from 1 April 2017 this will be NEL Commissioning Support Unit). We have also reviewed the Service Auditor Report
from the internal auditors of NHS Shared Business Services, who via a contract with NHS England, provide services to the CCG. Neither of these raised any significant control issues which impacted on this opinion. Issues judged relevant to the preparation of the annual governance statement.

Based on the work we have undertaken on the CCG’s system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS), although the CCG may wish to consider the potential significance of the control issues identified during the course of our review of GP Overpayments.

The CCG may also wish to consider whether any other issues have arisen, including the results of any external reviews which it might want to consider for inclusion in the Annual Governance Statement.

**Scope of the opinion**

The opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS).

**Nick Atkinson**

*Partner, RSM Risk Assurance Services LLP*

**Review of the effectiveness of governance, risk management and internal control**

I took up the role of Accountable Officer on 27 February 2017. Therefore my review of the effectiveness of the system of internal control for this year has been particularly informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have also drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.
Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

During the year, Internal Audit issued the following audit reports:

<table>
<thead>
<tr>
<th>Area of Audit</th>
<th>Level of Assurance Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Commissioning</td>
<td>Reasonable Assurance – No High Priority Recommendations</td>
</tr>
<tr>
<td>Financial Control Environment Assessment</td>
<td>There is a robust evidence based process to support the Financial Control Environment Assessment submission to NHS England.</td>
</tr>
<tr>
<td>Follow Up - Safeguarding Vulnerable Adults and Children</td>
<td>Merton CCG has demonstrated reasonable progress in implementing actions agreed to address internal audit recommendations – No High Priority Recommendations.</td>
</tr>
<tr>
<td>Quality, Innovation, Productivity and Prevention (QIPP) / Budget Setting</td>
<td>Reasonable Assurance – No High Priority Recommendations</td>
</tr>
<tr>
<td>Procurement and Contracts Register</td>
<td>Reasonable Assurance – No High Priority Recommendations</td>
</tr>
</tbody>
</table>

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms

**Conclusion**

No significant internal control issues have been identified.

**Sarah Blow, Accountable Officer**

Sarah is Accountable Officer for the South West London Alliance which is the result of five CCGs in south west London having chosen to work collectively to maximise health outcomes for local populations

25 May 2017
Remuneration and Staff Report

Remuneration Report

Remuneration Committee

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

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Role</th>
<th>Date joined committee</th>
<th>Date left committee</th>
<th>No of committee meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Derrick</td>
<td>Lay member for Audit and Governance</td>
<td>01.04.13</td>
<td>NA</td>
<td>3</td>
</tr>
<tr>
<td>Julie Hall</td>
<td>Independent Nurse Member</td>
<td>27.07.16</td>
<td>NA</td>
<td>1</td>
</tr>
<tr>
<td>Clare Gummett</td>
<td>Lay member for PPI</td>
<td>01.04.13</td>
<td>NA</td>
<td>2</td>
</tr>
<tr>
<td>Dr Andrew Murray</td>
<td>Clinical Chair</td>
<td>01.04.16</td>
<td>NA</td>
<td>3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona Stirling (employee of South East Commissioning Support Unit)</td>
<td>Human Resources Associate</td>
<td>Advice</td>
</tr>
<tr>
<td>Adam Doyle</td>
<td>Chief Officer</td>
<td>Advice</td>
</tr>
<tr>
<td>Karen Parsons</td>
<td>Chief Officer (Interim)</td>
<td>Advice</td>
</tr>
<tr>
<td>Andrew Hyslop</td>
<td>Chief Finance Officer (Interim)</td>
<td>Advice</td>
</tr>
<tr>
<td>Chris Moreton</td>
<td>Chief Finance Officer (Acting)</td>
<td>Advice</td>
</tr>
</tbody>
</table>

Remuneration Policy

The Committee’s deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures. NHS Merton CCG will be using the national pay and remuneration guidelines for the coming financial year.

Senior Managers’ Performance Related Pay

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

Senior Managers’ Service contracts

All senior managers’ at Merton CCG follow the national pay and remuneration guidelines.
# Senior manager remuneration (Audited)

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees</th>
<th>Taxable Benefits</th>
<th>Annual Performance Related Bonuses</th>
<th>Long-term Performance Related bonuses</th>
<th>All Pension Related Benefits</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynthia Cardozo – Director of Transformation (End Date 30/10/16)</td>
<td>105 - 110</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17.5 - 20</td>
<td>125 - 130</td>
</tr>
<tr>
<td>Dr Carrie Chill – Clinical Governing Body Member</td>
<td>115 - 120</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>115 - 120</td>
</tr>
<tr>
<td>Peter Derrick – Lay person with responsibility for finance and governance</td>
<td>10 - 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Adam Doyle – Chief Officer (End Date 19/10/16)</td>
<td>120 - 125</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>37.5 - 40</td>
<td>160 - 165</td>
</tr>
<tr>
<td>Clare Gummett – Lay person with responsibility for patient and public involvement</td>
<td>10 - 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Dr Andrew Murray – Chair</td>
<td>95 - 100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>95 - 100</td>
</tr>
<tr>
<td>Professor Stephen Powis – Secondary Care Consultant</td>
<td>10 - 15 (Note 1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Lynn Street – Director of Quality (End Date 31/12/2016)</td>
<td>90 - 95</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>40 - 42.5</td>
<td>135 - 140</td>
</tr>
<tr>
<td>Dr Tim Hodgson – GP Member</td>
<td>15 - 20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 7.5</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Julie Hall - GP Independent Nurse (Start Date 21/7/16)</td>
<td>10 - 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Andrew Hyslop – Chief Finance Officer (Interim) (End date 13/1/17)</td>
<td>180 - 185</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>180 - 185</td>
</tr>
<tr>
<td>Sue Hillyard – Director of Commissioning Operations (Interim) (End Date 19/9/16)</td>
<td>80 - 85</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>80 - 85</td>
</tr>
<tr>
<td>Chris Clark - Director of Performance, Planning and Informatics (Start Date 1/10/16)</td>
<td>85 - 90</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10 - 12.5</td>
<td>100 - 105</td>
</tr>
<tr>
<td>Chris Moreton - Acting Chief Finance Officer (Start Date 14/1/17)</td>
<td>40-45</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>790 - 792.5</td>
<td>835 - 840</td>
</tr>
<tr>
<td>Karen Parsons - 2 roles, Director of Commissioning Operations, Chief Officer (Interim) (Start Date 20/9/16, End Date 26/1/17)</td>
<td>120 - 125</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>120 - 125</td>
</tr>
</tbody>
</table>
Andrew Moore - Chief Officer (Interim) (Start Date 27/1/17) & 50 - 55 & 0 & 0 & 0 & N/A & 50 - 55 \\
Liam Williams – Director of Commissioning Operations (Interim) (Start Date 3/10/16, End Date 27/1/17) & 75 - 80 & 0 & 0 & 0 & N/A & 75 - 80 \\
Dagmar Zeuner - Director of Public Health, London Borough of Merton & 0 & 0 & 0 & 0 & N/A & 0 \\

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

Note 2: Sarah Blow became NHS Merton CCG’s Accountable Officer on 27 February 2017. For administrative reasons she is paid through NHS Wandsworth CCG. Therefore her remuneration details do not appear in the above table. Details can be found within note 5 of the Wandsworth CCG accounts.

NHS organisations are required to disclose the pension benefits for those persons disclosed as senior managers of the organisation, where the clinical commissioning group has made a direct contribution to a pension scheme.

Due to the nature of clinical commissioning groups, some GPs have served as office holders of NHS Merton CCG. However, for GPs who work under a contract for services with the CCG, they are not considered to hold a pensionable post and so no pension disclosure is required.

From 1 April 2013, NHS England became the employing agency for all types of GPs and pensions contributions have been made by NHS England rather than the CCG. The CCG has made no direct GP payments to NHS Pensions Agency for GP pension contributions.

**Pension benefits as at 31 March 2017 (Audited)**

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60</th>
<th>Real increase in pension lump sum at aged 60</th>
<th>Total accrued pension at age 60 at 31 March 2017</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2017</th>
<th>Cash Equivalent Transfer Value at 31 March 2016</th>
<th>Cash Equivalent Transfer Value at 31 March 2017</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Employer's contribution to partnership pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam Doyle – Chief Officer</td>
<td>0-2.5</td>
<td>0</td>
<td>5-10</td>
<td>0</td>
<td>41</td>
<td>59</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Lynn Street – Director of Quality</td>
<td>0-2.5</td>
<td>2.5-5.0</td>
<td>20-25</td>
<td>70-75</td>
<td>412</td>
<td>465</td>
<td>53</td>
<td>0</td>
</tr>
</tbody>
</table>

NHS Merton CCG
**Cash equivalent transfer values**

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable beneficiary’s) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

**Real increase in CETV**

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Pay multiples (Audited)

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

The banded remuneration of the highest paid director in the financial year 2016/17 was £190-195k (2015/16 - £120-125k). This was 4.6 times (2015/16 – 2.8 times) the median remuneration of the workforce, which was £42k (2015/16 - £44k).

In 2016/17 (and 2015/16), no other employee received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from 10k to £185k (2015/16 £10-125k).

For the purposes of calculating pay multiples, remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Staff Report

Communicating and Engaging

There are a number of ways in which the CCG communicates and engages with its staff. These include:

- A SWL Staff Partnership Forum where managers and staff from the six SWL CCGs meet to discuss and consult on issues.
- Regular team briefings with the staff and Executive Management Team

The CCG ran a bespoke Staff Survey in 2016 and an action plan has been put in place based on the results of the survey. The survey will be repeated in 2017 and will provide the CCG with an opportunity to build up a picture of staff experience.

Training and Development

There is a requirement for staff to undertake Statutory and Mandatory training, which they can complete either via e-learning from Skills for Health or through in-house sessions. Training compliance is reported back to the CCG on a regular basis. The SECSU was commissioned to implement a learning and development module including an E-PDR process and statutory and mandatory training onto the CCGs electronic Workforce System, which went live in April 2016.
Number of senior staff by band – as at 31 March 2017

- 1 Chief Finance Officer (Male) on AFC Band 9
- 2 Directors (1 male and 1 female) on AFC Band 9 and Band 8D

Employee numbers excluding Governing Body Members

(who are Office Holders not employees) as at 31 March 2017

- 41 staff
- 39.26 Full time equivalent

Total Staff Costs for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Staff Costs</th>
<th>Total £'000</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,686</td>
<td>2,470</td>
<td>2,216</td>
</tr>
<tr>
<td>Social security costs</td>
<td>277</td>
<td>277</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>273</td>
<td>273</td>
<td>0</td>
</tr>
<tr>
<td>Net employee benefits excluding capitalised costs</td>
<td>5,236</td>
<td>3,020</td>
<td>2,216</td>
</tr>
</tbody>
</table>

Staff composition by gender as at 31 March 2017 (Audited)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of persons of each sex who were on each of the Membership and Governing Body and Clinical Leads</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>The number of other senior manager of each sex who were a grade Very Senior Manager (Director)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>The number of persons of each sex who were employees of the CCG</td>
<td>9</td>
<td>29</td>
</tr>
</tbody>
</table>

The following tables are a profile of the CCG relating to the main protected characteristics. Tables do not include Governing Body membership / Clinical Leads.

Sickness Absence in 2016/17

(1 January 2016 - 31 December 2016)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>138</td>
</tr>
<tr>
<td>Total staff years</td>
<td>41</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>3</td>
</tr>
<tr>
<td>Number of persons retiring on ill health grounds</td>
<td>0</td>
</tr>
</tbody>
</table>
The CCG Sickness Absence percentage rate is presented monthly as part of the KPIs. The HR Business Partner works closely with managers to ensure that sickness absence cases are being managed in a timely way and in accordance with the CCGs Sickness Absence policy. An Occupational Health (OH) service is available to provide professional medical advice to the CCG. Staff can access OH for a self-referral and can access the OH Counselling service. The CCG also has access to an Employee Assistance Programme which is provided by Right Management, which offers confidential access to emotional and practical support, 24 hours a day, 7 days a week, including legal and financial advice.

**Staff policies**

The CCG has a full suite of up to date HR Policies in place based on best practice, employment legislation and national terms and conditions, and are available to all staff on the CCG intranet.

The following new policies were developed and implemented during the year:

- Recruitment Policy
- Learning and Development Policy
- Travel, Subsistence and Expenses Policy.

**Employee Consultation**

Organisational Change is managed in accordance with the principles and procedures contained within the CCG’s Organisational Change Policy. The CCG also informally communicates and consults with employees via global emails and regular staff briefings.

At the end of 2016 staff were consulted as part of the arrangements to create the new South West London Alliance and Merton and Wandsworth Local Delivery Unit.

**Policy on Disabled Employees**

Disabled employees are protected under the “protected characteristics” of the Equality Act 2010, one of which is disability. The CCG’s Equality & Diversity Strategy supports the CCG in ensuring that the requirements and reasonable adjustments necessary for employees with disabilities are taken into account during their employment and that people with disabilities are not discriminated against on the ground of their disability at any stage of the recruitment process or in their employment with the CCG.
The CCG’s Sickness Absence Policy confirms that where an employee becomes disabled as a result of sickness, the CCG will make any necessary reasonable adjustments, as required, and in accordance with the Equality Act to enable the employee to return to work. The types of adjustments may include adjustments to work base, working hours, redeploying the employee to another suitable position and providing any necessary equipment to assist the employee to perform their role.

**Equalities for Staff**

The CCG’s Equality and Diversity Strategy supports the promotion of a working environment in which all parties and procedures relating to recruitment, selection, training, promotion and employment are free from unfair discrimination, ensuring that no employee or prospective employee is discriminated against, whether directly or indirectly on the grounds of age; disability; gender reassignment; pregnancy and maternity; race including ethnic or national origins, colour or nationality; religion or belief; sex (gender); sexual orientation; marriage and civil partnership; trade union membership; responsibility for dependents or any other condition or requirement which cannot be shown to be justifiable.

**Off-payroll engagements**

**Off-payroll engagements longer than 6 months**

For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of existing engagements as of 31 March 2017</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
<td>1</td>
</tr>
</tbody>
</table>
New off-payroll engagements

For all new off-payroll engagements between 01 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017</td>
<td>15</td>
</tr>
<tr>
<td>Number of new engagements which include contractual clauses giving Merton CCG the right to request assurance in relation to income tax and National Insurance obligations</td>
<td>13</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>0</td>
</tr>
</tbody>
</table>

Off-payroll engagements/senior official engagements

Merton CCG had six off-payroll engagements in the financial year ending 31/3/17.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year</td>
<td>6</td>
</tr>
<tr>
<td>Number of individuals that have been deemed “Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements)</td>
<td>10</td>
</tr>
</tbody>
</table>

Expenditure on consultancy

<table>
<thead>
<tr>
<th>Consulting Ltd</th>
<th>Amount</th>
<th>Period</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSM UK Consulting Ltd</td>
<td>£129,497.00</td>
<td>April-16 to July-16</td>
<td>Financial Recovery Plan support</td>
</tr>
<tr>
<td>Apira Ltd</td>
<td>£15,754.50</td>
<td>Jan-17 to Feb-17</td>
<td>Support development and use of the DXS Best Triage Plus solution</td>
</tr>
<tr>
<td>Tricordant Ltd</td>
<td>£26,300.51</td>
<td>2016/17</td>
<td>Vision and Strategy/Organisational Development Support</td>
</tr>
</tbody>
</table>
Exit packages (Audited)

The CCG had one agreed exit package in 2016/17, analysis provided below.

Analysis of Other Departures

<table>
<thead>
<tr>
<th>Agreements</th>
<th>Total Value of agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>17</td>
</tr>
</tbody>
</table>

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

Merton CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.
Sarah Blow, Accountable Officer for Merton from 27 Feb 2017

Sarah is Accountable Officer for the South West London Alliance which is the result of five CCGs in south west London having chosen to work collectively to maximise health outcomes for local populations

25 May 2017
NHS MERTON CLINICAL COMMISSIONING GROUP
ANNUAL ACCOUNTS 2016/17
<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Primary Statements:</td>
<td></td>
</tr>
<tr>
<td>Auditor's Opinion on Accounts</td>
<td>3</td>
</tr>
<tr>
<td>Statement of Comprehensive Net Expenditure for the year ended 31st March 2017</td>
<td>6</td>
</tr>
<tr>
<td>Statement of Financial Position as at 31st March 2017</td>
<td>7</td>
</tr>
<tr>
<td>Statement of Changes in Taxpayers' Equity for the year ended 31st March 2017</td>
<td>8</td>
</tr>
<tr>
<td>Statement of Cash Flows for the year ended 31st March 2017</td>
<td>9</td>
</tr>
<tr>
<td>Notes to the Accounts</td>
<td></td>
</tr>
<tr>
<td>Accounting policies</td>
<td>10</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>13</td>
</tr>
<tr>
<td>Revenue</td>
<td>13</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>14</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>16</td>
</tr>
<tr>
<td>Better payment practice code</td>
<td>17</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>18</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>19</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>20</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>20</td>
</tr>
<tr>
<td>Provisions</td>
<td>20</td>
</tr>
<tr>
<td>Commitments</td>
<td>21</td>
</tr>
<tr>
<td>Financial instruments</td>
<td>21</td>
</tr>
<tr>
<td>Operating segments</td>
<td>23</td>
</tr>
<tr>
<td>Pooled budgets</td>
<td>23</td>
</tr>
<tr>
<td>Related party transactions</td>
<td>24</td>
</tr>
<tr>
<td>Events after the end of the reporting period</td>
<td>25</td>
</tr>
<tr>
<td>Losses and special payments</td>
<td>25</td>
</tr>
<tr>
<td>Financial performance targets</td>
<td>25</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS MERTON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Merton Clinical Commissioning Group (CCG) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014 (the “Act”). The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the “2016/17 GAM”) and the requirements of the Health and Social Care Act 2012.

This report is made solely to the members of the Governing Body of NHS Merton Clinical Commissioning Group, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the “Code of Audit Practice”) and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice as required by the Act.

As explained in the Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report by exception where we are not satisfied.

We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Performance Report and the Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.
Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Opinion on financial statements

In our opinion:

- the financial statements give a true and fair view of the financial position of NHS Merton Clinical Commissioning Group as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we have referred a matter to the Secretary of State under section 30 of the Act because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the CCG under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above matters.
Certificate

We certify that we have completed the audit of the financial statements of NHS Merton Clinical Commissioning Group in accordance with the requirements of the Act and the Code of Audit Practice.

Sarah Ironmonger

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

Grant Thornton UK LLP
Grant Thornton House Melton Street Euston Square London. NW1 2EP

26 May 2017
Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from sale of goods and services</td>
<td>(8,313)</td>
<td>(21,417)</td>
</tr>
<tr>
<td>Other operating income</td>
<td>(616)</td>
<td>(246)</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td><strong>(8,929)</strong></td>
<td><strong>(21,663)</strong></td>
</tr>
<tr>
<td>Staff costs</td>
<td>5,236</td>
<td>3,877</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>276,055</td>
<td>256,452</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td>200</td>
<td>129</td>
</tr>
<tr>
<td>Other Operating Expenditure</td>
<td>139</td>
<td>145</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td><strong>281,630</strong></td>
<td><strong>260,603</strong></td>
</tr>
<tr>
<td><strong>Net Operating Expenditure</strong></td>
<td><strong>272,701</strong></td>
<td><strong>238,940</strong></td>
</tr>
<tr>
<td><strong>Comprehensive Expenditure for the year ended 31 March 2017</strong></td>
<td><strong>272,701</strong></td>
<td><strong>238,940</strong></td>
</tr>
</tbody>
</table>

Income and Expenditure streams are no longer required to be categorised between administration and programme. The new format has been applied to prior year figures to ensure year on year comparability.
Statement of Financial Position as at 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>671</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td>671</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>8</td>
<td>4,959</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td>4,976</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>5,648</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
<td>(21,162)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td>(21,162)</td>
</tr>
<tr>
<td><strong>Non-Current Assets plus/less Net Current Assets/Liabilities</strong></td>
<td></td>
<td>(15,515)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td></td>
<td>(15,515)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers' Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(15,515)</td>
</tr>
<tr>
<td><strong>Total taxpayers' equity:</strong></td>
<td></td>
<td>(15,515)</td>
</tr>
</tbody>
</table>

The notes on pages 10 to 25 form part of this statement.

The financial statements on pages 6 to 25 were approved by the Governing Body on the 25th May 2017 and signed on its behalf by:

Chief Accountable Officer
Sarah Blow
### Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

#### Changes in taxpayers’ equity for 2016-17

<table>
<thead>
<tr>
<th>Description</th>
<th>General fund (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2016</strong></td>
<td>(13,671)</td>
</tr>
<tr>
<td><strong>Adjusted NHS Clinical Commissioning Group balance at 31 March 2017</strong></td>
<td>(13,671)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2016-17</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(272,701)</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(272,701)</td>
</tr>
<tr>
<td>Net funding</td>
<td>270,857</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td>(15,515)</td>
</tr>
</tbody>
</table>

#### Changes in taxpayers’ equity for 2015-16

<table>
<thead>
<tr>
<th>Description</th>
<th>General fund (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2015</strong></td>
<td>(10,693)</td>
</tr>
<tr>
<td><strong>Adjusted NHS Clinical Commissioning Group balance at 31 March 2016</strong></td>
<td>(10,693)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(238,940)</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(238,940)</td>
</tr>
<tr>
<td>Net funding</td>
<td>235,962</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2016</strong></td>
<td>(13,671)</td>
</tr>
</tbody>
</table>

The notes on pages 10 to 25 form part of this statement
Statement of Cash Flows for the year ended
31 March 2017

<table>
<thead>
<tr>
<th>Cash Flows from Operating Activities</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(272,701)</td>
<td>(238,940)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5</td>
<td>200</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>8</td>
<td>(1,866)</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>10</td>
<td>3,451</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td><strong>(270,916)</strong></td>
<td><strong>(235,764)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Flows from Investing Activities</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Payments) for property, plant and equipment</td>
<td>0</td>
<td>(198)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Investing Activities</strong></td>
<td><strong>0</strong></td>
<td><strong>(198)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net Cash Inflow (Outflow) before Financing</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(270,916)</strong></td>
<td><strong>(235,962)</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Flows from Financing Activities</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant in Aid Funding Received</td>
<td>270,857</td>
<td>235,962</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td><strong>270,857</strong></td>
<td><strong>235,962</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net Increase (Decrease) in Cash &amp; Cash Equivalents</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(59)</strong></td>
<td><strong>0</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>76</strong></td>
<td><strong>76</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17</strong></td>
<td><strong>76</strong></td>
<td></td>
</tr>
</tbody>
</table>

The notes on pages 10 to 25 form part of this statement.
Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

The accounts have been prepared under the going concern basis as:

- the CCG is a continuing entity and has its resource limit set for the following financial year;
- the CCG has submitted its financial plan for 2017/18 to NHS England;
- the CCG is a continuing entity and has its resource limit set for the following financial year;
- the agreed revenue resource limit provides Merton CCG with the drawdown.

1.2 Accounting Convention

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

1.3 Pooled Budgets

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

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

- the assets the clinical commissioning group controls;
- the liabilities the clinical commissioning group incurs;
- the expenses the clinical commissioning group incurs; and,
- the clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

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

In 2016/17 NHS Merton CCG had a pooled budget with the London Borough of Merton for the Better Care Fund and Integrated Community Equipment Services. Both these pooled budgets are jointly controlled operations where the fund is hosted and accounted for by the London Borough of Merton.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical Judgements in Applying Accounting Policies

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

- The accounting arrangements for balances transferred from predecessor PCTs ("legacy balances") are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories.

1.4.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements:

The largest estimated cost in the CCG’s accounts relates to the February and March 2017 prescribing accrual. This accrual has been calculated at £3.7m and is a best estimate based on the spend from April 2016 to January 2017.

1.5 Revenue

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

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

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

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

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

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

1.7 Other Expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, Plant & Equipment

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

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

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

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

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are recognised as an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

The item has a cost of at least £5,000; or,
· The cost of the item can be measured reliably; and,
· It is expected to be used for more than one financial year;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.13 Clinical Negligence Costs
The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with NHS Merton CCG.

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

1.15 Contingencies

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.16 Financial Assets

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

The only financial assets held are loans and receivables.

1.16.1 Loans & Receivables

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

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

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

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

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

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

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18 Value Added Tax

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

1.19 Losses & Special Payments

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

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

1.20 Joint Operations

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

1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.
2 Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Total</th>
<th>2016-17 Admin</th>
<th>2016-17 Programme</th>
<th>2015-16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, training and research</td>
<td>54 '000</td>
<td>40 '000</td>
<td>14 '000</td>
<td>62 '000</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>0 '000</td>
<td>0 '000</td>
<td>0 '000</td>
<td>60 '000</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>89 '000</td>
<td>0 '000</td>
<td>89 '000</td>
<td>51 '000</td>
</tr>
<tr>
<td>Other revenue</td>
<td>8,786 '000</td>
<td>178 '000</td>
<td>8,608 '000</td>
<td>21,490 '000</td>
</tr>
<tr>
<td>Total other operating revenue</td>
<td>8,929 '000</td>
<td>218 '000</td>
<td>8,711 '000</td>
<td>21,663 '000</td>
</tr>
</tbody>
</table>

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

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

Programme revenue relates to:
- Hosting Merton Borough Community Services contract - 52%
- Hosting South West London Cancer Network - 11%
- Primary Care transformation income - 11%
- Other - 27%

Merton Clinical Commissioning Group no longer hosts the community services contract on behalf of Sutton Clinical Commissioning Group and Sutton Borough Council. This has led to a reduction in other revenue compared to 2015/16.

3 Revenue

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Total</th>
<th>2016-17 Admin</th>
<th>2016-17 Programme</th>
<th>2015-16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>From rendering of services</td>
<td>8,929 '000</td>
<td>218 '000</td>
<td>8,711 '000</td>
<td>21,663 '000</td>
</tr>
<tr>
<td>Total</td>
<td>8,929 '000</td>
<td>218 '000</td>
<td>8,711 '000</td>
<td>21,663 '000</td>
</tr>
</tbody>
</table>

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

### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th>Employee Benefits</th>
<th>2016-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,686</td>
<td>2,470</td>
</tr>
<tr>
<td>Social security costs</td>
<td>277</td>
<td>277</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>273</td>
<td>273</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>5,236</td>
<td>3,020</td>
</tr>
</tbody>
</table>

### 2015-16

<table>
<thead>
<tr>
<th>Employee Benefits</th>
<th>2015-16</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>3,342</td>
<td>2,299</td>
</tr>
<tr>
<td>Social security costs</td>
<td>222</td>
<td>222</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>313</td>
<td>313</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>3,877</td>
<td>2,834</td>
</tr>
</tbody>
</table>


4.2 Pension costs

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

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

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

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

4.2.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2016-17, employers’ contributions of £272,705 were payable to the NHS Pensions Scheme (2015-16: £313,216) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.
5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Total</th>
<th>2016-17 Admin</th>
<th>2016-17 Programme</th>
<th>2015-16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>4,260</td>
<td>1,093</td>
<td>3,168</td>
<td>3,302</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>976</td>
<td>709</td>
<td>267</td>
<td>574</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td><strong>5,237</strong></td>
<td><strong>1,802</strong></td>
<td><strong>3,435</strong></td>
<td><strong>3,876</strong></td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>5,912</td>
<td>2,189</td>
<td>3,723</td>
<td>7,009</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>91,166</td>
<td>9</td>
<td>91,157</td>
<td>125,901</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>87,578</td>
<td>10</td>
<td>87,568</td>
<td>64,660</td>
</tr>
<tr>
<td>Services from other WGA bodies</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>33,726</td>
<td>0</td>
<td>33,726</td>
<td>29,108</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>139</td>
<td>87</td>
<td>52</td>
<td>145</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>182</td>
<td>61</td>
<td>121</td>
<td>576</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>171</td>
<td>31</td>
<td>140</td>
<td>0</td>
</tr>
<tr>
<td>Establishment</td>
<td>671</td>
<td>33</td>
<td>638</td>
<td>571</td>
</tr>
<tr>
<td>Transport</td>
<td>11</td>
<td>2</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Premises</td>
<td>1,988</td>
<td>189</td>
<td>1,799</td>
<td>614</td>
</tr>
<tr>
<td>Depreciation</td>
<td>200</td>
<td>0</td>
<td>200</td>
<td>129</td>
</tr>
<tr>
<td>Audit fees</td>
<td>57</td>
<td>57</td>
<td>0</td>
<td>57</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>23,510</td>
<td>0</td>
<td>23,510</td>
<td>23,750</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>30,355</td>
<td>0</td>
<td>30,355</td>
<td>2,732</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>316</td>
<td>85</td>
<td>231</td>
<td>476</td>
</tr>
<tr>
<td>Education and training</td>
<td>83</td>
<td>49</td>
<td>34</td>
<td>162</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>326</td>
<td>0</td>
<td>326</td>
<td>814</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td><strong>276,393</strong></td>
<td><strong>2,803</strong></td>
<td><strong>273,590</strong></td>
<td><strong>256,726</strong></td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>281,630</strong></td>
<td><strong>4,605</strong></td>
<td><strong>277,025</strong></td>
<td><strong>260,602</strong></td>
</tr>
</tbody>
</table>

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

Programme expenditure is expenditure incurred that is directly attributable to the provision of healthcare or healthcare services.

There was a significant reduction in services from foundation trusts in 2016/17, this was due to the Community Services contract ending with the Royal Marsden NHS foundation trust, which had a spend of £34.8m in 2015/16.

In April 2016, Merton Clinical Commissioning Group took over responsibility for the commissioning of Primary Care Services from NHS England, which has led to an increased spend of £28.7m in GPMS/APMS and PCTMS spend in 2016/17.
6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2015-16</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£'000</td>
<td>Number</td>
<td>£'000</td>
</tr>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>9,661</td>
<td>64,634</td>
<td>8,380</td>
<td>33,637</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>9,522</td>
<td>63,643</td>
<td>8,204</td>
<td>32,356</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>98.56%</td>
<td>98.47%</td>
<td>97.90%</td>
<td>96.19%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>2,626</td>
<td>186,848</td>
<td>2,675</td>
<td>196,170</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,545</td>
<td>185,809</td>
<td>2,557</td>
<td>195,736</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>96.92%</td>
<td>99.44%</td>
<td>95.59%</td>
<td>99.78%</td>
</tr>
</tbody>
</table>

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

#### 2016-17

<table>
<thead>
<tr>
<th>Information technology</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2016</td>
<td>1,001</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2017</td>
<td>1,001</td>
</tr>
<tr>
<td>Depreciation 01 April 2016</td>
<td>129</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>201</td>
</tr>
<tr>
<td>Depreciation at 31 March 2017</td>
<td>330</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2017</td>
<td>671</td>
</tr>
</tbody>
</table>

#### Asset financing:

<table>
<thead>
<tr>
<th>Owned - Purchased</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at 31 March 2017</td>
<td>671</td>
</tr>
</tbody>
</table>

#### 2015-16

<table>
<thead>
<tr>
<th>Information technology</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2015</td>
<td>0</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>198</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>803</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2016</td>
<td>1,001</td>
</tr>
<tr>
<td>Depreciation 01 April 2016</td>
<td>0</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>129</td>
</tr>
<tr>
<td>Depreciation at 31 March 2016</td>
<td>129</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2016</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Asset financing:

<table>
<thead>
<tr>
<th>Owned - Purchased</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at 31 March 2016</td>
<td>872</td>
</tr>
</tbody>
</table>

#### 7.1 Economic lives

<table>
<thead>
<tr>
<th>Information technology</th>
<th>Minimum Life (years)</th>
<th>Maximum Life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
## 8 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £'000</th>
<th>Current 2015-16 £'000</th>
<th>Non-current 2016-17 £'000</th>
<th>Non-current 2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,592</td>
<td>0</td>
<td>1,036</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,189</td>
<td>0</td>
<td>1,184</td>
<td>0</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>1,114</td>
<td>0</td>
<td>142</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>1,020</td>
<td>0</td>
<td>686</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>0</td>
<td>0</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>42</td>
<td>0</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>4,959</strong></td>
<td>0</td>
<td><strong>3,092</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Total current and non current</strong></td>
<td><strong>4,959</strong></td>
<td>0</td>
<td><strong>3,092</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

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

### 8.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>193</td>
<td>179</td>
</tr>
<tr>
<td>By three to six months</td>
<td>239</td>
<td>0</td>
</tr>
<tr>
<td>By more than six months</td>
<td>340</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>772</strong></td>
<td><strong>179</strong></td>
</tr>
</tbody>
</table>

£0 of the amount above has subsequently been recovered post the statement of financial position date.
9 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Balance at 01 April 2016</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(59)</td>
<td>0</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>17</td>
<td>76</td>
</tr>
</tbody>
</table>

Made up of:
Cash with the Government Banking Service | 17 | 76 |
Cash and cash equivalents as in statement of financial position | 17 | 76 |

Balance at 31 March 2017 | 17 | 76 |

10 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17</th>
<th>Non-current 2016-17</th>
<th>Current 2015-16</th>
<th>Non-current 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>NHS payables: revenue</td>
<td>1,138</td>
<td>0</td>
<td>6,438</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>4,217</td>
<td>0</td>
<td>(151)</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>6,106</td>
<td>0</td>
<td>2,979</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>6,864</td>
<td>0</td>
<td>7,982</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>44</td>
<td>0</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>43</td>
<td>0</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>2,750</td>
<td>0</td>
<td>392</td>
<td>0</td>
</tr>
<tr>
<td>Total Trade &amp; Other Payables</td>
<td>21,162</td>
<td>0</td>
<td>17,711</td>
<td>0</td>
</tr>
</tbody>
</table>

Other payables include £251,599 outstanding pension contributions at 31 March 2017 (£51,000 at 31 March 2016)

11 Provisions

The clinical commissioning group had no provisions at 31 March 2017.
12 Commitments

The NHS Clinical Commissioning Group has not entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements).

13 Financial instruments

13.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

13.1.1 Currency risk

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

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

13.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.
13 Financial instruments cont’d

13.2 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-17 £'000</td>
<td>2016-17 £'000</td>
<td>2016-17 £'000</td>
<td>2016-17 £'000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>2,705</td>
<td>0</td>
<td>2,705</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>1,020</td>
<td>0</td>
<td>1,020</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total at 31 March 2017</td>
<td>0</td>
<td>3,745</td>
<td>0</td>
<td>3,745</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-16 £'000</td>
<td>2015-16 £'000</td>
<td>2015-16 £'000</td>
<td>2015-16 £'000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>1,179</td>
<td>0</td>
<td>1,179</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>717</td>
<td>0</td>
<td>717</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>76</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total at 31 March 2016</td>
<td>0</td>
<td>1,977</td>
<td>0</td>
<td>1,977</td>
</tr>
</tbody>
</table>

13.3 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Other 2016-17</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-17 £'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>5,355</td>
<td>5,355</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>15,720</td>
<td>15,720</td>
</tr>
<tr>
<td>Total at 31 March 2017</td>
<td>0</td>
<td>21,075</td>
<td>21,075</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Other 2015-16</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-16 £'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>6,287</td>
<td>6,287</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>11,354</td>
<td>11,354</td>
</tr>
<tr>
<td>Total at 31 March 2016</td>
<td>0</td>
<td>17,641</td>
<td>17,641</td>
</tr>
</tbody>
</table>
14 Operating segments

The clinical commissioning group considers it has only one segment: commissioning of healthcare services.

15 Pooled budgets

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(5,555)</td>
<td>(5,756)</td>
</tr>
</tbody>
</table>

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

Under the joint arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund and Integrated Community Equipment Services.
## 16 Related party transactions

### Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>St George's University Hospitals Foundation Trust</strong></td>
<td>73,327</td>
<td>(36)</td>
<td>2,375</td>
</tr>
<tr>
<td><strong>Epsom &amp; St Helier University Hospitals NHS Trust</strong></td>
<td>38,495</td>
<td>0</td>
<td>181</td>
</tr>
<tr>
<td><strong>Central London Community Healthcare NHS Trust</strong></td>
<td>19,543</td>
<td>(22)</td>
<td>19</td>
</tr>
<tr>
<td><strong>South West London and St George's Mental Health NHS Trust</strong></td>
<td>16,858</td>
<td>(7)</td>
<td>1,164</td>
</tr>
<tr>
<td><strong>Kingston Hospital Foundation Trust</strong></td>
<td>10,895</td>
<td>0</td>
<td>366</td>
</tr>
<tr>
<td><strong>Dr Andrew Murray (Personal Medical Services Contract)</strong></td>
<td>3,421</td>
<td>(8)</td>
<td>238</td>
</tr>
<tr>
<td><strong>Dr Tim Hodgson (Personal Medical Services Contract)</strong></td>
<td>1,392</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td><strong>Andrew Hyslop (Sheephouse Consulting)</strong></td>
<td>228</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Karen Parsons (Wilson Grey)</strong></td>
<td>178</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Dr Andrew Murray and Dr Tim Hodgson are GP voting members of the Governing Body. The payments above are primarily Dr Andrew Murray's and Dr Tim Hodgson's practice's share of the Personal Medical Services contract and Local Enhanced Services payments made to the Nelson Medical Practice and Wimbledon Village Practice.

Andrew Hyslop and Karen Parsons were executive governing body members.

<table>
<thead>
<tr>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>St George's University Hospitals Foundation Trust</strong></td>
<td>65,817</td>
<td>(80)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Epsom &amp; St Helier University Hospitals NHS Trust</strong></td>
<td>37,274</td>
<td>0</td>
<td>504</td>
</tr>
<tr>
<td><strong>The Royal Marsden NHS Foundation Trust</strong></td>
<td>28,576</td>
<td>(77)</td>
<td>672</td>
</tr>
<tr>
<td><strong>South West London and St George's Mental Health NHS Trust</strong></td>
<td>16,893</td>
<td>(12)</td>
<td>362</td>
</tr>
<tr>
<td><strong>Kingston Hospital Foundation Trust</strong></td>
<td>10,582</td>
<td>0</td>
<td>273</td>
</tr>
<tr>
<td><strong>Dr Andrew Murray (Personal Medical Services Contract)</strong></td>
<td>98</td>
<td>(20)</td>
<td>50</td>
</tr>
<tr>
<td><strong>Dr Tim Hodgson (Personal Medical Services Contract)</strong></td>
<td>188</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

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

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

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

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

18 Losses and special payments

There were no Losses or Special Payments during the year ended 31 March 2017.

19 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). NHS Clinical Commissioning Group performance against those duties was as follows:

<table>
<thead>
<tr>
<th>Directive</th>
<th>Target £'000</th>
<th>Performance £'000</th>
<th>Variance £'000</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>283,733</td>
<td>281,631</td>
<td>2,102</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>274,803</td>
<td>272,701</td>
<td>2,102</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>4,425</td>
<td>4,387</td>
<td>38</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directive</th>
<th>Target £'000</th>
<th>Performance £'000</th>
<th>Variance £'000</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>260,829</td>
<td>260,801</td>
<td>28</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>198</td>
<td>198</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>238,968</td>
<td>238,940</td>
<td>28</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>4,973</td>
<td>4,543</td>
<td>430</td>
<td>Yes</td>
</tr>
</tbody>
</table>