Merton Clinical Commissioning Group
Annual Report and Annual Accounts
2014-15
Right care, right place, right time, right outcome
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Foreword

We are delighted to publish the Merton CCG Annual Report for 2014/15 where we look back on the year and celebrate our achievements.

Through the hard work of our team and with the support of our member practices, we have achieved much in the last year; embedding quality and engagement and developing a stable clinically led organisation delivering service change. We are now well placed to respond to the opportunities that exist to health and social care as described in the ‘Five-Year Forward View’.

This, our second Annual Report, describes the first year of a two-year plan submitted to NHS England in April 2014. The plan reflected our increased allocation in 2014/15 of 4.92%, which was the highest in England. Although a significant increase, Merton CCG was still 7.6% below the funding required for our population. We are delighted to have been able to invest in delivering improvements in services for local people and to live within our resources.

To support the work streams in our operating plan we increased the clinical leadership of our 2014/15 Clinical Reference Group (CRG) and commissioning support within the CCG. It has been a very busy year where we have made significant progress in:

- **Joining up health and social care**: better to coordinate care for adults and children with complex needs
- **Increasing mental health services in Merton**: a new complex depression and anxiety service (CDAS), autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) services
- **Increased diagnosis rate for dementia**: we have increased the detection and diagnosis rate of people with dementia from 49.9% to 66.5%
- **Increased access to psychological therapies**: we delivered the national target of 15% of our population
- **Out-of-hospital care**: opened a new 21st century health centre on the old Nelson hospital site and submitted plans to NHSE for a second health centre in Mitcham.

We were delighted that our Better Care Fund (BCF) submission was one of five plans out of 151 nationally graded ‘high quality’ and, as a result, hosted visits from:

- Ed Scully, Deputy Director of the Better Care Fund (BCF) Task Force NHS England, who took part in a programme of structured visits and meetings to see for himself how the implementation of Merton’s BCF Plan was progressing, complimented the overall programme of integration change in Merton and described the work taking place as “really impressive”. He recognised that massive amounts of work had taken place between the council, CCG, community services, GPs and providers and that there had been “significant benefit as a result of this with some great joint working”.

- Earl Howe (Health Minister) and Lord Ahmad of Wimbledon (Communities Minister) came to the new Nelson Health Centre, took part in a discussion about the Better Care Fund and visited a patient at her home, who told the Minister how grateful she was to have received such high-quality, joined-up care since moving to the London Borough of Merton. We received a very positive letter from Earl Howe regarding his and Lord Ahmad’s visit and the work we and colleagues are doing in Merton.
We have engaged and listened to our membership, who have contributed to the achievements detailed above and those listed in this report, during a time of great challenge in primary care. We are extremely grateful to practices and their teams for their support and commitment to their roles as commissioners.

Over the last year we have further developed networks and collaborative working across South West London (SWL) including publication of a five-year strategy with the other five CCGs in SW London and have agreed to form a joint committee to plan primary care services from 1 April 2015. It is important for us to build even closer work with partners in health care, the London Borough of Merton, the Merton Health and Well-being Board and with local voluntary and community groups, as well as continuing to develop dialogue with our patients.

Our local engagement events provided a forum where we communicated with patients, carers and the public. So far feedback from the local community has informed developments for mental health in Merton, the procurement of community services for April 2016 and improving access to talking therapies (IAPT) for October 2015 as well as the design and build of our first out-of-hospital facility (The Nelson Health Centre) which began to see patients on 1 April 2015 and the selection of a site for our second facility in Mitcham. Throughout the report you will see a number of projects we have launched that we believe will make a significant difference to patient experience in Merton.

It was with some sadness that we said farewell to Dr Howard Freeman, Chair of Merton CCG, on 31 March 2015. Howard worked in Merton for over 30 years both as a general practitioner and in senior clinical management roles for NHS organisations across London, South West London and Merton. Three years ago Howard began the set-up of the MCCG and became Clinical Chair on the 1 April 2013. On behalf of the Governing Body, the Merton CCG team, local colleagues and patients, we would like to thank Howard for his commitment, energy and wisdom to ensure Merton CCG has been successful in our role to commission services in the right place, at the right time, from the right people, with the right outcomes.

We hope that you will enjoy reading about the work of the CCG in 2014/15 and that, in future, you will engage with us by either attending one of our governing body meetings, or one of our patient/public events or contacting the CCG. Your opinions and experiences matter to us and we look forward to working with you.
1. Member Practices’ Introduction

1.1 Welcome to our 2014/15 annual report for Merton Clinical Commissioning Group. Our CCG is made up of 3 localities each of which has a GP locality clinical lead nominated by their colleagues to sit on Merton CCG’s executive management team. Dr Karen Worthington (East Merton Locality chair), Dr Sion Gibby (Raynes Park Locality chair) and Dr Tim Hodgson (West Merton Locality chair) provide their perspectives on 2014/15 and the achievements of the membership.

1.2 Each locality meets on a monthly basis either at Merton-wide level at the Practice Leads Forum or individually at a locality level. The locality meetings focus on the needs of the local population which vary considerably across the borough. The bimonthly Practice Leads Forum meetings have provided local clinicians with an increased impact on local health service changes. As a network of 25 practices in Merton we are able to shape the CCG’s priorities, suggest ideas and offer an evaluation of issues arising from and relating to services commissioned for our population. These have included decisions such as: to fund one cycle of IVF in 2014/15; to work through the implications of primary care co-commissioning; to specify the services and outcomes required within our community services.

1.3 In addition the Clinical Reference Group (CRG), which provides leadership in clinical pathway design and clinical scrutiny of the CCG’s plans, has increased membership in 2014-15 to align with the clinical work streams set out in the CCG’s Operating Plan 2014-16. Each work stream has a clinical director and is supported by commissioning managers. These work streams are:

- urgent care
- mental health
- children and maternity
- keeping fit and healthy
- early detection and management
- older and vulnerable adults
- acute and community care
- dementia and diabetes
- primary care

1.4 The CCG has directly invested in primary care this year with funding for patients aged 75 and over to deliver proactive care to our older population, as well as using winter pressure money to enhance paediatric emergency care in our practices and improve access for our patients.

1.5 We are very excited about the opening of the Nelson Health Centre (Nelson HC) in April 2015 and working in partnership with the providers at the Centre. During 2014/15 some of the membership worked with the management team on a competitive procurement exercise to appoint the acute provider to deliver outpatient services, diagnostics, phlebotomy and minor procedures at the Nelson HC. Through the application of focused evaluation criteria we ensured that the preferred partner placed core values of quality, integration and access at the heart of their proposed service delivery.
1.6 We are pleased that the CCG has commissioned a new complex depression and anxiety service (CDAS) which began delivering a service in February 2015, better to meet the needs of patients with more complex needs. Separating this cohort of patients from the core improving access to psychological therapies (IAPT) service is also expected to improve access and waiting times for patients with mild-to-moderate depression and anxiety.

1.7 Primary care, along with the rest of the NHS, is reacting to a rising demand in services and difficulty in workforce recruitment. The Raynes Park locality was successful in gaining funding from the Office of London CCGs to gain facilitated time to look at options for joint working across practices. During the year Merton CCG commissioned some short-term organisational development work across all localities in Merton so that other localities could also undertake this thinking and to ensure best practice is shared across all the localities. These facilitated workshops have enabled the localities and the member practices to consider how individually and collectively they would be able to increase access to primary care.

1.8 The membership has worked hard with the management team to improve access to psychological therapies (IAPT) by meeting the national target of 15% of our population by March 2015 and increasing the early dementia diagnosis rate from 49.9% to 66.5% by March 2015 for our population.

1.9 A successful membership event was held in December 2014 to consider our progress to date against our vision and objectives, consider the agenda for transforming primary care including the enabler of co-commissioning and to meet the governing body.

1.10 Moving forward in 2015, we are currently creating a federation of all 25 practices in Merton, which will enable us to work towards a more standard level of care across our borough, and allow us to develop a robust primary care base enabling us to adapt to the forthcoming changes within the health care system.

1.11 Some of our clinicians were also involved in the procurement of a new model of IAPT services for people with mild-to-moderate depression and anxiety. This service will be delivered from October 2015. This service is expected to result in further improvements to access and waiting times, and to respond to the feedback of patients who have been involved throughout this process. We are also in the process of procuring a new community services provider to start in April 2016 which has given us an opportunity to look in depth at the needs of our patients and to commission a first class service in future years.

1.12 As members, with other key stakeholders, we participated in a recent 360 degree survey which formed part of the annual assurance process carried out by NHS England. This monitors how well each CCG is engaging and communicating its work. For 2013/14 80% of member practices responded and had a good overall response rate from other stakeholders and partners. The detailed feedback contains comments, quantitative measures and comparison to other CCG feedback. Merton performs better in four areas and the same in seven areas where questions are asked, and performs better in the majority of areas than other CCGs nationally and across South London. One area we should improve on is
the communication of what we have changed in response to feedback we receive. We have used this report to strengthen our communications and engagement with the public, membership and staff. We have also recently taken part in the survey relating to 2014/15, the results of which will be available in late April 2015. Overall it has been a good year and we are now looking ahead. We know that there is a lot more work to do, particularly in terms of reducing health inequalities across Merton and delivering high quality care to all our patients.

Dr Karen Worthington
Locality Lead GP, East Merton

Dr Sion Gibby
Locality Lead GP, Raynes Park

Dr Tim Hodgson
Locality Lead GP, West Merton

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

2.1 **Overview**

2.1.1 **Who we are**

2.1.2 Merton CCG is a membership organisation consisting of 25 GP practices. We are responsible for planning, buying and monitoring (commissioning) health care services for the people who are registered, live or work in the borough of Merton. In 2014/15 we were responsible for spending £218m on hospital and community health services for our patients, in a way which ensures that good quality and the most effective services are available to them.

2.1.3 Our constitution sets out the way we operate and function. We work through our GP membership and governing body. The governing body includes:

- three Merton GPs – one of whom is the governing body chair;
- an independent nurse;
- a hospital doctor;
- the Director of Public Health from Merton Council;
- two lay members who are not clinicians – one with an expertise in financial oversight, and the other who brings great experience of the voluntary sector and local community organisations;
- Chief Officer; and
- Chief Finance Officer

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

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

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

2.1.7 **Our vision**

2.1.8 Our vision is to improve the health outcomes for the population of Merton by commissioning services tailored to the needs of individual patients whilst addressing the diverse health needs of the population.
2.1.9 Our guiding principle is that everyone in Merton should be able to receive the care they need, at the right time, in the right place and from the right health care professionals, bringing the right outcomes for each individual patient. To do this, we are looking carefully at the kinds of services people in Merton need: both now and in the future.

2.1.10 We aim to improve patient experiences and health outcomes in a financially and clinically sustainable way by achieving best value and acting with a view to ensuring that health services are provided in a way which promotes the NHS Constitution. We also commit to:

- putting patients first
- delivering high quality care
- working together with our providers
- providing system leadership
- preventing problems (ill health)
- taking action promptly

2.1.11 Merton’s health need

2.1.12 Merton has a population projected in 2013 to be 202,750 persons living in nearly 79,000 occupied households. Population density tends to be higher in the west wards of the borough than in the east wards.

2.1.13 Just over half the borough is female (50.7%) and the borough has a similar age profile to London as a whole. The largest number of households in the borough are single households (28% of all households) although 49% of the borough’s population live in family households with dependent children (31% of all households).

2.1.14 Based on current trends, Merton’s population would increase by 16,000 people between 2011 and 2017. A significant feature of Merton’s population in 2017 is the changing age profile of the borough’s residents, with the most notable growth in those under the age of 9 years and those over 65 years old. The ethnic composition of the borough is also forecast to change significantly, with the proportion of people from a black, Asian and minority ethnic (BAME) background increasing from 35% in 2011 to 39% in 2017. The Greater London Authority (GLA) population projection data for 2013 shows Merton’s BAME population to be 74,650 (36.8%) (Source: GLA 2012 Round Strategic Housing and Land Availability Assessment (SHLAA) Ethnic Group Population Projection (EGPP) population). At the time of the Census 2011 the percentage for BAME groups in Merton was 35.1%. This was lower than the percentage for London (40.2%).

2.1.15 Health outcomes for people in Merton are generally better than those in London and largely in line with or above the rest of England.

2.1.16 In Merton, overall life expectancy at birth is longer than the England average, but there is a difference between the most and least deprived areas within the borough: approximately nine years for men and 13 years for women. Between 2005-09 and 2006-10 this gap has remained the same for men, but has increased by about two years for women. The increase in the gap for women is because, for
women, life expectancy has increased at a faster rate in the most affluent areas compared with the most deprived areas of the borough.

2.1.17 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. Looking at rates of death in a population (rather than life expectancy), if East Merton had the same rate of deaths as West Merton, there would be around 113 fewer deaths each year in East Merton – an 18% reduction on the 640 deaths each year among East Merton residents. Of the 113 deaths, 81 are under 75 years of age.

2.1.18 In general, East Merton is younger, poorer, ethnically more diverse and with relatively lower levels of education outcome and training qualifications than West Merton.


2.1.20 Health provision landscape

2.1.21 Significant health and social care providers with whom we work include:

- 25 member GP practices
- Sutton & Merton Community Services (part of the Royal Marsden NHS Foundation Trust)
- Acute hospitals including; St George's Healthcare NHS Foundation Trust, Epsom and St Helier University Hospital NHS Trust, Croydon University Hospital and Kingston Hospital NHS Foundation Trust,
- A number of specialist hospitals in London and elsewhere, including The Royal Marsden NHS Foundation Trust and Royal Brompton and Harefield NHS Foundation Trust
- South West London and St George's NHS Trust for mental health services
- A range of independent and voluntary sector providers, such as residential and nursing homes, St. Raphael's and Trinity Hospices
- Other health service professionals such as pharmacists and optometrists
- Local authorities, in particular Merton Council
- Healthwatch Merton
2.1.22 In order to commission services that will support a reduction in health inequalities and meet the health needs of the population, we work collaboratively with other South West London CCGs (Croydon, Kingston, Richmond, Sutton and Wandsworth) and the South East Commissioning Support Unit.

2.1.23 How we operate

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

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

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

2.1.27 All CCGs have a cap on running costs based on per head of population. In 2014/15 this was £5m for Merton CCG. As a comparatively small CCG based on registered population, we have a streamlined in-house team of 57 staff (35 WTE – whole time equivalent). We buy in some support functions, such as human resources (HR), information technology (IT), transactional finance and communications from the South East Commissioning Support Unit (SECSU), particularly in instances where there are economies of scale from accessing a larger pool of expertise and knowledge. This support complements our in-house capacity and capability, and is under constant review to ensure we receive high quality services and best value for money.
2.2 Financial Review and Performance

2.2.1 Financial review

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

2.2.3 2014-15 has been an exciting year for Merton CCG, following a review of the funding formula for CCG allocations, Merton CCG received allocation growth of 4.92% in 2014-15. The increase was significantly higher than Merton’s population growth and brought the CCG closer to its target allocation.

2.2.4 An investment programme of £4m was approved by the Board, with significant investments made in new mental health services, commissioning of IVF services, introduction of integrated locality teams in community services and investment for the care of older people in primary care.

2.2.5 Financial performance

2.2.6 Merton CCG has delivered our financial duties in 2014-15:

- We achieved a 1.2% (£2.7 million) surplus by managing revenue expenditure within resource limits
- Managed the CCG functions within the running cost allocation. Running costs budget was under spent by £0.1m
- Delivered our QIPP (Quality, Innovation, Productivity and Prevention) target – we over-achieved this by £0.2m (2.5% above target)
- Staying within our capital resource limit – we managed capital expenditure within resource limits

2.2.7 Merton CCG also has an obligation to ensure all valid invoices are paid within 30 days of the due date or within 30 days of receipt of a valid invoice whichever is later. Overall, Merton CCG achieved 97% in terms of number of invoices and 99% in terms of value of invoices. The expected target is 95% which has been achieved throughout the year.

2.2.8 Revenue expenditure

2.2.9 The CCG receives a revenue budget from NHS England. This is in the form of a revenue resource limit imposed on the CCG, as to the amount of revenue expenditure the CCG can incur, but not in line with the needs of the population. NHS England also calculate the level of funding that CCGs should require based on size of population, age, deprivation of area and mortality of the population. Calculations for 2014-15 show that Merton CCG is 7.6% below the target funding (known as distance from target - DTF) required to meet the needs of our population. Allocation growth of 8.03% has been allocated to Merton CCG in
2015-16; this has significantly reduced the distance from target to 4.8%. It is hoped the remaining gap will be addressed in future years.

2.2.10 In 2014-15 Merton CCG had a delegated budget of £218m with which to purchase health care for our population. Revenue spending includes items such as commissioning of acute services, mental health, community services and primary care prescribing on behalf of the population.

**Chart 2: below shows the breakdown of spend for 2014-15**

![Pie Chart showing spend breakdown]

2.2.11 Delivery of a surplus position represents a strong performance in our second year, but there is no room for complacency as the national pressure to deliver significant level of efficiency savings continues for the next five years.

2.2.12 The surplus position is due to the efforts of member practices and staff in delivering their contribution to the CCG’s objectives. This is a firm foundation from which to deliver the future. However, over-spends were reported on acute, non-acute, primary care and corporate services. The over-spends were offset by slippage on investments, release of CCG reserves and contingency fund and return of some of the contribution from the South West London risk pool.
2.2.13 Acute spend totalling 59% of Merton CCGs total expenditure paid for the following activity;

**Table 1: Total acute activity broken down by points of delivery**

<table>
<thead>
<tr>
<th>Activity</th>
<th>2014-15 Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>64,016</td>
</tr>
<tr>
<td>Critical care</td>
<td>4,276</td>
</tr>
<tr>
<td>Outpatient first attendances</td>
<td>56,744</td>
</tr>
<tr>
<td>Outpatient follow up attendances</td>
<td>121,533</td>
</tr>
<tr>
<td>Outpatient procedures</td>
<td>31,433</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>10,100</td>
</tr>
<tr>
<td>Emergency</td>
<td>14,932</td>
</tr>
<tr>
<td>Elective</td>
<td>24,781</td>
</tr>
<tr>
<td>Non elective</td>
<td>1,543</td>
</tr>
</tbody>
</table>

2.2.14 The activity figures above are based on eleven months performance as full year final activity details will not be available until June 2015. In addition to the above activity, money is spent on non-activity related items such as drugs, medical devices, patient transport and paying providers for improvement in quality standards.

2.2.15 **QIPP (Quality, Innovation, Productivity and Prevention)**

2.2.16 The QIPP programme is about improving quality and innovation, so that every pound spent brings maximum benefit and quality of care to patients. The NHS needs to achieve up to £30 billion of efficiency savings by 2025, which will be reinvested back into front line care for patients. Merton CCG’s QIPP target for 2014-15 was £6.5m, of which £6.7m was delivered; an over achievement of £0.2m (102.5%) of the planned target.

2.2.17 Some schemes such as the acute portfolio scheme and the mental health placements scheme over achieved and some schemes like the urgent and intermediate care programme were slightly below target.

2.2.18 The planned care programme was significantly revised and unfortunately it was not possible to implement some of the original planned care schemes due to conflicts arising from the procurement of services for the Nelson Health Centre.

2.2.19 On a positive note, however, some schemes that were launched in 2013-14 such as the community prevention of admissions team (CPAT) were expanded in 2014-15 and efficiencies realised in 2014-15.
2.2.20 The QIPP agenda continues to be driven by the CCG with both strong clinical and management leadership to ensure process improvement, redesign and a clear programme management system.

2.3 Delivering Our Priorities in 2014-15

2.3.1 We agreed a set of priorities for 2014-15 which we believed would make a real difference to the quality of care in Merton. Many of these initiatives aimed to tackle the most common diseases which affect local people and their quality of life. Our performance against these priorities is detailed below.

2.4 Older and Vulnerable Adults

2.4.1 The aim of this work stream is to provide more proactive care, prevent exacerbations of conditions and support an increased number of patients in the community. This will maximise independent living, prevent unnecessary admissions to hospital, and the loss of independence and confidence that a hospital stay can bring about.

2.4.2 Where people do require hospital admission, services will be available to ensure that the stay is no longer than required, support is available with the transition from hospital back into the community, and where possible premature admission to long term residential care is avoided.

2.4.3 Expansion of the community prevention of admission team (CPAT)

2.4.4 This team was set up in October 2013 to ensure that patients could be supported at home where clinically appropriate. The team comprises nurses and therapists and a local GP for clinical leadership, who provide rapid integrated assessment with health and social care partners to support the reduction of inappropriate
emergency admissions. In 2014/15 the team continues to receive an average of 34 referrals a month and now also provides additional support to help improve care in nursing and residential care homes in Merton and reduce unnecessary ambulance conveyances and potential admissions to hospital, by providing increased information, training and support services to the homes.

2.4.5 Work to support this initiative in care homes has also included re-invigoration of the Merton Care Home Forum which has met three times during 2014/15 and development of a “concerned about a resident” tool to support homes to identify the best service to help them where they have concerns. As a result of this work, from the period April to November 2014, there have been 54 fewer 999 calls made from care homes in Merton compared to the same period in the previous year, representing an 8% reduction.

2.4.6 Helping people make the transition from hospital back to home

2.4.7 An integrated complex older people’s pathway has been implemented at St Helier, working with Sutton CCG. This service is led by a geriatrician and includes support from a navigator and therapists to optimise the frail elderly pathway and ensure a successful and prompt discharge.

2.4.8 Community services have been commissioned to provide ‘in-reach’ nursing at St George’s Hospital to help identify patients who could be supported in the community rather than remaining in an acute hospital and supporting these patients through the transition. This has been extended to the emergency department and short-stay wards through systems resilience funding. The team facilitated discharges for 266 patients up to the end of November 2014 and since its introduction into the emergency department, the service has enabled 40 Merton patients to return home rather than unnecessarily being admitted to hospital.

2.4.9 Additional intermediate care beds have been commissioned during the last quarter of 2014/15 and a model has been proposed to enhance the multi-disciplinary team care available to support these beds, providing a “halfway house” enabling a faster and more supported recovery from illness.

2.4.10 Integrated locality-based working

2.4.11 In order to manage patients with long-term conditions such as asthma, diabetes, coronary heart disease, stroke, heart failure, severe mental health conditions and epilepsy, closer to home, community services have redesigned their teams (of nurses, specialist nurses and therapists) to work on a locality basis alongside the health liaison social workers and general practice teams. Multidisciplinary team working has started, with the identification and management of those recognised through risk stratification and those aged 75 and over.

2.4.12 Key worker roles and responsibilities have now been designed to enable more proactive working. The aim of the key worker role is to provide those with the most complex needs who are at risk of hospital admission with additional co-ordination and support to help manage their overall care. There has been
agreement to fund three dementia nurses to provide additional support to people with dementia and their carers in the community as part of these teams and recruitment is under way.

2.4.13 **Patient story** - Mrs R was diagnosed with a degenerative condition and, after a long series of diagnostic tests, she was ultimately admitted to an acute bed. This was devastating news to her; not only in physical terms but also psychologically and financially, as she was in the middle of a university degree course following a number of years bringing up her children and could now no longer work. She needed a response from a number of different health and social care disciplines to help her return to an independent lifestyle.

2.4.14 The community nursing in-reach team supported her discharge from hospital and, as a result of integrated working in localities, were able quickly and effectively to access services from the local authority under a single care plan aligned with her GP. She received physiotherapy and, supported by her social worker and occupational therapist, Mrs R and her family were rehoused in a specially-adapted ground-floor flat where she could benefit from physiotherapy and other services and regain her independence in self care, looking after her family and continuing her studies in an environment that was conducive to her mental and physical wellbeing and that of her family. As a result of the coordinated working of her locality team, Mrs R is now looking forward to completing her studies, applying for jobs and a positive future.
2.4.15 Support for those with dementia and their carers

The Dementia Hub was launched in Mitcham with a number of partner agencies including London Borough of Merton and The Alzheimer’s Society. Work has been undertaken this year to increase the range of linked up services provided here and this has included follow-up memory clinics taking place at the Hub.

2.4.16 Training and support has been provided to primary care to help increase dementia diagnosis rates, to ensure that people with dementia are identified, treated and supported as early as possible. The dementia diagnosis rate has increased from 49.9% in April 2014 to 66.5% in March 2015, with further increases expected in the coming months. Merton CCG staff have undertaken Dementia Friends training.

2.4.17 End of life care

The End of Life Care (EOLC) Strategy has been refreshed, building on the work already achieved. Training for community staff and carers on a range of aspects of EOLC has also been delivered, information about bereavement support developed, an update of the booklet ‘What to do after a death at home’ has been published and arrangements made to enable home to hospice transportation, with the overall aim of improving support to people at the end of life.

2.4.18 On-going work continues to encourage use of the Co-ordinate My Care (CMC) record and, as at December 2014, there were 1,560 patients with a CMC record in Merton (the fourth highest of the London CCGs) and overall 72% of patients with a CMC record died in their preferred place.

2.4.19 Podiatry

A clinical review of the community podiatry service was completed and an action plan put in place to improve services, meet best practice guidance and take patient feedback into account.

2.4.20 Falls prevention

In 2014/15 public health took a lead in the development of falls prevention services and, as part of this, produced a health needs assessment. Work has started on the development of a falls prevention pathway in preparation for the transfer of the commissioning of falls prevention services back to Merton CCG in April 2015.

2.4.21 Learning disabilities

The Joint Health and Social Care Learning Disabilities Self-Assessment Framework was completed and will be used as a platform to review and strengthen our commissioning arrangements. The findings from this will be reviewed and an action plan developed to address the areas for improvement identified.
2.4.27 Carers

2.4.28 In Merton there are thought to be approximately 17,000 carers with an estimated economic contribution of £285.7million.

2.4.29 The National Carers Strategy of 2008, *Carers at the heart of 21st-century families and communities* and the 2010 strategy, *Recognised, valued and supported: Next steps for the Carers Strategy*, sets out the vision and priorities for supporting and valuing the contribution of carers. In October 2014 an action plan (*Carers Strategy: Second National Action Plan 2014–2016*) was published which builds upon these two strategies. A review of currently commissioned services to support carers has been undertaken in preparation for developing a Carers Strategy in 2015/16.

2.4.30 In 2014/15 the CCG has provided the following support to carers:

- Three dementia nurses have been recruited to provide additional support to people with dementia and their carers in the community.
- Training for carers to support EOLC has also been delivered, information about bereavement support developed, an update of the booklet *What to do after a death at home* has been published and arrangements made to enable home to hospice transportation, with the overall aim of improving support to people at the end of life.
- Expert patient programme carer’s course - Quote from a participant; “*One of the best things I have found is its ok to do something for myself. I have found that doing something outdoors does a world of good for my mental state of being. By taking time to rest and reflect you get a better perspective on your current situation and gain the energy you need to succeed. As a carer it is important to take time to look after yourself and keeping fit and healthy. Big Thank U.*”

2.5 Mental Health and Learning Disabilities

2.5.1 The mental health delivery work stream aims to ensure that the CCG’s patients receive high quality, timely care and support in line with national and local mental health strategies.

2.5.2 Merton CCG and three other South West London CCGs (Richmond, Sutton and Wandsworth) have agreed that Kingston CCG will act as the lead commissioner for collaborative mental health commissioning, helping to develop improved equity of mental health and share learning across services in South West London.

2.5.3 The Merton Health and Well-being Board commissioned Merton Public Health to undertake a mental health needs assessment (HNA) as part of a wider mental health review. The stakeholder workshop on 28th July 2014 looking at results of the health review elicited the following quotation from a participant “*This is possibly the first time since I became an unpaid carer in 2009 that I felt comfortable enough to speak honestly about my experiences and overcoming my fear of health professionals.*”
2.5.4 The HNA has provided an up-to-date, evidence-based position of mental health needs in Merton which has helped both commissioning organisations (MCCG and LBM) to inform future mental health commissioning intentions for the Borough. This approach will also help to ensure that opportunities for integrated pathways are explored whilst ensuring physical and mental health are brought much closer together.

2.5.5 The CCG has continued to improve mental health access and outcomes within primary and community care settings with the aim of re-focusing services towards prevention and early intervention and continued improvement of access into treatment for individuals who have a dual diagnosis (with a focus on mental health and substance misuse).

2.5.6 We worked closely with South West London and St George’s Mental Health Trust to re-launch the mental health crisis line in the borough and the South West London commissioners have further plans to improve crisis services in 2015-16 better to meet the principles set out in the Crisis Care Concordat.

2.5.7 Improving access to psychological therapies (IAPT)

2.5.8 The CCG has clinically reviewed the improving access to psychological therapies (IAPT) service and conducted a robust procurement process for this service throughout 2014/15. The new contract will start on 1 October 2015.

2.5.9 A new complex anxiety and depression service has been established in the borough to manage cases that are too complex for IAPT but not complex enough for community mental health services. The new service will create more capacity in IAPT and help prevent people needing to access secondary mental health services in the community.

2.5.10 Inpatient care

2.5.11 Inpatient capacity remains a key area of focus and Merton CCG, in partnership with Kingston CCG, has worked with South West London and St George’s NHS Trust to support the implementation of their estates strategy.

2.5.12 Work will continue in 2015/16 to review the use of inpatient beds to ensure the following:

- patients are cared for in the community wherever possible;
- length of stay and emergency readmission rates are reduced;
- improvements in the care pathway, discharge and transfer arrangements

2.5.13 The CCG maintains its commitment to ensuring the introduction of increased community rehabilitation services better to support people in their own homes and to create an improved step-down rehabilitation for patients into the community through supported living accommodation.
2.5.14 The CCG has made significant progress in the management of out of area specialist placements and pro-actively reduced the level of activity within tertiary and specialist services by management and review of secondary care pathways, improved contracting, review and repatriation to local services if clinically appropriate. This included the review and commissioning of a local attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder service which is now provided by South West London and St George’s Trust.

2.5.15 A review of older people’s community mental health services has commenced with a particular focus on patients who have cognitive impairment. The review will inform future investment and development of these services in 2015/16.

2.5.16 Progress has been made to work towards achievement of all the CCG’s objectives which is encouraging, but there is more work to be done, particularly where services may require large scale transformation. Our objectives will be continued through to 2015/16 and beyond to ensure that people receive the benefits of these improvements throughout all mental health services commissioned by the CCG.

2.6 Children and Maternity

2.6.1 Merton CCG is committed to ensuring that we improve health outcomes for all children. The priorities we focused on in 2014/15 directly link to the Merton Health and Well-being Strategy priority of giving every child a healthy start.

2.6.2 Children who are looked after away from their own homes are a very vulnerable group and we have reviewed the way that they receive health support, and an action plan to address the issues is being implemented. We have worked with the specialist children’s doctors at St Helier Hospital to improve performance in relation to the provision of initial health assessments for children looked after (CLA) by funding additional consultant time. In the four-month period June-Sept 2014 the target time for providing initial health assessments was met in 83% of cases – a significant improvement from 45% in 2013.

2.6.3 We have mapped the services for children and young people that are jointly provided with the London Borough of Merton to promote more integrated commissioning with their public health and children and families services. An integrated education health and care planning team with the London Borough of Merton supports the development of integrated care plans for children with special educational needs and disabilities. This is part of joint work to meet the requirements of the Children and Families Act 2014. The CCG has also been working with the London Borough of Merton during 2014 to support work to build on the integration of children’s community health universal services with the local authority to ensure that children’s health needs are met early.

2.6.4 In 2014 the CCG and London Borough of Merton have worked together on the delivery of a joint action plan to address concerns about the needs of children
transitioning from one service to another and this was implemented in 2014, to ensure that the transition at key points in a child’s life are managed effectively.

2.6.5 We commissioned a review by the Royal College of Paediatrics and Child Health in December 2014 to advise on how best to improve the health outcomes for families and children in Merton with complex health needs. A number of recommendations were made and from these the CCG has developed an action plan with clear timescales which will be progressed during 2015/16. A review of the process for children’s NHS continuing care has begun and will continue into 2015, to improve the response to children and families with complex health conditions.

2.6.6 A pilot service has been put in place during the winter months in 2014/15 to provide more primary care sessions targeting children and families, to improve access to primary care with the objective of reducing the number of unnecessary A&E attendances and hospital admissions. The results of this pilot will be analysed in spring 2015.

2.6.7 The CCG and London Borough of Merton have established a joint working group to improve child and adolescent mental health services (CAMHS) and refresh the Merton CAMHS strategy. The first phase of this work is a needs assessment and service review led by public health which began in December 2014. This will establish what the local needs are and how they can best be met.

2.6.8 As part of their transformation of services, South West London and St George’s Mental Health Trust have established new specialist services for eating disorders and for ASD/ADHD to speed up access to assessment and treatment.
2.6.9 Maternity and newborn

2.6.10 In 2014/15 the CCG has strengthened engagement with local and sector-wide providers of maternity services through the newly formed local Maternity Clinical Network. The Network brings together senior clinical leaders from providers of local maternity services, together with representatives of the local public, and other local CCGs, to review and improve local maternity services.

2.6.11 The Network supports maternity providers in developing a consistent approach to the delivery of maternity services across the local area, to ensure that all women receive the best possible standard of care.

2.6.12 In the last year, the Network has developed an information leaflet for women requesting elective caesarean section, to ensure a consistent approach to managing non-medical requests for caesarean sections. The leaflet, explaining the advantages and disadvantages of choosing a caesarean section, was developed by clinical staff from the five units.

2.6.13 This collaborative approach is being used with other developments including outpatient induction of labour, and an enhanced recovery programme (ERP), to enable suitable women who have undergone elective caesarean section to follow a defined pathway of care that enables them to go home on day 1 if they choose to and are fit to do so.

2.7 Keeping Healthy and Well

2.7.1 During 2014/15 Merton CCG has been at the forefront of taking on the prevention agenda in partnership with London Borough of Merton Public Health. The Keeping Healthy and Well work stream is supported by the LBM Public Health team and links to Priority 2 of the Merton Health and Well-being strategy.

2.7.2 Areas of activity during 2014/15 include:

- Work on developing a joint weight management pathway for Merton residents. Procurement for the tier 2 (public health responsibility – diet and exercise) and tier 3 (MCCG responsibility – pre-bariatric surgery) services has been started with a planned start-up in the second half of 2015/16.

- Work on a proactive GP pilot in the more deprived areas of Merton has been planned. The pilot aims to embed prevention in primary care and to reduce variation in long-term conditions between GP practices. Developed in collaboration with Merton GPs, the pilot supports delivery of GP proactive care standards through links with community health champions who screen members of their community groups and refer where appropriate to GP or lifestyle services. Initially the pilot focuses on smoking and COPD. GP practices are asked to train their own front line staff as health champions and either to provide stop smoking services directly or refer into the LiveWell stop smoking service. If successful, other long-term conditions and lifestyle prevention initiatives will be added. As part
of the proactive GP pilot, embedding prevention in front line staff involves training front line staff through Royal Society for Public Health NVQ 1 and 2 accreditation to provide brief advice and signposting to lifestyle prevention services. In addition, this training is offered to all front line staff across Merton in the NHS, local government and the voluntary and private sectors.

- Merton CCG and East Merton GP locality group established a task and finish group to develop a Model of Care for East Merton that addresses the specific health needs of residents of East Merton. A health needs assessment for the east of the borough pointed to the conclusion that residents in East Merton had a different profile than the rest of the borough. Residents in the east and south of the borough are younger, more deprived, and more multi-ethnic and are diagnosed with long-term conditions at a younger age. The model recognises that reducing variations in early detection is one of the most important things the NHS can do to address health inequalities.

- Embedding prevention requirements in the community services re-procurement. Specific KPIs to monitor training of front line staff and signposting to lifestyle prevention services will be included in the specification.

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Merton CCG has been at the forefront of taking on the prevention agenda in partnership with London Borough of Merton Public Health
2.8 Early Detection and Management

2.8.1 The aim of this work stream is to decrease the gap between the expected prevalence and recorded prevalence of long term conditions in Merton, improve the health outcomes for people who have been diagnosed with a long-term condition through supporting them to manage their condition and maintain their quality of life, and to increase the provision of health care in the community for people to reduce inequalities in the identification of, treatment and services for people with a long-term condition. This will improve patient outcomes, patient experience, and disease progression and prevent unnecessary admissions to hospital.

2.8.2 In 2014/15 there was a focus on diabetes, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD) and cancer. There have been several key achievements which include developing new models of care to be implemented in the Nelson Health Centre from 1 April 2015, piloting a clinical health coaching telephone service and the review of current service provision through engagement with the public and key stakeholders. Work to date has included developing new models of care, improving service provision and working with primary care to improve early diagnosis and management of patients. The work is described in more detail below.

2.8.3 Diabetes

2.8.4 We have reviewed the diabetes pathway with providers and key stakeholders to improve the model of care and ensure optimal care with improved patient outcomes. This will include training within primary care, improved communication between providers, improved early detection through NHS health checks and uptake of structured education and collaborative working to improve pathways. There is ongoing work with community services to improve and increase referral rates for community based tier 3 diabetes services to avoid unnecessary visits to hospital.

2.8.5 The CCG has commissioned a best practice surveillance clinic within the NHS England-commissioned Diabetic Eye Screening Programme to ensure low risk patients with diabetic maculopathy are monitored within the current DESP programme rather than referring those patients to secondary care. This will reduce the number of low risk screen positive patients managed through regular monitoring by photography combined with OCT within the screening service, as opposed to hospital outpatient appointments.

2.8.6 Coronary heart disease

2.8.7 The existing models of care have been reviewed and developed for heart failure and arrhythmia and will be implemented within the Nelson Health Centre and across Merton from April 2015. The improved models of care will improve patient experience through improved quality of referral.
2.8.8 We have invested in increasing the provision of cardiac rehabilitation which supports patients to self-manage and reduce risk of further illness; this will be implemented from April 2015. Cardiac rehabilitation is a treatment that saves lives, reduces disability, improves health-related quality of life and helps people fight back against heart disease by becoming active self-managers of their health. The enhanced provision will target hard to reach groups who currently opt out as well as extending the eligibility criteria to improve accessibility and equity.

Cardiac rehabilitation supports patients reduce risk of further illness

2.8.9 COPD

2.8.10 In 2014/15 the CCG began piloting a clinical health coaching telephone service for patients with COPD to support them to manage their condition and stay well. The health coaching model is based around clinically trained health coaches, providing in-hours access via telephone. The access by telephone means that patients who are predominantly housebound are still easily able to access services and support. It is expected that the majority of people receiving the health coaching will, over time, become able to self-manage more confidently and be able to navigate the health system. This model complements and enhances the work already being carried out by health care professionals resulting in improved outcomes for a wider cohort of patients.

2.8.11 Work is on-going with community services to improve pulmonary rehabilitation referral and uptake, to support patients to manage their own condition. Pulmonary rehabilitation is a deliberate supervised therapeutic process of restoring a patient’s function through the process of formal rehabilitation. This is accomplished through individualised tailored exercise training and long term behaviour change. It is estimated that three quarters of patients will benefit from pulmonary rehabilitation within four weeks, with many patients seeing it as changing their life as it confronts their fears and enables them to make changes to their behaviour.
2.8.12 Cancer

2.8.13 A Macmillan GP has been recruited to improve service provision and reduce inequalities. The Macmillan GP has reviewed screening, referrals and outcomes data at practice level and is working with each practice to improve early diagnosis.

2.8.14 A cancer health needs assessment has been completed for Merton. Key priorities and actions have been derived from the findings to improve screening and reduce inequalities. The actions will be delivered in partnership with the London Borough of Merton public health team and include improved communication, pathways training and further analysis into participation in screening and cancer presentation at a late stage.

2.8.15 Musculoskeletal service

2.8.16 The CCG has invested in providing an enhanced musculoskeletal service, which will commence in April 2015. The enhanced service will improve accessibility, waiting times and patient experience for Merton patients.

2.8.17 Expert patient programme

2.8.18 Our expert patient programme (EPP) is a free, six-week self-management education course for adults living with any long-term health condition(s), or for carers of those living with a long-term health condition(s). EPP provides generic and condition-specific courses designed to support patients with long-term conditions, by giving people tools, techniques and the confidence to manage their condition better. Nine EPPs have been delivered in 2014/15. One course was delivered in Tamil, an identified hard-to-reach group to improve access to services for this population. The courses have proven to be a success, with participants reporting that course has a very positive impact on their health and well being.

2.8.19 Quote from a participant on EPP Generic Course: “I learnt a lot from this course and felt inspired by our tutors who I feel are on our wavelength as they too have long term health conditions. The problem solving exercises based on our needs were marvellous. Two or more heads are indeed better than one. Health care professionals often do not have time to help with this. I would encourage others to do this course.”

EPP provides generic and condition-specific courses designed to support patients with long-term conditions.
2.8.20 Education in primary care

2.8.21 We have continued to enhance knowledge and skills within primary care to improve diagnosis and management of patients with long term conditions. This has included education events on diabetes, COPD, heart failure and atrial fibrillation as well as cancer update courses. The education events focused on best practice and will support improvements in patient outcomes.

2.8.22 Since 2013/14 we have seen unplanned admissions for coronary heart disease, diabetes and respiratory conditions remain steady despite increased prevalence. There has also been an increase in referrals to the tier 3 diabetes service, which enables patients who are at higher risk to be managed and supported.

2.9 Urgent Care

2.9.1 The aim of the urgent care work stream is to ensure a whole system approach focusing on the patient experience and clinical outcomes whilst providing a high quality, accessible service. CCGs continue to develop and promote alternative services to accident and emergency for non-emergency conditions. Local campaigns have been carried out in the lead up to winter and during the winter period. Campaign outcomes confirmed a positive impact in Merton this year, with a high ‘on street’ recognition rate.

2.9.2 Reducing pressure on local A&E departments

2.9.3 A number of initiatives were carried out in 2014/15 in support of reducing A&E activity.

2.9.4 Urgent care centres

2.9.5 Since the incorporation of urgent care centres into accident and emergency departments at St Helier Hospital, Carshalton and St George’s Hospital, Tooting more patients are being appropriately assessed and navigated away from A&E for non-life threatening conditions and receiving treatment in an alternative care setting. Both trusts support the re-direction of Merton patients back into primary care and, in doing so, the increasing numbers have resulted in less demand on A&E services. The service is underpinned by a robust triage service by a clinician who can then advise the patient on the best option for them. The patient will receive guidance from a non-clinical navigator on what alternative services are available, such as a nearby walk-in centre.

2.9.6 NHS 111

2.9.7 Merton CCG is currently undergoing a procurement of 111 services along with other SWL CCGs with the successful provider delivering services from February 2016. A number of workshops have been carried out for providers, public/patients and commissioners to plan and develop a robust service specification to provide a responsive and quality service to the public.
2.9.8  GP out-of-hours service in Merton

The Merton GP out-of-hours contract was commissioned as a step-in service in November 2013 and provides a fully supported service aligned to 111. Locally-based in the centre of Mitcham, this service sees on average 13,000 patients (annually), with urgent need who cannot wait until GP surgery opening hours. The service operating hours are Monday to Friday from 6.30pm to 8.30am, and 24 hours at weekends and during bank holidays. Patients are offered either a telephone consultation and advice, or an appointment to attend a primary care centre to see a doctor or advanced nurse practitioner, or a home visit. Patient satisfaction with this service is high.

2.9.10  Walk-in centre (The Wilson)

The CCG took over responsibility for commissioning the walk-in centre (WiC) at the Wilson Hospital site in April 2014. On average 2,100 patients per month attend the WiC from Merton and surrounding boroughs, and patient satisfaction rates are high.

2.9.12  Winter campaign

The CCG supports a number of campaigns each year that focus on key issues for the organisation and for local people. For example, in November 2014 the CCG launched the ‘Not always A&E’ campaign for the second year running. The campaign uses a range of techniques to signpost patients to alternative services over the busy winter period to ensure patients get seen quickly and to take pressure off A&E. The campaign included: posters, services guide leaflets, billboard and bus advertising, digital advertising, press coverage, social media and a launch event. The CCG also promotes national campaigns each month.

Winter ‘yellow man’ campaign
2.10 Planned Care

2.10.1 Bringing care closer to home – The Nelson Health Centre

In March 2013 construction began to develop the first of our local care centres in Merton which opened on 1 April 2015. The Nelson Health Centre, on the previous Nelson Hospital site, is a spacious and modern environment allowing more people to be seen, diagnosed and treated closer to home.

The Nelson Health Centre

2.10.2 The Nelson provides GP services, outpatient appointments, minor surgery and procedures, ophthalmology, X-ray, ultrasound and blood tests, physiotherapy, pharmacy services (later in 2015/following procurement), community mental health services and support services for people living with long-term conditions.

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

Signage at the Nelson Health Centre
2.10.5 *Mitcham Local Care Centre*

2.10.6 Merton CCG’s governing body has agreed that the Wilson Hospital should be the site for a potential new health facility in Mitcham. The governing body ratified the "Mitcham Health Centre Economic Case" report on 29 January 2015.

2.10.7 Merton CCG will next submit the report to NHS England for validation. Once it has been through that stage the development for a health facility will begin. Merton CCG will also work with the community on the design and development of the building and there will be a public planning consultation.

2.10.8 The aim of the health facility is to provide improved medical and other services for the East Merton community. The recommendation on the site was reached through an assessment process led by Merton CCG in conjunction with the public. The final site decision was reached by a project board looking at results from a public assessment where factors such as site suitability, location, accessibility and building layout were considered. The project board is made up of representatives from Merton CCG, Healthwatch and Merton Council.

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

2.10.10 The cost for this facility and the full project timeline will be determined by the final building layout, site and the services delivered. The costs of similar developments have been around £25 million. Funding of the project has not been set but all the options made available and approved by NHS England will be investigated looking at both quality and value for money.
2.11 Engagement

2.11.1 Listening as never before

2.11.2 Patients, carers and the public are at the heart of everything we do. Feedback on existing services, involvement in planning and designing new services is crucial if we are to achieve our aims and commitment in our quality strategy to ‘listen as never before’.

2.11.3 We want people in Merton to have a voice and to be able to influence how we plan and improve healthcare services. This is a key part of our commitment to openness in all our work.

2.11.4 Engage Merton

2.11.5 On 16 October 2014, we held the second of our annual engagement event, Engage Merton. This built on the success of our first event in 2013. The aim of the event was to discuss community service provision for 2016 and beyond and the new health facility for Mitcham.

2.11.6 Almost 70 people took part, including patients, members of the public, service users, carers, clinicians, members of community groups and representatives from the local NHS.

2.11.7 Participants were asked to help develop services for the new Mitcham health facility by giving their views on the proposed services, to identify which services were most important to the community, and how best we can involve them in the development.

2.11.8 The current contract for community services expires on 31 March 2016 and a full and competitive procurement process will take place in 2015/16. Participants were asked to help improve community health services for Merton by giving their views on what is good, what could be improved, and what community services are most important.

2.11.9 Ongoing engagement will continue around both these work streams to ensure that the voice of our local community is heard as services are developed and procured.

Idea wall
2.11.10 **Merton Better Healthcare Closer to Home patient and public group**

2.11.11 The Merton Better Healthcare Closer to Home (BHCH) patient and public group was established by Merton Clinical Commissioning Group in December 2014 as a forum for patients, the public and carers to inform and influence the planning, designing and delivery of BHCH projects.

2.11.12 The group supports the BHCH communications and engagement plan, and ensures the voice of patients, public and carers, including seldom-heard groups, is embedded and embraces the “no decision about me without me” promise.

2.11.13 Membership is open to the patients, public, carers, service users and patient representatives, who live, work or use Merton health services.

2.11.14 The group meets once a month, at different times of the day including evenings, and currently has a membership of 18. Members are taking part in training on equality and diversity, patient and public voice, NHS partnerships and working practices.

2.11.15 **Priorities delivered in 2014/15 included:**

- Listening to and involving patients through our engagement events and consultations on service change. For example, CAMHS, Dementia Care and Provision of Services, Continuing Care, Community Services and new health facility for Mitcham. One of the events was a Health hub at Mitcham Carnival - Feedback from the note board:
  - “I think the NHS tent is really helpful for all ages as it shows all ages the importance of staying healthy”
  - “Health Hub is an excellent event, Merton CCG have done very well, everything gone smoothly, we’ve had a great day”
  - “Its very nice to know there are people in Merton that care”

- Implementation of the Integration Project and Better Care Fund development of joined up services, including services to keep people well at home, prevent unnecessary emergency admissions to hospital and to help people back to independence following a hospital stay. Getting feedback from service users/carers on the impact of these services and reviewing whether changes have worked in the way intended

- Continuing to work with other CCGs on the South West London Collaborative Commissioning on our 5 year plan. This has involved jointly looking at how we can commission services more effectively to meet some of the challenges of increasing population levels and the increasing range and cost of health treatments

- Continue to work closely with Healthwatch Merton throughout this year on our involvement opportunities.
2.12 Working in Partnership

2.12.1 The Health and Well-being Board

2.12.2 The Health and Well-being Board is an example of the way Merton CCG work in partnership with Merton Council and the voluntary and community sector. This strategic forum brings together elected representatives with local commissioners and providers of health services, to advise support, challenge and direct the development of local health care services.

2.12.3 Merton CCG’s members on the Health and Well-being Board include the Chair, Chief Officer, Director of Commissioning and Planning and a GP member.

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

2.12.5 Health and Well-being Boards play a key role in developing the Joint Strategic Needs Assessment (JSNA) and a Health and Well-being Strategy for our local authority area. The Joint Strategic Needs Assessment (JSNA) provides a picture of health and well-being for Merton. It provides a basis of sound evidence for the planning and commissioning of local services.

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

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

2.12.8 Four priority themes were developed for 2014/15 with reference to the Joint Strategic Needs Assessment and existing strategic priorities. Each of the four themes have milestones, indicators and success measures, frequency of reporting and a specified lead for each action, as described in Table 4 below.

2.12.9 Each priority theme has a delivery plan which sets out how the Health and Well-being Strategy will be implemented. Merton CCG is the lead for priority three – enabling people to manage their own health and well-being as independently as possible.
Table 3: Health and Well-being Board’s four priorities and outcomes

<table>
<thead>
<tr>
<th>Priority themes</th>
<th>Supporting people to improve their health and wellbeing</th>
<th>Enabling people to manage their own health and wellbeing as independently as possible</th>
<th>Improving wellbeing, resilience and connectedness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving every child a healthy start</td>
<td>Promote and deliver an integrated approach to health and wellbeing</td>
<td>Improve health related quality of life for people with long term conditions.</td>
<td>Reduce poverty and increase income through economic development.</td>
</tr>
<tr>
<td>Ensure every baby has the best start in life.</td>
<td>Promote and deliver an integrated approach to health and wellbeing</td>
<td>Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support.</td>
<td>Improve wellbeing through safer communities and community cohesion.</td>
</tr>
<tr>
<td>Promote and improve the personal, social and mental wellbeing of our children and young people and their parents.</td>
<td>Promote sensible drinking, reduce alcohol related harm and harm from drug misuse.</td>
<td>Enable people with dementia and their carers to have access to good quality, early diagnosis and support.</td>
<td>Increase volunteering and make best use of local assets including parks, schools and leisure centres to promote wellbeing.</td>
</tr>
<tr>
<td>Promote and increase the proportion of healthy weight children and young people.</td>
<td>Improve sexual health and access to services.</td>
<td>Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support.</td>
<td>More people make a positive contribution to their own wellbeing through access to learning and development of skills.</td>
</tr>
<tr>
<td>Enable and increase the number of young people making healthy life choices.</td>
<td></td>
<td>Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.</td>
<td>Build a healthy environment including access to housing, local amenities and activities.</td>
</tr>
</tbody>
</table>

2.12.10 Better Care Fund

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

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

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

2.12.14 Merton’s BCF Plan seeks to deliver a series of health and social care integration schemes using a pooled budget to the value of £12.2m in 2015/16. This funding is already in the system, either through existing local authority grants or in the CCG’s commissioning budget.

2.12.15 The objectives of the plan are:

- To reduce the growth in non-elective admissions
- To reduce the length of stay in hospital beds
- To reduce permanent admissions to residential care homes
- To improve patient and service user satisfaction

2.12.16 Merton’s plan was initially submitted to the NHS England and the Local Government Association in April 2014 and work began immediately on delivering the schemes within the plan using an adapted version of the Prince2 formal project management structure.

2.12.17 The principal deliverable components of the overall project were managed through a work stream led by the ‘Merton model development group’, which structured the outputs of the schemes into three principal areas:

- Rapid assessment and diagnostics
- Reactive and rapid response services
- Proactive, planned and preventative services

2.12.18 In support of these, other work streams covered the enabling components of the plan, comprising:

- Finance and performance
- IT, data and information governance
- Workforce development and change
- Engagement
- Integrated quality commissioning

2.12.19 Under the leadership of an integration programme manager and the CCG’s clinical director for older and vulnerable adults, integration and end of life care, progress was managed through work stream development groups, a project team, the Merton Integration Board, the One Merton Group and the Health and Well-being Board.
In July 2014, it was announced that all Health and Well-being Board areas would have to re-submit their BCF plans using a more prescriptive framework, focusing the performance element of the fund solely on the reduction of non-elective admissions (NELs) by a suggested figure of 3.5%. Considerable work was undertaken to assess the potential to meet this target and the plan was completely rewritten and resubmitted in September 2014 with a detailed explanation of how the target could be met, assuming a growth in demand of 2.2%, which was based on best estimates available. Due to the reality of growth in demand rising to 4.1% during the winter of 2014/15, this target has subsequently been formally reduced to 1.4%, although it must be stressed that this has not had an effect on the target of 977 NELs that the plan seeks to reduce through the schemes.

The revised Merton BCF plan was ‘approved’ by NHS England in early January 2015. It was recognised as one of only five plans (out of 151 nationally) that was of a ‘high quality’ and was used as a national exemplar to support other areas in the development of their plans. Merton’s BCF team also received visits from the Department of Health and the Minister for Health, Earl Howe, and Minister for Local Government, Lord Ahmad, in February 2015 to see at first hand how Merton was approaching the challenges and opportunities of the BCF.

The following milestones within the programme were delivered:

- July 2014: Integrated locality teams established with community health staff working alongside newly-funded health care liaison social workers.
- December 2014: Additional intermediate care beds procured to prevent admissions and to support timely discharges from hospitals.
- January 2015: Restructuring of community reactive services to provide a more responsive prevention of admission, rapid response and in-reach support service.
- February 2015: Review of End-of-Life Care Strategy and extensive dementia training, piloting of discharge-to-assess and seven-day hospital social working pilots.

Further work will continue in 2015/16 to enhance the integration in localities and to extend the HARI service to urgent as well as routine referrals, among continuing deliverables of many of the other schemes. The BCF Plan will also continue to develop alongside the implementation of the Care Act.

The effect of Merton’s BCF schemes is already beginning to show in the performance data and the overall impact will be clearer once all the schemes have been implemented in 2015/16 and their impacts measured.
2.12.25 South West London Collaborative Commissioning (SWLCC)

2.12.26 Background

2.12.27 The six South West London CCGs (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) and NHS England, who commission specialised and primary care services in South West London, came together in April 2014 to work together under the umbrella name of South West London Collaborative Commissioning (also known as the SWLCC). The SWLCC is working to overcome a number of challenges in the years ahead:

- There are 1.45 million people living in South West London.
- The population is ageing and up to a third of people are living with long-term conditions, meaning we need to provide more and better care out of hospital and closer to where people live.
- None of our hospitals in South West London meets all the minimum safety and quality standards set out by clinicians based on Royal College guidance – the London Quality Standards.
- There is a variation in the quality of care between different hospitals and different times of the day, week and year.
- The NHS is unlikely to be given sustained and substantial extra funding in the foreseeable future, yet the costs of providing health care are rising much faster than the rate of inflation.
- We need to reshape mental health services so that they achieve the highest possible standards and are focused primarily in the community.
- We need to ensure that primary care and other community-based services meet the highest possible standards.
- We need to do more to prevent people becoming ill and to provide better information to patients about where to get help and when.

2.12.28 The SWLCC are working to ensure we have a long-term plan to overcome these challenges and to improve the quality of care in South West London for the benefit of patients and those living in South West London.

2.12.29 Approach to joint working across the six CCGS

2.12.30 During 2014/15 the SWLCC developed into a robust and meaningful collaboration as a result of stronger and more effective joint working between the CCGs. The programme is strongly owned and led by the CCGs who have developed a number of important principles, values and behaviours to underpin how they work together including where there is demonstrable benefit to patients and the wider public.

2.12.31 The SWLCC vision is that:

- People in South West London can access the right health services when and where they need them.
- Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients.
- Services are patient-centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable.

**2.12.32** SWLCC developed a ‘case for change document’ for the NHS in South West London which is available on the programme website [http://www.swlccgs.nhs.uk/the-case-for-change/](http://www.swlccgs.nhs.uk/the-case-for-change/)

The ‘case for change’ document sets out the challenges that the NHS faces in South West London and the reasons why we need to change.

**2.12.33** Development of the South West London Strategy

**2.12.34** In February 2014 the NHS in South West London was identified as one of eleven challenged health economies in England, primarily because more needed to be done to ensure that we could all work together across South West London to improve health care for local people.

**2.12.35** In April 2014 the SWLCC started to consider how the local NHS was going to address the challenges identified in the ‘case for change’ document.

**2.12.36** Clinicians from the trusts, SWLCCGs and NHS England across South West London worked together to develop a 5-year strategic plan, which sets out an ambitious vision for the transformation of our local health economy. During its development the CCGs were also keen to engage with local patients, the public and the voluntary/community sector to discuss the 5-year strategy from the beginning. A “listening and learning” event was held in May 2014, the outputs of which were fed into the 5-year strategy.

**2.12.37** This joint work was well received by NHS England and, as a result of this and the development of a comprehensive 5-year strategy, it was confirmed in the autumn 2014 that we were no longer considered a challenged health economy and we were able to take forward the next phase of the collaborative programme.

**2.12.38** The SWL strategy has four aims:

- to raise safety and quality standards;
- to address the financial gap;
- to address the workforce gap;
- to confront rising demand for health care.

**2.12.39** Hospital and community providers will play a key role in advising commissioners on the best way to implement this strategy; our aspiration is to agree on an approach which will be shared and owned by both commissioners and providers, working with local people to co-design solutions.
2.12.40 Setting up clinical work streams

2.12.41 Eight clinical work stream areas (clinical design groups) were established to help deliver the detail of the strategy. The clinical design groups consist of clinicians and commissioners from across South West London. The work streams are:

- children’s services
- integrated care (now called out of hospital)
- maternity care
- mental health
- planned care
- transforming primary care
- urgent and emergency care
- cancer care

2.12.42 The role of these clinical work streams is to develop clinical standards and requirements for our hospital and community health care in South West London. These groups provide a basis for sharing best practice across South West London’s CCGs, and for identifying solutions to problems shared across South West London particularly where such problems (e.g. patient flows) extend across CCG boundaries.

2.12.43 The CCGs have also been working with local NHS trusts, GPs and others about the role each part of the NHS plays and how we can work more closely with each other and with social care (local authorities) to respond to the challenges and what changes we need to make to deliver the strategy. Once we have identified what the potential solutions are, we will talk to local people about them. If major service changes are proposed, there will be a formal public consultation.

2.12.44 Clinical networks

2.12.45 Clinical networks bring together those who use, provide and commission a service to make improvements for patients. There are two such networks in South West London: the Maternity Network and Children and Young People’s Network. The South West London Children and Young People’s Network launched in January 2015. The network aims to facilitate the development and delivery of high quality, safe and sustainable services to all families and children across South West London.

2.12.46 The Maternity Network Board approved the launch of the South West London Maternity Network web site which went live in September 2014. For more information go to www.swlmaternitynetwork.nhs.uk

2.12.47 Commissioning intentions 2015/16

2.12.48 In August 2014, for the first time, the six South West London CCGs jointly developed commissioning intentions for providers for 2015/16, to focus on the priority work areas which were outlined in the five-year strategy. The joint commissioning intentions were agreed by each CCG governing body and were published in September 2014. This was an important step towards demonstrating
a commitment from the CCGs to work together for the benefit of patients and the NHS in South West London.

2.12.49 Primary care co-commissioning and the establishment of a SWL joint committee

2.12.50 The six CCGs in South West London have decided that they would like to plan (commission) primary care services across South West London, with NHSE. In order to do this they have agreed to pursue the model of a South West London-wide joint committee with NHSE which will have representation from each of our six CCGs, NHSE and colleagues from Health and Well-being Boards and local Healthwatch.

2.12.51 The South West London joint co-commissioning application was approved in March 2015. More detailed work continues to take place with CCGs, NHS England (London) and local authority colleagues to set up the joint committee including the work programme for 2015/16.

2.12.52 Our first joint committee meeting in public will take place in May 2015.

2.13 Our Focus on Improving Quality

2.13.1 Lord Darzi's definition of quality, first seen in ‘High Quality Care for All’ (2008) is now enshrined in legislation through the Health and Social Care Act 2012. The definition identifies the three elements of quality as:

- Safety – patients and service users suffer no avoidable harm
- Effectiveness – evidence-based and in line with best practice
- Patient experience – patients have a positive experience and are treated with dignity and respect.

2.13.2 To ensure services we commission are of a high quality we value:

- Strong clinical leadership – ensuring that models of care are fit for purpose and meet 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 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
- Listening and involving – listening to what people tell us about their needs and experiences and involving them in finding solutions
2.13.3 Quality assurance

2.13.4 During 2014/15 we continuously assured quality by:

- Monitoring performance of services we commission against agreed standards and outcomes
- Gaining assurance that the services met quality standards
- Providing assurance to other regulators and system leaders as required, for example the Care Quality Commission.

2.13.5 We review the quality of care given at our main NHS providers via clinical quality review groups and a programme of regular clinical quality committee meetings. As Merton does not have an acute trust within the borough, the CQRG meetings are chaired by a clinician of the ‘host’ CCG; Merton CCG is represented by our relevant GP clinical locality lead in our role as an ‘associate’ commissioner. This representation was supplemented by the introduction of a head of quality role into the quality directorate to provide further scrutiny and challenge.

2.13.6 We are the host CCG for Sutton and Merton Community Services (Royal Marsden Hospital) and lead the CQRG for this contract. During 2014/15 we reviewed the CQRG format and introduced patient stories onto the agenda. Each CQRG starts with a patient story or clinical presentation and has included a professional telling the story on behalf of a patient, a story being told using pictures of the patient and video recordings of patients.

2.13.7 At the Merton Clinical Quality Committee (MCQC) meeting in February 2015, a carer for a man in receipt of continuing health care (CHC) was invited into the meeting to tell of his experience of the CHC application process the previous year. The events that took place had resulted in a formal complaint being made to the CCG which was investigated and responded to by the Chief Officer. The overwhelming view was that patient experiences were welcomed within the organisation as a method for hearing the patient voice.

2.13.8 Safeguarding

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

2.13.10 Our governing body lead for safeguarding children is the Chief Officer and for safeguarding adults our Independent Board Nurse takes the lead.

2.13.11 We have arrangements in place for ensuring that all staff working with children, young people and adults within the services the CCG commissions are able to keep them safe. This includes ensuring safeguarding supervision and training is in place so that those at risk or are vulnerable are identified early and timely intervention occurs.
2.13.12 We also work closely with our partner agencies e.g. social services, police, education, housing and the voluntary sector to share information and initiatives that protect children and review cases when children or vulnerable adults have been seriously harmed or have died through abuse and/or neglect.

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

2.13.14 **Safeguarding children**

2.13.15 During 2014/15 we increased our resource in respect of safeguarding children. Designated professionals cover the Designated Nurse Safeguarding Children role, and we have additional arrangements to provide for Children Looked After.

2.13.16 In addition we have reviewed and continue to have a children’s safeguarding executive group to support safeguarding decision making within the CCG.

2.13.17 Arrangements for named GPs for each CCG area were reviewed nationally during 2014/15 to minimise the significant differences that currently exist with effect in London from 1 April 2015 with the following recommendations:

- Named GP sessions have been identified for each CCG area using a common formula; 2 per week in Merton
- A contract for services, rather than a contract of employment will be used to secure the named GP function
- Payment per session will be standardised across England

2.13.18 In 2015/16 MCCG will be implementing these recommendations.

2.13.19 **Merton MASH**

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

2.13.21 You can see our declaration outlining our commitments and responsibilities for protecting and safeguarding children and young people on our [website](#).
2.13.22 Safeguarding adults at risk

2.13.23 ‘No Secrets’ government guidance (DH, 2000) gives local authorities the lead role in coordinating work to safeguard adults at risk. We are committed to working with local stakeholders to protect adults at risk. The CCG is responsible for ensuring that health providers play their part in the multi-agency team which delivers the adult safeguarding procedures.

2.13.24 During 2014/15 the quality directorate commissioned additional resource to support some of the functions including adult safeguarding. A refresh of the safeguarding adults at risk tool has been undertaken and the links with the local authority and the Care Quality Commission (CQC), in respect of quality in care homes have been developed.

2.13.25 The Care Act was given Royal Assent in May 2014. The Act places adult safeguarding on a statutory footing, to reflect arrangements in place for children.

2.13.26 Sections 43-45 of the act relate to the role and responsibilities of Safeguarding Adults Boards from April 2015 to include:
- duty to establish a Safeguarding Adults Board (SAB) to include the local authority, CCG and police;
- undertaking a Safeguarding Adults Review (SAR) where a person has died through abuse or neglect, or a person has experienced serious abuse or neglect;
- duty to publish an annual strategic plan and in doing so must:
  - consulting Healthwatch
  - involving the community
  - duty to publish an annual report.

2.13.27 Merton Safeguarding Adults Board held a development event in October 2014, attended by the Director of Quality for Merton CCG, to consider the implications of the Act for Merton and develop a forward plan to ensure readiness for SAB to become a statutory body from April 2015.

2.13.28 CCGs are required to have a designated safeguarding adults manager. These responsibilities will be incorporated into the head of quality role.

2.13.29 Quality premium

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

2.13.31 The 2014-15 measures cover a combination of national and local priorities. To receive 100% of the quality premium we have to deliver on our local priorities, national targets and aspects of the constitutional pledges (A&E, cancer two-week wait and subsequent treatment, referral to treatment 18-week compliance and ambulance response times). We also have to ensure we meet our financial plan
for 2014-15. Where a CCG does not deliver the identified patient rights and pledges on waiting times, a reduction of 25 per cent for each relevant NHS Constitution measure will be made to the quality premium payment.

2.13.32  The six national measures, all of which are based on measures in the NHS outcomes framework, are:

- Reducing potential years of lives lost by 3.2% through amenable mortality (12.5%)
- For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16 (12.5%)
- Reducing avoidable emergency admissions remain at 2013/14 levels (25%)
- Increasing the proportion of people having a positive experience of hospital care (12.5%)
- Improving the reporting of medication-related safety incidents resulting in a 10% increased reporting between Q4 2013/14 and Q4 2014/15 of medication errors has been agreed by Epsom & St. Helier NHS Trust (12.5%)
- Ensuring roll-out of the friends and family test and improving patient experience of hospital services (12.5%)

2.13.33  In addition we have one local priority agreed by the Merton Health and Well-being Board and with NHS England: Increasing the number of patients by 2.5% from black and minority ethnic (BME) groups using psychological therapies (12.5%)

2.13.34  The table below details our performance on the quality premium indicators. For many of the indicators it is necessary to use proxy indicators to monitor in-year progress. At month 9 (April–December) progress towards the quality premium is as follows;

<table>
<thead>
<tr>
<th>Table 4: Are health outcomes improving for local people?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ref</strong></td>
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<tr>
<td>---------</td>
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<tr>
<td>E.A.1.1</td>
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<tr>
<td>E.A.1.a</td>
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<tr>
<td>E.A.1.b</td>
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<td>FFT (E.A.6)</td>
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<td>E.A.9</td>
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<tr>
<td>E.A.9</td>
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<td>L.P.1</td>
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</tbody>
</table>
2.13.35 The table above indicates that we are on track to achieve avoidable admissions, the local priority (LP.1) and 15% IAPT access target in quarter 4; which we have achieved. We are unlikely to achieve all of our constitutional pledges, other than the cancer two week wait target. We are actively working with our local providers to improve our performance on targets that were not achieved within 2014/15.

2.13.36 Notification of quality premium awards will be made in Quarter 3 2015/16. Assessment of the CCG’s position with respect to the six national quality premium measures will be carried out by the national support centre.

2.13.37 **Commissioning for quality and innovation (CQUIN)**

2.13.38 The key aim of the Commissioning for Quality and Innovation (CQUIN) Framework is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management.

2.13.39 This approach encompasses a system of setting national and local quality goals and targets, which if successfully achieved will bring financial rewards to the provider, which may constitute up to 2.5% the total contract value.

2.13.40 The CCG has worked with the CSU and neighbouring CCGs to agree CQUINs for its local Trusts for 2014/15.

2.13.41 There were four national CQUIN goals for 2014/15:

- Friends and family test (FFT)
- Improvement against the NHS safety thermometer (excluding VTE), particularly pressure sores;
- Improving dementia care, including sustained improvement in finding people with dementia, assessing and investigating their symptoms and referring for support (FAIR); and
- Venous thromboembolism (VTE) – 95% of patients being risk assessed and achievement of a locally-agreed goal for the number of VTE admissions that are reviewed through root cause analysis.

2.13.42 The above national CQUINs accounts for 20% of the potential 2.5% that the provider can earn. In addition, innovation health and wealth, accelerating adoption and diffusion in the NHS set out that from April 2013 compliance with high impact innovations would become a prequalification requirement for CQUIN. Below are the local CQUINs for our three main acute provider in 2014/15.
Table 5 - CQUINs

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Kingston Hospital NHSFT - Local CQUIN</th>
<th>St George’s Hospital NHSFT - Local CQUINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smiling and Cessation</td>
<td>Reducing Smoking 1.4%</td>
<td>Reducing Smoking 1.4%</td>
</tr>
<tr>
<td></td>
<td>Staff Training 0.5%</td>
<td>Staff Training 0.5%</td>
</tr>
<tr>
<td></td>
<td>Recruitment of 2 WTE Smoking Cessation Nurses 2.1%</td>
<td>Recruitment of 2 WTE Smoking Cessation Nurses 2.1%</td>
</tr>
<tr>
<td>NAI / PAU</td>
<td>Non-Accidental Injury and Paediatric Assessment Unit Cover 5.5%</td>
<td>Non-Accidental Injury and Paediatric Assessment Unit Cover 5.5%</td>
</tr>
<tr>
<td>GP Communication</td>
<td>Discharge information communicated to GPs 3.1%</td>
<td>Discharge information communicated to GPs 3.1%</td>
</tr>
<tr>
<td></td>
<td>Advance Booking of Next Appointment 3.1%</td>
<td>Advance Booking of Next Appointment 3.1%</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td>Early Supported Discharge 4.8%</td>
<td>Early Supported Discharge 4.8%</td>
</tr>
<tr>
<td></td>
<td>Quality of care 25%</td>
<td>Quality of care 25%</td>
</tr>
<tr>
<td>Maternity</td>
<td>Hospital 14%</td>
<td>Hospital 14%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Bundle of Care 6.0%</td>
<td>Bundle of Care 6.0%</td>
</tr>
</tbody>
</table>

2.13.43 Performance of CQUINs will not be known until end of June 2015.

2.13.44 Community CQUINs

2.13.45 The table below details the CQUINs agreed with Sutton and Merton Community services and the performance for quarter 3.

Table 6 CQUINs and performance

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Quarter 3 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Admissions to A&amp;E departments from Nursing and Residential Homes</td>
<td>No milestone for Q3 but progress against action plan included to ensure commissioners are updated</td>
</tr>
<tr>
<td>Friends and Family Test – Phased Expansion</td>
<td>Achieved</td>
</tr>
<tr>
<td>Pressure Ulcers – Data collection and improvement</td>
<td>Achieved</td>
</tr>
<tr>
<td>Uptake in Screening Services – NHS England</td>
<td>Achieved</td>
</tr>
<tr>
<td>Sign up to national safeguarding database</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

2.13.46 Performance for 2014/15 will be validated in June 2015.
2.13.47 Quality accounts

2.13.48 A quality account is a report about the quality of services by an NHS health care provider. Reports are published annually by each of our NHS providers, and are available to the public through the NHS Choices website.

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

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

2.13.51 Clinical commissioning groups are asked to comment on these accounts. Across South West London it was agreed that all CCG comments would be coordinated by each ‘host’ CCG. Merton CCG sent comments on the acute trusts to the host CCG. Merton CCG, in turn, coordinated comments for The Royal Marsden (which hosts the Sutton and Merton community services) quality account. This quality account mostly covered the acute services of The Royal Marsden Hospital, which is not commissioned by Merton CCG, so the CCG commented on the aspects which related to community care. We agreed the priorities which they set out for 2014-15 including improvements in pressure ulcer care and patient experience surveys.

2.13.52 The coordinated comments from the host and associate CCGs were all ‘signed off’ and published in the relevant provider’s quality account.

2.13.53 Quality accounts for our main NHS providers can be found on the trust websites:

- Sutton and Merton Community Services
- Epsom and St Helier University Hospitals NHS Trust
- St George’s Healthcare NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George’s Mental Health NHS Trust

2.14 Performance Review

2.15 NHS Constitution

2.15.1 The CCG regularly considers performance against the NHS Constitution standards and this is a routine part of the contract managing process with providers. At month 9 (quarter 3), the year to date CCG performance is as follows:
Table 7 – NHS Constitution

<table>
<thead>
<tr>
<th>NHS CONSTITUTION</th>
<th>Target</th>
<th>YTD Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA (PIR Assigned)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>C Difficile</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>RTT 18 weeks (admitted patients)</td>
<td>90.0%</td>
<td>88.1%</td>
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<tr>
<td>RTT 18 weeks (non admitted patients)</td>
<td>95.0%</td>
<td>94.9%</td>
</tr>
<tr>
<td>RTT 18 weeks (incomplete pathways)</td>
<td>92.0%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Diagnostic tests waiting time</td>
<td>99.0%</td>
<td>98.9%</td>
</tr>
<tr>
<td>A and E waiting times</td>
<td>95.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Cancer two weeks</td>
<td>93.0%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Breast symptoms two weeks</td>
<td>93.0%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Cancer first definitive treatment 31 days</td>
<td>96.0%</td>
<td>99.4%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, surgery</td>
<td>94.0%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, drug</td>
<td>98.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, radiotherapy</td>
<td>94.0%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, Includes 31 day rare standards</td>
<td>85.0%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, Screening</td>
<td>90.0%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, Consultant upgrade</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Ambulance Red 1 8 minute response</td>
<td>75.0%</td>
<td>67.6%</td>
</tr>
<tr>
<td>Ambulance Red 2 8 minute response</td>
<td>75.0%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Ambulance Red 19 minute transportation</td>
<td>95.0%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>RTT 52 weeks (admitted patients)</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>RTT 52 weeks (non admitted patients)</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>RTT 52 weeks (incomplete pathways)</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

- MRSA & C-difficile: all cases are investigated and reviewed at the relevant provider clinical quality review group.
- Referral to treatment: As at month 9, Merton CCG is not achieving the 18 weeks standard. This is due to the impact of additional investment to clear a backlog of people waiting beyond 18 weeks. The CCG are working with providers and commissioners to ensure that providers have sufficient capacity to meet the standard during 2015/16.
- Diagnostic test wait times: As at month 9, the CCG are slightly under-performing due to staff vacancies at our main providers. Whilst we are confident that we will meet this standard in 2014/15, the opening of the Nelson Local Care Centre will introduce additional diagnostics capacity for Merton patients from April 2015 and ensure that Merton CCG consistently meets the standard in 2015/16 and beyond.
- A&E waiting times: As at month 9, the CCG are not meeting the 95% standard for 4-hour A&E waits. This has been a challenging winter with our acute trusts experiencing higher than predicted demand on both A&E and emergency admissions. There has been some improvement in performance in the latter part of the last quarter, following an in-depth review of processes by providers during an exercise called ‘Perfect Week’.
- Cancer standards: The CCG is meeting all the cancer standards, except for 62 days following GP referral. This standard is increasingly difficult for both providers and commissioners, as it relates to a small number of people who are treated on often complex pathways across multiple providers.
- Ambulance response times: London Ambulance Service has experienced significant staff recruitment and retention challenges which have negatively
impacted on ambulance response targets. A recruitment plan is currently being implemented and with additional investment from all London CCGs, this standard is expected to be met in 2015/16.

- Mixed sex accommodation breaches: each breach is investigated and reviewed by the relevant clinical quality review group. Patients are advised of the issues at the time of the breach.

2.15.2 We are working with host commissioners to ensure that improvement plans are in place and met for all that targets above that are below plan.

2.16 Improved Health Outcomes

2.16.1 Improving the health of our local population is the basis of entitlement to the CCG Quality Premium. For many of the indicators it is necessary to use proxy indicators to monitor in-year progress. At month 9 progress towards achievement of the health outcome indicators is as follows:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing the proportion of people diagnosed with Dementia</td>
<td>67%</td>
<td>62.3%</td>
</tr>
<tr>
<td>Increasing the IAPT recovery rate</td>
<td>46.89%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Reducing Avoidable Emergency Admissions</td>
<td>Last Year performance</td>
<td>2,278</td>
</tr>
<tr>
<td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td>
<td>Last Year performance</td>
<td>764</td>
</tr>
<tr>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</td>
<td>Last Year performance</td>
<td>96</td>
</tr>
<tr>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>Last Year performance</td>
<td>1,300</td>
</tr>
<tr>
<td>Emergency admissions for children with lower respiratory tract infections (LRTI)</td>
<td>Last Year performance</td>
<td>118</td>
</tr>
<tr>
<td>Increasing the proportion of people having a positive experience in general practice &amp; community</td>
<td>≤ 8.04</td>
<td>10.4</td>
</tr>
<tr>
<td>Improving the reporting of medication errors</td>
<td>110</td>
<td>284</td>
</tr>
<tr>
<td>Increasing the proportion of people that enter IAPT treatment against the level of need in the general population *</td>
<td>1.25%</td>
<td>0.78%</td>
</tr>
<tr>
<td>Increasing the number of patients from BME groups using Psychological Therapies</td>
<td>57</td>
<td>610</td>
</tr>
</tbody>
</table>

Table 8: Health outcome indicators

- Dementia: The CCG is very pleased to have improved the dementia diagnosis rate from 49.9% to 66.5%.
- IAPT: The CCG is very pleased to report meeting the 15% access to IAPT in Quarter 4.
- Unplanned admissions: Despite a challenging winter period, proxy data indicates that Merton are on track to reduce the number of avoidable emergency admissions.
Positive experience in general practice and the community: The annual GP survey indicates that more people had a positive experience of general practice and community services in 2014/15 than in 2013/14.

Improving the reporting of medication errors: In accordance with the ambition to increase the reporting of medication incidents by 10% at Epsom and St. Helier NHS Trust the CCG are on track to achieve this target.

Local priority: The CCG are on track to increase the number of patients from BME groups using psychological therapies as submitted in our operating plan.

2.16.2 Sustainability

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

- We occupy a modern, shared-use office building with other NHS tenants, and have worked with the landlords to ensure the building is energy efficient, for example we recycle waste and encourage staff to reduce the use of energy (lighting, power etc.)
- Our staff are encouraged to use public transport for their travel to and from home and for business travel. To this extent, we have ensured that our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

2.16.5 Sustainability at the heart of the Nelson Local Care Centre

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

2.16.7 During 2014/15 the project team have been working to agreed principles to set the sustainability agenda and the building which opened on 1 April 2015 will provide a landmark in terms of its environmental credentials. These principles include:

- Integrating with the local neighbourhood and enhancing the local environment
- Provide sustainable transport options for all building users
- Deliver cleaner, greener and safer external spaces that are rich in biodiversity
- Use energy and water efficiently and maximise the use of renewable and natural resources
- Provide flexibility and adaptability to meet changing service needs (short and long term)
• Reduce pollution and waste during both the construction and operation phases of the building.

2.16.8 The Nelson will also result in approximately 50% reduction in carbon emissions compared to the previous estate.

2.16.9 Equality (annual report and equality delivery system)

2.16.20 Merton CCG has progressed steadily with its equality and diversity work programme in 2014-15. We undertook an extensive baseline assessment of our performance around equality and diversity against the refreshed Equality Delivery System (EDS2) between March and September 2014.

2.16.21 Following consultations with service users, providers, voluntary and community sector, staff and leadership teams between March and September 2014, we were assessed overall as ‘developing’, for goals 1, 2 and 3 and ‘achieving’ for goal 4.

2.16.22 The EDS report and improvement plans for all four goals can be found at http://www.mertonccg.nhs.uk/about-us/equality-and-diversity/Pages/default.aspx

2.16.23 These plans will be integrated into the organisation’s operating and organisational development plans. Overall they highlight how the CCG is meeting our public sector equality duties and delivering against its objectives in a planned and systematic method that promotes accountability and transparency.

2.16.24 In assessing grades for these goals, we followed a robust and transparent methodology, which included review by patients, voluntary and community organisations, staff and leadership teams.

2.16.25 In validating outcomes 4.1 and 4.2 (inclusive leadership and board papers taking into account equality and diversity in decision-making), we participated in an innovative peer review assessment in a reciprocal arrangement with Sutton CCG. Feedback and recommendations from the assessment informed grades and improvement plans for goal 4.

2.16.26 In the past year, we have also undertaken a range of equality analyses to ensure equality and diversity is integrated in service redesign and delivery. This is also integrated into the QIPP schemes completed since January 2014 including:

- mental health placements
- prescribing
- urgent care
- diabetes
- MSK
- health coaching COPD
- community DESP surveillance

2.16.27 We are involving stakeholders in the procurement process of the children and adult community health services. The planned consultations will inform the equality analysis of the procurement and findings will inform the service specification and
tender processes. A similar process is also underway to inform the improving access to psychological therapies procurement.

2.16.28 In addition, we have organised and participated in a series consultations to inform the changes to inpatient facilities at South West London and St George’s Mental Health Trust. Equality and analysis is being undertaken on an ongoing basis to ensure protected groups living in Merton are not adversely affected by the changes.

2.16.29 We are informed and supported in our equality and diversity work programme by an equality and diversity steering group, led by the director of quality. The group includes members from the commissioning and public health teams and the equality and diversity and patient and public engagement leads on the governing body. The EDG reports progress to the Clinical Quality Committee and steers the CCG’s programme around the EDS.

2.16.30 Merton CCG published its Annual Public Sector Equality Duty in January 2015 and will review how it is delivering against its equality objectives in April 2015 by mapping it against the findings of the EDS assessment process.

2.16.31 Staff continue to receive training, guidance and support in undertaking equality analysis and understanding their statutory duties. In addition, our staff have received training on bespoke areas, such as avoiding unconscious bias in selection processes. Our governing body will also participate in a training and development session in 2015-16 to understand their duties under the Equality Act.

2.16.32 Our staff

2.16.33 Communicating and engaging

2.16.34 There are a number of ways we have communicated and engaged with our staff during 2014/15 including:

- A SWL Staff Partnership Forum where managers and staff from the 6 South West London CCGs meet to discuss and consult on issues.
- An organisational development programme for the CCG has been undertaken including specific events to build the teams, inform and consult with the governing body members, management team and staff.
- There are regular directorate team meetings and staff meetings with all members of Merton CCG teams including the executive management team (EMT)
- The CCG is also participating in the national NHS Staff Survey that South London CSU is co-ordinating as part of its HR service offer.
2.16.35 Training and development

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

2.16.37 All staff have regular one-to-ones and have appraisals, objectives and PDPs in place.

2.16.38 Equalities for staff

2.16.39 The CCG promotes a working environment in which all parties and procedures relating to recruitment, selection, training, promotion and employment are free from unfair discrimination, ensuring that no employee or prospective employee is discriminated against, whether directly or indirectly on the grounds of gender, marital status, race, colour, ethnic or national origin, nationality, disability, age, sexual orientation, religion or belief, responsibility for dependants, trade union membership, HIV status, or any other condition or requirement which cannot be shown to be justifiable.

2.16.40 Merton CCG has policies in place to support staff in their working environment. All HR policies are impact assessed to ensure there is no detriment to any of the equality protected characteristics in line with the Equality Act 2010.
2.6.41 Information on the gender of staff

Table 9: Information on the gender of staff

<table>
<thead>
<tr>
<th>CCG</th>
<th>Members and Governing Body</th>
<th>Very Senior Managers (VSM)</th>
<th>Employees of the CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Merton</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Eleanor Brown

Signed:

Accountable Officer

28 May 2015
3. **Members’ Report**

3.1 **Details of Our Membership**

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

3.1.2 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 the nurse lead, further enhances our clinical decision making on wider transformational and system wide change.

3.1.3 **1. East Merton**

The locality GP lead is Dr Karen Worthington.

There are nine member practices:

Central Medical Practice  
Cricket Green Medical Practice  
Figgies Marsh Surgery  
Graham Road Surgery  
Ravensbury Park Medical Centre  
Rowans Surgery  
Tamworth House  
Wide Way Surgery  
Wilson Health Centre

3.1.4 **Achievements in 2014-15:**

3.1.5 The nine practices have continued to work closely together and with public health to target specific areas of health inequality. This has included specific projects on COPD, HIV screening and embedding preventative health strategies, such as smoking cessation in the way primary care services are delivered.

3.1.6 Of great importance to the future health of East Merton residents is the moving forward of the project to deliver a new local care centre in Mitcham with the site now having been selected and a clinical working group set up to start working on the model of care that the centre will support. The clinicians involved are hoping that new innovative ways of working can be found to work with secondary care, community services, mental health services and the voluntary sector to improve the health of the local population.
3.1.7 2. Raynes Park

The locality GP lead is Dr Sion Gibby

![Image](image.png)

There are eight member practices:

- Cannon Hill Lane Practice
- Church Lane Practice
- Francis Grove Surgery
- Grand Drive Surgery
- James O’Riordan Surgery
- Lambton Road Medical Practice
- Morden Hall Practice
- Stonecot Surgery

3.1.8 Achievements in 2014-15:

3.1.9 2014-2015 has been an exciting time for the Raynes Park locality. The initial interest in developing a federation across the Raynes Park practices has in turn developed into a Federation serving all of the patients of Merton, with all 25 practices forming a federation. This we hope will develop excellent opportunities for patients across Raynes Park locality and across the whole of Merton to improve care in the community.

3.1.10 1 April 2015 is scheduled to see the first patients use the Nelson Health Centre. This will be a fantastic facility for the residents of Raynes Park and now, along with the Raynes Park Health Centre in Lambton Road, we have a great choice of facilities locally that allow residents to access many investigations and resources without needing to travel to local hospitals. This is part of the process of providing "Better Healthcare Closer to Home" and will, we are sure, be a great success.
3.1.11 West Merton

The locality GP lead is Dr Tim Hodgson

There are eight member practices:

Alexandra Road Surgery
Colliers Wood
Merton Medical Practice
Mitcham Medical Practice
Princes Road Surgery
River House Practice
Vineyard Hill Practice
Wimbledon Village

3.1.12 Achievements in 2014-15:

3.1.13 The eight practices in West Merton have continued to grasp the opportunity to work together with both hands. We have been building closer working relationships across the practices, and how the future of general practice may look including federation. We have built our relationships with the senior clinicians and management of St George’s Hospital, and strive to improve quality for our patients.

3.1.14 Many of the GP practices will enjoy the benefits of the new Nelson Health Centre and have been contributing to the creation of new clinical care pathways.

3.1.15 Governing body

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

- Dr Howard Freeman – Chair
- Eleanor Brown – Chief Officer
- Cynthia Cardozo – Chief Finance Officer (from 8 August 2013)
- Dr Kay Eilbert – Director of Public Health, London Borough of Merton
- Peter Derrick – Lay Member, Chair of the Audit Committee and Vice Chair
- Clare Gummett – Lay Member, Patient and Public Involvement
- Mary Clarke – Independent Nurse Member
- Dr Andrew Murray – GP Clinical Governing Body Member (from 1 June 2013)
- Dr Caroline Chill – GP Clinical Governing Body Member (from 17 October 2013)
- Professor Stephen Powis – Secondary Care Consultant

3.1.18 In addition to the above Adam Doyle (Director of Commissioning and Planning), Lynn Street (Director of Quality) and Marek Jarzembowski (LMC chair) are in attendance at all governing body meetings and seminars.

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

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

3.1.21 Practice Leads Forum

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

#### Membership:

**Table 10: Merton CCG Member Practices and Practice Leads Names**

<table>
<thead>
<tr>
<th>Member GP Practice</th>
<th>Practice Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Alexandra Rd H85656</td>
<td>Dr Mayura Mahadevan</td>
</tr>
<tr>
<td>2 Cannon Hill Lane H85016</td>
<td>Dr Graham Mason</td>
</tr>
<tr>
<td>3 Central Medical H85070</td>
<td>Dr Elizabeth Higham</td>
</tr>
<tr>
<td>4 Church Lane H85020</td>
<td>Dr Shweta Singh</td>
</tr>
<tr>
<td>5 Colliers Wood H85649</td>
<td>Dr Saqib Ayub</td>
</tr>
<tr>
<td>6 Cricket Green H85038</td>
<td>Dr Andrew Otley</td>
</tr>
<tr>
<td>7 Figgies Marsh H85090</td>
<td>Dr Abdullah Zakaria</td>
</tr>
<tr>
<td>8 Francis Grove H85026</td>
<td>Dr Simon Vickers</td>
</tr>
<tr>
<td>9 Graham Road H85078</td>
<td>Dr Raghu Lall</td>
</tr>
<tr>
<td>10 Grand Drive H85101</td>
<td>Dr Sion Gibby</td>
</tr>
<tr>
<td>11 James O’Riordan H85072</td>
<td>Dr Jerome Jephcott</td>
</tr>
<tr>
<td>12 Lampton Road H85051</td>
<td>Dr Naz Dhalla</td>
</tr>
<tr>
<td>13 Merton Medical Practice H85634</td>
<td>Dr Rafik Taibjee</td>
</tr>
<tr>
<td>14 Mitcham Medical H85024</td>
<td>Dr Naem Khan</td>
</tr>
<tr>
<td>15 Morden Hall Medical Centre H85037</td>
<td>Dr Naheed Ahmad</td>
</tr>
<tr>
<td>16 Princes Rd H85028</td>
<td>Dr Ladan Sharifi</td>
</tr>
<tr>
<td>17 Ravensbury Park H85110</td>
<td>Dr Titus Keyamo</td>
</tr>
<tr>
<td>18 Riverhouse H85092</td>
<td>Dr Naveed Baig</td>
</tr>
<tr>
<td>19 Rowans H85035</td>
<td>Dr Karen Worthington</td>
</tr>
<tr>
<td>20 Stonecot H85076</td>
<td>Dr Vasa Gnanapragasam</td>
</tr>
<tr>
<td>21 Tamworth House H85033</td>
<td>Dr Geoff Hollier</td>
</tr>
<tr>
<td>22 Vineyard Hill Rd H85112</td>
<td>Dr Rob Jones</td>
</tr>
<tr>
<td>23 Wide Way H85029</td>
<td>Dr Sayanthan Ganesaratnam</td>
</tr>
<tr>
<td>24 Wilson Health Centre Y02968</td>
<td>Dr Anirban Gupta</td>
</tr>
<tr>
<td>25 Wimbledon H85027</td>
<td>Dr Tim Hodgson</td>
</tr>
</tbody>
</table>
3.1.25 **Audit and Governance Committee membership**

Full details about Merton CCG’s Audit and Governance Committees and membership can be found in the Governance Section on page 69.

3.1.27 **Pension liabilities**

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

3.1.29 **Sickness absence data for CCG staff**

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

3.1.31 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.

3.1.32 An occupational health (OH) service is available to provide professional medical advice to the CCG. Staff can access OH for a self-referral and can access the OH counselling service.

3.1.33 We also have access to an employee assistance programme which is provided by Right Management, which offers unlimited confidential access to emotional and practical support, including legal and financial advice.

3.1.34 **External audit**

The appointment of external auditors on behalf of Merton CCG was undertaken by the Audit Commission. Grant Thornton were appointed as the external auditors in September 2013. The appointment was made under section 3 of the Audit Commission Act 1998 and covers the audit of the accounts for 2013/14 to 2016/17.

The external audit fees for 2014/15 amount to £76,320. The fee covers the audit of the financial statements and work carried out to reach a conclusion on the economy, efficiency and effectiveness in the CCG’s use of resources. No further work in addition to the statutory audit and services carried out in relation to the statutory audit has been carried out by Grant Thornton in 2014/15.

3.1.36 **Disclosure of “serious untoward incidents” – information governance**

Our Governance Statement on page 83 outlines our policy relating to incidents involving data loss or confidentiality breaches.
3.1.38 Cost allocation and setting of charges for information

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

3.1.40 Principles of remedy

3.1.41 We encourage feedback, positive and negative, so that we can act to improve services based directly on the concerns of patients and the public.

3.1.42 Complaints

3.1.43 During 2014/15 there were 37 complaints compared to 47 in 2013/14. Of the 37 complaints, six related to primary care and were offered information and guidance to enable them to contact NHS England. Three complaints related to a hospital regarding access and treatment and care provided by a hospital. Two complaints related to community services. Two complaints related to treatment at a walk-in centre. One complaint related to the local authority. The final 23 related directly to the CCG; the main themes were eligibility for services and commissioning decisions, for example individual funding requests and continuing health care (CHC) assessments.

3.1.44 Complaints that resulted in changes and learning

- Complaint regarding the delay in funding transportation of a patient from a hospital in Kent back to their care home in Merton. We investigated this complaint and a conclusion was reached that enabled lessons to be learned about the process and systems for transporting patients from hospitals in Kent back to Merton. The organisation that provides the transportation service was given a direct contact number for the responsible person in the CCG who can authorise funding for these cases.

- The complaints in relation to commissioning IVF services led to a review of this important area of support to patients with assisted conception infertility issues, which led to the CCG offering one round of IVF treatment for women up to the age of 42 who fit the criteria as stated in the 2014/15 South West Effective Commissioning Initiative.

- Several complaints related to delays in communication to and from the continuing health care team. Two issues have been identified. Firstly, there are issues with the telephone system itself, which cuts the caller off, without offering a voicemail option after seven rings. This is being taken forward with the landlord and, in addition, the service has plans to have a dedicated receptionist. The second issue related to unexpected, extended staff leave due to sickness and bereavement. The service is now developing back-up plans in case this happens again.
3.1.45 Patient advice and liaison service

3.1.46 We provide a patient advice and liaison service (PALS) to deal with information requests, issues and concerns raised by patients and members of the public. During 2014/15 there were 83 PALS cases received compared to 108 in 2013/14.

3.1.47 Of the 83 PALS enquiries, 35 were related to services provided by the CCG; 48 were non-CCG related in regards to primary care services, NHS England, hospitals, GP out of hours, mental health trusts, community services, and the 111 service; 33 related to primary care and NHS England; seven related to hospital care; three related to GP out of hours; two related to mental health trusts; two related to community services; and one to the 111 service.

3.1.48 Freedom of information requests

3.1.49 The SECSU provides the coordination of the FoI requests for Merton CCG. The CCG complies with its statutory duty to respond to requests for information. During the first nine months of 2014/15 the CCG received 198 requests under the FoI Act 2000, of which 188 were completed within the stipulated 20 working days period.

3.1.50 Employee consultation

3.1.51 Organisational change is managed in accordance with the principles and procedures contained within the CCG's organisational change policy. The CCG also informally communicates and consults with employees via a monthly newsletter and regular staff and team meetings.

3.1.52 Disabled employees

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

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

3.1.56 NHS organisations were required to carry out a red/amber/green (RAG) rated self-assessment against NHS England Core Standards for EPRR and submit their assessment to NHSE by 29 September 2014.

3.1.57 Organisations participating in the process are required to ensure their Boards (or equivalent) are sighted on the level of compliance achieved, the results of the self-assessment and the action/work plan for the forthcoming period.

3.1.58 Following the assurance process Merton CCG declared an assurance level of Substantial requiring the CCG to provide an action plan addressing the actions they will take to achieve full compliance with the core standards.

3.1.59 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.

3.1.60 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 governing body.

3.2 **Statement as to Disclosure to Auditors**

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

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

**Eleanor Brown**

**Signed:**

**Accountable Officer:**

**28 May 2015**
4. Remuneration Report

4.1.1 The Remuneration Committee comprises of four members and has met on two 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>2</td>
</tr>
<tr>
<td>Mary Clarke</td>
<td>Independent Nurse Member</td>
<td>01.04.13</td>
<td>NA</td>
<td>2</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>Howard Freeman</td>
<td>Clinical Chair</td>
<td>01.04.13</td>
<td>31.03.15</td>
<td>1</td>
</tr>
</tbody>
</table>

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

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

4.1.3 Remuneration policy

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

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

4.1.6 Senior managers’ performance-related pay

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

4.1.8 Senior managers’ service contracts

4.1.9 All senior managers’ at Merton CCG follow the national pay and remuneration guidelines.
**Table 11: Senior Managers’ Salaries and Allowances (audited)**

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees (bands of £5,000)</th>
<th>Taxable Benefits (£000) (rounded to the nearest £000)</th>
<th>Annual Performance Related Bonuses (£000)</th>
<th>Long-term Performance Related Bonuses (£000)</th>
<th>All Pension Related Benefits (£000) (bands of £2,500)</th>
<th>TOTAL (£000) (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleanor Brown – Chief Officer</td>
<td>110-115</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55-57.5</td>
<td>165-170</td>
</tr>
<tr>
<td>Cynthia Cardozo – Chief Finance Officer from 8th August 2013</td>
<td>100-105</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>80-82.5</td>
<td>180-185</td>
</tr>
<tr>
<td>Dr Carrie Chill – 3 roles, Primary Care Lead, Clinical Lead for End of Life Care and Member of Governing Body</td>
<td>105-110</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12.5-15</td>
<td>115-120</td>
</tr>
<tr>
<td>Mary Clarke – Independent Nurse</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>5-10</td>
</tr>
<tr>
<td>Peter Derrick – Lay person with responsibility for finance and governance</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>10-15</td>
</tr>
<tr>
<td>Adam Doyle – Director of Commissioning and Planning</td>
<td>100-105</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17.5-20</td>
<td>115-120</td>
</tr>
<tr>
<td>Dr. Howard Freeman – Chair</td>
<td>70-75</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>70-75</td>
</tr>
<tr>
<td>Clare Gummett – Lay person with responsibility for patient and public involvement</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>5-10</td>
</tr>
<tr>
<td>Jenny Kay – Director of Quality from 1st April 2014 to 30th May 2014.</td>
<td>15-20 (Note 1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>On secondment with Merton CCG</td>
<td>15-20</td>
</tr>
<tr>
<td>Dr Andrew Murray – 2 roles – Clinical lead (full-year) and Governing Body member from 1st June 2013</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>15-20</td>
</tr>
</tbody>
</table>
4.1.10 Note 1 – Payment is made to a corporate body and includes employer’s on-costs such as national insurance and super-annuation contributions.

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

### Table 12: Senior Managers’ Pension Benefits (audited)

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at 31 March 2015 (bands of £5,000)</th>
<th>Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2014</th>
<th>Cash Equivalent Transfer Value at 31 March 2015</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Employer's contribution to partnership pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleanor Brown – Chief Officer*</td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>45-50</td>
<td>140-145</td>
<td>977</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cynthia Cardozo – Chief Finance Officer</td>
<td>2.5-5</td>
<td>10-12.5</td>
<td>35-40</td>
<td>105-110</td>
<td>563</td>
<td>673</td>
<td>95</td>
<td>0</td>
</tr>
<tr>
<td>Dr Carrie Chill – Primary Care, Clinical Support and Governing Body member</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15-20</td>
<td>45-50</td>
<td>291</td>
<td>322</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Adam Doyle – Director of Commissioning and Planning</td>
<td>0-2.5</td>
<td>0</td>
<td>2.5-5</td>
<td>0</td>
<td>10</td>
<td>23</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Jenny Kay – Director of Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lynn Street – Director of Quality</td>
<td>2.5-5</td>
<td>10-12.5</td>
<td>20-25</td>
<td>60 - 65</td>
<td>292</td>
<td>372</td>
<td>72</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note 1 – Payment is made to a corporate body and includes employer’s on-costs such as national insurance and super-annuation contributions.*
* Member is over normal retirement age 60 for 1995 Section, therefore a CETV calculation is not applicable.

4.1.12 **Pay multiples**

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

4.1.14 The banded remuneration of the highest paid director in the financial year 2014/15 was £110-115k (2013/14 - £105-110k). This was 2.7 times (2013/14 – 3.3 times) the median remuneration of the workforce, which was £41k (2013/14 - £33k).

4.1.15 In 2014/15 (and 2013/14), no other employee received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £10k to £115k (2013/14 £10-105k).

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

4.1.17 **Off-payroll engagements**

4.1.18 Merton CCG had two off-payroll engagements in the financial year to 31 March 2015.

<table>
<thead>
<tr>
<th></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>2</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>12</td>
</tr>
</tbody>
</table>

**Table 13: Off-payroll engagements**

Eleanor Brown

Signed:

Accountable Officer

28 May 2015
5. **Statement of Responsibilities of Accountable Officer**

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

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

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

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

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

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

**Eleanor Brown**

**Signed:**

**Accountable Officer**

**28 May 2015**
6. Governance Statement

6.1 Introduction and context

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

6.1.3 The CCG is comprised of 25 GP practices, across the three localities of Raynes Park, East Merton and West Merton. The CCG serves a population of 214,150 and manages a health care budget of £218 million in 2014/15.

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

6.1.5 The CCG have put in place, five overarching corporate objectives. The aim of this is to ensure that all the work of the CCG is aligned and seeking to achieve the same high standards for the Merton population. The objectives for 2014/15 have been:

- to deliver the quality strategy;
- to deliver the two year operating plan in partnership with the membership, and achieve our vision of right care, right time, right place, right outcome;
- to ensure MCCG is compliant with statutory (and non-statutory) duties and obligations;
- to engage in the health and social care system in Merton as a leader and partner, as appropriate;
- to develop and implement a clinically and cost effective 5 year collaborative strategic commissioning plan for SW London.

6.1.6 The full audited Annual Report and Accounts have been approved by the governing body on 28 May 2015 and signed by the Chief Officer.

6.1.7 Scope of responsibility

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

6.1.9 I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.
6.1.10 Compliance with the Corporate Governance Code

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

6.1.12 The Clinical Commissioning Group Governance Framework

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

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

6.1.15 Merton CCG’s constitution sets out the principles and methods that the CCG adheres to in delivering our role and functions. It describes how the governing body operates, confirms matters reserved for board decision, and other areas where certain powers of the board are delegated within the organisation. It sets out key processes for decision-making, including arrangements for securing transparency in the decision-making of the CCG and the governing body; and the arrangements for discharging our duties with regard to registers of interest and managing conflicts of interest. The CCG’s constitution has this year been updated to include provision for primary care collaborative commissioning with other South West London CCGs, with the agreement of the membership.

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

The governing body undertakes a proportion of their 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.

6.1.19 Governing body

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

6.1.21 Membership of the governing body is:

- Dr Howard Freeman – Chair
- Eleanor Brown – Chief Officer
- Cynthia Cardozo – Chief Finance Officer
- Dr Kay Eilbert – Director of Public Health, London Borough of Merton
- Peter Derrick – Lay Member, Chair of the Audit and Governance Committee and Vice Chair
- Clare Gummett – Lay Member, Patient and Public Involvement
- Mary Clarke – Independent Nurse Member
- Dr Andrew Murray – GP Clinical Governing Body Member
- Dr Caroline Chill – GP Clinical Governing Body Member)
- Professor Stephen Powis – Secondary Care Consultant

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

6.1.23 A Merton CCG governing body has now been in operation for two 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:

- the development of the five-year strategic plan
- QIPP delivery
- Transforming Primary Care and co-commissioning
- mental health service development
- patient and public involvement
- delivery against the two-year operating plan
6.1.24 The attendance of members at the governing body meeting is detailed below:

<table>
<thead>
<tr>
<th>Present</th>
<th>Apols</th>
<th>Prior to appointment/departure</th>
</tr>
</thead>
</table>

GOVERNING BODY MEETING 2014/15 GB = Full meeting S= Seminar

<table>
<thead>
<tr>
<th>Merton</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
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<tr>
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<tr>
<td>Eleanor Brown</td>
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<tr>
<td>Cynthia Cardozo</td>
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<tr>
<td>Dr Carrie Chill</td>
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<td>Mary Clarke</td>
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<tr>
<td>Peter Derrick</td>
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<tr>
<td>Dr Kay Eilbert</td>
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<tr>
<td>Dr Howard Freeman</td>
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<td>Clare Gummett</td>
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<tr>
<td>Dr Andrew Murray</td>
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<tr>
<td>Prof. Stephen Powis</td>
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</tr>
</tbody>
</table>

In attendance:

Jenny Kay
Adam Doyle
Lynn Street

6.1.25 Merton Clinical Quality Committee (MCQC)

6.1.26 The MCQC has met monthly throughout the year, with the remit of providing assurance to the governing body that commissioned services are being delivered in a high quality and safe manner. The MCQC has been vital in ensuring that quality sits at the heart of everything the CCG does which is reflected in the audit of Quality Governance undertaken as part of the approved internal audit plan for 2014/5.
6.1.27 The committee delivers its objectives by:

- continuously reviewing the quality of care given at main NHS providers via clinical quality review groups (CQRG) and ensuring action plans are in place. As Merton does not have an acute trust within the borough, the acute CQRG meetings are chaired by a clinician of the 'host' CCG, Merton CCG is represented by our relevant GP locality clinical lead in our role as an ‘associate’ commissioner. Merton CCG hosts Sutton and Merton Community Services (Royal Marsden Hospital) and leads the CQRG for this contract and is chaired by Dr A. Murray, one of our GP governing board members;
- scrutinising a range of quantitative and qualitative data and performance measures to manage risk appropriately and having robust mechanisms in place to effectively address clinical governance issues;
- reviewing and scrutinising the integrated quality and performance report, which provides a more in-depth picture of the quality of care provided to Merton patients by the main providers and is also presented to the governing body as part of the balanced score card;
- having oversight of the process and compliance issues concerning serious incidents (SIs); central alert systems (CAS); national reporting; and being informed of all 'never events' and informing the governing body of any escalation or sensitive issues in good time;
- receiving and reviewing reports relating to safeguarding adults and children including serious case reviews;
- receiving and scrutinising independent investigation reports relating to patient safety issues and agree publication plans;
- ensuring a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern;
- overseeing and promoting the general duty to improve the quality of primary care so as to improve the quality of services.

6.1.28 Membership and attendance of the committee is as follows:

6.1.29 Audit and Governance Committee

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

6.1.31 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.

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

<table>
<thead>
<tr>
<th></th>
<th>Present</th>
<th>Apols</th>
<th>Prior to appointment/departure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT &amp; GOVERNANCE COMMITTEE 2014/15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Clarke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Derrick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clare Gummett</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prof Stephen Powis</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

6.1.33 The committee’s main activities through the year have been focused on:

- planning and monitoring the delivery of the internal audit plan for the year;
- receiving the Head of Internal Audit Opinion on the system of internal control;
- receiving External Audit findings and audit opinion
- receiving and considering the counter fraud work plan and performance;
- reviewing and making recommendations on the corporate risk register and the Board Assurance Framework;
- reviewing the CCGs information governance arrangements.

6.1.34 Finance committee

6.1.35 The finance committee was established by the governing body to scrutinise financial planning and performance for Merton CCG, review areas of concern and report to the governing body as appropriate. It works alongside the audit and governance committee to ensure financial probity in the CCG.

6.1.36 The committee delivers their objective by:

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

6.1.37 Membership of the committee and attendance is detailed below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Present</th>
<th>Apols</th>
<th>Prior to appointment/departure</th>
<th>No meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-15</td>
<td>Mary Clarke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb-15</td>
<td>Peter Derrick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Howard Freeman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clare Gummett</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.1.38 Remuneration committee

6.1.39 During 2014/15, the remuneration committee’s primary aim has been oversight of remuneration and terms of service for the governing body, including the CO and CFO and directors.

6.1.40 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, the lay members of the governing body and clinical leads of the organisation.

6.1.41 Membership and attendance of the committee is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Present</th>
<th>Apols</th>
<th>Prior to appointment/departure</th>
</tr>
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</tr>
<tr>
<td>Feb-15</td>
<td>Peter Derrick</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Howard Freeman</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clare Gummett</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.1.42 Assessment of effectiveness

6.1.43 The governing body undertook a self-assessment tool in March 2015, in order to assess the organisational development needs and to identify any skills gaps which may need to be addressed. The questions posed to the governing body members focused on creating comparative data with previous self-assessments, in order to identify trends and areas where improvement can be shown. The results were reported to the governing body on 23 April 2015.

6.1.44 The self-assessment results indicated that:

- The governing body, as a leadership team, appears very confident about its ability to create effective commissioning strategies, to meet national and local expectations for improving health and health care, and to take forward initiatives to deliver the CCG’s clinical priorities.
- The governing body shows a growing confidence in patient and public engagement.
- Overall, the governing body is very confident of its ability to deliver better outcomes for patients.
- Governing body members were overall more confident this year about the robustness of their governance arrangements, with scores increasing compared to 2014 and mostly good/very good.
- The governing body’s assessment of how well the CCG is working in partnership with others was generally positive.
- Overall, the governing body rates its leadership as very effective, with a number of improved scores compared to last year.

6.1.45 The Clinical Commissioning Group Risk Management Framework

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

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

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

6.1.49 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.

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

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

6.1.51 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. Figure 1 below shows the format and structure of the current Board Assurance Framework.

Figure 1: Board Assurance Framework – risk 457

<table>
<thead>
<tr>
<th>Objective 4: To engage in the health and social care system in Merton as a leader and partner, as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF (patient and public) are not engaged appropriately. Not there will be a lack of planned and proactive health and social care services to meet Merton’s needs. (M2G)</td>
</tr>
<tr>
<td>Risk Rating</td>
</tr>
<tr>
<td>Hazard: Not Likely</td>
</tr>
<tr>
<td>Demerit: 3 x 3 = 9</td>
</tr>
<tr>
<td>Tolerance: 2 x 3 = 6</td>
</tr>
<tr>
<td></td>
</tr>
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</tr>
</tbody>
</table>

- Audit and assurance evidence (how do we know if things are being managed appropriates)
  - Development of a clear plan including action to prevent failure of the key performance indicators
  - CCG’s monitoring and patient feedback
  - Risk appetite (annual audit and risk profile)
  - Health and wellbeing feedback
  - Social care assurance advice from local community
  - Communication and Engagement strategy document
  - Improvement of local engagement and consultation
  - Risk appetite (annual audit and risk profile)
  - Communication and Engagement strategy document

6.1.52 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.

6.1.53 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.
6.1.54 The risk controls in place, enable the CCG to determine whether the risks are being managed effectively through:

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

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

- strategic and business plan targets
- adverse incidents and near misses
- complaints
- claims
- new projects
- research and trials
- environmental risk including health & safety risks
- fire safety
- security
- red risks from the directorate risk registers
- 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 aassurance framework.

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

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

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

6.1.59 A system of internal control is the set of processes and procedures within the CCG to ensure it delivers the policies, aims and objectives of the organisation. It is designed to identify and prioritise the risks, to evaluate the likelihood and the impact should they be realised, and to manage them efficiently, effectively and economically.
6.1.60 The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

6.1.61 **Information governance**

6.1.62 The NHS Information Governance (IG) Assurance Framework establishes the standard by which the handling of information about patients and employees is measured, in particular personal confidential data. The NHS Information Governance Assurance Framework is supported by the annual submission of a self-assessment through the information governance toolkit and audit processes, which provide assurance to CCG management, other organisations and to citizens that personal confidential data is effectively managed legally, securely, efficiently and effectively.

6.1.63 We place high importance on ensuring there are robust information governance systems and processes in place to protect patients and corporate information. We have established an information governance management framework and information governance processes and procedures, and these are continuously monitored and reviewed. We ensure all staff complete information governance training annually and provide staff with an information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

6.1.64 We recognise that information governance is an integral part of risk management. We are committed to monitoring these risks and this is overseen by the Senior Information Risk Owner (SIRO).

6.1.65 There is a formal process for co-ordinating and overseeing the self-assessment against the IG toolkit, and this is supported by IG experts. The self-assessment is independently audited to provide assurance that sufficient evidence is in place to support the levels assessed by the CCG and their experts.

6.1.66 A comprehensive IG action plan is agreed at the beginning of each year, and implementation 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 raising the importance of security and confidentiality in accordance with the Care Records Guarantee.

6.1.67 During this year we worked with our IG expert service, South East Commissioning Support Unit, to achieve level 2 in IG toolkit, which is the expected standard, although we actually raised our level of compliance from 70% last year to 93% this year.

6.1.68 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)
6.1.69 We continue to develop our information risk assessment and management procedures and programme to fully embed an appreciation of information risk in the culture of the CCG, and will continue in our diligence during the coming year.

6.1.70 Pension obligations

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

6.1.72 Equality, diversity and human rights obligations

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

6.1.74 Sustainable Development Obligations

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

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

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

6.1.78 We are also setting out our commitments as a socially responsible employer.

6.1.79 Risk assessment in relation to governance, risk management and internal control

6.1.80 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.
6.1.81 The establishment of both the audit and governance committee and finance committee provide the governing body with assurance over the wide range of business risks. For example, the finance committee has served to provide an overview of financial activity and a sound understanding of costs, performance and achieving efficiencies through reliable and timely financial reporting that met the needs of internal users, stakeholders and local people.

6.1.82 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.

6.1.83 At March 2015, the risks to the CCG with the highest residual scores were:

- planning of primary care GP premises
- collaboration between South West London CCGs
- stakeholder and public support for service redesign

6.1.84 These risks remain present going forward into 2015/16 and are being proactively managed and reviewed on a regular basis by the appropriate risk leads.

6.1.85 The CCG has five 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.

6.1.86 **Review of economy, efficiency and effectiveness of the use of resources**

6.1.87 The executive management team meets formally monthly to monitor the performance against all of the CCGs delivery plans. This includes ensuring that projects and programmes are delivering cost effective services and optimal benefits to our patient population. The executive management team also meets monthly to discuss and review strategic programmes and to make recommendations to the governing body.

6.1.88 In addition, 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.

6.1.89 Merton CCG’s QIPP target for 2014-15 was £6.5m, of which £6.7m was delivered; an over-achievement of £0.2m (102.5%) of the planned target.

6.1.90 Some schemes such as the acute portfolio scheme and the mental health placements scheme over achieved and some schemes like the urgent and intermediate care programme were slightly below target.
The planned care programme was significantly revised and unfortunately it was not possible to implement some of the original planned care schemes due to conflicts arising from the procurement of services for the Nelson Health Centre.

On a positive note, however, some schemes that were launched in 2013-14 such as the community prevention of admissions team (CPAT) were expanded in 2014-15 and efficiencies realised in 2014-15.

The QIPP performance is discussed on a monthly basis at the executive management team meetings, which has clinical representation from the three clinical locality leads and public health. Performance and identification of new schemes is also reviewed and discussed on a monthly basis at the QIPP delivery group which is chaired by the Chief Finance Officer.

Review of the effectiveness of governance, risk management and internal Control

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

Capacity to handle risk

To develop our capacity to manage risk a workshop was held with governing body members on authorisation, to describe and review the CCG’s risk management processes. The appointed corporate affairs lead from South East CSU provides support to governing body and CCG staff members wherever necessary, as well as attending committee meetings to present the corporate risk register and governing body assurance framework.

All of our key risks have been “owned” by a senior manager who is responsible for ensuring that controls are effectively implemented and appropriate actions are taken.

Our risk owners are supported by a corporate affairs lead at South East CSU, and provided with monthly support to review the risks and mitigation plans. Training has been provided to staff involved in the risk management processes and in how to use the CCG’s risk management software.

Review of effectiveness

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

The board assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving our principle objectives have been reviewed.
The governing body and audit committee have provided regular feedback on the completeness and effectiveness of our systems of internal control via their comments and feedback on the completeness of the board assurance framework. During the year gaps in assurance were identified and rectified.

In addition to this I can confirm:

- The CCG demonstrates their commitment to maintaining an awareness of the level of risk around corporate objectives by discussing the board assurance framework update at meetings of the governing body.
- The CCG has an established risk management policy that outlines how risks should be scored in terms of likelihood and impact (consequence) and the corporate risk register and board assurance framework show the controls/assurance the CCG has obtained against each risk.
- Appropriate training is provided to staff, tailored to reflect their involvement in the risk management process including one-on-one sessions with risk owners.
- The conflicts of interests policy, a revised version of which was approved by the governing body in March 2015 to incorporate the new guidance from NHS England, sets out what is expected of CCG employees and members. Conflicts of interest are declared as appropriate at the start of each governing body or sub-committee meeting to help ensure the CCG is operating transparently in all business dealings. The policy is also reviewed annually and updated as necessary to ensure it is complying with good practice.
- The CCG is able to demonstrate that our membership structure, required number of meetings and quorum for each committee is consistent with NHS England guidance.
- There is a good balance between allowing the governing body and sub-committees to fulfill their scrutiny roles and their decision-making responsibilities with agendas giving priority to those items which require a decision.

Internal audit

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT MERTON CCG FOR THE YEAR ENDED 31 MARCH 2015

1 Roles and responsibilities

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

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

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

The organisation’s Assurance Framework is one of the key mechanisms that the Accountable Officer can use to support their AGS.

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

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

2 The Head of Internal Audit Opinion

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

My opinion, based on work undertaken up to 20th May 2015, is set out as follows:

Based on the work undertaken in 2014/15, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently.

3 Further issues relevant to this opinion

We have considered the findings of the Service Auditor report carried out by the internal auditors of NHS England at South East CSU, on behalf of the CSU customers, including Merton CCG. Whilst we note a number of exceptions have been identified, we have liaised with the CSU and do not believe that there is anything significant requiring inclusion within the Annual Governance Statement.

4 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 internal control issues within the AGS. However, the CCG may 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.

Nick Atkinson
Head of Internal Audit, Baker Tilly

6.1.118 Data quality

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

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

6.1.121 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.

6.1.122 Business critical models

6.1.123 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.

6.1.124 The supplier of our information and computer technology (ICT) and business intelligence (BI) functions is South East CSU. Business critical models in use within ICT are subject to a number of quality assurance processes which link into the overall framework and management commitment to quality. There is transparency and management oversight over models and data sources used to make business critical and strategic decisions, with scrutiny within the IG and IAG senior management committees (through which 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.
6.1.125 Business critical models in use within BI include processes which support the identification and maintenance of a list of all business critical models and a schedule for periodic review. Qualified and experienced personnel exercise professional scepticism over the outputs from key models and organisational use of data. These processes are subject to review by internal audit, who review management information data and process owners, and external audit whose work covers the quality assurance processes of financial models.

6.1.127 Data security

6.1.128 We have submitted a satisfactory level of compliance (93%) with the information governance toolkit assessment.

6.1.129 The CCG has experienced no serious untoward incidents relating to data security breaches.

6.1.130 Discharge of statutory functions

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

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

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

6.1.134 Conclusion

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

Eleanor Brown

Signed:

Accountable Officer

Date 28 May 2015
## Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits</td>
<td>4.1.1</td>
<td>3,225</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>5</td>
<td>232,762</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
<td>(20,489)</td>
</tr>
<tr>
<td><strong>Net operating expenditure before interest</strong></td>
<td></td>
<td>215,498</td>
</tr>
<tr>
<td>Other (gains)/losses</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Finance costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net operating expenditure for the financial year</strong></td>
<td></td>
<td>215,498</td>
</tr>
<tr>
<td>Net (gain)/loss on transfers by absorption</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td></td>
<td>215,498</td>
</tr>
</tbody>
</table>

Of which:

### Administration Income and Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
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</thead>
<tbody>
<tr>
<td>Employee benefits</td>
<td>4.1.1</td>
<td>1,414</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>5</td>
<td>3,801</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
<td>(305)</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td></td>
<td>4,910</td>
</tr>
</tbody>
</table>

### Programme Income and Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits</td>
<td>4.1.1</td>
<td>1,811</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>5</td>
<td>228,961</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
<td>(20,184)</td>
</tr>
<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td></td>
<td>210,588</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total comprehensive net expenditure for the year</strong></td>
<td>215,498</td>
<td>204,906</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 120 form part of this statement
**Statement of Financial Position as at 31 March 2015**

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>9</td>
<td>803</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>10</td>
<td>2,466</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>11</td>
<td>76</td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>12</td>
<td>(14,037)</td>
</tr>
<tr>
<td>Provisions</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Current Assets plus/less Net Current Assets/Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Total non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets less Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financed by Taxpayers’ Equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total taxpayers’ equity:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The notes on pages 96 to 120 form part of this statement.

The financial statements on pages 88 to 120 were approved by the Governing Body on 28th May 2015 and signed on its behalf by:

Eleanor Brown  
Chief Accountable Officer
INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS MERTON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Merton Clinical Commissioning Group for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

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

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

This report is made solely to the members of NHS Merton Clinical Commissioning Group (the CCG) in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG's members and 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. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

**Opinion on regularity**

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

**Opinion on 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 2015 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

**Opinion on other matters**

In our opinion:

- the parts of the Remuneration Report subject to audit have been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we report by exception**

We report to you if:

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

We have nothing to report in these respects.
Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the CCG and auditor

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 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, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those 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 2015.

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 to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all significant respects, NHS Merton Clinical Commissioning Group put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.
Certificate

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

Susan M Exton
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House,
Melton Street
Euston Square
London
NW1 2EP

29 May 2015
# Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

## Changes in taxpayers’ equity for 2014-15

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2014</td>
<td>(10,618)</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 1 April 2014</td>
<td>(10,618)</td>
</tr>
</tbody>
</table>

## Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2014-15

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(215,498)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(215,498)</td>
</tr>
<tr>
<td>Net funding</td>
<td>215,423</td>
</tr>
<tr>
<td>Balance at 31 March 2015</td>
<td>(10,693)</td>
</tr>
</tbody>
</table>

## Changes in taxpayers’ equity for 2013-14

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>0</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>46</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 1 April 2013</td>
<td>46</td>
</tr>
</tbody>
</table>

## Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2013-14

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating costs for the financial year</td>
<td>(204,906)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(204,860)</td>
</tr>
<tr>
<td>Net funding</td>
<td>194,242</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>(10,618)</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 120 form part of this statement
### Statement of Cash Flows for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

**Cash Flows from Operating Activities**

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>2,013</td>
<td>4,479</td>
</tr>
<tr>
<td>12</td>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>946</td>
<td>14,983</td>
</tr>
<tr>
<td>13</td>
<td>Increase/(decrease) in provisions</td>
<td>319</td>
<td>319</td>
</tr>
</tbody>
</table>

**Net Cash Inflow (Outflow) from Operating Activities**

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>(215,498)</td>
<td>(204,906)</td>
</tr>
</tbody>
</table>

**Cash Flows from Investing Activities**

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(Payments) for property, plant and equipment</td>
<td>(771)</td>
<td>32</td>
</tr>
<tr>
<td>9</td>
<td>(Gain)/ Loss on disposal of property, plant and equipment assets other than by sale</td>
<td>0</td>
<td>46</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>(771)</td>
<td>14</td>
</tr>
</tbody>
</table>

**Net Cash Inflow (Outflow) before Financing**

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>(215,521)</td>
<td>(194,069)</td>
</tr>
</tbody>
</table>

**Cash Flows from Financing Activities**

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grant in Aid Funding Received</td>
<td>215,423</td>
<td>194,242</td>
</tr>
</tbody>
</table>

**Net Cash Inflow (Outflow) from Financing Activities**

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>215,423</td>
<td>194,242</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>(97)</td>
<td>173</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>173</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year**

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>76</td>
<td>173</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 120 form part of this statement.
1. Accounting Policies

NHS England has directed that the Financial Statements of clinical commissioning groups shall meet the accounting requirements of the Manual for Accounts, which shall be agreed with the Department of Health. Consequently, the following Financial Statements have been prepared in accordance with the Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

These accounts have been prepared on the going concern basis.

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

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

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 5 year LTFM shows the CCG meeting its financial targets;
- the CCG is able to meet its current liabilities;
- the CCG is a member of the SWL risk sharing arrangements to manage in year risk, which is part of the wider NHS arrangements to support CCGs where appropriate;
- the services the CCG commissions will continue to be commissioned; and
- 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 Acquisitions and discontinued operations

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

1.4 Movement of assets within the Department of Health Group

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

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

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied for 2013-14. For these transactions only, gains and losses are recognised in reserves rather than in the Statement of Comprehensive Net Expenditure. Modified absorption accounting does not apply for 2014-15.

1.5 Pooled Budgets

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

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

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:
- The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group’s share of any liabilities incurred jointly; and
- The clinical commissioning group’s share of the expenses jointly incurred.
Notes to the financial statements

1.6 Critical accounting judgements and key sources of estimation uncertainty

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

1.6.1 Critical judgements in applying accounting policies

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

NHS Merton CCG have created a provision for impairment. Also, the accounting arrangements for balances transferred from predecessor PCTs (“legacy balances”) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. However, the CCG has received new legacy claims in 2013-14 relating to 2011-12. The CCG created a provision for the claims as the liability sat with the CCG. A review of the provision in 2014-15 established that the provision was no longer required. The impact of the provision is disclosed in note 13.

1.6.2 Key sources of estimation uncertainty

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

The largest estimated cost in the CCG’s accounts relates to the March 2015 prescribing accrual. This accrual has been calculated at £2m and is a best estimate based on the spend from April 2014 to February 2015.

At 31 March 2014, NHS Merton CCG did not believe that 30% of the amount receivable from London Borough of Merton will be received. However, in 2014-15 the provision was reversed as credit notes were raised.

In 2013-14, NHS Merton CCG decided to provide for continuing care. NHS Merton CCG believed that 35% of the continuing care claims received would be successful. It was assumed that 15% would be settled within one year and the remaining in more than 1 but less than 5 years. Reviewing the provision in 2014-15, NHS Merton CCG decided that based on the information presented and the introduction of the Continuing Healthcare Risk Pool that the CCG should reverse the provision as it is unused. This position is consistent with the premise that the NHS Merton CCG should not be responsible for legacy PCT issues and that these should be handled by the NHS England Legacy Team.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Where the CCG hosts services and recharges other organisations, the recharges are also recognised as operating revenue.

1.8 Employee Benefits

1.8.1 Short-term employee benefits

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

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

1.8.2 Retirement benefit costs

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

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

1.9 Other expenses

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

1.10.1 Recognition
Property, plant and equipment is capitalised if:

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

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

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

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

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

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

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which NHS Merton CCG expects to obtain economic benefits or service potential from the asset. This is specific to NHS Merton CCG and may be shorter than the physical life of the asset itself.

Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over their estimated useful lives.

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but is capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.12.1 The Clinical Commissioning Group as Lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group’s surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.
Notes to the financial statements

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

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

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

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

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

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

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

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

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

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

The only financial assets held are loans and receivables.

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

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

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

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

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

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

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

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

1.20 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.

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

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

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

1.23 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 2014-15, all of which are subject to consultation:
- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.
## 2 Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
</tr>
<tr>
<td>Prescription fees and charges</td>
<td>(4)</td>
<td>0</td>
<td>(4)</td>
<td>0</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>(265)</td>
<td>(252)</td>
<td>(13)</td>
<td>(181)</td>
</tr>
<tr>
<td>Other revenue</td>
<td>(20,219)</td>
<td>(53)</td>
<td>(20,167)</td>
<td>(26,904)</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td>(20,489)</td>
<td>(305)</td>
<td>(20,184)</td>
<td>(27,085)</td>
</tr>
</tbody>
</table>

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

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

Programme revenue relates to:
- Hosting Community Services contract - 83%
- Hosting South West London Cancer Network - 5%
- Children Services recharges to Sutton CCG - 2%
- Integrated working recharges to Local Authority - 2%
- Other - 8%

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

## 3 Revenue

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
</tr>
<tr>
<td>From rendering of services</td>
<td>(20,487)</td>
<td>(305)</td>
<td>(20,182)</td>
<td>(27,085)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(20,487)</td>
<td>(305)</td>
<td>(20,182)</td>
<td>(27,085)</td>
</tr>
</tbody>
</table>

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

#### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th></th>
<th>2013-14</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,842</td>
<td>1,851</td>
<td>991</td>
<td>1,200</td>
<td>1,015</td>
<td>185</td>
</tr>
<tr>
<td>Social security costs</td>
<td>196</td>
<td>196</td>
<td>0</td>
<td>121</td>
<td>121</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>187</td>
<td>187</td>
<td>0</td>
<td>93</td>
<td>93</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,225</td>
<td>2,234</td>
<td>991</td>
<td>1,414</td>
<td>1,229</td>
<td>185</td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>3,225</td>
<td>2,234</td>
<td>991</td>
<td>1,414</td>
<td>1,229</td>
<td>185</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>3,225</td>
<td>2,234</td>
<td>991</td>
<td>1,414</td>
<td>1,229</td>
<td>185</td>
</tr>
</tbody>
</table>
4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanently employed</td>
</tr>
<tr>
<td>Number</td>
<td>35</td>
<td>24</td>
</tr>
</tbody>
</table>

Other average number of people employed has been calculated using average number of hours worked over a full year, this covers 28 employees at different grades.

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>78.0</td>
<td>24.0</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>32.8</td>
<td>25.0</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>2.4</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Total days lost covers 14 employees.

Number of persons retired early on ill health grounds

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total additional Pensions liabilities accrued in the year

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Ill health retirement costs are met by the NHS Pension Scheme.
4.5 Pension costs

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

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

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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years.” An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM

The latest assessment of the liabilities of the Scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.
4.5 Pension costs

4.5.3 Scheme Provisions

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

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

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI);

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

• For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total £000</td>
<td>Admin £000</td>
<td>Programme £000</td>
<td>Total £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>2,737</td>
<td>1,006</td>
<td>1,731</td>
<td>1,859</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>488</td>
<td>408</td>
<td>80</td>
<td>228</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td><strong>3,225</strong></td>
<td><strong>1,414</strong></td>
<td><strong>1,811</strong></td>
<td><strong>2,087</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>8,054</td>
<td>2,061</td>
<td>5,993</td>
<td>3,663</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>62,927</td>
<td>57</td>
<td>62,870</td>
<td>47,150</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>112,739</td>
<td>112,739</td>
<td>0</td>
<td>132,153</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>19,673</td>
<td>19,673</td>
<td>0</td>
<td>16,572</td>
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<tr>
<td>Chair and Non Executive Members</td>
<td>169</td>
<td>169</td>
<td>0</td>
<td>215</td>
</tr>
<tr>
<td>Supplies and services -- general</td>
<td>1,431</td>
<td>1,431</td>
<td>1,040</td>
<td>1,717</td>
</tr>
<tr>
<td>Establishment</td>
<td>949</td>
<td>444</td>
<td>505</td>
<td>210</td>
</tr>
<tr>
<td>Transport</td>
<td>3</td>
<td>7</td>
<td>(4)</td>
<td>15</td>
</tr>
<tr>
<td>Premises</td>
<td>659</td>
<td>248</td>
<td>412</td>
<td>2,339</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>(338)</td>
<td>0</td>
<td>(338)</td>
<td>338</td>
</tr>
<tr>
<td>Audit fees</td>
<td>76</td>
<td>76</td>
<td>0</td>
<td>84</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>23,124</td>
<td>23,124</td>
<td>0</td>
<td>22,701</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>2,581</td>
<td>2,581</td>
<td>0</td>
<td>1,784</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>465</td>
<td>366</td>
<td>99</td>
<td>429</td>
</tr>
<tr>
<td>Education and training</td>
<td>254</td>
<td>250</td>
<td>4</td>
<td>158</td>
</tr>
<tr>
<td>Provisions</td>
<td>(319)</td>
<td>(319)</td>
<td>0</td>
<td>319</td>
</tr>
<tr>
<td>Continuing Healthcare Risk Pool contributions</td>
<td>206</td>
<td>0</td>
<td>306</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td><strong>232,762</strong></td>
<td><strong>3,801</strong></td>
<td><strong>228,961</strong></td>
<td><strong>229,858</strong></td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>235,987</strong></td>
<td><strong>5,215</strong></td>
<td><strong>230,772</strong></td>
<td><strong>231,945</strong></td>
</tr>
</tbody>
</table>

The provision in 2013-14 has been reclassified from other expenditure in line with accounting treatment in 2014-15.

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.
6.1 Better Payment Practice Code

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 Income Generation Activities

The clinical commissioning group undertakes income generation activities with an aim of achieving profit, which is then used in commissioning healthcare services. None of these activities had a full cost which exceeded £1m or was otherwise material.
7. Other gains and losses

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gain/(loss) on disposal of property, plant and equipment assets other than by sale</strong></td>
<td>0</td>
<td>(46)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>(46)</td>
</tr>
</tbody>
</table>

8. Operating Leases

8.1 As lessee

The payment below reflects NHS Property Services Ltd charges for the financial year 2014-15 and relates to property owned and managed by NHS Property Services Ltd.

### 8.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Buildings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>609</td>
<td>609</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>609</td>
<td>609</td>
</tr>
</tbody>
</table>

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.
### 9 Property, plant and equipment

<table>
<thead>
<tr>
<th>2014-15</th>
<th>Assets under construction and payments on account</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cost or valuation at 1 April 2014</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Addition of assets under construction and payments on account</td>
<td>771</td>
<td>771</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cost/Valuation At 31 March 2015</td>
<td>803</td>
<td>803</td>
</tr>
<tr>
<td>Depreciation 1 April 2014</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation at 31 March 2015</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2015</td>
<td>803</td>
<td>803</td>
</tr>
<tr>
<td>Purchased</td>
<td>803</td>
<td>803</td>
</tr>
<tr>
<td>Total at 31 March 2015</td>
<td>803</td>
<td>803</td>
</tr>
</tbody>
</table>

**Asset financing:**

- **Owned**
  - 803 | 803

- **Total at 31 March 2015**
  - 803 | 803
9 Property, plant and equipment cont’d

9.1 Additions to assets under construction

<table>
<thead>
<tr>
<th></th>
<th>2014-15 (£000)</th>
<th>2013-14 (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings excluding dwellings</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Information technology</td>
<td>750</td>
<td>24</td>
</tr>
<tr>
<td>Furniture &amp; fittings</td>
<td>(8)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>771</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

Additions during the year of £771k relate to the purchase of IT equipment for the Nelson Health Centre. The Nelson Health Centre will be operational from the 1st April 2015.
The great majority of trade is with NHS organisations and local authorities. As NHS organisations and local authorities are ultimately funded by Government no credit scoring of them is considered necessary.

Concentration of credit risk is limited due to the fact that the customer base is large and composed of unrelated/government bodies. Due to this, the Governing Body believes that there is no future risk provision required in excess of the normal provision for doubtful receivables.

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

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>By up to three months</td>
<td>1</td>
<td>1,443</td>
</tr>
<tr>
<td>By three to six months</td>
<td>24</td>
<td>170</td>
</tr>
<tr>
<td>By more than six months</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>1,613</strong></td>
</tr>
</tbody>
</table>

£8K of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2015.

### 10.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2014</strong></td>
<td>(338)</td>
<td>0</td>
</tr>
<tr>
<td>(Increase) decrease in receivables impaired</td>
<td>338</td>
<td>(338)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td>0</td>
<td>(338)</td>
</tr>
</tbody>
</table>

Receivables are provided against at the following rates:

- London Borough of Merton: 0%
11 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2014</td>
<td>173</td>
<td>0</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(97)</td>
<td>173</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td><strong>76</strong></td>
<td><strong>173</strong></td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service 75 172
- Cash in hand 1 1
- **Cash and cash equivalents as in statement of financial position** 76 173

**Balance at 31 March 2015** 76 173
<table>
<thead>
<tr>
<th></th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>(4,986)</td>
<td>0</td>
<td>(2,750)</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>31</td>
<td>0</td>
<td>(3,817)</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>(2,273)</td>
<td>0</td>
<td>(4,460)</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>(6,557)</td>
<td>0</td>
<td>(3,811)</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>(28)</td>
<td>0</td>
<td>(26)</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>(34)</td>
<td>0</td>
<td>(33)</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>(190)</td>
<td>0</td>
<td>(86)</td>
<td>0</td>
</tr>
<tr>
<td>Total Trade &amp; Other Payables</td>
<td>(14,037)</td>
<td>0</td>
<td>(14,983)</td>
<td>0</td>
</tr>
</tbody>
</table>

Other payables include £41k outstanding pension contributions at 31 March 2015 (£34k as at 31 March 2014).
### Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing care</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>271</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>271</td>
</tr>
<tr>
<td>Total current and non-current</td>
<td>0</td>
<td>319</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS continuing healthcare claims relating to period of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £1.963m.
14 Commitments

14.1 Capital commitments

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property, plant and equipment</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>3,141</td>
</tr>
</tbody>
</table>

14.2 Other financial commitments

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

15 Financial instruments

15.1 Financial risk management

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

Because NHS Merton 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.

15.1.1 Currency risk

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

15.1.2 Interest rate risk

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

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.2 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NHS</td>
<td>0</td>
<td>517</td>
<td>0</td>
<td>517</td>
</tr>
<tr>
<td>- Non-NHS</td>
<td>0</td>
<td>356</td>
<td>0</td>
<td>1,783</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>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>0</td>
<td>952</td>
<td>0</td>
<td>2,379</td>
</tr>
</tbody>
</table>

|                                | At ‘fair value through profit and loss’ | Loans and Receivables | Available for Sale | Total     |
|                                | 2013-14 £000                           | 2013-14 £000         | 2013-14 £000      | 2013-14 £000 |
| Receivables:                   |                                        |                       |                    |           |
| - NHS                          | 0                                      | 822                   | 0                  | 822       |
| - Non-NHS                      | 0                                      | 3,603                 | 0                  | 3,603     |
| Cash at bank and in hand       | 0                                      | 174                   | 0                  | 174       |
| **Total at 31 March 2014**     | 0                                      | 4,599                 | 0                  | 4,599     |

15.3 Financial liabilities

|                                | At ‘fair value through profit and loss’ | Other | Total     |
|                                | 2014-15 £000                           | £000  | £000      |
| Payables:                      |                                        |       |           |
| - NHS                          | 0                                      | 4,955 | 4,955     |
| - Non-NHS                      | 0                                      | 9,020 | 10,447    |
| **Total at 31 March 2015**     | 0                                      | 13,975| 15,402    |

|                                | At ‘fair value through profit and loss’ | Other | Total     |
|                                | 2013-14 £000                           | £000  | £000      |
| Payables:                      |                                        |       |           |
| - NHS                          | 0                                      | 6,567 | 6,567     |
| - Non-NHS                      | 0                                      | 8,357 | 8,357     |
| **Total at 31 March 2014**     | 0                                      | 14,924| 14,924    |

Non-NHS payables for 2013-14 has been adjusted to include other payables £86K in line with the accounting treatment for 2014-15.
16 Operating segments

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

17 Pooled budgets

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

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(246)</td>
<td>(231)</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 arrangement, funds are pooled under Section 75 of the NHS Act 2006 for Integrated Community Equipment Services.

18 Intra-government and other balances

<table>
<thead>
<tr>
<th>Current Receivables</th>
<th>Non-current Receivables</th>
<th>Current Payables</th>
<th>Non-current Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Balances with:
- Other Central Government bodies: £0
- Local Authorities: £352

Balances with NHS bodies:
- NHS bodies outside the Departmental Group: £517
- NHS Trusts and Foundation Trusts: £1,564

Total of balances with NHS bodies: £2,081

- Public corporations and trading funds: £0
- Bodies external to Government: £33

Total balances at 31 March 2015: £2,466

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

Balances with:
- Other Central Government bodies: £41
- Local Authorities: £0

Balances with NHS bodies:
- NHS bodies outside the Departmental Group: £887
- NHS Trusts and Foundation Trusts: £285

Total of balances with NHS bodies: £1,172

- Public corporations and trading funds: £0
- Bodies external to Government: £3,266

Total balances at 31 March 2014: £4,479

The clinical commissioning group considers it has only one segment: commissioning of healthcare services.
19 Related party transactions

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments to Related Party £000</td>
<td>Receipts from Related Party £000</td>
</tr>
<tr>
<td>St George's University Hospitals Foundation Trust</td>
<td>60,513</td>
<td>0</td>
</tr>
<tr>
<td>Epsom &amp; St Helier University Hospitals NHS Trust</td>
<td>38,236</td>
<td>0</td>
</tr>
<tr>
<td>The Royal Marsden NHS Foundation Trust</td>
<td>33,941</td>
<td>0</td>
</tr>
<tr>
<td>South West London and St George's Mental Health NHS Trust</td>
<td>16,322</td>
<td>0</td>
</tr>
<tr>
<td>Kingston Hospital Foundation Trust</td>
<td>9,630</td>
<td>0</td>
</tr>
<tr>
<td>London Ambulance Service NHS Trust</td>
<td>5,581</td>
<td>0</td>
</tr>
<tr>
<td>Moorfields Eye Hospital NHS Foundation Trust</td>
<td>3,718</td>
<td>0</td>
</tr>
<tr>
<td>Dr Andrew Murray (Personal Medical Services Contract)</td>
<td>159</td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

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

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

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

**21 Losses and special payments**

**21.1 Losses**

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Cases</th>
<th>Total Value of Cases £'000</th>
<th>Total Number of Cases</th>
<th>Total Value of Cases £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative write-offs</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>46</td>
</tr>
</tbody>
</table>
22 Financial performance targets

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>239,423</td>
<td>236,679</td>
<td>2,744</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>847</td>
<td>771</td>
<td>76</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>218,166</td>
<td>215,498</td>
<td>2,668</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>4,992</td>
<td>4,908</td>
<td>84</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Target 2013-14 £’000</th>
<th>Performance 2013-14 £’000</th>
<th>Variance 2013-14 £’000</th>
<th>Target met 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>233,926</td>
<td>231,620</td>
<td>2,306</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>258</td>
<td>32</td>
<td>226</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>206,986</td>
<td>204,906</td>
<td>2,080</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>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>4,960</td>
<td>4,704</td>
<td>256</td>
<td>Yes</td>
</tr>
</tbody>
</table>

23 Impact of IFRS

No impact in 2014-15 existed from the implementation of IFRS, where this may differ from the Department of Health’s budgetary treatments.