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The past year has been one of change and innovation for the CCG and we are now firmly established as a strong, clinically-led organisation delivering patient-led service change and improvement for our local population.

The year has seen some excellent achievements thanks to the continued hard work of our dedicated team and the support of our member practices.

The CCG is now three years old and at the start of this financial year had a change in Clinical Chair and in July a change in Chief Officer when we took up the roles we now hold. We’ve taken the opportunity to review the current operating plan, models of care, financial plan, working and governance of the CCG to ensure that the CCG is both demonstrably clinically-led and that patients, partners and the public have a strong voice that is heard. The CCG will be working much more closely with local practices, partners and providers to take forward our ‘Whole Merton’ vision.

In the latter half of the year, we have spent considerable time working with local communities and voluntary groups to describe a Model of Health and Well-being for East Merton. The aim is to integrate prevention and self-care into people’s lives where they live. This work is being informed by emerging best practice from elsewhere in London and to that end members of the CCG Governing Body and leadership team, the Council, local GPs, community leaders and local MP went to see the innovative centre in Bromley-by-Bow in March. The work has the potential to make a real difference to people’s lives across the borough – both east and west – as the findings will feed into the wider Merton model being developed. This model will describe how services across the whole spectrum of health, social care and voluntary sector can work together to provide more local, integrated, preventive and proactive care.

The CCG plans to ensure that patients, partners and the public have a strong voice that is heard.

Our local engagement events have proved popular and have provided a forum for us to listen to patients, carers and the public. We have also continued to build strong working partnerships with Merton Council, the Merton Health and Well-being Board and local voluntary and community groups. We are grateful to all of our partners for their continued support of our work and for their help in building a more integrated approach to health and well-being across Merton.

The CCG has continued to work closely with the other south west London CCGs on its five-year strategy for local health services. In June, we jointly published an Issues Paper, summarising the challenges and emerging solutions set out in the strategy and putting forward questions for local people to respond to. The new financial year will bring further work on this as the ideas are further developed and we continue to talk to local people, provider Trusts, local authorities and other stakeholders.

We have also worked extremely hard to deliver improved mental health services, and following the introduction of a new provider for our talking therapies services in October, we expect to achieve the national recovery rate target in 2016, alongside the national target for access to psychological therapies. The CCG is also very pleased to have once again improved the dementia diagnosis rate from 72.1 per cent at the end of 2014/2015 to 75.3 per cent in March 2016.

Chair and Chief Officer’s Foreword

The CCG plans to ensure that patients, partners and the public have a strong voice that is heard.
Highlights this year have included the successful opening of the Nelson Health Centre in April, work to develop an entirely new model for health and well-being for East Merton and the creation of a Merton CCG Patient Engagement Group. The Patient Engagement Group was created in July 2015 and meets monthly to give advice and support on our public and patient engagement. Next steps include developing the membership and ensuring it plays a full and active role in supporting our engagement work.

For the last five months of 2015/2016, Merton CCG and Merton Council worked closely together to ensure a smooth transition to our new community service providers, Central London Community Healthcare and Connect Physical Health Limited. The contract with the new providers began on 1 April 2016. The decision to move to new providers was the result of a thorough and detailed procurement process involving Merton residents, Merton GPs, Merton CCG and Merton Council, community groups, service users and carers. Merton GPs and our Patient Engagement Group continued to be involved in the development of the new services ahead of the formal transfer on 1 April.

During 2015/2016, recognising the challenges and pressures on local primary care, we began to work towards taking on delegated responsibility for primary care. In parallel to the preparatory work undertaken for this – including due diligence – we and other South West London Clinical Commissioning Groups began to work together as a larger group to plan and develop local primary care health services. This is part of a package to improve primary care, including making it easier for local residents to access GP services.

We also have a lot of work to do with our providers and partners to deliver safe, high-quality care for our local population, particularly as we seek to manage the on-going financial pressures within the
commissioning system. This challenge is not unique to Merton but it has necessitated some very tough decisions be made now – and going forward. The CCG recognises that the scale of the challenges facing health and care services across London and that we cannot expect to fulfil our responsibilities by working alone. We need to make a step change and do much more. The money simply isn’t in the system to deliver as we have done.

We finished the year with a break-even position which is an under achievement of £2.4m against the originally planned surplus for 2015/2016. This means we have failed to meet the 1% surplus target as per NHS business rules. As a result we have had to submit a financial recovery plan to NHS England and discussions around that are on-going. Rebuilding the required one per cent surplus will put additional pressure on budgets in the coming year and beyond.

High quality of care remains our paramount aim and we are working closely with our acute trust colleagues to ensure there is a greater level of performance in cancer services, elective care pathways and in our local emergency departments. This year we worked with neighbouring CCGs to ensure a full recovery plan was put in place where providers were unable to deliver the agreed standards.

People are living longer and the population is increasing. We have an ageing population in which many more people have on-going physical or mental health conditions, meaning we are treating more people than ever, with more complex conditions.

So we know that 2016/2017 will need to be a year of further innovation and transformation. To ensure Merton CCG is well placed to meet that challenge, we have created a new post of Director of Transformation.

This past year, the CCG welcomed Dr Dagmar Zeuner as our new Governing Body member for Public Health and Sally Thomson as our Nurse Governing Body member. Both bring a wealth of experience and knowledge to the CCG. Three members also had their terms renewed including our Vice-Chair Peter Derrick, our lay PPI member Clare Gummett, our secondary care doctor Dr Stephen Powis and Dr Caroline Chill. We welcome their continued contribution to the work of the CCG and their commitment to ensuring the very best service possible is offered to the people of Merton.

Finally, we would also like to acknowledge the valuable contribution of the CCG’s former Chief Officer, Eleanor Brown, who left in July and Governing Body members Dr Kay Eilbert, Director of Public Health and Mary Clarke, our former Nurse Governing Body member, who also left us this year.

We know that 2016/2017 will need to be a year of further innovation and transformation and Merton CCG is well placed to meet that challenge.
Welcome to our 2015/2016 annual report for Merton Clinical Commissioning Group. Our CCG is made up of two 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 Lead) and Dr Tim Hodgson (West Merton Locality Lead) provide their perspectives on 2015/2016 and the achievements of the membership.

Each locality meets monthly, 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 enabled local clinicians to have an increased impact on local health service changes. As a federation of 24 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.

The CCG has focused on eight key delivery areas over the past year:

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

Members have played an active role in all these areas of the CCG’s work. Members have helped develop Health Help Now – the new website and app for local residents – and worked with the local authority to ensure the success of a variety of prevention projects.

There has also been considerable focus on developing an estates strategy and IT strategy.

One of the biggest areas of activity this year has been the procurement and contract mobilisation for new community health services. The new providers have been commissioned by the CCG and Merton Borough Council to deliver community health services in the borough from April 2016.

Central London Community Healthcare NHS Trust (CLCH) is now providing a range of both children’s and adult community services in the borough, while Connect Physical Health Limited provides adult musculoskeletal (MSK) and outpatient physiotherapy services.

Frontline health professionals and the services they provide will remain, so patients and GPs can be assured of continuity of services.

The new arrangements are the result of a detailed and thorough procurement process which had the overall objective of delivering improved health and well-being outcomes through community health services. Local clinicians have been involved at every stage and in every major decision. Together with the Council, we have been working closely with the new providers since October 2015, when they were named as our preferred bidders, to ensure a smooth transition for patients and staff.

Our main aim was to ensure that services were focussed on the needs of residents and which treated patients as individuals, providing a ‘wellness’ approach to universal and preventive services. We also wanted an increased focus on early intervention by providing targeted services for individuals who may be at
risk in the future with help at home, alongside support for adults in the community and children with complex needs. We have also made sure there is specialist support for adults and children who cannot be supported in the community, and for children in care.

It has been a very challenging year for the local health economy, and there has been increased pressure on our local primary care services and NHS hospital trusts. The CCG has also been working on its community programme with CLCH to ensure people spend no more time than is absolutely necessary in hospital and able to have prompt access the right care at home.

A number of our clinicians were also involved in the procurement and mobilisation of a new model of Increasing Access to Psychological Therapies (IAPT) services for people with mild-to-moderate depression and anxiety. This service began in October 2015 and is expected to result in further improvements to access and waiting times; early results show that despite inheriting a much greater than expected caseload, the new service is performing well. Recovery rates are the highest the CCG has seen and we are confident the new provider will help many more people in Merton.

We had a robust discussion on the new service ahead of its introduction at our Members AGM in September and there has been active engagement in supporting the transition to the new service. The membership Annual General meeting in September also provided an excellent opportunity for us to consider some of the more strategic issues we and other south west London CCGs are facing. The membership has played an active role working with colleagues across south west London on primary care co-commissioning and other areas of shared activity.

In 2015/2016, Merton CCG and the East Merton GP locality group established a ‘task and finish’ group to develop a model of care that addresses the specific health needs of residents of East Merton. A health needs assessment for this part of the borough pointed to the conclusion that residents in East Merton have a different health profile than the rest of the borough. The East Merton Model of Health and Well-Being is one of the key strategic priorities for developing and improving care and health services in Merton.

This project is also feeding into the Whole Merton Strategy, as the model will describe how services across the whole spectrum of health, social care and voluntary sector should work together to provide more local, integrated and preventive and proactive care.

In the past few months, the CCG’s primary care team has been supporting GP practices to make more routine appointments available to be booked online, and for repeat prescriptions to be ordered online. The Patient Online systems allows patients to take more control of their own health and well-being and enables GPs to ensure that the services they provide are more convenient, personal and efficient.

I hope this has given you a flavour of our work for Merton this year. We’ve achieved a great deal but there is a lot more work to be done in reducing health inequalities and ensuring that everyone in Merton has access to safe, high-quality care.

Dr Tim Hodgson
West Merton Locality Lead

Dr Karen Worthington
East Merton Locality Lead
Performance report

Overview

Purpose and activities of Merton CCG

Merton CCG is a membership organisation consisting of 24 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.

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

In 2015/2016 we were responsible for spending £238m 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.

All CCGs have a cap on running costs based on per head of population. In 2015/2016 this was £4,544k for Merton CCG.

Our Constitution sets out the way we operate and function. Changes to the Constitution were agreed by NHS England in November 2015. The changes were as follows:

- further strengthen clinical engagement and leadership in the CCG. In line with this the current governance structure was reviewed and updated. The new structure strengthened clinical engagement and leadership, particularly through the creation of a Clinical Transformation Committee as a formal Committee of the CCG Governing Body.
- reflect changes agreed in February 2015 to incorporate the power to enter into Joint Commissioning arrangements for Primary Care Services with NHS England and other CCGs. The changes were approved by the South West London Joint Committee for Commissioning Primary Care Services.
- add clarity to existing statements and remove redundant statements.
- reflect changes in local and national policy.
- update matters of fact.

We work through our GP membership and Governing Body. The Governing Body of Merton CCG must ensure that the CCG exercises its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance.

The Governing Body comprises:

- 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

The Governing Body also includes the Director of Quality and Performance, Director of Transformation (a new post created in February 2016) and Director of Commissioning and Planning. These positions are, however, without voting rights.
The CCG believes 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 its work is clinically-led, with input from local people.

During 2015/2016 the CCG was not responsible for commissioning primary care services – GP, pharmacy, optometry and dentistry services – nor specialist services, such as very complex mental health care or heart surgery. However, we are working closely with NHS England to develop a ‘joined up’ approach, known as co-commissioning, across the new health system.

As a comparatively small CCG based on our registered population, we have a streamlined in-house team of 45 staff, representing 41.9 whole time equivalent (WTE) posts. We buy in some support functions where we can achieve economies of scale from access to a larger pool of expertise and knowledge. We buy in human resources (HR), information technology (IT), transactional finance and communications/engagement services from South East Commissioning Support Unit (SECSU). This support complements our in-house capacity and capability, and is under constant review to ensure we receive high-quality services and best value for money.

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

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

The CCG has been in existence for three years, and had a change in both Clinical Chair and Chief Officer. The new leadership has taken the opportunity to review the current operating plan, models of care, working and governance of the CCG. There is a desire to ensure that the CCG is both demonstrably clinically-led and that patients, partners and the public have a strong voice that is heard.

The CCG has worked with local practices, partners and providers to take forward the ‘Whole Merton’ vision and will continue to do so in 2016/2017.

Merton CCG commissions services from a range of providers to meet local healthcare needs. The CCG has a particular focus on eight key delivery areas; older and vulnerable adults, mental health, children and maternity services, keeping healthy and well, early detection and management, and urgent care.

Merton CCG aims to improve patient experience and health outcomes in a financially and clinically sustainable manner by achieving best value and ensuring health services are provided in a way which promotes the NHS Constitution. We are committed to putting the patient first, delivering high-quality care and working with our partners to provide system leadership, taking prompt action and helping to prevent problems related to ill health.

NHS England has to date been responsible for commissioning Primary Care services. However these are now being co-commissioned with the CCG in Merton and in the new financial year (2016/2017) the CCG will take on full delegated responsibility.

The CCG is committed to working collaboratively with a range of partners across the wider health and social care system, including local authorities and voluntary organisations, to develop the Whole Merton vision and strategy. In particular the CCG will work with Merton Council as a key strategic partner to develop and implement the most appropriate joint commissioning and system leadership arrangements which support the ‘Whole Merton’ approach.

Health and Well-Being Board

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 geographical boundaries with our borough council which means we have a strong chance of impact locally and improving everyone’s long term health and wellbeing.

Merton CCG is represented on the Health and Well-Being Board (HWB) which considers matters relating to the provision of public health services and the commissioning of adult social services and children’s services across health and social care and the impact of these on the health and well-being of the local population.

The Joint Health and Well-Being Strategy (JHWS) sets out our approach to improving the health and well-being of everyone in Merton and reducing health inequalities between communities. It is available on Merton Council’s website. www.merton.gov.uk/merton-health-and-wellbeing-strategy-web.pdf
Key issues and risks

The CCG’s Assurance Framework identifies and prioritises the main risks to delivery and mitigating actions during 2015/2016. This has enabled the Executive Management Team to focus on key strategic priorities and risks built up from the various assurance and escalation processes that are in place within the CCG.

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

The key risks that we have been focussing on are:

- Over-performance of acute contracts.
- Significant poor performance of the continuing care service.
- External and internal pressures leading to the CCG being unable to deliver the planned budget for 2015/2016.
- The risk to finding high-quality sustainable solutions for healthcare in south west London. Without significant system change, quality of outcomes will be limited for patients and provider organisations may become unsustainable.

Merton’s health need

Merton has a resident population of approximately 211,000 which is set to increase by over 21 per cent by 2021. A significant feature of Merton’s population is the changing age profile, with an increasing and high birth rate alongside...
Premature mortality (deaths under 75 years) is very strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts. If East Merton had the same death rate as West Merton, it would see 113 fewer deaths each year – an 18 per cent reduction on its 640 deaths each year. Of the 113 deaths, 81 are under 75 years.

Local communities have become more diverse over the last 10 years; an estimated overall 49 per cent of the population is from Black, Asian and minority ethnic groups and non-British white communities, with emerging new Polish and Tamil communities in the borough. These changes and differences have significant implications for the planning and delivery of local health and care services.

The south west London health economy

As health care commissioners, we work to deliver excellent health care services for everyone in our borough.

The local population is growing and people are living longer. Meanwhile, medical technology advances and new treatments and medicines become available. This inevitably leads to more demands on NHS services, and this demand is set to increase. However, it is clear that the health service funding will not be able to keep pace with this rise in demand.

This year, we have worked hard to build closer working relationships with our partner south west London CCGs through co-commissioning initiatives and the work of the South West London Collaborative Commissioning (SWLCC).
It is vital that the six CCGs in south west London – Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth – work together to tackle challenges that cross borough boundaries. The six CCGs have established the South West London Collaborative Commissioning (SWLCC) partnership to achieve this.

SWLCC is working with local hospitals, mental health trusts, primary and community care services, local councils and local people to meet the challenges and aspirations set out in the NHS Five Year Forward View.

We want to continue to provide a safe and sustainable NHS that meets the needs of our changing population, ensuring that patients experience the same high-quality care wherever they access services. Other joint initiatives, such as delegated primary care commissioning and the Transforming Care Partnership for Learning Disabilities, are also managed via the SWLCC partnership.

What are the challenges?

- 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.

- All patients should get the best possible care but at the moment the quality and safety of our health services varies enormously depending where and when they are treated.

- The needs of our patients have changed, so we need to deliver health services differently.

- Patients need ‘joined up’ services that work together and across boundaries; this does not happen effectively enough yet.
The CCG has worked hard in 2015/2016 to maintain and improve the performance and quality of care for Merton patients.

- The NHS Five Year Forward View commits us to moving towards a seven-day NHS, so that patients get the same quality of care at weekends and out of hours as they do during the normal working day.
- The costs of providing healthcare are rising much faster than the rate of inflation. If we do not make changes, in five years’ time we will not be able to pay for the services we currently provide.
- There is a national shortage of key specialist staff and nurses so getting the right staff in our services is a major challenge.
- 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.
- While the clinical, financial and workforce challenges are daunting and urgent, there is compelling evidence that we can get improved services that are more affordable for the NHS if we spend our money differently.

In June 2015, all NHS organisations in south west London produced an Issues Paper, setting out the challenges we face, some emerging ideas and some questions for local people to consider. Large-scale focus groups were held in each of the six boroughs and we wrote to over 1,000 local organisations asking for their views. Independent feedback from the events can be found on the SWLCC website. During the next few months, we will publish further information on the feedback received to date and our response to it.

In December 2015, NHS England published new planning guidance requiring all NHS regions across the country to work together, and with local councils, on a five-year ‘sustainability and transformation plan’ for their local NHS. The six CCGs, local provider trusts and local authorities have formed a ‘Strategic Planning Group’ to deliver this work. The plan will be published later this year and will build on the five-year strategy published by SWLCC in 2014. Elements of the SWL plan which affect Surrey Downs residents will be managed in partnership with Surrey Downs CCG, via the newly-established South West London and Surrey Downs Healthcare Partnership. The main focus of this partnership will be how acute services are organised, improving productivity and a strategy to deliver more care outside hospital.

Final decision-making on any changes to local health services continues to rest with the local CCGs. Any significant changes to local services would be subject to public consultation.

**Financial position**

It has been a challenging year for the finances at Merton CCG. We finished the year with a break-even position at year end which is an under-achievement of £2.4m against the originally planned surplus for 2015/2016. This means we have failed to meet the 1% surplus target as per NHS business rules.

Critical and acute care and prescribing are all areas where over-performance has occurred during 2015/2016 and where continued pressure in 2016/2017 can be expected. Continuing healthcare is also an area of significant financial pressure.
This service grew at 21 per cent in 2015/2016 and is likely to continue to show significant growth in future years (estimating 15 per cent for 2016/2017).

The Executive Management Team is modelling the impact of the changes in the national tariff and our cost pressures for 2016/2017 and negotiating the control total for 2016/2017 with NHS England, alongside having some very robust contract discussions with providers. The CCG is further reviewing individual budgets in tandem with the contract negotiation process to identify further savings.

Rebuilding the required one per cent surplus will put additional pressure on budgets in the coming year and beyond.

**Capacity and resilience**

The CCG has undergone a period of senior staff transition during 2015/2016 and enters 2016/2017 with two interim Directors in post. The CCG has sought to ensure that full use is made of corporate briefings and record management systems to mitigate the risk of knowledge loss. Wherever possible, handover periods and careful prioritisation of work have also been used to mitigate the risks during periods of staff transition.

**Performance summary**

The CCG regularly considers performance against the NHS Constitution standards, as well as national and local indicators that consider how we are improving the health of our local population.

The CCG has worked hard in 2015/2016 to maintain and improve the performance and quality of care for Merton patients by setting firm expectations of standards with our healthcare providers. Overall, there are some areas of good performance, but a number where further work will be required throughout 2016/2017.

We have seen good performance against a number of the NHS Constitution standards. Six of the eight waiting time targets for cancer assessment or treatment were achieved; the CCG was also likely to achieve the target for C difficile infections. Other pledges have been a challenge for local providers though, particularly:

- waiting times (18 weeks from referral to treatment; patients waiting over 52 weeks; six weeks from referral to a diagnostic test; and A&E four-hour waiting times)
- the target to be seen by a specialist within two weeks of GP referral for all cancers; and the 62 day standard for patients to receive treatment following urgent referral by a screening programme.
- ambulance response times
- mixed sex accommodation breaches
- MRSA infections

For our indicators on improving health, we have similarly seen some areas of improved performance, with a reduction in the overall prescription of antibiotics, and the proportion of broad spectrum antibiotics; and an improvement in diagnosis rates for patients with dementia. Additionally, we have achieved the Improving Access to Psychological Therapies (IAPT) target of 50 per cent of patients moving from treatment to recovery.
Merton CCG's QIPP plan for 2015/2016 consisted of seven main programmes based around:

- **Acute Portfolio**
- **Medicines Management**
- **Mental Health**
- **Transformation, Placements and Demographic Growth**
- **Planned Care and Diagnostics**
- **Running Costs**
- **Urgent and Intermediate Care**

Areas where we were more challenged include:

- Higher than planned admissions for emergency avoidable admissions; this is in all categories except emergency hospitalisation for asthma, diabetes and epilepsy in patients aged under 19.
- Being below target for diagnosis rates for patients with diabetes, and increasing the number of people who access structured education on their condition.

Our system has seen a higher number of delayed transfers of care this financial year.

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

QIPP is a large-scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. It will improve the quality of care the NHS delivers whilst securing efficiency savings, which will be reinvested in frontline care.

**Summary**

The QIPP plan has delivered savings of £4,900k to date, £29k above plan.
Mental Health

This programme consists of:

i Mental Health Demographic Growth

ii Mental Health Redesign

iii Mental Health Placements.

The Mental Health Demographic Scheme savings of £312k were achieved as part of contracts negotiated for 2015/2016.

Mental Health Redesign mobilisation was adjusted following a market engagement event where potential providers advised that further mobilisation time would be required because of issues to do with premises. As a result the service began on 1 April 2016.

The Mental Health Placements programme was a system to review all fully-health funded and part-health funded placements for service users with complex mental health needs, whether in or out of borough. All service users are subject to Section 117 of the Mental Health 1983, which places a statutory duty on the CCG. The target QIPP saving was set at £125k for the financial year. This was a gross saving target, not a net saving, as there are no controls available in terms of new service users presenting with onset of illness, moving into the area, or patients with degenerative conditions increasing in chronicity. The scheme delivered savings of £268k, £143k above plan.

Planned care & diagnostics

The Planned Care QIPP programme consisted of a number of schemes, each of which is outlined in full below:

i The Nelson Health Centre Activity (including the More in Merton Initiative)

ii Outpatient Navigation

iii Diabetic Eye Screening Programme (DESP) Surveillance Clinic

iv Enhanced Musculoskeletal and Physiotherapy Service

v Outpatient QIPP Action Plan (including St George’s at the Nelson Minimum Income Guarantee (MIG) reimbursement)

The Outpatient Navigation project and the Nelson Health Care activity/reduction in tariff costs were combined into a single QIPP project which also included the negotiation of the conditional Minimum Income Guarantee at the Nelson Health Centre.

The Nelson Health Centre activity

A number of diagnostic and other outpatient specialist services are delivered from the Nelson Health Centre. The outpatient services are being charged at local tariffs which are lower than the acute provider tariffs, and therefore savings are achieved for the activity which takes place at the Nelson Health Centre rather than local acute hospital providers.

The majority of specialist outpatient services to be delivered at the Nelson Health Centre have been in operation since April 2015, although there was a delay in the opening of the Endoscopy Suite, and the Anticoagulation service began in November 2015.

The More in Merton campaign launched on 4 January 2016 to boost GP referrals to the Nelson Health Centre. There was an increase in the daily rate of direct referrals to the Nelson of 33 per cent, which is encouraging as we enter 2016/2017.
A number of diagnostic and other outpatient specialist services are now being delivered from the Nelson Health Centre.

**Outpatient Navigation Programme (OPN)**

Forty-two pathways have been developed and are ready for release into the DXS system.

The OPN programme has given visibility to clinic tariffs. GPs were given a aide-memoire to show indicative first outpatient and first follow-up tariff costs between local community clinics at the Nelson Health Centre, compared with our main provider (St George's University Hospitals NHS Foundation Trust).

GPs now have electronic access to the Nelson Health Centre clinics.

**Diabetic Eye Screening Programme (DESP) Surveillance Clinic**

This was a pilot of an Ophthalmology Surveillance Clinic within the National Diabetic Eye Screening Programme (DESP) which is intended to deliver benefits to patients and savings to the CCG from reduced outpatient attendances.

The previous national referral pathway from the DESP required all screen-positive patients to be referred to the hospital eye service for ongoing surveillance.

Many low-risk screen-positive patients do not, however, need immediate ophthalmological intervention but rather require more frequent monitoring until the disease either improves or progresses to the stage where treatment is required.

A change to the national DESP pathway provided for photographic surveillance clinics to be established within the screening programme, enabling specific groups of patients to be monitored in surveillance in the community rather than having to attend hospital.

In addition the service was interrupted by transition to the new DESP provider which has impacted on the savings in this current financial year.
Enhanced Musculoskeletal and Physiotherapy Service

This scheme involved implementing an enhanced pathway for musculoskeletal and physiotherapy services, including a ‘fast triage’ service for all patients presenting with an MSK-related condition, redirecting patients to increased capacity within the service (away from secondary care) and providing an early assessment and management plan for patients.

The financial benefits of this scheme were achieved through the change in service described above (£163k), and also a saving against additional investment of £105k originally expected to be required to deliver the scheme but which was not necessary.

Outpatient QIPP Action Plan

Analysis conducted by the CCG during the year highlighted that Merton CCG was a significant outlier in the number of outpatient referrals compared with London and nationally. Analysis of 2014/2015 Q4 data for appointments per 100,000 population showed that Merton CCG had the eighth-highest rate in London, and the second highest in south west London (Better Care Better Value analysis).

The high number of outpatient referrals is the key pressure and accounts for a majority of the backlog, leading to treatment delays.

a Negotiation on the Minimum Income Guarantee (MIG) agreement with St. George’s.

b More-in-Merton initiative, designed to make full use of the local outpatient and diagnostic services at the Nelson Health Centre. A range of communications is planned to promote the services at the Nelson Health Centre, and GP practices are asked to meet referral targets, based on the list size of each practice (weighted population), individual current referral rates to secondary care and geographic proximity/travel routes to the Nelson Health Centre.

c Outpatient Action Plan. This Action Plan was developed in September and engagement work began with GP practices throughout October and November, (through discussions at CRG, GP Localities and Leads Forums). Analysis of first and follow-up GP referred outpatient activity, on a month-by-month comparison from 14/15 to 15/16, demonstrates a reduction in activity and outpatient acute costs in the months of December 2015 and January 2016. This is a change in the usual trend of activity from the previous year:

- 150 fewer first outpatient referrals in December 2015 compared with December 2014, and
- 400 fewer first outpatient referrals in January 2016 compared with January 2015.

Running costs

The running costs QIPP scheme was based on savings arising from reclassification of South East Commissioning Support Unit (SECSU) running costs from administration costs to programme costs. The aim of the project was to follow running costs guidance and report costs incurred appropriately.
Urgent and intermediate care

This was the second year of a two-year programme to fundamentally change urgent and proactive care service delivery and care for often older and frail residents of Merton.

Schemes started in 2014/2015 included:
- expansion of Community Prevention of Admission Team, including working with nursing homes
- review and development of intermediate care beds
- redesign of Emergency Department/community interface (incorporating the establishment of interface geriatricians and the redesign of the STAR team at St George’s University Hospitals NHS Foundation Trust, as well as ICOPP pathway with Sutton at St Helier Hospital)
- development of HARI (Holistic Assessment & Rapid Investigations) formerly OPARS
- In-reach nursing, supporting hospital discharges
- care delivery undertaken by locality-based multi-disciplinary teams.

In 2015/2016, work continued on the above schemes and included the following:
- community crisis response expansion to accept GP, LAS, 111 and nursing home referrals seven days a week, 365 days a year.
- increased number of intermediate care beds, with seven-day therapy input
- further work to redesign Emergency Department/community interface (incorporating the establishment of interface geriatricians and review of in-reach nursing in Emergency Department).

The above schemes form part of the delivery of the Merton Model workstream within the Better Care Fund. Key milestones were developed to measure progress.
Performance analysis

How we measure performance

Merton CCG is committed to ensuring that NHS care is provided safely and to the highest quality possible for all patients. The CCG measures performance and quality standards based upon the national CCG Assurance Framework 2015/2016, which focuses on key constitutional pledges for patients, as well as the Improving the Health of our Local Population programme we developed to define local health priorities for Merton.

In an environment where NHS organisations across the country have experienced unprecedented growth in demand for NHS care with a tighter limit on resources, the CCG has worked hard in 2015/2016 to maintain and improve the performance and quality of care for Merton patients by setting firm expectations of standards with our healthcare providers.

We report performance and quality standards each month to our Governing Body and hold monthly meetings with our key acute, mental health and community care providers to review performance. Where we feel closer intervention is required, we meet providers more frequently to work with them to ensure performance improvement plans are effective.

Performance is monitored and measured through the Clinical Quality Reporting Committee. The committee scrutinises performance for Merton CCG and reviews areas of concern and reports to the Governing Body as appropriate. The Clinical Quality Committee is chaired by the Governing Body Lay Member, Patient and Public Engagement Lead.

The duties of the Committee are as follows:

- seek assurance that Merton CCG commissioned services are being delivered in a high-quality, safe manner, including against criteria set by the Care Quality Commission, Monitor and other regulatory bodies.
- oversee the performance of Merton CCG commissioned services, taking into account performance against Key Performance Indicators and the NHS and Public Health Outcomes Frameworks, with a focus on areas rated Red or where there has been deterioration in performance.
- challenge, scrutinise and ensure that exception reports, action plans and risk assessments submitted by the Commissioning Support Service (or body that undertakes the function), Joint Commissioning Unit, Locality Commissioning Groups and subgroups include robust mitigating actions and controls that would effectively address identified risk.
review information including staff survey data, patient experience surveys, PALS queries and complaints to identify potential risks and issues.

have oversight of the process and compliance issues concerning Serious Incidents (SIs); Central Alert Systems (CAS); National Reporting, and being informed of all Never Events and informing the Governing Body of any escalation or sensitive issues in good time.

approve the CCG quarterly and annual complaints report.

receive and review reports relating to Safeguarding Adults and Children including Serious Case Reviews to provide assurance. All Statutory Safeguarding Reports to be formally approved by the CCG Governing Body.

receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.

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

provide assurance that Merton CCG commissioned services, and jointly commissioned services are being delivered in a high-quality and safe manner, ensuring that quality sits at the heart of everything the clinical commissioning group does.

oversee and be assured that providers of commissioned services and jointly commissioned services manage risk appropriately and have robust mechanisms in place to effectively address clinical governance issues.

to ensure that the patient is at the heart of everything we do. To receive and review the Statutory Obligation to Involve Annual Report, prior to formal approval by the CCG Governing Body.

receive and review quarterly and annual Equality and Diversity reports to provide assurance to the Governing Body. Statutory reports to be formally approved by the CCG Governing Body.

Finance

The finance committee scrutinises financial performance for Merton CCG and reviews areas of concern and reports to the Governing Body as appropriate. It works alongside the audit and governance committee.

To ensure the governance arrangement used are fit for purpose a professional services company, RSM, were engaged at the start of 2016 to carry out a full financial governance review of the CCG with a full report, recommendations and associated action plan to be presented to the Governing Body by the summer.

The committee delivers its objectives by:

keeping under review strategic and operational financial plans and the current and forecast financial position of the CCG.

overseeing the arrangements in place for the allocation of resources and the scrutiny of all expenditure. This includes actual and forecast expenditure and activity on commissioning contracts.

reviewing the financial report to be presented to the Governing Body, incorporating financial performance against budget, financial risk analysis, forecasts and robustness of underlying assumptions.
receiving and reviewing a monthly report on the progress of the QIPP plan.

reviewing, scrutinising and recommending business cases to the Governing Body.

reviewing and approving tender waivers or seeking tenders from firms not on approved lists and ensure these are reported to the audit and governance committee.

scrutinising the CCG’s financial strategy and financial plans for future years.

The Merton CCG Integrated Quality and Performance Report

The report, presented each month to CQRG, provides a monthly update on quality and performance information, and reports on actions being taken to address any performance issues with progress to date.

The contents of the report are defined by the CCGs priorities, which are informed by nationally-defined objectives for commissioners – the NHS Constitution and Everyone Counts Guidance 2014/15 (operating framework).

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

The report provides:

- an update on CCG and related providers’ operational performance against national and locally agreed standards. This includes 18 weeks RTT, cancer waits, A&E waits and ambulance handover times, delayed transfers of care.

- detailed information on underachieving indicators including trends and direction of travel are included where there are measurable thresholds.

- provider quality and safety issues are also covered in the report. The key areas highlighted are Southern Health Report and associated recommendations and Serious Incidents. These are presented in trend charts and tables with commentary and actions for areas of concern to improve the focus on quality in the report.

- timeframes in the quality slides vary because more recent validated information is available.

The Governing Body

The CCG Governing Body has ultimate responsibility for making the final decisions and ensuring the CCG is performing as it should. It is accountable to NHS England and to member practices, as well as to the public.

Governing Body meetings are held in public and the meeting papers are published on the Merton CCG site. Meetings are voice recorded and the audio files made available on the CCG website.

All Governing Body members and senior managers are required to declare any relevant and material interests, which are detailed in the register of interests. The CCG’s constitution sets out the rules governing declarations of interest and the management of conflicts of interest.

We conducted a Governing Body Effectiveness Review and we aim to report on this later in the summer.
Financial performance

Funding for Merton CCG patients

The CCG is almost entirely funded by a central allocation by NHS England based upon a weighted capitation funding formula which adjusts funding per head of population registered with our GP practices to reflect local age and need profiles. The funding formula establishes a target level of funding. However, in 2014/2015, the CCG’s actual allocated funding was £17.3M or 7.67 per cent below the target level of funding. This was recognised by a significant uplift in growth funding allocated to the CCG in 2015/2016 which is outlined in the table below.

<table>
<thead>
<tr>
<th>Description</th>
<th>£M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15 Baseline funding</td>
<td>208.5</td>
</tr>
<tr>
<td>2015/16 Confirmed funding</td>
<td>226.0</td>
</tr>
<tr>
<td>Increase in funding</td>
<td>17.5</td>
</tr>
<tr>
<td>% Increase in funding</td>
<td>8.40%</td>
</tr>
<tr>
<td>Target Allocation</td>
<td>237.3</td>
</tr>
<tr>
<td>Distance from target</td>
<td>-11.3</td>
</tr>
<tr>
<td>Distance from target (2015/2016)</td>
<td>-4.77%</td>
</tr>
</tbody>
</table>

In 2015/2016, the CCG received an increase in its funding allocation of £17.6K or 8.40 per cent. This included funding in respect of former non-recurrent ‘winter pressures’ funding which was made recurrent. Therefore, the underlying rate of actual growth was £16.8M or 8.03 per cent. This significantly reduced the shortfall from the published target, which was also increased to reflect changes in the population and cost inflation. Consequently, in 2015/2016 the CCG’s funding allocation shortfall was reduced to 4.77 per cent.

How did the CCG plan to invest this growth?

As takes place every year, the CCG was required to submit an operating plan to NHS England detailing how it proposed to deploy its resources to achieve the delivery of key constitutional standards.

A key aspect of this process was ensuring that the CCG procured sufficient growth in activity from the portfolio of hospitals that it contracts with to deliver healthcare for our population. In order to ensure that contracted activity reflected changes to the size and age profile of the population and other anticipated trends in healthcare, the CCG increased its planned activity across the portfolio of contracts by 3.5 per cent.

The financial impact of this growth was partly tempered by the fact that the Department of Health required hospitals and other service providers to deliver nationally mandated efficiency improvements. Therefore, the planned cost of investing in activity growth was £4.4M, but this was lower than would have been the case had these efficiency improvements not been incorporated into the cost of services that we buy.

The most significant deployment of growth funding that the CCG made in 2015/2016 was to invest in the development of care out of hospital and in particular the Better Care Fund (BCF) which received £7.0M of additional funding.

The BCF is a key enabler to the CCG’s strategy of promoting greater integration between health and social care to improve outcomes for our population.
A key focus of the BCF programme is reducing non-elective admissions to hospitals. A key target of this investment in the BCF was to support the delivery of the QIPP programme through reducing non-elective admissions by 3.5 per cent and to support investment in mental healthcare issues to improve access to these services for our patients.

Other significant investments that the CCG made in 2015/2016 included:

- complex depression and IAPT services (£0.9M).
- investment in community services, including the Nelson Health Centre (£0.8M).
- investment to enable performance improvement in the London Ambulance Service (£0.5M).
- providing a single point of access for CAMHS services (£0.4M).

**Overall financial performance**

The financial performance of the CCG each year is assessed externally by a range of financial duties and targets. A summary of the CCG’s performance against these duties follows.

The CCG was unable to achieve a 1 per cent surplus target as per NHS business rules in 2015/2016. While the CCG was able to remain within its allocation by posting a surplus of £0.028M, this was significantly less than the £2.366M required.

This was largely driven by financial pressure in three key commissioned programmes:

- acute contracts were £4.7M overspent due mainly to a significant and unplanned growth in referrals for elective care.

- continuing healthcare expenditure grew by 22 per cent and resulted in an overspend of £2.2M.

- prescribing budgets were overspent by £0.9M.

The CCG was able to contain these areas of unplanned expenditure within the context of an overall surplus of £0.028M through the deployment of the 0.5 per cent contingency reserve and slippage on planned investments. Both of these were non-recurring measures focused upon a largely recurring pressure, so this pattern of expenditure will need to be funded on a recurring basis in 2016/2017.

All other statutory and non-statutorily targets were successfully met. This includes the delivery of a significant efficiency programme which has resulted in £4.9M of QIPP savings being achieved.

**Expenditure**

Total expenditure in 2015/2016 was £238.9M. This compares to £215.5M in 2014/2015. Acute expenditure accounts for 56 per cent of overall CCG expenditure. This has reduced from 59 per cent in 2014/2015, which reflects a deliberate and planned investment in out-of-hospital care and the Better Care Fund.

An analysis of how the CCG spent its resources in 2015/2016 is shown on the next page.

The CCG’s expenditure is largely is accounted for by contractual expenditure with NHS providers in south west London. An analysis of expenditure on all major contracts by provider is shown on the next page.
Capital investment

The CCG incurred £198K of expenditure on capital items in 2015/2016. This related to IT equipment at the Nelson Health Centre.

Better Payment Practice Code

The Better Payment Practice Code requires the CCGs to aim to pay all 95 per cent undisputed invoices by the due date or within 30 days or receipt of goods or a valid invoice, whichever is later. In 2015-16 the CCG maintained its performance from 2014/2015 and paid 99.3 per cent by value and 97.3 per cent by number of invoices within the required timescale.

There were no claims for interest payable under the Late Payment of Commercial debts (Interest) Act 1999.

Accounting policies

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

There are no changes to the accounting policies from the prior year.

External auditors

The CCG’s External Auditors for the 2015/2016 financial year were Grant Thornton LLP. Their fees amounted to £57K which was for services provided to conduct the statutory audit.

Managing our risks

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

Revenue

Outside of the main funding allocation from NHS England the CCG attracts very low levels of income. The most material element relates to the recharging of other commissioners for services that are hosted by the CCG. These include community services (£21.2M) and the South West London Cancer Network (£1.1M).
Pension liabilities

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

Financial outlook

The CCG experienced a number of significant areas of financial pressure in 2015/2016 which culminated in the under achievement of the required one per cent surplus. Given that the underlying driver of this change were recurrent cost pressures arising from growing demand in acute hospital activity and continuing healthcare placements and that much of this pressure was mitigated by the use of non-recurring funding sources, it is clear that the CCG will face a difficult year in 2016/2017. This is because the first call on funding growth for 2016/2017 will be needed to pay for levels of activity that were provided in 2015/2016 which can no longer be funded by non-recurring funding.

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

- a major change in the way that the funding formula is calculated. Having previously been in a position of 4.77 per cent under-funded, the new allocation formula for 2016/2017 means that the CCG is now virtually at parity with the target. This will mean that the CCG received significantly less growth funding in the next four years as nationally funding will be prioritised towards CCGs that are significantly below target.

- in previous years, NHS providers have been required to deliver significant efficiency improvements, which have reduced the cost of contracted services to the CCG. However, in 2016/2017 this efficiency target has been reduced and cost inflation has increased to take account of national policy pressures. In overall terms, this has meant that the national tariff has moved from a deflator of 1.57 per cent in 2015/2016 to an inflator of 1.60 per cent in 2016/2017. This will add a significant cost to the CCG for no additional activity.

- a requirement for the CCG to ensure that one per cent of its funding is uncommitted and available for non-recurring investment. In previous years, it was permissible to treat some existing expenditure programmes as uncommitted, but new guidance from NHS England means that this will no longer be permissible in 2016/2017. This will require the CCG to make a one-off investment of £1.7M to create the headroom for this reserve.

When the underlying position from 2015/2016 is combined with these additional pressures, it is clear that the CCG will find it difficult to avoid moving into a deficit position in 2016/2017. Accordingly, the CCG is currently in discussion with NHS England about the level of deficit that they are able to authorise.

The CCG is currently developing a financial recovery plan which will set out in detail the necessary measures that will be required to return to a sustainable financial position. It is likely that this will require a savings target of circa £30M to be delivered over the three-year period between 2016/2017 and 2018/2019. The programme of initiatives required to deliver savings of this magnitude will be very challenging and will clearly need to be aligned with the wider South West London Sustainability and Transformation Plan process.
The CCG Assurance Framework

In March 2015, a new CCG Assurance Framework was published by NHS England which takes into account all of the considerable changes which have taken place in the NHS environment since CCGs were authorised in 2013. The new framework acknowledges that CCGs have different starting positions, with different populations and challenges, requiring different leadership responses. Some are operating in an extremely difficult environment, within challenged health economies or with legacy financial issues. Assurance covers the overall delivery of a CCG and takes place continuously throughout the year, rather than as a one-off inspection.

The framework is used by NHS England to determine whether CCGs are meeting their statutory duties (the things they must do) and appropriately exercising their key statutory powers (the things they have the freedom to do). These duties and powers map to the five components of the assurance framework, which are shown in the diagram below:

![Diagram of the CCG Assurance Framework](image-url)
The Operating Manual to the 2015/2016 CCG assurance framework gives further detail on what is considered within each component. This list is not exhaustive but intended only as a guide:

**Well-led organisation**

1. Has strong and robust leadership
2. Has robust governance arrangements, including for the management of potential conflicts of interest and adherence to the CCGs' code of conduct policies
3. Actively involves and engages patients and the public
4. Works in partnership with others, including other CCGs
5. Secures the range of skills and capabilities it requires to deliver all its commissioning functions, using support functions effectively and getting best value for money
6. Has effective systems in place to ensure compliance with its statutory functions

**Delegated functions**

7. Governance and the management of potential conflicts of interest
8. Procurement
9. Expiry of contracts
10. Availability of services
11. Outcomes

**Finance**

12. Financial performance
13. Financial controls
14. Financial governance, resources and processes

**Performance**

15. Performs against the range of measures in the delivery dashboard

**Planning**

16. Performs against the range of measures in the delivery dashboard
17. Is performing to plan in year
18. Has an assured System Resilience Group plan
19. Has an assured Better Care Fund plan that complies with Guidance for the operationalization of the BCF in 2015-16
20. Has a long-term plan to implement the Five-Year Forward View

The possible levels of assurance rating are as follows:

**Assured as outstanding**
NHS England is fully assured by a CCG's performance in a component of assurance

**Assured as good**
There are minor concerns or a higher level of risk but the CCG is managing it effectively

**Limited assurance, requires improvement**
A CCG has more serious challenges and a higher level of risk in a component

**Not assured**
NHS England is satisfied that a CCG is (a) failing or is (b) at risk of failing to discharge its functions in a component
Therefore, a CCG would have an assurance rating for each component. The CCG’s overall, headline assessment for the financial year is expected to be communicated in May 2016.

As part of our assurance process during 2015/16, and alongside the routine review of performance indicators as noted above, Merton CCG undertook a number of ‘deep dive’ reviews with NHS England that allowed us to better reflect on areas where we thought we could improve. In 2015/2016 these included deep dives on Patient and Public Involvement, safeguarding and continuing healthcare. The deep dive on PPI was conducted in July 2015. NHS England assessed Merton CCG’s evidence for Domain 2 of the deep dive as ‘comprehensive, providing some excellent examples of engagement’. The deep dive on safeguarding was conducted in November 2015 and the CCG was assured as good in all four categories assessed – governance, capacity, workforce and assurance. We submitted initial evidence for a deep dive on continuing healthcare in January 2016 and the deep dive was conducted in April 2016.

Better Care Fund

Background

The Better Care Fund was announced in June 2013 to drive the transformation of local services to ensure that people receive better and more integrated care and support. Merton’s BCF Plan sought to deliver a series of health and social care integration schemes using a pooled budget to the value of £12.2m in 2015/2016.

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

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.

During 2015/2016 BCF delivered:

- the Holistic Assessment and Rapid Investigation (HARI) service which received both routine and urgent referrals
- the In-Reach nursing at St. Georges hospital to facilitate discharge
- seven-day-a-week social work cover to facilitate discharges from acute hospitals
- multi-disciplinary teams based on locality structures including health liaison social workers
- additional community provision, including specialist dementia nurses
- improved falls pathways, including direct referrals to community services from London Ambulance Service.

**Performance**

The Health and Well-Being Board was on track to meet the target for non-elective admissions achieving a reduction of 2.43 per cent against the 2014/2015 baseline and a target reduction of 0.4 per cent (see figure 11).

Reablement services provide personal care and help with daily living activities. This is usually in the service user’s home, and is offered to people with disabilities and those who are frail or recovering from an illness or injury. They are intended to encourage service users to develop the confidence and skills to carry out these activities themselves and continue to live at home. At the end of the year, we have exceeded our target for the number of people offered reablement. Data for effectiveness of reablement will be published in November 2016.

Permanent admissions of older people to residential and nursing care homes are rated Amber as there have been more admissions year to date than planned.

The system has experienced significant challenges with delayed transfers of care during 2015/2016, particularly September–December. The CCG has worked closely with the Local Authority and acute providers; and is now attending ‘Platinum Command’ meetings with St George’s Hospital to ensure that complex long-stay patients who are ready for discharge so not experience delayed discharge. The CCG has noted an improvement in the number of days lost to delays at the end of the year.

![BCF monthly performance – non elective admissions](image)

Figure 11

BCF performance

- 2024/15 Baseline
- 2015/16 Actual
- 2015/16 Target
<table>
<thead>
<tr>
<th>Health and Well-Being Board Metrics</th>
<th>2015/16 target</th>
<th>YTD</th>
<th>RAG Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</td>
<td>&lt;395.3</td>
<td>388.0</td>
<td>AMBER</td>
</tr>
<tr>
<td>Number of new placements to Permanent Care Homes 65+ (C72) (monitoring of number of people)</td>
<td>&lt; 100 new admissions</td>
<td>94</td>
<td>AMBER</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)</td>
<td>85.7%</td>
<td>Data available November 2016</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of older people (65 and over) who were offered a Reablement or Intermediate care service – (clients Reablement services started per month)</td>
<td>334</td>
<td>455</td>
<td>GREEN</td>
</tr>
<tr>
<td>Delayed transfers of care from hospital per 100,000 population (per quarter)</td>
<td>239</td>
<td>696</td>
<td>RED</td>
</tr>
<tr>
<td>Number of delayed transfers of care from hospital (bed days lost to delayed transfers)</td>
<td>1441</td>
<td>4066</td>
<td>RED</td>
</tr>
<tr>
<td>Social care-related quality of life (User Survey) Enhancing quality of life for people with care and support needs.</td>
<td>18.8 available late 2016</td>
<td>Data</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Figure 12
Health and Well-Being Board Metrics
Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, and if improvements are needed. Launched in 2010, the FFT has been rolled out across most NHS services, including community care, hospitals, mental health services, maternity services, GP and dental practices, emergency care and patient transport.

The FFT does not provide results that can be used to directly compare providers because of the flexibility of the data collection methods and the variation in local populations.

The test asks patients: ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment?’

Answers are ranked from:
- Extremely likely
- Likely
- Neither likely or unlikely
- Extremely unlikely
- Unlikely
- Don’t know

The results are published monthly for most services; or quarterly – looking at a different aspect of care each quarter – for maternity. The summary results are given as a percentage showing ‘Recommended’ (‘Extremely likely’ and ‘Likely’), ‘Not Recommended’ (‘Extremely unlikely’ and ‘Unlikely’); and ‘Neither/ Don’t know’.

Summary figures are shown below; more detail can be found in the data published monthly by NHS England and on NHS Choices.

The total score across all Merton CCG GP Practices showed that they were recommended by 90.4 per cent of patients.
For local acute services:

- St George’s University Hospitals NHS Foundation Trust was ‘recommended’ by 80.7 per cent of A&E users; 93.1 per cent of inpatients; 83.6 per cent of outpatients; and 90.0 per cent of postnatal ward maternity patients.

- Epsom & St Helier University Hospitals NHS Foundation Trust was ‘recommended’ by 87.4 per cent of A&E users; 95.1 per cent of inpatients; 94.9 per cent of outpatients; and 96.8 per cent of postnatal ward maternity patients.

- Kingston Hospital NHS Trust was ‘recommended’ by 94.3 per cent of A&E users; 95.8 per cent of inpatients; 92.0 per cent of outpatients; and 94.4 per cent of postnatal ward maternity patients.

- The Royal Marsden NHS Foundation Trust was ‘recommended’ by 98.2 per cent of users across their community services.

- South West London & St Georges Mental Health NHS Trust was ‘recommended’ by 92.4 per cent of users across all of their services.

For the main trusts that Merton CCG patients use, the responses (with number of respondents in brackets) were as follows:

### Acute Providers

#### St George’s University Hospitals NHS Foundation Trust: Friends & Family Tests

<table>
<thead>
<tr>
<th></th>
<th>A&amp;E / Walk in Centre (n = 1766)</th>
<th>Inpatient (n = 1176)</th>
<th>Outpatient (n = 581)</th>
<th>Maternity: Postnatal ward (n = 160)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Neither / Don’t know</td>
<td>6.6%</td>
<td>5.3%</td>
<td>6.4%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Percentage Not Recommended</td>
<td>12.7%</td>
<td>1.6%</td>
<td>10.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Percentage Recommended</td>
<td>80.7%</td>
<td>93.1%</td>
<td>83.6%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>
### Epsom & St Helier University Hospitals NHS Foundation Trust: Friends & Family Tests
February 2016 / Quarter 3 (maternity)

<table>
<thead>
<tr>
<th></th>
<th>A&amp;E / Walk in Centre (n = 791)</th>
<th>Inpatient (n = 1894)</th>
<th>Outpatient (n = 1928)</th>
<th>Maternity: Postnatal ward (n = 63)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Neither / Don't know</td>
<td>4.9%</td>
<td>2.7%</td>
<td>2.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Percentage Not Recommended</td>
<td>7.7%</td>
<td>2.2%</td>
<td>2.5%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Percentage Recommended</td>
<td>87.4%</td>
<td>95.1%</td>
<td>94.9%</td>
<td>96.8%</td>
</tr>
</tbody>
</table>

### Kingston Hospital NHS Foundation Trust: Friends & Family Tests
February 2016 / Quarter 3 (maternity)

<table>
<thead>
<tr>
<th></th>
<th>A&amp;E / Walk in Centre (n = 123)</th>
<th>Inpatient (n = 1084)</th>
<th>Outpatient (n = 522)</th>
<th>Maternity: Postnatal ward (n = 125)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Neither / Don't know</td>
<td>5.7%</td>
<td>2.4%</td>
<td>4.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Percentage Not Recommended</td>
<td>0.0%</td>
<td>1.8%</td>
<td>3.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Percentage Recommended</td>
<td>94.3%</td>
<td>95.8%</td>
<td>92.0%</td>
<td>94.4%</td>
</tr>
</tbody>
</table>
**The Royal Marsden NHS Foundation Trust: Friends & Family Tests**

**February 2016**

<table>
<thead>
<tr>
<th>Percentage Neither / Don’t know</th>
<th>0.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Not Recommended</td>
<td>0.9%</td>
</tr>
<tr>
<td>Percentage Recommended</td>
<td>98.2%</td>
</tr>
</tbody>
</table>

**ALL Services (n = 113)**

**South West London and St George’s Mental Health NHS Trust: Friends & Family Tests**

**February 2016**

NB: Results for Child & Adolescent (n=1) and Specialist services (n=3) were suppressed due to low numbers

<table>
<thead>
<tr>
<th>Services</th>
<th>Acute Services (n = 26)</th>
<th>Mental Health Other (n = 42)</th>
<th>Secondary Care Community Services (n = 50)</th>
<th>ALL Services (n = 122)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Neither / Don’t know</td>
<td>0.0%</td>
<td>0.0%</td>
<td>10.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Percentage Not Recommended</td>
<td>15.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Percentage Recommended</td>
<td>84.6%</td>
<td>100.0%</td>
<td>90.0%</td>
<td>92.4%</td>
</tr>
</tbody>
</table>
Patient safety

The CCG is responsible for ensuring that all services we commission provide safe care for our local population.

Patient safety incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare. When incidents do happen it is important that they are reported, actions taken and lessons are learned to prevent the same incident occurring elsewhere. Root Cause Analysis (RCA) investigation is a well-recognised way of understanding what happened and why. This analysis is used to identify areas for change and to develop recommendations which deliver safer care for our patients.

We therefore encourage healthcare providers and their staff to report all incidents, so that they can be reviewed and shared through the National Reporting and Learning Service.

Serious incidents – local review

Any serious incidents that involve a Merton CCG patient are reviewed by Merton CCG’s Clinical Quality Committee. The committee provides assurance for the Governing Body that incidents are reported, RCA is undertaken, and action plans are put in place. Additionally, as lead commissioner for South West London & St Georges Mental Health Trust, the committee reviews all incidents that the Trust reports.

As we move into 2016/17 the CCG is looking at how incidents are reported through the Quality Committee so that, as well as understanding individual incidents, the CCG can highlight any common themes or patterns in safety. This will ensure that we hold providers to account for the quality and safety of care given to local people.
The Merton Clinical Quality Committee provides challenge and assurance that issues are addressed.

Amber alerts

The CCG has introduced a system that allows GPs to raise concerns – and also praise providers that have provided a good service. Having been initially piloted with one practice in October 2016, by the end of the year twelve practices had used the service at any time over the six months; from the initial two alerts in October, the number submitted had grown to 40 in March. We will now be looking to gain feedback on the service to improve it during 2016/17.

Common themes for the alerts included ‘communication’, ‘referral/appointment issues’ and concerns regarding the ‘standard of care’.

Alerts that are classified as ‘high’ or ‘severe’ risks are sent for investigation with the providers. As with safety incidents, these alerts are also reviewed by the Merton Clinical Quality Committee.

NHS Safety Thermometer

The tool started out by allowing NHS teams to measure the proportion of patients that are ‘harm free’ from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism. This is a point of care survey that is carried out on 100% of patients on one day each month and is possibly the largest patient safety data collection of its kind in the world. This is the ‘Classic’ thermometer that is published for each month.

The tool has been expanded though, and now staff report on:

- medication safety which measures the following harms: Medication Reconciliation, Allergy Status, Medication Omission, and identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework
- mental health, which measures the following harms: self-harm, psychological safety, violence and aggression, omissions of medication and restraint (inpatients only)
- maternity, which measures the following harms: Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety ans
- children and young persons, which measures the following harms: Deterioration; Extravasation; Pain; Skin Integrity.

The CCG regularly receives updates on the ‘safety thermometer’ harms. As with other patient safety issues or concerns, these are discussed with providers at their Clinical Quality Review Group. The Merton Clinical Quality Committee provides challenge and assurance that issues are addressed, and lessons learned.
NHS Constitution Pledges

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target (%)</th>
<th>2015/16 year to date (%)</th>
<th>2014/15 year to date (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT 18 weeks (admitted patients)</td>
<td>90.0</td>
<td>80.7</td>
<td>88.2</td>
</tr>
<tr>
<td>RTT 18 weeks (non admitted patients)</td>
<td>95.0</td>
<td>92.4</td>
<td>94.8</td>
</tr>
<tr>
<td>RTT 18 weeks (incomplete pathways)</td>
<td>92.0</td>
<td>91.5</td>
<td>92.1</td>
</tr>
<tr>
<td>Diagnostic tests waiting time</td>
<td>99.0</td>
<td>98.9</td>
<td>96.8</td>
</tr>
<tr>
<td>A and E waiting times</td>
<td>95.0</td>
<td>92.1</td>
<td>93.8</td>
</tr>
<tr>
<td>Cancer two weeks</td>
<td>93.0</td>
<td>91.0</td>
<td>96.9</td>
</tr>
<tr>
<td>Breast symptoms two weeks</td>
<td>93.0</td>
<td>94.9</td>
<td>96.4</td>
</tr>
<tr>
<td>Cancer first definitive treatment 31 days</td>
<td>96.0</td>
<td>97.1</td>
<td>98.9</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, surgery</td>
<td>94.0</td>
<td>99.0</td>
<td>97.3</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, drug</td>
<td>98.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, radiotherapy</td>
<td>94.0</td>
<td>96.9</td>
<td>97.7</td>
</tr>
<tr>
<td>Cancer composite, 62 days first treatment plus rare cancers</td>
<td>85.0</td>
<td>89.2</td>
<td>83.4</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, screening</td>
<td>90.0</td>
<td>86.7</td>
<td>95.2</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, consultant upgrade</td>
<td>92.9</td>
<td>88.9</td>
<td></td>
</tr>
<tr>
<td>Ambulance Red 1 – 8 minute response</td>
<td>75.0</td>
<td>68.5</td>
<td>67.6</td>
</tr>
<tr>
<td>Ambulance Red 2 – 8 minute response</td>
<td>75.0</td>
<td>63.3</td>
<td>59.7</td>
</tr>
<tr>
<td>Ambulance Red 19 minute transportation</td>
<td>95.0</td>
<td>93.6</td>
<td>92.0</td>
</tr>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>RTT 52 weeks (admitted patients)</td>
<td>0</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>RTT 52 weeks (non admitted patients)</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>RTT 52 weeks (incomplete pathways)</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>MRSA (PIR assigned)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>C Difficile</td>
<td>2 per month</td>
<td>24</td>
<td>26</td>
</tr>
</tbody>
</table>
Referral to treatment (incomplete pathways)
This states that patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral; this should be achieved for 92 per cent of patients. From March 2016 onwards, the CCG has been working with the Trust to review demand on services, along with the capacity of those services to treat patients.

This standard states that patients waiting for a diagnostic test should wait fewer than six weeks from referral. The Nelson Local Care Centre opened on 1 April 2015 to allow more people to be seen, diagnosed and treated as quickly as possible, and Merton CCG will be continue working closely with all providers to ensure that this standard is met in 2016/17.

A&E waiting times
The A&E standard is that patients should have a maximum four-hour wait in A&E from arrival to admission, transfer or discharge; this should be achieved for 95 per cent of patients. This standard has not been achieved for Merton CCG patients throughout 2015/2016, which reflects a London-wide challenge in A&E performance. Since September 2015, each of the three local providers has under-performed. There have been particular pressures with our acute Trusts this year, due to higher than expected demand, bed management issues, capacity in the Emergency Department, delays in treatment decisions and waits for specialist advice. Merton CCG is working closely with Trusts and their lead commissioners to review progress against improvement plans. Merton CCG collaborated with Wandsworth CCG to review all elements of the emergency care pathway and we are monitoring their improvement trajectory closely.

Cancer standards
There are eight government pledges on waiting times for patients with, or suspected to have, cancer. For Merton CCG patients in the year to date, as at January 2016, these have been achieved for six of the eight; the two pledges not achieved are the 93 per cent standard for two-week waits (90.5 per cent), and the 90 per cent standard for 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer (86.8 per cent).

Performance against the two-week wait standard has improved over the year. Poor performance between July and November, however, meant that the target was not achieved for the financial year.

Performance against the 62-day standard is often difficult, as it relates to small numbers of people who are treated on often complex pathways across multiple providers. The CCG worked closely with our main cancer services provider, St George’s, throughout 2015/2016 to oversee a remedial action plan to improve cancer performance in a sustainable way. This included ensuring we commissioned sufficient capacity to cope with the increasing demand for high-quality cancer services, reducing the occurrence of delayed inter-trust transfer of patients awaiting cancer diagnosis or treatment, and overseeing the delivery or process improvement projects within our providers to make sure patients referred with suspected cancer symptoms are seen and treated within a reasonable and safe time. Whilst work continues to be done, we have observed a month-on-month improvement in cancer performance and are committed to delivering cancer performance standards across all areas.

Work has taken place to increase and improve the local availability of intermediate care beds in Merton, with up to 24 beds now available.
**Ambulance response times**
London Ambulance Service NHS Trust (LAS) has been performing poorly on response times since March 2014. The Trust was placed in the special measures regime in response to a recommendation from the Care Quality Commission (CQC) following an inspection in June 2015. As part of this move, the NHS Trust Development Authority (now part of NHS Improvement) put in place a wide-ranging package to support LAS to deliver rapid improvements to Londoners. This will be monitored closely in 2016/2017 and a number of actions will be taken with commissioners in south west London to ensure the improvement is delivered.

**Mixed-sex accommodation breaches**
All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except ‘where it is in the overall best interest of the patient’. There have been three breaches of this standard for Merton CCG patients. Each breach is investigated by the relevant Clinical Quality Review Group (CQRG). Patients are advised of the issues at the time of the breach.

**Methicillin-resistant Staphylococcus aureus (MRSA) & Clostridium Difficile (C Difficile)**
The NHS is committed to reducing the incidence of avoidable harm. As part of this, infection control has been a high priority for all NHS providers, and each case of MRSA or C Difficile is investigated and reviewed at the relevant provider Clinical Quality Review Group. There have been three cases of MRSA for Merton CCG patients, and 24 cases of C Difficile.

**Improved health outcomes**
In addition to the NHS Constitution pledges, national and local indicators are used to drive local improvements in health care quality and outcomes. These are taken from the CCG Outcomes Indicator Set and provide clear, comparative information for CCGs, Health and Well-Being Boards, local authorities, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.
Achievement of the quality premium is as follows:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2014/15 outturn</th>
<th>Target 2015/16</th>
<th>2015/6 year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing emergency avoidable admissions</td>
<td>3108</td>
<td>Against same period last year</td>
<td>2927</td>
</tr>
<tr>
<td>Unplanned hospitalisation care for chronic ambulatory care sensitive conditions</td>
<td>1032</td>
<td>Against same period last year</td>
<td>976</td>
</tr>
<tr>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</td>
<td>129</td>
<td>Against same period last year</td>
<td>93</td>
</tr>
<tr>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>1789</td>
<td>Against same period last year</td>
<td>1706</td>
</tr>
<tr>
<td>Emergency admissions for children with lower respiratory tract infections (LRTI)</td>
<td>158</td>
<td>Against same period last year</td>
<td>152</td>
</tr>
<tr>
<td>Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays</td>
<td>22.3%</td>
<td>22.7%</td>
<td>22.1%</td>
</tr>
<tr>
<td>A reduction in the number of antibiotics prescribed in Primary Care</td>
<td>1.068</td>
<td>1.046</td>
<td>0.930</td>
</tr>
<tr>
<td>Reduction in the proportion of broad spectrum antibiotics prescribed in Primary Care</td>
<td>13/9%</td>
<td>13.06%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Secondary Care providers validating their total antibiotic prescription data</td>
<td>N/A</td>
<td>N/A</td>
<td>G</td>
</tr>
<tr>
<td>Electronic Prescribing System</td>
<td>34.0%</td>
<td>51.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Increasing number of people diagnosed with type 2 diabetes accessing structured education</td>
<td>302</td>
<td>332</td>
<td>317</td>
</tr>
<tr>
<td>Improve diagnosis rate diabetes</td>
<td>N/A</td>
<td>5.86%</td>
<td>5.38%</td>
</tr>
<tr>
<td>Snapshot of number of people delayed on the last Thursday of the month (beds blocked)</td>
<td>84</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Total number of delayed Transfer of Care days due to both NHS and social care</td>
<td>36</td>
<td>3</td>
<td>82</td>
</tr>
<tr>
<td>Total number of delayed Transfer of Care days due to NHS</td>
<td>1613</td>
<td>134</td>
<td>2444</td>
</tr>
<tr>
<td>Total number of delayed Transfer of Care days due to social care</td>
<td>307</td>
<td>26</td>
<td>1540</td>
</tr>
<tr>
<td>Dementia – estimated diagnoses rate (65+)</td>
<td>72.1%</td>
<td>67.0%</td>
<td>75.9%</td>
</tr>
<tr>
<td>IAPT Access</td>
<td>16%</td>
<td>15%</td>
<td>1.4%</td>
</tr>
<tr>
<td>IAPT Recovery Rate</td>
<td>38.9%</td>
<td>50%</td>
<td>39.3%</td>
</tr>
<tr>
<td>IAPT – 6 week wait</td>
<td>95%</td>
<td>75%</td>
<td>53.4%</td>
</tr>
<tr>
<td>IAPT – 18 week wait</td>
<td>100%</td>
<td>95%</td>
<td>86.2%</td>
</tr>
</tbody>
</table>
Reducing emergency avoidable admissions
These indicators measure emergency admissions that could have been avoided through better management in primary or community care for adults and children. Four indicators are aggregated into a total number of emergency avoidable admissions; the target is for a reduction against the number in the previous year.

We have seen a slight rise in all categories of admissions except ‘unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s’.

Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.
When medically appropriate, patients should be discharged at weekends as easily as during the week. This needs to be seen as a ‘whole-system’ issue; with discharge planning requiring co-ordination between health and social care partners.

The CCG set a target of 22.75 per cent of patients admitted as an emergency to be discharged at weekends or on bank holidays.

Prescribing indicators
Merton CCG has identified four prescribing indicators (targets for 2015/2016 in brackets). These are:

- reduction in the number of antibiotics prescribed in Primary Care
- reduction in the proportion of broad spectrum antibiotics prescribed in Primary Care (13.06 per cent)
- Secondary Care providers validating their total antibiotic prescription data
- items prescribed using an Electronic Prescribing System (51 per cent)

The first three of these have achieved the targets set; the latest figure for the use of an Electronic Prescribing System is now at 40 per cent.

Diabetes
The CCG has an intention to improve the number of people diagnosed with diabetes entering a structured education programme; and the diagnosis rate for diabetes. In 2015/2016 Merton CCG has successfully reduced the percentage of individuals with undiagnosed diabetes and increased the number of individuals accessing structured education in line of the local Quality Premium targets.

Delayed transfers of care
Delayed transfers of care occur when a patient who has (or is likely to have) ongoing care and support needs is ready to be discharged from hospital but it is not considered safe to do so because either their care and support needs have yet to be assessed or their package of onward care has not been put together. This potentially contributes to worse outcomes for the individual, particularly in the context of their quality of life, as well as placing additional and sometimes costly burdens on the NHS.

Merton CCG has set targets for 2015/2016 that delays should be reduced from 2014/2015 outturn. This is measured as a snapshot of patients; and the number of days where patients occupied a bed, split by responsibility for the delay (targets in brackets):

- snapshot of the number of patients delayed on the last Thursday of each month (no more than seven a month)
- total number of delayed Transfer of Care days due to both NHS and Social Care (no more than three days a month)
Merton CCG are very pleased to have once again improved the dementia diagnosis rate.

- total number of Delayed Transfer of Care days due to NHS (no more than 134 days a month)
- total number of delayed Transfer of Care days due to Social Care (no more than 26 days a month).

To date, there has been a higher number of delays across all of the categories than reported for a similar period in 2014/2015. This is being closely monitored by our team in collaboration with Merton Council.

**Dementia estimated diagnosis rate (65+)**
The CCG is very pleased to have once again improved the dementia diagnosis rate from 72.1 per cent at the end of 2014/2015 to 75.3 percent in March 2016.

**Improving Access to Psychological Therapies (IAPT)**
Psychologies Therapies – or talking therapies – are recommended by National Institute for Clinical Excellence (NICE) for many people with depression or anxiety disorders. Merton CCG commissioned a new provider in 2015/2016; it took over the contract from 1 October 2015. Initially this was challenging for the new provider, who inherited a significant waiting list. While performance against targets was initially lower than planned, this has improved in the latter months of the year; with the recovery rate reaching the 50 per cent target in February 2016.
The work of the CCG this year

The following section describes the work of the CCG.

The CCG has focused on eight key delivery areas over the past year:

- Older and vulnerable adults
- Mental Health
- Children and Maternity Services
- Keeping healthy and well
- Early detection and management
- Urgent Care
- Medicines optimisation
- Transforming Primary Care

Older and vulnerable adults

Holistic Assessment and Rapid Investigation service (known as HARI)

With the opening of the award-winning Nelson Health Centre in April 2015, a new Holistic Assessment and Rapid Investigation service (known as HARI) was introduced in order to manage more complex needs in the community.

HARI delivers high-quality, accessible and responsive community-based holistic assessment, investigation and treatment for people with long-term conditions, co-morbidities or frailty, where primary care services need extra support in order to provide the best possible care.

HARI aims to keep patients well, promote independent living and empower patients to improve self-management of long-term conditions. It plays an important role in bringing care closer to people’s homes and in preventing avoidable hospital attendances and emergency admissions.

The service is led by a geriatrician (who works in acute and community settings) and is delivered by a multi-disciplinary team including advanced nurse practitioners, physiotherapists and occupational therapists. Over the year the team has been expanded and now includes a pharmacist and a community navigator, enabling a greater range of services and support to be provided.

When the model started in April 2015, the service offered routine appointments. At the end of January 2016, the urgent HARI pathway commenced. Initially the urgent pathway has involved accepting referrals for Merton patients directly from geriatricians working in the Medical Assessment Unit at St George’s, enabling HARI to support their management in the community and preventing a hospital admission. As the capacity of the service develops, the urgent pathway will be available to GPs and other geriatricians working in Acute Trusts.

The HARI service received over 500 referrals from April 2015–February 2016 and positive feedback has been received from patients about their experience of the service.

St George’s NHS FT have also commenced their frail elderly pathway, which enables a comprehensive geriatric assessment to take place on arrival to hospital and enable prompt and safe discharge and where appropriate onward referral to HARI.

Dr Caroline Chill, Clinical Director for Older and Vulnerable Adults said: ‘We are delighted to have commissioned such an innovative model of care and look forward to expanding the service so a wider range of people can benefit.’
With the opening of the award-winning Nelson Health Centre in April 2015, a new Holistic Assessment and Rapid Investigation service was introduced to manage more complex needs in the community.
Increase in intermediate care beds

Work has taken place to increase and improve the local availability of intermediate care beds in Merton, with up to 24 beds now available in Merton. One of the nursing homes commissioned to deliver the beds has recruited additional nursing staff to improve clinical quality and increase clinical leadership.

Continuing healthcare

Since April 2013 the Continuing Healthcare service (CHC) has been delivered on behalf of Merton Clinical Commissioning Group (CCG) by the South East Commissioning Support Unit (SECSU). The CCG monitors the delivery of the service through regular quality and performance meetings, including the response to a number of complaints about the service.

As a result of close monitoring a number of operational, financial and governance problems were highlighted during the

Case study

Clara Jones, the new Community Navigator began work in January 2016.

‘I work in the Nelson Health Centre as part of the Holistic Assessment and Rapid Investigation (HARI) service. The HARI service supports anyone over 18 who has multiple health problems, so this is mainly older adults, but could be anyone over 18 who lives in Merton.

‘The main part of my role as part of HARI is helping people to 'navigate' their way to local activities, volunteer opportunities, services and support to improve their health and wellbeing. I work with patients, carers and medical staff to help participants identify what support they need and what activities might benefit their wellbeing, health and happiness. Not everyone has access to a computer, has someone to encourage them to try something new or has the energy to visit lots of different places to see what they offer. That's where community navigation comes in.’

Falls prevention

A Falls Prevention Task and Finish Group with multi-professional and multi-organisational representation reviewed the findings of a Merton Health Needs Assessment undertaken by Public Health. The group drew upon this in order to develop a holistic Falls Prevention Strategy and Action Plan for 2015/2018.

During 2015/2016 direct referrals from the London Ambulance Service to Community Services have increased, with the development of a falls pathway. This enables people who do not need admission to receive the required support and remain independent in the community. With support from Community Services, the number of LAS call outs decreased from 962 in 2014/2015 to 872 in 2015/2016 (a decrease of 90) and the number of resulting conveyances reduced from 843 in 2014/2015 to 760 in 2015/2016 (a decrease of 83).
year to the Executive Management Team, Finance Committee and Quality Committee to include:

- poor patient experience
- lack of clear finance and performance reporting
- quality concerns, particularly in the process for reviewing CHC packages which have not occurred in a timely manner causing a backlog.

Due to lack of progress in addressing these concerns the CCG Governing Body made the decision in January 2016 to explore future options for service delivery. The incoming community service provider Central London Community Health (CLCH) was chosen as the provider to deliver the service, with oversight of the CHC function shared between Merton and Richmond CCGs to provide an independent level of scrutiny of the CHC process and service delivery. It is expected that the transition of the current service to CLCH will be complete by 30 June 2016.

**Dementia**

Community Dementia Nurses have been introduced into the community integrated locality teams. These nurses have a vital role in the care planning, delivery and coordination for individuals with dementia and adopt a holistic approach to ensure their physical and mental health needs are met.

Further progress has been made in relation to the dementia diagnosis rate. More memory assessment clinics now take place at the Merton Dementia Hub, which is a unique, community-based centre where a range of support services for people with dementia and their carers is provided.

More memory assessment clinics now take place at the Merton Dementia Hub, which is a unique, community-based centre where a range of support services for people with dementia and their carers are provided. As part of the memory assessment service pathway, people who receive a dementia diagnosis are immediately given the opportunity to speak to Dementia Advisers who provide personalised information, advice and guidance to people with dementia, from the point of diagnosis onwards; they also signpost and facilitate access to services in the borough to ensure that people with dementia have the help and care they need. Dementia Support Workers provide personalised practical and emotional support to people with dementia, their carers and their families depending on people’s needs.

A Dementia Health Needs Assessment has been completed by the Public Health team at Merton Council. This will be drawn upon in order to develop a new five-year Dementia Strategy for Merton which will play an important role in enhancing service provision in the borough both for people with dementia and their carers.

**Community services**

Procurement began in April 2015 for new community services providers. The evaluation and moderation of the bids were completed in August and the final procurement report was approved at the Project Board, Merton Borough Council’s (LBM) Cabinet, Finance Committee and the CCG Governing Body during September. The CCG and LBM decided to award a contract to Central London Community Health NHS Trust for a wide range of children’s and adult community services and the CCG decided to award a contract to Connect Physical Health
Patient Story

Harry was diagnosed with Alzheimer’s disease nearly five years ago. In 2015, he and his wife Joan moved to Merton to be closer to their son and daughter-in-law. Harry was referred to the Dementia Hub by a Community Psychiatric Nurse, and within a fortnight, a Dementia Services Adviser visited Harry and his family at home.

The Dementia Adviser was able to give Harry and his family a range of specialist information relating to dementia and tell them about support groups, workshops and courses that are especially designed for people with dementia, as well as their family and carers. Harry and Joan were interested in the Dementia Hub’s Blue Sky Café and Record club, and Joan was keen to take part in the courses. She also showed an interest in the Dementia Support Worker service, as she felt she would like someone to talk to and support her directly.

Although Harry is independent in many ways, his wife has to prompt him to take his medication and prepares all their meals. The Adviser told Harry and his family about financial support he may be entitled to, including Attendance Allowance and Council Tax exemptions. Harry likes to stay active and enjoys walking. As his family were concerned about Harry’s safety, the Adviser set out a number of practical options, such as using daily living aids, joining a walking group, carrying a mobile phone or making use of local agencies who can provide care staff to accompany clients on outings.

Harry and his family now keep in regular touch with their Dementia Adviser. She is their named contact and supports them in accessing services they may need – and services that they may not have otherwise known about.

Harry’s son James said: ‘It was very useful and instructive for us as we are still very new to all of this even though the diagnosis was almost five years ago now…. I just think dad was missing a support network around him (before he moved) but we see very positive support from the Hub and the memory clinic on top of an excellent GP here. With sincere thanks for the great work that you do.’

Limited for musculoskeletal (MSK) and outpatient physiotherapy services. These were announced publicly on 6 October.

The decision to move to new providers was the result of a thorough and detailed procurement process which had the overall goal of delivering improved health and well-being outcomes through community health services. The procurement involved Merton GPs, Important areas of work will be:

- discharge to assess pathways with a trusted assessor agreement between health and social care in order to reduce the number of delayed discharges of care.
- information sharing via an IT interoperability platform that enables sharing of clinical and care records.
- identification and case management of people at highest risk of admission to hospital and deterioration of their independence.
- further development of multi-disciplinary team working based on MDT meetings and a joint assessment process.
Carers

Two engagement events for carers took place during September 2015 which provided the opportunity for carers to:

- share views and experiences of caring for a relative or loved one in Merton.
- consider the support that is currently available for carers in the borough.
- identify the most important areas that should be focussed on in terms of developing local services.
- discuss ways in which the support for carers in Merton could be improved.

The outputs of engagement events helped us identify key areas for development. Work is now under way to develop a joint Carers Strategy with Merton Council. It is expected that the strategy will be ready by Autumn 2016.

People with learning disabilities, autism and mental health conditions

In the summer, the CCG launched ‘No voice unheard, no right ignored: a consultation for people with learning disabilities, autism and mental health conditions.’ The consultation asked people to comment on assessment and treatment in mental health hospitals for people (all ages) with learning disability or autism; and adult care and support, primarily for those with learning disability but also for adults with autism and the links to support for children and young people.
New step-down services

South West London and St George’s Mental Health Trust, working with the CCG and community groups, led the re-procurement of a Step-down service in Merton to provide a focussed 12-week recovery pathway supporting people to live well independently in the borough. During the procurement period an interim service was put in place, based on the principles of recovery. This proved successful with the five patients who used the service all successfully moving on to independent living within the 12-week recovery pathway.

Merton Mental Health Forum

The CCG has established a strong working relationship with Merton Mental Health Forum this year establishing a robust engagement pathway to ensure our residents and service-users stay well informed, involved and have lots of opportunities to inform and help influence local mental health services.

The new arrangement is helping to ensure that the CCG works even more closely with key organisations and their stakeholders regarding mental health services. The Mental Health Forum becomes a key partner in supporting the CCG to engage and encourage service users and carers to help influence and shape mental health services in the borough.

The Senior Commissioning Manager for Mental Health Services now attends every meeting to hear people’s concerns and to answer questions.

Mental Health

Improving Access to Psychological Therapies (IAPT)

The CCG completed the procurement of a new IAPT service during 2015 and the new service started on 1 October 2015. The new provider (Addaction) is working with the CCG to embed the new service. This included addressing a larger-than-expected waiting list for the service from 1 October 2015 and striving to achieve an improved recovery target of 50 per cent for this patient group.

The rates of referrals in the first six months have been encouraging with self-referral being offered for the first time and making up to 60 per cent of all referrals. Recovery rates for patients using the service have also strengthened with a 50 per cent recovery rate in February 2016 and a 56 per cent recovery rate for March 2016. We look forward seeing further sustained progress in 2016/2017.

Crisis Care Concordat

We established a Merton Crisis Care Concordat group this year which includes the CCG, Merton Council, South West London and St George’s Mental Health Trust and the Metropolitan Police. This group developed an action plan for the borough which was shared nationally on the Crisis Care Concordat website. There is more work needed now to include a wider range of stakeholders to start working with the group to address some of the bigger actions in the plan.
Psychiatric Liaison Services

In South West London all CCGs have worked with acute providers and South West London St George’s Mental Health Trust in order to introduce Core 24 Psychiatric Liaison Services.

Children and Maternity Services

1 Children’s Services including Child and Adolescent Mental Health services (CAMHS)

The CCG has continued to strengthen engagement with local and sector-wide providers of children’s services through multi-agency meetings and partnership boards to develop pathways and service provision. This has resulted in the continued review and development of key areas, particularly models of care for Looked After Children (LAC), Children with Complex Needs, Continuing Healthcare, Education Health and Care Plans (EHCPs) and Mental Health.

There has been collaborative working across South West London in the development of pathways through the SWL Children’s Clinical Network.

Increased investment into mental health services

The CCG allocated additional investment into mental health services to support children with eating disorders and liaison nursing in A&E to improve access and outcomes for children and young people. The single point of access began in October 2015. Feedback to date has been positive. In Q4 2015/2016 93.3 per cent of children and young people were assessed within eight weeks (target 80 per cent). This compares to 75 per cent at the same point in 2014/2015.

There has also been investment allocated to supporting children who have experienced sexual assault.

CAMHS transformation

The CAMHS transformation plan was developed in collaboration with partners based on local need following a CAMH Health Needs Assessment and Service Review (June 2015) and submitted and approved by NHS England in December 2015.


Work completed as a result in 2015/2016 includes:

- a training needs analysis was undertaken which will inform of the new training strategy to help to build capacity and capability across the workforce. Training has already commenced to enhance knowledge and how to identify a range of strategies that can be supportive to your staff and the child as mentoring. Training is also being provided to social care, special educational needs and disability service, youth justice and foster carers to enhance knowledge and skills.
a Merton CAMH conference for professionals was held in January 2016 bringing together over 70 professionals including health, social care, education, early years and the voluntary sector.

- dedicated working to improve links between CAMHS, health, social care, and education which has resulted in shared principles and commitment to improve outcomes for children and young people. It was agreed that initially ASD/ADHD would be focused on in 2016/2017 with key actions agreed.

- implementation of an enhanced Eating Disorder Service in 2015/2016 across south west London to increase capacity and enhance provision. This includes further online resources, a day service, increased therapies on offer, group therapy, multi-group family therapy and improve integrated service delivery for physical health check as well support between out-patients and day care. It is estimated that 24 more children and young people will be seen by year in Merton.

- the implementation of a seven-day service for liaison nursing across South West London to meet the London Quality Standards will provide improved access for children and young people. It is estimated in Merton that 52 more children will benefit from this service in Merton.

- pilots to support pre- and post-neurological assessments for ASD/ADHD to support children, young people and families/carers.

Early years
A review of the early years agenda at the start of the year led to the development of best practice in children’s centres (Early Years Pathways) to ensure a robust pathway and good communication between professionals who deal with young children. A workshop was held in November 2015 to identify priorities for pathway development and information sharing.

2 Maternity
During 2015/2016 the CCG has strengthened engagement and working relationships with local and sector-wide providers of maternity services through the SWL Maternity Clinical Network and Merton Early Years Partnership Board. An agreed dashboard enables better monitoring across South West London.

Maternity specification
A maternity service specification has been developed alongside the London Strategic Clinical Network service specification. The maternity services specification aims to ensure that all providers work to the same model of care to improve patient experience and service quality and to reduce unwarranted variation across South West London.

Audit
Trusts undertook audits of readmissions, post-partum haemorrhage, complaints and serious incidents through the south west London Maternity Network. The results are being used to improve processes and practice.
Keeping healthy and well

Merton CCG has been at the forefront of the prevention agenda in partnership with London Borough of Merton Public Health during 2015/2016. This is evidenced by the continued inclusion of Keeping Healthy and Well as a key workstream, and the appointment of a GP Clinical Director for this area.

During 2015/2016, the development of diabetes prevention service, the early diagnosis of Type 2 diabetes, and some respiratory conditions and the initiation of the development a model of care for East Merton have been the priority areas of work.

Merton CCG, together with Merton Council, has developed a proposal for Merton to become a first-wave implementer of the National Diabetes Prevention Programme. The joint bid submitted by all the south London CCGs was successful and a new diabetes prevention service will begin in Merton in June 2016.

Drug and alcohol services

The CCG and Merton Council Public Health team have been working together to develop a more integrated service specification for drug and alcohol services. This work is on-going and will conclude in 2016/2017, but there has been a real drive to try to ensure that these services are easy for patients to access and navigate.

A review of alcohol treatment Tier 4 services was completed and a joint alcohol pathway is being designed between Merton Council and the CCG. The aim is to make sure treatment services can be offered closer to home and in the community. The aim is to see a substantial reduction in alcohol specific hospital admissions.

Proactive GP pilot

The Proactive GP pilot launched in Autumn 2015 to run for six months in the more deprived areas of Merton. The pilot sought to embed prevention in primary care and to reduce variation in relation to long-term conditions between GP practices. The pilot supported the 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 focused on smoking and chronic obstructive pulmonary disease (COPD), a condition caused predominately by smoking. Symptoms include frequent chest infections and breathlessness.

GP practices were asked to train their own frontline staff as health champions to screen local people and either to provide stop smoking services directly or refer into the LiveWell stop smoking service.
As well as community-based health champions, GPs were also be part of the pilot and proactively carried out the same assessment on patients at their surgery who were known smokers.

As part of the Proactive GP pilot front line staff were trained through Royal Society for Public Health (RSPH) NVQ1 and 2 Accreditation to provide brief advice and signposting to lifestyle prevention services. In addition, this training is offered to front-line staff across Merton in the NHS, local government and the voluntary and private sectors. Six GP Health Champions have been trained.

**East Merton Model of Health and Well-Being**

In 2015/2016 Merton CCG and the 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.

The population profile in the east and south of the borough is younger, more deprived, and more multi-ethnic and is more likely to be diagnosed with long-term conditions at a younger age. The Model recognises that reducing variation in early detection is one of the most important things the NHS can do to address health inequalities.

The East Merton Model Health and Well-Being project is one of the key strategic priorities for developing and improving care and health services in Merton. It is being jointly led by Merton CCG and Merton Council. It has two over-arching objectives:

- to develop a model of care that meets the health and social care needs for the people of East Merton; and
- to provide a new Health Centre on the Wilson Hospital site that supports the delivery of this new model of care.

To take the work forward, Merton CCG and Public Health Merton commissioned a specialist agency to examine the evidence, views and current provisions for health and social care and to co-produce a model of care for East Merton.

A workshop was held in December to consult and explore potential models of care with all the major stakeholders in the borough. Attendees were drawn from local health, social care and public health professionals, representatives from the voluntary sector and service users.

At the end of January 2016 the initial findings were shared with the Patient Engagement Group and the Health and Well-Being Board and to agree next steps. In March 2016, a group of 50 stakeholders, including GPs, councillors, the local MP and CCG leaders, visited Bromley-By-Bow Health Centre to see their innovative scheme and to see what might be applicable for Merton.

**Development of the new health facility in Mitcham**

We need to agree our Model of Care before we finalise the design for the building. The model requirements will shape the design of the building.

The development of the new health facility will act as a hub for the Model of Care. The new building will need to effectively bring together the partners, providing facilities and space that will not
only support, but enable this fully integrated way of working with patients and residents.

The Community Health Partnerships Investment Committee has approved the scheme to be constructed as a New Project for South London Health Partnership (LIFTCo). They have undertaken an affordability analysis which has just been completed. The next steps will be to appoint the building design team and technical experts and to begin the initial site feasibility before starting the design development of the new facility.

**Development of the Merton Model of Health and Well-Being**

Work began in December 2015 and is closely linked to both the development of plans for the Mitcham Local Care Centre and the realisation of the Whole Merton Strategy. The model will describe how services across the whole spectrum of health, social care and voluntary sector can work together to provide more local, integrated and preventive and proactive care.
Early detection and management

In 2015/2016 Merton CCG has worked closely with a range of partners, including statutory and voluntary organisations, to support the development and delivery of projects and initiatives relating to the early detection and management workstream.

Cancer

In 2015/2016 the CCG jointly developed a cancer strategy with clinical leads, the commissioning team and Merton Public Health. The strategy was informed by national guidelines and findings of the Cancer Health Needs Assessment produced by Public Health Merton. The resulting action plan encompasses the entire cancer pathway from prevention via early detection and management to living with and beyond cancer.

A bid for NHS England funds was successful for a pilot programme in primary care to increase bowel cancer screening uptake, called the ACE (Accelerated, Coordinated and Evaluated) Bowel Cancer Screening Programme. This is being overseen in close partnership with Merton Council.

Merton Public Health also completed a Prostate Cancer Briefing document for Merton CCG. The paper will support the CCG to deliver appropriate initiatives to improve the prostate cancer care pathway in 2016/2017.

Throughout the year the Macmillan GP has been visiting GP practices in Merton to raise the profile on cancer and to support the early detection of cancer agenda. She also held two education sessions about cancer for ethnic minority groups during the ‘Be Clear on Cancer’ campaign in the summer of 2015. The CCG also supported the NHS national ‘Be clear on cancer – blood in your pee’ campaign in the spring of 2016.

Community MSK and Physiotherapy Services

In 2015/2016 MCCG invested additional funding into our local community MSK and Physiotherapy services to deliver an enhanced service and reduce waiting times.

An enhanced community MSK and physiotherapy service was procured during 2015/2016 and the new service began on 1 April 2016. Through this contract GP referrals are being consolidated into one provider, with a single referral route for related referrals into secondary care.
**Diabetes**

The CCG has worked closely with NHS England on the re-procurement of the Diabetic Eye Screening Programme (DESP). The CCG helped to ensure that the service location remained in the Nelson Health Centre and patients experienced a seamless transition between service providers.

During 2015/2016 the CCG has focused on timely Type 2 diabetes diagnosis in primary care and worked towards ensuring that more patients are referred to a structured education programme. There have been key achievements in these areas and progress has been monitored within the Quality Premium framework. As a result the CCG can report on improved access to structured education and a reduction in patients with undiagnosed diabetes in the borough.

Merton worked with other south London CCGs on a successful bid to become a first wave implementer of the National Diabetes Prevention Programme. The model for Merton is linked to the Public Health-run NHS Health Checks Programme and will be closely linked to the newly-procured integrated weight management, healthy lifestyles and stop smoking service.

**Nelson Health Centre**

The Nelson Health Centre opened to the public on 1 April 2015, offering a range of services in a convenient community location:

- primary care
- diagnostics
- consultant-led outpatient consultation
- assessment and investigation
- diabetic eye screening
- MSK and outpatient physiotherapy
- podiatry
- endoscopy and minor procedures
- community pharmacy.

Previously, whenever a Merton patient needed to see a specialist for assessment or treatment, they had no choice but to travel outside the borough, and often faced lengthy waiting times. The Nelson Health Centre now offers our patients outpatient and diagnostic services in a local Merton setting. In addition there is an on-site pharmacy.

**Respiratory conditions**

A bid was developed with the support of Public Health for Merton to be an early site for LTBI (Latent TB Infection) testing under the National TB Control Strategy. This bid was successful and in close partnership with Public Health, the programme commenced in April 2016.

A Health Needs Assessment for asthma was completed at the end of 2015/2016. The findings will feed into the development of the 2016/2017 respiratory services work package.

The CCG has piloted a clinical health coaching telephone service for patients with COPD to support them to manage their condition and stay well. The results of this pilot are now being evaluated.
**Patient story: Mr Andy Ray**

‘This is just to convey my more-than-pleasant surprise to see the re-developed Nelson Hospital (when I went in for a blood test this morning). It is immaculate in every sense of the word. I am genuinely pleased with the design, and it is so convenient having all the facilities in one place. With such a nice building, it is no wonder all the staff provided such a friendly service. I have told all my neighbours about the Nelson!’

*Visited in May 2015*

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**Patient story: A five-star review on NHS Choices regarding a patient’s experience of using the Centre: Cystoscopy (done at Nelson Health Centre)**

‘Following a bladder infection I was referred by my GP to St George’s. I was offered an appointment at the Nelson Health Centre. I was delighted with the new building. The car park had spaces and was very reasonably priced. The reception area was light and spacious. I was seen within a few minutes of the appointment time. The staff were all friendly, efficient and informative as they explained the procedure and I signed the consent form.

‘After an initial screening to make sure the procedure could go ahead, I was asked to get ready. I was presented with intriguing paper ‘dignity’ shorts and a hospital gown. In the operation room, there were two nurses and a consultant. I was apprehensive about how painful the procedure would be and was given helpful and honest information that the administration of the anaesthetic gel would sting. It did! However as told, the pain soon went. Throughout the procedure I was able to see what was happening on screen and everything was explained and my questions answered and thankfully nothing untoward found. Aftercare didn’t take long and once I had passed water I was able to get dressed and go.

‘The nature of the procedure was intimate and could have been embarrassing but I was treated with respect and dignity. I could not have asked or expected more. The modern NHS at its best. Thank you.’

*Visited July 2015*

*Posted on NHS Choices 24 July 2015*
The CCG has been supporting the national campaign ‘Stay Well this Winter’.

**Urgent care**

During 2015/2016 we undertook an integrated review of routine and urgent primary care. This included a review of services currently provided by GP out-of-hours services, the Wilson urgent care centre, NHS 111, general practices, A&E and London Ambulance Services. The CCG felt that existing services should enable people with urgent, but non-life threatening, needs to access responsive, effective and personalised services outside of hospital. Local residents were asked their views about these services and how they would like to access them in the future.

We are now analysing a number of options on how services could change in 2016/2017. This includes looking at evening and weekend access to GPs, and making more efficient use of Merton’s local urgent care centre and community pharmacies. A key component will also be a strengthened clinical triage that links the system together and helps patients navigate it successfully.

**Winter campaign**

The CCG supports a number of campaigns each year that focus on key issues for local people and the organisation. From November through to the end of the financial year the CCG has been supporting the national campaign ‘Stay Well this Winter’ which includes promoting the flu jab for vulnerable and at risk groups, encouraging people to seek help and advice at their local pharmacy and to use 111 and NHS Choices for help and advice to help avoid unnecessary attendance at A&E.
Health Help Now

Health Help Now is an award winning website and smart phone app that the CCG launched at the end of March 2016. The website aims to help people find the right service for their health needs, especially when they need medical help fast but it is not a life-threatening emergency.

It lists common symptoms and offers suggestions for treatment, with the one which works best for most people listed first. Health Help Now then links through to local services, and shows whether they are open or closed, their location and directions.

Patients will also be able to go online or use their smartphone to access self-care and signposting information about common symptoms, real-time opening hours and addresses of local services through Health Help Now, alongside NHS Choices.

A professional reference group involving clinicians and local council representatives was set up to advise on the development of the site. In addition, detailed engagement was undertaken with Merton residents, schools and community and voluntary groups. Merton’s Patient Engagement Group were also involved and invited to comment.

As a result a number of improvements were made to the website including the addition of:

- a list of health-related and non-health-related voluntary organisations and community support groups – sourced from Merton Voluntary Service Council and aligned to appropriate advice, to support integrated care and self-care
- a list of public health prevention and live well links, phone numbers and messages sourced from Merton Council and partners, to support people proactively taking action to improve their health.

http://merton.healthhelpnow-nhs.net
Medicines optimisation

The pharmaceutical needs assessment developed in conjunction with Merton Council in 2014/2015 was published on 1 April 2015. Over the course of the year we continued to ensure that any service commissioning considered the medicines aspects and implications to provide quality, value for money and impartiality of access and ensuring patient safety.

During 2015/2016 the CCG:

- invested in additional pharmacist resource in the CCG to support proactive reviews in primary care.
- worked with GP practices to increase the use of electronic prescribing to get the best out of this innovation.
- implemented proactive repeat prescription reviews in GP practices.
- improved the use of antibiotic prescribing to support the global need to prevent antibiotic resistance by working closely with all GP practices, community pharmacists, out of-hours providers and care homes.
- extended dietician work into more care homes, identified and supported reviews of other patient groups and supported training of care staff and primary care staff.
- started work on the development of guidelines for cow’s milk allergy in children to address the appropriate diagnosis and use as well as spend in this area.
- continued medication reviews in care homes and supported homes with systems for the safe handling, storage and administration of medicines as well as medicines waste reduction.
- commissioned a medicines adherence/support service as part of the community services re-procurement.
- worked with the main provider at the Nelson Health Care Centre to ensure medicines optimisation is central to services provided at the centre.
- worked with primary and secondary clinicians to promote appropriate use of antibiotics locally as part of the 2015/2016 Quality Premium.
continued to maintain good engagement with all providers in particular St George’s University Hospitals NHS Foundation Trust

- opened a community pharmacy at the Nelson Health Centre in September 2015 which is now providing pharmacy services for patients attending the centre.

‘Only order what you need’
The CCG ran a focussed medicines waste initiative during the summer of 2015. The campaign featured a public awareness campaign alongside initiatives involving community pharmacists, care homes, patient groups and GP practices.

The CCG team undertook active reviews of repeat prescriptions for 2015/2016 and attended patient groups, locality meetings, visited individual practices and forums to discuss practical implementation of the campaign.

The public campaign ran for 12 weeks. The key message was ‘only order what you need’. Patients were given leaflets and posters were displayed in GP practices, community pharmacies and care homes. The CCG also arranged for posters to be displayed on buses and a number of bus shelters across the borough. There was active promotion via digital channels including through the CCG’s website, twitter and facebook page. The local media also ran the story.

Transforming primary care
Co-Commissioning and the work of the Joint Committee
In collaboration with other CCGs in south west London, Merton CCG has been working as part of a larger group to plan and develop local primary care health services. A significant amount of work has been undertaken jointly with NHS England over the 2015/2016 financial year. For 2016/2017, Merton CCG will take on the full responsibilities of the GP contract via Co-Commissioning. This is part of a planned programme to continue improving primary care services, including making it easier to access general practice services. It is expected to bring the following benefits to our commissioning functions and partnership arrangements with general practices:

- more local control and flexibility to deliver the Whole Merton vision
- joint working with our neighbouring CCGs partners which will allow Merton CCG to collaborate at scale and share planning and resources
- help to reduce the administrative burden on GP practices and make it easier for them to manage their businesses, freeing up internal resources.

New models for primary care – Federation and MCPs
NHS England’s Five Year Forward View made an unequivocal commitment to ensuring the foundation of NHS care remains list-based primary care. However, it also recognises the pressures GPs are under and proposes a ‘new deal’ for General Practice: over the next five years the NHS is investing more in primary care, while stabilising core funding for general practice nationally over the next two years.
At the same time, new models of care are offered that will give GPs a greater role in the delivery of more services and which in turn, are intended to support the long term sustainability of primary care.

In Merton we fully recognise these challenges and the pressures our GPs are under. We have committed to delivering the London-wide Transforming Primary Care strategy and in 2015/2016, have developed a local work-plan for the next three years for the future of primary care. The work-plan helps to outline how the future sustainability of local GP services rests on the development of a Merton GP Federation and ultimately in the creation of Multispeciality Community Provider(s) (MCPs).

These models offer a focal point for a far wider range of care needed by registered patients, which will bring benefits to whole health and care system as well as securing the principles of registered lists. In 2016/2017 we will be looking to progress our plans for a GP Federation and in the longer term, MCPs. This will have an impact on prevention, early diagnosis and proactive services and in 2016/2017 will be working closely with all our health and care partners to co-design the models of care that will emerge from this work.

**GP referral support – pathway redesign**

Throughout 2015/2016, the CCG has, as part of the Outpatient Navigation programme, fully mapped all major acute pathways on to a software package called DXS so that there is a consistency of approach to referral decisions in each GP practice. Once the software is implemented in 2016/2017, it will support GPs by providing them with the current and relevant clinical material needed for given specialties, (for example, referral forms, care pathways, local healthcare guidelines and patient leaflets). It also contains Merton’s complete Directory of Services which provides GPs with information on all local services including hospital and community.

It is expected to improve the patient experience and provide real-time detailed GP referral information. In turn this enables commissioners to review referral activity to inform commissioning decisions and, if necessary, redesign of care pathways. It will therefore help deliver our aim of more care in the community and closer to (or within) patients’ homes. It will also be a key enabler to helping patients be seen in the right place, at the right time, and by the right clinician.

**Reviewing patient access**

The CCG has been working with member GP practices to review patient access to primary care services, including access to telephone appointments. As part of that work the CCG aims to support GPs to make greater use of technological developments so that patients can access some GP services online.

Patient Online is a new NHS England programme designed to offer patients the ability to access parts of their patient record, to book GP appointments and order repeat prescriptions. We have enabled all practices which have this capability to offer this service.

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**GP referral support – pathway redesign**

Throughout 2015/2016, the CCG has, as part of the Outpatient Navigation programme, fully mapped all major acute pathways on to a software package called DXS so that there is a consistency of approach to referral decisions in each GP practice. Once the software is implemented in 2016/2017, it will support GPs by providing them with the current and relevant clinical material needed for given specialties, (for example, referral forms, care pathways, local healthcare guidelines and patient leaflets). It also contains Merton’s complete Directory of Services which provides GPs with information on all local services including hospital and community.

It is expected to improve the patient experience and provide real-time detailed GP referral information. In turn this enables commissioners to review referral activity to inform commissioning decisions and, if necessary, redesign of care pathways. It will therefore help deliver our aim of more care in the community and closer to (or within) patients’ homes. It will also be a key enabler to helping patients be seen in the right place, at the right time, and by the right clinician.

**Reviewing patient access**

The CCG has been working with member GP practices to review patient access to primary care services, including access to telephone appointments. As part of that work the CCG aims to support GPs to make greater use of technological developments so that patients can access some GP services online.

Patient Online is a new NHS England programme designed to offer patients the ability to access parts of their patient record, to book GP appointments and order repeat prescriptions. We have enabled all practices which have this capability to offer this service.
The Patient Online Project for south west London has the following targets to be achieved over the nine months of the initiative:

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

**ICT strategy**

The effective use of ICT is also critical to help the CCG deliver our commissioning intentions, meet the specific underlying challenges in our local health economy and support the GP localities, which are essential to the future model of health and care delivery within Merton.

We have embraced and will expand the use of ICT to enable our vision and transform the delivery of healthcare in Merton.

In 2015/2016 the CCG agreed its strategic ICT objective was ‘to have in place robust and fit-for-purpose ICT systems and services that support service transformation and enable integration across commissioners and care providers.’

**Estates Service Development Plan**

In June 2015 the Department of Health published guidance to CCGs on the development of local estate strategies ‘Local Estates Strategies: A Framework for Commissioners’ (June 2015). The expectation was that most CCGs would have a local estate strategy in place by the end of December 2015. National and local drivers stress the importance of investment in proactive care, to develop responsive and sustainable primary, community and social care services, integrated and supported by the voluntary sector. This will require the development of new models of care and new organisational arrangements for their delivery.
The objectives of the Estates Service Development Plan for Merton CCG are to:

- understand the health and social care needs that are driving the development of new models of care and how the estate will need to respond to these developments;
- describe the Merton NHS estate as it is now, including opportunities and constraints;
- establish how the estate can best be configured to facilitate the delivery of the new models of care: and
- identify the priorities for investment and opportunities for savings, both short and long term.

Community Education Provider Network (CEPN)

Merton CEPN operates on a purely ‘not-for-profit’ basis and is tasked with collating training needs from general practice. This is managed via our CEPN Steering group, which includes both clinical and non-clinical members from primary care, education providers, pharmacy and the voluntary sector as well as CCG representation.

The CEPN is challenged with creating challenging and fulfilling roles that will appeal to both new (e.g. apprentices) and existing (e.g. nurses) workforce members. Such roles should offer a breadth of primary care experience and continuous career development, increasing job satisfaction and improving retention, with the ultimate aim being to develop a workforce of care professionals who can increasingly be used as appropriate alternatives to a GP.

Care Quality Commission (CQC) inspections

At the beginning of 2014/2015, CQC began revising the format they use for inspecting GP practices with a view to rating Practices in a similar way to the Ofsted inspection ratings for schools. Merton was visited by CQC in May 2014 and eight practices were inspected as part of a pilot for this proposed format.

To support practices prepare and understand the regulatory requirements for CQC visits in 2015/2016, the primary care team met with individual practices to support them in the process.

Performance on other matters

Quality

Merton CCG’s mission is to commission high-quality services for the people of Merton that deliver the right care in the right place at the right time and so achieving the right outcome. The focus on quality as the primary ‘organising principle’ is of paramount importance to the CCG.

Merton CCG strives to commission high-quality care which is safe, clinical effective and provides a good patient experience. Merton CCG expects our patients to be valued, respected, listened to and treated with care and compassion.
Positive outcomes and experiences for patients provide our measure of success in commissioning quality services. Performance indicators that highlight quality include evidence of:

- prompt and timely referrals to specialist services
- waiting times within national guidelines
- treatment adhering to best practice
- reduced hospital admissions and shorter lengths of stay in hospital
- development of innovative and responsive community-based health services, to caring and support people in their own home
- helping people to stay healthy through promoting healthy lifestyles and preventive services
- positive patient and stakeholder feedback on experience of services.

**Quality assurance**

During 2015/2016 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.

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 the 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.

We were the host CCG for Sutton and Merton Community Services (Royal Marsden Hospital NHS Foundation Trust) until 31 March 2016. Central London Community Healthcare NHS Trust succeeded the Royal Marsden on 1 April 2016 and Merton CCG continues to lead the CQRG for this contract.

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.

**Safeguarding children, young people and adults at risk of abuse and neglect**

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

Merton CCG has taken all reasonable steps to promote safe practice and protect children, young people and adults from harm, abuse and exploitation and are fully engaged in the work of the Merton Local Safeguarding Children Board and Merton Safeguarding Adult Board. MCCG as a commissioner of...
health services is fully compliant with the Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2015.

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

Employing the right staff and meeting our statutory requirements in relation to the Disclosure and Barring Service employment checks and safeguarding training

Merton CCG meets statutory requirements in regard to Disclosure and Barring Service (DBS) checks (previously known as a Criminal Records Bureau or CRB check). All eligible staff (as defined by NHS Employers) undergo robust employment checks prior to employment and those working with children, young people and adults at risk undergo an enhanced level of assessment. For staff currently employed by Merton CCG the DBS checks are repeated every three years. These functions and duties are managed through the Merton CCG HR service commissioned through the NHS South East Commissioning Support Unit (SECSU).

Safeguarding training in Merton CCG

The CCG ensures all staff have completed relevant safeguarding training at a level appropriate to their role and this training is regularly reviewed and updated.

Our position with regard to training of staff as of March 2016 is as follows:

- Safeguarding Children: Level 1 (all staff): 93 per cent
- Safeguarding Adults: Level 1 (all staff): 81 per cent

The CCG training offer to all staff has been extended to include PREVENT, promoting the Department of Health Counter-Extremism Strategy (2015), FGM mandatory reporting duties (2015) and Care Act 2014 duties.

In addition, the CCG safeguarding adult policy is currently being updated in line with the Pan-London Policy and Practice Guidance (2016).

Healthcare providers commissioned by CCG have a target of 80 per cent compliance for all safeguarding children training. The NHS Trusts and private healthcare provider organisations delivering services to the residents of Merton Council provide evidence that their staff have completed relevant safeguarding training at a level appropriate to their role.

NHS England has the duty to commission primary care services. Merton CCG has supported Merton GPs in achieving Level 3 safeguarding children training competencies by highlighting the Merton Safeguarding Children Board training offer and the online training from the Royal College of General Practitioners.
Patient and Public Involvement

Vision for engagement

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

Our most recent Patient and Public Involvement report which provides detailed information on our PPI activities is available on our website. www.mertonccg.nhs.uk/GetInvolved/Documents/Public_and_Patient_Engagement_Statutory_Obligations_Report_201415_Merton_CCG.pdf

The report presents information and evidence which demonstrates how we are meeting our statutory duties under 14Z2 of the Health and Social Care Act 2012 (as amended).

In 2015/2016 we have continued to ensure that the patient voice is heard in the planning and commissioning of key strategic projects such as the procurement of community services, in early discussions regarding the NHS five-year strategy and in the development of a Merton model of health and wellbeing.

In January 2016 Merton CCG received feedback from NHS England on the Annual Statutory Obligations Report for 2014/2015 along with the information provided during the 2014/2015 Quarter 4 assurance deep dive on PPI.

The right safeguarding professionals and Governance arrangements

The Merton CCG Chief Officer is the Governing Body Lead for safeguarding children and the Independent Board Nurse has the lead for safeguarding adults. Supporting these strategic roles are the following; Designated Doctor and Designated Nurse safeguarding children and head of quality and safeguarding adult lead.

The Governing Body reviews safeguarding across the organisation annually and has robust audit programmes to assure that systems and processes are working effectively to safeguard children, young people and adults at risk.

The Governing Body receives an annual report on safeguarding children and adults.

The right clinical performance monitoring systems in place across all with all providers, including the independent sector

A robust safeguarding children and adult performance monitoring framework is in place. Contracts are monitored and reviewed for quality.

Merton CCG has reviewed the safeguarding children and adult indicators in partnership with the local health economy. The safeguarding declarations from provider services are reviewed by the Designated Nurse Safeguarding Children on behalf of the CCG.
NHS England’s assessment of Merton CCG’s delivery of its statutory obligations is consistent with an assurance level for patient and public participation activity of ‘outstanding’ based on the following:

- the report built on comprehensive information from the Quarter 4 deep dive and provided some excellent examples of engagement activities. NHSE stated that the CCG is able to demonstrate partnership working with a range of organisations and networks and made reference to their stakeholder database as well as various communication and dissemination methods.

- excellent examples were provided within the report to demonstrate detailed engagement activities, including faith groups. The inclusion of measurable improvements from these activities would have further enhanced the report to evidence outcomes. The report demonstrated the use of feedback, highlighting how patient feedback (including Twitter and NHS Choices) is monitored.

- details of self-management courses shown and highlighting the vision for other particular groups to be involved in future. The case study included demonstrated the benefits of the course and details of how success will be measured in relation to care planning with patients were included.

**Patient Engagement Group**

In 2015/2016 the CCG set up its first Patient Engagement Group. The group was formed in July 2015 and has now met seven times. It has agreed a set of terms of reference – to be reviewed in summer 2016 – and has agreed to meet monthly.

**Merton Clinical Quality Committee**

The Merton Clinical Quality Committee is chaired by the lay member of the Governing Body and lead for Patient and Public Involvement (PPI), is a key forum in which the voice of the patient is heard within the CCG and provides assurance that the views of patients and the public are considered through the quality assurance process.

**Communications and engagement strategy**

The development of a new strategy was an opportunity to make sure that engagement with patients is coordinated, consistent and works effectively. Communications and engagement activities are complementary and work in parallel so the two strategies have been combined to create a coordinated plan for the future. The Governing Body agreed the new strategy at the end of May 2015 and the document is on the website.
Digital engagement

The CCG increased its focus on digital channels as a means of communicating and engaging with patients and the public during 2015/2016. The website acts as a source of information and engagement for patients, the public and all local stakeholders. See www.mertonccg.nhs.uk

People visiting the website can send feedback using a feedback form via the ‘Get involved’ page, find out about opportunities to get involved in local health services, or the results of consultations and engagement. The ‘Get involved’ pages have had 5,953 visits over the course of the year. The website also now offers visitors the option to directly email the Clinical Chair and the Chief Officer. This enables the questions and concerns of local people to be clearly visible to the senior leadership team and to ensure questions go to the right people for answer and that local concerns and issues are given clear visibility within the organisation. The ‘contact us’ page had 17,359 visits from April 2015 to March 2016.

Merton CCG also uses social media including Twitter and Facebook. Tweets cover a wide range of topics and include re-tweets of partner organisations posts. Twitter is also used to respond to queries and comments. Facebook is used to promote services and consultations.

During 2015/2016 the CCG has grown its digital channels particularly Facebook and Twitter. By April 2016, the CCG had around 3200 followers on its @NHSMertonccg Twitter account.

(Meeting the collective duty)

Engagement and participation activity

Engagement activity in 2015/2016 focused on two set-piece public engagement events – ‘Engage Merton’ and ‘at the health hub’ – and a range of engagement activity centred on specific groups and commissioning priorities. In addition, Merton CCG took part in and co-hosted a deliberative event with South West London Collaborative Commissioning.

Engagement utilised a variety of channels and encompassed a wide variety of groups and organisations from across Merton.
‘At the Health Hub’

Our ‘health marquee’ at Mitcham Carnival provided local residents with an opportunity to comment on any aspect of their healthcare experience. This year the CCG arranged for a ‘vox box’ to allow people to record their thoughts and views on local healthcare services. The Carnival attracts all ages and a wide variety of groups, many of whom our standard engagement might not always reach. It also allowed us to reach Merton families, particularly those with younger children.

Engage Merton

For ‘Engage Merton’ we invited members of the public and local voluntary and community groups to give their views on the five-year London plan. In addition, we delivered a presentation giving an update on our Vision and Strategy and also on the development of the model of health and well-being in East Merton.

South West London Collaborative Commissioning

The six south west London CCGs together with NHS England (which commissions specialist and primary care services in south west London) are working together under the umbrella name of South West London Collaborative Commissioning (SWLCC).

SWLCC jointly published an Issues Paper in June 2015. Issues Papers are increasingly viewed as best practice for public sector change programmes, setting out the case for change and questions for the public and stakeholders to consider at an early stage. This paper is the main vehicle for engaging residents across south west London during 2015/2016.

A meeting to brief local MPs was held in early summer and led by the South West London Collaborative Commissioning team on behalf of Merton and other CCGs.

Key engagement activities for Merton included:

- holding a deliberative event in the borough in September 2015 to gather in-depth feedback from recruited patients about the challenges and issues affecting local health services. The event was independently facilitated by the Office for Public Management and led by the Clinical Chair and Chief Officer.
the SWLCC with Merton CCG offering a complementary programme of outreach with local community and voluntary groups. The programme wrote to all key stakeholders and offered to attend their meetings to discuss the areas raised in the issues paper – seeking their feedback on the key challenges.

the CCG used the engagement toolkit provided by the SWLCC in August 2015 to support on-going engagement with key stakeholders, including local authorities, health and Well-Being boards, Overview and Scrutiny Committees, MPs.

under the SWLCC umbrella, Merton CCG and the other five south west London CCG have held monthly public meetings. There have been six meetings of the SWL Primary Care Co-commissioning Joint Committee at venues across south west London.

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

South West London Collaborative Commissioning Patient and Public Steering Group (PPESG) in 2015/2016

To ensure that there is effective lay involvement and public and patient engagement in the SWL Collaborative Commissioning programme, in April 2014 a steering group was set up, comprising patient and public lay representatives from each of the six CCGs, the six local Healthwatch organisations and the voluntary sector within each of the six CCG areas. It meets every six weeks.

During 2015/2016, the Group disseminated information about the case for change via Patient and Public Engagement Steering Group networks and social media and continued to update key stakeholders such as local MPs on developments with the programme. The programme worked with providers and Health and Well-Being Boards to consider the next steps.

Meeting our individual duty: The Expert Patients Programme

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

In 2015/2016 the EPP delivered six courses in community venues in Merton. Fifty-six individuals took part, with 45 receiving completion certificates. Some of these courses were delivered to specific groups, including carers, older people, mothers and people with mental health conditions. 2015/2016 also saw Merton CCG hold an EPP course in the evening for the first time.

79 per cent of the 2015/2016 course participants were female and 21 per cent male.
Expert Patient Katherine Rohan tells her story

I’d been very sick, getting fed up and depressed. I had been doing courses on depression but this sounded like it was a more holistic approach. It turned out to be exactly what I needed.

I had heard the term self-management but only in guru-type books about how to become more popular and succeed in life. During all my stays in hospital I hadn’t heard it mentioned by anybody. I felt at home immediately because everybody in the class is dealing with illnesses. I felt like an X-man who has found the rest of the team. We all have our own ‘super power’ and there is no need to explain to anyone else what we had – you just know that if you can’t walk very well, or if you can’t eat that type of food at the break, you don’t need to explain.

The course rose far above my expectations because it concentrated on all aspects of the person. It dealt with pain, healthy eating, exercise, and every week we did an action plan which we aimed to achieve during that week. It did not have to be related to our health – it could be an activity.

The focus on the healthy eating was very useful. I have a lot more vegetables now and a lot healthier diet generally. I’m the sort of person who if I say I will do something I really do try to achieve it. So saying each week what I was going to do has spilled over into the rest of my life – I may wake up in the morning and say, Right, today I am going to do this particular activity – whether it is to go round to the shops, or see a film or go up to town.

Otherwise I could become very housebound with my condition. I get exhausted very easily and get fed up. That is where the course has helped me a lot and I have achieved far more than I thought.

The secret was that people were interested in our progress. The tutors are interested in you as a person and how you are getting on. I thought we would be learning and doing tests but there was nothing like that – it was just very interesting and very useful.

Life has been more positive since I have done the course. It has helped me a lot. But I did complain that the course was only six weeks long. I wanted more – more support and for longer. But as the tutors pointed out, I’ve got the skills, I’ve got the tools I need for each situation. I can also keep in touch by coming to the reunions. I went to one in October which was marvellous, not just for the social aspect but there was a very useful talk on medications.

I still get sick but I am more pro-active. I do realise it will pass and I can get back onto my programme.
Transforming care

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

Reducing inequality

In 2015/2016, Merton CCG delivered a comprehensive work plan to reduce inequalities, which included completing an equality impact assessment (EA) on the QIPP programme.

Equality analysis

In addition, Merton CCG completed a full Equality Analysis on the procurement of Community Health Services for children and adults, and MSK and Outpatient Physiotherapy.

Equality Delivery System

For the second consecutive year, Merton CCG implemented the refreshed Equality Delivery System (EDS2) as part of its programme to reduce inequalities.

In 2015/2016, the following commissioning priorities were reviewed for Goals 1 and 2 of the EDS (Better Health Outcomes and Improved Patient Access and Experience): Early Intervention in Psychosis, Community Mental Health Services for People with Dementia and Structured Education Programme for People with Newly Diagnosed Diabetes.

The assessment of these services in terms of equality and diversity was undertaken at a public event on July 6, 2015, attended by 40 people, including carers, members of the voluntary sector, providers, CCG staff and Governing Body members.

The workshop graded each priority and identified areas for improvement which have been carried forward into the commissioning monitoring framework for the services reviewed. Key outcomes have included a review of the access to the Early Intervention in Psychosis service by age, as the service is now open to people over 18, increased sessions of the education programme for people with newly-diagnosed Type 2 Diabetes and increasing the capacity of the Memory Assessment Service to meet the needs of different groups more effectively.

The assessment of Goal 3 and Outcome 4.3 (which focus on staff experiences) took place at a staff workshop held on 15 September 2015. It was attended by a cross-section of staff from a range of teams, grades and protected characteristics.

Feedback from the workshop has helped inform the improvement plans for these areas. Key outcomes aimed at minimising inequalities have included, the development of a staff forum, which monitors critical issues affecting staff well-being, a staff health and well-being strategy and raising staff awareness on bullying and harassment.

As part of its work on Goal 4 of the EDS2, also known as ‘Inclusive Leadership’, the CCG’s Governing Body participated in training on equality and diversity and decision-making, following
which members requested a review of the assurance process on equality and diversity for all board papers.

**Health inequality**

To address health inequality strategically, Merton CCG is an active participant in key partnerships including: Merton Health and Well-being Board and the South West London Commissioning Collaborative (including the Collaborative’s patient and public engagement and clinical design programmes). It has participated in the development of Merton Borough’s Joint Strategic Needs Assessment, which provides an overview of the health and well-being of residents in the borough, the Health and Well-being strategy and works with the Public Health Team to deliver key initiatives to tackle health inequalities, such as the NHS Health Checks.

**Equality and Diversity Steering Group**

The CCG also facilitates the Equality and Diversity Steering Group (EDG), which includes representatives from the CCG’s Governing Body, commissioning and patient and public involvement teams and Merton Council’s Public Health Team.

The EDG oversees the implementation of the CCG’s equality and diversity work plan and makes recommendations for strategic plans related to addressing inequality.

Detail on Merton CCG’s progress on delivering its general equality duty can be found in its annual public sector equality duty report for the period January to December 2015: Merton’s Public Sector Equality Duty Annual Report

**Workforce Race Equality Standard (WRES) Provider assurance implemented**

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

Merton CCG has published an internal report on the WRES, which was approved by the Clinical Quality Committee and has developed a provider assurance framework whereby all key providers are expected to report progress against their WRES metrics every six months to the Clinical Quality Review Group of each provider.
**Sustainable development**

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

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

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

**Estates management**

**CCG headquarters**

120 Broadway is a building managed by Essentia Community Services (ESC), part of Guy’s and St Thomas’ NHS Foundation Trust. The CCG is one of several tenants of the building and we have therefore not been in a position to implement a separate Sustainable Management Development Plan; nor is it possible to obtain separate figures for individual tenants’ energy use and recycling.

However, ESC observes and complies with environmental legislation and sets targets for further environmental improvement and carbon reduction.

**The Nelson Health Centre**

The new Health Centre opened in April 2015 and is run by Community Health Partnerships. The design of the building aims to minimise the impact of the building on the surrounding and global environment and will result in approximately a 50 per cent reduction in carbon emissions, compared with the previous estate.

The principles of the design and maintenance of the building include:

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

The Health Centre won a national architectural award in 2016 for Best Primary Care Development.
Environmental policy
We work closely with Essentia to ensure improvements in terms of waste, utility consumption, water consumption and all other areas of building management.

- Waste and recycling points are provided
- Staff and visitors are encouraged to minimise the amount that goes to landfill.
- The CCG office space includes hot-desking facilities to enable us to maximise occupancy and accommodate staff from other NHS organisations that we work closely with, including from South East CSU.
- Staff and visitors are encouraged to minimise the amount that goes to landfill.

To see more details on ESC’s environmental and energy policies, please visit www.essentia.uk.com/what-we-do/sustainability

Partnerships
As a commissioning and contracting organisation, we need to ensure effective contract mechanisms to support sustainable healthcare delivery. Our approach is based on the national NHS policy framework for commissioners and providers. Our main provider organisations are St George’s University Hospitals NHS Trust, Epsom and St Helier’s University Hospitals NHS Trust and Kingston Hospitals NHS Foundation Trust, all of whom have their own sustainable development plans.

- St George’s Sustainability Plan can be seen here www.property.nhs.uk/what-we-do/sustainability
- Epsom and St Helier’s University Hospitals NHS Trust’s sustainability plan can be seen here www.epsom-sthelier.nhs.uk/5yearstrategy
- Kingston Hospitals NHS Foundation Trust’s sustainability plan can be seen here www.kingstonhospital.nhs.uk/our-trust/sustainability.aspx

Carbon footprint
As part of the NHS, public health and social care system, we have a duty to help reduce the carbon footprint of this system by 34 per cent (from a 1990 baseline), equivalent to a 28 per cent reduction from a 2013 baseline by 2020.

signed:

Adam Doyle
Accountable Officer
Members’ Report

Details of Membership
In April 2015 our 24 member practices were grouped into three localities supported by a central team covering commissioning, quality, finance, medicines management and primary care support. In summer 2015, our member practices reorganised into two localities.

Each locality is led by a nominated GP clinical lead, who is a member of the Clinical Quality Reference Group (CQRG) for their relevant major acute provider, as well as the CCG’s Executive Management Team and Clinical Reference Group.

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

East Merton: Locality lead is Dr Karen Worthington

There are nine member practices:
Cricket Green Medical Practice
Figges Marsh Surgery
Mitcham Family Practice
Mitcham Medical Practice
Ravensbury Park Medical Centre
Rowans Surgery
Tamworth House
Wide Way Surgery
Wilson Health Centre

East Merton is made up of nine practices that look after nearly 67,000 patients. Each practice is headed up by one clinician who regularly meets with members and clinical leads from West Merton.

West Merton: Locality lead is Dr Tim Hodgson

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

West Merton is made up of 15 practices looking after nearly 150,000 patients. Each practice is headed up by one clinician who regularly meets with members and clinical leads from East Merton.

Governing body and Executive Management Team

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

The membership of our Governing Body:

- Dr Andrew Murray, Chair
- Eleanor Brown, Chief Officer until 5/7/15 then Adam Doyle from 8/7/15
- Andrew Hyslop, Chief Finance Officer from 16/2/16
- Cynthia Cardozo, Chief Finance Officer until 15/2/16 (now Director of Transformation)
Practice Leads Forum

The Practice Leads Forum meets on alternate months (alternating with the locality meetings) to receive an update from the Executive Management Team and Clinical Quality Reference Group on the development of the CCG strategy and participate in service redesign and network good practice.

- Dr Kay Eilbert, Director of Public Health, London Borough of Merton until 30/11/15 then Dr Dagmar Zeuner from 1/2/16
- Peter Derrick, Lay Member, Chair of the Audit Committee and Vice Chair (reappointed 26/9/15)
- Clare Gummett, Lay Member, Patient and Public Involvement (reappointed 26/09/15)
- Mary Clarke, Independent Nurse Member (until 31/7/15)
- Sally Thomson, Independent Nurse Member (from 13/8/15)
- Dr Tim Hodgson, GP Clinical Governing Body Member (from 1/5/15)
- Dr Caroline Chill, GP Clinical Governing Body Member (reappointed 18/10/15)
- Professor Stephen Powis, Secondary Care Consultant (reappointed 26/09/15)

In addition to the above Sue Hillyard (Director of Commissioning Operations), Lynn Street (Director of Quality and Performance), Cynthia Cardozo (Director of Transformation) and Marek Jarzemowski (LMC chair) are in attendance at all Governing Body meetings and seminars.

The Register of interests for Merton CCG is published online
www.mertonccg.nhs.uk/News-Publications/Pages/test.aspx
Merton CCG Member Practices

Alexandra Surgery
39 Alexandra Road, Wimbledon SW19 7JZ

Francis Grove Surgery
8 Francis Grove, Wimbledon SW19 4DL

Grand Drive Surgery
132 Grand Drive, Raynes Park, London SW20 9EA

James O’Riordan Medical Centre
70 Stonecot Hill, Sutton SM3 9HE

Lambton Road Medical Practice
1 Lambton Road, Raynes Park SW20 0LW

Morden Hall Medical Centre
256 Morden Hall Road, London SW19 3DA

The Nelson Medical Practice
220 Kingston Road, London SW20 8DA

Princes Road Surgery
51 Princes Road, Wimbledon SW19 8RA

Stonecot Surgery
115 Epsom Road, Sutton SM3 9EY

Vineyard Hill Road Surgery
67 Vineyard Hill Road, Wimbledon SW19 7JL

Wimbledon Village Surgery
35A High Street, Wimbledon SW19 5BY

Central Medical Centre
42-46 Central Road, Morden SM4 5RT

Merton Medical Centre
12-17 Abbey Parade, Merton High Street SW19 1DG

Colliers Wood Surgery
58 High Street, Colliers Wood SW19 2BY

Figges Marsh Surgery
182 London Road, Mitcham CR4 3LD

Mitcham Family Practice
55 Mortimer Road, Mitcham CR4 3HW

Ravensbury Park Medical Centre
Ravensbury Lane, Morden Road, Mitcham CR4 4DQ

The Rowans Surgery
1 Windermere Road, Streatham SW16 5HF

Tamworth House Medical Centre
341 Tamworth Lane, Mitcham CR4 1DL

Cricket Green Surgery
75-79 Miles Road, Mitcham CR4 3DA

Mitcham Medical Practice
81 Haslemere Ave, Mitcham CR4 3PR

Riverhouse Surgery
East Road, Wimbledon SW19 1YG

Wide Way Surgery
15 Wide Way, Mitcham CR4 1BP

Wilson Health Centre
Cranmer Rd, Mitcham CR4 4TP

NHS England Core Standards for EPRR

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

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

NHS South East CSU coordinates Freedom of Information requests received by Merton CCG. The CCG complies with its statutory duty to respond to requests for information. During the 2015/2016 financial year, the CCG received 270 requests under the Freedom of Information Act 2000 (FOIA 2000), of which 260 were completed within the statutory 20 working days.

Complaints

During 2015/2016 there were 45 complaints compared to 37 in 2014/2015. Of the complaints received 29 related to the CCG and 16 were related to other providers such as the Local Authority, 111 service, hospital services and staff. The main themes of the complaints which relate to the CCG were regarding eligibility for services and commissioning decisions, for example individual funding requests and Continuing Healthcare. Of the complaints 20, 58 per cent, relate to Continuing Healthcare.

Complaints that resulted in changes and learning:

- in relation to concerns raised about the lack of response to emails and letters sent to the Continuing Healthcare team, the SECSU team re-organised and improved their administration systems.
The complaints were a significant contributing factor to our decision to go out to procurement for this service.

Sustainability

In order to promote sustainability Merton CCG 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 (lights, power etc.)
- 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.

- details about what Continuing Healthcare is, is now published on the Merton CCG website, including the telephone number of the Continuing Healthcare team.
- where complaints have been very poorly managed, internal investigation of the complaint is completed by an independent person; recommendations are made for the service.
- ensuring that Continuing Healthcare Public Information Leaflets are given to all patients and their representatives at all assessments.
- learning from complaints are now discussed at team meetings, individual staff one to one’s and management meetings.
- staff effective complaints handling workshops have recently been held in November 2015 to improve the quality of the complaints responses.
- the Continuing Healthcare senior management have included on the agenda of all staff one to one meetings, customer service and communication. This is also discussed in team meetings. Further, some of the team have undergone complaints training.
- a review of the financial processes for the payment of Continuing Healthcare was undertaken. A more efficient and streamlined process now ensures payments are processed in reasonable timescales.
- the Continuing Healthcare team have reviewed the pathways for ordering equipment. As a result, the team have implemented clearer processes including the monitoring of ordering of wheelchairs enabling any delays to be communicated to the client and family in a timely manner.
Staff Report

Communicating and engaging

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

- a SWL Staff Partnership Forum where managers and staff from the six SWL CCGs meet to discuss and consult on issues.
- regular team briefings with the staff and Executive Management Team.
- a bespoke Staff Survey in 2015 and an action plan based on the results of the survey including the establishment of a Staff Engagement Group to take forward the action plan with management. The bespoke survey will be repeated in 2016 and will provide the CCG with an opportunity to build up a picture of staff experience and to compare scores year against year.
- a Workforce Committee comprising management and staff representatives which meets bi-monthly to discuss staff issues.
- an all-staff workshop held in the Summer of 2015 at an external central London location.

Organisational Development

Following the change in both Clinical Chair and Chief Officer, the new leadership has taken the opportunity to review the current operating plan, models of care, working and governance of the CCG. An organisational development plane has been produced ‘The Merton CCG High Performing Plan’ and is working with local practices, partners, providers and staff to take forward the revised ‘Whole Merton’ vision as outlined in its revised Vision and Strategy. This document outlines the CCG’s assessment of its own development needs to meet the challenge of delivering the Whole Merton Vision in a context of increasing financial austerity, rising demand and complex challenges. It describes the key forward organisation development plans for the CCG including those of the Governing Body, Member Practices and staff and includes:

1. Vision and values, behaviour and culture
2. Leadership and people development
3. Communications, staff engagement and clinical engagement
4. Recruitment, retention, performance and reward

Training and Development

Staff must undertake Statutory and Mandatory training, which they can complete either via e-learning from Skills for Health or through in-house sessions. Training compliance is reported back to the CCG on a regular basis.

During this financial year a programme of training was rolled out to all management and staff on appraisals, objectives and Personal Development Plans (PDPs). The SECSU was commissioned to implement a learning and development module including an E-PDR process and statutory and mandatory training onto the CCGs electronic Workforce System, which went live in April 2016.

A training course on Dignity at Work was prepared during quarter four of 2015/2016 and was rolled out to all staff in April 2016.
Staff policies

The CCG has a full suite of up-to-date HR Policies in place based on best practice, employment legislation and national terms and conditions, which is available to all staff on the CCG intranet. The following new policies were developed and implemented during the year:

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

Equalities for staff

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

Staff composition by gender (subject to audit)

At the end of the financial year
(31 March 2016)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of persons of each sex who were on each of the Membership and Governing Body</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The number of other senior manager of each sex who were a grade Very Senior Manager</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The number of persons of each sex who were employees of the CCG</td>
<td>10</td>
<td>35</td>
</tr>
</tbody>
</table>
2015/2016 Sickness absence figures
(1 April 2015–31 March 2016)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>405.39</td>
</tr>
<tr>
<td>Total staff years</td>
<td>42.8</td>
</tr>
<tr>
<td>Average FTE days lost</td>
<td>9.47</td>
</tr>
</tbody>
</table>

#### Number of senior staff by band
1 x Chief Officer (Male) on VSM pay
1 x Chief Finance Officer (Male) – interim appointment
X3 Directors (Female) 2 on AfC Band 9 and 1 interim appointment

#### Employee numbers excluding Governing Body Members
(who are Office Holders not employees)
- 45 staff
- 41.90 Full time equivalent

#### Sickness absence
The CCG Sickness Absence percentage rate is presented monthly as part of the Key Performance Indicators (KPIs). The HR Business Partner works closely with managers to ensure that sickness absence cases are being managed in a timely way and in accordance with the CCGs Sickness Absence policy.

An Occupational Health (OH) service is available to provide professional medical advice to the CCG. Staff can access OH for a self-referral and can access the OH Counselling service.

The CCG also has access to an Employee Assistance Programme which is provided by Right Management, which offers confidential access to emotional and practical support, 24 hours a day, 7 days a week, including legal and financial advice.

#### Consultancy
In 2015/2016 there was no expenditure on consultancy.

#### Exit Package
There were no exit packages in 2015/2016.

#### Statement as to Disclosure to Auditors
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 CCG’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 CCG’s auditor is aware of that information.

Adam Doyle
Accountable Officer
Remuneration report

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>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Mary Clarke</td>
<td>Independent Nurse Member</td>
<td>01.04.13</td>
<td>31.07.15</td>
<td>2</td>
</tr>
<tr>
<td>Clare Gummett</td>
<td>Lay member for PPI</td>
<td>01.04.13</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Andrew Murray</td>
<td>Clinical Chair</td>
<td>01.04.15</td>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julia Morosi (employee of South East Commissioning Support Unit)</td>
<td>Human Resources Associate</td>
<td>Advice</td>
</tr>
<tr>
<td>Eleanor Brown</td>
<td>Chief Officer</td>
<td>Advice</td>
</tr>
<tr>
<td>Cynthia Cardozo</td>
<td>Chief Finance Officer</td>
<td>Advice</td>
</tr>
<tr>
<td>Adam Doyle</td>
<td>Chief Officer</td>
<td>Advice</td>
</tr>
</tbody>
</table>

Remuneration policy

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

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

Senior managers’ performance-related pay

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

Senior managers’ service contracts

All senior managers’ at Merton CCG follow the national pay and remuneration guidelines.
### Table 11: Senior Managers’ Salaries and Allowances (subject to audit)

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees (bands of £5,000)</th>
<th>Taxable Benefits (rounded to the nearest £00)</th>
<th>Annual Performance Related Bonuses (bands of £5,000)</th>
<th>Long-term Performance Related Bonuses (bands of £2,500)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>Total (bands of £2,500)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleanor Brown Chief Officer (end date 5/7/15)</td>
<td>25-30</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>25-30</td>
</tr>
<tr>
<td>Cynthia Cardozo Director of Transformation (with effect from 15/2/16). Previously Chief Finance Officer</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 Caroline Chil Clinical Governing Body Member</td>
<td>120-125</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>120-125</td>
</tr>
<tr>
<td>Mary Clarke Independent Nurse (end date 31/7/15)</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>0-5</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></td>
<td>N/A</td>
<td>10-15</td>
</tr>
<tr>
<td>Adam Doyle Chief Officer (with effect from 1/7/15). Previously Director of Commissioning &amp; Planning and Deputy Chief Officer</td>
<td>110-115</td>
<td>0</td>
<td>0</td>
<td></td>
<td>32.5-35</td>
<td>145-150</td>
</tr>
<tr>
<td>Clare Gummert Lay person with responsibility for patient and public involvement</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Andrew Murray Chair</td>
<td>70-75</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>70-75</td>
</tr>
<tr>
<td>Professor Stephen Powis Secondary Care Consultant</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>0-5</td>
</tr>
<tr>
<td>Lynn Street Director of Quality</td>
<td>80-85</td>
<td>0</td>
<td>0</td>
<td></td>
<td>27.5-30</td>
<td>105-110</td>
</tr>
<tr>
<td>Dr Tim Hodgson GP Member</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td></td>
<td>72.5-75</td>
<td>85-90</td>
</tr>
<tr>
<td>David Freeman Director of Commissioning and Planning (with effect from 22/6/15–15/1/16)</td>
<td>55-60</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>55-60</td>
</tr>
<tr>
<td>Sally Thomson GP Independent Nurse</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>5-10</td>
</tr>
<tr>
<td>Andrew Hyslop Chief Finance Officer (with effect from 15/2/16)</td>
<td>30-35</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>30-35</td>
</tr>
<tr>
<td>Sue Hillyard Director of Commissioning Operations (with effect from 4/1/16)</td>
<td>55-60</td>
<td>0</td>
<td>0</td>
<td></td>
<td>N/A</td>
<td>55-60</td>
</tr>
</tbody>
</table>

* Estimated.

Note 1 – Payment is made to a corporate body and includes employer’s on-costs such as national insurance and super-annuation contributions.
NHS organisations are required to disclose the pension benefits for those persons disclosed as senior managers of the organisation, where the CCG has made a direct contribution to a pension scheme. Due to the nature of CCGs, some GPs have served as office holders of NHS Merton CCG. However GPs who work under a contract for services with the CCG 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 the NHS Pensions Agency for GP pension contributions.

<table>
<thead>
<tr>
<th>Name &amp; title</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31/3/16 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension 31/3/16 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value (CETV) at 1/4/15</th>
<th>Cash Equivalent Transfer Value (CETV) at 31/3/16</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 (end date 5/7/15)</td>
<td>(0-2.5)</td>
<td>(0-2.5)</td>
<td>45-50</td>
<td>140-145</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cynthia Cardozo Director of Transformation (with effect from 15/2/16) Previously Chief Finance Officer</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>35-40</td>
<td>110-115</td>
<td>673</td>
<td>715</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Dr Caroline Chil Clinical Governing Body Member</td>
<td>(0-2.5)</td>
<td>(0-2.5)</td>
<td>10-15</td>
<td>40-45</td>
<td>294</td>
<td>299</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Adam Doyle Chief Officer (with effect from 1/7/15) Previously Director of Commissioning &amp; Planning and Deputy Chief Officer</td>
<td>0-2.5</td>
<td>0</td>
<td>5-10</td>
<td>0</td>
<td>23</td>
<td>41</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Lynn Street Director of Quality</td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>20-25</td>
<td>65-70</td>
<td>372</td>
<td>412</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>David Freeman Director of Commissioning and Planning (with effect from 22/6/15-15/1/16)</td>
<td>(0-2.5)</td>
<td>(2.5-5)</td>
<td>15-20</td>
<td>40-45</td>
<td>229</td>
<td>221</td>
<td>(6)</td>
<td>0</td>
</tr>
<tr>
<td>Timothy Hodgson GP Member</td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>10-15</td>
<td>40-45</td>
<td>155</td>
<td>205</td>
<td>49</td>
<td>0</td>
</tr>
</tbody>
</table>

* Member is over normal retirement age 60 for 1995 Section and therefore a CETV calculation is not applicable
Pay multiples

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

The banded remuneration of the highest-paid director in the financial year 2015/16 was £120–125k (2014/2015: £110–115k). This was 2.8 times (2014/2015: 2.7 times) the median remuneration of the workforce, which was £44k (2014/2015: £41k).

In 2015/16 (and 2014/15), no other employee received remuneration in excess of the highest-paid member of the Governing Body. Remuneration ranged from £10k to £125k (2014/15 £10–115k).

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.

Off-payroll engagements

Merton CCG had three off-payroll engagements in the financial year to 31 March 2016.

Table 13: Off-payroll engagements

<table>
<thead>
<tr>
<th>Number</th>
<th></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>3</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>7</td>
</tr>
</tbody>
</table>

signed:

Adam Doyle
Accountable Officer
Annual Governance Statement

The CCG was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2015, the CCG was licensed without conditions.

The CCG comprises 24 GP practices, across the two localities of East Merton and West Merton. The CCG serves a population of 218,195 and manages a health care budget of £239 million.

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 outcome 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.

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 seeks to achieve the same high standards for the Merton population. The objectives for 2015/2016 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-effective and cost-effective five-year collaborative strategic commissioning plan for south west London.

The full audited Annual Report and Accounts will be approved by the Governing Body in May 2016 and signed by the Chief Officer.

Scope of responsibility

As Accounting 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 personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Compliance with the UK Corporate Governance Code

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

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

*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.*

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.

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.

**Governance structure**

![Governance Structure Diagram](image)
Committee Structure

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

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

Governing Body

The Governing Body oversees the delivery of the CCG’s commissioning plan, 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.

Membership of the Governing Body

Eleanor Brown
Chief Officer (departed May 2015)

Cynthia Cardozo
Chief Finance Officer (departed Jan 2016)

Dr Carrie Chill
GP Member

Mary Clarke
Independent Nurse member (departed July 2015)

Peter Derrick
Lay member and Chair of Audit and Governance Committee

Adam Doyle
Chief Officer (commenced July 2015)

Dr Kay Elbert
Director of Public Health Merton (departed Nov 2015)

Clare Gummett,
Lay Member and PPI Lead

Dr Andrew Murray
Chair

Prof. Stephen Powis
Secondary Care Consultant

Dr Tim Hodgson
GP Member (commenced May 2015)

Sally Thomson
Nurse Member (commenced Aug 2015)

Andrew Hyslop, interim Chief Finance Officer (commenced Feb 2016)

Dr Dagmar Zeuner,
Director of Public Health Merton (commenced Feb 2016)

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

Merton CCG Governing Body has now been in operation for three 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:

- Continuing Health Care
- South West London Collaborative Commissioning
- Constitutional updates
- Progress against key performance indicators
- CAMHS Transformation
The MCQC has met monthly throughout the year, with the remit of providing assurance to the Governing Body that commissioned services are being delivered in a high-quality and safe manner. The MCQC has been vital in ensuring that quality sits at the heart of everything the CCG does.

The committee delivers 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, our GP Governing Board Chair

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

- reviewing and scrutinising the integrated quality and performance report, which provides a more in-depth picture of the quality of care provided to Merton patients by the main providers and is also presented to the Governing Body as part of the balanced scorecard
The committee’s main activities throughout the year have focused on:

- Children Looked After
- Continuing Health Care
- Performance monitoring
- Safeguarding adults and children
- PALS and Complaints

Membership and attendance of the committee is as follows:

**Clinical Quality Committee meeting attendance 2015/16**

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- Apologies
- Prior to appointment/after departure
Audit and Governance Committee

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

The committee delivers their objectives by:

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

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

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

- policy updates
- financial control
- internal audit work plan
- procurement

Audit and Governance Committee meeting attendance 2015/16

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<th>Merton Meetings monthly</th>
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Legend:
- Present
- Apologies
- Prior to appointment/after departure
The committee’s main activities through the year have been focused on:

- QIPP
- Financial planning
- Primary Care commissioning
- Procurement

**Remuneration and Nominations Committee**

During 2015/2016, the remuneration committee’s primary aims have been:

- Director/Chair remuneration
- Pay controls

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

- Governing Body members
- executive directors
- allowances under any pension scheme it might establish as an alternative to the NHS pension scheme
- reviewing the performance of the Chief Officer and other senior team members and determining annual salary awards, if appropriate.
- the committee delivers its objective by setting all aspects of salary for the Chief Officer, Chief Finance Officer, executive directors, the lay members of the Governing Body and clinical leads of the organisation.

**Finance Committee**

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

The committee delivers their objective by:

- keeping under review strategic and operational financial plans and the current and forecast financial position of the CCG
- overseeing the arrangements 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.
Membership of the finance committee and attendance is detailed below:

**Finance Committee meetings attendance 2015/16**

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**Remuneration and Nominations Committee meetings attendance 2015/16**

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**Executive Membership Team**

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

The committee delivers their objectives by:

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

identifying and implementing remedial plans as appropriate to address variances in performance, health outcomes and inequalities

preparing and reviewing plans in respect of the application and delivery of available financial resources, developing budgets for approval by the Governing Body and scrutinising expenditure.

Membership and attendance of the committee is as follows:

The committees’ main activities in 2015/16 have focused on:

- safeguarding adults and children
- mental health services
- emergency and seasonal planning
- transformation planning

Executive Management Team meetings attendance 2015/16

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- Apologies
- Prior to appointment/after departure
Clinical Transformation Committee

The Clinical Transformation Committee was established in December 2015, with meetings commencing in January 2016. The remit of the committee is to identify a transformation programme and drive delivery of strategic changes to the Merton health and care system that will improve outcomes for local people and ensure that services are financially sustainable.

The committee delivers their objectives by:

- taking advice and direction from the clinical reference group
- deciding on the main areas of work for the programme and driving delivery
- ensuring resources for programme delivery are in place and monitoring the use of these resources in line with the objectives of the programme

- ensuring that agreed programmes of change support Health and Well-Being Board priorities
- leading the development of a co-ordinated approach to public, patient and clinical engagement across the local health and care system in order to explain the rationale for change and ensuring effective engagement in designing and delivering the programme of work
- where appropriate, recommending for approval by the CCG Governing Body and provider boards the commissioning of specific packages of work from within the health and care economy to support delivery of the programme aims
- reporting annually to the Governing Body in respect of the fulfilment of its functions.

Membership and attendance of the committee is as follows:

Clinical Transformation Committee meeting attendance 2015/16

Meetings Bi-Monthly

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The committees’ main activities in 2015/16 have focused on:

- establishing the committee
- vision and strategy for health in Merton

Present
Apologies
Prior to appointment/after departure
The Clinical Commissioning Group
Risk Management Framework

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.

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

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

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

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

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

The reporting of the Board Assurance Framework accurately reflects the management of the current risks facing the CCG. The Board Assurance Framework is regularly reviewed to ensure it is in line with the risk management needs of the CCG. Figure 1 shows the format and structure of the Board Assurance Framework.

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

Risk appetites are determined by individual risk owners and moderated by the executive management team during the monthly review of the BAF. The audit committee and Governing Body approve the BAF periodically, as set out in the constitution, including the risk appetite scores. Control mechanisms have been chosen according to best practice and management approaches agreed as appropriate by risk leads.

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

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

Risk assessments are carried out by all services/departments to identify the significant risks arising out of all CCG activities; and their potential to cause injury, litigation, damage to the environment or property, or result in delays or impact upon reputation.
Risks associated with the following are assessed and recorded on the corporate risk register:
- strategic and business plan targets
- adverse incidents and near misses
- complaints
- claims
- new projects
- research and trials
- environmental risk including health and safety risks
- fire safety
- security
- red risks from the directorate risk registers
- quality and safeguarding leads meet regularly with the risk manager to ensure, risks are captured, controls documented and implemented and mitigating actions followed up. Quality and safety risks are monitored by the Clinical Quality Committee and risks of sufficient severity are escalated as required to the assurance framework.

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

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

Risk Assessment

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. These five objectives have been reviewed for 2016/2017 to reflect the current key objectives which the CCG is seeking to achieve.

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

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

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

At March 2016, the risks to the CCG with the highest residual scores were:

- 938 potential over-performance of acute contracts
- 1000 significant poor performance of the continuing care service
- 798 If external and internal pressures mean the CCG is unable to deliver the planned budget for 2015/2016, the CCG will be unable to deliver a robust financial position in the medium term, which reduces its ability to deliver its Commissioning Intentions
- 961 If there is lack of collaboration between SWL CCGs and providers then high-quality sustainable solutions may not be determined for healthcare in South West London.
- 962 Without significant system change, quality of outcomes will be limited for patients and provider organisations may become unsustainable

The Clinical Commissioning Group Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.

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

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

During this year we worked with our IG expert service, South East Commissioning Support Unit, to achieve level 2 in the IG toolkit, which is the expected standard.

We have processes for the reporting and investigation of information breaches. This year, reported information breaches were:

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

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

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

The Executive Management Team monitors the performance against all of the CCGs delivery plans monthly. This includes ensuring that projects and programmes are delivering cost effective services and optimal benefits to our patient population. The executive management team also meets monthly to discuss and review strategic programmes and to make recommendations to the Governing Body.

The finance committee has ownership of the management of financial risks and the CCG audit and governance committee takes an independent view of the CCG’s financial management (detailed below). The audit and governance committee is attended by our colleagues from internal audit and external audit and reports to the Governing Body.

Merton CCG’s QIPP target for 2015/2016 was £4.9m. Actual achievement was £5.87m. There were some minor variances to target. Medicines management and planned care and diagnostics overachieved by £0.3m and £0.1m respectively for example. However, urgent and intermediate care underachieved by £0.2m, the acute portfolio underachieved by £0.1m and placements underachieved by £0.1m.

The Medicines Management programme delivered a review of prescribing (medicines and oral nutritional supplements) by a clinical pharmacist or dietician in primary care to ensure it was evidence based, in line with local and national guidance, safe, cost effective and appropriate for individual patients.

The Planned Care QIPP programme consisted of a number of schemes, such as The Nelson Health Centre Activity (including the More in Merton Initiative) and Outpatient Navigation.

The Urgent and Intermediate Care QIPP is in the second year of mobilisation. It is designed to fundamentally change urgent and proactive care service delivery and care for complex, often older and frail residents of Merton.

QIPP performance continues to be discussed on a monthly basis at the executive management team meetings. These meetings have clinical representation from the three clinical
locality leads and public health. Performance and identification of new schemes is also reviewed and discussed on a weekly basis at the QIPP delivery group. This meeting is chaired by the Chief Finance Officer.

**Feedback from delegation chains regarding business, use of resources and responses to risk**

The CCG has set out a Scheme of Reservation and Delegation within the Constitution, which the Governing Body has approved. This details delegated responsibilities, whilst retaining the accountability of the CCG. The Governing Body has established committees to fulfil relevant functions under the Scheme, such as putting in place an operational scheme of delegation which details operational decision-making powers delegated to individual employees. Prime financial policies are also in place, as well as arrangements for managing exceptional funding requests.

The CCG agrees an annual plan of work with internal audit in relation to this. This plan ensures that delegated functions are being carried out effectively and according to the Scheme of Reservation and Delegation, as well as identifying any gaps and putting appropriate plans in place to address any issues. Internal audit then reports its findings to the Audit and Governance Committee.

**Review of the effectiveness of Governance, Risk Management and Internal Control**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group.

**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 the 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 the corporate affairs lead from South East CSU, and are provided with monthly support to review the risks and mitigation plans.

Training has been provided to staff involved in the risk management processes.

**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 clinical commissioning group 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 annual audit letter and other reports.
Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and risk/clinical governance/quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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, the CCG maintains an effective system of internal control through the following:

■ 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 is updated as necessary to ensure it is compliant 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 subcommittees to fulfil their scrutiny roles and their decision-making responsibilities with agendas giving priority to those items which require a decision.

■ An internal audit plan is in place and progress against it is reviewed by the Audit and Governance Committee regularly.

The CCG is planning a full governance review in early 2016/2017, to be carried out by RSM. An action plan will be agreed by the Governing Body and carried out appropriately following the outcome of this review.

Head of Internal Audit Opinion

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the
The organisation has an adequate and effective framework for risk management, governance and internal control. However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Factors and findings which have informed our draft opinion

We have issued one AMBER/RED rated report on Conflict of Interest; i.e. for this area the Governing Body can take partial assurance that the controls to manage risks are suitably designed and consistently applied, and that action is needed to strengthen the control framework to manage the identified risks.

The Conflict of Interest review highlighted a number of control design and non-compliance issues with one specific high-priority issue raised around completeness of interests recorded for Practice Leads Committee Members. Out of the total 24 members, the register was updated with 12 member declarations received during the year with the remaining 12 member responses not received at the time of the audit (final report issued 26 January 2016).

Other issues raised included a register of procurement decisions (as required by NHSE statutory guidance issued in December 2014) not developed at the time of the audit. Management has implemented all bar one of the actions identified plan to address the issue.

All other reports issued have received either AMBER/GREEN (Reasonable assurance) or GREEN (Substantial assurance) opinion reflecting good internal controls in place to manage the related risks.

Further issues relevant to this opinion

We have considered the findings of the interim 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 two identified exceptions, we have liaised with the CSU and do not believe that there is anything significant requiring inclusion within the Annual Governance Statement. We will review the final Service Auditor Report once issued and if material issues arise these will need to be reflected in a revised opinion.

Issues judged relevant to the preparation of the annual governance statement

Based on the work we have undertaken on the CCG’s system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant internal control issues within the annual governance statement (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.
Business Critical Models
The key business critical models on which the Governing Body relies are (i) in-year financial forecasts, (ii) medium-term financial planning and (iii) financial evaluation and forecasting of quality led savings schemes. These models are the responsibility of the Chief Finance Officer and operated by the financial management & planning team and the QIPP delivery group. The governance of these models is delegated from the Governing Body to the finance committee. Quality assurance on these models has been sought, and received, by (i) expert external review and (ii) the internal audit programme.

The 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.

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

Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

Discharge of Statutory Functions

Arrangements put in place by the clinical commissioning group and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

Conclusion

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

signed:

Adam Doyle
Accounting Officer
May 2016
Statement of Accountable Officer’s Responsibilities

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

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 Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the 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 judgements 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
- prepare the financial statements on a going concern basis.

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself or herself aware of any relevant audit information and to establish that the entity’s auditors are aware of that information.
- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

signed:

Adam Doyle
Accountable Officer
Statements of Financial Position
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## Notes to the Accounts

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<td>Financial performance targets</td>
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# Statement of Comprehensive Net Expenditure for the year ended 31-March-2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee benefits</strong></td>
<td>3,877</td>
<td>3,225</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td>256,726</td>
<td>232,762</td>
</tr>
<tr>
<td><strong>Other operating revenue</strong></td>
<td>(21,663)</td>
<td>(20,489)</td>
</tr>
<tr>
<td><strong>Net operating expenditure before interest</strong></td>
<td>238,940</td>
<td>215,498</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td>238,940</td>
<td>215,498</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administration Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employee benefits</strong></td>
<td>1,443</td>
<td>1,414</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td>3,336</td>
<td>3,801</td>
</tr>
<tr>
<td><strong>Other operating revenue</strong></td>
<td>(236)</td>
<td>(305)</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td>4,543</td>
<td>4,910</td>
</tr>
<tr>
<td><strong>Programme Income and Expenditure</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Employee benefits</strong></td>
<td>2,434</td>
<td>1,811</td>
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<td><strong>Operating Expenses</strong></td>
<td>253,390</td>
<td>228,961</td>
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<td><strong>Other operating revenue</strong></td>
<td>(21,427)</td>
<td>(20,184)</td>
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<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td>234,397</td>
<td>210,588</td>
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<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
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<tbody>
<tr>
<td><strong>Other comprehensive net expenditure</strong></td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Total comprehensive net expenditure for the year</strong></td>
<td>238,940</td>
<td>215,498</td>
</tr>
</tbody>
</table>

The notes on pages 10 to 31 form part of this statement.
### Statement of Financial Position as at 31-March-2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Non-current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>8272</td>
<td>803</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>8272</td>
<td>803</td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>3092</td>
<td>2466</td>
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<tr>
<td>Cash and cash equivalents</td>
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<td>76</td>
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<tr>
<td>Total current assets</td>
<td>3168</td>
<td>2541</td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(17711)</td>
<td>(14037)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>(17711)</td>
<td>(14037)</td>
</tr>
<tr>
<td>Non-Current Assets plus/less Net Current Assets/Liabilities</td>
<td>(13671)</td>
<td>(10693)</td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
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<tr>
<td>Trade and other payables</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Total non-current liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assets less Liabilities</td>
<td>(13671)</td>
<td>(10693)</td>
</tr>
<tr>
<td>Financed by Taxpayers' Equity</td>
<td></td>
<td></td>
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<tr>
<td>General fund</td>
<td>(13671)</td>
<td>(10693)</td>
</tr>
<tr>
<td>Total taxpayers' equity:</td>
<td>(13671)</td>
<td>(10693)</td>
</tr>
</tbody>
</table>

The notes on pages 10 to 31 form part of this statement.

The financial statements on pages 3 to 31 were approved by the Governing Body on the 20th of May 2016 and signed on its behalf by:

Chief Accountable Officer
Adam Doyle
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF
NHS MERTON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Merton Clinical Commissioning Group (CCG) for
the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

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

Respective responsibilities of the Accountable Officer and auditor

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

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

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

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

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

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

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 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.
Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the CCG under section 24 of the Act; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

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 Act and the Code of Audit Practice.

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

Grant Thornton UK LLP
Fleming Way, Manor Royal, Crawley, RH10 9GT

26 May 2016
### Statement of Changes In Taxpayers Equity for the year ended 31-March-2016

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

<table>
<thead>
<tr>
<th>General fund £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2015</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 1 April 2015</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16</td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
</tr>
<tr>
<td>Net funding</td>
</tr>
<tr>
<td>Balance at 31 March 2016</td>
</tr>
</tbody>
</table>

**Changes in taxpayers’ equity for 2014-15**

<table>
<thead>
<tr>
<th>General fund £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2014</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition</td>
</tr>
<tr>
<td>Adjusted NHS Commissioning Board balance at 1 April 2014</td>
</tr>
<tr>
<td>Changes in NHS Commissioning Board taxpayers’ equity for 2014-15</td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
</tr>
<tr>
<td>Net Recognised NHS Commissioning Board Expenditure for the Financial Year</td>
</tr>
<tr>
<td>Net funding</td>
</tr>
<tr>
<td>Balance at 31 March 2015</td>
</tr>
</tbody>
</table>

The notes on pages 10 to 31 form part of this statement
### Cash Flows from Operating Activities

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Net operating expenditure for the financial year</td>
<td>(238,940)</td>
<td>(215,498)</td>
</tr>
<tr>
<td>5</td>
<td>Depreciation and amortisation</td>
<td>129</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>(627)</td>
<td>2,013</td>
</tr>
<tr>
<td>11</td>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>3,674</td>
<td>(946)</td>
</tr>
<tr>
<td>12</td>
<td>Increase/(decrease) in provisions</td>
<td>0</td>
<td>(319)</td>
</tr>
<tr>
<td></td>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td><strong>(235,764)</strong></td>
<td><strong>(214,750)</strong></td>
</tr>
</tbody>
</table>

### Cash Flows from Investing Activities

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>(Payments) for property, plant and equipment</td>
<td>(198)</td>
<td>(771)</td>
</tr>
<tr>
<td></td>
<td><strong>Net Cash Inflow (Outflow) from Investing Activities</strong></td>
<td><strong>(198)</strong></td>
<td><strong>(771)</strong></td>
</tr>
</tbody>
</table>

### Cash Flows from Financing Activities

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grant in Aid Funding Received</td>
<td>235,962</td>
<td>215,423</td>
</tr>
<tr>
<td></td>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td><strong>235,962</strong></td>
<td><strong>215,423</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td><strong>0</strong></td>
<td><strong>(97)</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td><strong>76</strong></td>
<td><strong>173</strong></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>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Effect of exchange rate changes</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td><strong>76</strong></td>
<td><strong>76</strong></td>
</tr>
</tbody>
</table>

The notes on pages 10 to 31 form part of this statement.
Notes to the financial statements

1. Accounting Policies

NHS England has directed that the Financial Statements of clinical commissioning groups shall meet the accounting requirements of the 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 2015-16 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 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.

In 2015/16 NHS Merton CCG did not meet its 1% surplus target as per NHS business rules. The CCG is currently in discussions with NHS England regarding setting a deficit budget for 2016/17. These discussions are ongoing and a deficit budget will only be agreed following the completion of the financial recovery plan which details how the CCG will return to a sustainable financial position.

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 Pooled Budgets

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

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

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

In 2015/16 NHS Merton CCG had a pooled budget with the London Borough of Merton for the Better Care Fund and Integrated Community Equipment Services. The Fund is hosted and accounted for by the London Borough of Merton.
Notes to the financial statements

1.5 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.

1.5.1 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.

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

1.5.2 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 in the Financial Statements:

The largest estimated cost in the CCG’s accounts relates to the March 2016 prescribing accrual. This accrual has been calculated at £2m and is a best estimate based on the spend from April 2015 to February 2016.

1.6 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.

1.7 Employee Benefits

1.7.1 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.

1.7.2 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.

1.8 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.
Notes to the financial statements

1.9 Property, plant and equipment

1.9.1 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.

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

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

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

1.9.3 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.

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

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

1.11 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.

1.11.1 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.
1.12 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

1.13 Provisions
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group 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. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

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

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

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

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

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

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

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

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

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

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

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

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

1.18 Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when NHS Merton CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are 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.

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

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

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

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

1.22 Accounting Standards that have been issued but have not yet been adopted
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:
- IFRS 9: Financial Instruments
- 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 2015-16, 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>Prescription fees and charges</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>62</td>
<td>62</td>
<td>0</td>
<td>265</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>51</td>
<td>51</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other revenue</td>
<td>21,490</td>
<td>123</td>
<td>21,367</td>
<td>20,219</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>21,663</strong></td>
<td><strong>236</strong></td>
<td><strong>21,427</strong></td>
<td><strong>20,489</strong></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 - 89%
- Hosting South West London Cancer Network - 5%
- Other - 6%

2015/16 was the final year that NHS Merton CCG hosted the Community Services contract on behalf of NHS Sutton CCG and Sutton Borough Council. In 2016/17 NHS Merton CCG will host the Community Services contract on behalf of the London Borough of Merton only.

### 3 Revenue

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>From rendering of services</td>
<td>21,663</td>
<td>236</td>
<td>21,427</td>
<td>20,489</td>
</tr>
<tr>
<td>Total</td>
<td>21,663</td>
<td>236</td>
<td>21,427</td>
<td>20,489</td>
</tr>
</tbody>
</table>

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.
NHS Merton CCG - Annual Accounts 2015-16

4. Employee benefits and staff numbers

### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>3,342</td>
<td>2,299</td>
<td>1,043</td>
<td>1,223</td>
<td>894</td>
<td>329</td>
<td>2,119</td>
<td>1,405</td>
<td>714</td>
</tr>
<tr>
<td>Social security costs</td>
<td>222</td>
<td>222</td>
<td>0</td>
<td>94</td>
<td>94</td>
<td>0</td>
<td>128</td>
<td>128</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>313</td>
<td>313</td>
<td>0</td>
<td>126</td>
<td>126</td>
<td>0</td>
<td>187</td>
<td>187</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,877</td>
<td>2,834</td>
<td>1,043</td>
<td>1,443</td>
<td>1,114</td>
<td>329</td>
<td>2,434</td>
<td>1,720</td>
<td>714</td>
</tr>
</tbody>
</table>

Less recoveries in respect of employee benefits (note 4.1.2)

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>3,877</td>
<td>2,834</td>
<td>1,043</td>
<td>1,443</td>
<td>1,114</td>
<td>329</td>
<td>2,434</td>
<td>1,720</td>
<td>714</td>
</tr>
</tbody>
</table>

Less: Employee costs capitalised

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>3,877</td>
<td>2,834</td>
<td>1,043</td>
<td>1,443</td>
<td>1,114</td>
<td>329</td>
<td>2,434</td>
<td>1,720</td>
<td>714</td>
</tr>
</tbody>
</table>

### 4.1.2 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,842</td>
<td>1,851</td>
<td>990</td>
<td>1,200</td>
<td>1,015</td>
<td>185</td>
<td>1,642</td>
<td>836</td>
<td>806</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>
<td>75</td>
<td>75</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>
<td>94</td>
<td>94</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,225</td>
<td>2,234</td>
<td>990</td>
<td>1,414</td>
<td>1,229</td>
<td>185</td>
<td>1,811</td>
<td>1,005</td>
<td>806</td>
</tr>
</tbody>
</table>

Less recoveries in respect of employee benefits (note 4.1.2)

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>3,225</td>
<td>2,234</td>
<td>990</td>
<td>1,414</td>
<td>1,229</td>
<td>185</td>
<td>1,811</td>
<td>1,005</td>
<td>806</td>
</tr>
</tbody>
</table>

Less: Employee costs capitalised

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>Permanent Employees £000</th>
<th>Other £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>3,225</td>
<td>2,234</td>
<td>990</td>
<td>1,414</td>
<td>1,229</td>
<td>185</td>
<td>1,811</td>
<td>1,005</td>
<td>806</td>
</tr>
</tbody>
</table>

The 2015/16 Remuneration report can be found on the 2015/16 NHS Merton Clinical Commissioning Group Annual Report
4.2 Average number of people employed

<table>
<thead>
<tr>
<th>Total Number</th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent employed Number</td>
<td>48</td>
<td>42</td>
</tr>
<tr>
<td>Other Number</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Total Number</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

Other average number of people employed has been calculated using average number of hours worked over a full year.

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>405</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>43</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>9</td>
</tr>
</tbody>
</table>

Total days lost of 405 covers 28 employees.

<table>
<thead>
<tr>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons retired early on ill health grounds</td>
<td>0</td>
</tr>
<tr>
<td>Total additional Pensions liabilities accrued in the year</td>
<td>£000</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 assets and liabilities.

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

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

4.5.1 Full actuarial (funding) valuation

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

For 2015-16, employer’s contributions of £313,216 were payable to the NHS Pensions Scheme at the rate of 14.3% of pensionable pay (2014-15: £186,881 at the rate of 14%). The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.1.
### 5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2015-16 Total £000</th>
<th>2015-16 Admin £000</th>
<th>2015-16 Programme £000</th>
<th>2014-15 Total £000</th>
</tr>
</thead>
<tbody>
<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>3,302</td>
<td>1,070</td>
<td>2,232</td>
<td>2,737</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>574</td>
<td>373</td>
<td>201</td>
<td>488</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>3,876</td>
<td>1,443</td>
<td>2,433</td>
<td>3,225</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>7,009</td>
<td>2,073</td>
<td>4,936</td>
<td>8,054</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>125,901</td>
<td>1</td>
<td>125,900</td>
<td>62,927</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>64,660</td>
<td>0</td>
<td>64,660</td>
<td>112,739</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>29,108</td>
<td>0</td>
<td>29,108</td>
<td>19,673</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>145</td>
<td>135</td>
<td>10</td>
<td>169</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>576</td>
<td>424</td>
<td>152</td>
<td>1,431</td>
</tr>
<tr>
<td>Establishment</td>
<td>571</td>
<td>97</td>
<td>474</td>
<td>949</td>
</tr>
<tr>
<td>Transport</td>
<td>15</td>
<td>4</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Premises</td>
<td>614</td>
<td>249</td>
<td>365</td>
<td>659</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(338)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>129</td>
<td>0</td>
<td>129</td>
<td>0</td>
</tr>
<tr>
<td>Audit fees</td>
<td>57</td>
<td>57</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>23,750</td>
<td>0</td>
<td>23,750</td>
<td>23,124</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>2,732</td>
<td>0</td>
<td>2,732</td>
<td>2,581</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>476</td>
<td>226</td>
<td>250</td>
<td>465</td>
</tr>
<tr>
<td>Education and training</td>
<td>162</td>
<td>69</td>
<td>93</td>
<td>254</td>
</tr>
<tr>
<td>Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(319)</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>814</td>
<td>0</td>
<td>814</td>
<td>306</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>256,726</td>
<td>3,336</td>
<td>253,390</td>
<td>232,762</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>260,602</td>
<td>4,779</td>
<td>255,823</td>
<td>235,987</td>
</tr>
</tbody>
</table>

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

Programme expenditure is expenditure incurred that is directly attributable to the provision of healthcare or healthcare services.
6 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2015-16 Number</th>
<th>2015-16 £000</th>
<th>2014-15 Number</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>8,380</td>
<td>33,637</td>
<td>7,287</td>
<td>25,299</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>8,204</td>
<td>32,356</td>
<td>7,106</td>
<td>24,638</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>97.9%</td>
<td>96.2%</td>
<td>97.5%</td>
<td>97.4%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>2,675</td>
<td>196,170</td>
<td>2,782</td>
<td>188,240</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,557</td>
<td>195,736</td>
<td>2,703</td>
<td>187,130</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>95.6%</td>
<td>99.8%</td>
<td>97.2%</td>
<td>99.4%</td>
</tr>
</tbody>
</table>

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

7.1 As lessee
The payment below reflects Community Health Partnership’s and NHS Property Services Limited charges for the financial year 2015/16 and relates to properties owned or managed by them.

7.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Buildings £000</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>600</td>
<td>600</td>
<td>609</td>
</tr>
<tr>
<td>Total</td>
<td>600</td>
<td>600</td>
<td>609</td>
</tr>
</tbody>
</table>

Whilst our arrangements with Community Health Partnership’s Limited and 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 the arrangements.
## 8 Property, plant and equipment

### Assets under construction and payments on account

<table>
<thead>
<tr>
<th>Description</th>
<th>2015-16</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01-April-2015</td>
<td>803</td>
<td>0</td>
<td>803</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>0</td>
<td>198</td>
<td>198</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>(803)</td>
<td>803</td>
<td>0</td>
</tr>
<tr>
<td>Cost/Valuation At 31-March-2016</td>
<td>(0)</td>
<td>1,001</td>
<td>1,001</td>
</tr>
<tr>
<td>Depreciation 01-April-2015</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>0</td>
<td>129</td>
<td>129</td>
</tr>
<tr>
<td>Depreciation at 31-March-2016</td>
<td>0</td>
<td>129</td>
<td>129</td>
</tr>
<tr>
<td>Net Book Value at 31-March-2016</td>
<td>(0)</td>
<td>872</td>
<td>872</td>
</tr>
<tr>
<td>Purchased</td>
<td>(0)</td>
<td>872</td>
<td>872</td>
</tr>
<tr>
<td>Total at 31-March-2016</td>
<td>(0)</td>
<td>872</td>
<td>872</td>
</tr>
</tbody>
</table>

### Asset financing:

<table>
<thead>
<tr>
<th>Description</th>
<th>2015-16</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned</td>
<td>(0)</td>
<td>872</td>
<td>872</td>
</tr>
</tbody>
</table>

### Total at 31-March-2016

<table>
<thead>
<tr>
<th>Description</th>
<th>2015-16</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>(0)</td>
<td>872</td>
<td>872</td>
</tr>
</tbody>
</table>

### 2014-15

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<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 acce</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:

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned</td>
<td>803</td>
<td>803</td>
</tr>
</tbody>
</table>

### Total at 31 March 2015

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>803</td>
<td>803</td>
</tr>
</tbody>
</table>

### 8.1 Economic lives

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

<table>
<thead>
<tr>
<th></th>
<th>Current 2015-16 £000</th>
<th>Non-current 2015-16 £000</th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,036</td>
<td>0</td>
<td>517</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,184</td>
<td>0</td>
<td>1,269</td>
<td>0</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>142</td>
<td>0</td>
<td>295</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>666</td>
<td>0</td>
<td>356</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accrued income</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>8</td>
<td>0</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total Trade &amp; other receivables</td>
<td>3,092</td>
<td>0</td>
<td>2,466</td>
<td>0</td>
</tr>
<tr>
<td>Total current and non current</td>
<td>3,092</td>
<td>2,466</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The great majority of trade is with NHS organisations and local authorities. As NHS organisations and local authorities are ultimately funded by Government, no credit scoring of them is considered necessary.

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

9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>179</td>
<td>1</td>
</tr>
<tr>
<td>By three to six months</td>
<td>0</td>
<td>24</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>179</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

£179k 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 2016.

9.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01-April-2015</td>
<td>0</td>
<td>(338)</td>
</tr>
<tr>
<td>(Increase) decrease in receivables impaired</td>
<td>0</td>
<td>338</td>
</tr>
<tr>
<td>Balance at 31-March-2016</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
10 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01-April-2015</td>
<td>76</td>
<td>173</td>
</tr>
<tr>
<td>Net change in year</td>
<td>0</td>
<td>(97)</td>
</tr>
<tr>
<td><strong>Balance at 31-March-2016</strong></td>
<td><strong>76</strong></td>
<td><strong>76</strong></td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service | 76 | 75 |
- Cash in hand                              | 0  | 1  |
- **Cash and cash equivalents as in statement of financial position** | **76** | **76** |

**Balance at 31-March-2016** | **76** | **76** |
### 11 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2015-16 £000</th>
<th>Non-current 2015-16 £000</th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>6,438</td>
<td>0</td>
<td>4,986</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>(151)</td>
<td>0</td>
<td>(31)</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>2,979</td>
<td>0</td>
<td>2,273</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals</td>
<td>7,982</td>
<td>0</td>
<td>6,557</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>32</td>
<td>0</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>39</td>
<td>0</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>392</td>
<td>0</td>
<td>190</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>17,711</strong></td>
<td><strong>0</strong></td>
<td><strong>14,037</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

Other payables include £51k outstanding pension contributions at 31 March 2016 (£41k as at 31 March 2015).

The negative balance on NHS accruals is due to an anticipated reduction in payables relating to the Nelson Health Centre contract.

NHS Merton CCG had paid the full contract value as per the SLA agreements, however were awaiting a credit note for underperformance for which an accrual was done to reduce payables. The credit note was subsequently received by the CCG after 31 March 2016.

### 12 Provisions

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 NHS Merton CCG at 31 March 2016 is £1.713m. As at 31 March 2015 the total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of NHS Merton CCG was 1.963m.

The CCG has no other provisions at 31 March 2016.
13 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).

14 Financial instruments

14.1 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 Merton 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.

14.1.1 Currency risk

The 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. The NHS Merton Clinical Commissioning Group has no overseas operations. The NHS Merton Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

14.1.2 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.

14.1.3 Credit risk

Because the majority of the NHS Merton Clinical Commissioning Group's revenue comes 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.

14.1.4 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. The NHS Merton Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Merton Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.
14 Financial instruments cont'd

14.2 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables 2015-16</th>
<th>£000</th>
<th>Available for Sale 2015-16</th>
<th>£000</th>
<th>Total 2015-16</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-16</td>
<td>2015-16</td>
<td></td>
<td>2015-16</td>
<td></td>
<td>2015-16</td>
<td></td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>1,178</td>
<td>0</td>
<td>1,178</td>
<td></td>
<td>1,178</td>
<td></td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>717</td>
<td>0</td>
<td>717</td>
<td></td>
<td>717</td>
<td></td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>76</td>
<td>0</td>
<td>76</td>
<td></td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Total at 31-March-2016</td>
<td>0</td>
<td>1,178</td>
<td>0</td>
<td>1,178</td>
<td></td>
<td>1,178</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables 2014-15</th>
<th>£000</th>
<th>Available for Sale 2014-15</th>
<th>£000</th>
<th>Total 2014-15</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></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>
<td></td>
<td>517</td>
<td></td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>356</td>
<td>0</td>
<td>356</td>
<td></td>
<td>356</td>
<td></td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>76</td>
<td>0</td>
<td>76</td>
<td></td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total at 31-March-2015</td>
<td>0</td>
<td>952</td>
<td>0</td>
<td>952</td>
<td></td>
<td>952</td>
<td></td>
</tr>
</tbody>
</table>

14.3 Financial liabilities

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

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Other 2014-15</th>
<th>Total 2014-15</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>4,955</td>
<td>4,955</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>9,020</td>
<td>9,020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total at 31-March-2015</td>
<td>0</td>
<td>13,975</td>
<td>13,975</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15 Operating segments

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

16 Pooled budgets

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(5,756)</td>
<td>(246)</td>
</tr>
</tbody>
</table>

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

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

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>St George's University Hospitals Foundation Trust</td>
<td>65,817</td>
<td>(80)</td>
<td>60,513</td>
<td>0</td>
</tr>
<tr>
<td>Epsom &amp; St Helier University Hospitals NHS Trust</td>
<td>37,274</td>
<td>0</td>
<td>38,236</td>
<td>0</td>
</tr>
<tr>
<td>The Royal Marsden NHS Foundation Trust</td>
<td>28,576</td>
<td>(77)</td>
<td>33,941</td>
<td>0</td>
</tr>
<tr>
<td>South West London and St George's Mental Health NHS Trust</td>
<td>16,893</td>
<td>(12)</td>
<td>16,322</td>
<td>0</td>
</tr>
<tr>
<td>Kingston Hospital Foundation Trust</td>
<td>10,582</td>
<td>0</td>
<td>9,630</td>
<td>0</td>
</tr>
<tr>
<td>London Ambulance Service NHS Trust</td>
<td>6,543</td>
<td>0</td>
<td>5,581</td>
<td>0</td>
</tr>
<tr>
<td>Moorfields Eye Hospital NHS Foundation Trust</td>
<td>3,969</td>
<td>0</td>
<td>3,718</td>
<td>0</td>
</tr>
<tr>
<td>Dr Andrew Murray (Personal Medical Services Contract)</td>
<td>98</td>
<td>(20)</td>
<td>159</td>
<td>0</td>
</tr>
<tr>
<td>Dr Tim Hodgson (Personal Medical Services Contract)</td>
<td>188</td>
<td>0</td>
<td>155</td>
<td>0</td>
</tr>
</tbody>
</table>

Dr Andrew Murray and Dr Tim Hodgson are GP members of the Governing Body. The payments above are primarily Dr Andrew Murray's and Dr Tim Hodgson's practice's share of Local Enhanced Services payments made to the Church Lane Practice and Wimbledon Village 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.
18 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.

The CCG has been successful in its application to participate in delegated Primary Care co-commissioning from 1st April 2016. The associated income and expenditure will appear in the CCG's 2016/17 financial statements.

19 Losses and special payments

19.1 Losses

There were no Losses or Special Payments during the year ended 31 March 2016
NHS Merton CCG - Annual Accounts 2015-16

20 Financial performance targets

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

NHS Clinical Commissioning Group performance against those duties was as follows:

<table>
<thead>
<tr>
<th>Target</th>
<th>Performance</th>
<th>Variance</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>£260,829</td>
<td>£260,801</td>
<td>£28</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>198</td>
<td>198</td>
<td>0</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>£238,968</td>
<td>£238,940</td>
<td>£28</td>
</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>
</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>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>£4,973</td>
<td>£4,543</td>
<td>£430</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target</th>
<th>Performance</th>
<th>Variance</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>£239,423</td>
<td>£236,679</td>
<td>£2,744</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>
</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>
</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>
</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>
</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>
</tr>
</tbody>
</table>