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Welcome

Welcome to NHS Merton Clinical Commissioning Group’s (CCG) Annual Report for the financial year 2018/19.

This has been a year of change during which we’ve seen some of our greatest achievements as an organisation. We met our financial duties and at the same time redoubled our efforts to deliver better care for patients in Merton.

In times of change, it becomes even more important to work in partnership and remain dedicated to improving the health and wellbeing of our local population. This year we established the Merton Health and Care Together Board to oversee a collaboration of the CCG, Merton Council, NHS providers, Healthwatch and the voluntary sector.

We continued to look at how the system can change to deliver further improvements and how we can sustain these changes. Through the Merton Health and Care Plan we have set out our areas of focus for Merton, and how we will ensure the action we take has maximum impact for local people.

To inform our plan, we held an event which brought together health and care frontline staff, local people and representatives from lots of different community organisations to talk about what’s important for health and care in Merton. We talked about the kinds of things which no single organisation can achieve alone – like improving mental health and supporting people with diabetes. It was fantastic to hear from local people who are clearly very passionate about improving health and care in Merton and who brought a range of fresh ideas.

We also continued our wider collaboration with Merton Council and partners through the Health and Wellbeing Board. We published a joint Autism strategy which enables us to support people with autism in the most effective way possible. Board members were paired with people living with diabetes so they could co-design information services with those who use them.

In addition, due to successful partnership between Merton Council and the GP members through the Dementia Action Alliance (DAA), Merton was awarded the status of a ‘Dementia Friendly Community’ by the Alzheimer’s Society last summer.

Integrated working between NHS and adult social care has also led to people getting out of hospital and returning home more quickly – most recently by the CCG and Council establishing joint ways of working to make this happen.

We also saw exciting new programmes emerge and evolve to meet the changing needs of our local population. Social prescribing is a way of linking patients in primary care with sources of support within the community to improve someone’s wellbeing, recognising a range of factors that affect people’s health.

We piloted social prescribing in East Merton and demonstrated significant improvements in patient wellbeing and reduced need for additional GP appointments. The success of the pilot has led to us expanding the programme across Merton.

This year has also seen a new approach to adult mental health services. The CCG commissioned a new model of care which looks at emotional wellbeing as well as mental health. We’ve expanded our services in Merton to increase the number of appointments available and the range of therapies on offer as well as addressing need in relation to housing, benefits and employment.

Work also continued to develop a new health and wellbeing campus in East Merton on the old Wilson hospital site. We have engaged with local people on the kinds of things they’d like to see there and, although we’ve encountered difficulties in the funding arrangements for the project, we are very much committed to progressing its development. Once built in 2022, the campus will not just be a place people go when they’re ill, but somewhere to help the community connect and stay healthy. The campus will be a new home for the GP hub service in East Merton and will host most specialist diagnostic services like x-ray.
We don't even have to wait for a new building to develop new wellbeing services, which is why we're working to put these in place in other sites in East Merton as soon as we can. We are actively working with voluntary sector organisations in the area to do just that.

Our work through the Improving Healthcare Together programme continues and we remain committed to listening and taking seriously the views of our local community about the potential changes at Epsom and St Helier hospitals. In September, we carried out engagement work to test all the options on the table as well as reflect on the work we have done to date. We continue to work with local hospitals and ambulance services to help us understand the impact of potential changes on other local NHS providers. A decision will only happen after a public consultation and after all the evidence and feedback has been reviewed meticulously.

Following the development of the South West London CCG Alliance last year we have continued to work at a south west London level when it makes sense in terms of achieving economies of scale and reducing duplication. The South West London Health and Care Partnership, alongside the CCG and our partners, delivered innovative new projects across our boroughs.

The children and young people's mental health programme is a great example. It takes a south west London wide approach to ensure children and young people get the mental health and emotional wellbeing support they need regardless of what borough they live in. This partnership approach brings together school leadership teams with health and social care professionals to deliver training and support for children and young people, their families and teachers.

Another major milestone this year has been that St George's University Hospitals NHS Foundation Trust's Board took the decision to return to reporting its referral to treatment (RTT) data in March 2019 after suspending reporting in 2016. The Trust now has robust systems and processes in place for tracking and prioritising patients at St George's Hospital but acknowledges that waiting lists and making sure patients get the treatment they need remains a challenge. As commissioners and partners, we will do all we can to support the Trust to maintain this.

The NHS turned 70 on 5 July 2018 and we celebrated the occasion with a range of activities with our partners across the borough.

On the day itself, staff attended a service in Westminster Abbey in celebration of the NHS's 70th birthday. We joined around 2,000 NHS staff and representatives of charities, councils, and other key partners who work with the NHS. We also partnered with colleagues from social care, housing and the third sector.

This year we have continued aligning our processes with Wandsworth CCG as we work more closely together and share management functions through the Local Delivery Unit. Staff have now come together in one office creating a vibrant collaborative space. Staff were involved throughout the planning process to create a modern working environment and ensure the change ran smoothly.

Finally, I would like to say a huge thank you to our Board, member practices, partner organisations, local residents and all our NHS staff for their support this year and I look forward to Merton's bright future in the years to come.

Dr Andrew Murray, Clinical Chair
NHS Merton CCG

Sarah Blow, Accountable Officer
NHS Merton CCG
1. PERFORMANCE REPORT

Performance Overview

Who we are and what we do

Merton Clinical Commissioning Group (CCG) is responsible for planning, buying (commissioning) and
monitoring health services for the people who live or work in Merton. This includes:

- Hospital care (for example outpatient appointments and routine operations)
- Services for people with mental health conditions
- Services for people who need long term care (for example people with learning disabilities and those
who are physically frail)
- Urgent and emergency care (for example urgent care centres and A&E)
- Community health services (for example district nursing).

We are also responsible for commissioning core GP services. Our GP practices work together with NHS
partners to improve health and wellbeing, reduce health inequalities and make sure everyone has equal
access to healthcare services. These partners include pharmacists, hospitals and mental health providers,
the London Borough of Merton, and local community groups. We also work with NHS England which
commissions health services from dentists and pharmacists, and specialised services such as transplant
surgery and many screening programmes.

The Governing Body (the Board) oversees the delivery of our commissioning plan, leads and sets the
strategy for the CCG, and is accountable for the delivery of our functions as a statutory body. All GP
practices are entitled, through their member representatives, to elect members to the Board. This means
that members are represented and contribute clinical expertise at the highest level within the CCG.

In 2018/19 we were responsible for a budget of £284.6 million that we used to pay for hospital, primary
care, community and mental health services for people living in Merton.

Financially, this year has been challenging for the CCG, because of increasing costs in our local hospitals,
commitments to further invest in mental health services for local people and our plans to achieve a large
savings programme. Despite this, we have achieved a £1.9 million surplus for the year.

You can find out more about us and our work on our website

Our corporate objectives

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In 2018, Merton has an estimated resident population of 210,250 which is projected to increase by approximately 3.5% to 217,550 by 2025.

The age profile is predicted to shift over this time, with notable growth in the proportions of young people between the ages of 11 and 15 years (17%), and those over 50 years old (10%). The young and the old have more complex health needs. Increasing numbers of our local population are living into older age with multiple long-term conditions such as heart disease, diabetes, cancer, mental health conditions, and dementia.

Currently, 37% of Merton’s population are from a Black, Asian, or Minority Ethnic (BAME) group. By 2025 this is predicted to increase slightly to 38% with a greater proportion living in the east of the borough. Children and young people from BAME backgrounds make up 67.9% of those attending a Merton school which is lower than the London average (72.2%) but higher than England (30%). The CCG has continued its engagement with minority ethnic groups this year to ensure we understand their experience of healthcare and their health and wellbeing needs.

Overall, Merton’s population is comparatively healthy and life expectancy is higher than the national and London average for both men and women. However, there are stark differences between different areas of the borough and life expectancy is significantly lower in the most deprived areas in East Merton. We have continued to develop the east Merton model of health and wellbeing in 2018/19 and social prescribing is being rolled out to all GP practices to help address these inequalities.

The main causes of ill health and premature deaths in Merton are cancer and circulatory disease (including coronary heart disease and stroke). Known risk factors (unhealthy diet, smoking, lack of physical activity, and alcohol) account for around 40% of total ill health. Consequently, changing patterns of unhealthy behaviour is an important focus for prevention efforts. The CCGs works collaboratively with London Borough of Merton’s public health team to support initiatives to tackle childhood obesity and encourage people to make healthier lifestyle choices (for example blood pressure checks, stopping smoking, getting more exercise and reducing alcohol consumption). The CCG also actively works with local community groups to improve diabetes awareness and diagnosis and to develop better service user involvement to improve clinical outcomes for patients with diabetes.

Health and wellbeing strategy

Merton has longstanding health inequalities between the east and the west of the borough. Our commissioning activities and our primary care strategy acknowledge these inequalities and seek to ensure that services address these needs and that prevention is built into all of our plans. Key areas of work to support prevention in primary care include:

- improving uptake of bowel screening
- identification of frailty with a view to proactively preventing ill health
- ensuring strong uptake of immunisations in both children and adults
- prevention of diabetes complications by focussing on those with the least well controlled diabetes.

In addition, we have developed schemes to focus on frequent users of urgent care and patients with chronic obstructive pulmonary disease. Both of these issues are more prominent in the east of the borough and are linked to higher rates of long term conditions, smoking, deprivation and mental health problems.

The CCG, along with other partners, is engaging in a refresh of the health and wellbeing strategy in Merton, led by London Borough of Merton. The refresh is likely to reinforce the importance of the strategy in creating a healthy place that encourages greater health and wellbeing.

Full data on Merton’s health needs is taken from the Joint Needs Strategic Assessment which informs the Council and the CCG to develop its shared strategy for health and wellbeing.
Working with our partners in Merton

We work with a variety of partners to improve health and wellbeing in Merton and to reduce inequalities in health across the borough.

Working as a Local Delivery Unit with Wandsworth CCG

Merton CCG shares a management team with Wandsworth CCG and this shared management team is referred to as the Local Delivery Unit (LDU). There are clear benefits to closer working across the two CCGs, particularly when it comes to managing our larger contracts and the relationship with St George’s University Hospitals NHS Foundation Trust. Both CCGs have benefitted from shared experience, expertise and resources in areas such as continuing healthcare, tackling delayed transfers of care, mental health placements, primary care resilience and social prescribing.

The combined team brings out the strengths which both CCGs have brought to the LDU. Staff have moved from their previous Putney office to join Merton CCG staff in Wimbledon so we can all work more effectively together. Staff were involved throughout the planning process to create a modern working environment and ensure the change ran smoothly.

South West London Alliance of CCGs

The South West London Alliance is the result of five CCGs (Merton, Wandsworth, Kingston, Richmond and Sutton) in south west London having chosen to work together to share expertise and use resources more effectively. Wandsworth, Kingston, Merton and Richmond joined together as an alliance on 1 April 2017 with Sutton CCG joining on 1 April 2018. We remain close partners with Croydon CCG who are part of our South West London Health and Care Partnership, but not formally part of the alliance with their own accountable officer.

Working together helps us to make stronger collective commissioning decisions, share best practice and expertise across a wider footprint and reduce duplication. It also enables us to learn from our neighbours, bringing everyone up to the same high standards when planning and buying healthcare services.

Making joint commissioning decisions for south west London

Effectively commissioning healthcare services sometimes requires decisions to be made for more than just the residents of a single borough. Governing Body members from each of the six CCGs in south west London meet in public as the ‘Committees in Common’ to make decisions on issues that affect every borough.

An example of a collective decision we have made is all of the six CCGs unanimously agreeing how to collectively fund transformation of primary care for 2018/19 across south west London.

The General Practice Forward View set out a requirement for all CCGs in the country to ensure people can access primary care services 8am to 8pm, seven days a week.

In the past year Merton has benefitted from south west London CCGs receiving £8 million which equates to £5.41 per head of population. This is being used to develop extended GP services, ensuring the extra appointments are available for local patients. The funding will also be used to enable NHS 111 and A&E departments to book GP appointments directly.

Some of this funding has also been used to look at new ways of supporting primary care to work closely together at scale across south west London. This way of working can help to spread best practice, offer more personalised and preventative care, tackle workforce issues and manage a range of administrative functions more efficiently.

Working together gives us flexibility to use the money we will receive as a system. Making one decision across all six CCGs also ensures that everyone is able to make progress towards our collective vision.
Merton Council and the Merton Health and Wellbeing Board

As set out above, we work closely with the London Borough of Merton leads on helping local people to stay healthy. The public health team at the council provide information and expertise to support our work and the Director of Public Health for Merton is a member of our Governing Body. More information about the London Borough of Merton’s public health role can be found here: www.merton.gov.uk/health-social-care/publichealth

Health and wellbeing boards are designed to deliver strategic joined-up local leadership on health and care. The work of the Merton Health and Wellbeing Board is central to the commissioning of health and social care services in Merton. The Board brings together Merton Council, Merton CCG, Healthwatch Merton and the voluntary and community sector with a shared focus on improving health and wellbeing in Merton, tackling health inequalities and encouraging a greater focus on helping people to stay healthy and make healthier choices.

Further information about the Board’s work is set out in the Health and wellbeing strategy section above.

Merton Health and Care Plan

We believe a local approach works best, and health and care organisations across Merton have formed local partnerships to develop local Health and Care Plans which will help achieve our aspiration to support people to start well, live well and age well.

Merton’s Local Transformation Board and Health and Wellbeing Board are leading on the local health and care plans, and in November 2018, held a local partnership event which brought together health and care frontline staff, local people and representatives from different community organisations to talk about what’s important for health and care in Merton.

The event generated great energy and fresh ideas, and people were passionate about improving health and care in Merton.

The local partnership identified priority areas for improvement, but it was clear that health and care organisations must be better connected and more joined up, particularly in areas where no single organisation can achieve alone – like improving mental health, combating childhood obesity, and supporting people with diabetes.

Local partnerships in Merton will continue the conversation about improving health and care following the publication of the Health and Care plan.

South West London Health and Care Partnership

Over the past year, the NHS, local councils, Healthwatch and the voluntary sector in south west London have strengthened their commitment to working together to deliver better care for local people as the South West London Health and Care Partnership (SWLHCP). People told us, and we agreed, that a local approach works best. To support this the organisations providing health and care in our six London boroughs have come together as four local partnerships, acting as one team to keep people healthy and well in: Merton, Croydon, Kingston, Richmond, Wandsworth and Sutton.

Moving Forward Together

In line with the NHS Long Term Plan, south west London CCG governing bodies are discussing the proposed south west London CCG merger by April 2020. The headline case for change, our guiding principles, and details the five work streams that have been set up to deliver this change in south west London are explained below.

As a partnership, our headline case for change talks about the need to:
- Ensure that clinical leadership is enhanced and the patient remains at the heart of everything we do
- Ensure local accountability including financial delegation and freedom to transform
- Take the opportunity to take out layers of unnecessary governance and reduce duplication
• Enhance and improve support to deliver local priorities
• Pool resources and expertise to improve our delivery
• Make sure our people and functions are in the right place, at the right level and the right scale
• Get the benefit of integration at a local level
• Take control locally and ensure we can develop our own way of working by acting now
• Achieve a 20% reduction (£6.6m across SWL) in CCG management running costs and this will allow us to redirect money into frontline services and patient care

Our guiding principles
• We will maintain our focus on today
• We will streamline how we operate
• We will design an organisation with the future in mind
• We will move forward together, and engage people in how we do this

Work streams
• Functional review: to ensure that the organisation designed is right for the future and reflects local priorities and decision making
• HR: to guide the people implications of the change
• Finance: to guide the financial assessment and implications of the change
• Governance: to ensure robust, safe and clear governance is in place
• Communications and Engagement: to ensure all staff, governing bodies and their membership, and partners are informed of, and engaged in, the change process.

Over the next year, we will continue to work closely together with our partners to develop our future plans.

Healthy London partnership

NHS Merton CCG, along with all of London’s 32 CCGs, Greater London Authority, London Councils, Public Health England and NHS England (London) contributed funding towards Healthy London Partnership (HLP) in 2018/19. The aim was to bring together the NHS and partners in London to work towards the common goals set out in Better Health for London, NHS Five Year Forward View and the devolution agreement.

HLP works as a partnership across London’s health and care system and beyond to achieve these goals.

2018/19 has been another busy year for Healthy London Partnership. Highlights of the work included:

• Social prescribing, developing a draft ‘Social Prescribing Vision for London’ to support the scale and spread of social prescribing across London.

• Thrive LDN, to improve the mental health and wellbeing of all Londoners. A festival of cultural activity was organised as part of Thrive LDN’s wider Are we OK London? campaign. Good Thinking – London’s unique digital mental wellbeing service supported over 100,000 Londoners to actively tackle anxiety, sleeplessness, stress and depression.

• Great Weight Debate, which engaged Londoners on how best to tackle childhood obesity, HLP has worked on a pilot with fast food shops, businesses and charities and young people on the Healthy High Streets Challenge. Insights gained informed obesity strategies across all London boroughs and the Mayor’s policy to restrict the advertising of food and drink that is high in fat, sugar and salt across Transport for London’s advertising estate from February 2019.

• London’s annual #AskAboutAsthma campaign which launched at the start of the new school year when hospital admission rates for asthma are at their highest. Reaching over 5.9 million people online in 2018. Additionally, HLP developed the London asthma standards for children and young people, along with a new online toolkit for staff which to date has been accessed just under 19,000 times.
Performance analysis

Our achievements in 2018/19

Our ambition for the people of Merton is that they start well, live well and age well. Over the past year we have been working closely with our key partners to progress and improve the health of local residents. In the following section we will highlight some of our main achievements supporting our local patients in the following sections:

- Primary Care
- Start Well
- Live Well
- Age Well
- Planned Care
- Urgent and Emergency Care
- Supporting Programmes

Primary Care

- 8am – 8pm access to a GP
- DoctorLink - online advice and appointments
- Over the counter medicines
- Primary care at scale
- GP Federation

The GP practices in Merton CCG cover a registered population of 223,000 (March 2019), with individual practices ranging from 3,600 patients to nearly 30,000. The borough-wide registered population continues to grow approximately 3% year on year. In 2018/19, of the 22 GP practices in Merton, one was rated “Outstanding” by the Care Quality Commission (CQC) and 18 rated “Good”. In the 2018 GP Patient Survey 82% of patients rated their overall experience of their GP as “Good” (England Average 84%), an increase for Merton from 80% rated Good in 2017 and 2016.

Our vision for primary care is to deliver the right care in the community. In 2018/2019, south west London received £8 million to help continue to transform primary care services. All CCGs across south west London now offer access to primary care services 8am to 8pm, seven days a week, as set out in the General Practice Forward View, and has created around 19,000 extra appointments each month.

The funding has also been used to enable NHS 111 and A&E departments to book appointments directly into the services, for patients who would be better served by primary care, and therefore, has helped alleviate demand on other services within the local health and care system.

We have also invested in new ways to support our workforce because to deliver high quality care, we need a high quality workforce. We are now part of the International GP recruitment programme, and have secured GP retention funding to encourage and support GPs to remain in practice.

In addition, we have invested in new ways of supporting primary care to work collaboratively in larger groups across south west London. The benefits to practices, and our population, is that this way of working can help to spread best practice, reduce bureaucracy, offer more personalised and preventative care, tackle workforce issues and manage a range of administrative functions more efficiently.

Our focus for 2019/2020 will be to continue supporting general practices to operate across multiple delivery areas; to significantly expand the focus of the digital work from online consultations to how technology can transform ways of working; and we will continue working on retaining our workforce.
8am – 8pm access to a GP

In 2018/19 through 2 GP hubs in Merton, 1 in east Merton and another in west Merton, an additional 1,400 GP appointments and 620 Nurse appointments have been provided each month.

We have also implemented a process for direct bookings from urgent care services (NHS111 and local Emergency Departments) into the Hub sites. We are investing in rolling out direct bookings into GP Practices in 2019/20. During the last year, a comprehensive local marketing plan was also rolled out across the boroughs to improve awareness of 8am – 8pm access appointments.

GP Federation

The GP Federation (Merton Health) aims to deliver locally integrated health care in a cost effective and patient centred way. In Merton, it is responsible for GP Access Hubs, Healthchecks, the Referral Management Centre and a trial for improving the levels of cervical smears.

Primary care at scale

It has been recognised that practices working together or ‘at scale’ could provide opportunities to address many of the challenges facing primary care and could bring benefits for patients and practices themselves as well as the wider health system.

During 2018/19, we used available transformation funding to shape the direction of travel in terms of what primary care at scale should look like in Merton.

In Merton practices have formed Primary Care Networks (PCNs) which have evolved over the course of the year. The PCNs form part of overall Integrated Locality Teams which seek to develop effective collaborative working across a range of health and social care partners to improve patient care. Merton Health has aligned its governance structures and leadership teams to the PCNs in order to effectively oversee the delivery of initiatives and engage with practices.

Various borough wide developments have taken place, for example introducing an intranet across all practices and the Federation, reviewing potential centralised support functions and progressing with the introduction of standardised website portals.

Individual PCN initiatives have also taken place, for example developing a model of care for complex respiratory patients with community services, scoping a rapid response GP service and a project to improve the management of type 2 diabetic patients using digital solutions.

DoctorLink

Doctorlink is an online clinical triage tool that launched at the end of September to help patients get the advice or treatment they need in a convenient way, which streamlines access to GP appointments. The tool means that patients will be able to get clinically approved medical advice around the clock and advice on how to best manage their symptoms.

This new system will also allow patients who require an appointment to book directly with their practice, within a timeframe suitable to their clinical need. If appropriate, patients can also be directed to their local pharmacy, reducing unnecessary GP practice appointments by getting patients to the right place for their clinical need.

The system can be accessed online through practice websites or the DoctorLink website from any laptop, mobile phone or tablet device, available seven days a week from any location. An app has also been launched in March to make it easier for patients to be able to access the service.

Doctorlink is being introduced to all GP practices in south west London in an incremental rollout. By the end of March 2019, a total of over 70 out of over 200 practices had signed up to the service. This has been rolled out to practices who have shown and interest and currently there is representation in all boroughs across south west London.
There is currently a targeted programme of work to support practices to raise awareness of the service and increase uptake among patients living in our boroughs. This will include raising awareness of the app through digital marketing targeted at practices where the service is available, along with working with practices to promote the service through providing marketing materials and tactics to engage with patients.

**Over the counter medicines**

In March 2018, NHS England issued guidance that some over the counter medicines will no longer be routinely prescribed in primary care. This means that doctors, and other prescribers, will not routinely prescribe medicines for minor health conditions that can be purchased over the counter. In most cases the direct cost of over the counter medicines will be lower than the combined cost to the NHS of a GP consultation, buying, prescribing and then dispensing the medicine.

Merton alongside the other CCGs in south west London, developed an agreed position statement to help implement this guidance. The guidance is about reducing the prescribing of medicines or treatments for minor health conditions that are available to buy over the counter, and was informed by a national public consultation in 2017. We continue to work closely with local GPs to implement this guidance to reduce pressure on GP time, encourage local people to self-care and to seek advice early from local pharmacists.

We want to help people lead longer, healthier lives and support them to take better care of their health, and in particular, for minor health conditions such as coughs, colds, and mild dry skin.

By managing minor health needs through self-care will help ease the pressure on the NHS, saving an estimated £136 million a year nationally.

Therefore, in March 2018, in line with NHS England’s guidance, Merton together with all CCGs in south west London, decided to stop prescriptions for medicines for a number of minor health conditions that can be bought ‘over the counter’, and often at a lower cost than that which would be incurred by the NHS or at a cost less than the prescription charge.

We published our position statement in August 2018, and provided materials to support the implementation of the new guidance to all prescribers within south west London, including GPs, extended hours, urgent care and A&E departments.

These prescribing changes have saved approximately £778,000 annually (exceeding the 2018/19 annual target of £618,000) across south west London, positioned community pharmacists as the healthcare professional for minor health conditions, and has allowed GPs to focus more of their time on patients with more complex needs such as cancer, diabetes and mental health problems.

**Start Well**

**Achievements in Start Well in 2018/19**

- **Maternity**
- **New perinatal mental health service for mums**
- **Children and Young People programme**
- **Asthma Project**
- **Transforming care programme for patients with a learning disability and/or autistic spectrum disorder (ASD)**

**Maternity**

Our vision is to ensure that women and families are at the centre of the care provided in Merton and across south west London.

In 2018/2019, we successfully launched the booklet *My Maternity Journey in South West London* across four Trusts. The booklet is a collection of local maternity services to help empower women to make
informed decisions about the care they receive. We are currently developing an easy-read version of the booklet and producing an animated film which will be available soon.

With the aim to standardise the delivery of maternity services across south west London, we developed professionals involved in the delivery of maternity services to become Choice Champions to help ensure that women and families are informed on the choices available to them throughout the maternity care pathway. We secured funding to recruit a Specialist Midwife to work with Choice Champions and Trusts, implemented a training programme for midwifery staff, and held a training seminar for GPs.

Through our Continuity of Carer work stream, we ensured that 20% of in area women booking in south west London receive care from a known midwife throughout their pregnancy, during and after birth.

We are delighted to be one of the seven Maternity Choice and Personalisation Pioneers across the country commissioned by NHS England, and examples of our work on good practice and local development has been shared at the regional London Maternity Transformation Board, at Pioneer showcase events, and in webinars hosted by NHS England.

Looking ahead, we will work towards the national target of 35% of women receiving care from a known midwife throughout their pregnancy, during and after birth. This work will also focus on ensuring that women from BAME communities, and women from deprived communities receive these models of care as they have poorer outcomes. To ensure that staff are equipped to deliver continuity we shall be providing Train the Trainer courses for midwives as part of the AQuA: Continuity of Carer Maternity Improvement Programme.

New perinatal mental health service for mums

The South West London Health and Care Partnership secured £1.6 million to help new and expectant mums in Merton and across south west London to have access to specialist mental health teams.

Working together in teams that can be made up of doctors, nurses, social workers, psychologists, psychiatrists, occupational therapists and nursery nurses, we provide a comprehensive service to mums, tailored to their individual needs. These teams will offer psychiatric and psychological assessments and care for women with complex or severe mental health problems during the perinatal period.

By the end of March 2019, the service saw over 60 perinatal women since September 2018. These are women that prior to the service would have ended up in A&E or community mental health services, both of which do not adequately meet the needs of a perinatal woman experiencing ill mental health.

Children and Young People Mental Health

The Children and Young People’s programme takes a south west London wide approach to ensuring children and young people get the mental health and emotional wellbeing support they need regardless of what borough they live in. This partnership approach brings together school leadership teams with health and social care professionals to deliver training and support for children and young people, their families and teachers.

Working together helps us to make stronger collective commissioning decisions, share best practice and expertise across a wider footprint, and reduce duplication. It also enables us to learn from our neighbours, bringing everyone up to the same high standards when planning and buying healthcare services.

In December 2018 South West London Health and Care Partnership was awarded £1.85m of national ‘Trailblazer’ funding, money set aside by the Government to develop projects that enhance support for children and young people’s mental health.

This extra funding is enabling more support to be put in place in a greater number of schools in Merton, Sutton and Wandsworth.

The partnership brings together school leadership teams with health and social care professionals in ‘clusters’ to deliver training and support for children and young people, their families and teachers. The
clusters are overseeing the mobilisation of teams of school-based support workers which will be shared between the schools involved in each borough.

This new way of working will initially be piloted in around 15% of schools in south west London. The aim is to gather evidence to demonstrate this approach can make a difference so that all schools can be included in the future.

The support workers will offer both one-to-one support and group-work sessions for pupils and parents. Where needed, they will also signpost or refer to specialist child and adolescent mental health services.

The sessions they will deliver will give children and young people practical skills for managing a range of feelings and offer parents an opportunity to practise the conversations that encourage better mental health and wellbeing.

**Asthma Project**

A Joint Asthma Board was established in January 2018 with representatives from St George’s Hospital and Merton and Wandsworth CCG to collaborate on tackling asthma in response to national guidelines. The London Asthma Standards organisation are reporting that asthma is responsible for causing the highest mortality rates for children in the UK.

An Asthma red bag initiative was rolled out to 40 schools across Merton this year. This initiative aims to provide the school with the correct inhalers and the instruction or guidance on how to use them for staff and school nurses. Our goal is to educate and motivate children, teachers and parents to have greater involvement in the management asthma.

**Transforming care programme for patients with a learning disability and/or autistic spectrum disorder (ASD)**

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should be able to live within their community, develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

As a society, we are on a long journey to make that simple vision a reality, and it is for that reason that the [Building the right support](https://www.gov.uk/government/publications/building-the-right-support) was published in 2015 – a national plan to develop community services for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

South West London Health and Care Partnership is fully committed to support people with a learning disability and/or autism live happier lives.

Throughout 2018/19, the Partnership had been implementing the national model, and managing inpatients by repatriating them from out-of-area placements and/or discharging them to the most appropriate care setting in their local community.

A Positive Behaviour Support service is being provided for children and young people with a learning disability and/or autism, which is designed to find the purpose behind their behaviours, and design a personalised support plan that involves working together with the patient, their families and health and social care services.

In addition, the programme has been scoping and planning the development of a Crisis Intervention Service that will be a short term intensive support to help prevent the patient from being admitted; upskill staff; strengthen the community forensic team; and look at housing requirements so the patient can live a quality life within the community.

The focus for this work for 2019/2020, will be to continue working closely with all CCGs and local authorities in south west London on early intervention and preventative support.
Social prescribing

Social prescribing is a way of linking patients in primary care with sources of non-medical support within the community. It helps free up the professional time of GPs while connecting people to their community and its resources. It is an important tool to help address some of the non-medical determinants of health such as social isolation and employment issues.

Social prescribing is about GP practices signposting patients to non-medical services in the community - from walking or community groups where they can meet new friends to employment, benefits or housing advice.

A pilot social prescribing programme is to be expanded to 38 GP practices in Merton and Wandsworth from April 2019 after it dramatically improved patient's health and wellbeing. The pilot ran for a year in Wide Way Medical Centre and Tamworth Medical Centre in East Merton and supported people with anxiety and stress, and those experiencing social isolation and loneliness. A social prescribing co-ordinator based in the practices guides each patient to the best support for them in the community.

Merton CCG and Merton Council set out to test a model of social prescribing that would connect medical care with local voluntary and community resources, working with the Merton Voluntary Service Council. The pilot's aims were to improve patient health and wellbeing and reduce pressures on local GP and A&E services.

The independent evaluation of the pilot found in the first year 77 per cent of patients said it had improved their wellbeing; 33 per cent fewer GP appointments were needed because of the scheme; and hospital visits were reduced by 50 per cent.

We marked National Social Prescribing Day at a special event with patients and doctors in March to discuss the pilot’s success and encourage uptake of the service.

Adult mental health

We are committed to providing the best possible mental health support to people living and Merton and a project working across south west London has set out four key aspirations:

- To ensure that no person takes their own life
- No-one has to attend A&E for a mental health crisis
- Everyone with a long-term condition receives support for their mental health
- People with serious mental illness have the same life expectancy as the general population

In 2018/19, the South West London Health and Care Partnership continued to focus on delivering improvements to mental health in line with the Five Year Forward View for Mental Health. This includes:

- Meeting the 19% access rate for Improving Access to Psychological Therapies (IAPT) services for people with common mental health conditions in south west London.
- Increasing access to NHS-funded community services for children and young people with a diagnosable mental health condition.
- Seeing over 100 additional women in the newly expanded perinatal mental health service.
• Introducing primary care schemes to increase the numbers of people with Severe and Enduring Mental Illness receiving a comprehensive annual health check.
• Developing acute psychiatric liaison services to deliver 24 hours a day, seven days a week.

The Partnership’s focus in 2019/20 will be to continue delivering the objectives in the *Five Year Forward View for Mental Health* as well as planning for delivery of the *NHS Long-Term Plan*.

In addition, efforts will be focused on suicide prevention, jointly with local authority Public Health colleagues, both in our at-risk groups and for those bereaved by suicide.

Work will also take place across south west London to implement new NICE guidance for dementia care across all areas.

The very popular Recovery Café, provided through South West London St George’s Mental Health Trust continues to offer a safe and welcoming space for those struggling to cope with life’s challenges. The café is open to Merton residents 365 days.

**Merton uplift**

South West London and St George’s Mental Health NHS Trust was commissioned by the CCG to provide a new primary care mental health service, called Merton Uplift from April 2019. This was a clear investment in expanding and improving mental health services to give local patients greater support, with a focus on wellbeing. 'Merton Uplift' now offers a broad range of support for people in Merton who are experiencing mental health conditions such as anxiety, stress and depression. The service will include talking therapies as well as support with practical skills to help maintain a feeling of wellness. The service provides:

• One assessment for each patient – avoiding multiple appointments
• Partnership working with Carers Support for Merton,
• Focus 4-1 and Wimbledon Guild and relationships with a range of other organisations in Merton
• Greater choice for patients on the treatments locations and times to make support easy for everyone
• Digital service options including Ieso, SilverCloud and Skype – greater help for people with long term conditions with Central London Community Healthcare and other providers

**Wilson Health and Wellbeing Campus development**

Merton CCG is working in partnership to redevelop the Wilson Hospital site into a new health and wellbeing campus. The redevelopment is a joint piece of work between the CCG, Merton Council, Merton Voluntary Services Council, NHS Property Services and Community Health Partnerships, South London Health Partnership and local residents.

The Wilson project is focused on delivering care in a different way for local residents. We know people in the East of Merton, in areas like Mitcham and Morden, are often less well-off and prone to dying younger than those in the West of the borough, in places like Wimbledon.

People’s health can be affected by more than just how they’re feeling physically – other things like whether they have money troubles or if they live alone have a huge impact. That’s why we’re focusing on creating a new health and wellbeing campus at the Wilson - not just a building where people go to when they’re ill, but somewhere to help the community connect and stay healthy.

The programme has been delayed in 2018/19 the CCG due to discussions with the site’s developers over a national issue related to the risk of an interest rate rise. However, all partners remain fully committed to the programme. We anticipate the new facilities will open on the Wilson site by the end of 2022.

We are developing new wellbeing services so people will be able to access them in other places in the area before the building is complete. We’ve been doing a lot of work this year to develop what the range of wellbeing services and activities will look like following engagement with local residents and organisations. We are planning for the new site to have a community café and kitchen, garden and a social prescribing
service which is already available at GP practices in East Merton. This is in addition to providing space and opportunities for residents to meet and access information, advice and support from organisations when they need help.

We want the community to take the lead on making decisions about which services and activities would help people, as well making sure we make the best use of all available resources and avoid any potential for duplication. We considered setting up a social enterprise to make this happen. However, we’ve listened to feedback that it could create competition for funding for local voluntary services and so are not taking this route at the moment.

As an alternative a Wellbeing Steering Group is being set up, made up of representatives from the community who will lead the process going forward. This Group will be responsible for developing an interim Wilson wellbeing activity plan to make use of the resources already available locally as well as ahead of the new development.

As a first step, conversations are beginning to see how it might be possible to start a community gardening/growing project on the Wilson site. We’re also looking at whether the current Wilson building and space might be made available for use by community organisations for activities ahead of the building work starting. Developing Wilson wellbeing activities as a collaboration between the community and Canons Leisure Centre is also being investigated. Any services and activities developed now are those that the community sees as priority.

All the partners involved are committed to ensuring local people are involved in all stages of the development of the Wilson Health and Wellbeing Campus. In response to this commitment we have set up the Wilson Community Reference Group (WCRG). This group will provide regular updates to the Wilson Programme Board, with a focus on shaping communications and engagement plans for future phases of work and advising on communications and engagement activity undertaken through the work of the wellbeing work stream in agreeing ways to select activities and priorities.

Membership of the group includes a broad range of patients and community and voluntary groups which, for example, represent different races and religions, people with disabilities, mental health service users, children and young people, elderly people, carers, housing associations, deprived communities and local businesses. The group has met twice since it was set up in November 2018.

Members have been involved in developing our engagement plan and research to develop our initial Equalities Impact Assessment. This is helping us to ensure we are clear of the impacts on different groups due to the development of the Wilson Health and Wellbeing Campus.

For more information about the Wilson Community Reference Group, and how to get involved, you can read summary minutes on our website https://bit.ly/2TRG7iN

Age Well

Achievements in Age Well in 2018/19

- Extra support for care homes
- End of life care and Enhanced health in care homes

Extra support for care homes

The CCG continues to focus this year on proactive care to improve outcomes for vulnerable patients and high users of services through earlier inventions. We are running a care home scheme which is open to GP
practices and provides resources to support advanced care planning and improved end of life care for the most severely frail patients, in order to help prevent unnecessary hospital attendances and admissions.

We are working to improve the health of care home residents across both Merton and Wandsworth with increased specialist support.

Battersea Healthcare and Merton Health (on behalf of the CCG) have been assessing what is needed to design and develop of an enhanced local service to support the care of residents in care homes in both boroughs.

The work involved a review of primary care input and has included community services. This has required engagement with a range of partners.

Additional investment is being planned including:

- Work to achieve robust, high quality and equitable primary care support for care home residents.
- Additional Advanced Nurse Practitioners in Community Teams. To build upon existing good practice and to increase the capacity to assess need, provide appropriate care, advice and guidance and support with ensuring that GP are called out at appropriate times.
- To reduce the use (and cost) of oral nutritional supplements (ONS) in care homes as well as providing a range of specialist dietary treatments to meet the residents nutritional requirements with additional advice from dieticians.
- Extra IT to ensure more efficient working practices.
- Project Management to support improved integration of services supporting care homes across the health and social care.
- Extra support from therapists including speech and language therapists and physiotherapists.

**End of life care and enhanced health in care homes**

The End of Life Care and Enhanced Health in Care Homes work streams aims to improve the quality of care for those at the end of life and for residents in care homes, in alignment with the National Ambitions for Palliative Care and the Enhanced Health in Care Homes Framework.

The South West London Health and Care Partnership have been working collaboratively with local partners to support the sharing and spread of this work in Merton and across south west London.

- We are pleased to have Nicki Shaw, CEO of Princess Alice Hospice, as the Hospice representative on the South West London Partnership Board.
- We are working with GP practices, community and hospital staff to ensure that training on advance care planning is available and to ensure more care plans are recorded and shared on our online system, Coordinate my Care. This system allows healthcare professionals to record patients' wishes and ensure that their personalised urgent care plan is available 24/7 to all those who care for them. This includes the NHS 111 service, the GP out-of-hours and the ambulance service.
- We are working with Central London Community Healthcare’s Nursing Academy to pilot new ways of supporting clinical staff in care homes.
- We have introduced the Significant 7 training programme in 24 care homes across south west London to upskill care home staff support residents if they become unwell.
- We have received funding to pilot Falls Prevention therapists in care homes in four boroughs across south west London.
• We have promoted flu immunisations in care homes to protect the vulnerable residents and those who might not respond well to vaccination, and to staff and their immediate families.

• We have promoted the use of NHS 111, a new telephone line for care home staff who require urgent clinical advice and support.

• The agreement of the development of an End of Life Care “hub” in Sutton will mirror the successful outcomes the Wandsworth “hub” as achieved for people at the end of life. Merton CCG has agreed to establish a Clinical Review Group to review the learning from Wandsworth “hub” to determine whether this approach should also be taken forward in Merton.

For the year ahead, we look forward to continue working with our partners to deliver on our shared commitments, developing the shared care plans, and coordinating care and support to the social elements for people at the end of life. We will also continue to support care home residents by closely working with primary care providers and looking at how technology can transform ways of working.

**Planned care**

• Diabetes
• Cancer care
• Gastroenterology Clinical Assessment Service
• Musculoskeletal services
• Ophthalmology

**Diabetes**

During 2018/19 the South West London Health and Care Partnership, working with the Health Innovation Network and the London Diabetes Clinical Network, has implemented a number of diabetes projects following successful bids for NHS England transformation funding:

• Diversifying options for structured education courses, which help adults with diabetes improve their ability to manage the condition. The [Diabetes Book and Learn service](#) launched in October 2018. It provides people from South London with access to any diabetes education course in irrespective of where they live, including online, weekend and evening options.

• Reducing the number of amputations by improving access to multi-disciplinary foot care teams: Pathfinder podiatrists in all four acute trusts in south west London are now aiding discharge, rapid referrals and admission as well as supporting clinicians in primary care with training. Initial audit has shown fewer amputations in people with diabetes compared to previous years during 2018/19.

• Increasing the provision of diabetes hospital inpatient specialist nursing teams: Additional nurses are now in post at all four south west London hospitals working to improve management of people with diabetes while they are in hospital; reducing errors and incidents of harm and associated length of stay, which is significantly higher for people living with diabetes. Data shows that our length of stay for people with diabetes is lower than it was before the new nursing posts were established.

20 GP practices across south west London have been trained in a new approach to joint care and support planning for patients with diabetes, to give patients a greater say in the management of their condition.

Later this year, we will be focusing on the [You & Type 2](#) programme, as part of the NHS England Test Bed Programme where we won over £500,000 in funding. You & Type 2 is designed to make it easier for people living with Type 2 Diabetes to get the most from the health and social care systems, by combining innovative digital technologies and other support to provide each person with their own easily accessible personal plan of care, education and support.

We will also be launching new technology including personalised video messaging, a one-to-one digital diabetes support programme and a smartphone app to allow patients to access their care plans, alongside other resources that can help them, including educational materials, mental health support and local exercise groups.
Cancer

Following a mapping exercise of current cancer psychological services across south west London, including IAPT services, it was found that cancer psychological service provision across the six boroughs is variable, perpetuating inequalities within the patch.

It was agreed that a cancer psychological services (CaPs) service that is more seamless and coherent for patients and that provides equity across all CCGs and main cancer services should be rolled out across south west London.

This integrated approach to delivering CaPs will prevent duplication across CCGs and provide opportunities for joint working between providers.

Merton has successfully screened additional patients in both Bowel and Cervical Screening. This has been achieved by following up with non – responders and non-attenders to an initial invitation. It appears this has proved important wider learning for the NHS.

Local GPs have piloted a C-the-signs Cancer Decision Support Tool using the latest AI technology to increase early cancer detection rates. Early results have found this to be an efficient and safe way to refer patients with symptoms of suspected cancer.

Merton CCG has also been instrumental in the agreement of a model for the provision of Psychological Services for Cancer patients.

Gastroenterology Clinical Assessment Service

Both Merton and Wandsworth CCGs have been working together with St George’s Hospital to pilot a new approach for gastroenterology referrals to improve patient experience. The Clinical Assessment Service involves the GP carrying out tests in their surgery before referral, and the consultant then assesses the patient quickly online to determine the most appropriate next step.

Patients may then: be referred for further tests before being seen by the consultant; seen face to face; escalated if a cancer is suspected; or managed virtually with a management plan back to the GP. This service has significant advantages in that it helps patients by reducing unnecessary appointments and reducing the length of time that patients wait for an assessment (all referrals to the Cancer Assessment Service are reviewed by a consultant within 14 days).

It has also been shown to identify any worrying symptoms in patients who have been referred on a routine pathway, but actually have a suspected cancer. So far, 238 patients across Merton and Wandsworth have been assessed through the pilot with positive feedback from both patients and GPs.

We will be working with St George’s Hospital to further roll out this approach in additional specialities in 2019/20.

Musculoskeletal services

Musculoskeletal (MSK) are conditions that affect the joints, bones and muscles, and also include rarer autoimmune diseases and back pain. MSK conditions affect one in four adults and account for 30% of General Practice (GP) consultations and 10% of GP referrals.

MSK often refers to clinical services including physiotherapy, pain management, rheumatology and trauma and orthopaedics (T&O). Rheumatology and T&O are very high-spend specialties by CCGs across south west London, but there are identified opportunities for quality improvements and cost reductions across all of these services. Therefore, in 2018/19, the South West London Health and Care Partnership established an MSK programme of work.

The South West London Health and Care Partnership MSK Programme is led by the South West London MSK Clinical Reference Group. The Group is composed of MSK clinicians from different MSK specialities
across south west London and was established to work together as a system to standardise care and pathways to reduce variation in the area, and deliver the right care in the right place to improve care quality and make system cost efficiencies in south west London.

MSK clinicians and commissioners rolled-out the MSK Single Point of Access services across south west London, developed standardised orthopaedic pathways, and agreed principles for MSK pain management. Additionally, we are piloting First Contact Practitioner (FCP) – physiotherapists working in GP practices providing early access to MSK care, freeing up GPs, and promoting self-care. We are also piloting an innovative self-care getUbetter app, in Wandsworth to help patients self-manage lower back pain.

We have also recently appointed a physiotherapist, Nick Sullivan, as the Strategic MSK Clinical Lead. Nick will start in May 2019 and take forward the implementation of the NHS England and Health Education England MSK Capability Framework across south west London which aims to:

1. Improve patient care, experience and outcomes
2. Increase referrals into the Single Point of Access (SPA) services
3. Reduce the number of GP appointments related to MSK conditions
4. Increase surgical conversion rates
5. Increase workforce satisfaction
6. Decrease usage of diagnostic capacity to reduce spend on general practice ordered plain X-rays and Magnetic Resonance Imaging (MRI) scans
7. Increase shared learnings and collaborative working across local organisations.

During the next year, the MSK Programme team will strengthen the collaboration between south west London provider and commissioner organisations to drive forward the MSK programme and deliver the identified, measurable benefits.

**Ophthalmology**

After talking with patients and stakeholders, we, in partnership with Wandsworth CCG, have identified a significant health improvement opportunity for patients affected with eye conditions.

Merton, Wandsworth and Sutton CCGs are planning a Community Ophthalmology service across a number easily accessible locations in each borough in 2019 to deliver a:

- Minor Eye Conditions Service ((MECS) e.g. red eye, white eye)
- Cataract service to include direct referral from appropriately accredited clinician(s) and provide pre-operative appointments
- Glaucoma Referral Refinement Service
- Single Point of Access where there is clinical assessment and triage of all ophthalmology referrals from primary care

Some of the expected outcomes to be achieved from 2019 onwards through the community ophthalmology service will be to:

- Increase the quality of care and reduce patient waiting times
- Address any access inequalities, by offering the same eye care services across Merton, Wandsworth and Sutton
- Support the delivery of new services which are clinically effective and cost efficient

**Urgent and emergency care**

- Winter planning
- Supporting health and care providers over winter

**Winter planning**

In the past year Merton CCG has been working closely with colleagues in the acute hospitals and our GPs and community services to prepare for the increased winter pressures.
We have been raising awareness of our GP hubs, pharmacies and NHS 111 to ensure local residents know about the wide range of services available.

Streaming of patients who arrive at A&E Departments has been improved so they can be assessed quickly and directed to the best service for them preventing delays.

If a patient needs a local GP appointment this can be arranged straight away by St George’s Hospital.

Patients who are frail and have complex needs can also be identified early and referred for a geriatric assessment to prevent any worsening of their condition

**Supporting health and care providers over winter**

This winter 2018/19, health and care partners across south west London came together to agree joint health priorities to keep people well, while reducing demand on GP practices and on hospital A&E departments.

Using insight from local Merton people, and backed by Accident and Emergency Delivery Boards, we delivered targeted campaigns in each of our six boroughs, phased to sit alongside NHS England and Public Health England national campaigns to maximise impact.

In the first phase, parents of two and three year olds and staff working in care homes in south west London were identified as key audiences for the flu vaccination. In order to increase uptake among these audiences, we implemented an integrated communications campaign, using digital advertising, localised promotional materials and social media activity to share our messages almost 410,000 times between October and December 2018.

A key part of the campaign involved training CCG staff to become ‘Winter Champions’ – acting as ambassadors for the Partnership and sharing seasonal health advice with voluntary groups who support people who are more at risk of a winter illness.

Almost 10 per cent of our staff signed up to volunteer, attending events including mother and toddler groups, tea parties for older people and Christmas lunches for the homeless.

As we moved further in to the winter period, we also promoted extended access GP appointments and pharmacy first messages in specific boroughs, based on research highlighting pressure points in both primary and secondary care settings. This work continues, focusing on hyper-local pilots to encourage patients with minor health concerns to visit their local pharmacy before considering other NHS services.

**Supporting Programmes**

- Recruiting a health and care workforce for the future
- ‘Connecting your care’
- Making joint commissioning decisions

**Recruiting a health and care workforce for the future**

Following on from a pilot launched in Autumn 2018, South West London Health and Care Partnership has launched an innovative new careers programme for secondary school students in Merton and across south west London boroughs.

Developed in collaboration with Health Education England, Jobs that Care is a multi-faceted education programme aimed at year 8 students and encourages active participation through:

- An engaging and thought-provoking play, scripted specifically with students in mind, to introduce them to different health and social care roles
A bespoke game which reinforces all of the learnings from the play and encourages students to develop their general knowledge of the health and social care sectors and learn about particular roles in more detail.

A supplementary app and website, which brings all of the students’ newfound knowledge from the play and game to fruition in a form they’re most familiar with.

After an extremely successful launch, we’re now rolling out the programme to all Merton health and social care providers to use as part of their own school programmes.

Merton will also benefit from the work of South West London Health and Care Partnership working with Our Healthier South East London to develop a joined up approach to apprenticeships. This is in collaboration with Health Education England and health and social care organisations across south London.

The partnership is supporting health and social care organisations across south London to meet their 2.3% government apprenticeship targets and utilise levy funding before the end of May 2019, by recruiting new apprentices into the healthcare sector, and using apprenticeship programmes to upskill their existing workforce. Work is already in progress to share good practice, innovation and success stories.

‘Connecting your care’

As part of our commitment to improving care and increasing efficiencies in Merton, South West London Health and Care Partnership have been working with NHS providers and local authorities to connect health and care records across our six boroughs into a single, shared view for the benefit of direct patient care.

‘Connecting your Care’ means that professionals involved in your care such as your GP, hospital doctors, nurses and social workers will be able to access records from other health and care organisations when needed, through a secure system, helping them to make the best decisions about the care they provide.

We launched the Partnership’s ‘Connecting your Care’ privacy notice campaign in February 2019, to inform 1.6 million patients across south west London about the changes. The first practices and acute hospitals to go live on the system will be able to access Connecting your Care viewer in April 2019, with all practices, NHS providers and social care providers in Kingston and Sutton will follow later this year.

Looking forward to 2019/20, we will be working with partners across London to develop our digital collaboration even further – with other NHS providers including London Ambulance Service, our other local authorities and even care homes – all with the aim of connecting care to improve the health and wellbeing of the people living in our boroughs.

Making joint commissioning decisions for south west London

Effectively commissioning healthcare services sometimes requires decisions to be made for more than just the residents of a single borough. Governing Body members from each of the six CCGs in south west London, including Merton CCG, meet regularly in public as the ‘Committee in Common’ to make decisions on issues that affect every borough.

In 2019, Merton together with other CCGs in south west London, we refreshed the Effective Commissioning Initiative (ECI) which will help clinicians to prioritise which treatments and procedures are funded by the NHS, and ensure that NHS funded treatments are evidence based, clinically effective, safe and that access is fair and impartial for all patients with similar clinical need.

Through the implementation of this ECI policy across south west London, we have been able to save approximately £675,000 in Merton, directing the resources to where the most clinical benefit can be achieved for our patients.

To ensure compliance with the ECI policy, we have the Individual Funding Requests (IFR) process, and the Prior Approval Service.
IFR’s are funding applications made by clinicians who believe that a patient may receive benefit from treatment or service that is not routinely offered by the NHS. IFR’s go through a process that includes administrative and clinical screening, and a panel of doctors, public health experts, pharmacists, commissioners and lay members who determine each application.

IFRs are usually carried out in each CCG, but since September 2018, we merged all IFR services across all the CCGs in south west London into one single IFR service, achieving 30% efficiency savings.

The Prior Approval Service is a process that was put in place in 2017, where a clinical criteria must be met before any procedures or treatments can be carried out. Since November 2018, clinical oversight to the Prior Approval Service has been revised and tested which will lead to a reduction in running costs by 40% for 2019/20.

We are leading on this area of work both regionally and nationally, and selected as the first national exemplar as part of the national Evidence-Based Interventions (EBI) programme.

Our focus for 2019/20 will be to keep the ECI policy aligned with the national EBI programme, and to ensure that both IFR and Prior Approval processes are effective and efficient.
Assuring Delivery of Performance including NHS Constitution Standards

This section provides an overall explanation of how Merton CCG has discharged its functions including its financial, patient engagement and quality improvement duties. It includes the following information:

- How we measure and manage what we do
- Key Performance Indicators
- Quality Premium
- Better Care Fund Performance
- Improvement and Assessment Framework (IAF)
- Improvement and Assessment Framework Clinical Priority Areas Assessment

How we measure and manage what we do

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 and Assessment Framework 2018/19, which focuses on constitutional pledges for patients including key waiting times targets.

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

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

We report performance and quality standards to our Governing Body and hold monthly meetings with our key acute, mental health and community care providers to review performance. Where we feel further intervention is required, we meet providers on a regular basis to work with them to bring about performance improvement and ensure plans are effective.

Performance is monitored and measured through the Integrated Governance and Quality Committee held in common with Wandsworth CCG. The committee scrutinises performance for both CCGs and reviews areas of concern and reports to the Governing Bodies as appropriate.

Key Performance Indicators

We measure and monitor quality and performance metrics with all our health service providers, framed around the NHS Constitution and local quality measures. The CCG performance and information team reviews performance metrics alongside commissioning and contracting managers. These metrics are combined with local intelligence and information to produce a monthly performance report, presented to our Integrated Governance and Quality Committee and Governing Body, which is published on our website.

The performance report provides:

- An update on CCG and related providers’ operational performance against national and locally agreed standards. This includes 18 weeks referral to treatment (RTT), cancer waits, A&E waits, ambulance handover times and delayed transfers of care.
- Detailed information on underachieving indicators including trends and direction of travel are included where there are measurable thresholds.
- Longer term trends and benchmarking information.

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 a 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 position against each of the Constitution standards.

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<td>84.2%</td>
<td>95%</td>
</tr>
<tr>
<td>St George’s University Hospitals NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer two weeks</td>
<td>92.5%</td>
<td>95.2%</td>
<td>93%</td>
</tr>
<tr>
<td>Breast symptoms 2 weeks</td>
<td>94.7%</td>
<td>84.8%</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer first definitive treatment 31 days</td>
<td>96.2%</td>
<td>98.4%</td>
<td>96%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, surgery</td>
<td>94.8%</td>
<td>98.8%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, drug treatment</td>
<td>100%</td>
<td>99.4%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer subsequent treatment 31 days, radiotherapy</td>
<td>96.3%</td>
<td>95.5%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer composite, 62 days first treatment plus rare cancers</td>
<td>84.6%</td>
<td>85.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Cancer first treatment 62 days, screening</td>
<td>89.4%</td>
<td>78.1%</td>
<td>90%</td>
</tr>
<tr>
<td>Ambulance response time – Category 1</td>
<td>n/a</td>
<td>Jan-19 6:07 minute</td>
<td>7</td>
</tr>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>10</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>RTT 52 weeks (incomplete pathways)</td>
<td>15</td>
<td>76</td>
<td>0</td>
</tr>
<tr>
<td>MRSA (PIR assigned)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C Difficile</td>
<td>26</td>
<td>22</td>
<td>n/a</td>
</tr>
<tr>
<td>IAPT – recovery rate</td>
<td>47.9%</td>
<td>45.9%</td>
<td>50%</td>
</tr>
<tr>
<td>IAPT – entering treatment</td>
<td>10.64%</td>
<td>12.2%</td>
<td>19%</td>
</tr>
<tr>
<td>IAPT – Treatment within 6 weeks</td>
<td>79.6%</td>
<td>95%</td>
<td>75%</td>
</tr>
<tr>
<td>IAPT – Treatment within 18 weeks</td>
<td>98.0%</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Dementia diagnosis rate</td>
<td>71.0%</td>
<td>72.8%</td>
<td>67%</td>
</tr>
<tr>
<td>Early Intervention in Psychosis</td>
<td>59.7%</td>
<td>60.6%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Referral to Treatment (RTT)**

The NHS Constitution includes the Referral to Treatment (RTT) operational standards. This includes the target that 92% of patients who have not yet started treatment should have been waiting no more than 18 weeks.

One of the CCG’s main providers, St George’s University Hospitals NHS Foundation Trust, took the decision to suspend national RTT reporting in June 2016, due to significant concerns about the quality of data. The Trust has undertaken a RTT recovery programme including a validation exercise, a review of internal processes and a full assessment of its construction of patient tracking lists. The Trust delivered a plan to return to reporting of the RTT standard. This work addressed both improving and maintaining data quality and operational processes to ensure accurate and sustainable reporting.

During October 2018 the CCG commissioned an independent review of RTT data quality and operational management of waiting times. The scope of the report included leadership, operational resources, governance and staff training. The review concluded that enough progress had been delivered to support a return to reporting.

The CCG has deployed the e-Referral Service (e-RS), in line with national guidance, to allow patients and GPs to directly book appointments at the hospital of the patient’s choice. The system provides information on appointment availability and waiting times at a range of providers, which helps patients choose the earliest available appointment.

**Diagnostics test waiting time**

Early diagnosis is important to patients and the CCG. It is central to improving outcomes, for example early diagnosis of cancer improves survival rates. The CCG access performance is based on the performance measure: Number of patients receiving their diagnostics test within 6 weeks (expressed as a percentage) which collects data on waiting times and activity for 15 key diagnostic tests and procedures.
Good performance levels were maintained throughout 2018/19 and at the time of publishing the CCG is meeting the national target.

**A&E waiting times**

Despite not achieving the 95% 4 hour target throughout the year, St George’s University Hospitals NHS Foundation Trust have a number of work streams underway to help improve performance levels as well as provide better outcomes for our patients. This work includes the implementation of a 15-point A&E action plan covering the emergency and non-elective pathway from arrival to discharge. The plan includes a focus on process improvements to facilitate consistent delivery. As recommended by the National Emergency Care Improvement Programme, four key metrics are being tracked: ambulance handover, time to treat, four hour operating standard (admitted and discharge patients) and stranded patients (length of stay over 7 and 21 days).

The trust have also introduced a new management structure to address and resolve issues affecting patient flow as they arise. Our local Emergency Care Delivery Board has several schemes in place to improve streaming of patients to appropriate services and improve flow and discharge.

**Waiting times for cancer treatment**

There are eight cancer waiting times standards for patients with, or suspected to have, cancer. Six of the eight standards are currently being met.

Whilst the two-week breast symptomatic cancer wait standard did not meet target, improved performance levels for the later part of the year were seen with this measure consistently remaining above target for each month from September 2018 to January 2019.

Continuous efforts to maintain and improve cancer performance are being led by the CCG and south west London System Leadership Forum (SLF).

**Ambulance response times London Ambulance Service NHS Trust (LAS)**

During the quarter three of 2017/18 the LAS implemented the new national Ambulance Response Programme (ARP). This was a major national change. The new approach to measuring ambulance response times seeks to further improve the prioritisation of the sickest patients to ensure they receive the fastest response and ensure clinically and operationally efficient service delivery.

Performance is measured by four category types, listed below:

- **Category 1:** 7 minute response time
- **Category 2:** 18 minute response time
- **Category 3:** 60 minute response time
- **Category 4:** 180 minute response time

During 2018/19 the London Ambulance Service continued to deliver good response times for the residents of Merton with all standards meeting national targets.

**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 four breaches of this standard for Merton CCG patients where this ambition was not achieved. Each breach is investigated by the relevant Clinical Quality Review Group (CQRG). Patients are advised of the issues at the time of the breach.

**Infection prevention and control**

The NHS is committed to reducing the incidence of avoidable harm, including infections from Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Difficile). As part of this, infection control has been a high priority for all NHS providers, and each case of MRSA or C Difficile is investigated and reviewed at the relevant provider CQRG. There have been no cases of MRSA for Merton CCG patients. There were 22 cases of C Difficile.
Early Intervention in Psychosis

This performance indicator measure the percentage of people referred to service experiencing first episode psychosis or at “risk mental state” that start a NICE-recommended care package in the reporting period. 2018/19 (April 2018 – January 2019) performance is currently 60.6% exceeding the national 50% target.

Quality Premium

The Quality Premium (QP) scheme is about rewarding CCGs for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

The 2018/19 scheme was designed to support the delivery of the major priorities for the NHS, as well as local priorities identified for Merton. The national QP indicators are aligned with those in the CCG Improvement and Assessment Framework.

2018-19 Quality Premium Performance Measures

<table>
<thead>
<tr>
<th>National / Local</th>
<th>Description</th>
<th>2018/19 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>National measure 1</td>
<td>Emergency Demand Planning</td>
<td>Part a) Actual number of Type 1 A&amp;E attendances to be no greater than the planned number of Type 1 A&amp;E attendances. AND Actual number of non-elective admissions with length of stay (LOS) =0 days to be no greater than the planned number of non-elective admissions with LOS =0 days. Part b) Actual number of non-elective admissions with LOS of 1 day or more to be no greater than the planned number of non-elective admissions with LOS of 1 day or more.</td>
</tr>
<tr>
<td>National measure 2</td>
<td>Cancers Diagnosed at Early Stage</td>
<td>1. Demonstrate a 4-percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour) that are diagnosed at stages 1 and 2 in the 2018 calendar year compared to the 2017 calendar year. Or 2. Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour) that are diagnosed at stages 1 and 2 in the 2018 calendar year.</td>
</tr>
<tr>
<td>National measure 3</td>
<td>Overall experience of making a GP appointment</td>
<td>Achieve a level of 85% of respondents who said they had a good experience of making an appointment, or; Achieve a 3 percentage point increase from July 2018 publication on the percentage of respondents who said they had a good experience of making an appointment.</td>
</tr>
<tr>
<td>National measure 4</td>
<td>NHS Continuing Healthcare</td>
<td>80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from notification of the checklist. Ensure that less than 15% of all full comprehensive NHS CHC assessments take place in an acute hospital setting.</td>
</tr>
<tr>
<td>National measure 5</td>
<td>Mental Health</td>
<td>Equity of access and outcomes in IAPT services</td>
</tr>
</tbody>
</table>
Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups.

Reducing gram negative blood stream infections (BSI) across the whole health economy.
Reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care.
Sustained reduction of inappropriate prescribing in primary care.

RightCare Indicator

Injuries due to falls in people aged 65 and over

The outcomes of the 2018/19 Quality Premium will be finalised in June 2019.

Better Care Fund (BCF)

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

The BCF was created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

Merton’s BCF Plan for 2018/19 sought to continue to build on the work already undertaken in the previous year and strengthen the relationships and collaboration between multiple providers in Merton with a focus on the following key areas:

<table>
<thead>
<tr>
<th>Performance Metric</th>
<th>Rationale</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective admissions (aligned to the Merton Health &amp; Wellbeing Board)</td>
<td>Good management of long-term conditions requires effective collaboration across health and care system to support people managing conditions and promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for non-elective admissions.</td>
<td>(Apr-Dec) 16,453 admissions</td>
</tr>
<tr>
<td>Admissions to residential and nursing care homes of older people (65 and over)</td>
<td>Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the BCF framework supports local health and social care services to work together to reduce avoidable admissions.</td>
<td>(Apr-Feb) 67 placements</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement</td>
<td>There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.</td>
<td>Annual reporting Not yet available</td>
</tr>
</tbody>
</table>
Delayed transfers of care - delayed bed days

Measuring delayed transfers of care is an important marker of the effective joint working of partners, and is a measure of effectiveness of the interface between health and social care services. Minimising delayed transfers of care, enabling timely discharge to the most appropriate care setting and promoting smooth flow through the system for medically optimised patients, is one of the desired outcomes of social care.

| Quarter 3 (Apr-Dec) | 1344.7 per 100,000 population |

BCF Performance

There were 16,453 non-elective admissions (April 2018 – December 2019) which is better than the Health and Wellbeing Board target for non-elective admissions for this period of 18,778.

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

The reablement performance indicator ‘Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services’, is collected on an annual basis based on clients discharged between 1 October and 31 December and of those clients, the number that were still at home 91 days later. At the time of publishing this report the 2018/19 year end position is not yet available.

We are on track to meet the target for permanent admissions of older people to residential and nursing care homes, although the final year end position is not yet available.

Merton’s overall delayed transfers of care performance remains within the target threshold and has consistently been below the London average throughout 2018/19. There are continued challenges with ensuring the most-timely discharges from hospital for the number of delayed days attributable to the NHS which is not currently compliant with the annual target, however this is not necessarily an indication of poor performance, but a reflection of the stretching target for 2018/19 as performance levels being achieved place Merton within the top 10 best performing London CCGs (April 2018 - December 2019 per 100,000 delayed days).

Improvement and Assessment Framework (IAF)

Our performance as a clinical commissioning group is monitored by NHS England through the CCG IAF which assesses us against four domains: Better Health; Better Care; Sustainability and Leadership.

The CCG is given an annual assessment rating against the IAF based upon performance of key performance indicators (KPIs) during 2018/19 covering Quality, Constitutional Targets, Effective Leadership and Commissioning and Financial Sustainability. We anticipate our 2018/19 assessment results will be published in June 2019.

Key IAF 2018/19 highlights at time of publishing.

We are achieving good results (best quartile nationally) in the areas of:

- appropriate prescribing of antibiotics in primary care;
- provision of high-quality care: adult social care;
• effectiveness of working relationships in the local system.

Additionally, under the clinical priority areas of mental health, cancer, dementia, diabetes, learning disabilities and maternity, the CCG performance in these areas listed below are also within the best quartile nationally at the time of publishing:

• one-year survival from all cancers;
• people with an urgent GP referral having first treatment for cancer within 62 days of referral;
• reducing the reliance of specialist Inpatient care for people with a learning disability and/or autism,
• continued prioritisation of action to reduce smoking at delivery (maternal/pregnancy)
• choices in maternity services.

The CCG estimated diagnosis rate for people with dementia aged 65 is currently 72.8% placing Merton above the national 66.7% benchmark for this measure.

Performance information for diabetes measures for 2018/19 at the time of publishing this report are not yet available for comment and are expected to be published by NHS England in June 2019.

During 2018/19 London committed to delivering an Improving Access to Psychological Therapies (IAPT) access standard of 4.75% and a recovery rate of 50% in Quarter 4. The CCG’s performance is currently 4.1% (rolling quarterly average November 2018 – January 2019). This target has proved challenging to meet. The CCG are working with service providers and making ongoing positive steps to improve this position. A new service provider will begin delivering this service from April 2019 onwards.


The methodology for the calculation of the CCG ratings is still being finalised by NHS England.

**IAF - Clinical Priority Areas Assessment**

The Five Year Forward View and planning guidance set out national ambitions for transformation in several vital clinical priorities such as mental health, dementia, learning disabilities, cancer, maternity and diabetes. To reinforce collective efforts in these areas, NHS England is committed in the Government’s Mandate to creating a separate clear rating for each of these six clinical areas, on a four point ‘Ofsted-style’ scale. Our current rating for each clinical area is summarised below.

**2017/18 Priority Areas** (2018/19 not yet available)

<table>
<thead>
<tr>
<th>Clinical Priority Area</th>
<th>Overall Performance Measure Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td>54.2%  83.0%  74.9%  8.6</td>
</tr>
<tr>
<td>Good</td>
<td>new cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed</td>
</tr>
<tr>
<td></td>
<td>of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
</tr>
<tr>
<td></td>
<td>of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis.</td>
</tr>
<tr>
<td></td>
<td>Average score given by patients asked to rate their care on a scale of 1 to 10</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>73.80%  72.56%</td>
</tr>
<tr>
<td>Requires Improvement</td>
<td>estimated diagnosis rate for people with dementia</td>
</tr>
<tr>
<td></td>
<td>of patients diagnosed with dementia whose care plan has been received a face-to-face review in the preceding 12 months</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>38.8%  9.0%</td>
</tr>
<tr>
<td>Requires</td>
<td>of diabetes patients have achieved all the NICE recommended treatment targets</td>
</tr>
<tr>
<td></td>
<td>of people with</td>
</tr>
</tbody>
</table>
### Learning Disabilities

<table>
<thead>
<tr>
<th>Good</th>
<th>30 Per million registered population</th>
<th>52.0%</th>
<th>0.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliance on specialist inpatient care for people with a learning disability and/or autism (per million registered population)</td>
<td>Proportion of people with a learning disability on the GP register receiving an annual health check</td>
<td>Completeness of the GP learning disability register</td>
<td></td>
</tr>
</tbody>
</table>

### Maternity

| 5.1% | 4.6 per 1,000 births | 83.1% | 68.6% |
| Maternal smoking at delivery | The rate of stillbirths and deaths within 28 days of birth per 1,000 live births and | The score out of 100 for women's experience of maternity services based on the 2015 CQC National Maternity Services Survey | The score out of 100 for choices offered to women in maternity services based on the National Maternity Services Survey |

### Mental Health

| 46.6% | 3.70% | 60.6% | Green |
| Improving Access to Psychological Therapies - Recovery | Improving Access to Psychological Therapies - Access | People with 1st episode of psychosis starting NICE recommended treatment within 2 weeks of referral | Delivery of the Mental Health Investment Standard |

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**Financial Performance**

**Overview**

Our main financial objective is the delivery of financial performance against our budget allocation. Performance against this allocation is monitored throughout the year, allowing prompt action to be taken to alleviate any particular financial pressures that should arise.

In all but exceptional cases, CCGs are set a target to achieve a surplus against their annual allocation (known as their Revenue Resource Limit or RRL). This ensures that the NHS as a whole has a degree of flexibility for unforeseen events. In 2018/19 Merton CCG was set a target of a £1.9m surplus against an RRL of £286.5 million.

The year has been challenging for us financially, due to increasing cost pressures, driven by increased demand for health services attributable to demographic growth and an increasing prevalence of long term health conditions among our population. Despite this, we have achieved the target surplus for the year.

**Expenditure**

In 2018/19, we spent £284.6m on the commissioning and provision of healthcare services as shown in the chart below:
The CCG’s largest providers of healthcare are:

- St George's University Hospitals NHS Foundation Trust (acute hospital and community services),
- Epsom and St Helier University Hospitals NHS Trust (acute hospital services),
- South West London and St George's Mental Health NHS Trust (mental health services),
- Central London Community Healthcare NHS Trust (adult community services).
Quality, Innovation, Productivity and Performance programme (QIPP)

Every year we are required to generate efficiency savings and improve value for money as part of its QIPP programme. For 2018/19, the QIPP requirement was £10.2m (net), which we achieved, this equates to 3.6% of the CCG’s RRL.

General Practice Forward View Investment

We are required to invest £3 per head of population across 2017/18 and 2018/19 in primary care over and above its previous spending levels. This is to support the General Practice Forward View by improving patient care and access and investing in new ways of providing primary care. For Merton, this equates to £0.7m over two years. We have met this requirement, investing £0.35m in 2017/18, with the balance of £0.35m invested in 2018/19.

Mental Health Investment Standard

We are also required to invest to improve quality and access to Mental Health services, with an increase at least equal to its overall increase in RRL. We have met this requirement, spending an additional £1.3m on mental health in 2018/19, a 4.8% increase compared to 2017/18, principally driven by investment in IAPT and more placements.

Additional statutory requirements

- Within its allocation, there is a specific allocation for running costs, which CCGs are required to not exceed. The running cost allowance (RCA) is calculated centrally by NHS England, and is based on a starting point of £25 per head of population in 2013/14, which has reduced by 10% every year since. The CCGs has met its running cost target for 2018/19, with a break even position against the target of £4.5m.
- The CCG has also achieved the Better Payment Practice Code (BPPC), which is a requirement to pay 95% of invoices in total within 30 days.
- The CCG has a requirement to hold a cash balance at the end of every month of no more than 1.25% of the cash it has drawn down from NHS England to pay for its monthly costs. The CCG has complied with this requirement throughout 2017/18.

Looking ahead

The financial climate in the NHS remains challenging going into 2019/20. We have identified an increased cost pressure for this year and we are planning to deliver a £11.5m QIPP programme to ensure the CCG hits its breakeven position. We remain confident that we can achieve this plan, although it will require a great deal of hard work and innovation from all colleagues, both management and clinicians, across commissioners, primary care, acute, mental health and community providers.
Improving Quality

- Quality Assurance Framework
- Quality Alerts
- Customer Care (complaints and queries)
- Quality Monitoring of Providers
- Attendance at Clinical Quality Review meetings (CQRMs) as Associate Commissioner
- Safeguarding children, young people and adults at risk of abuse and neglect

We have sought to secure continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis and treatment of illness. This drive to secure positive health outcomes for local people and continuously improves the quality of services is at the heart of our work.

Nationally, the NHS quality agenda sets out the three key elements for commissioning high-quality care:

- **Patient safety**: commissioning high quality care which is safe and prevents all avoidable harm and risks to the individual's safety, and having systems in place to protect patients
- **Clinical effectiveness**: commissioning high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes, and making sure care and treatments achieve their intended outcome
- **Patient experience**: commissioning high quality care which looks to give the individual as positive as possible an experience of receiving care, including being treated according to what the individual wants or needs, and with compassion, dignity and respect, and listening to the patient’s own perception of their care

These three elements for high-quality care are fundamental to the CCG and our work in monitoring and improving the quality of services.

Quality Assurance Framework

We aim to raise the quality of services we commission through robust contract monitoring with our providers. We monitor and review the quality of the services to ensure that the needs of our population are being met. Learning from previous failures in quality across the NHS has emphasised the important role commissioners should play in preventing failures and driving improvements.

A wide range of quality intelligence is used against identified ‘early warning’ quality outcome indicators in order to form a picture of the quality of each commissioned service. Where we identify areas of concern, these are addressed directly with providers to understand the causes and to support improvements.

We hold providers to account for the delivery of high quality care through Clinical Quality Review Groups (CQRGs) which are established through the NHS standard contract. As well as monitoring performance of contracts, the CCG also obtains updates regarding the quality and safety of services via an alert system and through visits, both announced and unannounced, to services enabling the exploration of patient experience to understand the reality behind the data.

From February 2018 the previous Merton CCG Clinical Quality Committee and the NHS Wandsworth CCG Integrated Governance Committee have been working together as an LDU Integrated Governance and Quality Committee. The work of the CQRMs is reported to the LDU Integrated Governance and Quality Committee, which provides assurance to the Board. The remit and further details about the Integrated Governance and Quality Committee can be found on page x

The CCG has ensured the patient experience is considered and their voice heard at the CCG Clinical Quality Committee and the LDU Integrated Governance and Quality Committee meetings by embedding stories from real patients. Patient Engagement Group meeting notes are also presented, ensuring the patient voice is a thread through the committee process.
The Integrated Governance and Quality Committee is co-chaired by the Clinical Chairs of the two CCGs. The Merton CCG Governing Body Lay Member, Patient and Public Engagement Lead is a member of the committee. This ensures there is clear sight of all emerging issues and that any concerns raised can be swiftly investigated and assurance provided. The Clinical Quality Committee/Integrated Governance and Quality Committee identifies any emerging concerns and ensures these are investigated and will raise a challenge/assurance to the Governing Bodies as necessary.

In 2018/19 the CCG continued to focus on strengthening processes to help deliver our mission of putting quality at the heart of everything we do and ensuring we meet our statutory duties in respect of the quality of services we commission.

Quality Alerts

All 23 GP practices in Merton have access to a quality alert system to help them easily raise quality issues, concerns or to praise providers that have provided a good service. In 2018/19 the quality alert system became available to all healthcare professionals and providers, including care homes, and now all can raise quality alerts.

Quality alerts are forwarded to the appropriate provider to provide a response with the aim of having a positive impact on patient safety, effectiveness and patient experience and to enhance learning.

Common themes from the alerts raised in 2018/19 included referral and appointment issues, diagnosis, medication/prescribing, discharge concerns, service delivery, transfer of care and communication.

Customer Care (complaints and queries)

Complaints, queries and concerns are very important sources of information about what our patients think about the quality of the services and care provided by Merton CCG. Our aim is to continue to improve our services by responding positively to the complaints, queries and concerns we receive and aiming to put things right. Lessons learnt from all investigated cases are there to improve the quality of patient care and to prevent repeated failings within the organisation.

Complaints - The CCG received 30 complaints in 2018/19 (1 April 2018 to 28 February 2019). 17 of those complaints were for the CCG to formally respond to while 13 were redirected to the appropriate service provider. Top themes were about Continuing Healthcare (CHC) and access to services. In cases where complainants are not content with the CCG’s response, this can be escalated to the Health Service Ombudsman. This occurred once in 2018/19.

Queries - The CCG received 68 new queries requiring formal responses in 2018/19, including 17 from local MPs. Main themes were Provider Services (14), CHC (13), Commissioning (13) and Access to services (8). The CCG aims to respond to all queries in the quickest time possible.

Quality Monitoring of Providers

- Quality monitoring of smaller providers
In 2018/19 Merton CCG started a piece of work to standardise and improve quality monitoring of small providers. A quality monitoring framework was developed for smaller contracts outlining quality monitoring and reporting requirements. All contracts directly commissioned by Merton CCG were reviewed and assigned a quality monitoring process. In addition to this a standardised quality dashboard and reporting templates were developed.

In January 2019 a new Clinical Quality Review Meeting was established to monitor and review the smaller providers directly commissioned by Merton CCG.

- Quality Monitoring of Primary Care
From April 2016, Merton CCG took on delegated commissioning from NHS England for the Merton GP contracts, including responsibility for assessing and assuring quality and outcomes of these services.

Merton CCG has developed a process for identifying, reviewing and managing quality issues within primary care. This includes development of a Local Quality Tracker and a Practice Support Team. This is all overseen by the Primary Care Quality Review Group (PCQRG) and involves working closely with other organisations, mainly NHS England, Care Quality Commission and the GP Federation to assure the quality of primary care in Merton.

The PCQRG meets monthly, monitors national and local quality standards as well as holding providers to account for any contractual requirements relating to clinical quality and safety of the services. The group reviews the work areas described above to direct areas of focus and inform decisions or recommends where issues need to be escalated further for information or decision. The PCQRG reports to the Quality subcommittee, and where appropriate to the Primary Care Committee

**Central London Community Healthcare NHS Trust (CLCH)**

The CCG commissions community services Central London Community Healthcare NHS Trust (CLCH) and holds a formal dedicated CQRM each month to monitor and discuss all aspects of the quality of care provided. The CQRM is chaired by the Director of Quality and Governance. The CQRG meeting forms part of our quality oversight and scrutiny process. It allows the transparent and open discussion of issues and monitoring of improvements. A number of issues that the CQRM meeting for CLCH discussed in 2018/19 led to tangible improvements:

- Scrutiny and analysis into serious incident themes – ensuring evidence of wider learning and dissemination of learning particularly surrounding pressure ulcers
- Deep dive providing scrutiny and assurance around staffing and workforce issues
- Good practice recognised in the achievement of the UNICEF Baby Friendly accreditation.

**Attendance at Clinical Quality Review meetings (CQRMs) as Associate Commissioner**

We are an associate commissioner for providers such as St George’s University Hospitals NHS Foundation Trust, Epsom and St Helier University Hospitals NHS Trust, South West London & St George’s Mental Health Trust and Kingston NHS Foundation Trust. We send a representative to meetings and quality is monitored in association with colleagues from the Lead Commissioner CCG.

**St George’s University Hospitals NHS Foundation Trust**

Merton CCG are an associate commissioner of St George’s University Hospital. Merton CCG supports Wandsworth CCG in its role as lead commissioner of the St George’s University Hospital contract.

The Care Quality Commission (CQC) inspected the trust in June 2016 and gave a rating of ‘inadequate’ resulting in the trust being put in special measures for quality. Further CQC inspection took place in March/April 2018 and the report was published in July 2018 with the Trust being rated as ‘Requires improvement’. While some improvements had been made from the previous inspection, there were regulatory requirements were needed.

Throughout 2018/19 Wandsworth CCG worked closely with the Trust and a number of agencies such as NHS Improvement, CQC, and NHS England, to support the trust to deliver on the CQC action plan developed to address the regulatory requirements, must do’s and should do’s which were identified in the March 2018 CQC inspection.

Wandsworth CCG, as lead commissioner, has responsibility for chairing the CQRM. A number of issues that the CQRM at the trust discussed in 2018/19 led to tangible improvements:

- Effective management of the clinical harm process to ensure that the harm to patients who have waited a long time as a result of the Referral to Treatment (RTT) issues, has been kept to a minimum, and where harm has been identified this has been managed appropriately.
• Review into the support provided by Cancer Clinical Nurse Specialists to improve the experience of cancer patients receiving treatment at the hospital.
• Increased scrutiny and thematic analysis of GP quality alerts, to ensure that recurring issues are investigated and addressed. This has included discharge related issues, as well as Outpatient and referral process related issues.
• Increased scrutiny into the work around managing the deteriorating patients to ensure that early warning signs are identified early and escalated appropriately so that these patients are effectively managed.

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

Our commitment to safeguarding children and vulnerable adults: The CCG is committed to protecting and safeguarding children, young people and adults at risk of abuse and neglect and are fully engaged in the work of the Merton Local Safeguarding Children Board and Merton Safeguarding Adult Board.

Our Safeguarding Vision: Our vision is for the children, young people and adults at risk in Merton to have access to safe, effective, responsive health services enabling them to achieve the best possible health outcomes and to have their views and experiences heard.

Safeguarding at the heart of our commissioning: As a commissioner of health services the CCG are compliant with the Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2015 and this is 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 Safeguarding / Designated Nurse Safeguarding Children and Designated Safeguarding Adult Lead through performance reporting frameworks.

Our trained and competent workforce: The CCG ensures all staff complete relevant safeguarding training at a level appropriate to their role and this training is regularly reviewed and updated. Training of staff is as follows (March 2019):

• Safeguarding Children: Level 1 (all staff) 90%
• Safeguarding Adults: Level 1 (all staff) 90%

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

In 2018/19 the CCG has hosted two Safeguarding Children Learning Events which have promoted learning through listening and reflecting on the experiences and view of adults who have experienced challenging childhoods. The Events were well attended and evaluated. The first event focussed on promoting trauma informed practice and was presented by a care experienced trainer. The second event was hosted in partnership with Central London Community Health Care (CLCH) and was delivered by adult survivors of child sexual abuse.

In addition, 82% of staff received the counter terrorism training Prevent during the year.

Celebrating success:
We have successfully recruited to the post of Merton Named GP.

The Chid Protection Information Sharing project has been successfully implemented in all unscheduled care settings across Merton and Wandsworth. This project enabled basic information about children on a child protection plan and children who are looked after to be shared between health professional in unscheduled care setting and social workers. Health professionals in unscheduled care setting are alerted to the vulnerability of these children so have a more complete picture of any safeguarding risks.
The LeDeR (Learning Disabilities Mortality Review) programme has been successfully implemented across Merton and Wandsworth. The programme reviews the deaths of people who have learning disabilities (aged over 4 years) with the aim of reducing inequalities and premature mortality through sharing best practice, identifying areas of improvement and a local responsibility to improve services. Merton and Wandsworth LeDeR programme has been recognised by NHSE in achieving outstanding performance in the timely and quality of completion of LeDer Reviews.

Engaging people and communities

- Our commitment to patient and public involvement
- Reflection on our year
- How we engage
- Assurance
- Feeding back
- Promoting opportunities for involvement
- Co-production
- Information to support our commissioning
- Meeting the Collective Duty – examples of how we engaged

Our commitment to patient and public involvement

The CCGs Constitution describes our commitment to and principles for engagement. Our Chair, Andrew Murray, in the Constitution states that "to achieve our vision of better care and a healthier future for Merton, we will involve and engage our patients in designing services, support them to co-produce systems of care and empower them to look after their own health."

We aim to actively work with patients, carers and the public to embed the values of the NHS Constitution into everything that we do.

We follow and have built on NHS England’s 10 principles for involvement:

- Use several different methods to reach people – rather than expecting them to come to us
- Be proactive in seeking the views of people who experience health inequalities and poor health outcomes
- Provide clear and easy to understand information in a diverse range of formats
- Make sure patient and public involvement is properly resourced
- Be open, honest and transparent about what can be influenced and maximise those opportunities
- Work in partnership with other organisations to share learning to avoid duplication
- Review experience of involvement
- Recognise people's contributions and feedback
- Involve people as early as possible
- Be clear how feedback has or will influence decision making

We provide support to all patients and lay members who work with us. The more informed our patients and public representatives are, the better able they are to meaningfully engage with us.

Our support includes:

<table>
<thead>
<tr>
<th>Training and policies</th>
<th>Increasing understanding</th>
<th>Briefings and advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>We offer training opportunities to our PEG</td>
<td>Attending PPG meetings and voluntary and community group meetings to explain</td>
<td>We have 1 to 1 meetings to support people to get involved and adapt our approaches if they have different needs.</td>
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<tr>
<td>Members through London wide training courses.</td>
<td>more about the CCG, our work and how to get involved.</td>
<td>We provide training for patient representatives on our procurement systems, so that they can read bids and score appropriately.</td>
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<td>We have an expenses policy to cover out of pocket expenses for those who volunteer with us.</td>
<td>We meet with staff on an individual or team basis to provide expert advice and support on engaging with stakeholders and patients. We also give them tools to make sure they are planning patient and public involvement into their projects as early as possible.</td>
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**Reflecting on our year**

Involving patients and the public is a part of everything we do in Merton and our commitment is to involve them in all the different stages of our work; from planning, designing, procuring and monitoring through to delivering new and improved services.

Year on year the impact of patient and public involvement grows as our relationships with partners and voluntary and community groups flourish. Commissioners also become more practised in ensuring involvement happens at as early a stage as possible to influence service design, delivery and improvement.

Looking back over involvement projects completed this year, those that have been most successful have involved going to people where they are and partnering with local organisations to deliver involvement activities. We will continue to work in this way and review our approach year on year.

We could not achieve effective patient and public involvement without our connections to the voluntary and community sector – most especially Healthwatch Merton, our Patient Engagement Group and Merton Voluntary Services Council.

These relationships continue to provide welcome critical friend challenge to our processes and plans and opens doors to community leaders who may be uniquely placed to support us to access communities we’ve not worked with before – including through cascading involvement opportunities on our behalf through their networks.

By funding Healthwatch, both through the South West London Grassroots project and equalities work undertaken as part of the Improving Healthcare Together programme, we have not only been able to capitalise on the extensive community connections that they had developed with local grassroots organisations, but we were also able to strengthen our own relationship with them as key stakeholders in health and care.

**How we engage**

**Patient Engagement Group**

Our Patient Engagement Group (a forum for patients, local people, carers and members of local voluntary and community organisations) have directly informed and influenced the planning, designing and delivery of local health services.

This year the group has been involved in contributing to the development of local initiatives such as:

- developing commissioning intentions and our approach to engaging on them
- improving services for adults with a learning disability, supporting a local MSK provider to improve their patient and public engagement and their overall service for patients
- inputting into a new ophthalmology service in the community
• influencing our approaches to communications and engagement around the development of the Wilson Health and Wellbeing Campus
• reviewing public facing documents such as our PPI annual report and Ageing Well guide to ensure they are accessible and understandable to the public
• sharing experiences of 111 services to inform a new service model
• reviewing the Tackling Diabetes Action Plan and Child Healthy Weight Action plans and providing feedback on how well they combat the issues and advice on how to engage more widely

Supporting and developing Patient and Public Involvement in Primary Care

Work has been started this year to support and enhance patient and public involvement in primary care. We are auditing patient participation groups (PPGs), understanding best practice and what support the CCG can provide to help make PPGs as effective as possible. During 2019/2020 we will be working with GPs and practice managers to introduce innovative and complementary approaches to patient and public engagement.

Assurance

Our Patient Engagement Group assures our patient and public involvement activity – this is through reviewing our annual engagement reports and through providing feedback about communications and engagement plans throughout the year when commissioners attend and present to test their ideas.

All patient and public involvement activity, including the work of the Patient Engagement Group, is reviewed at the quality sub-committee. Annual Patient and Public Involvement Reports are produced and considered by the Governing Body, and demonstrate what patient and public involvement activity has been undertaken and the difference feedback has made.

The Governing Body Lay Member for PPI provides assurance and challenge on work undertaken around PPI and how it has improved patient experience by engaging and listening to patients and stakeholders. She provides a link between issues and concerns expressed by patients and service users and the ability to listen and address these by the Governing Body and our staff. The Lay Member for PPI has regular meetings with both the Chair of the Governing Body and the Director of Quality and Governance which gives the opportunity for any questions or concerns to be raised directly.

Feeding back

Closing the feedback loop is important to us and we regularly publish “you said, we did” reports on our website and share these with those who have worked with us. Our website content has been refreshed to ensure local people interested in getting involved with us to understand the work we do, how people have been involved, what our current projects are and the various ways to have their say.

We work with Healthwatch Merton and Merton Voluntary Services Council to share this information more widely within the local community.

Promoting opportunities for involvement

We have continued to use digital channels as a means of communicating and engaging with local people and promoting opportunities for involvement. We are refreshing our leaflet to recruit local people to our Patient Engagement Group.

Our website acts as a source of information for patients, the public and all local stakeholders. People can send feedback via email or by using an online form, find out about up-coming opportunities to hear about our work or get involved in engagement activity. See www.mertonccg.nhs.uk
We also use social media including Twitter and Facebook to ensure local people can find out about the work we are doing and to ask questions or give feedback. We use our social media accounts to help promote local health and care initiatives, events and job opportunities by partner organisations. This can include re-tweeting public meeting dates, calls for patient participation or helping to raise awareness of local initiatives.

Follow us @NHSMertonCCG or find us on facebook

Co-production

During 2018/19 the CCG and local partners have continued to involve and engage patients and service users on commissioning and service improvement work, moving closer to co-production.

We co-designed our Local health and Care Plan event with Healthwatch and Merton Voluntary Services Council to ensure it was accessible and gave local people the right level of information to make an informed contribution. Feedback from the event was extremely positive. See our website for a summary video from the day.

In 2018/2019 CCG commissioning staff undertook a wide and varied listening exercise to develop commissioning priorities as part of the CCG’s commissioning intentions development. The CCG met with over 100 people from groups and communities in Merton.

Through the establishment of our Wilson Community Reference Group we have co-designed our engagement plans for seeking views on the redevelopment of the Wilson Health and Wellbeing Campus. Members of the local voluntary and community organisations such as the LGBT forum, Polish Family Community and the BAME forum worked with us to ensure local people have opportunities at each stage of the project to contribute and have commented on our draft Equalities Impact Assessment.

Information to support our commissioning

Our Clinical Quality Review Groups work with providers to understand how they are ensuring, amongst other things, that patient and public involvement and equalities information is influencing the ways in which services are delivered. We review information from providers Friends and Family Tests, patient experience surveys as well as annual reports about equalities to help ensure services continue to improve.

At the very start of any project, an Equality Impact Assessment (EIA) is undertaken. This is to ensure that the project has considered any impacts it will have on the nine protected characteristics and other vulnerable groups and ensures this informs who we engage with as part of the project. Commissioners use data from public health about the local population as well as the outputs from engagement activity to help make sure equalities impact assessments are informed by qualitative and quantitative data.

When planning for engagement, commissioners are encouraged to consider what existing data there might be available to understand patient’s experiences of those services, including data from providers about who is using the service, relevant Healthwatch reports and local and national charity data.

Meeting the Collective Duty – examples of how we engaged

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

- Merton Health and Care Plan Event
- Mitcham Health Hub 2018
- Improving access to psychological therapies

Developing our Local Health and Care Plan – November event
Health and care organisations in Merton are working more closely together to make services better connected and more joined up. The NHS, Merton Council, voluntary sector and Healthwatch are developing a Local Health and Care Plan for how this might be achieved.

To develop our ideas, we brought together local people, frontline staff and key stakeholders (including local councillors and voluntary and community groups) to help us agree priority areas for all the partners to focus on.

More than 130 people attended the day – including around 50 local people who had been specifically recruited to represent the diverse community in Merton and who had never worked with us before.

We worked with a specialist organisation to reach out to a representative cross section of the community using online advertising and on-street recruitment. As a result, we heard from a range of people we wouldn't ordinarily have reached including from those in deprived communities, young adults and people from multi-cultural backgrounds.

The outcomes of the event have formed the basis of our Merton Health and Care Plan which will be drafted by April 2019.

**Mitcham Health Hub 2018**

We hosted a Health Hub at Mitcham Carnival on the 20th of June 2018, had a footfall of around 1000 people where we promoted local health and wellbeing services and organisations across Merton. We invited many of our local groups to join us. The event gave us and our partners the opportunity to:

Engage and communicate with local people on promoting health and wellbeing

- Providing information on the new GP hubs
- Promote when, where and how to access services, gain sign-up to initiatives including the Expert Patient programme
- Raise awareness and seek feedback on the development of the Wilson Health and Wellbeing campus
- Encourage patients, public and carers to take part in opportunities to get information on healthy eating, advice on blood pressure, how to avoid strokes and practical support to individuals and families on health and wellbeing.

We attracted over 1,000 people and many of the visitors took away leaflets and information about local services and support.

**Improving access to psychological therapies**

A new Improving Access to Psychological Therapies (IAPT) service Merton Uplift started in April 2019, following a procurement process which includes; a wellbeing service (including social prescribing) and a primary care recovery service (for patients discharged from hospital with severe mental illness).

To help inform the new service, focus groups were held in the summer of 2018, involving mental health service users and carers to discuss mental wellbeing, IAPT services and primary care recovery. Two lay/community representatives also took part in the procurement process of evaluating potential providers. As a result of feedback, the new providers established a service user group, include carers' support and carers' assessments are included and work in closer partnership with the voluntary sector to enhance the lives of those in need of support for their mental health.

**Meeting the individual duty- examples of how we engaged**

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

**Diabetes Truth Programme**

With an increase in the prevalence of diabetes across Merton, the Health and Wellbeing Board built on the work undertaken in 2017/2018 to ‘buddy’ members of the board with those at risk of diabetes, living with diabetes or caring for someone with diabetes. This deepened their understanding, hear people's stories and to identify root causes, barriers and influencers of change.

Mini conversations were held in October 2018 to develop a tackling diabetes action plan. Conversations focussed on how to support people to be healthy, attend structured education courses, other support available, the best places to deliver services and how information should be provided and supporting self-management. It is hoped that this work will help to inform new approaches and lead to a long-term improvement in the clinical outcomes for patients across the borough.

**Expert Patients Programme**

The Expert Patients Programme (EPP) is a six week programme for people with one or more long-term health conditions.

The EPP is peer-led by tutors who have previously completed the course and then trained as a tutor due to the positive effect it has had on their daily lives. This peer-led approach allows tutors to support the participants by acting as role models in self-management and sharing their experiences of living with a long-term health condition. It also helps them encourage peer support within the room, which allows for relationships to build and continue once the participants have completed the six-week programme. The EEP offers three different courses:

- The Expert Patients Programme: A generic course for anyone living with any long-term condition
- Looking After Me: a course for anyone who is a carer
- New Beginnings: a course for anyone living with a mental health condition.

In Merton 36 people attended Expert Patient Programme Courses in the past year.

**Working with our diverse community**

To be effective commissioners, we need to understand our local population, identify those least likely to be heard, be proactive in reaching them through our engagement activities and consider the needs of those who experience the worst health outcomes.

To do this we:

- Work with public health colleagues in the Local Authority to understand available data and information about the health and wellbeing of local people. You can read more about this on the London Borough of Merton website and in our Public Sector Equality Duty Report
- Use our Equality Impact Assessments (EIA) to inform who we speak to during our engagement activities. As a result of intelligence from our EIAs we targeted BAME communities during the community ophthalmology project and Merton Healthwatch ran five focus groups reaching people with physical and learning disabilities, mental health needs and children and young people as a result of an early EIA on the Improving Healthcare Together programme. You can read more about these and other projects in our PPI Annual Report
- Use a range of methods to reach and work with local people - for example, working through voluntary and community partners to talk to deprived communities about the development of the Wilson Health and Wellbeing Campus and through partnering with Healthwatch on the Grassroots programme, reaching the Polish community at a community event.
Ensuring we are engaging with all our communities is very important to us.

We collect protected characteristic data when doing large scale engagement so that we can do our best to ensure we reach all these groups. We capture this by asking those who engage with us to complete an equality monitoring form. We use this information to decide if there are more groups we need to engage with, or indeed if we are engaging in the right ways to meet different communication needs.

We recognise that different groups of people have different needs when it comes to engagement. We want to make sure those with disabilities and learning difficulties are supported to be involved in the most appropriate ways and are considered when we are planning who we need to engage with – so that no groups are overlooked.

Recognising that different communities have different needs; we aim to ensure our involvement activities are accessible by seeking advice from community leaders, making information available in different formats and languages, on request, presenting information in plain English and considering the physical accessibility of our activities.

**Patient and Public Involvement (PPI) across south west London**

An integrated approach to engagement and communications for the South West London Health and Care Partnership ensures consistency across the six boroughs of our Partnership in our locally delivered engagement activity. A small central team provides support for our CCG-based engagement teams, facilitating knowledge sharing and collaboration, and coordinating activity that is best carried out at scale across SW London’s six boroughs.

We created professional communities through borough-level communications and engagement steering groups that bring together leads from local authorities, NHS trusts, CCGs, the voluntary sector and Healthwatch to work on joint projects, share knowledge, map and stakeholders and channels, and coordinate plans for involving local people. These met every six weeks approximately during 2018-19.

Local people and their representatives are involved in all areas of the South West London Health and Care Partnership’s work, from assessment of local need and development of strategy, in close collaboration with our partners, to monitoring of contracts with providers.

Our engagement work is overseen, and constructively challenged by our SW London Patient and Public Engagement Steering Group (PPESG), an advisory sub-group to the South West London Health and Care Partnership Programme Board. The PPESG membership includes representatives from Healthwatch, south west London’s voluntary and community sector organisations, as well CCG lay members from across the six boroughs. Two representatives from this group are also members of the SWL Programme Board. Standing items for this meeting include SWL programme and borough updates.

The PPESG met six times in 2018-19 and agenda items included children and young people’s mental health, the development of health and care plans and, more widely, an integrated care system for SW London, as well as digital and winter communications campaigns.

Following our STP refresh in 2017, informed by feedback and engagement with local people and stakeholders, our strategic approach has shifted to working in local partnerships at borough level to integrate health and care, and encouraging partnerships to develop local health and care plans at borough level to set joint priorities for local action. During November 2018, we coordinated six large-scale deliberative events, with each local partnership hosted an event in their borough to engage on their Local Health and Care Plan. Each event brought together around 150 people including local people, stakeholders including local councillors, community organisations and Healthwatch, alongside senior managers and front-line staff to discuss the key challenges for health and care in each borough and to generate priority actions for joint action across our Partnership to enable people to start well, live well and age well.
Careful sampling and recruitment of local people to reflect each borough’s demographic brought new faces and fresh insights, as well as a pool of people who have registered an interest in working with us to improve health and wellbeing in the coming months and years. Following publication of local health and care plans in each borough in March 2019, engagement will involve more focused codesign work with target populations. We will continue to work together with local people, community organisations and our partners to put these plans into action in the months and years to come.

Patient and public voice representatives, or PPVs, sit on SWL clinical workstreams including mental health, planned care and cancer. Together with Healthwatch, PPVs bring insight and challenge to support more effective planning and decision-making. PPVs have an induction and ongoing support to enable them to fulfil their role. PPVs are also members of a new readers’ panel we established in 2018 to help us test materials prior to publication.

Focused engagement influences and shapes strategy and service development in each of our workstreams. Activities include focus groups, interviews and online channels such as surveys and readers’ panels. Examples include:

- Children & young people
- Diabetes
- NHS 111 Telephone Service
- Macmillan Primary Care Nursing Project – Cancer Care Reviews

Our Grassroots Programme, run in collaboration with Healthwatch, ensures we are tapping into seldom heard voices to inform service improvement, strategy and the development of our health and care plans. It also informed our STP strategy refresh in 2017-18. By funding and attending a series of fun, community-based events in existing groups, our commissioners have had the opportunity to hear about people’s experiences and understanding of local services. In this year’s programme, which ended in November 2018, we met with 67 groups reaching over 1900 people and having in-depth conversations with over 1500 people.

The programme expanded our reach into communities and enhanced our understanding of the needs of specific populations where health is just one of a number of challenges associated with daily living. We used insights from these sessions in presentations to set the scene and present a picture of health at our large-scale deliberative events in Merton, Croydon, Wandsworth, Kingston, Richmond and Sutton in November 2018. You can read more about the Health and Care Plan events [here](#).

**Next steps**

In 2019/2020 our priority areas of patient and public involvement will include:

- Developing our Local Health and Care Plan
- Supporting engagement to inform the national NHS 10-year plan
- Continuing to involve local people in the development of IAPT services
- Supporting the re-procurement of community services
- Supporting children's emotional wellbeing in schools through a trailblazer pilot
- Continuing to engage our local community in the development of the Wilson Health and Wellbeing Campus
- Enhancing patient and public engagement in primary care – complementing the work of PPGs

Taking on board learning and encouraging best practice we will:

- Be developing a refreshed patient and public engagement strategy
- Create stronger links with provider engagement teams to support more effective partnership working
• Deliver training to commissioning staff to support innovation and best practice around patient and public involvement and the consideration of equalities

Reducing health inequalities

Our role as a Clinical Commissioning Group is to reduce inequalities between patients in accessing the services we commission. To reduce health inequality and improve outcomes for all we work with colleagues in the public health team at Merton Council, as they provide us with a source of expertise in using health related data sets to inform commissioning, reduce inappropriate variation in the local area, identify vulnerable populations and marginalised groups, and support commissioning to meet their needs.

Key developments over the past year

• We continue to work towards our Equality Objectives for 2017-21 which were developed through active engagement with key CCG stakeholder groups
• A Merton and Wandsworth Equality and Diversity Working Group, with representatives from both CCGs, has been refreshed to guide the work of both CCGs
• A Merton and Wandsworth Joint Staff Forum continues to work to ensure employee concerns are addressed across both CCGs
• A range of patient and public engagement activities have taken place, which have ensured engagement with all groups, with those less involved in healthcare commissioning
• Findings from benchmarking exercises, such as the Workforce Race Equality Standard (WRES) and the Equality Delivery System (EDS2) continue to be considered by the CCG
• To increase access to primary care, GP Hubs have been established for weekend and evening appointments. Merton residents now have access to a GP seven days a week. Communications campaigns are underway to ensure as many members of the public are aware of access to these services
• Co-commissioning of key initiatives with London Borough of Merton, including the East Merton Model of Health and Wellbeing (Wilson Project), children young people’s mental health and Diabetes (within the Asian community) and a Social Prescribing Pilot – both of which are aimed at supporting greater inclusion and reducing health inequalities.
• Key providers continue to be monitored on equality and diversity as part of the NHS Standard Conditions of Contract assurance process.

Equality Delivery System

To ensure Merton CCG meets its statutory equality duties under the Equality Act 2010 we use the Equality Delivery System2 (EDS2). EDS2 is a tool created by the NHS to help local NHS organisations, in discussion with local partners and the public, to review and improve their performance for people with characteristics protected by the Equality Act 2010.

The four EDS2 goals are:
Goal 1 - Better health outcomes
Goal 2 - Improved patient experience
Goal 3 - Representative and supportive workforce
Goal 4 - Inclusive leadership

During 2017-2019 we reviewed IAPT and Latent TB services and received a grading of developing for all Goals. In 2019/2020, two new service areas will be selected for review and grading will be informed by stakeholder input.

Equality Impact Assessments

At the very start of any project, an Equality Impact Assessment (EIA) is undertaken. This is to ensure that the project has considered any impacts it will have on the nine protected characteristics and other
vulnerable groups and ensures this informs who we engage with as part of the project. This process is embedded in our governance processes - no project can progress unless an EIA has been produced.

Equality and Diversity Group
The equality and diversity work programme is monitored by the joint Merton and Wandsworth Equality and Diversity Group (EDG), which includes Governing Body members, commissioning and patient and public involvement teams and representatives from the Public Health Teams from London Borough of Merton and Wandsworth Councils. The EDG makes recommendations for strategic decisions related to addressing inequality. Detail on Merton CCG’s progress on equality and diversity can be found in its annual public sector equality duty report for the period January to December 2018. For more information visit the CCG website.

Commissioning to reduce health inequalities

Social Prescribing
The expanded Social Prescribing service in Merton has demonstrated benefits for people who are socially isolated or belong to vulnerable groups and those who frequently attend either primary or secondary health services by offering alternative means of support, improving self-reported wellbeing and symptom management.

Extended Access
In Merton patients can now access primary care appointments between 8am to 8pm, seven days a week, with over 4000 additional primary care appointments each month. These opening times make it easier for registered patients to see a GP in Merton. These additional appointments are provided within individual GP practices and also from two “hubs” located within the borough.

Diabetes
We know there is a higher prevalence of diabetes amongst BAME groups. The CCG has been working throughout the year to develop a new model of diabetes care. One of the key benefits includes having care closer to home as more patients will be supported in primary and community settings. This will lead to reduction in the variation in the quality of care and will also provide enhanced support and improvement to patient outcomes.

In partnership with other South London CCGs, Merton CCG has commissioned an on-line diabetes booking portal to support improved choice and access to diabetes structured education which is accessible to both GPs and patients. The portal, Diabetes Book & Learn service was launched on 1st October 2018 and provides information about all lifestyle and community services including mental health where patients can be signposted to or self-refer. This is in addition to extra accredited structured education for patients with diabetes commissioned through the transformation funding received from NHS England as part of Diabetes Treatment & Care programme. The accredited structured education covers an on-line/digital education which is accessible via the Diabetes Book & Learn Hub, extra capacity during evenings & weekends and sessions targeting primarily BAME patients. The CCG will continue to work to increase uptake of these services from key population groups as we move into 2019/20.

Ophthalmology
Through engagement with patients and stakeholders, Merton and Wandsworth CCGs have identified a significant health improvement opportunity for patients affected with eye conditions.

Approximately a third of the Wandsworth and Merton population are of the Black, Asian and Minority Ethnic community (BAME) and it is expected that the population will become more diverse. While there are no particular races that have a higher prevalence of minor eye conditions, it is known that certain races have a higher prevalence of Diabetes (South East Asian and African /Caribbean communities), which is linked to complications of the eye.

Merton, Wandsworth and Sutton CCGs plan to procure and mobilise a Community Ophthalmology service across a number of easily accessible locations in each borough in 2019 to deliver a:

- Minor Eye Conditions Service ((MECS) e.g. red eye, white eye)
• Cataract service to include direct referral from appropriately accredited clinician(s) and provide pre-operative appointments
• Glaucoma IOP Referral Refinement Service
• Single Point of Access where there is clinical assessment and triage of all ophthalmology referrals from primary care

Some of the expected outcomes to be achieved from 2019 onwards through the implementation of the community ophthalmology service will be to:
• Increase patient quality outcomes and reduce patient waiting times
• Address access inequalities, by delivering an equitable provision of eye care services across the Merton, Wandsworth and Sutton geography
• Support the delivery of new services which are clinically effective and cost efficient

Improving Cervical Screening Inequality for Women
The Merton CCG Cervical Screening Pilot run in conjunction with Royal Marsden Partners and Merton GP Federation is intended to increase the overall uptake of cervical screening through the targeting non-participants of the programme in particular working women (who will often be at work at the time of their appointment). Within this initiative working women have the option of attending a range of service locations to have their screening and at a time and location that is convenient to them.

The aim is that by adding this option of convenience of time and location that women that would not normally attend for their cervical smear are now encouraged / incentivised to do so. The locations of the service are evenly distributed across the localities and appointments are available in the evenings as well as weekends. Patients can attend from any GP Practice to any location. Staff can also work across different practices and localities to ensure that there is workforce to match the additional demand.

Women that attend for screening in these additional sessions are requested to complete a survey in order that we can evaluate the effectiveness of offering services in this way.

Integrated Locality Teams
In order to provide more proactive support to older, frail people, Integrated Locality Teams have been introduced into Merton.

Multi-disciplinary working across health and social care has been developed further by establishing four integrated locality teams (ILTs) across Merton responsible for proactively managing care, to support keeping people well at home and avoiding unnecessary emergency admissions to hospital by providing an integrated person-centred approach to delivering care.

These include complex patients, those with severe frailty and those in the last year of life. Each GP practice in Merton has committed to working in one of four clusters, with an ILT co-ordinator supporting co-ordination with Central London Community Healthcare NHS Trust (CLCH) where community nursing teams have been aligned to the four ILTs and the London Borough of Merton (LBM) has a link Senior Health Liaison Social Worker (HLSW) for each GP practice. South West London and St George’s Mental Health Trust (SWLStG) has identified link care coordinators for working age adults for each GP practice and a liaison point of contact across all practices for services for older people. St Raphael’s Hospice works closely with other partners and CNSs attend practice MDTs.

Through this person-centred approach, it is anticipated that older people, potentially those with a disability and people who are socio-economically deprived, will receive more co-ordinated care, designed to meet their individualised needs and through which inequalities will be reduced. Since the start of this initiative, emergency admissions that last two days or more for those aged 65 and over have reduced.

Further work is taking place to track anonymised details of people having been through the ILTs and the enhanced support offered through GP practices and the impact of this will be reviewed and it is hoped that health inequalities will be reduced through this work.

Mental health inequalities
People diagnosed with severe mental illness are known to have a life expectancy that is around twenty years less than that in the general population. People suffering from long term conditions, particularly heart
disease, chronic respiratory disease and diabetes, are known to suffer higher rates of common mental health problems (depression and anxiety). Primary mental health care services in Merton have under-gone development over the last two years to integrate physical and mental health services to address these health inequalities.

In 18/19, the focus has been on establishing care pathways for people with long term conditions who may benefit from psychological therapies. The local IAPT (Improving Access to Psychological Therapies) service provider has focused on patients with cancer, diabetes, and heart failure. With this focus, the Addaction IAPT service has ensured that 27% of patients making use of the service (April 2018 to January 2019) are people with diagnosed long term conditions (LTCs). These data demonstrate the Merton IAPT service has been successful in making sure the proportion of clients receiving treatment for psychological therapy is very close to the proportion of the local population it is estimated would be living with a LTC, and suffering from a common mental health problem.

For the year ahead (19/20), Merton CCG has procured a new primary mental health care service to build on this success.

**Workforce Race Equality Standard**

The Workforce Race Equality Standard (WRES) is a set of nine indicators that, for the first time, require all organisations with NHS contracts, to demonstrate progress against several areas of race equality, including a specific indicator to address the low levels of BAME Board representation.

Merton CCG has published an internal report on the WRES for 2018/19, which was approved by the Integrated Governance and Quality Committee and key providers report progress against their WRES metrics through our Clinical Quality Review Group. The WRES action plan and data is available on the CCG website.

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

**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.

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

**Estates**

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

**Paper free at point of care**

We are working hard to improve our performance in relation to ‘paper-free’ at the point of care. Average electronic prescribing for Merton practices as of March 2018 was 63% which is above the national average. There is a target for this to reach 70% in 18/19 and 80% by 19/20. We are also working with GP practices and providers to increase the use of an e-referral system with a view to going paperless by mid-2018.

**CCG paper free**

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

Corporate Governance Report

Members report

Member Profile
NHS Merton CCG consists of 22 GP practices with 222,000 registered patients. The CCG consists of two Locality areas:

- East Merton
- West Merton

Each locality consists of GP practices that work in collaboration with patients, the public and key stakeholders to influence health service commissioning.

Member GP practices decide how the CCG operates by developing a constitution with a Governing Body made up of lay members, clinicians (GPs, nurses and a hospital doctor) and NHS managers.

### West Merton CCG Member Practices

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Alexandra Surgery</td>
<td>39 Alexandra Road, Wimbledon SW19 7JZ</td>
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<tr>
<td>Francis Grove Surgery</td>
<td>Francis Grove Surgery</td>
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<tr>
<td>Grand Drive Surgery</td>
<td>Grand Drive Surgery</td>
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<tr>
<td>Lambton Road Medical Practice</td>
<td>1 Lambton Road, Raynes Park, SW20 0LW</td>
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<tr>
<td>Morden Hall Medical Centre</td>
<td>256 Morden Hall Road, London SW19 3DA</td>
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<tr>
<td>The Nelson Medical Practice</td>
<td>220 Kingston Road, London SW20 8DA</td>
</tr>
<tr>
<td>Princes Road Surgery (1/4/18 – 25/11/18)</td>
<td>51 Princes Road, Wimbledon, SW19 8RA</td>
</tr>
<tr>
<td>Wimbledon Medical Practice (26/11/18 – 31/3/19)</td>
<td>79 Pelham Road, SW19 1NX</td>
</tr>
<tr>
<td>Stonecot Surgery</td>
<td>115 Epsom Road, Sutton SM3 9EY</td>
</tr>
<tr>
<td>Vineyard Hill Road Surgery</td>
<td>67 Vineyard Hill Road, Wimbledon SW19 7JL</td>
</tr>
<tr>
<td>Wimbledon Village Surgery</td>
<td>35A High Street, Wimbledon SW19 5BY</td>
</tr>
<tr>
<td>Central Medical Centre</td>
<td>42-46 Central Road, Morden SM4 5RT</td>
</tr>
<tr>
<td>Merton Medical Centre</td>
<td>12-17 Abbey Parade, Merton High Street SW19 1DG</td>
</tr>
<tr>
<td>Colliers Wood Surgery</td>
<td>58 High Street, Colliers Wood, SW19 2BY</td>
</tr>
<tr>
<td>Riverhouse Surgery</td>
<td>East Road, Wimbledon, SW19 1YG</td>
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James O’Riordan Medical Centre has now become part of Sutton CCG and is therefore no longer included as part of the West Merton locality.

### East Merton CCG Member Practices

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<th>Name</th>
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<tbody>
<tr>
<td>Figges Marsh Surgery</td>
<td>182 London Road, Mitcham CR4 3LD</td>
</tr>
<tr>
<td>Mitcham Family Practice</td>
<td>55 Mortimer Road, Mitcham, CR4 3HW</td>
</tr>
</tbody>
</table>
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
Wide Way Surgery  15 Wide Way, Mitcham CR4 1BP

Composition of the Governing Body

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

<table>
<thead>
<tr>
<th>Voting Members</th>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Dr Andrew Murray</td>
<td>GP, CCG Clinical Chair</td>
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<tr>
<td>Sarah Blow</td>
<td>Accountable Officer</td>
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<tr>
<td>James Murray</td>
<td>Chief Finance Officer</td>
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<tr>
<td>James Blythe</td>
<td>Managing Director</td>
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<tr>
<td>Dr Karen Worthington</td>
<td>GP Locality Lead East Merton</td>
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<tr>
<td>Dr Andrew Otley</td>
<td>GP Locality Lead East Merton (from 1/9/18)</td>
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<tr>
<td>Dr Tim Hodgson</td>
<td>GP Locality Lead West Merton</td>
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<tr>
<td>Andrew Leigh</td>
<td>Lay Member – Governance</td>
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<tr>
<td>David Smith</td>
<td>Lay Member – Finance (CCG Vice Chair from 1/9/18)</td>
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<tr>
<td>Clare Gummett</td>
<td>Lay Member – Patient &amp; Public Engagement</td>
<td></td>
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<tr>
<td>Mike Greenberg</td>
<td>Secondary Care Consultant</td>
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<tr>
<td>Julie Hall</td>
<td>Board Nurse (until 31/6/18)</td>
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<tr>
<td>Sam Page</td>
<td>Board Nurse (from 1/9/18)</td>
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<tr>
<td>Dr Dagmar Zeuner</td>
<td>Director of Public Health – London Borough Merton</td>
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<tr>
<th>Non-Voting Members</th>
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<tbody>
<tr>
<td>Neil McDowell</td>
<td>Local Finance Director</td>
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<tr>
<td>Josh Potter</td>
<td>Director of Commissioning</td>
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<tr>
<td>John Atherton</td>
<td>Director of Performance Improvement</td>
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<tr>
<td>Andrew McMylor</td>
<td>Director of Primary Care Transformation (to 31/8/18 on secondment)</td>
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<tr>
<td>Katherine Denton</td>
<td>Acting Director of Primary Care Transformation (from 1/9/18)</td>
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</table>
Committee(s), Including Audit Committee
Details of Committees of the Governing Body and Sub Committees including their membership are set out in the Governance Arrangements and Effectiveness section of the Governance Statement.

Register of Interests
The Register of interests for Merton CCG is maintained throughout the year and published on the CCG website.

Personal data related incidents
There have been no serious internal incidents or information governance issues and one provider incident requiring reporting to the Information Commissioner’s Office for Merton CCG.

Statement of Disclosure to Auditors
Each individual who is a member of the CCG at the time the Members’ Report is approved, confirms:
- so far as the member is aware, there is no relevant audit information of which the CCG’s auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG’s auditor is aware of it.

Modern Slavery Act
Merton CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2
Statement of Accountable Officer’s Responsibilities

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

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

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

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

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

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

To the best of my knowledge and belief, and subject to the disclosures set out below (eg. directions issued, s30 letter issued by external auditors), I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.
I also confirm that:

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

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

Sarah Blow,
Accountable Officer

NHS England Core Standards for EPRR

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

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

Introduction and context

Merton CCG is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 or any section 30 Audit directions.

Scope of responsibility

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

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

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

The CCG membership is derived of GP practices located in two Locality areas East Merton and West Merton. Each locality holds members forums where a representative member of each practice attends to work in a shared framework to deliver the commissioning strategy and agreed operational plan whilst providing support and help in the development of future commissioning priorities. The members’ forums are also tasked with selecting a Locality Lead GP who will act on their behalf as a voting member on the Governing body.

The CCG has established a constitution that defines how the organisation will operate to ensure governance standards are upheld and the organisation remains accountable to the member practices and local population. This includes how the principles of good governance are applied to the structure and operations, specifically around the relationship between the governing body and the membership, and the process for electing and appointing the CCG Clinical Chair and clinical leadership team.
The CCG Constitution takes account of the Nolan principles, the Good Governance Standards for public services and the key principles of the NHS Constitution.

Governing Body meetings are held on a bi-monthly basis in public as part of the organisation's commitment to openness and transparency, enabling the public to attend the meeting and submit questions they wish to be answered. An annual business cycle sets out the programme of business to be covered by meetings and ensures there is clear structure by which governance, transparency and oversight is maintained without increasing the bureaucratic burden on Executives and staff. During 2018/19 this has specifically included key reports to the Governing Body on the South West London Health and Care Partnership and the Wilson Health and Wellbeing Campus Service Design.

Membership of the governing body is structured to ensure a clinical majority of voting members. Overall there are four elected GPs including the Clinical Chair along with two further independent clinical experts in the form of a Board level nurse and secondary care doctor. Three non-clinical lay members ensure the Governing Body has a strong mix of independent insight and external scrutiny when making decisions.

**Governance structure 2018/19**

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 summarised and presented to the Governing Body meetings.

A corporate calendar agreed at the start of each financial year schedules committee meetings throughout the year in line with the agreed terms of reference. Each committee has a defined quoracy that dictates the minimum attendance required for decisions to be taken.
## GOVERNING BODY ATTENDANCE 2018/19

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<th>Name</th>
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<td>Dr Mike Greenberg</td>
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### Meeting Attendance

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Audit and Governance Committee

Chair: Andrew Leigh

The Audit and Governance Committee meets 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 is composed entirely of non-executive members although attendees are invited from Internal and External Audit, Local Counter Fraud Service and the CCG Executive including Managing Director, Finance Director and Director of Quality and Governance.

The committee’s main activities through the year have been focused on financial controls, cyber security, corporate risks, internal control system reports and External Audit assurance reporting.

<table>
<thead>
<tr>
<th>AUDIT AND GOVERNANCE COMMITTEE ATTENDANCE 2018/19</th>
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<tbody>
<tr>
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<tr>
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<td>Andrew Leigh</td>
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<td>Dr Mike Greenberg</td>
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<td>Julie Hall</td>
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</table>

Primary Care Commissioning Committee

Chair: Clare Gummett

This is a committee of the Governing Body as prescribed by schedule 1A of the “NHS Act” relating to delegated commissioning.

The committee functions as a corporate decision-making body for the management of the delegated primary care commissioning functions and the exercise of the delegated powers.

The committee has been established to enable the Members to make collective decisions on the review, planning and procurement of primary care services in Merton, under delegated authority from NHS England.
It is a committee comprising Lay member, Clinicians and Executives with non-voting representatives from NHS England, London Borough of Merton, Local Medical Committee and Healthwatch Merton.

### Remuneration committee

This committee provides advice and recommends decisions to the Governing Body in determining remuneration, fees and allowances payable to employees and other persons providing services as well as determining allowances payable under pension schemes established by the CCG.

In respect of Alliance wide roles, the Remuneration Committee meets as a committee in common to agree a unanimous basis for decision making.
Integrated Governance and Quality Committee (IGQC)

Chair: Andrew Murray (MCCG Chair) / Nicola Jones (WCCG Chair)

The IGQC is a monthly meeting that meets in common with Wandsworth CCG. The key focus of the meeting is to scrutinise the effectiveness of quality and governance arrangements in support of the CCG’s activities. Its focus is on ensuring that an integrated approach to decision making and consideration of risks is effectively in operation. Monthly reports on key quality concerns, significant and emerging risks, provider performance reporting and focussed work on specific key elements of service provision are considered. Summary highlights from the meeting are reported to the Governing Body.

| INTEGRATED GOVERNANCE AND QUALITY COMMITTEE ATTENDANCE 2018/19 |
|-----------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|                             | Apr    | May    | Jun    | Jul    | Aug    | Sep    | Oct    | Nov    | Dec    | Jan    | Feb    | Mar    |
| Dr Andrew Murray            | √      | √      |        |        |        |        |        |        |        |        |        |        |
| Dr Karen Worthington        | √      | √      | √      |        |        |        |        |        |        |        |        |        |
| Dr Tim Hodgson              |        |        |        | √      |        |        |        |        |        |        |        |        |
| Clare Gummett               |        |        |        |        | √      |        |        |        |        |        |        |        |
| Andrew Leigh                |        |        |        |        |        | √      |        |        |        |        |        |        |
| Julie Hall                  |        |        |        |        |        |        | √      | √      |        |        |        |        |
| Sam Page                    |        |        |        |        |        |        |        |        |        |        |        | √      |
| James Blythe                |        |        |        |        |        |        |        |        |        |        | √      |        |
| Julie Hesketh               |        |        |        |        |        |        |        |        |        |        |        | √      |
| Neil McDowell               |        |        |        |        |        |        |        |        |        |        |        |        |
| John Atherton               |        |        |        |        |        |        |        |        |        |        |        |        |
| Josh Potter                 |        |        |        |        |        |        |        |        |        |        |        | √      |

LDU Finance Committee in Common

Chair: David Smith (Merton) / Chris Savory (Wandsworth Lay Member – Finance)

The finance committee operates as a committee in common with Wandsworth CCG and was established to scrutinise the financial planning and performance for Merton CCG, review areas of concern and report to the Governing Body as appropriate. It works to ensure financial probity within the CCG.

During 2018 a South West London Finance Committee in Common was established to specifically consider the financial landscape across SWL. This meeting meets on a bi-monthly basis and alternates with the LDU Finance Committee.
In addition to the above Governing Body committees the CCG is supported by the following operational groups:

| FINANCE COMMITTEE ATTENDANCE 2018/19 (LDU, M, SWL) |
|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                | Apr LDU | May LDU | Jun LDU | Jul LDU | Aug LDU | Sep LDU | Oct SWL | Nov LDU | Dec M | Jan LDU | Jan SWL | Feb SWL | Feb LDU | Mar SWL |
| David Smith    | √       | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
| James Blythe   | √       | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
| Neil McDowell  | √       | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
| Dr Andrew Murray | √      | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
| James Murray   | √       | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
| Dr Tim Hodgson | √       | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
| Dr K. Worthington | √    | √       | √       | √       | √       | √       | √       | √       | √     | √       | √       | √       | √       | √       |
Executive Management Team

This is a Local Delivery Unit meeting and as such covers both Wandsworth and Merton CCG business. The meetings are attended by the executive management team and lead clinicians and are chaired by the Managing Director.

This group is focussed on fulfilling the responsibilities of the CCG and to enable the development and delivery of corporate direction. This includes:

- Consideration of key strategic issues
- National policy initiatives
- Corporate responsibilities and leadership
- Overseeing operational management of the CCG
- Consideration of risks and priorities across the directorates and organisation
- Identifying and monitoring the implementation of remedial action plans as appropriate.

Clinical Oversight Group

This is a clinically led group that supports the Executive Management Team in the development and delivery of corporate direction. Through the provision of clinical expertise in areas of service design including the commissioning and decommissioning of services the group provide guidance and challenge to the CCG to ensure commissioned services are of the highest quality.

This group meets on a monthly basis and consists of all the Clinical Directors and Clinical Leads for the CCG along with the Executive Management. Senior commissioning staff attend as required. The meetings are chaired by the CCG Chairs on an alternate basis.

South West London Committees in Common (CiCs)

The South West London Clinical Commissioning Groups have agreed the establishment of Committees in Common (CiCs) for the purpose of strategic decision making, with particular reference to the South West London Five Year Forward Plan or any successor strategy as agreed by the CCGs.

The role of a CiCs is to take decisions on behalf of the CCGs as set out in the Establishment Agreement. Decisions will be taken by the representatives of each CCG on behalf of their individual CCG and will be taken only after consideration of the issues by the CCG Governing Body and the engagement of the CCG membership. The meeting convenor (a pre-agreed SWL CCG Lay member) chairs the meetings on a quarterly basis.
UK Corporate Governance Code
We are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the clinical commissioning group and best practice.

Discharge of Statutory Functions
The clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group’s statutory duties.

Risk management arrangements and effectiveness
Merton CCG has a comprehensive, robust risk management framework in operation which supports the identification and assessment of specific risks, identifies accountability for risk and responsibility for mitigation of those risks at both a strategic and operational level. Key risks are highlighted and discussed at the Governing Body committees with the Integrated Governance and Quality Committee holding overall responsibility for agreement and review of the risk management systems. The principal risks identified as most likely to impact on the achievement of the corporate objectives are reported to the Governing Body through the Board Assurance Framework on a bi-annual basis.

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 scrutinise the effectiveness and completeness of the system of integrated governance including 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. Risks go through the following regular review cycle:

- risk leads and the Risk Manager review and update risks on a regular basis throughout the year in line with prescribed timeframes dependant on the residual risk score;
- risk owners (Executive Directors) review risks;
- the Executive Management Team considers the corporate risk register;
- risks are reviewed by their relevant committee at each meeting (Integrated Governance, Finance, Primary Care Committees);
- The Integrated Governance Committee retains overall management of the risk management framework;
- the Governing Body approves the Risk Assurance Framework, with amendments;
- Audit Committee provides independent oversight of the Risk Assurance Framework process.

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 corporate objectives can be achieved;
- has a process in place for identifying, minimising and prioritising risks that may prevent the achievement of corporate objectives;
- ensures strategic controls are in place to manage those risks; and
- 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.

At an operational level, 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. Target risk scores are agreed for each risk based on identified opportunities for further mitigation. This is supported by agreed actions required to reduce the risk score in line with the target risk.
The Audit Committee and Governing Body approve the BAF periodically, as set out in the constitution. 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. Sharing the learning through risk related issues reported through committee meetings, incident reports, complaints data and claims, all form essential components to maintaining the risk management culture within the CCG.

Capacity to Handle Risk

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

Risk Assessment

Our risk profile reflects both the wide range of services we are responsible for commissioning and our responsibilities as leaders of the local health economy.

The CCG Risk Register sets out all the current risks describing the nature of these risks, the existing controls in place and also actions required to manage the risks.

New risks identified for inclusion on the CCG Risk Register are assessed for their ‘Likelihood and Consequence’ using a 5x5 risk matrix in accordance with the Integrated Risk Management Framework.

Risks assessed as having a rating of 15 or above (red risks) before considering any control mechanisms we have in place, are mapped against our corporate objectives and included within the Board Assurance Framework. These are considered at each of the Audit Committee meetings where controls and assurances are scrutinised as part of ensuring an effective system of internal control is upheld. The Governing Body review the Board Assurance Framework risks bi-annually to assess the current level of risk and its impact on the achievement of corporate objectives.

Risks assessed as residually scoring 15 or above once all current control mechanisms in place have been considered, are reviewed monthly by the risk owner and reported through the Integrated Governance and Quality Committee.
During 2018/19 there were a total of 19 risks that were either carried forward from 2017/18 or were added during the year that were initially assessed as scoring 15 or above. Of these risks there were 10 that were for a period of time during the year being managed at a high level (15+ risk score). These included:

- Risk 148 – Potential failure to deliver ‘constitutional pledges’ and other priority performance goals
- Risk 1030 – Potential failure of Stakeholders to buy in to the transformation programme
- Risk 116 – Concerns around the identification rules for specialised commissioning activity transferred from NHSE potentially impacting on the achievement of the 17/18 financial target.
- Risk 136 – The potential concern around financial and clinical challenges across South West London requiring the organisation to alter current ways of working as a result of the changing needs of local population. This could have impacted upon resource allocation and service provision.
- Risk 151 - The potential failure to manage providers effectively to deliver care to the required standards along with not fully implementing long term strategies to improve outcomes in six key areas could lead to financial incentives not being achieved and potential reputational damage.
- Risk 144 - Workforce pressure in primary medical services results in insufficient clinical capacity to meet local patient demand or support local Acute transformation / shift of care.
- Risk 132 - Internal and external structural changes if not managed well may impact upon staff morale and staff retention at Merton CCG.
- Risk 111 - If care is not integrated across health and care providers and STP, activity shifts may not be delivered locally, causing financial pressure and poor outcomes.
- Risk 99 - Failure to provide assurance to associate commissioners on the management of the significant challenges faced by St George’s Hospital may compromise the CCG’s position as Lead Commissioner.
- Risk 152 - If the CCG experiences in year slippage within its QIPP delivery programme, there are limited reserves available to offset the financial impact.

Through the extensive work that has taken place during the year around the mitigation of these risks, it is pleasing to note that these risks have either now been closed or their current risk levels are substantially lower than initially reported. At the time of writing, Merton CCG is reporting no current risks with a score of 15 or above.

During the year Internal Audit conducted a review of the risk management and assurance processes across both Merton and Wandsworth CCGs. The review considered the extent to which the BAF process remained live throughout the year and how risks progressed during the period. The Internal Audit opinion concluded that: “taking account of the issues identified, the Governing Body can take substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively”.

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Other sources of assurance

Internal Control Framework

Merton CCG operate a system of internal controls that is designed to maximise the organisation’s ability to achieve its key objectives and for management to retain effective authority over operational activities. Key controls in operational will include policies and procedures that define the rules and basis of conduct coupled with operational checks, passwords and management review, ensuring that a consistent approach to our work is always upheld. The system of controls also helps to identify and prioritise risks, to evaluate the likelihood of those risks being realised, the material impact should they be realised and what is required to manage them efficiently, effectively and economically. It is recognised that risk can only be mitigated to a reasonable level and as such cannot eliminate all risk; and as such the system of internal controls will only ever provide reasonable and not absolute assurance of effectiveness.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016 and further updated in June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

An Internal Audit review was carried out in December 2018 on the Conflicts of Interest processes set in place within the CCG. The outcome of the review noted that the Board can take reasonable assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.

Data Quality

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

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

The quality of information that the Governing Body and other governance forums receive to consider including direct decision making, is assured through the service level specification arrangements with the NEL Commissioning Support Unit and the use of contractual
requirements defined with each of our commissioned providers. Validation processes exist to ensure data is complete, accurate, relevant and timely. Formal contract monitoring arrangement in place with all key providers ensure we retain responsibility for monitoring the quality of data for services commissioned.

The CCG has a Data Quality Policy in place that defines the organisation’s requirement for maintaining and enhancing the high levels of data quality.

The Governing Body and Membership Body are satisfied that the quality of data provided to them is of a good standard.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection 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 Data Security and Protection 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 have developed information risk assessment and management procedures and a programme has been 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 information governance steering group, chaired by the Caldicott Guardian 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.

The Data Security and Protection Toolkit (DSP) came in to force for the 2018/19 financial year and replaces the Information Governance Toolkit. The DSP toolkit is now the recognised standard for cyber and data security within the NHS. The toolkit requires the CCG to demonstrate compliance with ten data security standards along with demonstrable compliance with the General Data Protection Regulations (GDPR).

We have been working with our information governance expert service, NEL Commissioning Support Unit, in respect to the DSP toolkit and have assessed our compliance at (awaiting figures) for the year.
Throughout the year the CCG has completed a series of Data Protection Impact Assessments on key information systems to determine the most effective way to ensure ongoing compliance with our data protection obligations and to ensure we meet individuals’ expectations around privacy. These assessments allow us to proactively fix or manage problems at an early stage and therefore reducing the potential cost or reputational damage resulting from instances of non-compliance.

The Information Governance Group meet four times and are responsible for overseeing the effective development and implementation of information governance policies, procedures and processes and for reviewing any breaches of information security or confidentiality.

**Business Critical Models**

The CCG confirms that no business critical models have been identified that would require information about quality assurance processes for those models to be provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

**Third party assurances**

During the year the CCG has received a number of assurance reports relating to audits performed on other organisations that provide services to the CCG. Key reports received include the following:

*KPMG ISAE 3402 Type II report – Primary Care Support England*

This audit provided assurance over the service provider (Capita Business Services Ltd) control systems in place for Primary Care Support England services for processing GP, Ophthalmic and Pharmacy payments and the administration of the pension scheme on behalf of NHS England. The report provided a qualified opinion for 3 of the 16 control objectives which although not considered acceptable does represent an improvement from the 7 qualifications the previous year. Further steps have been laid down in the report to address the control gaps.

*Deloitte Report on Internal Controls – NHS England NEL Commissioning Support Unit*
This report provides annual assurance over the following business process areas provided by NEL CSU:

- Payroll
- Financial Ledger
- Accounts Payable
- Accounts Receivable
- Financial Reporting
- Treasury and Cash Management

Summary of opinion to be added when received.

The CCG uses the NHS Standard Contract which includes the requirement that providers cannot enter sub-contracts without the prior approval of the coordinating commissioner. The approval may include the terms of the sub-contract. The provider remains responsible for the performance of sub-contractors. Any positive obligation or duty on the part of the provider includes an obligation or duty to ensure that sub-contractors comply with that positive obligation or duty. The process for receiving assurance about the performance of sub-contractors will vary depending on the specific case, but can for example include where a substantial portion of contracted activity is to be provided by a sub-contractor that routine contract monitoring information is disaggregated by the main provider and the sub-contractor(s).

Control issues

No significant control issues have been identified during 2017/18.

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

The Governing Body through its meetings retains primary oversight of the appropriateness of arrangements in place within the organisation to exercise its functions in an effective, economic and efficient manner. It is my role as Accountable Officer to retain overall executive responsibility for the use of our resources.

The organisation has a number of key processes and internal mechanisms that provide assurance that we are operating within our statutory authority:

- Within our constitution there are clearly defined standards for conducting business, standing orders, scheme of delegation and reservation along with prime financial policies that ensure the effective management and protection of assets and public funds.
- Key policies are in operation in respect of Contract Management and Procurement that ensure effective operational and financial performance whilst ensuring we operate within regulatory frameworks and reduce the likelihood and impact of risk.
• There is a clearly defined process for the consideration of business cases and saving opportunities to ensure transparency and value for money is upheld. The Benefits realisation working group evaluate the robustness of proposed business cases before these are then considered by the Strategy and Planning Group. Significant financial decisions are then approved by the Finance Committee. In addition, there is a Financial Recovery Oversight Group that retains effective oversight of the delivery and performance of financial decisions and will take action to recover the financial position where necessary.

• The Governing Body approves the annual accounts, considers a finance report at each meeting, and discusses any risks in relation to the use of resources.

• An Accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks. This service is provided in accordance with the NHS Protect Standards for NHS Commissioners 2018-19 relating to fraud, bribery and corruption published by NHS Counter Fraud Authority (NHS CFA) covering the four key sections: Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account. A proportionate proactive work plan addresses identified risks and appropriate action is taken regarding NHS CFA quality assurance recommendations.

Head of Internal Audit Opinion

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

Head of Internal Audit Opinion 2018/19

Our opinion, based on work undertaken up to 31st March 2019, is set out as follows:

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.
Based on work undertaken in 2018/19 there is an adequate and effective system of internal control, designed to meet the CCG's objectives, and controls are generally being applied consistently. Whilst we have not identified any significant control gaps, we have however, identified some enhancements to internal control, primarily within the "reasonable assurance" opinioned reports, detailed below. In these cases, we have agreed actions with management with agreed deadlines for implementation. These are followed up on a regular basis and their status reported to each meeting of the Audit Committee.

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

<table>
<thead>
<tr>
<th>Area of Audit</th>
<th>Level of Assurance Given</th>
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<tbody>
<tr>
<td>Medicines Management</td>
<td>Substantial Assurance</td>
</tr>
<tr>
<td>Governance – Committees in Common</td>
<td>Reasonable Assurance</td>
</tr>
<tr>
<td>QIPP</td>
<td>Reasonable Assurance</td>
</tr>
<tr>
<td>Financial Management</td>
<td>Substantial / Reasonable Assurance</td>
</tr>
<tr>
<td>Conflicts of Interest</td>
<td>Reasonable Assurance</td>
</tr>
<tr>
<td>Commissioning</td>
<td>Reasonable Assurance</td>
</tr>
<tr>
<td>Risk Management &amp; Assurance</td>
<td>Substantial Assurance</td>
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</table>

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

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 this review by:

- The Governing Body
- Integrated Governance and Quality Committee
- The audit committee
- Internal audit
- Other explicit review/assurance mechanisms

Conclusion

Internal Audit has not identified any significant issues that need to be flagged as significant control issues within the Annual Governance Statement.

Sarah Blow,
Accountable Officer
Remuneration and Staff Report

Remuneration Report

Under the Government *Financial Reporting Manual* NHS bodies are required to prepare a remuneration report that is published as part of their annual report and financial accounts. This report must contain information about the remuneration of (pay received by) senior managers.

Senior managers are defined as people in senior positions having authority or responsibility for directing or controlling the major activities of the clinical commissioning group. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments. For the purpose of this report, this has been taken to include only the voting members of the governing body.

To ensure remuneration is in line with national guidance, current good practice and ensures value for public money, the CCG has set up a Remuneration Committee.

The committee, which is accountable to the governing body, makes recommendations on the remuneration, fees and other allowances for employees and for people who provide services to the CCG. This includes advising on salaries for the CCG’s most senior staff (known as very senior managers). It would also make recommendations on allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

Remuneration Committee

The Committee meets as frequently as is necessary to advise the Board on the appropriate remuneration and terms of service. The committee does not regularly consider the remuneration of the CCG lay members or those senior managers whose pay is subject to national Agenda for Change terms and conditions of service. This year, the committee met once.

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.

The main components of the Board members’ and senior officers’ remuneration are set out below.
Remuneration Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Leigh (Chair)</td>
<td>Lay member for Audit and Governance</td>
</tr>
<tr>
<td>Clare Gummet</td>
<td>Lay member for Public Patient Involvement</td>
</tr>
<tr>
<td>Dr Andrew Murray</td>
<td>Clinical Chair</td>
</tr>
</tbody>
</table>

**Remuneration policy**

Remuneration for governing body members, including the Accountable Officer and Chief Finance Officer, is determined on the basis of reports to the Remuneration Committee, taking into account national guidance on pay rates, any independent evaluation of the post and national and market rates.

All other managers are covered by terms and conditions set out in the national NHS Agenda for Change arrangements. Individual staff performance is assessed as part of the staff appraisal process, which includes objective setting and annual reviews with line managers. In line with national guidance and the Agenda for Change programme, staff progress through an incremental pay scale if their performance during the year has been in line with agreed targets and objectives.

**Remuneration of very senior managers**

The table below discloses salaries and allowances paid by the CCG to directors of significant influence of the governing body in 2018/19.

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary and/or fees (bands of £5,000)</th>
<th>Taxable benefits (rounded to the nearest £00)</th>
<th>Annual performance related bonuses (bands of £5,000)</th>
<th>Long-term performance related bonuses (bands of £5,000)</th>
<th>All pension related benefits (bands of £2,500)</th>
<th>TOTAL (bands of £5,000)</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Murray, CCG Chair (7)</td>
<td>100 to 105</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>100 to 105</td>
<td>£000</td>
</tr>
<tr>
<td>David Smith, Vice Chair</td>
<td>10 to 15</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>10 to 15</td>
<td>£000</td>
</tr>
<tr>
<td>Sarah Blow, Accountable Officer (1)</td>
<td>25 to 30</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5 to 7.5</td>
<td>30 to 35</td>
<td>£000</td>
</tr>
<tr>
<td>James Murray, CFO (2)</td>
<td>25 to 30</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>25 to 30</td>
<td>£000</td>
</tr>
<tr>
<td>Name</td>
<td>Hours</td>
<td>Minutes</td>
<td>Days</td>
<td>Hours</td>
<td>Minutes</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>Jonathan Bates, Director of Commissioning Operations, SWL Alliance (3)</td>
<td>20 to 25</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>2.5 to 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charlotte Gawne, Director of Communications, SWL Alliance (4)</td>
<td>20 to 25</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5 to 7.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Blythe, Managing Director (5)</td>
<td>55 to 60</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>25 to 27.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samantha Page, Registered Nurse (from 1/6/18) (6)</td>
<td>5 to 10</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>37.5 to 40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julie Hall, Registered Nurse (until 30/6/18)</td>
<td>0 to 5</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>0 to 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clare Gummett – Lay Member (patient and public involvement)</td>
<td>15 to 20</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>15 to 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Karen Worthington - GP Clinical Board Member (7)</td>
<td>100 to 105</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>100 to 105</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Andrew Otley, GP Locality Lead (7)</td>
<td>55 to 60</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>55 to 60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Tim Hodgson, GP Locality Lead (7)</td>
<td>15 to 20</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>15 to 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Mohan Sekeram, GP Locality Lead (from 01/03/19)</td>
<td>5 to 10</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5 to 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andrew Leigh, Lay Member (Governance)</td>
<td>10 to 15</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>10 to 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Dagmar Zeuner, Director of Public Health, Merton Council</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mike Greenberg, Secondary Care Doctor</td>
<td>15 to 20</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>15 to 20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Notes

1: Sarah Blow is the Accountable Officer for South West London Alliance, and is on Wandsworth CCG’s payroll; her total salary is in the range £140k-£145k. Merton CCG is responsible for 20% of her costs.

2: James Murray is Chief Financial Officer for South West London Alliance and is on Wandsworth CCG’s payroll; his total salary is in the range £140k-£145k and WCCG does not make any employer’s pension contribution in respect of James Murray.

3: Jonathan Bates is Director of Commissioning Operations for South West London Alliance and is on Wandsworth CCG’s payroll; his total salary is in the range £115k-£120k. Merton CCG is responsible for 20% of his costs.

4: Charlotte Gawne is Director of Communications for South West London Alliance and is on Wandsworth CCG’s payroll; her total salary is in the range £115k-£120k. Merton CCG is responsible for 20% of her costs.

5. James Blythe is Managing Director for Merton and Wandsworth CCGs and is on Wandsworth CCG’s payroll; his total salary is in the range £115k-£120k. Merton CCG is responsible for 50% of his costs.

6. Samantha Page is the Nurse Board Member for Wandsworth and Merton CCGs. Her total pension figures are shown in this report.

7. There was a change in the NHS GP contribution method of collection which effects Andrew Murray, Karen Worthington, Tim Hodgson, Andrew Otley and Mohan Sekeram.

The table below gives the equivalent information for 2017/18.

<table>
<thead>
<tr>
<th>Name &amp; Title</th>
<th>Salary &amp; Fees (Bands of £5,000)</th>
<th>All Pension Related Benefits</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Andrew Murray – Chair (1)</td>
<td>115-120</td>
<td>37.5-40</td>
<td>135-140</td>
</tr>
<tr>
<td>Sarah Blow, Accountable Officer</td>
<td>25-30</td>
<td>27.5-30</td>
<td>55-60</td>
</tr>
<tr>
<td>Clare Gummett – Lay person with responsibility for patient and public involvement</td>
<td>10-15</td>
<td>0</td>
<td>10-15</td>
</tr>
<tr>
<td>Dr Tim Hodgson – GP Member (1)</td>
<td>15-20</td>
<td>0-2.5</td>
<td>20-25</td>
</tr>
<tr>
<td>Julie Hall- GP Independent Nurse – from 21/7/16</td>
<td>5-10</td>
<td>0</td>
<td>5-10</td>
</tr>
<tr>
<td>Dagmar Zeuner- Director of Public Health (LBM)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Dr Karen Worthington - GP Clinical Board Member from 25/5/17 (1) | 110-115 | 15-17.5 | 125-130
---|---|---|---
David Smith - Lay person with responsibility for Finance and Governance from 1/1/18 | 0-5 | 0 | 0-5
Andrew Leigh – Lay person with responsibility for Audit from 8/11/17 | 0-5 | 0 | 0.5
James Blythe- Managing Director from 1/5/17 | 40 -45 | 10-12.5 | 50-55
Jonathan Bates Director of Strategic Commissioning, SWL | 25-30 | 15-17.5 | 45-50
Charlotte Gawne Director of Communications, SWL | 15-20 | 15-17.5 | 30-35
James Murray, Chief Finance Officer | 65-70 | 0 | 65-70

Notes:

Pension figures are shown for Andrew Murray, Karen Worthington and Tim Hodgson in the 2017/18 table but not in the 2018/19 table. This is due to a change in the method of collection of standard GP pension contributions.

### Pensions entitlement table

Where the CCG contributed to pension schemes for senior managers, the benefits are shown in the table below:

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60</th>
<th>Real increase in pension lump sum at aged 60</th>
<th>Total accrued pension at age 60 at 31 March 2019</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2018</th>
<th>Cash equivalent transfer value at 31 March 2019</th>
<th>Cash equivalent transfer value at 31 March 2018</th>
<th>Real increase in cash equivalent transfer value</th>
<th>Employer’s contribution to stakeholders pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Blow, Accountable Officer (1)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>James Murray, CFO (2)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Page 78 of 100
<table>
<thead>
<tr>
<th>Name</th>
<th>Pay Range</th>
<th>Hours Worked</th>
<th>Full Payne</th>
<th>MCCG Pays</th>
<th>Other</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jonathan Bates, Director of Commissioning Operations, SWL Alliance (3)</td>
<td>0 to 2.5</td>
<td>-2.5 to 0</td>
<td>35 to 40</td>
<td>90 to 95</td>
<td>678</td>
<td>557 105 16</td>
</tr>
<tr>
<td>Charlotte Gawne, Director of Communications, SWL Alliance (4)</td>
<td>2.5 to 5</td>
<td>0 to 2.5</td>
<td>30 to 35</td>
<td>70 to 75</td>
<td>554</td>
<td>441 99 16</td>
</tr>
<tr>
<td>James Blythe, Managing Director (5)</td>
<td>2.5 to 5</td>
<td>0</td>
<td>15 to 20</td>
<td>0</td>
<td>178</td>
<td>113 61 16</td>
</tr>
<tr>
<td>Samantha Page - Registered Nurse to the Board (6)</td>
<td>0 to 2.5</td>
<td>2.5 to 5</td>
<td>35 to 40</td>
<td>100 to 105</td>
<td>791</td>
<td>659 111 3</td>
</tr>
</tbody>
</table>

**Notes**

1. Sarah Blow is the Accountable Officer for South West London Alliance on Wandsworth CCG’s payroll. MCCG is responsible for 20% of her costs, but we are showing the full costs.

2. MCCG does not make any employer’s pension contribution in respect of James Murray.

3. Jonathan Bates is Director of Commissioning Operations for South West London Alliance on Wandsworth CCG’s payroll. MCCG is responsible for 20% of his costs, but we are showing the full costs.

4. Charlotte Gawne is Director of Communications for South West London Alliance on Wandsworth CCG’s payroll. MCCG is responsible for 20% of her costs, but we are showing the full costs.

5. James Blythe is Managing Director for Merton and Wandsworth CCGs and is on Wandsworth CCG’s payroll; MCCG is responsible for 50% of his costs, but we are showing the full costs.

6. We are showing the full costs for Samantha Page (Nurse Board Member)

The following individuals are considered to be senior management of the CCG during all or part of 2018/19. Some of them have opted out of the NHS Pension Scheme, and some are not eligible to join. In other cases, they are GPs whose pensions are paid through NHS England:

- Andrew Murray
- David Smith
- Karen Worthington
- Andrew Otley
- Tm Hodgson
- Andrew Leigh
Cash equivalent transfer values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 200833.

Real increase in CETV
This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Compensation on early retirement or for loss of office
There were no early retirements or redundancies in 2018/19

Payments to past members
There were no payments to past members

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

Fair pay (ratios) disclosure
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 annualised remuneration of the highest paid governing body member in the financial year 2018/19 was £170k to £175k per annum (2017/18: £185k to £190k). This was 3.36 times the median remuneration of the workforce, which was
£52k (the figures for 2017/18 were 3.5 and £53k respectively). The workforce only includes permanent staff and excludes off payroll engagements.

In 2018/19, no employees received higher remuneration than the highest paid member of the governing body (this was also the case in 2017/18). Remuneration of employees other than governing body members ranged from £8k to £171k (in 2017/18 remuneration ranged from £18k to £187k).
Staff Report

Communicating and engaging

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

- A South West London Staff Partnership Forum where managers and staff from the six south west London CCGs meet to discuss and consult on issues
- Regular team briefings with the staff and Executive Management Team

The CCG has a duty to eliminate discrimination and promote equality, fairness and respecting human rights, both as an employer and a commissioner of local health services. We believe that diversity is about recognising and valuing the diverse population we serve and implementing good employment practices. We recognise our responsibility to promote inclusion regardless of age, disability gender reassignment, marital status, pregnancy, race/ethnicity, religious beliefs, sex (male or female) or sexual orientation and respecting family values attached to conception and parenting capabilities. We have been working hard over the past year to embed the consideration of equality and diversity issues into all aspects of our work, including policy development, commissioning processes and employment practices.

Composition of the workforce

As at 31 March 2019, the composition in the workforce of Merton CCG is:

<table>
<thead>
<tr>
<th>Clinical Lead</th>
<th>Governing Body</th>
<th>Lay Member</th>
<th>Local Salary</th>
<th>Employee</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Number of staff by category and gender (headcount) – as at 31 March 2019

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>Headcount</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time</td>
<td>51</td>
<td>51.00</td>
</tr>
<tr>
<td>Part Time</td>
<td>28</td>
<td>10.10</td>
</tr>
<tr>
<td>Grand Total</td>
<td>79</td>
<td>61.10</td>
</tr>
</tbody>
</table>
### Staff composition by gender – substantive employees

<table>
<thead>
<tr>
<th>Gender</th>
<th>Band</th>
<th>Headcount</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Band 5</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>Band 6</td>
<td>6</td>
<td>6.00</td>
</tr>
<tr>
<td></td>
<td>Band 7</td>
<td>6</td>
<td>5.40</td>
</tr>
<tr>
<td></td>
<td>Band 8a</td>
<td>17</td>
<td>15.60</td>
</tr>
<tr>
<td></td>
<td>Band 8b</td>
<td>6</td>
<td>6.00</td>
</tr>
<tr>
<td></td>
<td>Band 8c</td>
<td>2</td>
<td>1.60</td>
</tr>
<tr>
<td></td>
<td>Band 8d</td>
<td>4</td>
<td>4.00</td>
</tr>
<tr>
<td></td>
<td>Local Salary</td>
<td>10</td>
<td>2.07</td>
</tr>
<tr>
<td></td>
<td><strong>Female Total</strong></td>
<td><strong>53</strong></td>
<td><strong>42.67</strong></td>
</tr>
<tr>
<td>Male</td>
<td>Band 5</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Band 6</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>Band 7</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>Band 8a</td>
<td>4</td>
<td>4.00</td>
</tr>
<tr>
<td></td>
<td>Band 8b</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>Band 8c</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>Band 8d</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Band 9</td>
<td>1</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td>Local Salary</td>
<td>10</td>
<td>3.33</td>
</tr>
<tr>
<td></td>
<td><strong>Male Total</strong></td>
<td><strong>26</strong></td>
<td><strong>18.43</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Grand Total</strong></td>
<td><strong>79</strong></td>
<td><strong>61.10</strong></td>
</tr>
</tbody>
</table>
**Disability** (Fixed Term and Permanent Employees and VSMs only)

<table>
<thead>
<tr>
<th>Disabled</th>
<th>Headcount</th>
<th>Percentage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>45</td>
<td>76%</td>
<td>43.40</td>
</tr>
<tr>
<td>Not Declared</td>
<td>12</td>
<td>20%</td>
<td>10.30</td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>3%</td>
<td>2.00</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100%</strong></td>
<td><strong>55.70</strong></td>
</tr>
</tbody>
</table>

---

**Disability**

Bar chart showing the distribution of disability status among employees:

- **No**: 76% of employees
- **Not Declared**: 20% of employees
- **Yes**: 3% of employees
## Ethnic Origin (Fixed Term and Permanent Employees and VSMs only)

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Headcount</th>
<th>Percentage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A White - British</td>
<td>27</td>
<td>46%</td>
<td>25.40</td>
</tr>
<tr>
<td>B White - Irish</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>C White - Any other White background</td>
<td>2</td>
<td>3%</td>
<td>1.80</td>
</tr>
<tr>
<td>E Mixed - White &amp; Black African</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>F Mixed - White &amp; Asian</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>H Asian or Asian British - Indian</td>
<td>9</td>
<td>15%</td>
<td>8.40</td>
</tr>
<tr>
<td>L Asian or Asian British - Any other Asian background</td>
<td>2</td>
<td>3%</td>
<td>2.00</td>
</tr>
<tr>
<td>M Black or Black British - Caribbean</td>
<td>4</td>
<td>7%</td>
<td>4.00</td>
</tr>
<tr>
<td>N Black or Black British - African</td>
<td>5</td>
<td>8%</td>
<td>5.00</td>
</tr>
<tr>
<td>R Chinese</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>S Any Other Ethnic Group</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>Z Not Stated</td>
<td>5</td>
<td>8%</td>
<td>4.10</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100%</strong></td>
<td><strong>55.70</strong></td>
</tr>
</tbody>
</table>

![Ethnic Origin Pie Chart]

- A White - British
- B White - Irish
- C White - Any other White background
- E Mixed - White & Black African
- F Mixed - White & Asian
- H Asian or Asian British - Indian
- L Asian or Asian British - Any other Asian background
- M Black or Black British - Caribbean
- N Black or Black British - African
- R Chinese
- S Any Other Ethnic Group
- Z Not Stated
**Sexual Orientation** (Fixed Term and Permanent Employees and VSMs only)

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Headcount</th>
<th>Percentage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay or Lesbian</td>
<td>1</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Heterosexual or Straight</td>
<td>42</td>
<td>71%</td>
<td>40</td>
</tr>
<tr>
<td>Not stated (person asked but declined to provide a response)</td>
<td>16</td>
<td>27%</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100%</strong></td>
<td><strong>55.7</strong></td>
</tr>
</tbody>
</table>

---

**Sexual Orientation**

- Not stated (person asked but declined to provide a response)
- Heterosexual or Straight
- Gay or Lesbian

---

Page 86 of 100
**Religious Belief** (Fixed Term and Permanent Employees and VSMs only)

<table>
<thead>
<tr>
<th>Religious Belief</th>
<th>Headcount</th>
<th>Percentage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atheism</td>
<td>8</td>
<td>14%</td>
<td>7.40</td>
</tr>
<tr>
<td>Christianity</td>
<td>25</td>
<td>42%</td>
<td>23.80</td>
</tr>
<tr>
<td>Hinduism</td>
<td>2</td>
<td>3%</td>
<td>1.80</td>
</tr>
<tr>
<td>I do not wish to disclose my religion/belief</td>
<td>18</td>
<td>31%</td>
<td>16.70</td>
</tr>
<tr>
<td>Islam</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5%</td>
<td>3.00</td>
</tr>
<tr>
<td>Sikhism</td>
<td>2</td>
<td>3%</td>
<td>2.00</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100%</strong></td>
<td><strong>55.70</strong></td>
</tr>
</tbody>
</table>

![Religious Belief Chart]

---

Page 87 of 100
### Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Headcount</th>
<th>Percentage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>1</td>
<td>2%</td>
<td>1.00</td>
</tr>
<tr>
<td>25-29</td>
<td>2</td>
<td>3%</td>
<td>2.00</td>
</tr>
<tr>
<td>30-34</td>
<td>6</td>
<td>10%</td>
<td>5.80</td>
</tr>
<tr>
<td>35-39</td>
<td>6</td>
<td>10%</td>
<td>5.40</td>
</tr>
<tr>
<td>40-44</td>
<td>8</td>
<td>14%</td>
<td>6.50</td>
</tr>
<tr>
<td>45-49</td>
<td>10</td>
<td>17%</td>
<td>10.00</td>
</tr>
<tr>
<td>50-54</td>
<td>13</td>
<td>22%</td>
<td>13.00</td>
</tr>
<tr>
<td>55-59</td>
<td>11</td>
<td>19%</td>
<td>10.40</td>
</tr>
<tr>
<td>60-64</td>
<td>2</td>
<td>3%</td>
<td>1.60</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100%</strong></td>
<td><strong>55.70</strong></td>
</tr>
</tbody>
</table>

**Age Range**

![Age Distribution Chart]
### Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Headcount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>53</td>
<td>66%</td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>34%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>80</td>
<td>100%</td>
</tr>
</tbody>
</table>

![Gender Pie Chart]

**Gender**

- Female: 33%
- Male: 67%

### Sickness 01-Apr-2018 – 31-MAR-2019:

<table>
<thead>
<tr>
<th>Absence % (FTE)</th>
<th>Absence Days</th>
<th>Abs (FTE)</th>
<th>Avail (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.08%</td>
<td>207</td>
<td>200.60</td>
<td>18,540.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FTE Days Lost</th>
<th>Total Staff Years</th>
<th>Average Working Days Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>479 NHS Merton CCG</td>
<td>51.35</td>
<td>3.90</td>
</tr>
<tr>
<td>Grand Total</td>
<td>51.35</td>
<td>3.90</td>
</tr>
</tbody>
</table>
Expenditure on Consultancy

In 2018/19 the CCG spent £112k on consultancy fees (£0 in 2017/18).

Off-Payroll Engagements

Table 1: Off-Payroll Engagements Longer than Six Months

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of existing engagements as of 31 March 2018</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
<td>4</td>
</tr>
<tr>
<td>for between one and two years at the time of reporting</td>
<td>3</td>
</tr>
<tr>
<td>for between two and three years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>for between three and four years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>for four or more years at the time of reporting</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2: New Off-Payroll Engagements

For all new off-payroll engagements between 01 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of new engagements, or those that reached six months in duration, between 1/4/18 and 31/3/19</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. assessed as being in scope of IR35</td>
<td>0</td>
</tr>
<tr>
<td>No. assessed as being out of scope of IR35</td>
<td>8</td>
</tr>
<tr>
<td>Number engaged directly via PSC contracted to the CCG on the CCG payroll</td>
<td>0</td>
</tr>
<tr>
<td>Number of engagements reassessed for consistency/assurance purposes during the year</td>
<td>0</td>
</tr>
<tr>
<td>Number of engagements that saw a change to IR35 status following the consistency review</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 3: Off-Payroll Engagements / Senior Official Engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2018 and 31 March 2019:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or</td>
<td>0</td>
</tr>
<tr>
<td>senior officers with significant financial responsibility,</td>
<td></td>
</tr>
<tr>
<td>during the financial year</td>
<td></td>
</tr>
<tr>
<td>Total number of individuals on payroll and off-payroll that</td>
<td>17</td>
</tr>
<tr>
<td>have been deemed &quot;board members and/or senior officials with</td>
<td></td>
</tr>
<tr>
<td>significant financial responsibility&quot; during the financial</td>
<td></td>
</tr>
<tr>
<td>year. (This figure should include both on payroll and off-payroll engagements)</td>
<td></td>
</tr>
</tbody>
</table>

Parliamentary Accountability and Audit Report

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

Sarah Blow
Accountable Officer
3. GLOSSARY OF TERMS

Some of the words and names we use are unfamiliar to many people and sometimes it is difficult to replace these with more simple words. We have listed below some of the key words and acronyms used in planning and funding health services.

**A&E (Accident & Emergency):** a hospital service which provides care for emergency, life threatening and critical conditions for patients of all ages, twenty four hours a day, seven days a week. This is also known as ED (Emergency Department). It is common for paediatric (children) emergencies to be managed in a separate area of the department.

**Acute care:** short-term treatment, usually provided in hospital

**Acute trust:** an NHS Hospital Trust or NHS Foundation Trust providing and/or managing hospitals. Some acute trusts also provide community services, such as St. George’s NHS Foundation Trust

**Admission** (to a hospital): needing (at least) an overnight stay in hospital, either for an emergency or following a planned procedure

**ALOS (Average Length of Stay – also sometimes LOS, Length of Stay):** is an average of the length of time a patient stays in a hospital when admitted. Collection of this data is essential to service planners and audit

**Asthma:** Chronic lung disorders with a variety of causes but all characterised by reversibility of small airway obstruction. Not to be confused with COPD (see below)

**‘At Scale’ Provision:** existing or proposed services which are or can potentially be provided across a greater population or geographical area (larger scale). Usually used in the context of the whole of South West London or across more than one borough. In primary care, this term is also used to mean a service provided at a much larger scale than found in current GP practices e.g. serving populations of 50,000 or more

**BAME:** Black, Asian or Minority Ethnic

**Board (Governing Body):** sets the direction of the CCG by developing plans and priorities for improving NHS services to ensure people in their borough get the best healthcare services possible, and ensures strong and effective leadership, management and accountability. Governing Body members are primarily GPs, together with CCG executive staff and lay members

**BCF:** Better Care Fund

**CAMHS:** Child and Adolescent Mental Health Services

**Care Pathway:** the care and treatment a patient receives from start to finish for a particular illness or condition, usually across several parts of the health service and often including
social care. Care pathways as planned for a condition can ensure full seamless integration of all the necessary services

**Carer**: a person who looks after or supports someone else due to illness or disability. This can be unpaid, **informal carers**, who may be family members, including children and young people, who live with the person they care for, or family, friends or neighbours who live elsewhere. **Carer** is also used to describe paid staff working in care homes and/or supporting people at home, particularly staff who do not have professional qualifications

**CETV**: Cash Equivalent Transfer Value

**CCG (Clinical Commissioning Groups)**: Statutory Organisations which plan and fund (commission) most local health services. CCGs are led by GPs and other clinicians. All GP practices in a CCG area are members. Each CCG in South West London covers one borough

**CHD (Coronary Heart Disease)**: the narrowing or blockage of the coronary arteries, the major blood vessels around the heart (see also CVD)

**CHC**: Continuing Healthcare

**Clinical Lead**: individual recognised by the CCG as the leading clinician who represents the clinical voice of its members

**Commissioning**: the planning, buying (procurement) and contract management of health and health care services. This can be for a local community, a specific population or a specific condition. This can be done at National NHS, Local NHS or CCG levels

**Continuing Healthcare**: CCG-funded packages of care given to those meeting set criteria

**COPD (Chronic Obstructive Pulmonary Disease)**: the name for a collection of lung diseases including chronic bronchitis and emphysema characterised by irreversible airways and lung damage (see Asthma)

**CSU (Commissioning Support Unit)**: an organisation providing back-office support (such as IT, HR, contract management and communications) to CCGs

**CQC (Care Quality Commission)**: an organisation funded by the Government to inspect all hospitals, care homes and care services in England to make sure they are meeting government standards and to share their findings with the public

**CQUINs (Commissioning for Quality and Innovation)**: a contractual mechanism that allows commissioners to pay providers for completing activities that directly relate to improving the quality of care received by patients

**CVD (Cardiovascular Disease)**: also known as heart disease, this refers to diseases that affect the heart or blood vessels (CVS). Hypertension (high blood pressure) is the most common form
CVS (Cardiovascular System): the heart, arteries, capillaries and veins

CQRG: Clinical Quality Review Group

Day Case or Day Surgery: patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day

Deficit: the net financial position of an organisation where expenditure (outgoings) is greater than income (opposite: Surplus)

DSP: Data Security and Protection Toolkit

C Difficile: Clostridium Difficile

ECG (Eletrocardiogram): a test of the electrical activity of the heart

ECI: Effective Commissioning Initiative policy ensures that NHS funded treatments are evidence based, clinically effective, safe and that access is fair and impartial for all patients with similar clinical need

Elective Centre: a hospital or a distinct part of a hospital which provides elective (planned) care, separated from urgent and emergency care

Elective Surgery: planned / non-emergency surgery (i.e. not immediately necessary to save life). This is usually carried out in a hospital either as a day case or an inpatient. Minor surgery may be carried out in a range of approved settings

Emergency Admission: a patient who is admitted to hospital on the same day due to urgent need (also known as urgent admission and unplanned care)

End of Life Care: dignified care of the dying planned, as far as possible, to include the patient’s wishes as to where they are cared for

EPRR: Emergency Preparedness Resilience and Response

Financial Surplus: the net financial position of an organisation where income is greater than expenditure (outgoings), so there is a surplus of money at year end

Foundation Trust: a NHS hospital that is run as an independent, public benefit corporation, controlled and run locally. Foundation Trusts have increased freedoms, including around funding of and investment in services. They are regulated by Monitor, the independent regulator of NHS Foundation Trusts (which became NHS Improvement from April 2016)

General Practice: the medical specialty providing a range of healthcare services within the community. Typically includes doctors and nurses, and may include physiotherapists and other community services

GP: General Practitioner(s), your local doctor(s). Usually practising in a group
Health and Wellbeing Strategies: jointly-agreed and locally-determined set of priorities for local partners (including CCGs and local Authorities) to use as the basis of commissioning plans

Healthwatch Merton: an independent organisation giving people a local voice about their health and social care services

HESL: Health Education England – South London region. Health Education England (HEE) is responsible for the education, training and personal development of the workforce in the NHS, and recruiting for values; HESL is the organisation with responsibility for south London within the overall umbrella of HEE

Home Ward: a care pathway (system) in which professional care is delivered to patients in their own homes rather than on a ward in hospital, organising the care in a similar way to a ward. It is a cost-effective system and avoids hospital admissions which can cause stress to elderly and vulnerable patients

IAF: Improvement and Assessment Framework

IAPT: Improving Access to Psychological Therapies services

IFR: to ensure compliance with the Effective Commissioning Initiative policy

Implementation: putting into practice the plans and strategies that have been developed

Independent Sector: a range of non-public sector organisations involved in service provision, including private, voluntary and charitable organisations

Inpatient: a patient who stays overnight in hospital, either following an emergency admission or a planned procedure

IOP: intraocular pressure

Intervention: term for the point at which a medical, social care or other professional gets involved in a person’s healthcare. Early intervention is when this happens before a person’s health is severely affected. This term is also used as a general name for a medical or nursing procedure

JSNA (Joint Strategic Needs Assessment): a document which analyses the health needs of a population to inform the commissioning of health, well-being and social care services. This document is updated annually

Local Transformation Board: NHS commissioners and providers from Merton and Wandsworth, together with local Healthwatch review progress towards the delivery of the Sustainability and Transformation Plan

LeDeR: Learning Disabilities Mortality Review
LDU: Local delivery Unit

**LIS (Local Incentive Scheme):** a process to encourage GPs to look proactively at specific health objectives for the local population. This has included long term conditions (such as COPD and diabetes), early cancer diagnosis and effective prescribing

**London Quality Standards:** these are the minimum standards of care that patients attending A&E / admitted as an emergency or using maternity services should expect to receive in every acute hospital in London. These standards are set out by NHS England and have been agreed by all CCGs. Although they are specific to London, they are consistent with, and sometimes build on, national standards

**LTC (Long Term Condition):** a long term or chronic condition or illness that cannot be cured (but can be managed through medication and/or therapy) and that people live with for a long time, such as diabetes, heart disease, dementia and asthma

**LGBT:** lesbian, gay, bisexual, transgender

**THRIVE LDN:** an abbreviating of London. Thrive LDN is a citywide movement to improve the mental health and wellbeing of all Londoners. It is supported by the Mayor of London and led by the London Health Board partners

**MCCG:** Merton Clinical Commissioning Group

**Mortality Rate:** a measure of the number of deaths (in general or due to a specific cause) in a defined population, scaled to the size of that population, per unit of time. National and local mortality rates can be compared and are essential in determining local priorities for services

**Multi-Disciplinary / Multi-Professional Teams (MDTs):** teams comprising different kinds of staff involved in patient care – these could include GPs, nurses, psychologists, occupational therapists, pharmacists, social care staff, hospital doctors and other specialists

**MRSA:** Methicillin-resistant Staphylococcus

**NHS England:** this body oversees the day-to-day operation of the NHS (from April 2013 as set out in the Health and Social Care Act 2012) and is responsible for commissioning some local services, such as GPs, and all specialised services such as healthcare for prisoners, HIV, and transplant surgery. It also assures the performance of CCGs

**NELCSU:** North East London Commissioning Support Unit

**OoH (Out of Hours):** a term usually referring to services available between 6.30pm and 8.00am and sometimes also at weekends. This sometimes specifically refers to GP-type services. OoH may also mean Out of Hospital

**PCQRG:** Primary Care Quality Review Group

**PEG:** Patient Engagement Group
Perinatal: pertaining to the period immediately before and after birth

PHB (Personal Health Budgets): a personal health budget is an amount of money to support an individual’s identified health and wellbeing needs, planned and agreed between them and their local NHS team. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive. Personal health budgets work in a similar way to the personal budgets that many people are already using to manage and pay for their social care

Planned Care: where a patient is referred for treatment and there is a pre-determined pathway of care

Primary Care: sometimes used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services

PIRG: The Patient and Public Involvement Reference Group

Proactive Care: care that actively seeks to prevent ill health or a deterioration in health by intervening and working with people before they get ill (also called preventive care)

QIPP (Quality, Innovation, Productivity and Prevention): an NHS-wide initiative to deliver more and better services, care and outcomes with fewer resources

RRL: revenue resource limit

RTT (Referral to Treatment Time): standards included in the NHS Constitution that establish a patient’s right to be treated within a specified timeframe. These standards are the Referral to Treatment (RTT) operational standards of which the main standard is that 92% of patients who have not yet started treatment should have been waiting no more than 18 weeks.

Secondary Care: more specialised care, usually after referral from GP (primary care). This can be provided in a hospital or in the community

Social Care: a range of non-medical services arranged by local councils to help people in need of support due to illness, disability, old age or poverty. Social care services are available to everyone, regardless of background – though rules about eligibility apply

Specialist Hospital: a hospital which provides specialist care for complex conditions. An example in South West London is the Royal Marsden cancer hospital (or Moorfields Eye Hospital in north London)

SWLHCP: South West London Health and Care Partnership

STP: sustainability and transformation partnership

TB: Tuberculosis
**Tertiary Care**: very specialised care, usually provided in hospital, where a patient is referred by a secondary care provider

**Triage**: the assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties

**UCC (Urgent Care Centre)**: a centre which provides care and treatment for minor illnesses and injuries that require urgent attention but that are not critical or life-threatening

**Unplanned Care**: care that is not planned or pre-booked with your GP or hospital

**Voluntary and Community Sector / Organisations**: not-for-profit organisations set up to offer services to specific groups in society. These can be run and staffed by paid professionals as well as volunteers

**WRES**: Workforce Race Equality Standard

**WCCG**: Wandsworth Clinical Commissioning Group
4. ANNUAL ACCOUNTS
Independent auditor’s report to the members of the Governing Body of
NHS Merton Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion
We have audited the financial statements of NHS Merton Clinical Commissioning Group (the ‘CCG’) for
the year ended 31 March 2019, which 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 notes to the financial statements, including a summary of significant accounting policies. 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 Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion, the financial statements:

 give a true and fair view of the financial position of the CCG as at 31 March 2019 and of its
  expenditure and income for the year then ended; and

 have been properly prepared in accordance with International Financial Reporting Standards
  (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health
  and Social Care Group Accounting Manual 2018-19; and

 have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and
applicable law. Our responsibilities under those standards are further described in the ‘Auditor’s
responsibilities for the audit of the financial statements’ section of our report. We are independent of the
CCG in accordance with the ethical requirements that are relevant to our audit of the financial
statements in the UK, including the FRC’s Ethical Standard, and we have fulfilled our other ethical
responsibilities in accordance with these requirements. We believe that the audit evidence we have
obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require
us to report to you where:

 the Accountable Officer’s use of the going concern basis of accounting in the preparation of the
  financial statements is not appropriate; or

 the Accountable Officer has not disclosed in the financial statements any identified material
  uncertainties that may cast significant doubt about the CCG’s ability to continue to adopt the going
  concern basis of accounting for a period of at least twelve months from the date when the financial
  statements are authorised for issue.

Other information
The Accountable Officer is responsible for the other information. The other information comprises the
information included in the Annual Report, other than the financial statements and our auditor’s report
thereon. Our opinion on the financial statements does not cover the other information and, except to the
extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion
thereon.
In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

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 Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the Health and Social Care Act 2012; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity required by the Code of Audit Practice

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.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 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 make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.
Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer’s responsibilities set out on pages 55 and 56, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG’s ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit and Governance Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the CCG’s financial reporting process.

Auditor’s responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor’s report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council’s website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor’s report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Report on other legal and regulatory requirements – Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG’s resources.
Auditor’s responsibilities for the review of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. 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.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, 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 this criterion 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 2019, 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 be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Merton Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. 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.

Sarah L Ironmonger

Sarah L Ironmonger, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
Crawley
Date 28 May 2019
Data entered below will be used throughout the workbook:

Entity name: NHS Merton CCG
This year 2018-19
Last year 2017-18
This year ended 31-March-2019
Last year ended 31-March-2018
This year commencing: 01-April-2018
Last year commencing: 01-April-2017

These account templates are a proforma for a set of NHS England Group Entity Accounts, this is not a mandatory layout for local accounts.

Please review and adjust to local reporting requirements
NHS Merton CCG - Annual Accounts 2018-19

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<td>Statement of Financial Position as at 31st March 2019</td>
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<tr>
<td>Statement of Changes in Taxpayers' Equity for the year ended 31st March 2019</td>
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<tr>
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Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £’000</th>
<th>2017-18 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from sale of goods and services</td>
<td>2</td>
<td>(6,779)</td>
</tr>
<tr>
<td>Other operating income</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Total operating income</td>
<td></td>
<td>(6,779)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>4</td>
<td>5,529</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>5</td>
<td>285,278</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td>5</td>
<td>258</td>
</tr>
<tr>
<td>Provision expense</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Other Operating Expenditure</td>
<td>5</td>
<td>348</td>
</tr>
<tr>
<td>Total operating expenditure</td>
<td></td>
<td>291,413</td>
</tr>
<tr>
<td>Net Operating Expenditure</td>
<td></td>
<td>284,634</td>
</tr>
<tr>
<td>Finance income</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Finance expense</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Net expenditure for the year</td>
<td></td>
<td>284,634</td>
</tr>
<tr>
<td>Net (Gain)/Loss on Transfer by Absorption</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Total Net Expenditure for the Financial Year</td>
<td></td>
<td>284,634</td>
</tr>
<tr>
<td>Other Comprehensive Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Expenditure for the year</td>
<td></td>
<td>284,634</td>
</tr>
</tbody>
</table>

The notes on pages 7 to 31 form part of this statement.
### Statement of Financial Position as at 31 March 2019

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>387</td>
<td>625</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>56</td>
<td>78</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td><strong>445</strong></td>
<td><strong>703</strong></td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>4,986</td>
<td>5,538</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>179</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>5,165</strong></td>
<td><strong>5,582</strong></td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>5,610</strong></td>
<td><strong>6,285</strong></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(22,795)</td>
<td>(23,895)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td><strong>(22,795)</strong></td>
<td><strong>(23,895)</strong></td>
</tr>
<tr>
<td><strong>Non-Current Assets plus/less Net Current Assets/Liabilities</strong></td>
<td><strong>(17,185)</strong></td>
<td><strong>(17,610)</strong></td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td><strong>(17,185)</strong></td>
<td><strong>(17,610)</strong></td>
</tr>
<tr>
<td><strong>Financed by Taxpayers' Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td>(17,185)</td>
<td>(17,610)</td>
</tr>
<tr>
<td><strong>Total taxpayers' equity:</strong></td>
<td><strong>(17,185)</strong></td>
<td><strong>(17,610)</strong></td>
</tr>
</tbody>
</table>

The notes on pages 7 to 31 form part of this statement.

The financial statements on pages 3 to 6 were approved by the Governing Body on 23rd May 2019 and signed on its behalf by:

Sarah Blow  
Accountable Officer
## Changes in taxpayers’ equity for 2018-19

<table>
<thead>
<tr>
<th></th>
<th>General fund £'000</th>
<th>Revaluation reserve £'000</th>
<th>Other reserves £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2018</td>
<td>(17,610)</td>
<td>0</td>
<td>0</td>
<td>(17,610)</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impact of applying IFRS 9 to Opening Balances</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 31 March 2018</td>
<td>(17,709)</td>
<td>0</td>
<td>0</td>
<td>(17,709)</td>
</tr>
</tbody>
</table>

## Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2018-19

- Net operating expenditure for the financial year: (284,634)
- Net gain/(loss) on revaluation of property, plant and equipment: 0
- Net gain/(loss) on revaluation of intangible assets: 0
- Net gain/(loss) on revaluation of financial assets: 0
- Total revaluations against revaluation reserve: (284,634)
- Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year: (284,634)
- Net funding: 285,158
- Balance at 31 March 2019: (17,185)

## Changes in taxpayers’ equity for 2017-18

<table>
<thead>
<tr>
<th></th>
<th>General fund £'000</th>
<th>Revaluation reserve £'000</th>
<th>Other reserves £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2017</td>
<td>(15,515)</td>
<td>0</td>
<td>0</td>
<td>(15,515)</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 31 March 2018</td>
<td>(15,515)</td>
<td>0</td>
<td>0</td>
<td>(15,515)</td>
</tr>
</tbody>
</table>

## Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2017-18

- Net operating costs for the financial year: (282,689)
- Net funding: 280,594
- Balance at 31 March 2018: (17,610)

The notes on pages 7 to 31 form part of this statement.
**Statement of Cash Flows for the year ended 31 March 2019**

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(284,634)</td>
<td>(282,689)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5</td>
<td>258</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>10</td>
<td>552</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>12</td>
<td>(1,100)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Operating Activities</strong></td>
<td>(284,924)</td>
<td>(280,334)</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments for property, plant and equipment</td>
<td>0</td>
<td>(155)</td>
</tr>
<tr>
<td>Payments for intangible assets</td>
<td>0</td>
<td>(76)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Investing Activities</strong></td>
<td>0</td>
<td>(233)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow before Financing</strong></td>
<td>(284,924)</td>
<td>(280,567)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant in Aid Funding Received</td>
<td>285,158</td>
<td>280,594</td>
</tr>
<tr>
<td>Non-cash movements arising on application of new accounting standards</td>
<td>(99)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash Inflow from Financing Activities</strong></td>
<td>285,059</td>
<td>280,594</td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td>11</td>
<td>135</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td>44</td>
<td>17</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td>179</td>
<td>44</td>
</tr>
</tbody>
</table>

The notes on pages 7 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 Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are relevant for clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

- Merton CCG has been allocated funds from NHSE for 2019/20 and indicative allocations up till 2023/24. Four years further in total
- The CCG is forecasting an in-year break even in 2019/20
- Detailed financial plans have been submitted to the Governing body and NHSE for 2019/20

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 Movement of Assets within the Department of Health and Social Care Group

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

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

Where NHS Merton Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 NHS Merton 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 NHS Merton Clinical Commissioning Group is in a "jointly controlled operation", NHS Merton Clinical Commissioning Group recognises:

- The assets NHS Merton Clinical Commissioning Group controls;
- The liabilities NHS Merton Clinical Commissioning Group incurs;
- The expenses NHS Merton Clinical Commissioning Group incurs; and,
- NHS Merton Clinical Commissioning Group’s share of the income from the pooled budget activities.

If NHS Merton Clinical Commissioning Group is involved in a “jointly controlled assets” arrangement, in addition to the above, NHS Merton Clinical Commissioning Group recognises:

- NHS Merton Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
- NHS Merton Clinical Commissioning Group’s share of any liabilities incurred jointly; and,
- NHS Merton Clinical Commissioning Group’s share of the expenses jointly incurred.

1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application. In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.
Notes to the financial statements

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are 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 schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other Expenses

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

1.8 Property, Plant & Equipment

1.8.1 Recognition

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

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

1.8.2 Measurement

All property, plant and equipment is 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.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expense, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3 Subsequent Expenditure

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

1.9 Intangible Assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group’s business or which arise from contractual or other legal rights. They are recognised only:
- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.
Notes to the financial statements

1.9.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.9.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.10 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 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

1.12 Cash & 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 the clinical commissioning group’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:

- Early retirement provisions are discounted using HM Treasury’s pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
  - A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
  - A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
  - A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
  - A nominal very long-term rate of 1.98% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructurin and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.14 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.15 Non-clinical Risk Pooling

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

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

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

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

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.17.1 Financial Assets at Amortised cost
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 Impairment
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm’s lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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

1.18.1 Financial Guarantee Contract Liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and;
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.18.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.18.3 Other Financial Liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

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

1.20 Third Party Assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

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

1.22 Critical accounting judgements in applying accounting policies

In the application of the clinical commissioning group’s accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.22.1 Critical accounting judgements in applying accounting policies

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

Better Care Fund

The Clinical Commissioning Group has entered into a partnership agreement and a pooled budget with London Borough of Merton in respect of the Better Care Fund. This is a national policy initiative and the funds involved are material in the CCG accounts. Having reviewed the terms of the partnership agreement, the Group Accounting Manual 2018/19 issued by the Department of Health and the appropriate financial reporting standards, the CCG has determined that there are three elements to the Better Care Fund and they are accounted for as follows:

1. The major part is controlled by London Borough of Merton which commissions services from various non-NHS providers. Whilst the services are determined in partnership, the risks and rewards of the contracts remain wholly with the council. The CCG accounts for this on a lead commissioner bases as healthcare expenditure with the local authority.

2. The second part is controlled by the CCG which commissions various services from NHS and non-NHS providers. The risks and rewards of these contracts are the responsibility of the CCG, which considers itself to be acting as a lead commissioner for those services on behalf of the partnership. The CCG accounts for these costs as healthcare purchased from NH and non-NHS providers.

3. The final part of the BCF is an integrated community equipment store. London Borough of Merton acts as the host body for this service across Merton which is provided by a third party. Each partner is however wholly responsible for their own share of the expenditure and this is accounted for as a joint operation.

1.22.2 Sources of estimation uncertainty

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

1.22.2.1 Prescription Services

The Clinical Commissioning Group receives financial information from NHS Business Services Authority relating to the cost of drugs prescribed by independent GPs, CCG run practices and the other CCG services. The total expenditure for the 2018/19 financial year includes estimates for February and March 2019 of £3.4m, based on the estimated profile of spend and local knowledge. This is in comparison to an estimate in 2017/18 for both February and March of £3.8m, as the financial information was not available at the time of producing the accounts.

1.22.2.2 Secondary Healthcare

Secondary activity reports are received from providers monthly, but activity information for the final month of the year is not available in time for the accounts, so estimates are made. A full reconciliation is undertaken once actual activity is agreed which is at the end of the first quarter of the following year. Any increase or decrease in activity (if any) becomes a charge or credit in the next financial year. Historically, when these estimates have been compared to the subsequent actual data, they have not been materially different. Estimate techniques are used to ensure that the correct levels of income and expenditure due relating to the current year are included through the inclusion of accruals based on known commitments and local knowledge.

1.22.2.3 Pooled Budgets

The Clinical Commissioning Group has entered into a pooled budget arrangement under section 75 of the NHS Act (2006) with London Borough of Merton. The Better Care Fund was introduced in 2015-16, which requires the pooling of health and social care funds. Due to timing differences in closing respective annual accounts, an estimate of the total expenditure with LBM for the Better Care Fund has been made, based on LBM forecast expenditure. A full reconciliation will be undertaken once the audit of local authority accounts is complete and any difference is a charge or credit in the next financial year.

1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.
2 Other Operating Revenue

<table>
<thead>
<tr>
<th>Income from sale of goods and services (contracts)</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, training and research</td>
<td>-</td>
<td>83</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>6,681</td>
<td>5,538</td>
</tr>
<tr>
<td>Other Contract income</td>
<td>98</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Income from sale of goods and services</strong></td>
<td><strong>6,779</strong></td>
<td><strong>5,621</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other operating income</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other non contract revenue</td>
<td>-</td>
<td>1,790</td>
</tr>
<tr>
<td><strong>Total Other operating income</strong></td>
<td></td>
<td><strong>1,790</strong></td>
</tr>
</tbody>
</table>

| **Total Operating Income**                      | **6,779** | **7,411** |

Administrative 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.

Within Non-patient care services to other bodies, the CCG has received £3.958m from Merton Borough Council in relation to Central London Community Healthcare services hosted by Merton CCG. The proportion of services hosted by the CCG and those paid directly by LBM to the provider changed over the two years under analysis.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General fund.
### 3.1 Disaggregation of Income - Income from sale of goods and services (contracts)

<table>
<thead>
<tr>
<th>Source of Revenue</th>
<th>Non-patient care services to other bodies £'000</th>
<th>Other Contract income £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>2,396</td>
<td>-</td>
</tr>
<tr>
<td>Non NHS</td>
<td>4,285</td>
<td>98</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,681</strong></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timing of Revenue</th>
<th>Non-patient care services to other bodies £'000</th>
<th>Other Contract income £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point in time</td>
<td>6,681</td>
<td>98</td>
</tr>
<tr>
<td>Over time</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,681</strong></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>
4. Employee benefits and staff numbers

4.1.1 Employee benefits

<table>
<thead>
<tr>
<th>Employee Benefits</th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>3,988</td>
<td>849</td>
<td>4,837</td>
</tr>
<tr>
<td>Social security costs</td>
<td>355</td>
<td>0</td>
<td>355</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>335</td>
<td>0</td>
<td>335</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>4,680</strong></td>
<td><strong>849</strong></td>
<td><strong>5,529</strong></td>
</tr>
</tbody>
</table>

Less recoveries in respect of employee benefits (note 4.1.2)  
Total - Net admin employee benefits including capitalised costs  

<table>
<thead>
<tr>
<th></th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net employee benefits excluding capitalised costs</td>
<td>4,680</td>
<td>849</td>
<td>5,529</td>
</tr>
</tbody>
</table>

In 17/18 Merton CCG consolidated its staffing structure through creating a joint management unit with Wandsworth CCG and was able to fill vacancies and reduce reliance on interims.

There were no recoveries in respect of employee benefit (nil in 2017/18) and no employee costs were capitalised in the year (nil in 2017/18).
### 4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>Permanently employed</th>
<th>Other</th>
<th>Total</th>
<th>Permanently employed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td></td>
<td>Number</td>
<td>Number</td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Number</td>
<td>51</td>
<td>10</td>
<td>61</td>
<td>45</td>
<td>10</td>
<td>55</td>
</tr>
</tbody>
</table>

No CCG staff was engaged on capital projects.

### 4.3 Exit packages agreed in the financial year

#### 2017-18

<table>
<thead>
<tr>
<th>Departures where special payments have been made</th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory redundancies</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other agreed departures</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

#### 2018-19

<table>
<thead>
<tr>
<th>Departures where special payments have been made</th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory redundancies</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other agreed departures</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

#### Less than £10,000

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>-</td>
<td>1,795</td>
</tr>
</tbody>
</table>

#### Total

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>-</td>
<td>1,795</td>
</tr>
</tbody>
</table>

### Analysis of Other Agreed Departures

#### 2018-19

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>-</td>
<td>1,795</td>
</tr>
</tbody>
</table>

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

There were no early retirement or ill-health retirement costs.

No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.
4.4 Pension costs

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

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are 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 schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2018-19, employers’ contributions of £335,000 (2017-18: £284,886) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.
### 5. Operating expenses

<table>
<thead>
<tr>
<th>Purchase of goods and services</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>3,822</td>
<td>5,193</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>98,500</td>
<td>95,379</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>90,265</td>
<td>89,305</td>
</tr>
<tr>
<td>Services from Other WGA bodies</td>
<td>45</td>
<td>-</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>33,231</td>
<td>33,897</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>157</td>
<td>217</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>21,785</td>
<td>23,527</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>31,451</td>
<td>31,012</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>1,946</td>
<td>1,474</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>112</td>
<td>-</td>
</tr>
<tr>
<td>Establishment</td>
<td>359</td>
<td>659</td>
</tr>
<tr>
<td>Transport</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Premises</td>
<td>3,287</td>
<td>3,160</td>
</tr>
<tr>
<td>Audit fees</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal audit services</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Other services</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Other professional fees</td>
<td>59</td>
<td>80</td>
</tr>
<tr>
<td>Legal fees</td>
<td>38</td>
<td>77</td>
</tr>
<tr>
<td>Education, training and conferences</td>
<td>148</td>
<td>234</td>
</tr>
<tr>
<td><strong>Total Purchase of goods and services</strong></td>
<td>285,278</td>
<td>284,289</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>239</td>
<td>201</td>
</tr>
<tr>
<td>Amortisation</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Depreciation and impairment charges</strong></td>
<td>258</td>
<td>201</td>
</tr>
<tr>
<td>Provision expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Provision expense</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Operating Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>415</td>
<td>301</td>
</tr>
<tr>
<td>Expected credit loss on receivables</td>
<td>(67)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Other Operating Expenditure</strong></td>
<td>348</td>
<td>301</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td>285,884</td>
<td>284,791</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.

The increase of expenditure for services from foundation trusts and healthcare from non-NHS bodies is due to the impact of new tariffs.

#### 5.2 Limitation on auditor's liability

In accordance with the terms of engagement with the CCG's external auditors, Grant Thornton UK LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £2million in the aggregate in respect of all such services.

Audit fees of £32k inc VAT were paid to Grant Thornton LLP for external audit services in 2018/19. A further £12k has been accrued for the MHIS audit and this is included in the Other Professional Fees line.
### 6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2018-19</th>
<th>2018-19</th>
<th>2017-18</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£'000</td>
<td>Number</td>
<td>£'000</td>
</tr>
<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>9,567</td>
<td>81,128</td>
<td>10,254</td>
<td>71,372</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>9,194</td>
<td>78,561</td>
<td>9,835</td>
<td>67,363</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>96.10%</td>
<td>96.84%</td>
<td>95.91%</td>
<td>94.38%</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>2,902</td>
<td>184,125</td>
<td>2,707</td>
<td>189,627</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,808</td>
<td>182,630</td>
<td>2,616</td>
<td>188,464</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>96.76%</td>
<td>99.19%</td>
<td>96.64%</td>
<td>99.39%</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. There is a performance target of 95% for each measure.
## Operating Leases

### 7.1 As lessee

#### 7.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land £’000</td>
<td>Buildings £’000</td>
<td>Other £’000</td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>-</td>
<td>1,201</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>1,201</td>
</tr>
</tbody>
</table>

(Where the NHS clinical commissioning group has not gone a signed lease please include the description:

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 only.

#### 7.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land £’000</td>
<td>Buildings £’000</td>
<td>Other £’000</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Since July 2014, NHS Merton Clinical Commissioning Group has been a lessee for the 5th Floor, 120 The Broadway, London SW19. The lessor is NHS Property Services.

The operating lease commitments disclosed above also include payments to NHS Property Services Limited and Community Health Partnerships Limited for void space at various clinical estate within the borough for which NHS Merton Clinical Commissioning Group is liable to pay charges if this space is not utilised.

NHS Merton Clinical Commissioning Group is liable for future costs relating to properties owned by NHS Property Services and Community Health Partnerships where the building or space within the building is not occupied (called a void space). However if this space gets occupied NHS Merton Clinical Commissioning Group is not liable for any costs relating to those properties unless it has leased the building or space under a formal agreement which will then be accounted for as per any operating lease. This is assessed on an annual basis so NHS Merton Clinical Commissioning Group is unable to estimate with any certainty potential liabilities over a 1 year time span.
## 8 Property, plant and equipment

### 2018-19

<table>
<thead>
<tr>
<th>Information technology</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2018</td>
<td>1,156</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2019</td>
<td>1,156</td>
</tr>
<tr>
<td>Depreciation 01 April 2018</td>
<td>530</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>239</td>
</tr>
<tr>
<td>Depreciation at 31 March 2019</td>
<td>769</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2019</td>
<td>387</td>
</tr>
<tr>
<td>Purchased</td>
<td>387</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>387</td>
</tr>
</tbody>
</table>

#### Asset financing:
- **Owned**: 387
- **Total at 31 March 2019**: 387

### 2017-18

<table>
<thead>
<tr>
<th>Information technology</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2017</td>
<td>1,001</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>155</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2018</td>
<td>1,156</td>
</tr>
<tr>
<td>Depreciation 01 April 2017</td>
<td>330</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>201</td>
</tr>
<tr>
<td>Depreciation at 31 March 2018</td>
<td>530</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2018</td>
<td>625</td>
</tr>
<tr>
<td>Purchased</td>
<td>625</td>
</tr>
<tr>
<td>Total at 31 March 2018</td>
<td>625</td>
</tr>
</tbody>
</table>

#### Asset financing:
- **Owned**: 625
- **Total at 31 March 2018**: 625

### 8.1 Additions to assets under construction
There were no additions to assets under construction in 2018-19

### 8.2 Donated assets
No assets were donated to Merton CCG in 2018-19

### 8.3 Government granted assets
No Government granted assets were received by Merton CCG in 2018-19

### 8.4 Property revaluation
There was no property revaluation in 2018-19

### 8.5 Compensation from third parties
No compensation from third parties for assets impaired, lost or given up was received and included in the Statement of Comprehensive Net Expenditure.

### 8.6 Write downs to recoverable amount
No assets were written down to recoverable amounts and no reversals of previous write-downs took place.

### 8.7 Economic lives

<table>
<thead>
<tr>
<th>Information technology</th>
<th>Minimum Life (years)</th>
<th>Maximum Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

20
9 Intangible non-current assets

<table>
<thead>
<tr>
<th></th>
<th>Purchased</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2018</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>Cost / Valuation At 31 March 2019</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>Amortisation 01 April 2018</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Amortisation At 31 March 2019</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2019</td>
<td>58</td>
<td>58</td>
</tr>
<tr>
<td>Purchased</td>
<td>58</td>
<td>58</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>
### 10.1 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2018-19 £'000</th>
<th>Non-current 2018-19 £'000</th>
<th>Current 2017-18 £'000</th>
<th>Non-current 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>2,143</td>
<td>-</td>
<td>1,423</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,061</td>
<td>-</td>
<td>1,003</td>
<td>-</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>949</td>
<td>-</td>
<td>995</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>390</td>
<td>-</td>
<td>1,530</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>352</td>
<td>-</td>
<td>236</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>85</td>
<td>-</td>
<td>294</td>
<td>-</td>
</tr>
<tr>
<td>Expected credit loss allowance-receivables</td>
<td>(228)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>16</td>
<td>-</td>
<td>68</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>219</td>
<td>-</td>
<td>29</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>4,986</strong></td>
<td>-</td>
<td><strong>5,538</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

The majority of receivables are with other NHS bodies. No credit scoring of them is considered necessary.

Receivables past due at the balance sheet date have been reviewed by CCG management and are considered collectable.

As at 21 May 2019, £0.288m of the amount above has subsequently been recovered post the statement of financial position date.

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

<table>
<thead>
<tr>
<th></th>
<th>2018-19 DHSC Group Bodies £'000</th>
<th>2018-19 Non DHSC Group Bodies £'000</th>
<th>2017-18 DHSC Group Bodies £'000</th>
<th>2017-18 Non DHSC Group Bodies £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>102</td>
<td>509</td>
<td>413</td>
<td></td>
</tr>
<tr>
<td>By three to six months</td>
<td>439</td>
<td>0</td>
<td>577</td>
<td></td>
</tr>
<tr>
<td>By more than six months</td>
<td>195</td>
<td>266</td>
<td>334</td>
<td>373</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>634</strong></td>
<td><strong>388</strong></td>
<td><strong>843</strong></td>
<td><strong>1,363</strong></td>
</tr>
</tbody>
</table>

### 10.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018

<table>
<thead>
<tr>
<th></th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification under IAS 39 as at 31st March 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assets held at FVTPL</td>
<td>-</td>
<td>44</td>
<td>-</td>
<td>2,378</td>
<td>-</td>
<td>1,853</td>
</tr>
<tr>
<td>Financial assets held at Amortised cost</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31st March 2018</strong></td>
<td><strong>44</strong></td>
<td><strong>2,378</strong></td>
<td>-</td>
<td><strong>1,853</strong></td>
<td><strong>4,275</strong></td>
<td></td>
</tr>
<tr>
<td>Classification under IFRS 9 as at 1st April 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total at 1st April 2018</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes due to change in measurement attribute</td>
<td>44</td>
<td>2,378</td>
<td>-</td>
<td>1,853</td>
<td>4,275</td>
<td></td>
</tr>
<tr>
<td>Change in carrying amount</td>
<td>44</td>
<td>2,378</td>
<td>-</td>
<td>1,853</td>
<td>4,275</td>
<td></td>
</tr>
</tbody>
</table>

### 10.4 Movement in loss allowances due to application of IFRS 9

<table>
<thead>
<tr>
<th></th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment and provisions allowances under IAS 39 as at 31st March 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total at 31st March 2018</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss allowance under IFRS 9 as at 1st April 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assets measured at FVOCI</td>
<td>-</td>
<td>-</td>
<td>(99)</td>
<td>-</td>
<td>(99)</td>
<td></td>
</tr>
<tr>
<td><strong>Total at 1st April 2018</strong></td>
<td></td>
<td></td>
<td>(99)</td>
<td></td>
<td>(99)</td>
<td></td>
</tr>
<tr>
<td>Change in loss allowance arising from application of IFRS 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 11 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2018</strong></td>
<td>44</td>
<td>17</td>
</tr>
<tr>
<td><strong>Net change in year</strong></td>
<td>135</td>
<td>27</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>179</td>
<td>44</td>
</tr>
</tbody>
</table>

Made up of:

- Cash with the Government Banking Service: 179 44
- Cash and cash equivalents as in statement of financial position: 179 44

**Total bank overdrafts**: - -

**Balance at 31 March 2019**: 179 44
12 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2018-19 £'000</th>
<th>Non-current 2018-19 £'000</th>
<th>Current 2017-18 £'000</th>
<th>Non-current 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: Revenue</td>
<td>7,500</td>
<td>-</td>
<td>5,430</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>349</td>
<td>-</td>
<td>1,391</td>
<td>-</td>
</tr>
<tr>
<td>NHS deferred income</td>
<td>-</td>
<td>-</td>
<td>68</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>3,902</td>
<td>-</td>
<td>3,742</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>4,650</td>
<td>-</td>
<td>6,623</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>64</td>
<td>-</td>
<td>48</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>68</td>
<td>-</td>
<td>32</td>
<td>-</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>6,262</td>
<td>-</td>
<td>6,565</td>
<td>-</td>
</tr>
<tr>
<td>Total Trade &amp; Other Payables</td>
<td>22,795</td>
<td>-</td>
<td>23,895</td>
<td>-</td>
</tr>
</tbody>
</table>

Other payables include £203k outstanding pension contributions at 31 March 2019 (£320k, 31 March 2018).

12.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

<table>
<thead>
<tr>
<th></th>
<th>Trade and other payables - NHSE bodies £000s</th>
<th>Trade and other payables - other DHSC group bodies £000s</th>
<th>Trade and other payables - external £000s</th>
<th>Other borrowings (including finance lease obligations) £000s</th>
<th>Other financial liabilities £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification under IAS 39 as at 31st March 2018</td>
<td>6,820</td>
<td>-</td>
<td>16,929</td>
<td>-</td>
<td>-</td>
<td>23,749</td>
</tr>
<tr>
<td>Financial Liabilities held at FVPL,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total at 31st March 2018</td>
<td>6,820</td>
<td>-</td>
<td>16,929</td>
<td>-</td>
<td>-</td>
<td>23,749</td>
</tr>
<tr>
<td>Classification under IFRS 9 as at 1st April 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total at 1st April 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes due to change in measurement attribute</td>
<td>6,820</td>
<td>-</td>
<td>16,929</td>
<td>-</td>
<td>-</td>
<td>23,749</td>
</tr>
<tr>
<td>Other changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in carrying amount</td>
<td>6,820</td>
<td>-</td>
<td>16,929</td>
<td>-</td>
<td>-</td>
<td>23,749</td>
</tr>
</tbody>
</table>
13 Financial instruments

13.1 Financial risk management

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

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

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

13.1.1 Currency risk

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

13.1.2 Interest rate risk

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

13.1.3 Credit risk

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

13.1.4 Liquidity risk

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

13.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.
13 Financial instruments cont’d

13.2 Financial assets

<table>
<thead>
<tr>
<th>Financial Assets measured at amortised cost</th>
<th>Total 2018-19</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Trade and other receivables with NHSE bodies</td>
<td>2,893</td>
<td>2,893</td>
</tr>
<tr>
<td>Trade and other receivables with other DHSC group bodies</td>
<td>283</td>
<td>283</td>
</tr>
<tr>
<td>Trade and other receivables with external bodies</td>
<td>390</td>
<td>390</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>219</td>
<td>219</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>179</td>
<td>179</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>3,965</strong></td>
<td><strong>3,965</strong></td>
</tr>
</tbody>
</table>

13.3 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities measured at amortised cost</th>
<th>Total 2018-19</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Trade and other payables with NHSE bodies</td>
<td>2,934</td>
<td>2,934</td>
</tr>
<tr>
<td>Trade and other payables with other DHSC group bodies</td>
<td>8,314</td>
<td>8,314</td>
</tr>
<tr>
<td>Trade and other payables with external bodies</td>
<td>5,154</td>
<td>5,154</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>6,262</td>
<td>6,262</td>
</tr>
<tr>
<td>Private Finance Initiative and finance lease obligations</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>22,664</strong></td>
<td><strong>22,664</strong></td>
</tr>
</tbody>
</table>
## 14 Operating segments

### 2018/19

<table>
<thead>
<tr>
<th></th>
<th>Gross expenditure £'000</th>
<th>Income £'000</th>
<th>Net expenditure £'000</th>
<th>Total assets £'000</th>
<th>Total liabilities £'000</th>
<th>Net assets £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning of Healthcare</td>
<td>291,413</td>
<td>(6,779)</td>
<td>284,634</td>
<td>5,610</td>
<td>(22,795)</td>
<td>(17,185)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>291,413</td>
<td>(6,779)</td>
<td>284,634</td>
<td>5,610</td>
<td>(22,795)</td>
<td>(17,185)</td>
</tr>
</tbody>
</table>

### 2017/18

<table>
<thead>
<tr>
<th></th>
<th>Gross expenditure £'000</th>
<th>Income £'000</th>
<th>Net expenditure £'000</th>
<th>Total assets £'000</th>
<th>Total liabilities £'000</th>
<th>Net assets £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning of Healthcare</td>
<td>290,100</td>
<td>(7,411)</td>
<td>282,689</td>
<td>6,285</td>
<td>(23,895)</td>
<td>(17,610)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>290,100</td>
<td>(7,411)</td>
<td>282,689</td>
<td>6,285</td>
<td>(23,895)</td>
<td>(17,610)</td>
</tr>
</tbody>
</table>
**15 Joint arrangements - interests in joint operations**

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

### 15.1 Interests in joint operations

<table>
<thead>
<tr>
<th>Name of arrangement</th>
<th>Parties to the arrangement</th>
<th>Description of principal activities</th>
<th>Amounts recognised in Entities books ONLY</th>
<th>Amounts recognised in Entities books ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>2018-19</strong></td>
<td><strong>2017-18</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>£’000</strong>  <strong>£’000</strong>  <strong>£’000</strong>  <strong>£’000</strong></td>
<td><strong>£’000</strong>  <strong>£’000</strong>  <strong>£’000</strong>  <strong>£’000</strong></td>
</tr>
<tr>
<td>Better Care Fund initiative</td>
<td>London Borough of Merton</td>
<td>Community Health and Social Care services</td>
<td>0  0  99  -  12,102</td>
<td>0  0  0  -  11,788</td>
</tr>
</tbody>
</table>

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

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

Details of related party transactions with individuals are as follows:

**Table 1. Governing Body Related Party Transactions**

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Nelson Medical Practice (Dr Andrew Murray)</td>
<td>4,019 (24)</td>
<td>0</td>
<td>0</td>
<td>4,374</td>
</tr>
<tr>
<td>Cricket Green Surgery (Dr Andrew Otley)</td>
<td>1,848 (7)</td>
<td>0</td>
<td>0</td>
<td>1,840</td>
</tr>
<tr>
<td>Wimbledon Village Surgery (Dr Tim Hodgson)</td>
<td>1,627 (8)</td>
<td>0</td>
<td>0</td>
<td>1,474</td>
</tr>
<tr>
<td>Wide Way Surgery (Dr Mohan Sekeram)</td>
<td>1,293 (8)</td>
<td>0</td>
<td>0</td>
<td>1,157</td>
</tr>
<tr>
<td>Central Medical Centre (Dr Karen Worthington)</td>
<td>1,131 (6)</td>
<td>0</td>
<td>0</td>
<td>1,118</td>
</tr>
</tbody>
</table>

**Table 2. Material Related Party Transactions**

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>St George’s University Hospitals NHS Foundation Trust</td>
<td>71,747 (42)</td>
<td>144</td>
<td>(856)</td>
<td>69,288 (36)</td>
</tr>
<tr>
<td>Epsom St Helier University Hospitals Trust</td>
<td>36,895</td>
<td>0</td>
<td>45</td>
<td>(113)</td>
</tr>
<tr>
<td>Central London Community Healthcare</td>
<td>21,977</td>
<td>0</td>
<td>446</td>
<td>(43)</td>
</tr>
<tr>
<td>South West London &amp; St George’s Mental Health NHS Trust</td>
<td>18,205 (21)</td>
<td>884</td>
<td>0</td>
<td>17,321 (54)</td>
</tr>
<tr>
<td>Kingston Hospital NHS Foundation Trust</td>
<td>12,103 (14)</td>
<td>273</td>
<td>(170)</td>
<td>11,965</td>
</tr>
<tr>
<td>London Ambulance Service NHS Trust</td>
<td>7,042 (2)</td>
<td>122</td>
<td>0</td>
<td>6,921</td>
</tr>
<tr>
<td>Moorfields Eye Hospital NHS Foundation Trust</td>
<td>4,038 (2)</td>
<td>129</td>
<td>0</td>
<td>3,955</td>
</tr>
<tr>
<td>London Borough of Merton</td>
<td>6,738 (4,506)</td>
<td>642</td>
<td>(339)</td>
<td>5,673</td>
</tr>
</tbody>
</table>

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

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

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

Table 1 - Disclosure is made when a Governing Body member has an interest in an organisation that has material transactions with the clinical commissioning group. This disclosure applies to all GP governing body members. The materiality level set for Table 1 is £50k.

Table 2 - Disclosure is made for the seven NHS organisations with which the clinical commissioning group spends most of its resources. The materiality level set for Table 2 is £3m which is 1% of the clinical commissioning group’s total operating expenses.
17 Events after the end of the reporting period

There were no non-adjusting events after the reporting period.

18 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>Description</th>
<th>2018-19 Target</th>
<th>2018-19 Performance</th>
<th>2017-18 Target</th>
<th>2017-18 Performance</th>
<th>Target achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>293,273</td>
<td>291,413</td>
<td>290,374</td>
<td>290,333</td>
<td>Target achieved</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>233</td>
<td>233</td>
<td>Target achieved</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>286,494</td>
<td>284,634</td>
<td>282,730</td>
<td>282,689</td>
<td>Target achieved</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Target achieved</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Target achieved</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>4,490</td>
<td>4,485</td>
<td>4,451</td>
<td>4,433</td>
<td>Target achieved</td>
</tr>
</tbody>
</table>
The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

<table>
<thead>
<tr>
<th>Administrative write-offs</th>
<th>Total Number of Cases 2018-19</th>
<th>Total Value of Cases 2018-19 £'000</th>
<th>Total Number of Cases 2017-18</th>
<th>Total Value of Cases 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£'000</td>
<td>Number</td>
<td>£'000</td>
</tr>
<tr>
<td>Administrative write-offs</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>