This document gives an overview of the CCG’s revised ‘Whole Merton’ vision and strategic direction. It also outlines how the CCG will work with partners to take this forward and the CCG’s current key priorities.
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**Quick Read Summary**

The CCG is now 3 years old and has recently had a change in both Clinical Chair and Chief Officer. The new leadership has taken the opportunity to review the current operating plan, models of care, working and governance of the CCG. There is a desire to ensure that the CCG is both demonstrably clinically led and that patients, partners and the public have a strong voice that is heard.

The CCG will be working with local practices, partners and providers to take forward the revised ‘Whole Merton’ vision shown here. This document outlines the CCG’s forward work plans for the rest of this year. These include addressing significant in year operational and financial pressures faced by the CCG.

Merton CCG commissions services from a range of providers to meet local healthcare needs. This includes acute hospital care, community healthcare and mental health. Within this the CCG has a particular focus on 8 key delivery areas; older and vulnerable adults, mental health, children and maternity services, keeping healthy and well, early detection and management, and urgent care. A Merton model of care will be developed for out of hospital care. This will increasingly seek to integrate and join up services around people’s needs.

Currently NHS England has the responsibility to commission Primary Care services. However these are now being co-commissioned with the CCG in Merton and there is a possibility that the CCG will take on full delegated commissioning in the coming years.

The CCG is committed to working collaboratively with a range of partners across the wider health and social care system including local authorities and voluntary organisations to develop the Whole Merton vision and strategy. In particular the CCG will work with the London Borough of Merton as a key strategic partner to further develop and implement the most appropriate joint commissioning and system leadership arrangements to progress the ‘Whole Merton’ approach.
The CCG recognises the need to work on its own internal development and to succeed as a high performing organisation. To that end an organisation development programme has been commissioned.

A detailed implementation workplan has been produced to programme manage delivery of all proposed work programmes and projects.
1. Introduction

The CCG is now in the second year of its current 2 year plan 2014-2016\(^1\) and has recently had a change in both Clinical Chair and Chief Officer. The new leadership has taken the opportunity to review the current operating plan, models of care, working and governance of the CCG. There is a desire to ensure that the CCG is both demonstrably clinically led and that patients, partners and the public have a strong voice that is heard.

This document\(^2\) provides an overview of the revised ‘Whole Merton’ vision and strategic direction for the CCG. It provides an overview of the forward work programme which will inform and be further developed by the CCG’s 2 year operating plan for 2016-18 once national guidance is issued at the end of 2015 calendar year. The current priority work programme includes a focus on addressing significant in year operational and financial pressures faced by the CCG.

The current Merton CCG 2 year plan, in common with the vast majority of CCG’s nationally, concentrates on the commissioning of specific services from a range of providers to meet specific healthcare needs. Primarily this covers acute hospital care, community healthcare and mental health. Merton CCG has had a particular focus on 8 key delivery areas; older and vulnerable adults, mental health, children and maternity services, keeping healthy and well, early detection and management, urgent care, medicines optimisation and transforming primary care. There will continue to be a strong focus on these areas, particularly in the Merton model of care developed locally for out of hospital care, with an increasingly integrated and joined up approach.

Currently NHS England has the responsibility to commission Primary Care services, however, this is now being co-commissioned with the CCG in Merton. Consideration is now being given to the potential for a move to full delegated commissioning.

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

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\(^1\) See appendix 1 for the summary CCG’s 2014-16 ‘Plan on a Page’

\(^2\) This document has been produced by the Executive Directors of the CCG working with Tricordant Ltd; external consultants commissioned to assist both with the initial review subsequent development of this strategic plan plus the associated organisation development work.
2. Where are we today?

2.1. THE PEOPLE OF MERTON

The CCG’s commissioning plans are informed by the 2013/14 Joint Strategic Needs Assessment (JSNA), currently being refreshed by the Public Health team within the London Borough of Merton, which sets out a big picture of local health and wellbeing with the priorities for improvement and reducing health inequalities.

Merton is relatively “healthy” in comparison with much of London, but within the borough there are unacceptably wide differences in life expectancy and death rates for some of the major causes of death—cancer, heart disease and respiratory disease. These inequalities are reflected in key predictors of health and wellbeing such as obesity prevalence, smoking prevalence and teenage conceptions.

Strong partnerships and innovative ways of working are central to improving health and reducing inequalities.

Merton, shown in figure 1, is suburban in character, and has significant amounts of green space, with 18% of the borough area being open space, compared to a 10% London average. The health and wellbeing of Merton’s population is closely defined by the characteristics which make Merton a unique borough. While Merton generally performs well on health indicators overall, the east of the borough experiences higher levels of social and economic deprivation, which result in significant differences in life expectancy and mortality between and within electoral wards in Merton.

Figure 1: London Borough of Merton
The 2011 Census identified a resident population of 199,693 (the figure I have from the public health team is 203,300). The age profile in Merton is atypical to outer London Boroughs currently. There is a very high proportion of young working age adults, and a smaller proportion of older people. The proportion of working age population is likely to decrease from 68% (2014) to 66% by 2020, with a rise in 0-15 year olds and 50+ year olds (JSNA 2013-14). About 1.1 % of the population is in the age group of 85-89 years, which is similar to the national age profile (1.5% in the 85-89 age band).

There are around 3,500 new births each year, a 40% increase since 2002. By 2021 it is expected that there will be a 20% increase in children born each year. The population is predicted to increase in size through increasing birth rates and migration, and will remain relatively young compared to the national profile and more in line with what is expected in London. However, there is an expected increase of the very elderly population that is more in line with the national profile.

Approximately 50.6% of the population is female and 49% of the population lives in family households with dependent children, while 29% lives in single occupant households. 4.8% of men and 5.7% of women have disabilities or health problems that limit day-to-day activities

ETHNICITY

Approximately 37% of the population are from Black, Asian and Minority Ethnic (BAME) communities, a figure expected to rise to 40% in 2020. An additional 16% of the population are from non-British White communities (mainly South African, Polish and Irish). Combined, 51% of Merton’s population are from diverse communities. About 40% speak a first language other than English – and about 121 languages are spoken in Merton schools.

FAITH

Approximately 56% of Merton’s population identified itself as being Christian, followed by 21% who identified with no religion, 8.1% as Muslim, 6.1% as Hindu, 0.9% as Buddhist and 0.4% with other religions.

LESBIAN, GAY, BISEXUAL AND TRANSGENDER

Of the population aged 16+ years, 2.5% or 4,100 people are estimated to be lesbian, gay or bisexual. Of the transgender population survey respondents, 80% were trans women and 20% trans men.

CARERS

Approximately 199,693 people living in Merton provide some form of unpaid care. This amounts to approximately, of which 1.7% of the population provides 50 or more hours of unpaid care a week, while 1.2% provides 20-49 hours of unpaid care (Census 2011).

HEALTH INEQUALITIES

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

- Health outcomes in Merton are better than the London and national average, evident in lower premature mortality rates and longer life expectancy at birth.
- Wards in East Merton are found to experience greater deprivation and poorer health outcomes compared to West Merton – evident in higher rates of premature deaths.
- East Merton is overall younger, poorer and ethnically more diverse, with lower levels of education and training compared to West Merton.


2.2. THE CURRENT SERVICES PROVIDED FOR MERTON

A wide range of health and social care services are provided in Merton based around 24 GP practices providing a ‘universal’ primary care service to local residents. GPs and their teams coordinate the care of patients who are provided with support where needed through services commissioned from a range of local providers. Around 60% of the CCG budget is spent with the three main acute hospital providers. Key preventative and ongoing care support for people is also commissioned by the local council. Figure 2 below summarises the key providers.
Note that the Community Service Provider will be changing from April 2016 as a result of a recent re-procurement. The new provider will be Central London Community Healthcare NHS Trust.

2.3. OUR CHALLENGES

All health and social care commissioners and providers are facing increasing pressures as demand continues to increase with resources constrained, or in the case of councils reducing. In Merton the local health and social care system has generally performed well compared to other Boroughs and CCGs. The CCG has, however, identified a number of key challenges;

- Delivering high quality services within budget.
- Increasingly the NHS and council cannot meet all people’s wants, therefore primary focus must be on understanding and meeting genuine needs.
- The CCG cannot ‘do it alone’, therefore we must involve partners including patients, carers, voluntary services and the wider community
- We also need to work with the community to develop the concept of individual responsibility. Not everything needs to be or indeed can be managed by the NHS. Appropriately supported individuals can be part of the whole system.

2.4. OUR CONTEXT

The CCG is developing our updated strategy within a complex local health and social care system which itself sits within further regional and national complexities. Our review work has looked at the range of factors. We have identified the following major external factors:

- Economy – Austerity–constrained limited resources
- Politics – National and local drivers
- Workforce – Specific skills shortage likely to be exacerbated in social care by the National Living Wage.
- Demographics – Increased diversity & demand
- Fragmented organisational structures & systems
- Transformational work needed in Leadership, IT, Workforce and Patient engagement
- System Inertia

Whilst these were agreed to be the most significant individual factors it will be important not to lose sight of the others where the cumulative effect of a number of, apparently lesser, factors may actually be significant. Figure 3 visually demonstrates the wide range of factors that were initially highlighted by the CCG Governing Body.
3. The Vision for our Community

3.1. OVERVIEW

We have developed a revised vision for the health and wellbeing of the people of Merton, which we have called ‘Whole Merton’. We have shared and refined this vision working with a range of our partners. It is summarised in Figure 4 below.
The sections below describe our vision in more detail and what it means for different groups of the population.

### 3.2. Whole Person in Whole Community

#### The whole population

Through the early review work it became clear that the CCG should have more of a people focus, rather than just on services; and that the focus should work from the whole population through to the individual ensuring fairness and equality of provision. In response to the question “What would success look like for the population?” a selection of responses were:

- I feel well and illness is not the defining feature of my life.
- When I do need the NHS I want all its parts to speak to each other.
- I am confident in the ability of the NHS to support me when I need it to.
- I know how to look after myself and manage my own health to a large extent – before I need to access the NHS.
- I want to have clear two-way communication at every step of my interaction with the NHS.

Through asking this question a number of key issues were highlighted:

- ‘Access’ – Where to go and getting what is needed when needed.
- Responsive services – efficient, seamless and timely.
- Pathways of care working effectively e.g. not telling story twice.
- Quality and equality of care.
- Individual ownership and responsibility of own health and conditions.
- Individual is informed, empowered, confident

From the responses areas of clear action for the CCG, providers and individual citizens have been highlighted which have the ability to positively impact both the whole population and individuals. Mostly, these issues are neither new nor unique to Merton but are faced by NHS organisations and populations across the country. The challenge for Merton CCG is to find workable solutions appropriate to our local population. This will mean working with providers and other local partners including community representatives using all available communication channels to bring about the necessary change within a complex multi-organisation system facing numerous challenges; not the least of which is financial.

#### The individual resident

In a strategic move from a focus on services to a focus on population there is a real danger of still losing sight of the individual and a key concern raised through our review is that there should be equality of access and service provision. A one-size fits all approach will not satisfy this need and this must be viewed alongside the financial challenges and constraints that do not allow everything that is desirable to be immediately achieved. Work will though have to be done across the provider spectrum to develop a provision which at the very least satisfies:

- Extended and varied opening hours.
• Understanding and provision for a range of cultural and social needs and variants; beyond just language.
• Education and individual empowerment especially through creative use of such mechanics as personal health and care budgets.
• Technological integration to pass basic data between providers and also patients.
• Going beyond standard geographic deprivation and disease prevalence data to provide necessary and appropriate services and care for all.

Families and carers

In developing joined up services focussed round people, we recognise services need to take account of the wider family and social contexts. In particular we need to understand and support informal carers better in their vital roles particularly supporting those who are vulnerable. The wider extended community including voluntary and community services often also play a critical role in providing the network of informal support and care that helps vulnerable people maintain their independence, avoid social isolation and manage their chronic health challenges.

3.3. WHOLE HEALTH AND WELLBEING SYSTEM

We recognize that we will never be able to achieve our vision and ambitions for Merton working alone. Partnership is at the heart of our vision. In particular the London Borough of Merton (LBM) is our key strategic partner and together we will draw together residents’ groups, voluntary and community sector groups and providers around the Whole Merton vision.

Our strategic partnering with the Council reflects a number of areas of shared interest:

• Improving the health and wellbeing of Merton residents.
• Developing more integrated and effective services to better meet the needs especially of vulnerable local people and ensure better use of diminishing public sector resources.
• Transforming the way services are commissioned and provided to meet our shared strategic challenges
• Leading the development of effective and vibrant partnerships with local voluntary and community sector, statutory partners, business and providers.

Central to improving the overall health and wellbeing of the residents of the borough, is the Health and Wellbeing Board (HWBB) which has a key strategic local leadership role. The work of the HWBB is central to informing and performance managing the commissioning and outcomes of health and social care services in Merton and it has a core role in encouraging joined-up services across the NHS, social care, public health and other local partners. The Merton HWBB brings together the Council, Merton Clinical Commissioning Group, Health Watch and the voluntary and community sector with a shared focus on improving health and wellbeing in Merton.
Merton’s Health and Wellbeing Strategy has four priority areas that Merton CCG are actively involved in:

**Priority 1**
Giving every child a healthy start

**Priority 2**
Supporting people to improve their health and wellbeing

**Priority 3**
Enabling people to manage their own health and wellbeing as independently as possible

**Priority 4**
Improving wellbeing, resilience and connectedness

### 3.3.1. Better Care Fund

The Better Care Fund (BCF) is a national initiative which has introduced a pooled budget between NHS Clinical Commissioning Groups and Local Authorities to provide an opportunity to transform local services so that people are provided with better integrated care and support. Now that the basic administrative arrangements for the Fund are in place we want to work with LBM and other partners to use the BCF as an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

We will focus effort on improving the lives of some of the most vulnerable people in our population, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. The BCF supports our shared aims of providing people with the right care, in the right place, at the right time and with the right outcome, including through a significant expansion of care in community settings, instead of in hospital or care homes. The drive behind the BCF is focused on adults, in particular older people.

A core part of our focus is the existing Merton Integration Project which began in 2013. A partnership of the CCG, LBM, Trusts and Voluntary Sector, it aims to develop integrated care between social and health care. The focus is on two phases of individuals’ care:

- **A proactive phase**, including the identification of high risk individuals, allocation of a key worker, person-centred planning and a common care plan across organisations with the development of integrated locality teams and multi-disciplinary review meetings.

- **A reactive phase**, developing improved responses to short term crises and exacerbation of conditions, including rapidly available alternatives to hospital admission, supported hospital discharge, rehabilitation, intermediate care, reablement, and increasing the integration of these health and social care responses.

This focus is reflected in the revised specification for our new community services provision and is consistent with our new Whole Merton vision and strategy.
One of the legacies of previous partnership working in Merton is the Better Services Better Value (BSBV) programme. This work has now concluded but has left a clinical case for change which still exists. As General Practitioner (GP) leaders of the local NHS, we have a unique opportunity as a CCG to work together with partners to transform services for our patients in south west London (SWL).

We are determined to tackle the variation in quality across all local health services. Our services are inter-dependent and the challenges we face cross borough boundaries. Our Whole Merton vision only reinforces the need for closer working between our hospitals and between the hospitals, GPs, community and mental health services if we are to improve quality for everyone in south west London and make the local NHS sustainable.

Furthermore we recognise that the scale of change needed will only be achieved by working with our local authorities, HWBB, mental health trusts, primary and community care providers, local hospitals, patients and neighbouring CCGs to achieve substantial and lasting improvements in our health services.

Recently our local acute providers in the SWL Acute Provider Collaborative (SWLAPC) have proposed how local acute services need to develop and change to meet the London Quality Standards (LQS) – which are the minimum safety standards developed by senior clinicians, based on Royal College guidance – and to meet the requirement that all hospitals provide seven-day, consultant-led services.

SWLAPC have estimated that by 2019/20 their combined annual deficit will be over £400million after investment to meet the LQS requirements and bring their estate to a reasonable level. After delivering an assumed 2.5% efficiency gain each year the projected deficit reduces to £247million. They have estimated a share of additional government funding of £63-110million and have proposed a number of joint actions to close this gap. These include:

- Reducing non-elective admissions through improved ambulatory emergency care, introducing a new emergency care model, and partnership working with community providers.
- Reducing length of stay through seven day working plus expanding intermediate care and using it where appropriate to substitute for acute care.
- Joint administrative work including repatriation, shared back office, procurement, recruitment, and nurse bank.
- Clinical reconfiguration whilst retaining 4 A&Es, by networking specialities across sites and pooling elective activity.

Even after these identified actions there is a projected gap of between £35 and £146 million.

We will be work with our neighbouring CCGs, through the South West London Commissioning Collaborative, and NHS England, who commission specialist services in south west London, to develop new local responses and strategies for local health services in response to these proposals. For Merton this centres on strengthening and enhancing our Out of Hospital services.
3.3.3. PARTNER PERSPECTIVES AND THE CHALLENGES OF INTEGRATED WORKING

We recognise that working together in partnership can be challenging. We have begun discussing with partners some of these challenges and how together we can overcome them. Key issues which have emerged so far include:

- A strong desire from partners to work together as one entity as much as possible whilst recognising the differing statutory obligations and governance of the CCG and other partners.
- Acknowledging and understanding the challenges and tensions within the system.
- A shared recognition with LBM of the need to develop effective joint commissioning arrangements which will be enhanced by the agreed appointment of an Assistant Director to oversee and drive integration.
- Recognition of the need to change financial flows and contract incentives and disincentives to support integrated working.
- The CCG must present a clear, simple, joint purpose with which partners can engage. This will require spending time with each of them to target and plan appropriately to develop win/win strategies.
- There are a number of current strengths and these should be built upon to further develop strong relationships and trust.
- A number of ‘blockers’ are capable of undermining the work if not acknowledged and managed carefully. Everything from rules, contractual and structural differences through capacity issues and strategic purposes need to be better understood through joint working rather than the CCG expecting providers to necessarily ‘jump to their tune’.
- Clarity on what integrated working really means and how that will be enacted.
- Obligations of all, including the population, to make the money go around.
- Patients, public and staff all must feel they are partners in the solution, not just the problem, and the CCG, including Board meetings, should be easily accessed.
- The CCG needs to engage more proactively and effectively with local voluntary and community services (VCS) partners. We do recognise the huge and often unseen contribution of the local VCS sector and are committed to working in partnership more effectively.

Given the difficult circumstances that partner organisations face with managing finance and service demand the CCG are very aware of the scale of the challenge they face.

There is a positive picture, however and during one of the review sessions with GP Practice Leads all of the participants were either in the “we are actively listening” or “let’s go for it” groups with more than 50% in the latter group. Nobody was in the “need a lot of convincing” group. Additionally the group had a number of very positive contributions to make in terms of moving forward to deliver the updated vision.
4. Our strategy to deliver the vision

4.1. Strategy Overview

We have found encouraging support from our partners and stakeholders for the Whole Merton focus, integrated and joined up around the needs of people and our communities. We recognise that making the vision a reality requires concerted and consistent effort by many people – inside and outside the CCG.

There are a number of key enablers which the CCG will work with partners to address to create the environment and context for services to be commissioned in an increasingly integrated and joined up way.

Figure 5 summarises how we can work together to progress our vision along with the strategic enablers and the key model of care principles which will guide our commissioning especially focussed on the community.

4.2. Models of care

The CCG is deliberately focussing on the development of robust and sustainable models of care for people in the community (i.e. ‘out of hospital’). Figure 5 above summarises the key principles which we will use to guide the
development of our local services, working closely with local GP practices, Local Authority colleagues, VCS representatives and key local providers. Our aim is to develop robust integrated local services in line with the ‘multi-speciality community providers’ (MSCPs) model described by NHS England in the 5 Year Forward view³.

These robust local services will be centred on integrating, supporting and enhancing existing primary care, community and social care services. These services will manage the interface with hospital services ensuring rapid access, where needed, to more acute specialist care and also supporting prompt, safe and effective discharge back to home and/or local care.

Primary care has a critical role in delivering our strategy. We will work with local GP Practices using the greater local influence available from co-commissioning and in time, delegated commissioning, to support the strengthening of local primary care services. This will include their role in delivering the reshaped primary care offer around proactive, accessible and coordinated care, described by recent collaborative work across London⁴.

We recognise that local acute providers will need to develop greater integration around clinical networks of care across SWL as described in section 3.3.2 above. We support this as the best way to ensure the provision of high quality sustainable and accessible acute services for Merton and the wider SWL population. We will support this process through our work with the SWL CCG Collaborative.

The table in Figure 6 describes the outcomes we will commission and plan for with local partners and providers across each model of care principle, within the specific service commissioning plans outlined in section 5 and the CCG work programme described in section 6.

<table>
<thead>
<tr>
<th>Model of care Principle</th>
<th>Associated Outcomes</th>
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</thead>
</table>
| Prevention              | • People are supported and encouraged to manage their own health and wellbeing.  
                          | • There is a strong focus on early years as this is a key way of improving health and wellbeing in later years.  
                          | • Healthy living and health promotion support for both physical and psychological aspects of wellbeing is embedded across services.  
                          | • Healthy and supportive working environments promote the health and wellbeing of staff. |
| Early Detection         | • Early detection of disease is prioritised, which enables early intervention.  
                          | • Relevant education is provided and there is good awareness of key signs and symptoms.  
                          | • Robust and effective health check and screening programmes are delivered.  
                          | • Once clinical suspicion is established, people have timely access to the services required to establish a diagnosis. |

⁴ Transforming Primary Care in London: A strategic commissioning framework. 2015. NHS England
Treatment and Ongoing Management

- Intervention, treatment and care are available for people with one or several short-term, acute needs or long-term conditions.
- Advice, information and education are provided to people, their carers and their families to support self-care and self-management.
- When people’s health and/or social circumstances change, or those of their carers, the support required can be accessed in a timely manner.
- Holistic support services are available to enhance the quality of life for people with long-term conditions and their carers.

Crisis Response

- In the event of crisis, appropriate services are responsive and accessible, and meet the needs of people and their carers.
- Services are able to support people to remain within the community where appropriate and to ensure efficient and timely access to acute or tertiary services if necessary.
- People’s vulnerability at times of crisis is acknowledged and the care, support and communication provided are guided by individual circumstances.

Recovery, Rehabilitation and Reablement

- Following illness, injury or trauma people are helped to recover and are supported to return to living as independently as possible.
- High quality, accessible and responsive services work to meet the needs of people and their carers, and where people have had to leave their homes, they are supported to return home as quickly and safely as possible where this is viable.
- Interventions are responsive to people’s preferences and wishes, and seek to improve confidence and wellbeing, maximise self-management and maintain optimal quality of life.

Complex and End of Life Care

- People with complex needs and those at the end of life are supported to live life as fully as possible.
- Holistic care and support is provided to reduce symptoms, suffering and distress.
- Carers and those close to the person are supported and have their needs met.
- People and their carers are aware of the choices available to them and appropriate steps are taken to make wishes and preferences a reality.
- Care is coordinated effectively and the right services and professionals are involved in meeting the needs of people and their carers.

Figure 6: Model of Care Commissioning Outcomes

4.3. THE ENABLERS

We recognise that critical to enabling the integration and alignment of care across Merton, are a number of key enablers. These are described in Figure 7 below in terms of the outcomes required. Our CCG work programme and organisational development plans ensure that each key enabler has a multi-disciplinary group leading the work with partners and is supported by clear CCG Executive leadership.
<table>
<thead>
<tr>
<th>Enabler</th>
<th>Associated Outcomes</th>
</tr>
</thead>
</table>
| **Leadership and Culture**    | • Leaders convey a compelling and meaningful vision.  
                                 • There is clear, consistent and honest communication.  
                                 • A strong positive culture promotes commitment and success.  
                                 • Effective clinical leadership enables the full contribution of all staff. |
| **Engagement and Communication** | • The membership, patients and the public, the NHS ‘family’ and other stakeholders and partners are involved and engaged.  
                                 • People and communities in Merton are empowered to manage and improve their own health and wellbeing. |
| **Workforce Capacity and Skills** | • The knowledge, skills and experiences of professionals are optimally used and developed.  
                                 • There is capacity in the system to deliver the right care at the right place at the right time. |
| **Commissioning and Contracting Arrangements** | • Effective commissioning and contracting arrangements help to support the delivery of high-quality, integrated care.  
                                 • Data and evidence are used to inform and shape the nature of commissioning. |
| **Information Management Technology** | • Information flows and is shared with the right safeguards in order to support patient care.  
                                 • Technology is used to enhance efficiency and the quality of care. |
| **Collaboration and Partnerships** | • There is a commitment to collaborative working.  
                                 • Partnership working is successful across health, social care, voluntary sector and other services and organisations. |

Figure 7: Strategy Enablers

5. The services we commission

The detail of the services that we will commission from April 2016 is contained within our separate Commissioning Intentions document\(^5\). This document has yet to be finalised since it will need to take account of national planning guidance due in December 2015 and also final Governing Body approval.

The commissioning intentions are consistent with the vision and strategic direction and continue to articulate Merton CCG’s vision for how health and care services will be delivered over the coming years. They capture how we are working across the health system to improve quality and drive efficiency. We will continue to do this by working together with all our partners and stakeholders in order to develop a health and care system that delivers sustainable services, value for money and meets our financial targets.

Starting in 2014 we identified eight key priorities; these were developed based on the Joint Strategic Needs Assessment for Merton and have incorporated key national and regional priorities that have emerged over time. Our eight priority areas are:

1. Older and Vulnerable Adults  
2. Mental Health  
3. Children and Maternity Services  
4. Keeping Healthy and Well

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\(^5\) Merton CCG 2016/17 Commissioning Intentions
These priorities remain critical in helping us organise and develop services to meet the needs of our population and as such, our commissioning intentions are set out against these areas.

At Appendix 2 we list the details of the Models of Care shown in Figure 6 and an outline of the work we will undertake to achieve our planned outcomes.

6. Making the vision a reality through our strategy

6.1. MODEL OF CARE DEVELOPMENT

The CCG is committed to working with partners and providers to develop robust and sustainable models of care for people in the community (i.e. ‘out of hospital’) as described above in section 4. We have yet to develop the detail of this model but will be doing so particularly around the planned Mitcham Care Centre. Figure 8 shows an illustrative view of how services might develop, taken from a recent primary care strategic framework.6

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6 Transforming Primary Care in London: A strategic commissioning framework. 2015. NHS England
Our aim is to develop robust integrated local services in line with the ‘multi-speciality community providers’ (MCPs) model described by NHS England in the 5 Year Forward view.

We have recently re-procured a new community services contract which will be mobilised over the coming months and effective from April 2016. The community services provider will have a key role in integrating, supporting and enhancing services around patients drawing on existing primary care, community and social care services. These services will continue to manage the interface with hospital services helping to ensure acute hospitals are only used by local residents when clinically needed, but when they do access is rapid and simple and discharge safe, timely and effective. Figure 9 below shows the development of our longer term vision towards integrating services in a model of care based around an integrated ‘multi-speciality community provider.

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6.2. STRATEGIC IMPLEMENTATION WORK PLAN

The current CCG workplan priorities are outlined in Appendix 3. These include addressing the current financial and performance challenges whilst developing local services in line with the Whole Merton Vision and laying the early foundations for others.

Until such times as the national operating guidance is published, the commissioning intentions and the overall strategy are agreed it is not possible to produce a definitive programme of work. However, at this stage enough is known for the major areas of work to produce a high level outline of the workplan.

7. Financial strategy

Historically Merton has been under-funded to deliver the health needs of its population. In 2015/16 Merton received an 8% increase in its allocation which is now £226 million p.a and this has helped the CCG to deliver some of its commissioning strategy and achieve its objective of right care, right place, right time and right outcome. Despite the increased allocation the CCG is under-funded by 4.77% for its population.

Future allocations for CCGs will be announced in December 2015; it is anticipated that CCGs will be given 3 year allocations with minimal increase in funding. Hence Merton CCG needs to continue its focus on transformational changes to achieve efficiencies going forward.

In addition, the local hospitals in South West London (SWL) have identified a potential deficit of circa £100 million in 2015/16. The reality is that we face a stark choice between making change that is planned and agreed by local clinicians or some services becoming clinically and financially unsustainable – which will ultimately lead to changes over which we have no control.

The financial resources of our Clinical Commissioning Group are and will continue to be aligned to support the delivery of our commissioning strategy and strategic programmes that are also aligned with SWL for example:

- **Integration** – The CCG has increased its investment for the Better Care Fund (BCF) by £3.6m for 2015-16 in addition to the 2014-15 spend. Some of this investment will form part of the pooled funds with LBM to deliver social care aspects such as reablement and domiciliary packages. In addition the money will also be used to provide 7 day services across community and social care.

- **Out of Hospital/Community based care** – Merton CCG opened the Nelson Health centre on 1st April 2015, which provides outpatient, diagnostics, minor procedures, older people’s rehabilitation, mental health and primary care services in one building in the community. The cost of these services is estimated to be circa £6m.

- **Mental Health** – A needs assessment was commissioned by the Merton Health & Wellbeing Board in 2014-15. As a result of this the CCG will work with LBM to meet the recommendations of the report and has also invested in 2014-15 and in 2015-16 (8% more) into mental health services such as:
  - a new complex depression and anxiety service
  - improving access to psychological therapies (IAPT)
o a Merton based Attention Deficit Hyperactivity Disorder/Autism spectrum disorder (ADHD/ASD)

The continued identification and delivery of transformational change will ensure that funds invested are targeted at those areas of greatest need and health impact, whilst at the same time ensuring a sustainable financial future. It seeks to ensure value for money and the fair and effective use of resources to improve the health and wellbeing of the community and secure the provision of safe high quality services.

The overriding objective of the Financial Strategy is to maintain, through prudent control, sustainable financial viability in order to enable the CCG to achieve its purpose, goals as well as its statutory and financial duties.

The purpose of the financial strategy is to:

- Monitor and ensure the on-going financial viability of the CCG.
- Ensure the resource needs of the CCG and potential financial risks are correctly identified.
- Enable the CCG to make informed decisions on new initiatives, future developments and opportunities.
- Support the CCG’s service strategies through effective and prioritised use of resources and enable service review and redesign.
- Enable the movement of financial resources to support changing health needs and changes to the delivery of health.
- Enable the CCG to demonstrate robust financial management and decision making.

8. Our development and performance

8.1. BECOMING A HIGH PERFORMING ORGANISATION

Merton CCG is 3 years old as an organisation, has a range of statutory obligations and a governance framework to reflect its membership and clinically led structure. It is now led by its second Clinical Chair and Chief Officer both of whom have been appointed within the last six months.

The relationship that the CCG has with NHS England is changing through its participation in co-commissioning and the potential move to full delegated commissioning within the next year. There is also a desire from the new leadership to ensure the CCG has the necessary internal capacity and capability and is organised to deliver on its strategic aims. They are the ‘wrap-around’ the strategic vision to enable its fulfilment.

The Chief Officer has developed a 5 point ‘manifesto’ that encompasses the values he sees necessary within the CCG; these are:

- Honest
- Organised and planned
- Patient Centric
- Engaged and engaging
- High quality outputs

During the review process a staff workshop was held to review and support the CCG’s development work. This was a positive experience for attendees with some clear initial actions agreed. A number of key challenges were identified including:
• Be visible and develop
• Vision and space to innovate without worry
• Open and honest, including with the public
• Improve partnership working and collaborative membership
• Great communication
• Strong, clear and positive leadership
• Positive ‘can do’ culture
• Better planning in organisation, maximise potential and skillset
• Avoid last minute rush and increase quality
• Enjoyment and fulfilment in work

In response to this feedback and further feedback from the Governing Body, Clinical Directors, Practice Leads, local Partners including LBM and local Voluntary and Community Services, the Executive team have identified a number of initial organisation development priorities. Figure 10 diagrammatically shows these priorities and, significantly, how they are interlinked and act as drivers for each other. The CCG has commissioned Tricordant Ltd to work with us over the coming months to ensure delivery of this programme of work.

The organisational development plan has also been informed by the recommendations made at the staff workshop held to grade the CCG’s performance using the Equality Delivery System.

8.2. MERTON TRANSFORMATION

We recognise that as well as paying attention to the CCG’s own organisation and working we need to work better with the wider Merton system. We are committed to working collaboratively with a range of partners across the wider health and social care system including local authorities and voluntary organisations to develop the revised vision and strategy. In particular the CCG will work with the London Borough of Merton as a key strategic partner to further develop and implement the most appropriate joint commissioning and system leadership arrangements to progress the ‘Whole Merton’ approach.
We have set ourselves some standards to which we will work as an organisation and will work with our partners for them to observe also. We believe these are key to transformational working and for our community to see real difference in health and social care provision. These standards are:

1. **Listening**
   - We will listen to patients, carers and relatives in a way we have not consistently done previously (they are trying to tell us what is wrong)
   - We will listen to people’s whole story and take into account their physical, mental and social health in every interaction (holistic care)
   - We will not make assumptions about what is best for our population and patients, we will listen to what they say and involve them in shaping services (Public Patient Engagement)

2. **Connecting**
   - We will connect services together so people have a seamless experience of health and social care
   - We will connect people to organisations and individuals who can help them (especially the use of the voluntary sector)
   - We will connect people to health and social care electronically (access, remote monitoring, webtools)

3. **Empowering**
   - We will help people to make informed choices about their use of health and social care (signposting, use of technology, simplification)
   - We will give people the tools to manage their own conditions when they choose to do so
   - We will encourage people to lead in planning their own care

4. **Supporting**
   - We will design services around people so that they are at the centre of their care and feel supported
   - We will be proactive in supporting those with health and social care needs so that they do not feel isolated or neglected
   - We will support those caring for loved ones as they are a cornerstone of our society

5. **Caring**
   - We will protect health and social care staff from the pressures of targets, workload and poor working patterns that can lead to burn out and a lack of compassion
   - We will ensure that across South West London we have a culture that prioritises caring for people and the needs of the person in front of us
   - We will ensure that people have access to the right care, at the right time in the right place with the right outcome

9. **Getting involved in the success**

   We believe the Whole Merton Vision and strategy we have outlined is an exciting one. We are keen that local people can have their say as individuals, or through patient and local voluntary and community services groups.

   All feedback can be sent to the following email address – chief.officer@mertonccg.nhs.uk
## Context and scale of the Challenge

A financially challenging health and social care system is broadly the same across the country, with local variations in levels of funding and increasing demands on services. The key points are:

- **Newly diagnosed**: A 4% increase in new diagnoses per annum (2015-16 vs. 2014-15).
- **Increased use of services**: A 6% increase in use of services per annum (2015-16 vs. 2014-15).
- **Slowest economic recovery**: The UK has the slowest economic recovery (2015-16 vs. 2014-15).
- **High unemployment**: A 4% increase in unemployment per annum (2015-16 vs. 2014-15).

## CCG Organisational Development Priorities

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Patient Involvement Priorities</th>
<th>SWLCC Priorities</th>
<th>SVLCC Priorities</th>
<th>Better Care Fund Priorities</th>
<th>System Resilience Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Plan</strong>: The main priority in all CCGs is to deliver a safe and sustainable system.</td>
<td><strong>Children and young people</strong>: To ensure children and young people’s mental health services are provided in a timely and effective manner.</td>
<td><strong>Redesigning emergency admissions</strong>: To improve patient flow and reduce waiting times.</td>
<td><strong>Care and Support</strong>: To ensure that care and support services are provided in a timely and effective manner.</td>
<td><strong>Early intervention</strong>: To provide early intervention services for children and young people.</td>
<td><strong>Reducing burden of work</strong>: To reduce the burden of paperwork and administrative tasks.</td>
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<tr>
<td><strong>Clinical governance</strong>: To improve clinical governance and ensure safe and effective care.</td>
<td><strong>Improving quality of services</strong>: To improve quality of services and patient outcomes.</td>
<td><strong>Improving outcomes</strong>: To improve outcomes and reduce readmissions.</td>
<td><strong>Effective commissioning</strong>: To ensure effective commissioning of services.</td>
<td><strong>Improving access and responsiveness</strong>: To improve access and responsiveness to patient needs.</td>
<td><strong>Increasing capacity</strong>: To increase capacity and reduce waiting times.</td>
</tr>
<tr>
<td><strong>Patient Centricity</strong>: To ensure that patients are at the heart of all decisions and that their needs are prioritized.</td>
<td><strong>Patient voice</strong>: To ensure that patients can have a say in their treatment.</td>
<td><strong>Patient voice</strong>: To ensure that patients can have a say in their treatment.</td>
<td><strong>Patient choice</strong>: To ensure that patients have a choice of service providers.</td>
<td><strong>Patient involvement</strong>: To ensure that patients are involved in decision-making.</td>
<td><strong>Patient engagement</strong>: To ensure that patients are engaged in their care plans.</td>
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## SWLCC Priorities

<table>
<thead>
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<td><strong>Increasing capacity</strong>: To increase capacity and reduce waiting times.</td>
<td><strong>Patient engagement</strong>: To ensure that patients are engaged in their care plans.</td>
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## System Resilience Priorities

<table>
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<tr>
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<th>Better Care Fund Priorities</th>
<th>System Resilience Priorities</th>
</tr>
</thead>
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<tr>
<td><strong>System Resilience Priorities</strong>: To ensure that patients are at the heart of all decisions and that their needs are prioritized.</td>
<td><strong>Patient voice</strong>: To ensure that patients can have a say in their treatment.</td>
<td><strong>Improved outcomes</strong>: To improve outcomes and reduce readmissions.</td>
<td><strong>Effective commissioning</strong>: To ensure effective commissioning of services.</td>
<td><strong>Increasing capacity</strong>: To increase capacity and reduce waiting times.</td>
<td><strong>Patient engagement</strong>: To ensure that patients are engaged in their care plans.</td>
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</tbody>
</table>
11. **APPENDIX 2: MODEL OF CARE WORK PLANS**

11.1. **PREVENTION**

**Outcomes**
- People are supported and encouraged to manage their own health and wellbeing.
- There is a strong focus on early years as this is a key way of improving health and wellbeing in later years.
- Healthy living and health promotion support for both physical and psychological aspects of wellbeing is embedded across services.
- Healthy and supportive working environments promote the health and wellbeing of staff.

**Key areas to evaluate**
The outcomes above will lead to improvements such as reduced incidence of long term conditions; increase healthy life expectancy; reduce inequalities in health, which can be measured through the national Public Health Outcomes Framework (PHOF) indicators e.g. Slope Index of Inequality; smoking; alcohol etc as well as other shared national outcome indicators.

**Key Challenges**
We have an ageing population and rising burden of avoidable illness and co-morbidity. Nearly 60% of our population are overweight or obese, 60% are inactive, 14% smoke, and 30% drink at unsafe levels. One in ten are diagnosed with depression and a fifth have high anxiety levels. There are significant health inequalities between the east and the west of the borough, generally associated with deprivation and the social determinants of health. Unless we act now across the system to support Merton residents to be healthier – by making most of existing healthy lifestyle opportunities and through creating health promoting environments that make behaviour change easier, our population will not only be older but sicker, and inequalities in health will remain and widen. This will put increasing pressure on local services: the sustainability of health and social care services depends on a step change in prevention of ill health. We need to act now to halt and reverse current trends. A radical shift in approach is required: breaking down silos to work across organisational boundaries and across risk factors, shifting resources towards prevention. We need to refocus NHS services away from a ‘sickness’ service and towards promoting wellbeing, in order to keep our population healthy, able to self manage and remain independent for longer.

**What We Can Build On**
We can build on the existing prevention model of care in development by LBM public health colleagues with whom we work very closely. This covers prevention of both mental and physical ill health as well as promotion of mental and physical health and wellbeing. Action is at several levels to both support individual

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8 NHS Five Year Forward View (2014) [https://www.england.nhs.uk/ourwork/futurenhs/5yf-v-exec-sum/](https://www.england.nhs.uk/ourwork/futurenhs/5yf-v-exec-sum/)
behaviour change but also on the wider social determinants of health (income, education, housing, built environment etc).

Prevention work needs to happen at three levels, for different population cohorts.9

<table>
<thead>
<tr>
<th>Level</th>
<th>Cohort</th>
<th>Approach</th>
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<tbody>
<tr>
<td><strong>Primary prevention</strong></td>
<td>General population (the “well”)</td>
<td>• Proportionate universalism (universal and targeted to need)10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lifecourse (start early, target receptive points e.g. transitions)</td>
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<td></td>
<td></td>
<td>• Through existing settings where people spend time or have links/peer groups e.g. schools, workplaces, community groups</td>
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<td></td>
<td></td>
<td>• Making every contact count (across whole system not just health)</td>
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<tr>
<td><strong>Secondary prevention</strong></td>
<td>Those with risk factors for ill health</td>
<td>• Evidence-based targeting e.g. NHS Health Checks, Screening</td>
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<tr>
<td></td>
<td></td>
<td>• Accessible to those most at risk (reduced barriers)</td>
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<tr>
<td></td>
<td></td>
<td>• Effective/appropriate advice, signposting and referral once risk factors identified</td>
</tr>
<tr>
<td><strong>Tertiary prevention</strong></td>
<td>Those with diagnosed conditions (acutely unwell),</td>
<td>• Patient-centred rather than disease specific (e.g. takes into account co-morbidities; support to whole family/carers; considers wider determinants e.g. benefits, housing adaptations, return to work)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients enabled, empowered to self manage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rehabilitation</td>
</tr>
</tbody>
</table>

What Needs to Happen

- Use and build on Health and Wellbeing Strategy 2015-2018 to work across the system (Whole Merton), develop shared commitment, shared objectives/indicators, and where appropriate joint budgets.
- Significant existing investment into healthy lifestyle services commissioned by Public Health and others.
- Develop proactive approach to prevention: rebalance resources and effort upstream, 1) towards prevention rather than treatment, and 2) towards primary prevention rather than tertiary (based on best practice/NICE PH guidelines, underpinned by case for change/evidence of return on investment). Need to maintain a good balance between:
  - High quality specific services to support individuals and family behaviour change
  - Increasing focus on influencing the upstream wider determinants of health
- Make most of/build on existing services (e.g. effective use of NHS Health Checks and onward referral depending on risk factors identified; build prevention into all new contracts) to ensure best value for money out of current commissioning resource, and best use of existing assets across the borough (public, voluntary, private sector).

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Whole system approach in order to “make every contact (/relationship) count”:
  o Targeted (proportionate universalism across the lifecourse, particularly at receptive points)
  o Intergenerational rather than individual: making most of an individual’s position within a family to spread messages, brief advice and signposting e.g. Health Visitor empowered to spot falls hazards of older person in the same household on a home visit, and refer appropriately.
  o Proactive rather than reactive, particularly around wider determinants e.g. District Nurse visiting a home trained and empowered to notice/refer to LBM housing team (or appropriate voluntary sector) if poor housing conditions/cold home.
  o Additive impact: working across conditions rather than condition specific e.g. empowering a patient to deal with one condition in a way that impacts on other co-morbidities but also other a range of health issues within that family or community group
  o Empowered referral routes where money follows referral e.g. pathways established so that voluntary sector could formally refer into health or other commissioned services

Utilise data better across organisations to identify risk factors and target services/resources e.g. smoking

This work is anticipated to be progressed through the Public Health Board (sub-group of Health and Wellbeing Board) and will include work with a number of key partners including
  o LBM Public Health, LBM directorates and levers that impact on the social determinants of health e.g. early years, education, housing, planning, licensing
  o MVSC and voluntary sector
  o Merton Chamber of Commerce and local business

11.2. **EARLY DETECTION**

**Outcomes**

- Early detection of disease (including mental health conditions) is prioritised, which enables early intervention.
- Relevant education is provided and there is good awareness of key signs and symptoms.
- Robust and effective health check and screening programmes are delivered.
- Once clinical suspicion is established, people have timely access to the services required to establish a diagnosis.

**Key Areas to Evaluate**

- Detection rates for common diseases (report local prevalence compared with expected prevalence).
- Waiting times to diagnostics and specialist appointments (e.g. the cancer two week wait).
- Prevalence of late diagnoses and relevant indicators (e.g. fewer strokes due to detection and management of high risk patients).
- Uptake of local and national screening programmes.
- Awareness and access by different population cohorts.
Key Challenges

- Variation in delivery of services in primary care and waiting times for GP appointments.
- Engagement of the wider population (rather than just existing service users).
- Skills and capacity in generalist and specialist services to recognise signs and symptoms.
- Ensuring that there is sufficient capacity in the system to meet the needs of the increased number of patients receiving a diagnosis as a result of targeted interventions.

What We Can Build On

- Work undertaken already to improve rates of diagnoses for certain diseases (i.e. COPD in 2013/14, Dementia in 2014/15 and, in 2015/16, Diabetes).
- Plans in place for a programme to increase the uptake of the national bowel cancer screening programme.
- Patient Navigation System being implemented in 2015/16, which endeavours to support GPs and improve patient journeys.
- Bid submitted for funding to improve detection of latent tuberculosis.
- Progress in relation to undertaking holistic assessments to detect emerging issues.

What Needs to Happen

- Review of potential for risk stratification and other tools to assist primary care in identifying patients for screening/diagnostics.
- Provision of support to public health to raise awareness of screening programmes and improve uptake.
- Improved links and interconnections between services to support timely access to appropriate services which can aid with early detection.
- Enhanced education and awareness amongst the wider workforce regarding signs and symptoms of physical and mental health conditions.
- Maintenance of a systematic and structured approach to early detection work across health, social care and key voluntary sector organisations.

11.3. **TREATMENT AND ON-GOING MANAGEMENT**

Outcomes

- Intervention, treatment and care are available for people with one or several short-term, acute needs or long-term conditions.
- People are educated, informed and able to self-manage their condition.
- When people’s health and/or social circumstances change, or those of their carers, the support required can be accessed in a timely manner.
- Holistic support services are available to enhance the quality of life for people with long-term conditions and their carers.
- People’s care is well-managed and coordinated, and people experience smooth care pathways which meet combinations of needs, rather than singular needs.
Key Areas to Evaluate

- Patient and carer experience.
- Accessibility of services, including amongst those with protected characteristics.
- Waiting times for treatment and effective, proportionate follow-up.
- Effectiveness of care pathways and care coordination between health, social care, education, voluntary sector and other services.

Key Challenges

- Coordinating care amongst the multiplicity of services and organisations.
- Sharing information between professionals and organisations in a seamless manner and the use of different IT systems to store service user records across primary, secondary and community care, social care and physical and mental health services, which presents challenges for data sharing and integration. A key enabler programme is planned to address this.
- Delivering care closer to home – services that are based locally and where possible delivered in primary care and the community, reducing reliance on secondary care.
- Ensuring demand and capacity are balanced across the system.
- Preventing deterioration by delivering the most effective, evidence-based interventions.
- Developing more effective programmes for education and self-management, and secondary prevention and health promotion.
- Effective contingency planning to prevent and manage crises and exacerbations.

What We Can Build On

- Joint Strategic Needs Assessment and focussed Needs Assessments (e.g. the Mental Health Needs Assessment 2014), provided by Public Health.
- Using integrated multidisciplinary teams, risk stratification, robust multi-professional care planning (including contingency/ ‘what if’ plans) and key workers to maximise proactive care.
- Structured work relating to the Equality Delivery System (EDS) to assess the equity of provision across the nine protected characteristics for a number of service areas related to patient outcomes and access.
- Cancer Action Plan that focuses on waiting times and the provision of holistic treatment.
- Quarterly SW London Commissioners and Providers Cancer Forum, presenting the opportunity to challenge providers when cancer waiting times are breached.
- A range of community and voluntary sector services which support people with a range of needs.
- Progress regarding the undertaking of annual reviews and the development of care plans for people with long term conditions.
- Opening of the Nelson Health Centre.
• Development of the East Merton Model of Care and the planned health facility on the Wilson Hospital site.
• Development of the Outpatient Navigation programme and the directory of services for Merton.

What Needs to Happen
• Greater patient and public involvement when designing and commissioning services.
• Increased focus on education, self-management and contingency planning for people with on-going conditions.
• Improved joint working with partner organisations to improve the patient journey.
• Further work regarding the coordination and integration of health, education, social care and other services, including developing multi-agency care pathways and care plans.
• Increased proportion of people with long term conditions who benefit from holistic assessments, including mental health and social care needs where appropriate.
• Provision of more accessible and flexible services to meet people’s needs.
• Improved ways of sharing patient records among health, social care and other professionals whilst adhering to information governance principles.
• Improved relationship between mental and physical health, and better integration of/ better links between mental and physical health services.

11.4. Crisis Response

Outcomes
• In the event of crisis, appropriate services are responsive and accessible and meet the needs of people, their families and carers.
• Vulnerability at a time of crisis is recognised and people feel safe and supported.
• Services are able to support people to remain within the community where appropriate and ensure efficient and timely access to acute or tertiary services if necessary.
• The services provided work seamlessly with any post crisis care and support required, care planning is updated to reflect any changing needs and this is communicated to relevant parties.

Key Areas to Evaluate
• Patient and carer experience.
• Accessibility of services.
• Achievement in terms of people getting the right treatment.
• Service user knowledge regarding where to access care and support in times of crisis.
• Effectiveness of response and coordination with other services.
• Progress against Merton’s plans to improve care and support of people in crisis.
Key Challenges
- Over reliance on hospital-based services and lack of public and professional knowledge regarding alternatives.
- Coordinating a response amongst the multiplicity of providers/agencies.
- Accessing the required care and support at the right time, in particular out of hours.
- Ensuring that there is sufficient capacity and capability in the system to deliver the necessary care to enable people to be supported in the community.
- Sharing and accessing relevant patient information including ‘out of hours’.

What We Can Build On
- Development of more integrated services, with multi-professional care planning and key workers.
- Use of contingency/ ‘what if’ plans in community services.
- Use of risk stratification to identify people at increased risk of hospital admission.
- Expanding crisis services and further development of relationships across agencies, so people at high risk of hospital admission and/ or with complex needs know how to access support 24/7.
- Crisis Care Concordat principles and guidance (across all patient groups).

What Needs to Happen
- Expanding multi-agency support services to operate seven days a week, and where required, provide some level of service 24/7.
- Borough wide equality impact assessment for crisis services.
- Development of a helpline and enhanced support services in the community for people at high risk of hospital admission and/ or with complex needs.
- Greater use of alternative care pathways with LAS and Emergency Departments so we maximise use of alternatives to hospital where appropriate.
- More work to ensure people are followed up post crisis and that steps are taken to minimise the risk of future crises.
- Provision of support for other agencies (e.g. police) so they recognise and are able to provide appropriate help to people in crisis where they are the first point of contact.
- Increased awareness among professionals of the available crisis pathways within the community.
- Development of the model of care for older people within the acute hospitals, to reduce admissions and overall length of stay.
- An urgent care review is underway as a key part of the CCG’s current work programme which will review access to urgent care including A&E, GP access, GP walk in centres, 111 and other related services. This will seek to address many of the issues above.

11.5. **Recovery, Rehabilitation and Reablement**

Outcomes
- Following illness, injury or trauma people are helped to recover and are supported to return to living as independently as possible.
- High quality, accessible and responsive services work to meet the needs of people, their families and carers, and where people have had to leave their homes, they are supported to return as quickly and safely as possible.
Interventions are responsive to people's preferences and wishes, and seek to improve confidence and wellbeing, maximise self-management and maintain optimal quality of life.

**Key Areas to Evaluate**
- Patient and carer experience.
- Accessibility of services.
- Effectiveness of response, and immediate and longer term outcomes.
- Coordination with other services.
- Achievement in terms of meeting people's needs holistically.

**Key Challenges**
- Coordinating a holistic response amongst the multiplicity of providers/agencies.
- Ensuring that there is sufficient capacity in the system to deliver the necessary care to enable people to be supported in the community, including specialist services e.g. neuro-rehabilitation.
- Evidencing longer term outcomes and the sustainability of different service models.
- Linking services with the voluntary and community sector to ensure longer term outcomes and sustainability.

**What We Can Build On**
- Using integrated multidisciplinary teams, risk stratification, robust multi-professional care planning and key workers to maximise proactive care.
- Increased carers support and increased links with the voluntary sector to support recovery and improve wellbeing e.g. on-going exercise programmes, befriending and support groups.
- Expanding early supported discharge programmes such as those for stroke patients and enhanced levels of rehabilitation in patients' homes.
- Development of the HARI model.

**What Needs to Happen**
- Expansion of multi-agency support to seven days a week to enable rehabilitation to be maximised.
- Development of a helpline and enhanced support services in the community for people with complex needs, their families and carers, who may need timely access to advice and support to maximise their recovery.
- Timely access to rehabilitation and reablement services, including reduction in delayed transfers of care from acute settings due to waits for rehabilitation.
- Clear, Merton-specific pathways communicated to local acute settings where Merton community services do not in-reach (e.g. Kingston and Croydon).
- More integrated recovery services across health and social care.
- Increased focus on engaging people in their own recovery, to improve motivation and on-going self-management.
11.6.  COMPLEX AND END OF LIFE CARE

Outcomes
- People with complex needs and those at the end of life are supported to live life as fully as possible.
- Holistic care and support is provided to reduce symptoms, suffering and distress.
- Carers and those close to the person are supported and have their needs met.
- People and their carers are aware of the choices available to them and appropriate steps are taken to make wishes and preferences a reality.
- Care is coordinated effectively and the right services and professionals are involved in meeting the needs of people and their carers.

Key Areas to Evaluate
- Patient and carer experience
- Effectiveness of care coordination
- Patient and carer choice e.g. those approaching the end of life achieving their preferred place of death
- Identification of people with complex needs and those at the end of life

Key Challenges
- Coordinating care amongst the multiplicity of providers involved in caring for people with complex needs and those at the end of life.
- Barriers and obstacles to sharing information between professionals and organisations.
- Developing multi-professional and multi-agency care pathways and care plans
- Accessing the required care and support at the right time, in particular out of hours.
- Ensuring that there is sufficient capacity in the system to deliver the necessary care to enable people to be supported in their preferred place of care.

What We Can Build On
- Merton’s End of Life Care Strategy and Implementation Plan
- Care pathways for children with complex needs
- Developments relating to the care of Looked after Children
- Progress relating to risk stratification
- Integrated multidisciplinary teams

What Needs to Happen
- Establishment of IT and IG solutions to overcome data sharing barriers.[see enablers]
- Collective review of how effective joint care planning can work optimally.
12. **Appendix 3:**

**CCG Strategic Priorities Development and Implementation Plan 2015/16 – 2016/17**

<table>
<thead>
<tr>
<th>Priority Area and Work Packages</th>
<th>Planning and Implementation Timeline</th>
<th>Notes and Dependencies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24 15-16 Q1 16-17 Q2 16-17 Q3 16-17 Q4 16-17</td>
<td></td>
</tr>
<tr>
<td><strong>1. Developing, implementing and monitoring a sustainable and effective Finance and Performance Plan to ensure good patient care and achieve financial balance (led by Exec Team)</strong></td>
<td>Planning</td>
<td>Complete</td>
</tr>
<tr>
<td>Produce a 15/16 financial and performance analysis and recovery plan including quality assurance.</td>
<td>Complete</td>
<td>Analysis completed, recovery plan to be finalised</td>
</tr>
<tr>
<td>Improve management of major contracts through a new specification for support from CSU.</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Implement a new Operational Delivery Group for effective management of key performance issues.</td>
<td>Complete</td>
<td>Completed</td>
</tr>
<tr>
<td>Develop and implement a Practice engagement plan.</td>
<td>Complete</td>
<td>Link with Primary Care Transformation</td>
</tr>
<tr>
<td>Clear priority programme of work for commissioning team focused on population needs.</td>
<td>Complete</td>
<td>Almost complete waiting to finalise in line with 16/17 national operating guidance; risks from not working on some services</td>
</tr>
</tbody>
</table>

| **2. Planning for 16/17 and beyond based on financial allocations, NHSE operating framework guidance and the plans of our strategic partner London Borough of Merton (led by CFO)** | Planning | Complete |
| Clinically led engagement and prioritisation | Complete | |
| Develop and implement a revised patient and public engagement strategy | Complete | |
| Produce the required Operating Plan supported by detailed service commissioning, funding and delivery plans. | Complete | 3 year QIPP plans + need to coer revised strategy |

| **3. Planned Care programme (led by DoP&C)** | Planning | Complete |
| Align OP navigation project resources & outputs with planned care recovery plan | Complete | Practice engagement and clarity on activity to move |
| Medicine management (pathway improvements/alternatives to more invasive interventions etc) | Complete | Contribution to other other workstreams e.g. pathways for OP navigation |
| Ensure Nelson set up and used for optimal planned care capacity | Complete | GP engagement and St George’s readiness |
| MSK opportunity | Complete | Link with OP Navigation. Current MSK provider lost Community Services contract |

| **4. Engaging with South West London strategic landscape (led by Chief Officer)** | Planning | Complete |
| Clarify the role and positioning of MCCG in SWL collaborative | Complete | Success Regime now being implemented in South West London and Surrey Downs Healthcare Partnership out of which various decisions will be made regarding the South West London Commissioning Collaborative and Acute Providers Collaborative |
| Ensure appropriate strategic engagement with and response to SWLACPC and Acute Trust proposals to ensure CCG sustainability | Complete | |

<p>| <strong>5. Developing and implementing a sustainable and effective strategy for out of hospital services (led by DoP&amp;C)</strong> | Planning | Complete |
| Ensure clear and compelling East Merton Model of Care | Complete | Engagement events and detailed development plans |
| Ensure sustainable business case for Mitcham | Complete | Business case sign off March 2017 - planned opening Summer 2019 |
| Mobilising community services contract | Complete | New contract live from April 16 |
| Further development of integrated working through the BCF | Complete | Link to joint commissioning with LBM |
| Agree and implement effective joint commissioning arrangements with LBM | Complete | Review of ambitions plus expectations of national operating guidance |
| Plan for transformational working in primary care | Complete | Decision on delegated commissioning |
| Service development for MH, IAPT and Dementia | Complete | |
| Develop and implement a transformation plan for CAMHS | Complete | Plan submitted to NHSE and waiting for funding decision |</p>
<table>
<thead>
<tr>
<th></th>
<th>Develop effective Mental Health commissioning arrangements to deliver service transformation (led by DoF&amp;C)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Develop effective mental health commissioning arrangements</td>
<td>Plan complete; CSU employing collaborative Director</td>
</tr>
<tr>
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<tr>
<td></td>
<td>Develop the CCG as an effective high performing organisation (led by Chief Officer)</td>
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<tr>
<td>a</td>
<td>Develop, implement and monitor an OD plan to embed &quot;Whole Merton&quot; new ways of working and develop CCG as a high performing organisation</td>
<td>Plan agreed and to be implemented along with Tricordant</td>
</tr>
<tr>
<td>b</td>
<td>Ensure effective implementation of revised governance arrangements</td>
<td>New governance arrangement agreed and being implemented</td>
</tr>
<tr>
<td>c</td>
<td>Develop engaged and effective clinical leadership with clear roles and structures to optimise contribution of clinical directors and other clinical leaders</td>
<td>Implement alongside OD work with Tricordant and aligned to Clinical Engagement plans</td>
</tr>
<tr>
<td>d</td>
<td>Successful CCG assurance review [achieve at least &quot;good&quot;]</td>
<td>First of new reviews completed, now ongoing BAU</td>
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<tr>
<td></td>
<td>Ensure effective development and implementation of key enabler strategies (led by CFO)</td>
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<tr>
<td>a</td>
<td>Develop and implement an Estates strategy (SSDP) to enable delivery of Whole Merton vision.</td>
<td>Linked with new models of care, primary care transformation and new community provider</td>
</tr>
<tr>
<td>b</td>
<td>Digital project supporting move to paperless systems across CCG and providers within national 2020 target timescale to include specific Merton CCG and Primary Care strategic plan with understanding of and collaborative leadership in whole system interoperability.</td>
<td>Plan almost complete for CCG and primary care; dependency on practice willingness also needs provider system change and inter-operability, BCF can be driver</td>
</tr>
<tr>
<td>c</td>
<td>Support development of an effective CEPN [a local community provider professional workforce education network] and clarify CCG workforce development strategy for primary care.</td>
<td>Clarity needed for primary care workforce strategy, Federation development</td>
</tr>
</tbody>
</table>