Merton Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: Thursday, 16th May 2013

Agenda No: 8.1 **ATTACHMENT:** 08

Title of Document: NHSSM and Merton CCG Performance Management Report: Month 12	**Purpose of Report:** To receive and Note
Report Author: Amelia Whittaker Associate Director of Commissioning, SLCSU	**Lead Director:** Andy Smith, Director of Commissioning
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Executive Summary: Month 12 Acute performance report for Sutton and Merton (prior to disaggregation). Paper also includes Director of Commissioning Report, providing an update on QIPP developments, contract status, procurements and service developments together with an update on recent appointments to the commissioning team.	
Key sections for particular note (paragraph/page), areas of concern etc: Whole document.	
Recommendation(s): The Merton Clinical Commissioning Group Governing Body is requested to receive and note this paper.	
Committees which have previously discussed/agreed the report: None	
Financial Implications:	
Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing)	
Equality Analysis: NA	
Information Privacy Issues: NA	
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) NA	

NHS

South London
Commissioning Support Unit

Integrated Performance Report 12/13 Outturn

Sutton & Merton CCG

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Healthcare Acquired Infections

The DH has set challenging targets for both MRSA and CDI reduction for 2012/13. The trust based MRSA thresholds are a 45% reduction on last year's levels and for CDI the reduction is 12%. The Government has been clear the NHS should adopt a zero tolerance approach to all avoidable healthcare associated infections. The infections that the Department are seeking the NHS to minimise are those infections that have occurred through non-adherence to best practice in infection prevention and control practices. It is recognised there are some infections that cannot be prevented.

CDIF

C. difficile infections are a significant patient safety issue with almost 20,000 reported cases in the baseline 12 month period (October 2010 to September 2011) in England. Along with other healthcare associated infections, it can cause illness and, sometimes, death. It is distressing for patients who acquire an infection, for their family and friends and for staff who treat them. Reducing C. difficile infections will lead to significantly improved patient safety outcomes as well.

Sutton & Merton CCG performance for February showed that performance is Green with 80 YTD cases against a target of 83. This is shown in the table below which also details the breakdown by Trust, Acute and Non Acute:

HCAI	Feb-13	YTD
C-Difficile	**5**	**80**
St Georges	*1*	*20*
Royal Marsden (Surrey)	*0*	*3*
St Helier	*0*	*15*
Other providers	*0*	*5*
Apportioned to non acute trust	*4*	*37*

Around half of the cases were apportioned to non-acute Trusts with the other half apportioned to Acute Trusts mainly at St Georges. St Georges have had a total of 20 C. difficile cases to date with the last case being recorded in February. A review meeting with ST Georges involving Trust Clinicians and CCG leads is being hosted by the CSU to address the rate of C. difficile infections.

C. difficile performance has been reviewed throughout the year at the CQRG meetings where action plans have been reviewed and breach analysis undertaken.

More detailed trend analysis is included in the C-Difficile HCAI dashboard below:

Commissioner Report: Healthcare Associated Infections (HCAI)

Date of production: 17/04/2013

Please select what information you would like to see:

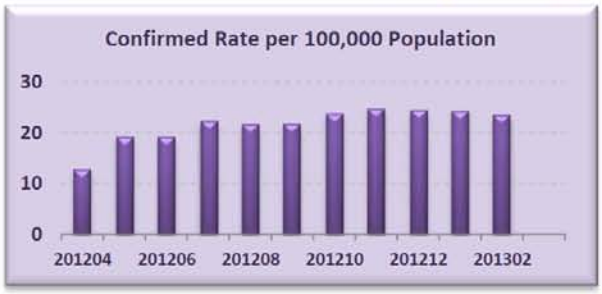
Indicator

- C-Difficile
- MRSA

Clinical Commissioning Group

- Merton
- Richmond and Twickenh...
- Sutton
- Sutton and Merton

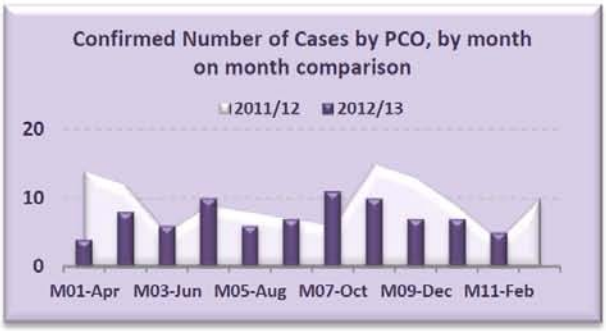
Current Performance for Primary Care Organisation (2012/13 Financial Year)

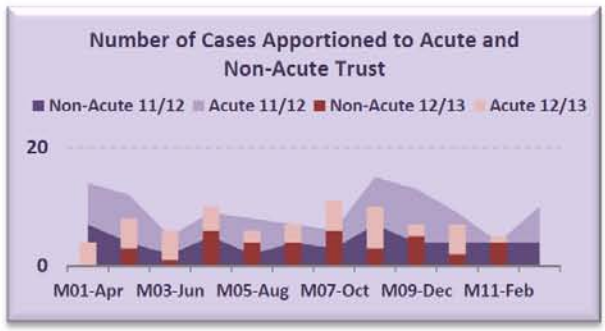


Number of cases YTD -	81
Year to date target -	83
YTD Performance -	

PCO Confirmed Cases broken down by Responsible Provider

Sum of Cases	2012 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Apportioned to Non-Acute Trust	0	3	1	6	4	4	6	2	5	2	4
Other Acute Trusts	0	1	0	0	1	1	1	0	1	0	0
St George's Hospital	4	2	1	1	0	1	2	4	0	0	1
St Helier Hospital	0	1	4	3	1	1	2	2	1	4	0
The Royal Marsden Hospital	0	1	0	0	0	0	0	1	0	1	0
Grand Total	4	8	6	10	6	7	11	9	7	7	5





Information Source: HCAI Data Capture System and London.gov.uk
Report produced by the NHS South London Commissioning Support Unit Performance Team

MRSA

PCOs (PCTs and Care Trusts) are accountable for all cases of MRSA bloodstream infections occurring in their responsible populations. Cases will be attributed to responsible PCOs via the NHS Connecting for Health's Demographics Batch Service (DBS) using the NHS number and date of birth or, where this has not proved possible, they will be attributed to the lead PCO (sometimes called the coordinating PCO) for the trust reporting the case.

The Government has been clear the NHS should adopt a zero tolerance approach to all avoidable healthcare associated infections. The infections that the Department are seeking the NHS to minimise are those infections that have occurred through non-adherence to best practice in infection prevention and control practices. It is recognised there are some infections that cannot be prevented.

MRSA is still a significant patient safety issue with over 1,200 bacteraemias reported in the 12 months to September 2011 in England. Along with other healthcare associated infections, it can cause illness and, sometimes, death. It can be very distressing for patients who acquire an infection, for their family and friends and for staff who treat them. Reducing MRSA bacteraemia will lead to significantly improved patient safety, outcomes as well as deliver cost savings and reputational gains for the NHS.

Sutton and Merton performance for February showed that performance is red with 13 YTD cases against a target of 10. This is shown in the table below which also details the breakdown by Trust, Acute and Non Acute:

HCAI	Feb-13	YTD
MRSA	**1**	**13**
St Georges	*0*	*5*
Royal Marsden (Surrey)	*0*	*0*
St Helier	*0*	*4*
Other providers	*1*	*1*
Apportioned to non acute trust	*0*	*3*

The MRSA indicator counts the number Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia cases within the GP registered population.

MRSA performance has been reviewed throughout the year at the CQRG meetings. There has also been input from Cluster infection control leads and expert input from NHS London to review root cause analysis and action plans.

More detailed trend analysis is included in the MRSA HCAI dashboard below:

Commissioner Report: Healthcare Associated Infections (HCAI)

Date of production: 17/04/2013

Please select what information you would like to see:

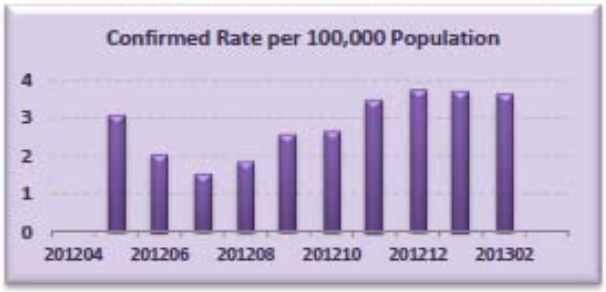
Indicator

- C-Difficile
- MRSA

Clinical Commissioning Group

- Merton
- Richmond and Twickenh...
- Sutton
- Sutton and Merton

Current Performance for Primary Care Organisation (2012/13 Financial Year)



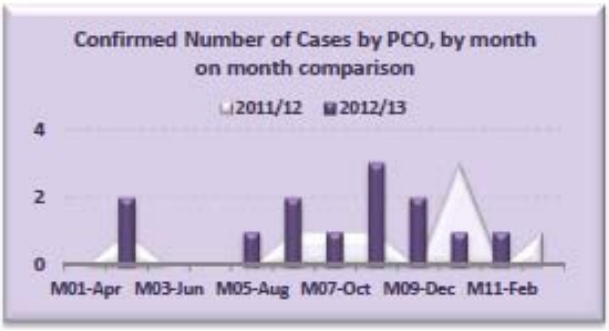
Number of cases YTD - 13

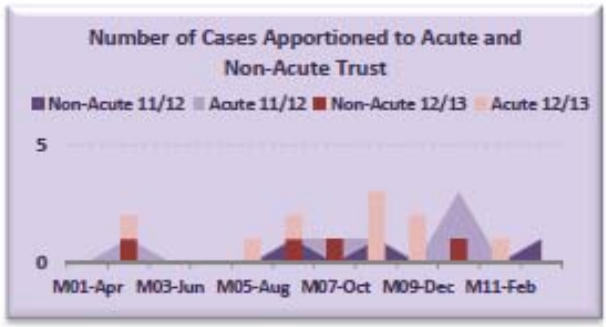
Year to date target - 10

YTD Performance -

PCO Confirmed Cases broken down by Responsible Provider

Sum of Cases	2012 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Apportioned to Non-Acute Trust	0	1	0	0	0	1	0	0	0	1	0
Other Acute Trusts	0	0	0	0	0	0	0	0	0	0	1
St George's Hospital	0	0	0	0	0	0	1	2	2	0	0
St Helier Hospital	0	1	0	0	1	1	0	1	0	0	0
The Royal Marsden Hospital	0	0	0	0	0	0	0	0	0	0	0
Grand Total	0	2	0	0	1	2	1	3	2	1	1





Information Source: HCAI Data Capture System and London.gov.uk
Report produced by the NHS South London Commissioning Support Unit Performance Team

A & E 4hr DTA

Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen and financial effects. It is critical that patients receive the care they need in a timely fashion, so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays, and patients who are fit to go home are discharged safely and rapidly. There is professional agreement that some patients need prolonged times in A&E. However, these exceptions are rare and unlikely to account for more than 5% of attendances. International literature suggests increases in adverse outcomes for patients who have been in the A&E for more than 4-6 hours.

Excessive total time in the A&E is linked to poor outcomes and patient delays should be minimised (but care should not be hurried or rushed). Changes in the practice of emergency medicine in some departments also means that more is being done for patients in the A&E, which may take longer but is for the benefit of the patient.

A&E performance for all types was achieved at Epsom & St Helier in quarter 4. The Trust also achieved 95% for the A&E All Types indicator over the period of the year:

A&E 4hr DTA	Mar-13	YTD
All Types		
Epsom & St. Helier	96.80%	97.35%

A number of services impact on the achievement of the indicator including the urgent care centre, the emergency department and the ambulance service.

There has been a period of sustained pressure in SWL throughout March. All Trusts have reported an increase in attendances, a rise in the acuity of patients attending and patients needing to stay in hospital longer when admitted. There has been some D&V affecting and the Trusts have also reported an increase in out of area ambulance arrivals from SECAMB (South East Coast Ambulance) particularly at Epsom & St Helier. Due to the sustained pressure in SWL a system wide approach was taken to relieve the pressure and all SWL Trusts used their escalation beds to accommodate the increase in pressure.

Ambulance handover

Ambulance handover and turnaround delays are not good for anybody – least of all patients. National policy direction on this issue is clear: long delays in handing patients over from the care of ambulance crews to that of emergency department (ED) staff are detrimental to clinical quality and patient experience, costly to the NHS, and should no longer be accepted.

The national agreement is that no patient should wait an hour or more for handover; incidents where this occur are recognised as handover breaches and treated as serious incidents.

Epsom and St Helier have had some issues in this area with consistent breaches throughout the year. The table below shows the level of 60 minute breaches that Epsom & St Helier had throughout 12/13 alongside total SWL breaches:

Ambulance Handover – 60 minute breaches	2012 YTD
SWL Trusts	485
St. Helier	66

Epsom & St Helier have been particularly affected by an increase in ambulances arriving from SECAMB (South East Coast Ambulance). This causes particular issues as SECAMB use different IT and communications systems to the LAS meaning that multiple ambulances from both organisations can arrive at the same time causing a stacking effect. The Trust has been having communications with SECAMB to address this and the CSU is meeting the SECAMB commissioners in May to work through the issues posed by the border boundaries and different ways of working.

RTT

As set out in the NHS Operating Framework for 2012/13, the operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits as set out in the NHS Constitution remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks. The referral to treatment (RTT) operational standards should be achieved in each specialty by every organisation and this will be monitored monthly.

Performance will be judged against the following waiting time standards:

• Admitted operational standard of 90% – the percentage of admitted pathways (on an adjusted basis) within 18 weeks should equal or exceed 90%

• Non-admitted operational standard of 95% – the percentage of non-admitted pathways within 18 weeks should equal or exceed 95%

• Incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92%

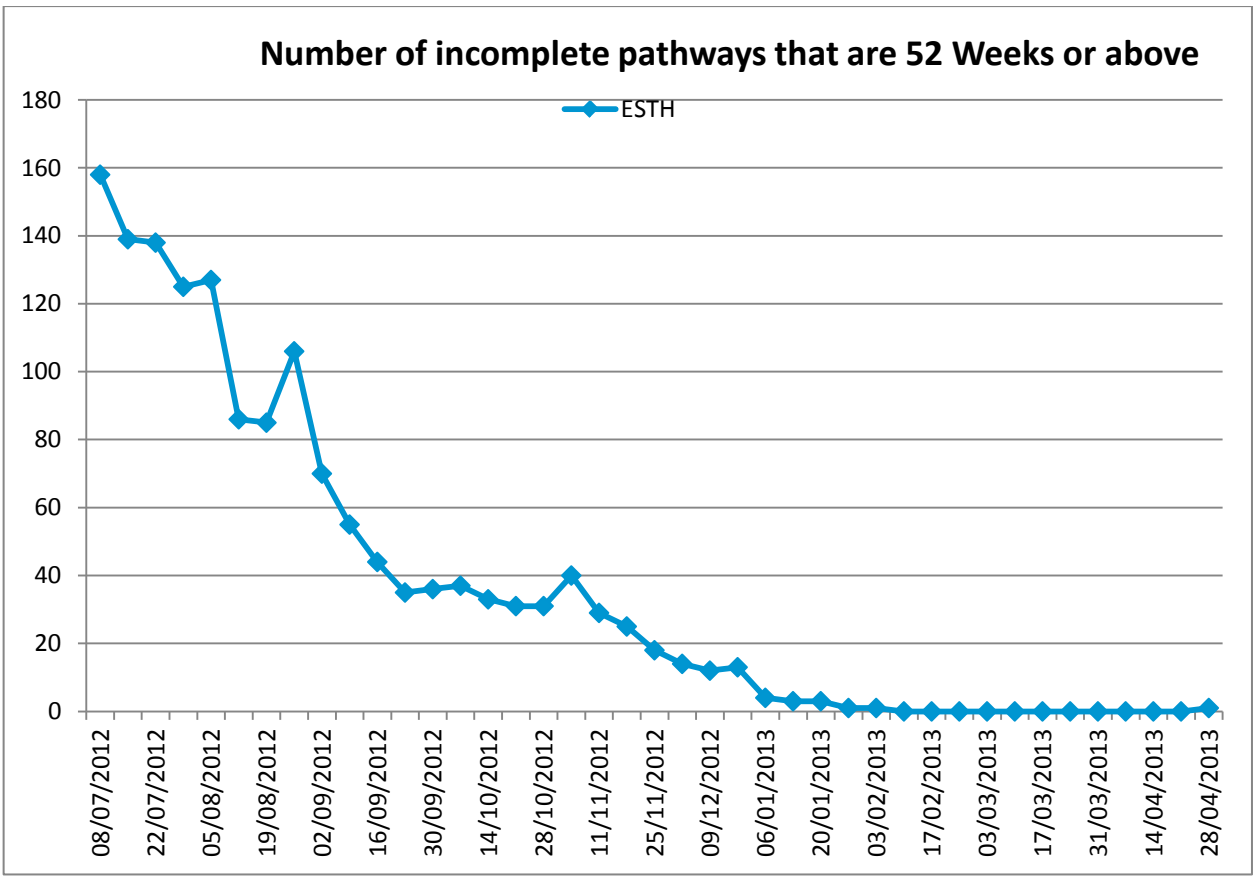
The Performance target for Sutton and Merton was achieved in March for both admitted, non admitted and incompletes shown in the table below:

RTT	Mar-13
RTT admitted patients compliant percent	91.90%
RTT non admitted patients compliant percent	97.00%
RTT incomplete pathway patients compliant percent	94.80%

Performance will be continued to be monitored through the appropriate contract meetings.

52 weeks

52 week waits have an issue at Epsom & St Helier all year although the trust has made huge progress in reducing the number from around 160 to just 3 or 4. This has been in preparation for moving to zero tolerance in 13/14. The graph below shows that Epsom & St Helier have been managing 52 week waits down to a minimal level:



The number of 52 week waits for Sutton and Merton is now down to 3 as shown in the table below:

52 weeks	Mar-13
Number of incomplete pathways that are 52 weeks or above	**3**

This is continuing to be addressed in the SLA contract meetings.

Diagnostics

The number of patients waiting 6 weeks or more for a diagnostic test (15 key tests) based on monthly diagnostics data provided by NHS and independent sector organisations and signed off by NHS commissioners as a percentage of the total number of patients waiting at the end of the period.

Performance will be judged against the following standard:

• Diagnostic operational standard of 1% – the percentage of patients waiting 6 weeks or more for a diagnostic test should be less than 1%

The table below shows that Sutton and Merton performance is well within the threshold for both February and year to date performance:

Diagnostics	Feb-13	YTD
Diagnostic tests waiting 6 weeks or more	**0.02%**	**0.14%**

Performance is Green and there are no anticipated issues for continuing to meet the target.

Mixed Sex Accommodation

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, in accordance with the definitions set out in the Professional Letter CNO/2010/3.
From April 2011, all providers of NHS funded care must routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected.

The above focus means that organisations will be held to account for managing beds and facilities to eliminate MSA. It also better facilitates commissioners' application of sanctions to NHS organisations that breach the guidance. Publication of the associated breach data means that patients and the public will be better informed about an organisation's progress in eliminating mixed sex accommodation.

MSA	Jan-13	YTD
Mixed Sex Breaches	**25**	**483**
Croydon	*9*	*107*
Kingston	*0*	*0*
Epsom & St. Helier	*2*	*143*
Royal Marsden	*0*	*0*
St. George's	*14*	*233*

MSA breaches have reduced significantly throughout the year and are now at a minimum. There were more cases over the winter period due to outbreaks of D&V where patients are cohorted together to stop spreading of the infection. There have been particular problems at Epsom & St Helier and St Georges largely due to winter pressures and critical care delayed discharges (+6hrs). At St Georges, clinical commissioners have agreed that the Trust acted in the best interest of the patients to wait for a specialty specific bed.

At St Georges, a clinical review of breaches each month will be undertaken in 13/14 and NHSE London are looking at reporting anomalies from London vs. the rest of the country.

Cancer Waits

Maintaining these standards will ensure that a cancer patient will receive timely access to treatment and move along their pathway of care at a clinically appropriate pace, thus providing better patient-centred care and improve cancer outcomes.

Cancer	Mar-13
Cancer first treatment 62 days wait: GP urgent referral	**86.7%**
Cancer first treatment 62 days wait: Screening referral	**100.0%**
Cancer first treatment 62 days wait: Consultant's upgrade	**100.0%**
Cancer first definitive treatment within 31 days of diagnosis	**100.0%**
Cancer subsequent treatment within 31 days: surgery	**100.0%**
Cancer subsequent treatment within 31 days: drug	**100.0%**
Cancer subsequent treatment within 31 days: radiotherapy	**97.4%**
All cancer two week waits	**97.4%**
Breast symptoms (cancer not initially suspected)	**92.9%**

Currently performance is being maintained above target.

VTE

VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated by a Health Committee Report in 2005 that there were around 25,000 deaths from VTE each year in hospitals in England and many these deaths were avoidable. VTE is now recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team and the Three Professions (Academy of Medical Royal Colleges, Royal College of Nursing and Royal College of Pharmacists).

Providers using the NHS Standard Acute Contract who achieve 90% against this indicator will be financially rewarded through the Commissioning for Quality and Innovation (CQUIN) payment framework in 2012/13, as in 2011/12. However the indicator is also included as a performance measure for national oversight in 2012/13 in order to ensure that all providers are improving their overall performance, even if they do not achieve the threshold required to receive a CQUIN payment.

The table below details the underperformance at Epsom & St Helier and the Royal Marsden:

VTE	Jan-13	YTD
% of adult patients admitted in the month, who were assessed for VTE on admission to hospital		
Epsom & St. Helier	***95.19%***	***93.64%***
Royal Marsden	***97.46%***	***96.80%***

Performance demonstrates that both Trusts relating to Sutton & Merton CCGs comfortably achieved the VTE performance. The focus in 13/14 will be to sustain performance and move towards hitting the 95% CQUIN target.

NHS Sutton and Merton CCG Performance Scorecard 2012-13

Freeze Date: 30-Apr-2013

	Year to Date			Jan	Feb	Mar	Year End		
	Calculation	Actual	*Target*				Forecast	*Target*	Last Year
Monthly Indicators									
PHQ03: Cancer first treatment 62 days wait: GP urgent referral	Average	90.0% G	*85.0%*	86.0% G			88.5% G	*85.0%*	89.7% G
PHQ04: Cancer first treatment 62 days wait: Screening referral	Average	97.5% G	*90.0%*	100.0% G			98.4% G	*90.0%*	97.5% G
PHQ05: Cancer first treatment 62 days wait: Consultant's upgrade	Average	84.0%		66.7%					95.2% G
PHQ06: Cancer first definitive treatment within 31 days of diagnosis	Average	99.0% G	*96.0%*	98.0% G			98.8% G	*96.0%*	98.9% G
PHQ07: Cancer subsequent treatment within 31 days: surgery	Average	97.7% G	*94.0%*	95.7% G			97.6% G	*94.0%*	98.5% G
PHQ08: Cancer subsequent treatment within 31 days: drug	Average	100.0% G	*98.0%*	100.0% G			100.0% G	*98.0%*	99.8% G
PHQ09: Cancer subsequent treatment within 31 days: radiotherapy	Average	96.8% G	*94.0%*	97.8% G			97.3% G	*94.0%*	99.1% G
PHQ15: Unplanned admissions (ambulatory care) per 100,000 population	Average	777.90		882.40	748.83				
PHQ16: Unplanned admissions (asthma etc, U19) per 100,000 population	Average	224.49		128.61	115.75				
PHQ17: Unusual emergency acute admissions per 100,000 population	Average	983.24		1,259.21	1,173.01				
PHQ19: RTT admitted patients compliant percent	Average	91.9% G	*90.0%*	91.7% G	92.4% G		92.0% G	*90.0%*	90.3% G
PHQ20: RTT non admitted patients compliant percent	Average	97.1% G	*95.0%*	97.2% G	96.7% G		97.1% G	*95.0%*	97.2% G
PHQ21: RTT incomplete pathway patients compliant percent	Average	94.2% G	*92.0%*	94.3% G	94.8% G		94.2% G	*92.0%*	
PHQ22: Diagnostic tests waiting 6 weeks or more	Average	0.14% G	*1.00%*	0.13% G	0.02% G		0.14% G	*1.00%*	
PHQ23: A and E waiting (provider)	Average							*95.0%*	
PHQ24: All cancer two week waits	Average	96.6% G	*93.0%*	96.6% G			96.8% G	*93.0%*	96.7% G
PHQ25: Breast symptoms (cancer not initially suspected)	Average	96.1% G	*93.0%*	94.9% G			95.9% G	*93.0%*	96.4% G
PHQ26: Mixed Sex breaches per 1000 episodes	Most recent								
PHQ27: MRSA	Cumulative	13 R	*10*	1 G	1 R		14 R	*10*	8 G
PHQ28: C-Difficile	Cumulative	80 G	*83*	7 G	5 G		90 R	*90*	112 R
PHS06: Non-elective FFCEs	Cumulative	32,484 A	*32,452*	2,842 R	2,439 G	2,668 G		*32,452*	31,344 G
PHS07: GP written referrals to hospital	Cumulative	93,572 R	*83,691*	8,663 R	7,821 R	7,901 A		*83,691*	85,855 G
PHS08: Other referrals for a first outpatient appointment	Cumulative	27,090 G	*28,147*	2,361 R	1,899 G	2,131 G		*28,147*	27,041 G
PHS09: First outpatient attendances following GP referral	Cumulative	74,066 R	*65,321*	6,716 R	6,361 R	6,028 G		*65,321*	68,496 G
PHS10: All first outpatient attendances	Cumulative	121,367 R	*109,917*	11,049 R	10,124 R	9,928 G		*109,917*	114,707 G
PHS11: Elective FFCEs	Cumulative	43,736 R	*40,787*	3,761 R	3,382 G	3,617 G		*40,787*	43,278 G
PHS14: Diagnostic tests, endoscopy	Cumulative	11,146 R	*9,586*	1,027 R	958 R	1,026 R		*9,586*	
PHS15: Diagnostic tests, non-endoscopy	Cumulative	99,963 R	*91,986*	9,219 R	8,324 R	9,081 G		*91,986*	
PHS16: Numbers waiting on incomplete RTT	Most recent	20,408 R	*13,887*	20,296 R	20,408 R		20,300 R	*13,887*	19,968 G
PHF07: Bookings to services where named consultant led team available	Average	62.5%		58.3%	61.0%	57.3%			66.8%
PHF08: GP Referrals to first OP appointments booked using Choose and Book	Average	22.7% R	*90.0%*	22.3% R	21.5% R	19.9% R		*90.0%*	26.8% R
PHF09: Patients treated at non NHS providers	Average	1.8%		1.9%	2.0%	2.6%			
PHF10: Electronic access to medical records									
HQU16: Emergency Readmissions within 30 days	Average	8.4%		8.5%	7.7%				8.3%
SQU04: Ambulatory care admission rate per 1,000 population (cellulites)	Average	0.03		0.02	0.01				0.04
SQU04: Ambulatory care admission rate per 1,000 population (DVT)	Average	0.01		0.01	0.00				0.01
SQU29: Emergency admissions for long term conditions	Cumulative	10,425		1,096	976				12,960

Acute Contracts

Month 12 performance based on Month 11 provider reports

MERTON	YEAR TO DATE
TRUST	ACTUAL
Epsom St Helier	36,746,748
St Georges Healthcare Trust	67,969,483
Kingston Hospitals	8,362,584
Others	37,868,762
	150,947,576

SUTTON	YEAR TO DATE
TRUST	ACTUAL
Epsom St Helier	85,572,080
St Georges Healthcare Trust	28,622,476
Kingston Hospitals	1,672,296
Others	32,370,328
	148,237,181

SUTTON & MERTON	YEAR TO DATE			FORECAST OUTTURN		
TRUST	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE
Epsom St Helier	118,485,329	122,318,828	3,833,499	118,485,329	122,318,828	3,833,499
St Georges Healthcare Trust	90,685,298	96,591,959	5,906,661	90,685,298	96,591,959	5,906,661
Kingston Hospitals	10,304,504	10,034,880	(269,624)	178,480	166,535	(11,945)
Others	68,903,286	70,239,089	1,335,803	79,029,310	80,107,434	1,078,124
	288,378,417	**299,184,757**	**10,806,340**	**288,378,417**	**299,184,757**	**10,806,340**

Notes

Methodology

Sutton and Merton report their financial position to each CCG split as follows:

Budget - this is split on a fair shares basis and is taken as the overall acute budget rather than split down by Trust

Actual Expenditure - overall contract value is split by PbR/NPbR based on the actual expenditure coming through SLAM

Values above exclude expenditure against national commissioning board and dental

For ESH, SGH and KHT the actual PbR spend by practice is taken from SUS. The difference between SUS and SLAM is then divided out pro rata by practice to their actual PbR SUS expenditure

For all the other providers the expenditure is handled in the same way but no breakdown by provider is done

For non PbR the actual expenditure as per SLAM has been split on a fair shares basis for each provider

The values above are as per appendix 1 Acute Commissioning of the PCT report excluding acute provisions, non NHS providers ESH high cost drugs and lasercare

Contractual over performance issues-

St George's Hospital

This contract continues to over perform ay £5.9m above the plan but has maintained its run rate at M11. Most of the over performance is within A&E, critical care and emergency admissions although this latter service line has some mitigation due to the fact that the activity is above the emergency threshold and is therefore only payable at 30% of tariff. Drugs and devices is another area of significant performance although some of this can be attributed to the cancer drugs fund which had not been included in the plan but for which the PCT receives additional funding.

The specialities where most of the over performance is being seen is general medicine, renal medicine, cardiology, neurology, rheumatology and T&O. Some of the specialities where under performance is being seen is obstetrics, general surgery and vascular surgery. This is consistent with previous months.

An end of year settlement has been agreed for this contract.

Actions

The multidisciplinary team responsible for SGH contracting are ensuring the principles of challenges are carried forward and adjusted in 2013/14 contract. Heads of agreement have been reached for 2012/13 for this contract.

Epsom & St Helier Hospital and Renal

This contract is over performing by £3.8m forecast from M11 to M12. Areas of over performance have continued in line with previous months i.e. Unplanned care, outpatients and planned care. A&E continues to perform above plan although this is more to do with case mix rather than volume driven when compared with the same period last year.

Main specialties where over performance is being seen is general medicine (mainly emergency), dermatology (outpatient plan set to low), neonatology and ophthalmology. This latter area has seen an increased usage of day cases although we have successfully challenged the charging of lucentus patients as a day case rather than an outpatient procedure.

An end of year settlement has been agreed for this contract.

Actions

The multidisciplinary team responsible for SGH contracting are ensuring the principles of challenges are carried forward and adjusted in 2013/14 contract. Heads of agreement have been reached for 2012/13 for this contract.

Merton Clinical Commissioning Group

Director of Commissioning Report – 7 May 2013

QIPP

Commissioning ownership

Reflecting the fact that it is the commissioning team that will project manage the QIPP schemes through implementation to delivery, QIPP has been realigned within the CCG from the finance function to the commissioning function. The QIPP manager has changed her reporting line from the CFO to the Director of Commissioning. Work has started to more clearly define expectations and roles of commissioning managers and clinical leads in the management of the QIPP schemes and this continues. The chair of the monthly QIPP meeting has transferred from a clinical lead to the Director of Commissioning.

Governance

A more formal governance arrangement for reporting the progress of the QIPP delivery has been discussed internally. It is proposed that the commissioning team, as owners of the QIPP schemes, meet on a monthly basis to report progress and agree actions as required and to summarise by exception to the more widely attended monthly QIPP meeting and the exec team. A detailed progress report is proposed to be presented to the finance committee and QIPP shall be a standing agenda item at each Governing Body meeting.

Implementation plans

PwC continue to support the CCG in the devising and delivery of QIPP schemes. At a recent session facilitated by them a standard format for a suite of scheme documents was agreed including a gant style implementation plan (devised by a commissioning team member) which allows all tasks required to deliver the scheme to be captured, capacity (at individual person level) to be calculated and facilitates easy progress reporting. These documents are now being produced for each scheme.

Investment approval

A number of schemes require investment to deliver the savings (as detailed in the project charters). Investment is currently initially approved by the exec team with a paper subsequently produced for the finance committee for final approval. All investment costs have been accounted for in the CCG budget.

Contracts

Community Services Contract

The collaboration and s75 agreements have now been produced by the solicitors in draft form and received by the CCG. These will be refined and then distributed to the relevant parties for comment and signature. It is anticipated this will be completed by end of May although this may be dependent upon the approval process within the LAs, Sutton CCG and NHS England and the scheduling of internal meetings.

Mental Health Contract

The mental health acute contract is ready for signature.

Epsom & St Helier

Merton CCG has a contract with EStH for the provision of community paediatric services which is separate to the main acute contract (for which Heads of Terms have been signed). The trust have proposed a 5.3% increase to the contract value instead of the -1.3% deflator agreed nationally. The CCG has offered this year to maintain last year's contract value and 'unbundle' the services in year (which is a more favourable financial position than the national agreement). The trust have to date rejected the commissioners offer. It may be that this contract is considered within the arbitration process set up by NHSE London.

Procurement

OOH

Decisions regarding the OOH spec, evaluation criteria and evaluation panel membership have been delegated to the OOH sub group which will meet w/c 13th May. The CCG membership will subsequently agree and approve the spec and the formal procurement process will commence early to mid June. The CCG has engaged a procurement specialist to support the process and it is his recommendation that we pursue a single-stage procurement. The contract with our existing provider of OOH services has been extended.

IAPT

The IAPT contract ceases in September 2013. It was envisaged that we would procure a single IAPT service in conjunction with Sutton CCG. However a chance conversation has revealed that Sutton CCG wish to alter the service spec to include an additional bereavement counselling service. This procurement should now be revisited to consider what services Merton CCG wish to commission and the procurement configuration that allows this to be met. Our new MH commissioning manager will progress this and work with Sutton CCG in agreeing a contract extension to the existing service.

People

Our new MH commissioning manager started on 1st May filling the final vacancy in the commissioning manager team. A substantive Director of Commissioning has been appointed and when in post the one remaining vacancy in the current structure (Head of Commissioning) will be considered.

Service Developments

Child IAPT

A multi organisation (LA, school, NHS, voluntary sector) bid has been submitted to the DH for funding to provide Child IAPT. If successful this will develop services across the Borough in Cognitive Behaviour Therapy and Parenting support at no initial or recurrent cost to the CCG.