NHS
Merton
Clinical Commissioning Group

REPORT TO MERTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Date of Meeting: 26th January 2016

Agenda No: 7.2 **Attachment:** 10

Title of Document: Quality and Performance Report (Balanced Scorecard)	**Purpose of Report:** For Review
Report Author: Angela O'Connor (SECSU)	**Lead Director:** Lynn Street, Director of Quality and Performance
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Executive Summary:

The Quality and Performance Report presents performance of the key performance indicators demonstrating progress towards the five domains outlined in Everyone Counts.

The Merton CCG Balanced Scorecard is aimed at providing a monthly update on the quality and performance information available, and reporting on actions being taken to address any performance issues with progress to date. The contents of the report are defined by the CCGs priorities, which are informed by nationally defined objectives for commissioners-the NHS Constitution and Everyone Counts Guidance 2014-15 (operating framework).

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

The report provides an update on CCG and related providers' operational performance against national and locally agreed standards. This includes 18 weeks RTT, cancer waits, A&E waits and ambulance handover times, delayed transfers of care, Improved Access to Psychological Therapies (IAPT) and Dementia. Detailed information on underachieving indicators including trends and direction of travel are included where there are measurable thresholds.

Key sections for particular note (paragraph/page), areas of concern etc:

- A/E four hour waits
- Referral to Treatment Incomplete (RTT)
- Diagnostics
- Cancer 2 week wait
- IAPT is below plan YTD
- London Ambulance services continue to breach response time standards due to on-going staff capacity

Recommendation(s):
The Governing Body is asked to review the report.

Committees which have previously discussed/agreed the report:
Clinical Quality Committee – 15 January 2016

Financial Implications:
A Quality Premium of c£1m is dependent on the CCG meeting all constitutional pledges and improving the quality of health for local people**.** Failure to achieve a local priority reduces the maximum award by 12.5%.

Implications for CCG Governing Body:
The Governing Body should be assured that mechanisms are in place to identify areas of concern and ensure that appropriate mitigating actions are put in place to address Quality and Performance issues.

How has the Patient voice been considered in development of this paper:
Performance indicators are based on the five domains outline in “Everyone Counts.”

Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing)
Relates to Risk register number 802:
Failure to deliver 'constitutional pledges' and other priority performance goals (4 x 3 = 12)

Equality Assessment:
Not completed for this report.

Information Privacy Issues:
In year proxy measures and unplanned hospitalisation data is derived from unpublished sources and subject to data quality issues.

Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution)
The paper will be available to the public as part of Governing Body papers.

NHS
Merton
Clinical Commissioning Group

Balanced Scorecard

Month 7

Angela O'Connor and MDT team
Quality and Performance
report – Month 7

right care
right place
right time
right outcome

Executive Summary

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1. Improving the Health of our Local Population

Indicator	2014-15 Outturn	2014-15 YTD	Target 2015-16	Quarter 1			Quarter 2			Quarter 3	2015-16 YTD	Quarter	
				Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15		Quarter 1	Quarter 2
Reducing Emergency avoidable admissions	3108	1665	4 year trend	252	222	246	265	216	227	293	1723	720	708
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1032	556	4 year trend	74	76	92	82	76	81	106	587	242	239
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	129	55	4 year trend	7	2	5	7	5	6	12	44	14	18
Emergency admissions for acute conditions that should not usually require hospital admission	1789	1003	4 year trend	164	136	139	169	133	133	160	1034	439	435
Emergency admissions for children with lower respiratory tract infections (LRTI)	158	51	4 year trend	7	8	10	7	2	9	15	58	25	18
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	22.3%	23.1%	22.75%	21.5%	23.8%	22.9%	21.6%	22.3%	21.8%	22.1%	18.9%	22.9%	21.9%
A reduction in the number of antibiotics prescribed in Primary Care	1.068	1.227	1.046	1.063	1.054	1.046	1.036	1.025	1.013	1.002	1.013	1.046	1.013
Reduction in the proportion of broad spectrum antibiotics prescribed in Primary Care	13.9%	14.4%	13.06%	13.8%	13.80%	13.70%	13.6%	13.4%	13.2%	12.95%	13.20%	13.7%	13.1%
Secondary Care providers validating their total antibiotic prescription data	NA	NA	NA	G	G	G	G	G	G	G	G	G	G
Electronic Prescribing System	34%	NA	51%	31%	34%	33%	35%	31%	33%	37%	33%	33%	33%
Increasing number of people diagnosed with type 2 diabetes accessing structured education	302	140	332	38	14	20	30	31	35	40	208	72	96
Improve diagnosis rate diabetes	NA	5.85%	5.86%	5.89%			5.95%			Q3 data due in Feb	5.95%	5.89%	5.95%
Snapshot of number of people delayed on the last Thursday of the Month (beds blocked)	84	12	7	12	17	10	11	9	15	18	92	39	35
Total number of delayed Transfer of Care days due to both NHS and Social care	36	0	3	0	6	10	33	12	0	12	73	16	45
Total number of delayed Transfer of Care days due to NHS	1613	325	134	259	187	212	198	226	227	330	1639	658	651
Total number of delayed Transfer of Care days due to Social care	307	11	26	145	101	89	58	42	129	187	751	335	229
Dementia - Estimated Diagnoses Rate (65+)	72.1%	49.6%	67.0%	68.1%	67.8%	66.8%	66.9%	75.5%	75.80%	76%	75.8%	67.6%	72.20%
IAPT Access	16%	3.36%	15%	2.7%			2.80%			Q3 data due in Feb	2.7%	2.7%	2.80%
IAPT Recovery Rate	38.9%	38.5%	50%	40.1%			35%			Q3 data due in Feb	40%	40%	35%
IAPT - 6 week wait	95% *	100%	75%	93.6%	96.4%	95.3%	93.0%	96%	92.6%	42.1%	92.6%	95.1%	94.0%
IAPT- 18 week wait	100%*	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%

Improving the health of our local population

Indicator	Status	Actions
MRSA	No cases of MRSA identified in October.	None Identified
Potential Years of life Lost	This is a long term product of the overall commissioning agenda. And difficult to monitor in-year progress.	Public health have completed a review regarding the major causes of premature mortality. This needs to be considered as part of the 2016/17 commissioning intensions.
Reducing Emergency avoidable admissions	Overall composition position is 58 worse than last year.	• Support from GPs is essential to achieve this measure. This includes: • Referral to CPAT for avoidable admissions – current main contributor being UTIs • MDT case management and referral to HARI for patients with complex needs • Referral to falls prevention
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	CCG is currently 0.68% (22.07%)below target (22.75%)	• To liaise with membership and identify gaps in current commissioned services that facilitate weekend discharges.
Reduction number of people with severe MH illness who are currently smokers	• Baseline and monitoring mechanism to be established • Additional resource will be required for the initiation phase	• Mechanism identified and piloted with one GP practice to collect baseline from EMIS. • Escalated resource requirements to support the initiation phase to Director of Finance and Director of Commissioning and planning.
A reduction in the number of antibiotics prescribed in Primary Care	Scheme is rated as Green and performance data indicates target is currently being achieved	• GP Practices support is essential to maintain current performance and drive improvement.
Reduction in the proportion of broad spectrum antibiotics prescribed in Primary Care	Scheme is rated as Green. This is because although the CCG is currently above target, the trajectory is on track	• GP Practices support is essential to maintain current performance and drive improvement

Improving the health of our local population

Indicator	Status	Actions
Secondary Care providers validating their total antibiotic prescription data	Scheme is rated as Green.	▪ Both SGH & ESH completed as pilots ▪ St Georges & Epsom St Helier have both confirmed that they have validated their data
Electronic Prescribing System	This is rated as Red and data issues have been clarified with the HSCIC.	▪ Merton CCG have been visiting practices with high utilisations rates and sharing their knowledge and good practice with low utilisation rate practices ▪ More practice visits will begin in the New Year, once arrangements can be made
Increasing number of people diagnosed with type 2 diabetes accessing structured education	August data shows the scheme has met the target (30) however, YTD performance shows that the scheme is above trajectory.	1. Patients who are referred to structured education; • Understand the reason for the referral • Understand the benefits of the service to their health • Are encouraged to respond to the invite letter 2.To support practice visits by the project manager who will advise practices regarding local processes required to deliver this QP.
Snapshot of number of people delayed on the last Thursday of the Month (beds blocked)	Rated red due to delayed discharges of Care at South West London and St George's MH Trust	• CHC discharge process for complex patients has been reviewed and streamlined at Kingston and St Georges • MH commissioner is meeting with the SWL and St George's MH Trust on a weekly basis • St George's Hospital is developing a new software package that will be updated on daily basis with discharge related information for individual patients. This will improve data quality and Local intelligence about DTOCs
Total number of delayed Transfer of Care days due to both NHS and Social care	The majority of delayed bed days are attributable to Health, for both CCG and NHS England commissioned services.	

Performance Overview

Access	Threshold	Previous Month	Month 7
18 Week RTT - Admitted Pathways	90%	81.00%	NA
18 Week RTT - Non- Admitted Pathways	95%	92.20%	90.20%
18 Week RTT - Incomplete Pathways	92%	90.40%	91.2%
RTT 52 weeks Waiters -admitted patients	0	0	NA
RTT 52 weeks Waiters- Non admitted patients)	0	0	0
RTT 52 weeks - Incomplete pathways	0	0	1
6 Weeks Diagnostics waiting	99%	98.80%	99.4%

Cancer waits	Threshold	Previous Month	Month 7
2 week of an urgent referral	93%	81.0%	87.4%
Breast symptoms two weeks	93%	87.8%	93.0%
Cancer first definitive treatment 31 days	96%	100.0%	96.1%
Cancer subsequent treatment 31 days, surgery	94%	100.0%	100%
Cancer subsequent treatment 31 days, drug	98%	100.0%	100%
Cancer subsequent treatment 31 days, radiotherapy	94%	92.3%	100%
Cancer composite, 62 days first treament plus rare cancers	85%	89.7%	89.7%
Cancer first treatment 62 days, Screening	90%	75.0%	100%
Cancer first treatment 62 days, Consultant upgrade	85%	--	--

A&E / Out of Hospital Services	Threshold	Previous Month	Month 7
A&E Waiting Times	95%	92.1%	92.8%
Ambulance Red 1 8 minute response	75%	62.2%	70.1%
Ambulance Red 2 8 minute response	75%	62.1%	64.8%
Ambulance Red 19 minute transportation	95%	92.2%	92.9%

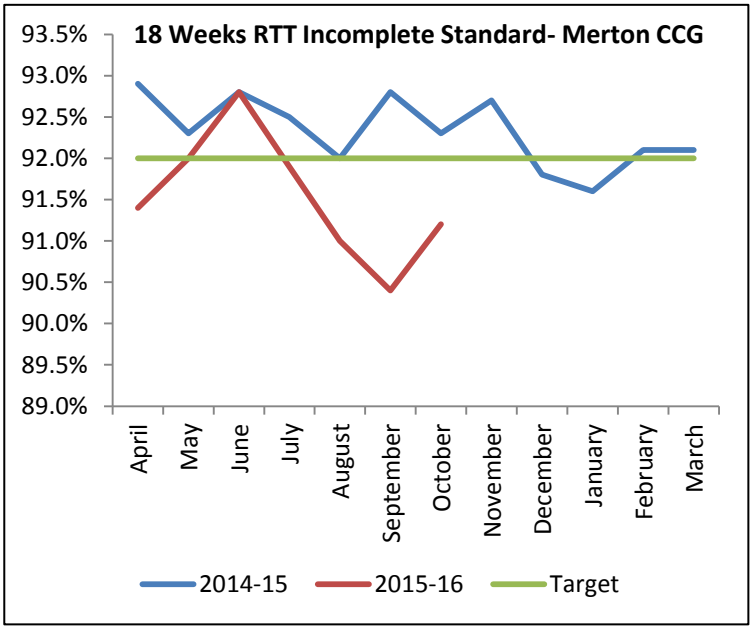
Performance Overview

Quality Premium / Community Services	Target	Previous Month	Month 7
Reducing Emergency avoidable admissions	4 year trend	227	293
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	4 year trend	81	106
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	4 year trend	4	12
Emergency admissions for acute conditions that should not usually require hospital admission	4 year trend	133	160
Emergency admissions for children with lower respiratory tract infections (LRTI)	4 year trend	9	15
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	0.5% increase	21.80%	22.1%
A reduction in the number of antibiotics prescribed in Primary Care	1.046	1.014	1.002
Reduction in the proportion of broad spectrum antibiotics prescribed in Primary Care	13.06%	13.17%	12.95%
Secondary Care providers validating their total antibiotic prescription data	NA	G	G
Electronic Prescribing System	51%	41%	37%
Increasing number of people diagnosed with type 2 diabetes accessing structured education	28	35	40
Improve diagnosis rate diabetes (Q1)	5.86%	5.94% (Q2)	Q3 data Due in Feb
Dementia - Estimated Diagnoses Rate (65+)	67.0%	75.80%	76.0%

Mental Health	Target	Previous Month	Month 7
IAPT Access	3.75%	2.8% (Q2)	Q3 data Due in Feb
IAPT Recovery Rate	50.0%	35% (Q2)	Q3 data Due in Feb
IAPT - 6 week wait	75%	92.6%	42.1%
IAPT- 18 week wait	95%	100%	100%
Snapshot of number of people delayed on the last Thursday of the Month (beds blocked)	7	15	18
Total number of delayed Transfer of Care days due to both NHS and Social care	3	0	12
Total number of delayed Transfer of Care days due to NHS	134	227	330
Total number of delayed Transfer of Care days due to Social care	26	129	187

Other Measures	Target	Previous Month	Month 7
Mixed sex accommodation breaches	0	0	1
Number of C.Difficile infections	3	2	4
MRSA (PIR Assigned)	0	0	0

RTT 18 weeks



Root Causes:

- Merton CCG failed to meet the RTT Incomplete standard in M7 with the performance at 91.2%.
- The target was not met due to underperformance at St George's Hospital who achieved a 90.2%
- Poor performance in general surgery, T&O, ENT, gastro and gynaecology had the biggest impact on Merton's performance.
- St George's backlog is 1.54 times weekly activity, as apposed to NHSE's target of 0.75 times weekly activity. The trust needs to reduce its backlog by 2000 cases to achieve the NHSE target.

Mitigating Actions:

Merton:

- Ongoing work with GPs and St George's to ensure the Nelson capacity is fully utilised.

St George's:

- A key focus at St George's has been the validation of waiting lists and getting a clean PTL.
- The November submission will be a clean backlog position.
- In addition to validation, the Trust has plan to improve front end training to reduce the need for future validation.
- The clean PTL will allow commissioners to understand the scale of the RTT problem at St George's and set a clear plan for recovery.
- The trust will be using IS providers to reduce the backlog where possible.
- New COO has improved the escalation and monitoring of RTT performance at specialty level to increase the grip in the trust.

Assurances:

St George's:

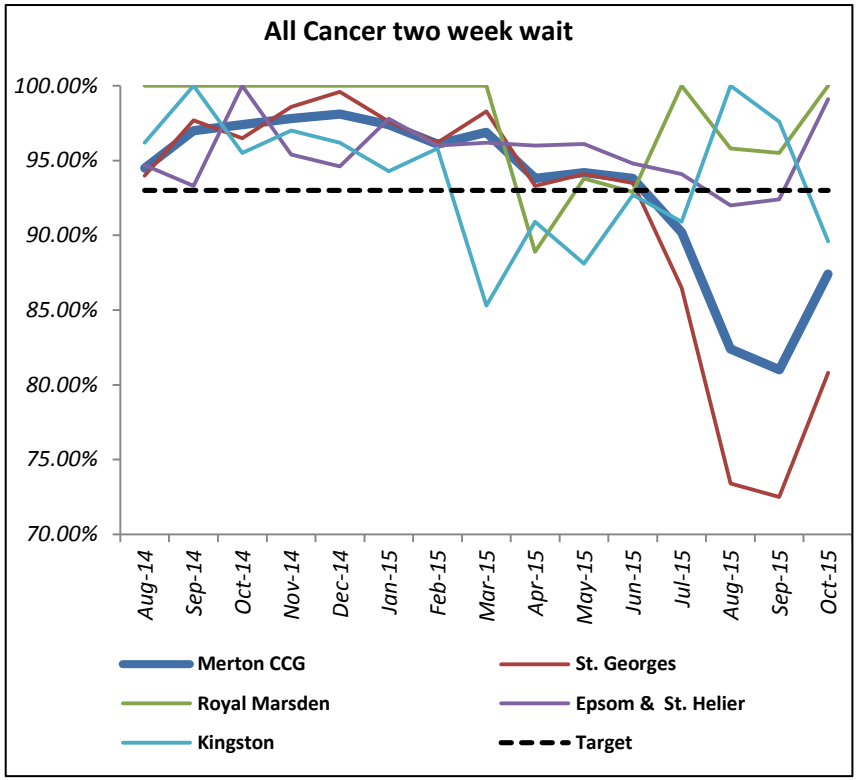
- IST review of RTT at St George's due to deliver in early January
- IST supporting trust with rewriting their access policy.
- Improved escalation process within the trust will ensure earlier identification of growing backlogs and lack of capacity.

Gap In Assurance:

St George's:

- Trajectory still to be agreed for achieving sustainable performance.
- Plan to achieve 0.75 weeks backlog by 31st March still to be agreed.

Cancer 2 week wait



Root Causes:
The CCG did not meet the standard with a performance of 87.4% in month 7.
This was due to 53 breaches from 422 Patient Pathways. 1 breach was at ESTH which was attributed to Patient choice; 5 breaches at KHFT and 3 of these were due to patient choice, 1 administrative and 1 capacity issues; 46 breaches at SGH and 2 were administrative breaches, 34 breaches were due to capacity and the remaining 10 were due to Patient choice.

Capacity and staff leave been the main drivers of performance pressures at St George's, with skin, gynae and upper GI being the worst performing areas.

Mitigating Actions:

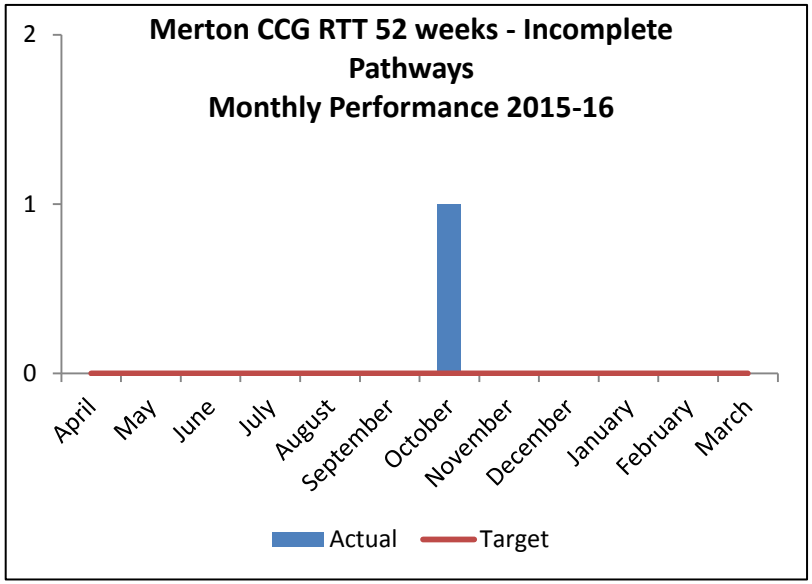
Contract Query Notice Issued by Wandsworth CCG Sept 2015
Remedial Action Plans to produced for the 2WW an 62 Day Standards by COP Friday 8th January.
New Interim COO leading on delivery of Cancer Action Plans
Weekly face-to- face meeting instigated with the Trust.

Recovery plans focus on improving capacity, improving PTL management and moving to seeing patients within 7 days.

Assurances:
Recovery plan being managed as part of the contract query and contract levels will be utilised as required.
Weekly performance meeting to review progress with agreeing the plan and performance. Mitigations will be agreed at these meetings as required.

Gaps in Assurances:
Commissioners are due to agree a recovery plan and trajectory by COP Friday 8th January.

RTT 52 weeks Incomplete Pathways



Root causes:

- Merton CCG had 1 52 week wait in October which attributed to general surgery at St. George's.
- SGH had 4 52 week wait, 3 in gynaecology and 1 in general surgery.

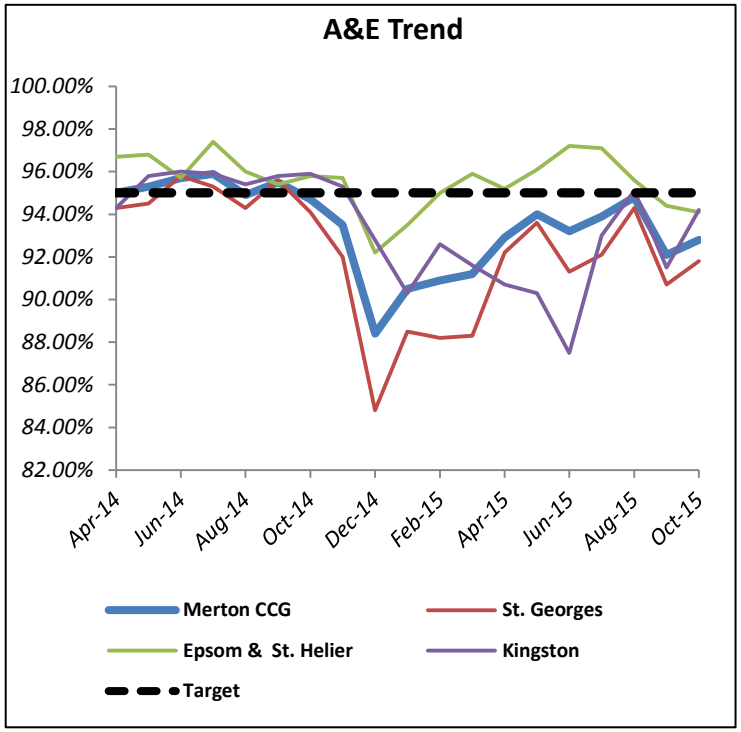
Mitigating Actions:
None identified

Assurances:

- 2 of the gynaecology patients have been booked for treatment in November and the 3rd has been booked in for December.
- The general surgery patient had an 8 week delay due to patient choice and was also delayed due to capacity constraints.

Gaps in Assurances:
None Identified

A&E Waiting Time



Root Causes:

- Merton CCG did not meet the A&E target in October with a performance of 92.8%.
- St. George's did not meet the target with a performance of 91.9% although this represented an improvement of just over 1% on the figure reported in September. The provisional and un-validated position for November shows a drop to 89.1%.
- Bed pressures and specialists waits were main reasons given for the month's figures, although surges in attendance were also reported an issue along with discharges occurring late in the day.
- Epsom & St.Helier did not meet the target with a performance of 94.2% trust wide.
- Un-validated November performance was 94.41%.
- The primary reason for the breach was cited as being bed capacity, with admissions frequently outweighing discharges.

Mitigation Action:

St George's

- Daily calls continued between the Trusts, the CCG and the CSU to discuss the previous days performance and any assistance/ escalation the trusts requires to resolve any issues they are experiencing.

Epsom & St Helier

- The Trust and SRG has now started their winter resilience scheme, including increased staffing at St Helier and a new SWOOP team.
- As Part of Winter Surge Management, the CSU and SRG have initiated daily conference calls with the trust to review pressures and initiate escalation actions.

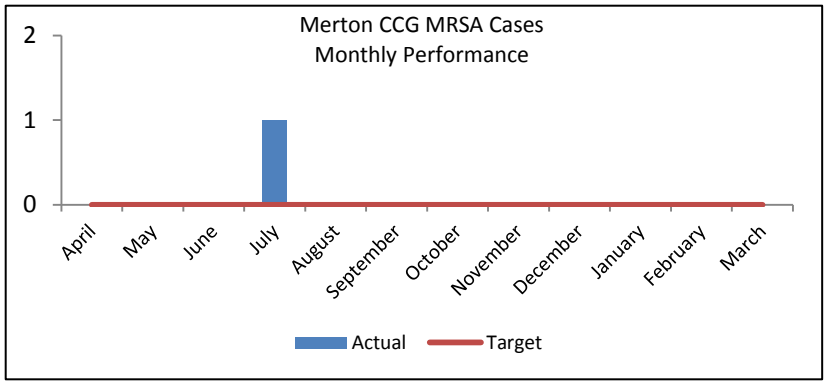
Assurances

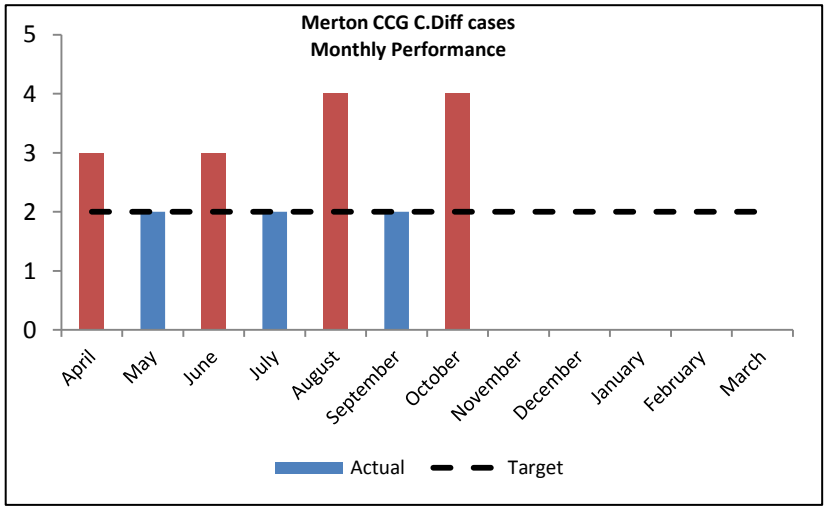
The McKinsey work is due to be complete at the end of December and it will include an action plan with short term, medium term and long term actions.

Gaps in assurances

None Identified

Healthcare Associated Infection





Root causes:
Merton CCG had a further 4 cases of Clostridum Difficile infection in October, taking the YTD total to 20 cases.

Mitigating Actions:
There is robust infection control, management and scrutiny undertaken by Merton CCG Infection Control Lead.

Assurances:

The Infection Control Lead regularly apprises the Director of Quality and Performance of Infection control issues and/or concerns. HCAI's reported but unvalidated are discussed at the weekly Executive Leadership Team.

Gaps in Assurances:

London Ambulance Service

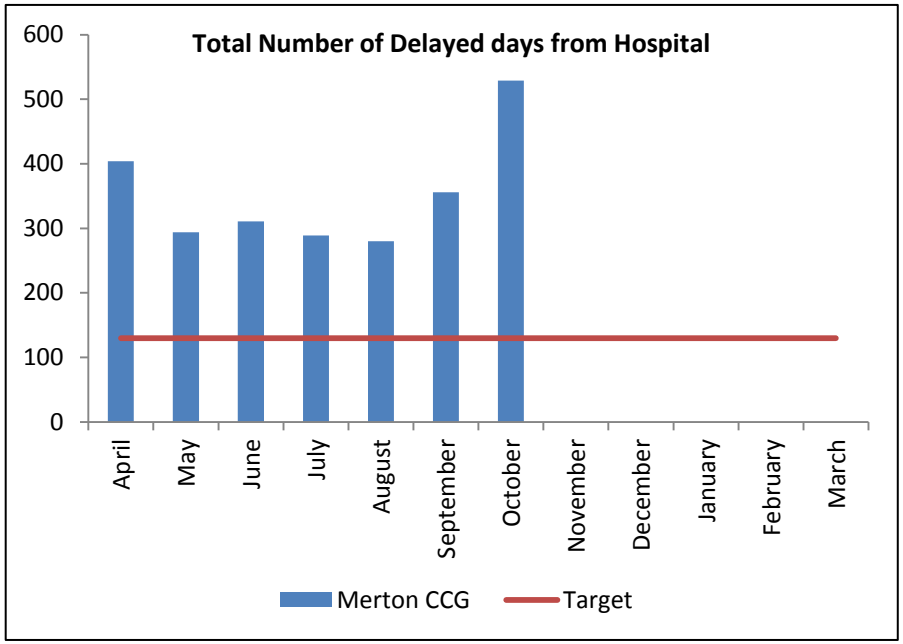
A&E / Out of Hospital Services	Threshold	Month 7	YTD
Ambulance Red 1 8 minute response	75%	70.1%	67.0%
Ambulance Red 2 8 minute response	75%	64.8%	65.0%
Ambulance Red 19 minute transportation	95%	92.9%	93.4%

Root causes:
The Trust has been performing poorly on response times since March 2014. The service had a high number of frontline vacancies; with paramedic levels under established levels, a long hours culture and accusations of bullying and harassment. November was the 3rd busiest month for Cat A incidents in LAS history. Ambulance utilisation rates high , meaning LAS are unable to cope with surges in demand in the system

Assurances:
Monitored every week at Executive Leadership team.

Mitigating Actions:
London Ambulance Service NHS Trust (LAS) has been placed into the special measures regime in response to a recommendation from the Care Quality Commission (CQC) following an inspection in June 2015. As part of this move, the NHS TDA has already put in place a wide ranging package to support LAS to deliver rapid improvements to Londoners, including:
The appointment of an experienced NHS operator as Improvement Director, Lesley Stephen, to support the Trust to put in place improvements.
A relationship with the Defence Medical Services (DMS) to provide leadership training and development to senior and middle management focused on improving the working practices within LAS
Dedicated resource from the Association of Ambulance Chief Executives to provide additional specialist expertise, with a particular focus on supporting improvements in operational performance within LAS and sharing best practices across ambulance services
Helping the Trust to identify and appoint an interim HR Director
Supporting the Trust to put in place specialist organisational development support and a specialist bullying and harassment advisor to support them to improve culture within the organisation
Deploying senior staff from within the NHS TDA in the areas of workforce, quality improvement and medicines management, to further enhance the expertise available to the Trust

Delayed Transfers of Care (DTOC)



Root causes:
Month 7 data shows the number of delayed days has increased in October compared to August. Figures show that DTOC has increased by 173 days. The significant increase occurred in Further Non Acute NHS.

Assurances:
CCG monthly performance meetings with CHC team

Mitigating Actions:

- CHC discharge process for complex patients has been reviewed and streamlined at Kingston and St Georges
- MH commissioner is meeting with the SWL and St George's MH Trust on a weekly basis
- St George's Hospital is developing a new software package that will be updated on daily basis with discharge related information for individual patients. This will improve data quality and Local intelligence about DTOCs.

Gaps in Assurances:
None Identified

IAPT service update

The trajectory versus actuals for Entry into Treatment, as a cumulative measure is:

	Trajectory	Actual	Variance
Total	265	196	-69

The trajectory versus actuals for Entry into Treatment, as a weekly measure is:

	Trajectory	Actual	Variance
Total	38	21	-27
Step 2	18	10	-8
Step 3	20	1	-19

The trajectory versus actual for Movement to Recovery, as a monthly measure is:

	October	November	December	January	February	March
Trajectory		30%	35%	40%	45%	50%
Actual	18%	38%				
Variance		+8%				

Root causes:

- The variance gap is currently increasing. New staff are starting on 4th January who after 2 weeks training, which will increase treatment capacity. In addition an 'in-principle' agreement with Wimbledon Guild to second some staff in to further increase capacity.
- The data on numbers entering treatment at Step 2 since 23rdThe data on numbers entering treatment at Step 2 since 23rd November shows a fluctuating curve and with some weeks above trajectory and some below. In order to create trajectories at Step 3, an average length of treatment has to be predicted. Within Step 3 the length of treatment is variable both for clinical and contractual reasons. The data is now revealing
- Improvements in recovery rates are expected in line with increased activity as additional resource comes on line. December and January trajectories have been maintained at 35% & 40% respectively, to allow for the seasonal effect of the Christmas and New Year period.

Mitigating Actions:

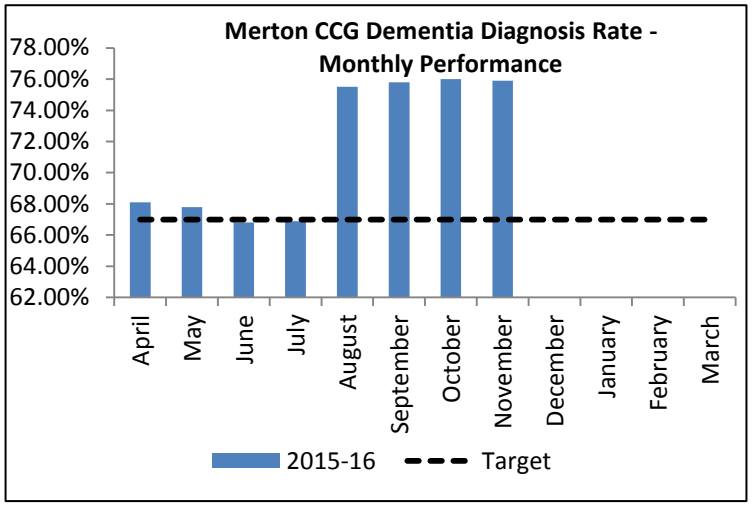
- The activity for Christmas period was always expected to be low, but this was further reduced to a number of patients not accepting appointments during this period.
- Formal contracting monitoring meeting with the provider next week, where progress to date will be reviewed and further mitigations will be considered. If assurance isn't provided that the trajectories cant be delivered, it is likely that senior management will become

Assurances:

- The CCG receive a weekly update and monitor performance at the OGD

Gaps in Assurance:
None detailed

Dementia



April – July data

• The Primary Care Web Tool has not published dementia diagnosis rate data during FY15-16.

• The diagnosis rate figures presented have been calculated using:

1. The number of registered patients diagnosed with dementia from QMS.
2. The latest estimated prevalence of dementia from the Primary Care Web Tool (from March 15).

August – September data

• NHS England is moving to a more accurate method of estimating local dementia prevalence, based on the MRC Cognitive Function and Aging Study (CFAS).

• NHS England has published figures for August, September and October (established bearing in mind the new method). The figures are for the 65+ cohort.

Root Causes

Dementia Diagnosis Rate

• The increase in the CCG's diagnosis rate has been the result of targeted work that has been undertaken, and is also (during 15-16) due to a change in the methodology to determine the CCG's expected prevalence of dementia (this resulted in all CCGs seeing an increase in their diagnosis rates as the new methodology indicates that the expected prevalence for dementia is lower than what was originally calculated).

• To date in FY15-16 targeted work on the CCG's dementia diagnosis rate has not been undertaken, and the focus has been on other areas. In terms of the diagnosis rate, the aim will be to maintain the position, and later in the year, some work may take place in order target the variation that exists across Merton practices.

Impact on Memory Assessment Service

• Suboptimal waiting time performance is likely to continue until the end of the financial year. Additional funding will be released from April 16 to deliver a new enhanced MAS model and it is anticipated that steady improvements in waiting time performance should be seen from this point.

Mitigating Actions:

Note: The commentary relates to the impact on the MAS, rather than the diagnosis rate position itself.

Work is underway with regard to the introduction of a dedicated MAS. It is recognised that the MAS is an area of provision which requires increased capacity and does not at present align with best practice standards (for example those of the Memory Services National Accreditation Programme). As such it is a priority for redesign. A draft pathway reflecting the desired service delivery model has been developed and the required staffing composition has been established. Benefits that should be seen include shorter waiting times for the Memory Assessment Service, consistent incorporation of collaborative care planning discussions in the service pathway and a greater focus on supporting people to live well and independently in the community. An investment proposal for this service development was submitted to EMT in September and was approved. However, as a result of the current financial position, it was not considered to be viable to release any funding during the current financial year, and so funding will be released from April 16. The CCG is in contact with operational leads at the Trust and the position is being monitored in real time. Internally, this matter is being reviewed at the Out of Hospital Working Group.

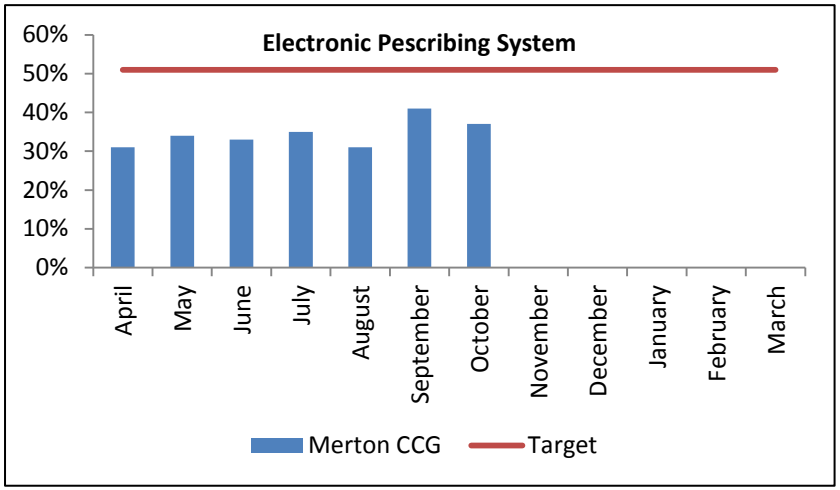
Assurance

MCCG has experienced an upward trajectory in terms of its diagnosis rate and is exceeding the national target. The focussed work relating to dementia has led to pressure on the Memory Assessment Service (MAS) which has had an impact on waiting times.

Gaps in Assurances

Real time monitoring will ensure that, should any service delivery issues arise, they can be addressed in a timely manner.

Electronic Prescribing System



Root Cause:
GP practices in Merton CCG are not utilising EPS to it's fullest potential, and are currently one of the lowest users of EPS in London.
NHS England have set a nationwide CCG target of 51% utilisation to be achieved by Dec 2015. The current national average stands at 43% in October 2015. December's EPS usage data will not be reported by HSCIC until March 2016

Mitigating Actions:
Since the initial launch of EPS, practices signing up patients has dropped considerably. Practices with low utilisation rates have staff and GPs not 'fully engaged' with the EPS process. Merton CCG have been visiting these practices to share good working practice and encourage higher utilisation.
Community pharmacies have been encouraged to revamp their EPS service by asking their patients to sign up, if not using EPS already.

Assurance:
Merton CCG have been visiting practices with high utilisation rates and sharing their knowledge and good practice with low utilisation rate practices. Merton currently stands at 37% as of October 2015, a slight decrease from a CCG high of 41% in September. More practice visits will begin in the New Year, once arrangements can be made.
This project will help practices familiarise themselves with the EPS process once more, and encourage both staff and GPs to engage with patients to use EPS

Gaps in Assurance:
GP practices with no local community pharmacy nearby, tend to have lower utilisation rates, than practices with 'bolt on' or 'next door' pharmacies. GP admin staff not fully engaged and need re training, and better links with community pharmacy in addressing, as one tends to blame the other if an EPS prescription goes missing in the system, leaving the patient stuck in the middle. One GP practice is currently 'not live' with EPS, one practice undergoing retraining via EMIS and will be ready to use EPS in March 2016