“Right care, right place, right time, right outcome – year 2”

Merton CCG 2015/2016 Operating Plan Refresh

All enquiries to Lucy Lewis, PA to Director of Commissioning and Planning

18 May 2015

Refresh version 2.4

Foreword

This is the first refresh of NHS Merton Clinical Commissioning Group's Two-year Operating Plan and continues to signal the direction of travel for service improvement. This refreshed Operating Plan takes into account changes in national and local policy and will be used to notify all relevant stakeholders and service providers of the priorities for 2015/16. It makes particular reference to our plans to respond the NHS Five-year Forward View and London Health Commission whilst responding to our identified local needs.

The Operating Plan will be delivered by the CCG in partnership with the local authority & public health (London Borough of Merton), with support from the South East Commissioning Support Unit (SECSU) and the voluntary sector.
Merton CCG has worked through the commissioning cycle with our patients, clinicians and members to identify the emerging priorities for 2015/16 based on the Joint Strategic Needs Assessment and other intelligence. Our key delivery areas continue to be:

- Older and Vulnerable Adults (including Integration)
- Mental Health
- Children and Maternity Services
- Keeping Healthy and Well
- Early Detection and Management
- Urgent Care

As part of our refreshed plans we have added another two delivery areas, Transforming Primary Care (TPC) and Medicines Management and are excited to inform all stakeholders of our plans for next year. Our refreshed Operating Plan describes further the priorities and actions we will deliver during 2015/2016 and outlines the platform for delivery of continuous commissioning improvement in subsequent years. This continues to be an iterative document subject to active review as national and local policy emerges.

We look forward to working with our population and colleagues across the health and social care economy to continue to deliver high quality care.

Signed

Dr Andrew Murray
Clinical Chair

Eleanor Brown
Chief Officer

1. Context

1.1 About Us

NHS Merton Clinical Commissioning Group (MCCG) is a GP-led membership organisation responsible for planning, buying (commissioning) and monitoring local health services. We serve a population of over 210,000 people in Merton.

We took over this responsibility on 1 April 2013 as a result of Government reforms, which created Clinical Commissioning Groups replacing Primary Care Trusts. At the same time, NHS England took responsibility for the commissioning of primary care services such as GPs, dentists, community pharmacists and optometrists. Merton Council is now responsible for public health.

Our group of 25 GP practices work in partnership with the local NHS – hospitals, community services, mental health services, pharmacists and dentists, Merton Council and our local community to improve health and well-being, reduce health inequalities and ensure people in Merton have equal access to high quality healthcare services.

1.2 Aims and Ambition

Since authorisation, Merton CCG has worked to ensure we deliver the right care, right place, right time, right outcome. Our out-of-hospital plan is built on having two hubs of planned care within Merton that enable Merton residents to have access to a local high quality and cost effective diagnostic and treatment service.

We are working to ensure that in an emergency we have responsive community-based services that are able to ensure a person's needs are catered for at home where possible.

2. Local and National Priorities

Merton CCG has to respond to a number of key changes and requirements at a national level but it is still important that the local feel to clinical leadership and service delivery is maintained. This section explains the local, regional and national drivers that shape the CCG's business.

2.1 Clinical Leadership

We now have a fully established team of Governing Body, Locality and Clinical Director level clinicians who help to ensure that the clinical voice from the membership is heard.

Every strategic and operational project is clinically led and has robust leadership and management. Throughout 2015/16 we plan to develop further clinical leadership throughout the organisation, to ensure we are equipping these key individuals with all the skills they need for their role.

2.2 Health and Well-being

We are key members of the Merton Health and Well-being Board (HWBB) and are currently working with members of the Board to ensure that there are focused outcomes for the following areas:

- best start in life – early years and achieving a strong educational base for children and young people;
- good health – preventing illness, ensuring early detection of illness and accessing good quality care;
- good life skill, lifelong learning and good work;
- community participation and feeling safe;
- a good built and natural environment.

Working jointly with our colleagues in public health, we will be focusing on the following preventative areas:

- prevention is embedded into local public policy to make health everyone's business and ensure that influences on health make a positive impact;
- healthy settings, such as work places and schools that enable individuals to make healthy choices, are promoted and supported;
- every contact is made to count, embedding prevention of ill health into the day-to-day role of front line staff;
- the number of adults making healthy life choices is increased, including taking up clinical prevention services;
- health services are developed to meet the needs of residents of East Merton;
- Better Care Fund – with a focus on elements that have potential to address health inequalities;
- mental health – ensures access to timely assessment, diagnosis, treatment and long term support for both mental and physical health;
- East Merton Model of Care – focus on early detection and long-term conditions.

Merton CCG is working closely with public health colleagues to ensure that, within our published health and well-being strategy, there is a focus on behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity. It is also expected that we publish our local ambition for personal health budgets (PHB). This is currently being reviewed and will be signed off by the Health and Well-being Board in due course.

2.3 Merton Better Healthcare Closer to Home

2014/15 Achievements

Merton Better Healthcare Closer to Home (MBHCH) is a transformational programme that aims to deliver a step change in the delivery of out–of-hospital care for the residents of Merton.

The programme has six key delivery objectives:

- improving outcomes for patients;
- providing more care locally;
- tackling health inequalities;
- meeting changing demographics and healthcare needs;
- modernising the estate; and
- using resources more effectively.

The MBHCH programme aims to commission modern, integrated and accessible health services designed around the needs of the patient. The services delivered will reflect the latest evidence on high quality care, and care pathways are being designed to deliver the best possible outcomes for patients.

To facilitate this delivery the CCG has sponsored the development of two new modern health care facilities, the Nelson Health Centre in West Merton and an equivalent development in East Merton, on the Wilson Hospital site. These new facilities will house a range of primary, community and acute care services that provide a real alternative to services delivered in a hospital setting.

The completion of the construction and the handover of the Nelson Health Centre in January 2015 realised a major milestone in the delivery of the MBHCH programme. This new, modern health care facility will play a major part in bringing care closer to home and providing the opportunity for the integration of services to deliver improved outcomes and an improved patient experience.

The delivery of the Nelson Health Centre has been a prime illustration of the benefits of partnership working, delivering a high quality building, on time and within budget.

During the year we have also carried out a competitive procurement exercise to appoint the acute provider to deliver services from the new Nelson facility. This was a robust process involving our clinicians, commissioning managers and members of the public. Through the application of focused evaluation criteria we ensured that the preferred partner placed core values of quality, integration and access at the heart of their proposed service delivery.

We are currently in the process of developing a new model of care for East Merton, working with the HWBB to ensure that the health care needs of the most deprived areas within the borough are taken into account. Working with our clinicians and the public this work will conclude in 2015/16 and will inform the service strategy for the new health care facility in East Merton.

The project in East Merton is in the second stage of development. Following an economic appraisal a site has now been selected for the development of the new health care facility. The option appraisal was an inclusive process involving CCG clinicians and members of the public. An open event was held for the public to seek their views and an online survey was made available on the CCG website for those unable to attend. The preferred location is the current Wilson Hospital site.

2015/16 Plans

The Nelson Health Centre

The Nelson Health Centre is due to open to the public on 1 April 2015 and the MCCG project team will be working closely with all the providers to ensure that there is a smooth transition into the new building.

The new centre will offer the following range of services:

- primary care – two practices, Church Lane and Cannon Hill Lane will merge to deliver a range of high quality services;
- diagnostics;
- outpatient consultation;
- assessment and investigation;
- diabetic eye screening;
- MSK and outpatient physiotherapy;
- podiatry;
- endoscopy and minor procedures; and
- community pharmacy.

The final service provider to be identified for the Nelson Health Centre will be for community pharmacy. MCCG are running a mini-competition to identify a preferred partner; this will conclude in May 2015. We will be specifically exploring the added value propositions that support the other tenants within the building, encouraging service integration and offering enhancements to the core services.

A key priority for the CCG post commencement of services is to ensure that the utilisation of the facility is maximised thus realising the benefits to be accrued from the investment of £12 million in the community estate. The CCG has appointed an interim Centre Manager to oversee the running of the building and manage utilisation for the first six months of operation.

Mitcham Health Care Centre and East Merton Model of Care

The first quarter of the year will see the finalisation of the model of care for East Merton and the development of the service strategy for the new healthcare facility. We anticipate that in early 2015/16 we will receive permission to proceed with the development of the new facility and we will be working towards submitting a stage 1 business case in early 2016.

Of key importance to the CCG is that the planning and commissioning of services involves patients and the public at all stages honouring the commitment of "no decision about you without you". The MBHCH programme has established a Patient and Public Engagement Group to ensure that the public are able to voice their views and ideas in all aspects of the programme, from the design of models of care to the actual design of the new buildings. This group meets on a monthly basis.

We will also be establishing a Community Reference Group, which is more specific to the development of the new facility and the chosen site, and will include membership from local residents, businesses, community groups and public services such as the police and fire services. The aim of this group will be to ensure that we develop a design that not only meets the needs of the services but is also sympathetic to the locality in which it is to be developed.

Key areas for focused engagement with the public will be:

- development of the East Merton Model of Care
- the procurement of clinical services
- development of the design principles for the new facility
- disability and access issues to be addressed within the facility
- community issues relating to the development of the site
- selection of furniture and art within the new building

To supplement this engagement we will also be visiting established community groups to discuss specific issues pertinent to the group.

The table below provides an outline programme for the delivery of the Mitcham development:

Task	Timeline
Obtain instruction to proceed from NHS England	March 2015
Stage 1 Business Case preparation	April 2015 - February 2016
Obtain CCG sign off of Stage 1 business case	February 2016
Obtain NHS England approval of Stage 1 business case	April 2016
Stage 2 Business Case preparation	April – May 2016
Obtain CCG sign off of Stage 2 business case	May 2016
Obtain NHS England approval of Stage 2 business case	May 2016
Financial Close	July 2016
Start on site	July 2016

Targets and Trajectory

Nelson Health Centre

- Numbers of referrals received at the Nelson Health Centre – monitored on a monthly basis by service.
- Room utilisation – monitored on a monthly basis by the Centre Manager. Target utilisation 85% by end of year one.
- Patient satisfaction survey – carried out nine months after service commencement and repeated at six-monthly intervals.

Mitcham

- Progress against project plan – monitored on a monthly basis by Project Board
- Approval of key documents e.g. NHSE PID, stage 1 and stage 2 business cases in line with the project programme.

Communication and Engagement

- Google analytic statistics – number of people visiting the Nelson Health Centre web page
- Numbers of people attending and engaging in events
- Twitter updates – number of followers, shares, re-tweets and favourites
- Complaints and compliments

2.4 Transforming Primary Care

In November 2014, NHS England (London) published *Transforming Primary Care in London: General Practice A Call to Action*, which examines the challenges facing general practice in London today. The framework recommends 17 specifications covering three areas in general practice to

be implemented over the next five years that support the direction of travel outlined in the Five-year Forward View

The specifications include:

- Proactive Care – supporting the health and wellness of the population, capacity for self-care and keeping people healthy;
- Accessible Care – providing a responsive, timely and accessible service that responds to different patient preferences and access needs;
- Coordinated Care – providing patient-centred, coordinated care and GP-patient continuity.

The 25 member practices within Merton are forming a federation and are currently working through the governance and leadership aspects to ensure the provider development arrangements are appropriate.

Within 2015/16, Merton CCG will develop a comprehensive local programme that helps to transform primary care.

2.5 Community Services Procurement

Merton CCG inherited the Transforming Community Services contract that Sutton and Merton Primary Care Trust awarded to The Royal Marsden NHS Foundation Trust. Whilst there have been some good improvements for our patients, we are now at the end of the contract term and need to award a new contract for this service.

Through significant engagement with our practices, public and the existing commissioners of the contract it has been agreed that Merton CCG, in collaboration with public health in Merton, will commission a Merton-only community service. We are currently working with Sutton CCG, NHS England and public health in Sutton to ensure that the new service is mobilised appropriately without any disruption to patient care. We are working to the timescale of an invitation to prospective bidders to tender at the beginning of June 2015 and awarding the new contract at the beginning of October 2015.

2.6 SWL Commissioning Collaborative

We submitted our 5 year strategic plan as part of our South West London Strategic Planning Group (SPG) on 10 June 2015 and following feedback from NHS England we are now in the implementation phase for the following areas across SWL:

- cancer
- children and young people
- integration

- maternity
- mental health
- planned care
- transforming primary care
- urgent and emergency care

Each of these areas has a clinical design group including representation from Merton on each group. We are also pleased that our provider organisations are working together to ensure we are able to deliver London Quality Standards (LQS) by 2017/18. Merton CCG Chief Officer and Director of Commissioning and Planning lead on two of the clinical design group areas.

2.7 Co-commissioning

In May 2014, NHS England invited Clinical Commissioning Groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View.

Co-commissioning is a key enabler in developing seamless, integrated, out-of-hospital services based around the needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- improved access to primary care and wider out-of-hospital services
- high quality out-of-hospital care;
- improved health outcomes, equity of access, reduced inequalities; and
- a better patient experience through more joined up services.

Merton CCG in one of six CCGs in South West London who have submitted a joint application to commission primary care with NHSE from 1 April 2015.

NHS England is expected to publish new models of care for dentistry, eye services and community pharmacy within 2015/16. Merton CCG will respond to these challenges appropriately.

2.8 Five year Forward View

Through its planning guidance, NHS England set out how the NHS budget will be invested so as to drive continuous improvement and to make high

quality care for all, now and for future generations, a reality. It seeks to ensure that the NHS is on as strong a footing as possible, capable of remaining focused on quality through a period of significant economic challenges and delivering models of care that will be sustainable in the longer term.

Everyone Counts, *Planning for Patients 2014/15 – 2018/19* was published in December 2013. It set out an ambition for high quality care together with details of the planning process to achieve this ambition, including the development of five-year strategic plans and detailed two-year operational plans by CCGs and NHS England's direct commissioning teams for the years 2014/15 – 2015/16.

Leaders of the NHS in England have published planning guidance for the NHS, setting out the steps to be taken during 2015/16 to start delivering the NHS Five-year Forward View.

The major parts of this plan include the following:

- To deliver a radical upgrade in prevention of illness with England becoming the first country to implement a national evidence-based diabetes prevention programme.
- Explains how £480 million of the £1.98 billion additional investment will be used to support transformation in primary care, mental health and local health economies.
- Makes clear the local NHS must work together to ensure patients receive the standards guaranteed by the NHS Constitution.
- Underlines the NHS's commitment to giving doctors, nurses and carers access to all the data, information and knowledge they need to deliver the best possible care.
- Details how the NHS will accelerate innovation to become a worldleader in genomic and genetic testing, medicine optimisation and testing and evaluating new ideas and techniques.

As part of the Five-year Forward View there are seven different models of care that CCGs and Strategic Planning Groups (SPGs) should consider as follows:

- Multispecialty community providers (MCPs)
- Primary and acute care systems (PACS)
- Urgent and emergency care networks
- Viable smaller hospitals
- Specialised care
- Modern maternity services
- Enhanced health in care homes

Merton CCG is currently working through a number of these models and will be aiming to submit bids within wave two, in collaboration with local CCGs.

2.9 London Health Commission

The Commission, chaired by Professor the Lord Darzi, examined how London's health and health care can be improved for the benefit of the population. On 15 October 2014, the London Health Commission published its Better Health for London report to the Mayor of London. Better Health for London proposes tough measures to combat the threats posed by tobacco, alcohol, obesity, lack of exercise and pollution, which harm millions of people. Together the proposals amount to the biggest public health drive in the world. It contains over 60 recommendations and sets out 10 ambitions for the City with targets. It is our responsibility to respond to these in a robust way.

The Mayor of London, NHS England (London), Public Health England, London councils and the 32 GP-led clinical commissioning groups have come together to outline how, individually and collaboratively, they will work towards London becoming the world's healthiest major city.

The new partnership has been established in response to the challenges set out in the London Health Commission's Better Health for London report and the NHS Five-year Forward View. The aim is to work together at all levels to make the best use of resources and build on best practice to improve the health and well-being of all Londoners, wherever they live in the capital. The plan is a good basis to explore how London could benefit from more autonomy to improve the future of the capital's health.

Better Health for London: Next Steps sets out shared ambitions and how they will measure progress towards the following shared goals:

- Give all London's children a healthy, happy start to life
- Get London fitter with better food, more exercise and healthier living
- Make work a healthy place to be in London
- Help Londoners to kick unhealthy habits
- Improve care for the most mentally ill in London so they live longer, healthier lives
- Enable Londoners to do more to look after themselves
- Ensure that every Londoner is able to see a GP when they need to and at a time that suits them
- Create the best health and care services of any world city, throughout London and on every day
- Fully engage and involve Londoners in the future health of their city

- Put London at the centre of the global revolution in digital health.

Merton CCG will be working with NHSE, London CCGs, SWL CCGs and the local authority to agree an implementation plan for Merton that relates to these eleven work streams within 2015/16.

2.10 Integration Programme – Better Care Fund

2014 Achievements

In 2014/15 the Merton Integration Programme, which had been operating as a system-wide re-design across commissioner and partner organisations since June 2013, incorporated *The Better Care Fund (BCF) Plan*. The Plan was initially submitted by the HWBB for approval by NHS England and the Local Government Association in April 2014. Following a period of assessment, all HWBs in England were advised that they would have to re-submit their BCF Plans focusing on a reduction of non-elective admissions (NELs) as the principal performance measure.

The revised plan was formally approved by NHS England in January 2015 with a commitment to work towards reducing NELs of Merton residents by 3.5% in 2015/16. This used an assumption that the 2014/15 QIPP schemes will curtail growth of emergency admissions to 2.2% or below. In real terms, this would represent a reduction in NELs of 986, of which 600 would be delivered by the 3.5% reduction as a consequence of the schemes.

In order to deliver the BCF Plan, a formal project was set up to manage the outputs and a project manager appointed. The project reports via the project team to the Integration Board, consisting of commissioners and providers ultimately to the Health and Wellbeing Board

The principal component of the Plan remains the 'Merton Model', constituted as a work stream within the project and responsible for delivering the principal outputs of service redesign across the health and social care environment. In April 2014, the 'Merton Model' outputs were combined with the outputs of the MCCG Operating Plan's 'Older and Vulnerable Adults' Work Stream, the deliverables of which are set out below in section 3.3.

Alongside the 'Merton Model', the BCF Project also developed work streams focusing on performance management, IT and data, workforce development, engagement and commissioning for quality, all of which supported the implementation of schemes within the 'Merton Model' and BCF Plan, working alongside the broader initiatives being delivered by the South West London Commissioning Collaborative.

As part of the BCF Plan, a full, formal performance management framework was established, incorporating prevention of admission, hospital discharge, admission to residential homes and reablement/rehab measures.

Performance recording began from April 2014 as the measures were developed and formal reporting commenced from Q4 of 2014/15 in January 2015.

The BCF Plan stipulates a number of supporting metrics alongside the 3.5% reduction in NELs and measurement started from Q4 2014/15, although baseline performance had been recorded since April 2014 for comparison purposes with a baseline from 2013/14.

In 2014/15, the following performance has been recorded so far:

Metric	Target 14/15	Actual 2014/15
Reduction in NELs	3.5% (600)	TBC
BCF1a: Permanent admissions to residential and nursing care homes per 100,000 population	<403.2	231.1 (at Dec 14)
BCF1b: Number of new placements to permanent care homes 65+	<100 new admissions	64 (at Dec 14)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service)	85.7%	Data expected April 2015
Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during 2014/15	2%	TBC
Number of older people (65 and over) who were offered a Reablement or Intermediate care service - (clients Reablement services started per month)	24	51 per month average over nine months (at Dec 14)
Delayed transfers of care from hospital per 100,000 population (average per month)	239.0	113.3 (at Dec 14)
Number of delayed transfers of care from hospital	388.5	TBC

2015/16 Plans

The BCF will continue to deliver according to the schemes that are set out in detail in the section below on 'Older and Vulnerable Adults', which incorporates the 'Merton Model'.

In 2015/16, BCF work will increasingly focus on the enabling work streams with the SW London-wide development of IT, data, information governance and workforce strategy as the broader integration programme seeks to embed service improvements into the local health economy.

Management of integration initiatives will be incorporated into the business as usual activities of the CCG and partner organisations, and plans are being developed to determine the best way of resourcing this.

2015/16 Targets and Trajectory

Assessment and review of BCF performance targets will continue through the HWB, Integration Board and System Resilience processes using the continuing recording and reporting of performance through the BCF performance management framework, which will continue to respond to

performance measurement needs. At this stage, the following targets for 2015/16 have been agreed but will be kept under review by the Merton Integration Board.

Metric	Target 2015/15
Reduction in NELs	TBC
BCF1a: Permanent admissions to residential and nursing care homes per 100,000 population	<395.3
BCF1b: Number of new placements to permanent care homes 65+	< 100 new admissions
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service)	85.7%
Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during 2015/16.	TBC
Number of older people (65 and over) who were offered a Reablement or Intermediate care service - (clients Reablement services started per month)	24 per month (to be reviewed)
Delayed transfers of care from hospital per 100,000 population (average per month)	238.7
Number of delayed transfers of care from hospital	392.8

3. Delivery

3.1 CCG Work Programme

As part of our review of the work that we have undertaken, we have evaluated our key work programmes for 2014/15 to ensure they are fit for purpose in 2015/16.

3.2 Older and Vulnerable Adults

2014/15 Achievements

The aim of this work stream is to provide more proactive care, prevent exacerbations of conditions and support an increased number of patients in the community; to maximise independent living, prevent unnecessary admissions to hospital and the loss of independence and confidence that a hospital stay can bring about.

Where people do require hospital admission, services will be available to ensure that the stay is no longer than necessary, support is available with the transition from hospital back into the community and, where possible, premature admission to long-term residential care is avoided.

Key areas that have been achieved to address this in 2014/15 include the following:

- Expansion of the community prevention of admission team (CPAT) to provide additional support to help improve care in nursing and residential care homes in Merton and reduce unnecessary ambulance conveyances and potential admissions to hospital, by providing increased information, training and support services. This has also included reinvigoration of the Merton Care Home Forum and development of a "concerned about a resident" tool.
- An integrated complex older people's pathway has been implemented at St Helier, working with Sutton CCG. This service is led by a geriatrician and includes support from a navigator and therapists to optimise the frail elderly pathway and ensure a successful and prompt discharge.
- Community services have been commissioned to provide "in-reach" nursing at St George's Hospital to help identify patients who could be supported in the community rather than remaining in an acute hospital and supporting these patients through the transition. This has been extended to the emergency department and short stay wards through systems resilience funding.
- Commissioning of additional intermediate care beds with a model proposed for future commissioning of beds to enhance the services currently available, providing a "halfway house" giving a faster and more supported recovery from illness.
- Integrated locality based working – community services have redesigned their teams (of nurses, specialist nurses and therapists) to work on a locality basis alongside the health liaison social workers and primary care. MDT working has started, with the identification and management of those identified through risk stratification and people aged 75 and over. Key worker roles and responsibilities have now been designed to enable more proactive working, providing those with the most complex needs who are at risk of hospital admission with additional co-ordination and support to help manage their overall care.
- The Dementia Hub was launched in Mitcham with a number of partner agencies including London Borough of Merton and The Alzheimer's Society, providing a range of linked up services including follow-up memory clinics. Three dementia nurses have been recruited to provide additional support to people with dementia and their carers in the community.
- Training and support has been provided in primary care to help increase dementia diagnosis rates, to ensure that people with dementia are identified, treated and supported as early as possible. The CCG staff members have undertaken Dementia Friends training.
- The End of Life Care (EOLC) Strategy has been refreshed, building on the work already achieved. Training for community staff and carers on a range of aspects of EOLC has also been delivered,

information about bereavement support developed, an update of the booklet "*What to do after a death at home*" has been published and arrangements made to enable home to hospice transportation, with the overall aim of improving support to people at the end of life.

- Delivery of five expert patient programmes (EPP) to date, with a further three planned before year end. These have had a particular focus on Tamil and Polish communities to support patients with long-term conditions, by giving people tools, techniques and the confidence to manage their condition better.
- A clinical review of the community podiatry service was completed and an action plan put in place to improve services, meet best practice guidance and take into account patient feedback.
- The Joint Health and Social Care Learning Disabilities Self-Assessment Framework was completed and will be used as a platform to review and strengthen our commissioning arrangements. The findings from this will be reviewed and an action plan developed to address the areas for improvement identified.
- A review of what is currently commissioned to support carers has been undertaken in preparation for developing a carers strategy.

Supporting Data

- The community prevention of admission team now receives an average of 34 referrals a month from Merton.
- From the period April to November 2014, there have been 54 fewer 999 calls made from care homes in Merton compared to the same period in the previous year, an 8% reduction.
- The in-reach nursing team based at St George's Hospital has facilitated discharges for 266 patients up to the end of November 2014 and since its introduction into the emergency department, the service has enabled 40 Merton patients to return home rather than unnecessarily being admitted to hospital.
- In terms of overall activity, up to the end of November 2014, 239 fewer emergency admissions have taken place in targeted areas with 288 fewer excess bed days supporting the delivery of our QIPP programme.
- The dementia diagnosis rate has increased from 49.9% in April 2014 to 52.4% in November 2014, with further increases expected in the coming months.
- As at December 2014, there were 1,560 patients with a Co-ordinate My Care record in Merton (the fourth highest of the London CCGs) and overall 72% of patients with a CMC record died in their preferred place.
- 89 people have completed the expert patient programme to date in 2014/15.

A clinical delivery dashboard has recently been developed which will help measure progress against key work streams.

2015/16 Plans

In 2015/16 the CCG will build on the significant progress made during 2014/15, with many of the plans and developments for integration and new models of care achieving full implementation during the year. These include the following areas:

- A Community Hub at the Nelson Health Centre with the delivery of HARI (Holistic Assessment and Rapid Investigation Service), building on the existing older people assessment and rehabilitation service (OPARS) to provide a multidisciplinary holistic service led by an interface geriatrician, providing both urgent and routine holistic assessments, with ongoing rehabilitation where required. The aim of this service is provide a community-based solution to manage appropriately more complex needs in the community.
- Work with our local acute trusts to build upon their frail elderly models to provide a comprehensive geriatric assessment on arrival to hospital and enable prompt and safe discharge.
- Increase the local availability of intermediate care beds in Merton and provide a wider MDT input into the beds as well as seven-day working to enhance the services currently available, providing a faster and more supported recovery from illness.
- Increase community admission prevention services, to enable more people, where appropriate, to be supported in the community by enabling referrals from London Ambulance Service to community services over weekends and evenings.
- Increase the dementia diagnosis rate with a corresponding increase in services to support this, e.g. memory clinics.
- Delivery of the End of Life Care Strategy including an enhanced 'hospice-at–home' service, a service to help co-ordinate and deliver care in the last few days and hours of life, further work to improve the use and implementation of Co-ordinate My Care record and further training to support professionals to undertake difficult conversations about the different dimensions of dying.
- Develop and commission a 'home from hospital' service to offer time-limited support to enable older people transition back to being at home following a hospital stay.
- Development and delivery of a falls prevention pathway, including bridging the gaps identified within the health needs assessment to reduce the risk of falls in the population.
- Implementation of the podiatry action plan developed in 2014/15 to improve services, meet best practice guidance and take into account patient feedback.

- Continue the development of Expert Patient Programmes to maximise opportunities to support people to manage their own condition.
- Develop an action plan to address the key findings from the Joint Health and Social Care Learning Disabilities Self-Assessment Framework, including embedding improvements in safe and compassionate care.
- Engage users and carers to review opportunities for personal health budgets/integrated personal budgets across health and social care for people with learning disabilities and, where possible, reduce reliance on inpatient care, enabling appropriate people with learning disabilities or autism to be supported back into the community as part of the Winterbourne View Concordat.
- Develop a joint carers strategy with the London Borough of Merton, drawing up plans to identify and support carers, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers who themselves are over 85, and provide better support.
- Working with Wandsworth CCG, commission further support regarding care home selection and pathways to support timely discharge from St George's Hospital to support the continuing care process.
- Review what further opportunities there are to provide more choice in continuing care through use of personal health budgets.

2015/16 Targets and Trajectory

- We have recently developed a clinical delivery dashboard which will enable the CCG to measure progress against the various work streams by use of a range of performance metrics.
- As part of the Better Care Fund, we have projected reductions in emergency admissions over the two year period of 986. This is also being measured through QIPP.

3.3 Mental Health

2014/15 Achievements

The mental health delivery area aims to ensure that the CCG's patients receive high quality, timely care and support in line with national and local mental health strategies.

As a member of the South West London Commissioning Collaborative, the CCG aims to deliver the following objectives for mental health:

- improving mental health and well-being;
- reducing rates of admission and re-admission to acute care;

- improving crisis services;
- integrating mental and physical health;
- improving quality of life.

Key areas that have been achieved to address this in 2014/15 include the following:

- The CCG has commissioned a new complex depression and anxiety service (CDAS) which will be delivered from February 2015, better to meet the needs of patients with more complex needs. Separating this cohort of patients from the core improving access to psychological therapies (IAPT) service is also expected to improve access and waiting times for patients with mild- to-moderate depression and anxiety.
- A procurement exercise has been undertaken to commission a new model of IAPT service for people with mild-to-moderate depression and anxiety from October 2015. Delivery of this service is expected to result in further improvements to access and waiting times, and to respond to the feedback of patients who have been involved throughout this process.
- More patients who need ongoing mental health placements and support have been placed in facilities or supported either within or close to the borough.
- The CCG has commissioned an in-borough attention deficit hyperactivity disorder/autistic spectrum disorder (ADHD/ASD) service to replace the service previously provided out of borough. Not only does this provide a more local service but waiting times have been reduced.
- During 2013 the Merton Health and Well-being Board commissioned the LB Merton Public Health service to undertake a mental health needs assessment as part of a wider mental health review. The CCG supported this work, which was completed and reported to the Board in September 2014.

Supporting Data

We have developed a series of metrics which will be measured and monitored from 2015 to gain better insight into whether or not the work carried out in mental health is meeting the following planned outcomes:

- improvements in access and waiting times, including for people with long term conditions and mental health needs, and for harder-to-reach groups
- improved recovery rates in IAPT services
- reduced rates of admission and re-admission to acute care
- improved quality of life

As of 1 January 2015, Merton CCG has 51 patients in ongoing mental health placements, of whom 35 (almost 70%) are placed in Merton or neighbouring boroughs.

2015/16 Plans

In 2015/16 the CCG will work jointly with LB Merton, South West London and St George's Mental Health Trust and other partners in response to the recommendations of the Mental Health Needs assessment and stakeholder engagement. Merton CCG welcome the expectation that the percentage rise in our financial allocation is applied to our mental health services development through service development improvement plans (SDIPs), for the introduction of new access and waiting time standards for IAPT and psychosis in 2015/16.

Specific plans include the following:

- Work with other South West London CCGs to develop effective liaison psychiatry services, for patients of all ages with mental health needs presenting at acute hospitals, to ensure that they get the support they need.
- Improve and increase the mental health crisis services in Merton, including commissioning a street triage pilot, to reduce the impact of crisis on patients and carers and reduce the likelihood of deterioration and acute admission.
- Review the demand and capacity of the early intervention in psychosis service, to ensure that patients experiencing a first episode of psychosis get early treatment and support.
- Commission a mental health education programme for primary care and community pharmacy, to improve support for people with mental health needs in primary care and improve integration of mental and physical health services.
- Increase support for carers, to ensure that they feel supported in their caring role and are enabled to carry on caring for as long as they wish.
- Ensure services better address the needs of people with a dual diagnosis of substance misuse and mental ill-health, by establishing better links between these services and improving skills, knowledge and competencies across the range of presenting needs.
- Re-design the provision of rehabilitation and step-down services for people discharged from acute inpatient beds to ensure that they are placed in local facilities and able to access long term care locally.

2015/16 Targets and Trajectory

Provision of effective liaison psychiatry services for patients of all ages with mental health needs presenting at acute hospitals is an enabler contributing to the achievement of the A&E four-hour wait target.

To ensure that local providers achieve the new waiting time and access targets Merton CCG will monitor:

- The proportion of adults entering a course of treatment in IAPT services who have their first treatment session within six weeks of referral. The national directive is that this will be 75% from April 2016, and the CCG has therefore set interim targets of 65% in 2015/16 Q1, 70% in 2015/16 Q2 and 75% from 2015/16 Q3 onwards.
- The proportion of adults entering a course of treatment in IAPT services who have their first treatment session within 18 weeks of referral. The national directive is that this will be 95% from April 2016, and the CCG has therefore set interim targets of 85% in 2015/16 Q1, 90% in 2015/16 Q2 and 95% from 2015/16 Q3 onwards.
- The proportion of people experiencing a first episode of psychosis who receive treatment within two weeks (the national target is 50% by April 2016, and the CCG will work with providers to agree a robust trajectory to achieve this).

To ensure that people with mild-to-moderate depression and anxiety are benefiting from the new and increased services to be delivered in 2015/16, the CCG will monitor:

- the proportion of the population entering a course of IAPT (15%)
- the proportion of IAPT service users from BME groups
- the proportion who have achieved recovery or reliable improvement through the service

These indicators will be assessed against nationally mandated standards and targets.

Outcomes of other local investments will be measured as shown below:

- GP Education programme: at least one GP from each practice and one community pharmacist from each pharmacy will have completed the mental health education programme in 2015/16.
- Support for carers:
  - Increase the number of carers registered with Carer's Support Merton
  - Increased activities for carers to have respite and maintain well-being.
- Dual diagnosis:

- Increase the number of staff from community teams and other agencies trained to manage patients with dual diagnosis.
- Increase the number of patients with dual diagnosis being managed by community team.
- Reduction in acute admissions of patients who have mental ill-health and misuse substances.

- Mental health crisis services:
  - Availability of 24 hour crisis service with the ability to self-refer
  - Reduction in acute admissions
  - Reduction in number of people held in police custody

3.4 Children and Maternity Services

3.4.1 Children's Services

2014/15 Achievements

Merton CCG is committed to ensuring that it improves health outcomes for all children. The priorities we are focusing on directly link to Priority 1 of the Merton Health and Wellbeing Strategy.

- Improved performance in relation to the provision of initial health assessments Children Looked After (CLA) by the part funding of additional consultant time for the designated doctor role. June-Sept 2014 the target time for providing initial health assessments was met in 83% of cases – a significant improvement from 45% in 2013.
- A review of the health care of CLA was carried out, and an improvement plan has been developed.
- The extent of joint services has been mapped and a proposal developed for taking forward more joint commissioning with LB Merton Public Health and Children and Families Service.
- A review of the process for children's NHS continuing care has begun and will continue into 2015, to improve the response to children and families with complex health conditions.
- Personal Health Budgets arrangements in place for children receiving NHS continuing care.
- An integrated education, health and care planning team has been developed with LB Merton. This is part of joint work with LBM to meet the requirements of the Children and Families Act 2014.
- The CCG commissioned a review by the Royal College of Paediatrics and Child Health in December 2014 to provide recommendations on how to improve the outcomes and experiences of families and children.
- The CCG and LB Merton have delivered a joint action plan to improve the experience of young people transitioning into adult services.

- A service has been piloted during the winter months in 2014/15 to improve access to primary care with the objective of reducing the number of unnecessary A&E attendances and hospital admissions.
- The CCG and LB Merton have re-established a joint working group to improve child and adolescent mental health (CAMHS) services and refresh the CAMHS strategy. A specification for a health needs assessment and service review led by public health has been agreed.
- As part of their transformation programme SWL & St George's Mental Health Trust have established new specialist services for eating disorders and for ASD/ADHD, to speed up access to assessment and treatment.

Supporting Data

A series of metrics has been developed which will be measured and monitored from 2015 to gain better insight into whether or not the work carried out is meeting the planned outcomes:

- Ensuring children with continuing care needs have their health needs met by meeting the target of 100% of annual reviews completed.
- Ensuring children with needs for specialist therapy services have their care needs met by meeting the targets of 75% of routine referrals being assessed within 30 days and 95% receiving treatment within 18 weeks.
- Ensuring all children transitioning to adulthood have their care needs met by having a transition plan in place.
- Ensuring that children with community mental health needs are able to access services – target is 80% seen within 8 weeks of referral.

2015/16 Plans, Targets and Trajectory

- Consultation work will be undertaken with families in receipt of NHS continuing care and the CAMH service, as part of the service improvement process, working with LB Merton and Healthwatch.
- Work with families and young people to draw up plans to provide improved support to young carers, by June 2015.
- Modernise and streamline the child health pathways, working with all local partners to improve the quality and effectiveness of health and care outcomes, with a target for completion by Jan 2016. Work on the asthma pathway will be progressed taking account of the work of the South West London Commissioning Collaborative.
- The CCG has undertaken a review of the health care of Children Looked After (CLA) and will take forward the issues identified in that review to improve health outcomes for CLA. Ensuring as a priority that the 4 week target for newly looked after children to receive a health assessment is consistently met.

- The review of the process for children's NHS continuing care will be completed in 2015 and actions implemented to provide more integrated care for children with complex health needs.
- An integrated education, health and care planning team will be fully operational by the end of April 2015 and its operation reviewed by the end of October 2015. It will deliver joined-up, high quality plans for 200 children with special educational needs and disabilities.
- Joint commissioning arrangements with LB Merton will be strengthened, building on the working arrangements put in place in 2014 between LB Merton and CCG managers.
- Integrated local early intervention services for children and families will be developed working with school nursing, health visiting and children's centres to form the basis of a community service, to improve child health in Merton.
- Implementation of the recommendations of the review by the Royal College of Paediatrics and Child Health undertaken in December 2014. The aim is to improve health outcomes for children by closer integrated working across health providers in Merton.
- Children's community services will be re-commissioned based on a new specification, to improve services from April 2016.
- Community alternatives to hospital admission for children will be developed as part of the work with the SWL Commissioning Collaborative with the aim to reduce avoidable admissions by at least 10%.
- The CAMHS tier 2 provision will be reviewed jointly with LBM. A single point of access will be put in place to meet the target of 80% of children and young people accessing a service within 8 weeks, and improving the pathway to a wider range of local mental health services for children, young people and their families.

It is also expected that the CCG will work in close partnership with NHSE to ensure that there is a robust children's eating disorders service that, where appropriate, local children can access.

3.4.2 Maternity Services

2014/15 Achievements

In 2014/15 the CCG has strengthened engagement with local and sector-wide providers of maternity services through the newly formed local SWL Maternity Clinical Network. The SWL Network brings together senior clinical leaders from providers of local maternity services, together with representatives of the local public, and other local CCGs, to review and improve local maternity services.

The SWL Network supports maternity providers in developing a consistent approach to the delivery of maternity services across the local area, to ensure that all women receive the best possible standard of care.

The following improvements have been delivered in 2014/15:

- A new clinical director for children's and maternity services was recruited
- The SWL Network has developed an information leaflet for women requesting elective caesarean section, to ensure a consistent approach to managing non-medical requests for caesarean sections. The leaflet, explaining the advantages and disadvantages of choosing a caesarean section, was developed by clinical staff from the five units.
- Other developments include outpatient induction of labour, and an enhanced recovery programme (ERP), to enable suitable women who have undergone elective caesarean section to follow a defined pathway of care that enables them to go home on day one if they choose to and are fit to do so.

The SWL Network, with the support of the South West London Commissioning Collaborative, has commenced a review of local services against London Quality Standards.

Supporting Data

The SWL Network has developed a maternity dashboard, containing a set of metrics and definitions that enable all maternity providers and commissioners to share performance-related information in a consistent and open manner. This enables good practice to be identified so that it can be shared with other network members, and supports focused audit and learning that can help organisations to learn from others.

Evaluation of the maternity services dashboard data has highlighted variations and these form the basis of work between providers to share best practice. For example, the caesarean section rate across the three trusts where the majority of women in Merton deliver varies from 23% to 29% (data as at September 2014).

In 2015/16 the CCG will work to deliver:

- Improved maternal and neonatal health outcomes
- Improved choice of delivery setting, and community ante- and post-natal care
- Beginning to deliver LQS standards

The CCG will review local maternity services to consider how we can address specific health issues in relation to maternity (e.g. smoking during pregnancy, breast-feeding, low birth weight, drug and alcohol abuse, maternal mental health and screening for infectious diseases). This work will also consider health inequalities within the borough.

Within Merton mothers choose to deliver in a variety of settings and maternity units. In addition, ante- and post-natal care is often not provided by the same team of midwives who deliver the baby. The review will address the need identified in the recently published planning guidance for commissioners to work with service users and the public to review local services, to improve the delivery of meaningful choice in maternity care.

The findings of the review will enable the CCG, working within the local Maternity Clinical Network and in partnership with the South West London Commissioning Collaborative, to develop pathways to support choice, and continuity of maternity care in a woman-centred model rather than an organisational model, whilst ensuring that high quality obstetric care is in place.

In addition, the recommendations of the NHS England review of maternity services (including perinatal mental health) expected in autumn 2015 will be reviewed and incorporated into future commissioning plans where relevant.

2015/16 Targets and Trajectory

In order to be assured of the ongoing excellence of local maternity services Merton CCG will monitor, in collaboration with the South West London Commissioning Collaborative, various quality indicators within local maternity services.

Our five-year plan is targeting achievement of the London Quality Standards (LQS) that obstetric units are “staffed to provide 168 hours a week (24/7) of obstetric consultant presence on the labour ward” by April 2019. The collaborative has targeted achievement of 114 hours by April 2016.

In recognition of the focus on midwife-led care for women with normal pregnancies (with an aim to improve clinical outcomes and experiences of care) the SWL Commissioning Collaborative will also continue to monitor local midwifery staffing levels in order to support achievement of the LQS of a minimum of one midwife to 30 births, and one consultant midwife for every 900 expected normal births.

In addition, in order to achieve the improvements in maternal choice, including in ante-natal and post-natal care, it will be necessary for local providers to adopt more uniform information and processes. The number of such uniform services will therefore be monitored.

Merton CCG has identified the following indicators of improved maternal health and increased maternal choice:

- unplanned C-section rate
- delivery complication rate
- non-obstetrics lead births

Merton CCG will be working to establish these metrics within the reporting of local maternity providers in order to be assured of high quality care in a women-centred model.

3.5 Keeping Healthy and Well

Merton CCG has been at the forefront of taking on the prevention agenda in partnership with LBM Public Health during 2014/15. This is evidenced by the inclusion of a keeping healthy and well priority among the CCG six priorities, as well as appointment of a GP clinical director for this area. The keeping healthy and well work stream is supported by the LBM public health team and links to Priority 2 of the Merton Health and Well-being strategy.

Areas of activity during 2014/15 include development of an integrated weight management service; design of a Proactive GP pilot and agreement to develop a model of care for East Merton.

2014/15 Achievements

- Agreement to develop a joint weight management pathway for Merton residents. Procurement for the tier 2 (public health responsibility – diet and exercise)) and tier 3 (MCCG responsibility – pre-bariatric surgery) services has been started with a planned start-up in the second half of 2015/16.
- Agreement to work on a Proactive GP pilot in the more deprived areas of Merton has been reached. The pilot aims to embed prevention in primary care and to reduce variation in long-term conditions between GP practices. Developed in collaboration with Merton GPs, the pilot supports delivery of GP proactive care standards through links with community health champions who will screen members of their community groups and refer where appropriate to GP or lifestyle services. Initially the pilot focuses on smoking and COPD. GP practices are asked to train their own frontline staff as health champions and either to provide stop smoking services directly or refer into the LiveWell stop smoking service. If successful, other long-term conditions and lifestyle prevention initiatives will be added.
- As part of the Proactive GP pilot, embedding prevention in front line staff involves training front line staff through Royal Society for Public Health NVQ1 and 2 accreditation to provide brief advice and signposting to lifestyle prevention services. In addition, this training is offered to all front line staff across Merton in the NHS, local government and the voluntary and private sectors.

- Merton CCG and the East Merton GP locality group established a task and finish group to develop a model of care for East Merton that addresses the specific health needs of residents of East Merton. A health needs assessment for the east of the borough pointed to the conclusion that residents in East Merton had a different profile than the rest of the borough. Residents in the east and south of the borough are younger, more deprived, more multi-ethnic and are diagnosed with long-term conditions at a younger age. The model recognises that reducing variations in early detection is one of the most important things the NHS can do to address health inequalities.
- Agreement to embed prevention requirements in the community services re-procurement. Specific KPIs to monitor training of frontline staff and signposting to lifestyle prevention services will be included in the specification.

Supporting Data

Metrics are embedded in all contracts/plans to help measure and monitor progress on achieving overall outcomes. These include:

- The weight management tier 2 contract will focus on the percentage of customers/patients who successfully complete their intervention
- The Proactive GP pilot will include measures for identifying increases in early detection of COPD and smoking referrals from GP practices, among others
- Embedding prevention in front line staff will measure the % of staff who participate in RSPH training and the numbers of patients/residents referred into lifestyle prevention services
- When the model of care for East Merton has been designed, this will then lead to commissioning against the model with appropriate targets and KPIs
- Targets for smoking quitters, successful completion of tier 2 weight management services and reductions in alcohol-related harm have been set within the Health and Well-being strategy
- Targets/KPIs will be embedded in additional joint prevention work currently being identified – see below

2015/16 Plans, Targets and Trajectory

As part of the planning guidance it is expected that the CCG in collaboration with public health set a number of targets. Each of these areas has a robust action plan to ensure they are delivered. The targets will be reviewed in year to ensure there is appropriate stretch to ensure the widest possible population gain.

- In Merton, 13.9% of the adult population are smokers. NICE guidance states that 5% of the estimated population should be treated in one year. As such we will ensure that we work closely with our colleagues in Public Health to ensure this cohort have access to smoking cessation services.
- A weight management pathway will be developed across primary prevention, tier 2 and tier 3. This will build on a Merton Food Summit in April and an audit of physical activity opportunities across Merton. The pathway will bring together LiveWell, the weight management services and frontline prevention training, thus offering a single point of referral/access for providers and patients. In preparation for this, public health is commissioning an evaluation of the LiveWell service. A similar methodology has been applied to targeting obesity. We have targeted the population who have a Body Mass Index (BMI) of between 35 and 40. We will expect that 5% of this cohort access the weight management service and 65% of those that complete the programme will have a 5% weight loss.
- A review of alcohol treatment tier 4 services is underway and will be followed by design of a joint alcohol pathway between LBM public health and MCCG. This will lead to treatment services being provided more appropriately closer to home in the community and to savings that will support these community and primary prevention services. The aim is to see a substantial reduction in alcohol specific hospital admissions. We are currently validating the data to ensure the new pathway will be fit for purpose.
- The Proactive GP pilot will be finalised in May for a roll-out to GP practices in the east of Merton. A formative evaluation is being designed to ensure that an effective process is designed so that the pilot can be expanded to other areas of Merton and to include other long-term conditions and prevention interventions.
- The East Merton model of care will be developed by the end of the calendar year. This will then require a review of and redesign of appropriate acute services that can be delivered either in community or primary care. The model will inform the design of a health centre on the Wilson site.
- Merton CCG has agreed to apply for accreditation within the London Workplace Charter. To facilitate this, the CCG will join a task and finish group established within LBM to take forward this work. An inventory of existing council health and well-being services is under way. A public health pilot has recently been awarded to provide a service for small and medium businesses in Merton to enable them to achieve accreditation of the London Workplace Charter or some form of it.
- LBM Public Health is actively developing partnerships and initiatives to tackle health risks from alcohol, fast food, and tobacco. For

example, public health is now a 'responsible authority' for licensing and comments regularly to LBM licensing on applications for alcohol licenses. In addition, an environmental health officer is being recruited to motivate existing fast food outlets to deliver the London Healthy Catering Commitment. Involvement of MCCG in this work will be explored once further NHS guidance has been issued.

3.6 Early Detection and Management

2014/15 Achievements

In 2014/15 there was a focus on diabetes, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD) and cancer. There have been several key achievements which include developing new models of care to be implemented in the Nelson Health Centre from 1 April 2015, piloting a clinical health coaching telephone service and the review of current service provision through engagement with the public and key stakeholders.

Work to date has included developing new pathways, improving service provision and working with primary care to improve early diagnosis and management of patients. The work is described in more detail below.

Diabetes

- The diabetes pathway has been reviewed with providers and key stakeholders and actions are in place to improve the model of care to provide optimal care and improve patient outcomes.
- The CCG has commissioned a best practice Surveillance Clinic within the (NHS England-commissioned) diabetic eye screening programme to ensure low-risk patients with diabetic maculopathy are monitored within the current DESP programme rather than referring those patients to secondary care.
- Work is ongoing with community services to improve and increase referral rates for community based tier 3 diabetes services to avoid unnecessary visits to hospital.
- An education event was held for primary care on hypoglycaemia, insulin initiation, foot care and the tier 3 diabetes services to improve early diagnosis and management of patients.

Coronary Heart Disease

- Existing models of care have been reviewed and developed for heart failure and arrhythmia and will be implemented within the Nelson Health Centre and across Merton.
- The CCG has invested in increasing the provision of cardiac rehabilitation which supports patients to self-manage and reduce risk of further illness. Hard-to-reach groups will be included as well as extending the eligibility criteria to improve accessibility and equity.

- An education event for primary care on heart failure and arrhythmia was delivered to enhance knowledge of implementing best practice, including self-management to improve patient outcomes.

COPD

- The CCG is piloting a clinical health coaching telephone service for patients with COPD to support them to manage their condition and stay well.
- Work is ongoing with community services to improve pulmonary rehabilitation referral and uptake, to support patients to manage their own condition.
- An education event for primary care on COPD was delivered to improve early diagnosis and management of patients through best practice and self-management.

Cancer

- A Macmillan GP has been recruited to improve service provision and reduce inequalities. The Macmillan GP has reviewed screening, referrals and outcomes data at practice level and is working with each practice to improve early diagnosis.
- A Cancer Health Needs Assessment has been completed for Merton. Key priorities and actions have been derived from the findings to improve screening and reduce inequalities.
- A cancer update course has been delivered in primary care to help GPs in their understanding of cancer, providing easy access to the latest evidence, guidelines and best practice.

Musculoskeletal Service

- Merton CCG has invested in providing an enhanced musculoskeletal service, which will commence in April 2015. The enhanced service will improve accessibility, waiting times and patient experience for Merton patients.

Supporting Data

Since 2013/14 Merton CCG has seen:

- Unplanned admissions for coronary heart disease, diabetes and respiratory conditions remain steady;
- An increase in referrals to the tier 3 diabetes service.

We have developed a series of metrics which will be measured and monitored from 2015 to gain better insight into whether or not the work carried out in early detection and management is meeting the following planned outcomes:

- A reduction in unplanned admissions for coronary heart disease, diabetes and respiratory condition
- Improved health related quality of life for people with long-term conditions.

2015/16 Plans

The planning guidance for 2015/16 highlights the need for collaborative working to set and share quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. The CCG is working with LB Merton to incorporate disease prevention into the early detection and management work stream through improving self-management, raising awareness and increasing referral for lifestyle risk factors, and carrying out health needs assessments.

The CCG is exploring ways to improve early detection, diagnosis and management of patients with a long term condition, and will build upon the new models of care that encompass the whole of primary care including community pharmacy. As such Merton CCG will work with public health in Merton during 2015/16 to develop a clear prevention strategy which will inform future commissioning priorities. Health needs assessments will be completed for asthma, neurological conditions, cardiovascular disease and diabetes, which will inform the prevention strategy.

Improvements in models of care will also be delivered, including:

- An improved cardiac rehabilitation service which will include heart failure patients
- Improved access to structured education for people with diabetes, including targeting hard to reach groups
- Improved access to pulmonary rehabilitation to support patients to manage their condition
- A bowel screening initiative will be implemented in primary care to proactively encourage patients to take up the national screening programme
- Ensuring that mental health and well-being is included as part of the patient care process to enable both mental and physical health to be addressed
- Implementing the outpatient navigation model of care in primary care to improve proactive detection, diagnosis and management of disease
- Work with our providers to deliver improved models of care including MSK, cardiology, respiratory, dermatology and gynaecology services within the Nelson Health Centre to improve patient outcomes and experience

- Improved diagnostic services for housebound patients to reduce inequalities and improve patient outcomes and experience
- To ensure that once a patient has a diagnosis, Merton CCG is committed to ensuring there is sufficient capacity in acute trusts to meet the demands of 18-week referral to treatment (RTT) pathways to ensure that backlogs do not develop.

2015/16 Targets and Trajectory

- A 10% increase in access to and attendance at rehabilitation services across Merton for cardiology by September 2015 and respiratory by April 2016
- A 10% increase in access to and attendance at education for patients with diabetes by December 2015
- Improved recording of diagnosis and management within primary and community services e.g. annual reviews
- An increase in interventions taking place at the right time to prevent progression of condition
- Achievement of waiting times for referral to treatment (RTT) so that the CCG is able consistently to meet the national targets for admitted (90%), non-admitted (95%) and incomplete pathways (92%)
- A 5% increase in bowel cancer screening uptake by April 2016

3.8 Urgent Care

2014/15 Achievements

In 2014/15 the CCG continued to work in close collaboration with other SWL CCGs to support and progress delivery of urgent care services for patients. This remains as one of the key priorities due to further increasing demand placed on these services.

New services have been introduced to address the changing urgent care landscape and ensure services are easier to navigate for patients and clinicians, whilst aiming to maintain a high quality, accessible service.

System Resilience

- Following national guidance released in June 2014 Merton Clinical Commissioning Group (MCCG) worked in collaboration with Sutton and Wandsworth Clinical Commissioning Groups, to acknowledge and respond to system pressures within urgent care.
- The System Resilience Group brings together local commissioners and providers to develop and implement additional capacity and provision across the whole system to sustain sufficient services at times of significant system pressures, including winter.

Walk-in Centre Services

The CCG acquired commissioning responsibility from NHSE for the management of the Wilson Walk in Centre in April 2014. An evaluation specifically to determine local needs for walk-in and related services will be undertaken during quarter 1 in 2015/16.

111 Service

Following a joint review to evaluate the current 111 service, the CCG commissioned a South West London service along with other local CCGs. The new service was in place from 1 October 2015. [will be in place? Or is the date wrong?]

Winter Schemes (Local Priorities)

Following analysis of paediatric attendances at A&E, MCCG supported local GP practices to provide additional provision during the period of high demand in winter to alleviate the pressure on local Emergency Services, and improve access to primary care for children. The impact of this scheme will be closely monitored to determine whether to extend it or commission differently in 2015/16. The aim is that this will be part of our new commissioning plan for Primary Care.

Communications

The MCCG winter campaign 'Don't just go to A&E' was one of the steps used to encourage people to consider alternatives to A&E. Statues with ailments (yellow mannequins), press releases, social media and bus advertising were implemented in support of raising awareness.

Supporting Data

Analysis of the effectiveness of urgent care services is set against a background of increasing demand on such services, both nationally and locally. Systems are in place to monitor progress and gain better insight into how services are being used and whether expected outcomes are being delivered.

System Resilience

- Regular A&E performance reports are received from the three local acute trusts (St Georges, St Helier and Kingston Hospitals), enabling Merton CCG to have an awareness of system pressures. Should trusts fail to meet the standard that 95% of patients are seen within four hours then SWL CCGs support the trusts in implementing actions for re-balancing services.
- During Q3 Merton's local trusts struggled to meet the 95% target, mirroring the national experience of additional pressures in December. Across the quarter St George's University Hospitals Foundation Trust performance was 90.69%, with Kingston Hospital

NHS Foundation Trust at 94.82% and Epsom and St Helier University Hospital NHS Trust 94.65%.

Walk-in Centre Services

In the period April to September 2014 there were approximately 12,600 attendances at the Wilson Walk-in Centre for treatment. The CCG receives regular reports from the local Walk-in Centre Service which allow robust monitoring of both quantitative and qualitative data. Since April 2014 the service has demonstrated 100% patient satisfaction.

111 Service

- On average over the 12 month period to October 2014 there were approximately 100 calls per day from Merton CCG patients to the 111 service, although over the Christmas period more than twice this number of calls were received daily
- Daily performance reports are received from the CCG's 111 provider. Reviewing these reports provides assurance to the CCG that Merton patients are receiving a well-managed and responsive service. For example there are daily reports against National Quality Requirements (NQRs) such as the 95% target for "total number of calls answered with 60 seconds". This target at an aggregate level has been met but, when there are concerns regarding performance, the CCG ensures measures are taken to address this.

Winter Schemes (Local Priorities)

- The GP-led winter paediatric drop-in scheme which commenced in November 2014 has delivered additional face to face and telephone consultations for ages 0-17 years. Data provided by the participating GP practices show that there were 1,937 additional appointments made available in November, and 2,056 additional appointments in December.

Communications

- As in previous years, the 2014/15 communication campaign will be evaluated in 2015 to inform future plans

2015/16 Plans

In 2015/16 the CCG will carry out an appraisal of the Urgent and Emergency Care Review to ensure that proposals are effective in transforming future services. This will be done in collaboration with other SWL CCGs

System Resilience

- Merton CCG is currently working will local CCGs to ensure that the demand and capacity modelling for 2015/16 includes:

- admitted care
- non-admitted care
- bed modelling
- diagnostic capacity

Walk-in Centre Services

- Taking into consideration local health needs, the CCG will engage Healthwatch Merton and the SWL Communications Team to design and undertake a local user survey of provision and future need. This will inform the development of a Merton vision for walk-in centre services.

111 Service

- Commission an integrated 111 service across South West London CCGs. Implement learning from the NHS England London-wide pilots to enhance future provision.

Communications

- Work with local Polish and Tamil communities to inform them of access to services other than A&E as an option for treatment, to reduce the number of inappropriate attendances.
- Continue to introduce targeted bursts of communication activity that inform the public of alternative care pathways and enhance advertising to reach a wider audience.
- Increase the number of patient satisfaction surveys to be completed.

2015/16 Targets and Trajectories

In 2015/16 key indicators of effective use of A&E services, and the success of communication campaigns to advise people of services available, will be monitored to identify areas for improvement (e.g. number of patients attending A&E who are redirected to primary care as their needs can be met there). This will include measuring:

- Overall A&E activity
- A&E activity with no intervention, treatment or follow-up required
- Number of redirects from A&E to other services
- Number of people admitted after 3½ hours who stay for less than one day

3.9 Medicines Management

2014 Achievements

In 2014/15, the CCG ensured medicines optimisation was considered as part of all services commissioned, in particular the proposed clinical services at the Nelson Health Centre. Engagement with secondary care providers has been strengthened, notably St George's Healthcare NHS

Trust via the Drugs and Therapeutics Committee which has enabled joint decision making with respect to medicines used in both primary and secondary care. Other achievements in 2014/15 are as follows:

- There was a review of prescribing of oral nutritional supplements within three care homes.
- Continuation of medication reviews in care home reviews by pharmacists and engagement with Merton Care Homes Forum.
- Implementation of the medicines optimisation QIPP work plan which focused on safe, cost effective prescribing in primary care.
- Supported the London Borough of Merton to develop the statutory pharmaceutical needs assessment (PNA) to inform future commissioning from community pharmacies.
- Supported education events for both diabetes and chronic obstructive pulmonary disorder (COPD) as well as local stakeholder group for diabetes.

Supporting Data

- Our dietician reviewed prescribing records of 108 care home patients and identified 17 that required interventions from September to December in two care homes. Work in the third care home commenced in January.
- Clinical records of 83 patients in care homes have been reviewed by two pharmacists and 218 clinical interventions made.
- Draft pharmaceutical needs assessment was out for consultation until 31 December and will be published on 1 April 2015.

2015/16 Plans

In 2015/16, we will continue to build on the achievements of 2014/15 to ensure that any service commissioning considers the medicines aspects and implications to provide value for money, impartiality of access, quality and patient safety. There will be an investment in additional pharmacist resource to support proactive reviews in primary care. We will work with GP practices to increase the use of electronic prescribing to get the best out of this innovation. We will:

- implement proactive repeat prescription reviews in GP practices;
- extend dietician work into more care homes, identify and support reviews of other patient groups and support training of care staff as well as primary care staff;
- continue medication reviews in care homes and work to identify policies and systems for the safe handling, storage and administration of medicines as well as medicines waste reduction in care homes;
- commission a medicines adherence/support service as part of the community services re procurement;

- work with local community pharmacies to reduce medicines waste and run a waste campaign;
- ensure medicines optimisation is central to the work of all providers who work within the Nelson Health Care Centre;
- work with primary and secondary clinicians to promote appropriate use of antibiotics locally as part of the 2015/16 Quality Premium;
- develop a local network to enable the sharing of learning from medicines incidents
- use the Pharmaceutical Needs assessment to review community pharmacy services with NHSE and commission services to meet the need of the local population.

2015/16 Targets and Trajectory

- Numbers of patient care home medication reviews for 2015/16
- Numbers of patient records proactively reviewed by practice support team
- Reduction in medicines waste identified through the medicines waste initiatives
- Number of care pathways developed for the Nelson that include elements relating to medicines
- An increase in the number of care home patients on ONS that have had their nutritional supplements reviewed, target 500
- A medicines support service commissioned as part of the community service
- An increase in the use of electronic prescribing from 44% to 60% and ensure 60% practices are transmitting prescriptions electronically.
- Achieve the target in the 2015/16 Quality Premium (not known yet)
- Standardised method of sharing trends and learning from medicines related incidents
- Number of community pharmacy services reviewed and amended to meet the needs of the local population.

4. Quality

4.1 Quality and Patient Safety

Achievements 2014/15

Lord Darzi's definition of quality, first seen in *High Quality Care for All* (2008) is now enshrined in legislation through the Health and Social Care Act 2012.

The definition identifies the three elements of quality as:

- Safety – patients and service users suffer no avoidable harm;
- Effectiveness – evidence based and in line with best practice;

- Patient experience – patients have a positive experience and are treated with dignity and respect.

To ensure services we commission are of a high quality we advocate:

- strong clinical leadership – ensuring that models of care are fit for purpose, and meet the needs of our patients;
- value for money – providing high quality care by ensuring effective and efficient use of resources;
- equality – treating our staff and patients equitably and ensuring services address inequality;
- partnership and collaboration – delivering high quality services to achieve the best possible outcomes.
- honesty and integrity – working openly with the public, our patients and all other stakeholders to build a mutual level of trust and understanding, and doing what we say we will do;
- openness and transparency – being open about what can and cannot be done, and being accountable for the decisions made
- listening and involving – listening to what people tell us about their needs and experiences, and involving them in finding solutions.

Priorities for 2015/16

The Merton CCG Quality Strategy was developed and presented to the Governing Body in May 2013. Two years on, it is time to review 2015/16 to reflect changes across the health and social care landscape and to encompass the evolving vision and values of the organisation.

The plan will be refreshed and an implementation plan developed and monitored through internal governance structures by the end of June 2015.

Improving Patient Safety

In recent years a number of seminal reports have been published centred on the safety of care for individuals receiving NHS care:

- Winterbourne Review *Transforming Care: A national response to Winterbourne View Hospital* (2012)
- DH Winterbourne View Review: *Concordat; Programme of Action* (December 2012)
- Francis Inquiries 2010 and 2013 and the initial Government response *Patients First and Foremost* (March 2013)
- Cavendish Review *An independent review into healthcare assistants and support workers in the NHS and social care settings* (July 2013)
- Keogh Review: *Review into the quality of care and treatment provided by 14 hospital Trusts in England* (July 2013)

- Berwick Review: *Improving the safety of patients in England* (March 2013)

Merton CCG has worked with NHSE to ensure care and treatment reviews have been undertaken for appropriate patients to assist in achieving the aim of discharging or transferring at least 50% of London patients who were in the Winterbourne View cohort at 1 April 2014.

Priorities for 2015/16

The recommendations from these reports continue to influence care delivery. During 2015/16 Merton CCG will continue to drive and embed improvements in safe and compassionate care in response to the Francis Report, the failings at Winterbourne View and the Berwick Review.

The CCG will maintain the focus on achieving the requirements of the Winterbourne View Concordat to ensure CCG-funded individuals are regularly reviewed, are cared for in an appropriate setting with a robust plan of care. The CCG will comply with mandated returns for monitoring these individuals.

The CCG will also ensure providers of healthcare are prepared for the introduction of nursing and midwifery revalidation from the end of December 2015. This will set new requirements for nurses and midwives when they renew their registration every three years.

Safeguarding Adults at Risk - Achievement 2014/15

During 2014/15 MCCG commissioned further resources to focus further on adult safeguarding. A refresh of the safeguarding adults at risk tool has been undertaken and the links with the local authority and the Care Quality Commission (CQC), in respect of quality in care homes have been developed.

The Care Act (2014) was given Royal Assent in May 2014. The Act places adult safeguarding on a statutory footing, to reflect the arrangements in place for children, but it is still non-prescriptive about service organisation.

Priorities for 2015/16

- Focus on the quality and monitoring of safeguarding adults at risk systems and processes, commissioned by Merton CCG
- Ensure attendance at Merton Safeguarding Adults Board, which will be placed on a statutory footing following the implementation of the Care Act from 1 April 2015.
- Develop a work plan to reflect the priorities identified in the safeguarding adults at risk self-assessment tool

- Participate in an advisory audit with our internal auditors to identify areas of good practice and further develop priorities.

Safeguarding Children – Achievement 2014/15

During 2014/15 two independent consultants for safeguarding children were commissioned review the designated nurse safeguarding children role, which includes looked after children responsibilities.

Arrangements for named GPs for each CCG area have been reviewed nationally to minimise the significant differences that currently exist with effect in London from 1 April 2015 with the following recommendations:

- Merton CCG should have 2 sessions per week
- A contract for services rather than a contract of employment will be used to secure the named GP function

Priorities for 2015/15

- To continue to focus on the quality and monitoring of safeguarding and looked after children systems and processes, commissioned by Merton CCG.
- To respond to externally commissioned review of children looked after (CLA) services and to develop the strategic aspects of the service
- To enhance the regular meetings and supervision of all safeguarding lead professionals in all provider units in order to develop a consistent standard of reporting and information sharing for safeguarding
- Continuing to ensure CCG staff are aware of and compliant with mandatory safeguarding training
- With changes in commissioning and co-commissioning arrangements, it is proposed that the CCG takes over managing the arrangements for securing a named GP in Merton.

Workforce – Achievement 2014/15

Merton CCG recognises that to ensure quality is delivered we need to ensure we support and continually develop our workforce.

Throughout 2014/15 we have worked, with human resources support, to develop and ratify a range of supporting polices to assist staff and managers to fulfil their duties.

We will take actions in 2015/16 to improve the physical and mental health and well-being of our staff by developing plans to implement NICE guidance on promoting healthy workplaces. We will administer and review the findings of a revised staff survey to understand how it feels to be a member

of staff in Merton CCG and develop a robust action plan that responds to this.

All NHS employers are encouraged to take significant additional actions in 2015/16 to improve the physical and mental health and well-being of their staff.

Priorities for 2015/16

- Building on the current arrangements further to develop clinical leadership at the core of CCG decision making and pathway redesign to provide better outcomes for patients.
- To fulfil the aspiration to be a good employer, supporting staff to develop the skills and competencies to undertake their roles efficiently and effectively.
- Where practicable, joint pieces of work will be undertaken with the local authority, for example, signing up to the 'London Healthy Workplace Charter.'
- Work with Health Education South London (HESL) and the Local Education and Training Board (LETB) to identify current and future workforce needs to plan for the changing health and social care landscape.

4.2 Empowering Patients

NHS Citizen

Merton CCG supports the approach of NHS England to develop the NHS Citizen model with the aim of eventually forming a new culture of collaboration between NHS England and the public. The project has been designed to develop a method of for NHS England to take into account the views of the public when it makes decisions.

The aim of NHS England is to create a change in the culture with patients and the public actively involved at the heart of its decision making to help solve long-term problems, deal with ongoing issues, and take part in its decision-making. Citizens will no longer be just end-users of the NHS, but active participants in its future with the power to raise issues for discussion, connect with others who have the same interests, and hold the NHS England Board to account.

Patient Engagement

In December 2014 Merton CCG held a stakeholder event to begin the refresh of our communications and engagement strategy, outlining the direction of travel and the ways we communicate and engage with our stakeholders to fulfil our statutory duties on public and patient involvement.
The combined strategy provides members of staff with support and guidance in the form of a communications and engagement protocol to

support commissioning activity. Merton CCG has identified the following priorities to support patient and public involvement in commissioning:

- To ensure the key principles and values of the NHS Constitution are integral to everything we do by providing safe care and ensuring people experience better care
- To ensure the patient voice is heard throughout all levels within the organisation with particular use of Patient Engagement Group/s
- To ensure that the views of patients, service users and carers are represented in the planning, delivery and evaluation of commissioning decisions within the organisation.
- To ensure that the values underpinning equality, diversity and human rights are central to our policy making, service planning, employment practices and community engagement and involvement.

Priorities in 2015/16

Merton CCG will maintain its focus on how we will meet our statutory duties on public and patient involvement in our commissioning decisions. We will work with our members, staff and stakeholders to embed the refreshed communications and engagement strategy and protocol and to continue to 'listen as never before.'

The CCG will continue to explore all the options for patient and public engagement by:

Individual involvement - Engaging individual members of the public in their own health and care through shared decision-making and giving them more choice and control over how, when and where they are treated – helping to deliver "no decision about me without me".

Collective involvement – We will engage with the public and groups with common health and care issues. We will help get services right for them. We will involve the public and patients in decisions about the planning, design and reconfiguration of health services; proactively as design partners and reactively through effective consultation.

Co-production – Working collaboratively with local communities from different geographical areas, communities of interest and seldom heard groups to ensure their views are integral in the commissioning, design, delivery and evaluation of services.

We will ensure that the patient voice is heard in the planning and commissioning of key strategic projects such as the reprocurement of community services and the development of the health facility in Mitcham.

The CCG will support NHS England to further develop the NHS Citizen approach and consider how we can engage the local community to influence decision-making.

Prevention

The Expert Patients Programme (EPP) is a free self-management course that supports people in Merton living with one or more long-term health condition. Common long-term conditions include: diabetes, back pain, high blood pressure, depression, anxiety, asthma, arthritis and chronic obstructive pulmonary disease (COPD). The course offers a tool kit of techniques to enable participants to manage their conditions better on a daily basis, by increasing their confidence and quality of life. During 2014/15 courses delivered included generic EPP courses and specific courses with a focus on carers, a translation into Tamil and specifically for COPD and asthma.

Priorities for PPI within 2015/16

- 2 language courses: July – August 2015; February – March 2016
- 2 carers courses: May – June 2015; October – November 2015
- 1 diabetes self-management course: November – December 2015
- 3 generic EPP courses: April – May 2015; September – October 2015; January – February 2016
- General promotion, including stands at events to include Mitcham Carnival; Ageing Well Festival; Carers Week
- Targeted promotion, including GP's/practice nurses, localities, practice leads, PPG members, LiveWell
- Building a team of volunteer tutors: approach local groups and organisations staff and volunteers; progress existing tutors to become assessors and master trainers, and train in other self-management courses.

Choice

Everyone who is cared for by the NHS in England has formal rights to make choices about the service that they receive. These include the right to choose a GP surgery, to state which GP they would like to see, to choose which hospital they are treated at and to receive information to support their choices. These rights form part of the NHS Constitution. Merton CCG recognises this right and during 2015/16 we will continue to work together with patient groups to understand how health care is currently delivered, ensuring patients are further supported in exercising their right to choose.

Personal Health Budgets

For some NHS services patients can choose to have a personal health budget. A personal health budget is an amount of money with an associated plan detailing how the budget will be used to achieve health outcomes.

The plan is agreed between a patient and their health care professional or clinical commissioning group. It sets out the patient's health needs, the amount of money available to meet those needs and how this money will be spent.

When a care plan has been agreed, a personal health budget can be managed in three ways, or a combination of the three:

- A 'notional budget': the money is held by a clinical commissioning group or other NHS organisation who arrange the care and support that you have agreed, on your behalf
- A 'third party budget': the money is paid to an organisation which holds the money on your behalf (such as an independent user trust) and organises the care and support you have agreed
- A direct payment for health care: the money is paid to the individual or their representative to buy and manage the care and services as agreed in the care plan.

In each case there will be regular reviews to ensure that the personal health budget is meeting the agreed needs. If there is a direct payment there will be a review of how the money was spent. There has been a legal 'right to ask' for a personal health budget from April 2014, which was extended to a legal 'right to have' a personal health budget (with some exceptions) from October 2014, for people receiving NHS continuing health care (including children).

NHS continuing health care is a package of care arranged and funded solely by the NHS and provided free to the patient. This care can be provided in any setting – including an individual's own home. An assessment is carried out by the clinical commissioning group using a multi-disciplinary team of health and social care professionals. Merton CCG has offered personal health budgets to individuals in receipt of continuing healthcare who are supported to live in their own homes.

Clinical commissioning groups are able to provide personal health budgets to other groups of patients on a voluntary basis, if they recognise that there is a benefit to the patient and the NHS from offering packages of care in this way.

Priorities for 2015/16

Merton CCG will engage widely with the local community and patients and Healthwatch with the aim of expanding the opportunity for individuals to access a personal health budget for both adults and children.

Support for Carers

The 2011 census revealed that there were approximately 5.8 million people in England and Wales providing unpaid care, representing just over one-tenth of the population. In Merton there are thought to be approximately 17,000 carers with an estimated economic contribution of £285.7million.

The National Carers Strategy of 2008, *Carers at the heart of 21st-century families and communities* and the 2010 strategy, *Recognised, valued and supported: Next steps for the Carers Strategy,* set out the vision and priorities for supporting and valuing the contribution of carers.

In October 2014 an action plan (*Carers Strategy: Second National Action Plan 2014– 2016*) was published which builds upon these two strategies. The South West London Five-year Strategy emphasises the fundamental importance of supporting informal carers to ensure that their health and well-being needs are met and that they receive support to maintain finances and to stay in work, where relevant.

Priorities for 2015/16

- Ensure that improving support for carers is a priority for all of the core delivery areas and is incorporated into work packages as appropriate.
- Embed carers support more firmly in existing contracts and incorporate this as a common area of exploration in contract review discussions.
- Explore introducing CQUINs to incentivise best practice in relation to carer support.
- Work with the London Borough of Merton to gain a clearer understanding of the local implications of the Care Act and the Children and Families Act and the associated responsibilities of different organisations and agencies.
- Collaborate with the London Borough of Merton and other key organisations and stakeholders to develop a new Carers Strategy for Merton.

4.3 Provider Assurance

During 2014/15 the role of Merton Clinical Quality Committee has continued to evolve to reflect its role in providing assurance to the Governing Body of the quality of provider services. Our integrated quality and performance report has been redesigned to reflect patient safety data, along with key performance indicators.

Merton CCG has a programme of quality assurance whereby it reviews the care given at its main NHS providers, through our GPs who are members of their local Clinical Quality Review Groups (CQRG). The CQRGs are clinically led committees which review quality of care within each provider

and are chaired by a clinician of the 'host' CCG, and attended by GPs and other members of the associate CCGs.

During 2015/16 Merton CCG will continue to work with providers, partner organisations, and through forums such as the system resilience group, to gain assurance that patients receive high quality, safe care.

Priorities for 2015/16

- Further development of reporting frameworks, reflecting local and national priorities
- Strengthening the support for clinicians who attend CQRGs to reflect issues affecting Merton residents
- Continued attendance by the Director of Quality at the South London Quality Surveillance Group to share intelligence and disseminate learning
- During 2015/16, we aim to develop our quality assurance programme to ensure scrutiny of the quality of care given by all our providers, including intermediate care, continuing care, nursing and residential homes.

4.4 Quality Premium

The Quality premium rewards CCGs for improvements in the health outcomes of our population and each year it is worth approximately £1m to Merton CCG.
To be eligible to receive the quality premium Merton CCG must ensure that it has met the following constitutional standards:

- A&E 4 hour waits
- Referral to treatment in maximum 18 weeks
- Maximum 14 day wait from an urgent GP referral for suspected cancer
- Ambulance 8 min Cat A (red 1) response.

For the 2015/16 Quality premium the Clinical Reference Group has committed to:

- Reduce premature mortality by at least 1.2%
- Urgent and emergency care:
  a) Achieve a reduced four year trend in avoidable emergency admissions
  b) Increase discharges at weekends and bank holidays by 0.5%
- Reduce the number of people with severe mental illness who are smokers
- Medicines management:
  a) Reduce the number of antibiotics prescribed in primary care by 1% (or greater) from the 2013/14 value.

b) Reduce the number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care by 10% from the 2013/14 value
c) St Georges and Epsom and St. Helier to validate their total antibiotic prescribing data as certified by Public Health England

- Increase the number of people diagnosed with type 2 diabetes accessing structured education
- Improve diagnosis rates for diabetes

4.5 CQUINs

Merton CCG will offer each provider, through the commissioning for quality and innovation payment framework (CQUIN), the opportunity to earn up to 2.5% of its annual contract value (excluding drugs, devices and other items funded on a pass through basis).

The 2015/16 CQUIN scheme will feature four national indicators, with an even balance between physical and mental health:

- Two of the current national indicators will remain in place, with limited updating; these cover improving dementia and delirium care and improving the physical health care of patients with mental health conditions
- Two new indicators will be introduced, one on the care of patients with acute kidney injury, the other on the identification and early treatment of sepsis
- There will be a new national CQUIN theme on improving urgent and emergency care across local health communities (commissioners will select indicators locally from a menu of options)
- National CQUIN indicators in 2014/15 covering the safety thermometer and the friends and family test will instead be covered from 2015/16 by new requirements within the NHS Standard Contract.

SWLCC has developed a suite of CQUINs for acute and community providers and KPIs for acute providers. These build on the joint SWL commissioning intentions developed for 2015/16 and are intended to support the service development being driven by SWL clinical design groups. There are no penalties attached the KPIs in 2015/16 but it is our intention as a collaborative that moving into 2016/17 the sophistication of the indicators will evolve.

The acute CQUINs are intended to:

- Support the development of LQS, including inter-hospital transfers

- Develop strategic data sets where a lack of data currently inhibits service development for specific CDGs (children, UEC, integrated care and mental health)

The community CQUIN is intended to:

- Support the development of the integrated care and out of hospital agenda

Where providers are not able to access CQUIN due to the tariff they have selected, the CCG will work to ensure that quality improvements are made. Due to some issues related to the tariff selected by local trusts we still do not have a comprehensive position on CQUIN for all services.

4.6 Equality Objectives

The Equality Act 2010 and Public Sector Equality Duty

The Equality Act 2010 provides a legal framework to strengthen and advance equality and human rights. The Act brought all existing equality law into a single piece of legislation and covers race, sex, disability, age, marital status and civil partnership, sexual orientation, religion or belief, pregnancy and maternity and gender reassignment. These categories are also referred to as 'protected characteristics.'

Under the Equality Act (Public Bodies), the CCG has a general duty to show 'due regard' to three aims:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

To meet the general duty, the CCG has two 'specific duties', which include:

- Publishing 'equality information' to demonstrate compliance with the general duty
- Publishing 'equality objectives' needed to meet the aims of the general duty.

Embedding equality and diversity: Equality Delivery System (EDS2)

The Equality Delivery System (EDS) was launched on 11 November 2011 by NHS England to help NHS organisations embed equality and diversity into their service delivery and employment practices.

The refreshed EDS, or EDS2, was launched in November 2013 with the support of the NHS Trust Development Authority. It was designed to be an outcome-focused and accessible tool that would enable NHS organisations to assess and improve their performance against four goals and 18 outcomes. The four goals are described below and the outcomes under each goal are:

- Goal 1: Better health outcomes
- Goal 2: Improved patient access and experience
- Goal 3: A representative and supported workforce
- Goal 4: Inclusive leadership

Since authorisation in April 2013, the CCG has placed a strong emphasis on promoting equality within the organisation and the way it works. To guide and support the implementation of the EDS2 to deliver fairer outcomes for patients, communities and staff, Merton CCG has set up an equality and diversity group (EDG), chaired by the Director of Quality.

The CCG gathered extensive quantitative and qualitative evidence throughout 2014 to assess its performance against EDS2. This took place in two phases.

The first phase, which took place between March and July 2014, assessed goals 1 and 2 by focusing on the three commissioning priorities, namely: improving access to psychological therapies (IAPT), children and adolescent mental health service (CAMHS-Tier 3) and older people's services in community settings.

The second phase assessed goals 3 and 4 by engaging staff and leadership teams between July and November 2014.

Implementation plans focus on the CCG taking actions to ensure:

- it is recruiting and developing its workforce fairly;
- staff have positive experiences of being part of the workforce;
- the CCG leadership sustains its commitment to equality and diversity;
- equality and diversity are integrated into the decision-making processes;
- governing body members have access to training and development and user-friendly resources to assist with decision-making.

Priorities for 2015/16

- Review communications and engagement strategies as inclusive and actively responding to needs of diverse community

- HR: Demonstrate improvement of disaggregated staff views on current workforce issues (including health and well-being, bullying and harassment).

The CCG currently uses the NHS Standard Conditions of Contract with all providers, which includes a clause on equality and diversity. The CCG has also put in place a process to receive assurance reports on equality and diversity from key providers. Following the NHS England's consultations on the standard conditions of contract, new reporting requirements related to work place race equality standards will be placed on providers. These will be integrated into the conditions of contract template after guidelines on the metrics are published by NHS England.

5. Performance Monitoring and Delivery

5.1 Progress Against 2014/15 Indicators

Merton CCG currently monitors the organisation's performance against three of the measurable rights and pledges described in the NHS Constitution handbook (March 2013):

1. People's right to access certain services commissioned by NHS bodies within maximum waiting times
2. Government pledges on waiting times and
3. CCGs' responsibility to secure continuous improvements in the quality of services provided to individuals.

This will be reported at year end.

5.2 Outcome Ambitions 2015/16

As part of the two-year Operating Plan we are continuing to deliver the outcome ambitions for 2015/16 that we agreed to deliver in 2014/15.

5.3 Performance Standards 2015/16

The mandate from the government to the NHS is unchanged from previous years and Merton CCG has committed to meeting the following constitutional standards:

Constitutional standards	Target
Referral to treatment 18 weeks for admitted patients	90.0%
Referral to treatment 18 weeks for non-admitted patients	95.0%
Referral to treatment 18 weeks for incomplete pathways	92.0%
Diagnostic tests waiting time within 6 weeks	99.0%
Cancer: All cancer following urgent GP referral for suspected cancer within two weeks	93.0%
Cancer: Two-week wait for breast symptoms where cancer was not initially suspected	93.0%
Cancer: Patients receiving first definitive treatment within 31 days of a cancer diagnosis	96.0%
Cancer: Subsequent treatment for surgery within 31 days	94.0%
Cancer: Subsequent treatment for drugs within 31 days	98.0%

Cancer: Subsequent treatment for radiotherapy within 31 days	94.0%
Cancer: First treatment following GP referral within 62 days	85.0%
Cancer: First treatment following referral from an NHS cancer screening service within 62 days	90.0%
Cancer: First treatment following referral from a consultant's decision to upgrade the patients priority within 62 days	90.0%

In order consistently to meet waiting time standards, it is the CCG's responsibility to ensure that providers increase capacity in line with the predicted growth in activity. In order to support delivery of these standards, Merton CCG forecasted the levels of activity expected during 2015/16 for each of the constitutional indicators.

The following methodology and the rationale for its use is summarised for each of the indicators:

Constitutional standard	Methodology used to forecast activity	Rationale for the methodology
Cancer standards	Linear growth applied to predict 2015/16 activity. The predicted activity then multiplied by the tolerance of the performance standard to identify the number of patients that may not meet the performance standard.	Historic activity shows a linear growth trend. Performance standards have occasionally not been met, but this has occurred mostly in months when there was a low number of referrals and missed waiting times standards for a small number of patients significantly affects the performance standard. *(Please note narrative regarding cancer 62-day waits below.)*
Diagnostics	Linear growth applied to predict 2015/16 activity. The predicted activity then multiplied by the tolerance of the performance standard to identify the number of patients that may not meet the performance standard.	Historic activity shows a linear growth trend. *(Please note narrative regarding diagnostics waits performance below.)*
Referral to treatment	1. Linear growth applied to the number of incomplete pathways to predict the future demand of referral to treatment pathways. 2. Incomplete pathways apportioned to admitted and non-admitted pathways using the 2014/15 ratio of admitted to non-admitted	1. The historic growth of incomplete pathways shows a linear trend. *(Please see note below regarding referral to treatment backlogs.)* 2. Incomplete pathways include both admitted and non-admitted activity. 3. RTT guidance suggests that a provider should be able to treat all the

	pathways. 3. The number of admitted and non-admitted incomplete pathways divided by a run rate of 2.5.	patients on its backlog in 11 weeks, this requires a run rate of 2.5.

Cancer 62-day waits:
Monthly breach analysis of the cancer 62 days standard shows that the majority of breaches occur on patient pathways where more than one acute provider is involved in the treatment pathway. Providers are currently performance managed and penalised at completion of the patient pathway, even when they have received referrals from other providers late in the patient pathway. Although failing providers are penalised for breaching the 62 day standard, they are not penalised for individual breaches. As Merton CCG patients use a variety of acute and tertiary providers for Cancer care, although providers may meet the cancer 62-day standard, the CCG may not meet the standard. Merton CCG will therefore work with our co-commissioners across London to facilitate mechanisms to monitor and where possible, performance manage provider's contribution to the whole patient pathway with the aim of ensuring CCG performance of the cancer 62-day standard.

Diagnostics and referral to treatment:
Analysis of historic performance and activity data for Merton CCG suggests that our main providers increase capacity following a period of below threshold performance, which is evident in diagnostics pathway, or allow backlogs to occur, which is evident in the referral to treatment pathways. (A backlog is when a patient is waiting for treatment beyond the waiting time standard, but this activity has not been counted as the patient has not yet been treated.) This indicates that the need for increased capacity may not have been anticipated and adequately communicated.

As occurred nationally, during 2015/16 Merton CCG had a large number of people waiting for treatment beyond the 18 weeks RTT waiting time standard, but not counted in the RTT performance returns, as these patients had not yet been treated.

Merton CCG will therefore work with our co-commissioners to ensure that predicted growth in activity is sufficiently shared with providers as part of the contracting process to support delivery of the performance standards.

Ambulance and A&E:
Merton CCG is not the lead commissioner for Ambulance services or an acute trust, therefore the CCG is not responsible for predicting the levels of activity to support delivery of these targets. However, the CCG will work with associate commissioners in order to support the delivery of the A&E 4

hour waits target and the Ambulance 8 minute response times for category A calls and 18 minutes for category B calls.

Forecast of Operating Plan Activity

The following assumptions were applied to predict the 2015/16 Operating Plan activity:

Operating plan activity														
	Spells	Spells	Spells	Spells	Spells	Spells	OP	OP	OP	OP	OP	A&E	Refs	Refs
Assumptions applied	Daycase elective spells (all specialities) EC32	Non-elective spells - all specialties E.C.23	Non-elective spells - G&A E.C.4	Daycase Elective Spells - G&A E.C.2	Elective Spells - all specialties E.C.21	Ordinary Elective Spells - G&A E.C.1	All First Outpatient Attendances all specialties E.C.24	All First Outpatient Attendances - G&A E.C.5	First Outpatient Attendances following GP Referrals - all specialties E.C.25	First outpatient attendance following a GP referral - G&A E.C.12	All subsequent outpatient attendances - all specialities E.C.6	A&E attendances all types E.C.8	GP Referrals E.C.9	Other Referrals E.C.10
2015/16 Growth forecast	2.10%	3.50%	5.00%	2.10%	2.10%	2.10%	4.20%	4.20%	4.20%	4.20%	4.20%	4.00%	4.20%	2.10%
Activity reduction due to BCF/QIPP		896	896				1891	1564	1203	1001	3409		1188	
Predicted change in activity between 14/15 and 15/16	-2.10%	0.09%	0.01%	-2.10%	-2.10%	-2.10%	-2.31%	-2.31%	-2.31%	-2.31%	-2.32%	-4.00%	-2.10%	-2.10%

1. 2015/16 growth was assumed based on past activity growth.
2. Actual reduction of activity was calculated based on the timing of implementing BCF/QIPP schemes.
3. The predicted change in activity between 14/15 and 15/16 was calculated based on the forecast outturn for 14/15 activity (as at month 9), plus demographic growth, minus activity reductions due to BCF/QIPP schemes.

6. Financial Strategy and Financial Plan 2015/16

6.1 The financial resource of our Clinical Commissioning Group will 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 Merton LA to deliver social care aspects such as reablement and domiciliary packages. In addition the money will also be used to provide seven-day services across community and social care.

- Out-of-hospital/community-based care – Merton CCG will be opening the Nelson Health centre on 1 April 2015, which will provide 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 & Well-being Board in 2014-15. As a result of this the CCG will work with Merton Local Authority 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)
    - a Merton-based attention deficit hyperactivity disorder/autism spectrum disorder (ADHD/ASD)
    - single point of access to CAHMs services
    - enhancing the community services e.g. home treatment teams.

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. It builds on the initial strategic, operational and financial planning that was developed for 2013/14.

6.2 It is good news for Merton CCG that the change in the national allocation has acknowledged that Merton has historically been underfunded and therefore received growth of 8.03% in 2015-16. This helps the CCG to deliver its commissioning strategy and achieve its objective of right care, right place, right time and right outcome.

6.3 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.

6.4 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.

Financial plan 2015-16

6.5 Summary Plan

Table 1 below shows the resource allocation adjusted for non-recurrent resource and spend identified to date to deliver the 1% planned surplus requirement for 2015-16.

Table 1

	£000s	£000s	Ref
Resource			
Start position adjusted for non-recurrent resource		**209,153**	
Growth allocation		16,798	
BCF (S256)		3,428	
Running cost		4,544	
Surplus b/fwd		2,667	
Total 2015-16 resource allocation		**236,590**	
Expenditure			
Forecast recurrent spend	**(210,055)**		
FYE of QIPP	879		
Gross QIPP	4,087		
Cost pressures	(6,018)		Table 4
Non-recurrent cost pressures	(1,234)		Table 5
FYE of Investments	(2,445)		Table 6
New investments	(11,276)		Table 7
Growth & inflation for contract	(4,365)		
Non-recurrent investment	(2,612)		Table 8
Contingency fund	(1,183)		
Total Expenditure		**(234,224)**	
Surplus		**2,366**	

6.6 The proposed draft plan has been put together following discussions with budget holders and an investment process to prioritise investments. Work is still on-going to ensure the plan is robust and deliverable. There are significant risks with the plan as a tariff for 2015-16 has not been published which, in turn, is causing delay on agreeing contracts with providers.

6.7 The financial plan meets the requirements set out by NHS England in the national financial planning guidance. The business rules for 2015-16 are the same as the 5 year plan:

- Surplus – 1%

- Contingency reserve – 0.5%
- Non recurrent reserve – 1%

2014-15 forecast out-turn position

6.8 The CCG is forecasting a surplus of £2.7m; £0.5m better than plan. The improved position is as a request from NHS England to increase our surplus in line with the amount returned from the CHC top-slice to cover legacy payments. The position assumes delivery of the QIPP plan at £6.5m, utilisation of our contribution to the SWL risk pool £1.1m to fund the underlying position and release of all recurrent reserves.

6.9 The resource allocation for 2014-15 is forecast to be £218m inclusive of £5m for running costs. This is an increase of £2m from the starting plan; predominantly to cover winter resilience funding £1.1m, GP IT £0.5m and 2013-14 quality premium £0.4m.

6.10 The forecast expenditure position is as follows; acute contracts are to over spend by £1.6m, non-acute services are to over-spend by £0.3m, primary care (including prescribing) is to over-spend by £0.7m and corporate and estate costs are to over-spend by £0.7m. These over-spends are offset by the contingency and reserves. Running costs are forecast to be in line with plan.

Resource Allocation

6.11 In December 2013 the CCG was allocated an increase of £9.4m funding above the 2014-15 allocation to give a programme allocation of £218m. Following the autumn statement by the Chancellor of Exchequer on 3 December 2014, a further increase of £7.4m was allocated to the CCG. This results in an overall increase of £16.8m which represents an increase of 8.03% giving a programme allocation of £226m. Following the revised allocation the CCG is 4.77% below distance from target. In addition the programme allocation will increase for the S256 transfer from the Local Authority (£3.4m) and the surplus for 2014/15, giving a total allocation of £236m.

6.12 The resource allocation excludes non-recurrent adjustments for GP IT (£0.5m) and a reduction for overseas visitors (£0.2m) that were made in 2014-15 and are expected in 2015-16.

6.13 The allocation ring-fenced for the Better Care Fund (BCF), is £11.2m. In addition £0.9m will transfer to the Better Care Fund from Local Authority making the minimum amount expected in the Better

Care Fund to be £12.2m. The make up of the funding is as follows;:

	2015-16
	£000s
S256 transferred to CCG allocation	3,428
CCG transfer to BCF	7,826
Total CCG allocation to BCF	**11,254**
LA -Disabilities Facilities Grant	528
LA -Social Care Capital Grant	416
Total transfer to BCF	**12,198**

Table 2

6.14 The S256 funding currently sits with NHS England and is paid directly to Local Authority. This will continue in 2014-15, but will transfer to Merton CCG in 2015-16. The transfer from CCG to the Better Care Fund of £7.8m is approximately 3.5% of its allocation; this funding is currently committed by the CCG and includes funding for carers breaks and reablement.

6.15 Merton's running cost allocation is £4.5m a reduction of £0.5m from 2014-15, which was notified in December 2013.

Expenditure planning assumptions

6.16 Planned expenditure for 2015-16 starts with the 2014-15 forecast outturn position as at month 11, adjusted for tariff deflator, QIPP and growth.

6.17 The draft 2015-16 tariff was issued in November 2014 for consultation, which closed on 24 December 2014. The 2015-16 draft tariff has an efficiency assumption of 3.8% and an increase of 1.93% to reflect inflationary prices and national cost pressure increases, giving an overall tariff deflator of 1.87%. However due to an increase in CNST costs, specific HRGs (healthcare resource grouper) have been uplifted giving an overall average impact on the national tariffs of 0.8% lower than 2014-15. In addition mental health providers are to be funded an additional 0.35% for early intervention in psychosis over and above the tariff deflator. Marginal rates for non-elective activity above the agreed threshold increased from 30% to 50%. Specialised commissioning marginal rate reduces from 100% to 50%. The 2015-16 draft national tariff is based on 2011-12 reference costs, which included a revised HRG design compared to the 2014-15 tariff.

6.18 The consultation response resulted in the objection threshold being reached, hence Monitor has to decide whether to refer the matter to the Competition and Markets Authority (CMA) or whether they should develop further proposals on which to re-consult. The process and resolution under either process means that a new tariff will not be in place by April 2015. In order to give some stability to the whole system, Monitor and NHS England wrote directly to all NHS Providers on 18 February 2015 giving them two options for 2015-16 tariff. These options were:

Option A: Enhance tariff option (ETO) – this is achieved by modifying the original 2015/16 tariff in three ways:

- the marginal cost reimbursement for emergency hospital admissions is increased from its current 30% to 70%, compared to the originally proposed increase to 50%, estimated to cost £130m;
- the marginal cost reimbursement for specialised services is raised from the originally proposed 50% to 70%, estimated to cost £170m;
- the gross tariff deflator (excluding uplifts for pay and price inflation) is reduced by approximately £200 million in providers' favour, from 3.8% to 3.5%, estimated to cost £200m.

Option B: Default Tariff Roll-over (DTR) – the default position for any provider not opting for the ETO is that current 2014/15 national prices will remain in force until such time as they are formally superseded. Any changes in the roll-over 2014/15 tariff that occur at that time will not be backdated. Providers opting for DTR will therefore for the time being:

- continue to be paid a 30% marginal rate for emergency hospital admissions, versus the 70% rate on offer through the ETO option;
- not benefit from prices that incorporate additional funding for CNST premium increases;
- not benefit from the 2015/16 proposed service uplift for mental health;
- providers opting for the DTR will not be eligible for 2.5% CQUIN for the entirety of 2015/16 in recognition of the lower efficiency implied in the DTR.

6.19 Providers who opt for the ETO will do so for the full year 2015/16, with no ability to move from the ETO back to the DTR option and on the basis that it would be continued under any subsequent national tariff for 2015/16. Likewise providers who stick with the DTR or its eventual successor will not be able to switch to the ETO mid-year.

6.20 ETO is worth around £500 million more to providers than the 2015-16 tariff proposals consulted on in 2014. The majority of these extra costs will ultimately be borne by NHS England, who will offer £150m as targeted additional funding support to CCGs to help offset some of the pressures arising with their element of this package. The remainder is likely to be used to support specialised commissioning.

6.21 In South West London the majority of the providers have opted for ETO other than St George's and The Royal Marsden, who did not respond and therefore default to DTR. The estimated impact of the provider's choice on these options is a reduction of £1.3m on our acute contracts. The national timetable requires contracts to be agreed by 31 March 2015. However, it is unlikely that this will be met

as, although providers have made a choice of their tariff option, it is clear that commissioners will want to ensure that providers who are on DTR continue to deliver some of the quality initiatives that were planned for 2015-16.

6.22 Guidance from *The Forward View into Action: Planning for 2015/16* expects that each CCG's spending on mental health services in 2015/16, increases in real terms and grows by at least as much as each CCG's allocation increase.

6.23 Local planning assumptions are as follows:

Demographic and Non Demographic Growth	15/16
Acute - Demographic growth	2.14%
Acute - Non Demographic growth	1.36%
Mental Health - Demographic growth	2.14%
Mental Health - Non Demographic growth	1.36%
Community - Demographic growth	2.14%
Community - Non Demographic growth	1.36%
Continuing Care - Demographic growth	2.14%
Continuing Care - Non Demographic growth	1.86%
Prescribing	5.00%
Other Programme	1.90%

Table 3

6.24 The planning guidance requires commissioners and providers to align their plans before final submission.

6.25 The demographic and non-demographic growth based on the assumptions above are £3.6m each. The non-demographic growth is used as flexibility in provider contracts to pay for growth over demographics or service developments. However, this has been reduced by £0.6m to £3m to meet the business rules.

Activity assumptions

6.26 The contract proposals starting position for activity starts with 2014-15, months 1-6 (April – September) doubled as these figures are validated and signed off by commissioners and providers. The following adjustments are applied:

- Seasonality to bring the activity in line with month 11 forecast out-turn
- Full-year effect of any agreed service developments
- Demographic growth of 2.1%
- Additional activity to meet referral to treatment waiting times
- Reductions in activity due to QIPP schemes

6.27 The above assumptions align the activity to the financial plan.

Cost pressures

6.28 Cost pressures of £6m have been identified covering the following items:

- Community and children's services – £1m
- Extension and renewal of 111 contract – £0.3m
- Mental health services – £0.2
- Reinstatement of acute SLA and NETA reserve – £3m
- LAS £0.5m
- Increased SLA with CSU for additional services £0.4m
- Void cost pressure at Nelson £0.4m
- Increase in NCA in month 11 – £0.2m

6.29 The cost pressures identified above reflect the movement from recurrent forecast outturn. The majority are estimates, which have been reviewed by EMT. The values continue to be validated as part of procurements or contract negotiations. It should be noted that the LAS have indicated that the likely cost pressure for Merton is £1.3m. However, this figure does not appear to be robust and all CCGs have requested that the LAS further validate the overall cost pressure and apportionment to CCGs. The CCG has also put aside non-recurrent cost pressures of £1.2m of non-recurrent cost pressures:

- SWL collaborative fees – £0.3m
- BCF performance fund – £0.4m
- SWL CC transformation schemes – £0.5m

Investments

6.30 The full year effect of 2014-15 investments is £2.4m as detailed below:

- IVF £0.4m
- Complex depression services and IAPT services £0.9m
- Community services £0.8m
- Primary care LIS for over 75s £0.3m

6.31 In addition to the full year effect of investments from last year, additional investments of £11.3m have been incorporated into the plan. This includes £7m of Better Care Fund investments. Table 4 itemises the investments included in the plan.

No	Budget line	2015/16
		£000s
1	CAMHS - Single point of access	401
2	Establish an effective crisis management service	200
3	Improving investment and support for community	463
4	**Community health services**	
5	HARI	165
6	Tier 3 weight management services	303
7	Better Care Fund - FYE of 14/15 investments	1,499
8	BCF 2015-16	6,961
9	**Primary care services**	
10	Proactive repeat prescribing review	147
11	**Other programme services**	
12	Systems resilience fund from baseline	1,137
13	**Total 2015-16 Recurrent Investments**	**11,276**

Table 4

6.32 Investments 1,2,3,5, and 10 have been included in the draft financial plan following the prioritisation process in December 2014. The prioritisation process for this year involved the Clinical Reference Group, the Chair of the Health & Well-being Board and a representative of Healthwatch to score the following criteria:

- Strategic fit
- Strength of evidence and quality of proposal
- Magnitude of health benefit
- Number of people benefiting
- Health Inequalities
- Patient and public engagement
- Clinical/professional engagement
- Value for money and cost
- Feasibility

6.33 In total £10.3 m of bids were received. The maximum score is 520. Scoring is rag rated into red, amber and green

- Red (scoring 100 or less): not approved.
- Amber (scoring 101 to 200): schemes may proceed but will be further prioritised for implementation as the financial position enables them to be affordable (this list is reviewed at each quarterly EMT meeting).
- Green (scoring 201 or above): approved if funding available.

6.34 The outcome of the scoring is shown in Appendix 1. EMT had originally approved £2.5m of the green approved schemes (£9.9m) to be implemented for 1 April, with the remainder being approved as and when funding is available. However as the original QIPP target of £6.4m has not been achieved only £1.2m of schemes have now been agreed to proceed. EMT will review the position on a quarterly basis. In addition to the schemes detailed above the 2013-14 quality premium (£0.5m) will be used to support the outpatient navigation scheme.

6.35 The investments prioritised are aligned to our operating plan for 2015-16 and our strategic programme in SWL over the next 5 years.

In particular the investments have focused on delivering care out of hospital/community-based care, mental health services to meet the parity of esteem requirement and the ambitions of the Better Care Fund (BCF).

6.37 The BCF is an enabler to Merton's integration programme between health and social care to improve outcomes for our population. Merton's plan for the BCF which was submitted in September 2014 and formally approved in January 2015 gave a commitment to work towards reducing non-elective admissions (NEL) by 3.5% in calendar year 2015 compared to 2014 and curtailing growth of 2.2%. In real terms this was a reduction of 977 cases equating to a performance fund of £894k.

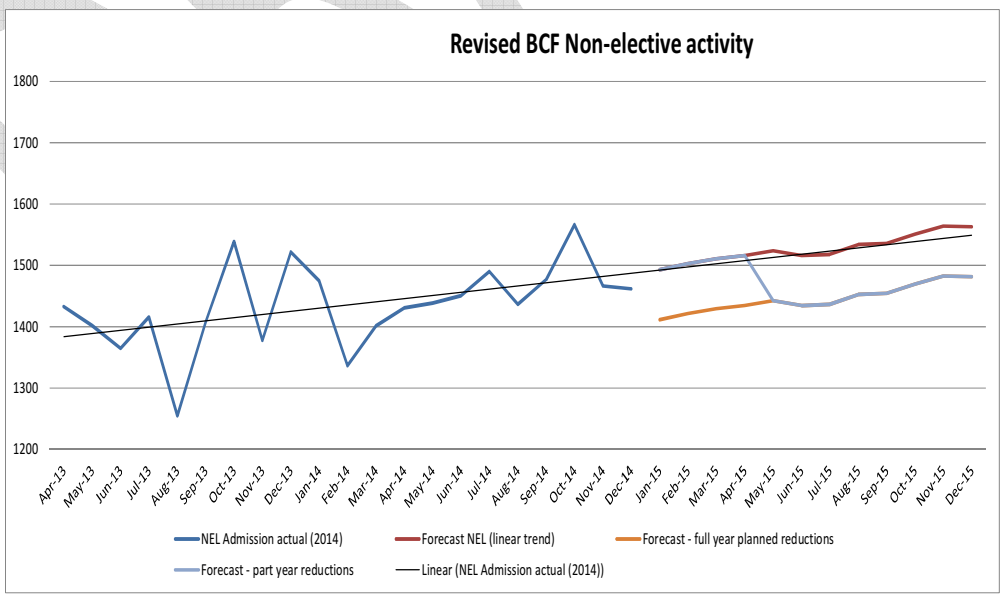
6.38 Since the submission and approval in fact, NELs grew by 4.1% in 2014. Based on a linear trend over the past 18 months, NELs are forecast to increase by 5.2% in 2015.

Preventing 977 admissions for this period would have curbed growth and resulted in a 0.5% gross reduction on activity.

6.39 However, implementation of BCF schemes such as HARI and dementia nurses has been delayed due to recruitment issues with any impact of implementation now expected from May 2015 at the earliest.

6.40 The expected impact of BCF during 2015 is therefore 66% of the original plan.

When considering forecast growth and delayed implementation of BCF schemes, a gross increase of 1.42% in non-elective admissions has been forecast.



6.41 Despite the revised increase in projection of the BCF target for non-elective admissions, the CCG will still commit to reduce admissions by 651 in the 2015 calendar year and by 896 cases in the 2015-16

financial year. The CCG has also kept £0.5m as a risk reserve to mitigate the planned reduction in non-elective admissions.

6.42 The CCG is committed to deliver integration and seven day working. Some of the planned schemes are detailed below:

- Engage users and carers to review opportunities for personal health budgets/integrated personal budgets across health and social care for people with learning disabilities and where possible reduce reliance on inpatient care, enabling appropriate people with learning disabilities or autism to be supported back into the community as part of the Winterbourne View Concordat.
- Develop a joint carers strategy with the London Borough of Merton, drawing up plans to identify and support carers, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers
- Increase the local availability of intermediate care beds in Merton and provide a wider MDT input into the beds as well as seven-day working to enhance the services currently available, providing a faster and more supported recovery from illness.
- Increase community admission prevention services, to enable more people, where appropriate, to be supported in the community by enabling referrals from London Ambulance Service to community services over weekends and evenings.
- Increase the dementia diagnosis rate with a corresponding increase in services to support this, e.g. memory clinics.

6.43 Work is on going with budget holders to identify and validate the investment costs and produce full business cases where the value exceeds £250k.

Non recurrent spend

6.44 The 1% mandatory non-recurrent fund requirement equates to a reserve of £2.2m. However, the non-recurrent forecast spend for 2015-16 is £2.6m:

- SWL risk pool – £1.5m
- Continuing care legacy provision – £0.8m
- London transformation fund – £0.3m

6.45 The SWL risk pool contribution consists of 0.5% equating to £1.1m and £0.4m which relates to 2013-4 borrowing of £0.6m from the SWL risk pool to pay Sutton CCG for learning disabilities, which was to be repaid over two years. The continuing care provision is the legacy payment to NHSE. The London Transformation Fund is 0.15% of our resource allocation, which will be used to support London-wide

transformation programmes in line with the London Health recommendations.

QIPP

6.46 The QIPP schemes will align with the CCGs operating plans and is focused on the following areas:

(a) Urgent and intermediate care

- Long-term conditions and case management; through improving the management of long term conditions through risk stratification and better use of community specialist and existing service partners
- Expansion of community prevention of admission team, including working with nursing homes
- Redesign of emergency department/community interface (incorporating the establishment of interface geriatricians and the redesign of the STAR team at SGH, as well as ICOPP pathway with Sutton at St Helier)
- Development of Holistic Assessment & Rapid Investigations (HARI) formerly OPARS
- Care delivery undertaken by locality-based multidisciplinary teams (proactive/preventative/rehab/reablement stream)
- Redesign psychiatric liaison services to align more effectively with other ED/UCC services to reduce emergency admissions
- Support from Psycho-geriatrician, particularly for proactive support and advice in the community
- Community prevention admission team within community services seeing all urgent referrals for assessment to the appropriate setting.

(b) Planned Care and diagnostics

- Prevention and early diagnosis; this involves working closely with public health to promote health checks and educating GPs on early diagnosis.
- Redesign of outpatient services and lower cost delivery through the Nelson; achieving the same or better outcomes for patients for less cost by redesigning and reorganising the way in which services are delivered and/or delivering services in a lower cost setting.
- Improving the outpatient journey from a patient perspective such that its smoother, faster and better. A clinical decision support service will assist GPs when accessing and referring patients. The clinical decision support service provides standardised

evidence-based clinical pathways, clear referral criteria and a local directory of service. A centrally managed team will embed pathways, facilitate ongoing training and peer reviews, audit the use of pathways and feedback gaps in local services to commissioners. This should reducing GP referrals into acute hospitals by finding other alternative pathways in the community.

(c) Medicines Management

The medicines management workstream consists of two areas:

- The medicines waste campaign is aimed at reducing medicines wastage, minimising possible harm from medicines and improving appropriate and quality of prescribing. There are four elements to the campaign:
    - Order only what you need
    - Patient returns scheme
    - Un-dispensed items scheme
    - Uncollected items scheme
- Repeat prescription management service (RPMS) is aimed at reducing medicines wastage, minimising possible harm from medicines and improving the quality of repeat prescribing. Regular pharmacist visits will allow targeted screening of repeat prescriptions with the main aim of reducing waste and making clinical interventions.

(d) Transactional

These schemes cover procurement savings and contractual savings on provider contracts.

6.47 Table 5 below summarises the progress to date on the schemes.

QIPP 2015/16	Gross	Investments	Net
	£'000s	£'000s	£'000s
Urgent and intermediate care			
BCF	729	0	729
Mental Health			
Inpatient redesign	175	0	175
Planned care and Diagnostics			
DESP	80	57	23
Outpatient Navigation	728	0	728
Medicines Management			
Care homes pharmacy	59	0	59
Nutrition	68	0	68
Prescribing	690	0	690
Medicines waste campaign	200	96	105
Transactional			
Acute challenges	1,409	0	1,409
MH demographic growth	312	0	312
MH placements	125	0	125
Running costs	448	0	448
Total Identified QIPP	**5,022**	**153**	**4,870**

Table 5

6.48 Gross QIPPs of £5m have been identified in the plan. This is £1.4m below previous assumptions in draft plans. EMT have agreed that to increase the QIPP plan a significant piece of work needs to be done on transforming primary care. This work will start in-year with the intention that a part year QIPP will be realised in 2015-16.

6.49 The QIPP initiatives have been shared with providers and implementation plans are being produced.

Capital plans

6.50 In December 2014 CCGs were asked to submit capital plans for 2015-16 in consultation with all stakeholders i.e. primary care, NHS Property Services and NHS England. The capital plan submitted is detailed below:

	Case Submitted (Y/N)	2015/16 Value £'000s
Capital Grants		
On Line Backup for GP Practices	Y	130
GP ICT Refresh	Y	351
TOTAL		**481**

6.51 The items detailed in the table above relate to primary care IT which will be supported and delivered by SECSU.

6.52 Merton CCG has submitted a strategic outline case for a local care centre in East Merton, which it is hoped will result in an outline business case to NHSE in 2015-16.

Statement of Financial Position (SoFP)

6.53 It is assumed that the current forecast position will continue in 2015-16 for current assets and liabilities.

	2014/15 Outturn (£000)	2015/16 Plan (£000)											
	March	Apr	May	June	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March
Assets													
Non Current Assets													
Opening Balance	32	878	854	830	806	782	758	734	710	686	662	638	614
Depreciation	-	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)
Additions	846	-	-	-	-	-	-	-	-	-	-	-	-
Total Non Current Assets	**878**	**854**	**830**	**806**	**782**	**758**	**734**	**710**	**686**	**662**	**638**	**614**	**590**
Current Assets													
Inventories	-	-	-	-	-	-	-	-	-	-	-	-	-
NHS Trade and Other Receivable	186	186	186	186	186	186	186	186	186	186	186	186	186
Non NHS Trade and Other Recei	2,060	2,060	2,060	2,060	2,060	2,060	2,060	2,060	2,060	2,060	2,060	2,060	2,060
Cash and Cash Equivalents	250	250	250	250	250	250	250	250	250	250	954	602	250
Total Current Assets	**2,496**	**2,496**	**2,496**	**2,496**	**2,496**	**2,496**	**2,496**	**2,496**	**2,496**	**2,496**	**3,200**	**2,848**	**2,496**
Total Assets	**3,374**	**3,350**	**3,326**	**3,302**	**3,278**	**3,254**	**3,230**	**3,206**	**3,182**	**3,158**	**3,838**	**3,462**	**3,086**
Liabilities													
Non Current Liabilities													
Provisions (non current)	(271)	(271)	(271)	(271)	(271)	(271)	(271)	(271)	(271)	(271)	(271)	(271)	(271)
Total Non Current Liabilities	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**	**(271)**
Current Liabilities													
Provisions (current)	(48)	(48)	(48)	(48)	(48)	(48)	(48)	(48)	(48)	(48)	(48)	(48)	(48)
Trade and Other Payables (curre	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)	(13,521)
Total Current Liabilities	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**	**(13,569)**
Total Liabilities	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)	(13,840)
TOTAL ASSETS EMPLOYED	**(10,466)**	**(10,490)**	**(10,514)**	**(10,538)**	**(10,562)**	**(10,586)**	**(10,610)**	**(10,634)**	**(10,658)**	**(10,682)**	**(10,002)**	**(10,378)**	**(10,754)**
Taxpayers' Equity													
General Fund	(10,466)	(10,490)	(10,514)	(10,538)	(10,562)	(10,586)	(10,610)	(10,634)	(10,658)	(10,682)	(10,002)	(10,378)	(10,754)
TOTAL ASSETS EMPLOYED	**(10,466)**	**(10,490)**	**(10,514)**	**(10,538)**	**(10,562)**	**(10,586)**	**(10,610)**	**(10,634)**	**(10,658)**	**(10,682)**	**(10,002)**	**(10,378)**	**(10,754)**

Table 7

6.54 The additions of fixed asset relate to capital approved in 2014-15 for the Nelson Health Care Centre.

Cash Plans

6.55 The cash plan is in line with the revenue resource allocation for each year excluding primary care prescription costs which are paid directly by the Prescription Pricing Authority. The CCG will always aim to manage its working capital with the utmost efficiency to meet the Better Payment Practice Code, therefore no significant swings would affect the cash plan are predicted.

7. Summary

7.1 In summary, Merton CCG has refreshed our exciting and innovative Two-year Operating Plan and we are confident that we are well placed to deliver our strategic ambition and ensure that we

constantly challenge ourselves, manage effectively within our resource allocation, to ensure that people receive the right care, at the right place, at the right time, with the right outcome.

Merton Clinical Commissioning Group (CCG) Plan on a Page 2015/16

Merton CCG – Right Care, Right Time, Right Place, Right Outcome

Merton – registered population 215, 018 | 3 Acute Trusts | 1 Local Authority | 1 Mental Health Trust | 1 Community Services | 3 Localities

Key Strategic Projects

South West London Commissioning Collaborative, Integration of Key Services, Merton Better Healthcare Closer to Home (MBHCH), System Resilience

Context and scale of the challenge

One clinically-led CCG with 25 member practices covering the same area as Merton Local Authority.

- A clinically and patient led organisation with 1 Clinical Chair, 1 Secondary Care Doctor, 1 Nurse, 2 GPs and lay member for PPI on the governing body
- An Executive Management Team led by the Chief Officer.
- 3 Locality Clinical Leads
- 13 Clinical Directors
- 25 Practice Leads
- Over 100 GPs
- 60 Practice Nurses

A financially challenged health and social care system due to historical low levels of funding and increasing demands on services.

- Historically low levels of funding, however, 4.92% allocation growth in 14/15 and 4.49% allocation growth in 15/16 to bring Merton CCG closer to target.
- The 2015/16 indicative resource limit is £229m.
- A 1% surplus of £2,287k will need to be delivered.
- The net Quality Innovation Productivity and Prevention target for 15/16 is £5.8m which is 2.5% of the resource limit.
- A joint Better Care Fund (BCF) plan of £12.2m and a CCG investment plan will need to be delivered.

Large inequality gap between more affluent (West) and less affluent (East) wards.

- East Merton is younger, more ethnically diverse and more deprived than West Merton.
- Residents of East Merton have lower educational achievement and levels of income (the biggest influences on health)
- If East Merton had the same rate of deaths as West Merton, it is estimated that there would be around 113 fewer deaths each year in East Merton
- Cardiovascular disease contributes the most to the differences in mortality between East and West Merton, but admission rates for cardiovascular disorders are lower in East Merton
- West Merton has an increasing older population with associated health and social care needs
- Challenges we face with regard to healthy life expectancy are an increase in obesity, ageing population, ethnic diverse population with different health needs, high levels of smoking , co-morbidities, and mental health issues

A need to operate to scale but still provide a local solution to commissioning

- To work with CCGs and NHSE in South West London through the South West London Commissioning Collaborative (SWLCC) to redesign services as part of our 5 year strategic plan.
- To continue to link our local six priority themes to the seven themes of the SWLCC.
- To embed quality improvements across all key areas.
- To procure Community Health Services now that Transforming Community Services (TCS) has come to an end.
- To ensure a quality assurance programme is embedded within the organisation
- To ensure that prevention and wellbeing are considered at every stage of clinical pathway redesign.
- To ensure that where relevant, pathways optimise the use of medicines and that we use the skill of our medicines management team to assist all areas of delivery

CCG Organisational Development Priorities

- Strong clinical leadership is the core of how the CCG makes decisions, redesigns pathways and provides better outcomes for patients.
- To have demonstrated and delivered robust managerial and clinical succession planning and to work with neighbouring CCG's and the Local Authority to ensure, where practical, joint pieces of work are undertaken.
- To aspire to be a good employer, supporting staff to develop the skills and competencies to undertake their roles efficiently and effectively

Patient Involvement Priorities

- To ensure the key principles and values of the NHS Constitution are integral to everything we do by providing safe care and ensuring people experience better care
- To ensure the patient voice is heard throughout all levels within the organisations
- To ensure that the views of patients, service users and carers are represented in the planning, delivery and evaluation of commissioning decisions within the organisation.
- To ensure that the values underpinning equality, diversity and human rights are central to our policy making, service planning, employment practices and community engagement and involvement

SWLCC Priorities

- Children's services
- Maternity Services
- Planned Care
- Urgent and Emergency Care
- Integrated Care
- Mental Health
- Primary Care

Merton BHCH Priorities

- Full utilisation of the Nelson Health Care Centre
- Business Case approval of the business case for the Mitcham development with an associated clinical-led model of care

Better Care Fund Priorities

- Reducing emergency admissions
- Improve effectiveness of reablement
- Reducing length of hospital stay
- Reducing permanent admissions to care homes
- Improving service user and carer experience

Performance Priorities

- A&E and emergency admissions
- Referral to Treatment (RTT)
- Cancer
- Diagnostics
- Health Visiting
- Improving Access to Psychological Therapies (IAPT)
- Dementia
- Winterbourne experience

System Resilience Priorities

- To enable better and more accurate capacity modelling and scenario planning across the system
- Work with NHS 111 providers to identify the service that is best able to meet patients urgent care needs
- Additional capacity and service redesign for primary care
- Enable better integration through the Better Care Fund
- Seven day working arrangements
- Expand and improve ambulatory pathways for high intensity users within the emergency department i.e. Frail elderly, minor's pathways, mental health pathways. Consultant-led rapid assessment and treatment systems within the emergency department and acute medical units during hours of peak demand
- All parts of the system should work towards ensuring patients medicines are optimised prior to discharge
- Cross system patient risk assessment systems in place and being used effectively

Our Six Delivery Areas

Older and Vulnerable Adults = SWLCC Integrated Care.

- We will aim to increase resources to our community services to extend the hours in which it operates including improved access to dementia services in crisis
- We will continue to use of risk stratification and we will target those with particular needs to ensure that people are given a robust care plan and that we proactively support them to be independent as possible
- We will monitor patients through Winterbourne
- We will ensure that work is targeted to reduce unnecessary non-elective admissions in people with long term conditions, co-morbidities or frailty through our redesign of the Older People's Assessment service and our Interface Older Persons services
- We will commission our services for people with learning disability services with greater rigor through our contract with the local authority
- We will aim to increase the number of people offered choice at end of life and supported and enabled to die at home where this is their preference

Mental Health = SWLCC Mental Health.

- We will be focussing the results of our Health Needs assessment to make sure that services respond to the collective challenge we face
- We will work to ensure all aspects of the Crisis Care Concordat are appropriately implemented
- We will have delivered increased transfer of services to the community and considered models where mental health and physical health teams are co-located.
- We will continue to redesign step down services to ensure all long term placements are tailored to the individual patient's needs.
- We will have redesigned IAPT services and procured a new model of care
- We will continue to review our out of borough placements to ensure where possible, that people are able to access long term care within Merton.

Children's and Maternity = SWLCC Children's Care and Maternity Care.

- We will review of implementation of the Children's and Families act and review our arrangements for Education, Health and Care plans and Personal Health Budgets
- We will invest in Community Services to ensure that we can start to treat children more closely to their home. Our East Merton development is a key platform for this initiative.
- We will provide better access and innovative models for CAMHS services to ensure that children access psychological support in a way that meets their needs.
- We will support a woman-centred pathway to ensure high quality of obstetric care is in place.
- We will ensure that all post natal care has a defined standard.
- We will ensure that our safeguarding and looked after children services are robust and meet the population needs

Urgent Care = SWLCC Urgent and Emergency Care.

- We will work across SWL to find a 111 solution that is resilient yet flexible.
- We will review our Out of Hours services in line with Primary Care and Community transformation to ensure patients can access primary care services at a time that suits them.
- We will ensure there is greater system surveillance across Merton and that it links in to the wider urgent care picture for South West London.
- We will work with our providers to develop more ambulatory care pathways linked to our Urgent Care Centres

Early Detection and Management = SWLCC Planned Care

- We will draw up a strategy, based on local need, which will inform future commissioning priorities through identifying and prioritising the long term conditions and the planned care pathways for which we can deliver improvements
- We will work with partners to develop and deliver models of care, ensuring that mental health and wellbeing is included as part of the patient care process
- We will work with partners to improve to develop and deliver models of care to deliver improvements in proactive detection, diagnosis and management of disease, starting with cancer and respiratory diseases
- We will use the opportunity presented by the Nelson Local Care Centre to begin the delivery of improved models of care, starting with cardiology, respiratory and gynaecology services
- We will monitor access to diagnostic services and treatment to ensure that waiting time from referral to treatment (RTT) is in line with, or better than, national targets
- We aim to improve diagnostic services for housebound patients.

Keeping Healthy and Well = SWLCC Commissioning themes.

- We will design a coordinated weight management pathway and commission Tiers 2 -3 services
- We will embed prevention and provide training for frontline health staff in behaviour change techniques and in providing brief advice and signposting
- We will work with CCG colleagues to design plans to encourage the population to take a more active role in their health (diet, exercise, smoking cessation and risky drinking)
- We will be rolling out a Proactive GP programmes within East Merton and support Public Health closely in this initiative

Primary Care Support and Improvement

This theme is aligned to the NHSE theme of Transforming Primary Care

- We will work with our membership to ensure transforming is built on a platform of solid robust and resourced Primary Care.
- We will work with our membership to ensure that they are supported to find new solutions by working closely together to provide improved access, specialism, and improved patient outcome.
- We will ensure that when we are transferring services to primary care and community services we will educate practitioners about new pathways and update/up skill practitioners to manages the new responsibilities

We will deliver	Enhanced Commissioning through	Key Risks and mitigations
• The NHS Constitution for people in Merton • The NHS Outcomes Framework • The Social Care Outcomes Framework • Public Health Outcomes Framework • Innovation by turning good ideas into services to benefit patients • Moving towards London Quality Standard for Acute and Primary Care	• Working closely with patients and clinicians to design services and following our own commissioning methodology • Working with CSU, CCG and NHSE colleagues to ensure decisions evidence based • Integration of services through our commissioning	• Call to Action – system wide financial pressure and an ageing population, • Rising emergency admissions • Provider ability to make the efficiency savings required

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