Merton Council
Health and Wellbeing Board

Date: **29 September 2015**

Time: **1.00 pm**

Venue: **Committee rooms B, C & D - Merton Civic Centre, London Road, Morden SM4 5DX**

Merton Civic Centre, London Road, Morden, Surrey SM4 5DX

Next Meeting Dates

Tuesday 24 November 2015 1pm – 3pm

This is a public meeting – members of the public are very welcome to attend.

Requests to speak will be considered by the Chair. If you would like to speak, please contact democratic.services@merton.gov.uk by midday on the day before the meeting.

For more information about the work of this Board, please contact Clarissa Larsen, on 020 8545 4871 or e-mail democratic.services@merton.gov.uk

Press enquiries: press@merton.gov.uk or telephone 020 8545 3483 or 4093.

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

Health and Wellbeing Board Membership

Merton Councillors

- Councillor Caroline Cooper-Marbiah (Chair)
- Councillor Gilli Lewis-Lavender
- Councillor Maxi Martin

Council Officers (non-voting)

- Director of Community and Housing – Simon Williams
- Director of Children, Schools and Families – Yvette Stanley
- Director of Environment and Regeneration – Chris Lee
- Director of Public Health - Dr Kay Eilbert

Merton Clinical Commissioning Group (CCG) representatives

- Chief Officer Merton CCG - Adam Doyle
- Director of Commissioning and Planning Merton CCG - David Freeman
- Chair Merton CCG - Dr Andrew Murray - (Vice Chair)
- Dr Karen Worthington

Healthwatch and Voluntary Sector

- Chair of Healthwatch – Brian Dillon
- Chief Executive Merton Voluntary Service Council – Khadiru Mahdi
- Merton Community Engagement Network Representative (Carer Support Merton) – Melanie Monaghan

Quorum

Any 3 of the whole number.

Voting

3 (1 vote per councillor)
4 Merton Clinical Commissioning Group (1 vote per CCG member)
1 vote Chair of Healthwatch
1 vote Merton Voluntary Services Council
1 vote Community Engagement Network

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HEALTH AND WELLBEING BOARD
23 JUNE 2015

(13.00 – 14.33)

PRESENT
Councillor Caroline Cooper-Marbiah (Chair)
Councillor Maxi Martin
Yvette Stanley – Director of Children, Schools and Families
Chris Lee – Director of Environment and Regeneration
Simon Williams – Director of Community and Housing
Kay Eilbert – Director of Public Health
Dr Andrew Murray – Chair of CCG
Adam Doyle – Chief Officer of CCG
David Freeman – Director of Planning Merton CCG
Khadiru Mahdi – Chief Executive Merton Voluntary Services Group
Brian Dillon – Chair of Healthwatch
Dave Curtis - HealthWatch

ALSO PRESENT
Julia Groom – Public Health Consultant
Clarissa Larsen – Health and Wellbeing Board Partnership Manager
Lisa Jewell – Democratic Services Officer

The Chair began the meeting by congratulating Adam Doyle for his new role of Chief Officer of Merton CCG.
She then welcomed the following new members of the Health and Wellbeing Board: Dr Andrew Murray the new Chair of the CCG, David Freeman - Director of Planning Merton CCG and Brian Dillon – Chair of HealthWatch

1 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 1)

No declarations received

2 APOLOGIES FOR ABSENCE (Agenda Item 2)

Apologies were received from Councillor Gilli Lewis-Lavender and Dr Karen Worthington

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The Minutes of the Health and Wellbeing Board held on the 24 March 2015 were approved as a correct record.

4 PROPOSAL FOR HEALTH AND WELLBEING BOARD VICE CHAIR (Agenda Item 12)

Following the motion regarding creation of a co-chair at the last Board meeting, board members noted the legal considerations and precedent and it was agreed to create the role of Vice Chair of the Health and Wellbeing Board and that this role would be taken by the Chair of the Merton Clinical Commissioning Group. Accordingly The Chair nominated Dr Andrew Murray, as the Chair of the CCG to become the Vice Chair of the Health and Wellbeing Board and this was seconded by Councillor Maxi Martin. The Director of Public Health informed the board that there was training available for the Chair and Vice Chair from 'London Councils'.

RESOLVED:

The Board agreed the Chair of Merton Clinical Commissioning Group to become The Vice Chair of the Health and Wellbeing Board.

5 MSCB ANNUAL REPORT (Agenda Item 4)

The Director of Children, Schools and Families introduced the Annual Report of the Merton Safeguarding Children Board (MSCB). It was noted that a slightly amended version of the report was now available. The Board noted that the Annual Report considered the MSCB's achievements, priorities for improvement and areas of focus going forward, and that the conclusion of the Annual Report was that the MSCB was compliant with statutory guidance and that partners were working together to protect children and young people in LBM,
Members of the board were pleased to receive the report and commented on the good work and sustained improvement in the effectiveness of the MSCB over the last 3 years.

RESOLVED

That the report was received by the Health and Wellbeing Board

6 INFORMATION SHARING TO SUPPORT CHILDREN'S SAFEGUARDING & PROTECTION (Agenda Item 5)

The Director of Children, Schools, and Families introduced the report on Information Sharing to support Children's safeguarding and protection. The Board noted that the ministerial letter attached to the report had been sent in response to the recent series of national child protection cases relating to the sexual exploitation of children and young people, and that it proposed five principles to support information sharing; integrated working, joint risk assessment, a victim focused approach, good leadership and clear governance and frequent reviews of operations.
The Director of Children Schools, and Families told the Board that Merton had signed up to pan London safeguarding protocols and that a recent CSE partnership event to launch our refreshed local strategy and supporting tools had been well attended and useful. Future action would involve extending discussion to wider partners who are less focussed on children and families to see how these agencies could also support children's safeguarding.

RESOLVED

That the Health and Wellbeing Board commit to continuing to ensure that their agencies are compliant with legislation and good practice

7 HEALTHY CHILD 0-5 YEARS SERVICES (Agenda Item 6)

Julia Groom, Public Health Consultant, introduced the report which provided an update on the transfer of commissioning responsibilities for the Healthy Child 0-5 years services (Health Visiting) to the London Borough of Merton from October 2015, and the establishment of the Merton Early Years partnership which strengthens the integrated planning and delivery of core services across health and local authority.

The Health and Wellbeing Board agreed:

A) To note the progress on the transfer of commissioning responsibilities for Healthy Child 0-5 years services (Health visiting) to the London Borough of Merton from October 2015.
B) To note progress and consider opportunities for the further development of partnerships and close integration of early years services.

8 HWB OPERATING PLAN (Agenda Item 7)

The Chief Officer of the CCG presented the report detailing updates to and a refresh of the Health and Wellbeing Board Operating Plan 2015/16. The Chair asked for an update on the planned Mitcham Care Centre. The CCG Chief Officer replied that the site had been selected but that the model of care and funding arrangements were now to be determined.
The Director of Public Health asked the Board to note the achievements of the CCG in working with LBM public health on prevention and community health care, and for developing the model of care for East Merton. The Director of Children, Schools and Families thanked the CCG for its work for Children and young people and its investment in health and prevention and cited this as a good example of the Health and Wellbeing Board helping all partners join up and work together.

RESOLVED:
That the board notes the progress and approves the direction of travel of the Health and Wellbeing Operating Plan

9 COMMUNITY SERVICES (Agenda Item 8)

The Chief Officer of the CCG introduced the report that presented the progress made regarding the procurement of Community Health Services.
The Board noted that the overall aim of the project is to ensure that a community service provider is identified and a contract entered into to ensure that there is continuity of community services provision when the existing contract expires on 31 March 2016. The Board noted that there would be robust communications with staff regarding their transfer to the new provider.

RESOLVED:
That the Board note the progress of the Community Services Procurement Plan

10 MERTON HEALTH AND WELLBEING STRATEGY 2015-18 (Agenda Item 9)

The Director of Public Health introduced the Health and Wellbeing Strategy 2015-18. The Board noted that this had been well received by Cabinet and that it had its public launch at the Mitcham Festival. Councillor Maxi Martin commented that the Strategy summary page had been well received by Cabinet.
The Director of Public Health also outlined the Merton on the Move programme which was launched alongside the Strategy – this is a challenge to businesses and residents to form teams and join the Council in walking, running and cycling 'to the Moon'. Everyone was encouraged to sign up and details are available from barry.causer@merton.gov.uk

RESOLVED:
The Board received the refreshed Merton Health and Wellbeing Strategy 2015-18

11 PUBLIC HEALTH - TWO YEARS ON (Agenda Item 10)

The Director of Public Health presented the report setting out the work and achievements of the Public Health Team and its partners in the first two years following transition to LBM, and outlining the next steps for the team. Councillor Maxi Martin commented on the good work on public health. She raised the remaining gap in life expectancy across the borough. The Director of Public Health confirmed that work was targeted at preventing the gap widening and the Chief Executive of MVSC commented that this work had and will be done together. The Chair of the CCG said that there is increasingly a greater focus on prevention, for example, Proactive GP Practice and the board agreed the need to communicate and embed prevention across all partners.

RESOLVED:
That the Board notes the work of Public Health and progress made two years into its transition to the local authority.

12 HEALTHWATCH MERTON UPDATE JUNE 2015 (Agenda Item 11)

Brian Dillon was introduced as the newly appointed Independent Chair of Merton Healthwatch Operational Committee. Dave Curtis, Manager of Healthwatch then introduced an update on the progress of Healthwatch Merton. The Board noted the update on the main workstreams for 2015/16, an update on current activities and changes to the governance and the new Merton Operational Committee.

RESOLVED:
That the Health and Wellbeing Board note the progress made by Healthwatch Merton

13 SOUTH WEST LONDON JOINT COMMITTEE NOMINATION (Agenda Item 13)

The Board noted that the South West London Joint Committee was set up to oversee the joint commissioning function of the six South West London Clinical

Commissioning Groups alongside NHS England. Each Health and Wellbeing Board has been asked to provide a representative to the group. Councillor Maxi Martin nominated Councillor Cooper-Marbiah to be the Merton Health and Wellbeing Board representative on the South West London Joint Committee, and this was seconded by the Director of Public Health.

RESOLVED
That Councillor Cooper-Marbiah was nominated and agreed as the Merton Health and Wellbeing Board representative on the South West London Joint Committee.

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Committee: Health and Wellbeing Board/Children Trust Board

Date: 29th September 2015

Agenda item: Update on implementation of the Children and Families Act 2014 Part 3

Wards: All

Subject: Children & Families Act 2014 Part 3; progress on implementation of SEN and Disabilities elements

Lead officer: Jane McSherry, Assistant Director, Education

Lead member: Cllr Maxi Martin; Cllr Martin Whelton

Forward Plan reference number:

Contact officer:

Recommendations:

A. That the Board/Trust notes the progress made in implementation of the Children & Families Act 2014 Part 3.

B. That the Board/Trust considers the risk implications outlined in Section 9 of the report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. To inform the Health and Wellbeing Board/Children's Trust of the progress being made in the implementation the Children & Families Act 2014 Part 3 reforms.

1.2. To inform the Health and Wellbeing Board/Children's Trust of further action required to implement and fully imbed the reforms in routine practice.

1.3. This update report is focussed on the key delivery areas from the Children & Families Act 2014 Part 3. There are separate sections outlining: programme governance; the local offer; Education Health and Care Plans (EHCPs); 0-25 agenda including preparation for adulthood; personal budgets; joint commissioning and work with health. The report will outline work so far, next steps and any risks for the Board/Children's Trust to consider.

2 PROGRAMME GOVERNANCE

2.1. The Children's Trust Board was the key governance group for the implementation of the Every Child Matters agenda and has been the strategic driver for the implementation of the Children and Families Act Part 3 requirements.

2.2. During 2014, management and oversight of the implementation of the SEN reforms in the Children and Families Act 2014 Part 3 was through a

Programme Board, focussed on initial planning for implementation. The Board was supported by a number of workstream groups (detailed below):

- Assessment Framework and revised SEN Code of Practice;
- Education, Health and Care Plan
- Local Offer
- Personal budgets
- Preparation for adulthood
- Workforce development

2.3. These workstream groups included representatives from a range of partner agencies and parents who were an integral part of these groups. The Board and workstream groups were disbanded towards the end of 2014 in order for us to take stock and consider how best to govern the next stages of implementation. Parents have been actively involved and it is right that they play a role at a strategic level in shaping services as well as being involved in detailed developments as part of the change programme. To that end a group was convened in January 2015. However, key agencies raised concerns re servicing that group in addition to other partnership structures. Further practice and service development across a range of partners is required to ensure the implementation of the act continues. It was therefore proposed that strategic oversight of the Children and Families Act implementation was aligned alongside existing partnership structures and proposals were taken to the Children's Trust Board and the One Merton Group.

2.4. As the Children's Trust Board currently has oversight of the CYP Plan and outcomes particularly for children and young people with complex needs and most of the partners who were involved in the original Programme Board for the SEN reforms are already on this group it was proposed and accepted that the strategic governance for the Children and Families Act 2014 Part 3 would become part of the Children's Trust Board's forward work plan. As parents are not represented on this group but are a key part of the implementation of the SEN reforms parent representatives have been invited to join this group.

2.5. The parent representatives will be made up of four parents: two parents from current groups representing parents of disabled children; and two parent governors from the governing bodies of Merton schools.

2.6. The Terms of Reference of the Children's Trust Board will be amended to include the new functions, priorities and membership.

2.7. It is also proposed that additional dynamic consultation with parents and carers is undertaken outside the Children's Trust Board but overseen by it and that these consultations have clear themes to inform the work of the Board.

2.8. The strategic governance through the Children's Trust Board will:

- Be responsible for the overall direction and management of the implementation to ensure it is a local solution and 'fit for purpose'
- Ensure that the implementation remains on course to deliver the planned outcomes in the allocated timescales and to the required quality
- Commit required resources
- Agree and implement policy decisions
- Be 'advocates' of the cultural change needed; and
- Make strategic decisions on workforce development

3 LOCAL OFFER

3.1. The Local Offer is a statutory website for the council and was first published on 30 September 2014. (www.merton.gov.uk/localoffer).The required content under the SEND reforms is significant and will increase as practice develops and new processes become embedded within SEND practice.

3.2. Currently there are four established templates that organisations and internal services are invited to complete to advertise their SEN specific services in the Local Offer. These include education, health, training and other; the latter being the default or general template used by most other services.

3.3. As per the Children and Families Act 2014 Merton has remained faithful to the Local Offer remit of making information available for parents that is specific to children and young people with SEND. Therefore the website is not a directory of services with links that move you to other websites; rather it contains detailed information of use to parents.

Information currently available in the Local Offer includes:

- 57education providers (41 Primary, 8 Secondary, 3 Specialist, 3 Colleges and 2 Alternative Providers)
- 20 children and young people health services
- 13 short breaks services
- 40 early education and childcare services
- 13 leisure services
- 13 Information and advice articles for parents including: How to request an EHC needs assessment, Personal Budgets, Local NHS services, national advice and support.

3.4. Initial testing with parents and young people took place during September 2014. The next phase of consultation and testing is scheduled in Autumn 2015.

3.5. Local Offer; the Next Phase

A Local Offer Steering Group has been set up to ensure that Merton is meeting the requirements in relation to this aspect of work. Elements of the local offer that have been updated recently include:

- Post-16 education and training provision
- Apprenticeships, traineeships and supported internships
- More leisure activities
- Collation and verification of data from different service areas before it is uploaded onto the Local Offer
- SEN transport

Areas to still be developed or completed include:

- Information about provision to assist in preparing children and young people for adulthood
- Support to help children and young people move between phases of education
- The local authority's accessibility strategy
- A revised CSF complaints policy that reflects the SEN changes
- Redesign the look, feel and usability of the local offer to improve the overall user experience
- Design an approval process for external providers or organisations looking to join the Merton Local Offer
- Renew the Local Offer database contract

3.6. The current IT system contract provider is Open Objects who built and currently host the service support. This contract is due to expire on 31st March 2016. Future contract renewals and systems will be linked to the "Family Services Directory" contract for children and young people and the Framework-i IT system hosted by Adults, Community & Housing.

3.7. The Information Services Manager for Early Years is the gatekeeper and manager of information for the Local Offer.

3.8. There is a risk in relation to the breadth and completeness of the local offer in that it needs capacity to check and update information provided, follow up with new or changed services and ensure that everything presented is accessible and accurate. Capacity to undertake this work is very limited.

4 EDUCATION, HEALTH & CARE (EHC) ASSESSMENT & PLANNING

4.1. From September 2014 Merton has implemented the new statutory 20 week pathway for EHC assessments and plans as stipulated in the Children & Families Act 2014. Multiple partner agencies have contributed towards the development of a pathway and the current EHC plan in use will be updated over time as professionals and partners work together to develop the

process. In addition to the local authority staff engaged in EHC planning, commissioners agreed that co-located health staff would join the EHC planning team in SENDIS and some of this capacity is already in place.

4.2. New EHC plans

Between 1st September 2014 and 31st May 2015 there were 159 requests for new assessments. This compares with 111 in the same period the previous year. 87% of new EHC plans have been completed within the 20 week timescale.

4.3. EHCP Transitional Arrangements

The transfer of all existing Statements of Special Educational Needs (SEN) and Learning Difficulty Assessments (LDAs) to EHC plans started in September 2014. In line with the reforms the council has consulted on and published a summary of the process for transferring a "statement" into an EHC plan. This summary, with key information and advice, is found on the local offer database via the following link: Transferring to an Education, Health and Care Plan (EHCP).

4.4. Merton had 1033 current statements that needed to be transferred between September 2014 and March 2018. 217 transfer reviews were held between September 2014 and May 2015. The initial 16 week timescale for transfer of EHCPs was changed in July 2015 to 20 weeks. Using the 16 week timescale 65% of transfers were completed within timescale.

4.5. For the next two to three years there are considerable risks in relation to the capacity of the SENDIS service and partners to meet the demand of increasing requests for statutory assessment at the same time as transferring all the existing Statements of Special Educational Needs (SEN) and Learning Difficulty Assessments (LDAs). For the first 19 months there has been limited additional funding provided which we have used to add capacity in the SENDIS service to co-ordinate and write EHCPs. This funding ceases in March 2016.

4.6. Data analysis for the last 3 years (2012-15) indicates that whilst the 0-18 Merton population has increased by 4% the number of Merton resident children with statement of SEN has increased by 18%. This increase has been incremental year on year. Increased numbers of children with statements of SEN and EHCPs coupled with the increase in requests for statutory assessment (outlined in paragraph 4.2 will add further pressure across the system.

4.7. The multi-disciplinary approach to EHC planning which Children's Trust agencies are committed to achieve is still in its early stages and there is a clear recognition of the need to continue to develop joint working practices in the next phase of implementation.

5 PREPARATION FOR ADULTHOOD AND IMPLCIATIONS OF THE CARE ACT 2014

5.1. It is acknowledged that much work is still needed on preparation for adulthood and this is an area where allocated resource is needed to develop the Local Offer and key services for children and young people 14-25 years.

5.2. The Care Act 2014 includes provisions to support transition into adulthood running in parallel with the Children & Families Act 2014 and therefore needs further consideration in this context.

5.3. There will be significant resource implications to meet the statutory requirements presented in the Care Act. Areas to consider include structures and governance to monitor strategic and operational implementation ensuring links to the work on the Children and Families Act, workforce development and financial implications.

6 PERSONAL BUDGETS

6.1. In line with the Children & Families Act 2014 (Part 3) the Council is encouraged to consider and make available services as part of a personal budget offer available to young people and parents to meet identified outcomes within their Education Health and Care (EHC) plans.

6.2. A Personal Budget policy statement has been produced and published on the local offer (see www.merton/gov.uk/localoffer). The policy contains information about how Merton will aim to deliver personal budgets. This is a "live" and evolving document; and currently focuses on the two key areas identified for the first phase of personal budgets - transport and short breaks.

6.3. Personal Travel Assistance Budgets (PTABs)

An agreed proposal is being implemented which amends the way in which Merton delivers its statutory obligation for some children and young people with SEND that are eligible for transport services.

This includes offering a personal budget to:

i. NEW EHC plan transport eligible children and young people under the new name of a "Personal Travel Assistance Budgets" or PTABs.

ii. Targeted existing eligible taxi users currently being paid for by the SEN transport service

iii. Existing pre legislation families who already receive some form of a direct payment or travel reimbursement for transporting their child/ren or young person to school or college

To implement PTABs we have developed:

- A revised application form for transport eligibility that promotes PTABs and "greener" travel options
- A communications leaflet that explains the key benefits and answers the key questions about PTABs
- A PTABs agreement outlining the responsibilities of the council and families taking a PTAB

- An implementation plan for contacting and discussing PTABs with targeted families using a commissioned taxi service via our transport services; and families already accessing a form of personal budget (pre-legislation)

6.4. Short Breaks

In exploring the use of personal budgets for "Short Breaks" we are generally looking at the following:

- services that provide disabled children and young people with an opportunity to spend time away from their parents or carers.
- services that provide families and carers with a valuable break from their caring responsibilities; giving parents and carers a chance to unwind, rest or spend time with other children
- services that support the care and social needs of a child or young person
- Domiciliary care services

6.5. To assess and achieve a personal budget offer Merton are currently looking at various short break commissioned and non-commissioned services to see what could potentially be part of the personal budget pot and on what service and financial scale.

7 JOINT COMMISSIONING

7.1. There is a requirement in the Act for agencies to adopt more joint commissioning of services for children and young people with SEND.

7.2. In addition to the joint commissioning decisions which led to the co-location of health staff into the EHC team noted above, the Local Authority and CCG are developing a medium and long term joint commissioning strategy. Commissioners from CSF department, Public Health and the CCG have recently focused on the re-commissioning of community health services for children including school nurse and health visitor services and some therapies, all of which are significant services for children and young people with SEND as well as for the wider children's population.. Currently, there are monthly joint ('Tripartite') panel arrangements for discussing high need cases and agreeing funding across education, health and social care budgets for placements and care packages. It is possible that Section 75 arrangements will be used to pool budgets between the Local Authority and CCG in the future.

8 HEALTH

8.1. A "Designated Medical Officer" has been identified and is attending decision making panels on a regular basis and liaises with the health lead within SENDIS when not able to attend.

8.2. The health lead within SENDIS is in place and the recruitment to the Occupational Therapy, CAMHs and administrative roles is ongoing.

8.3. As noted above, it is important that the full team can be integrated within the SENDIS service to assist with the further development of the integrated EHC planning approach and to inform health commissioners of emerging health needs within the cohort.

9 SUMMARY OF RISK MANAGEMENT IMPLICATIONS

9.1. Staff Training

As the reforms continue to be implemented the current processes, policies and documentation will change. For outcomes to improve for children and young people with SEND, services are required to work in a more integrated way. Without significant multi-service and multi-agency professional development, the required level of change, including culture change, will not be achieved. A robust and integrated professional development programme is essential.

Failure to implement a rolling training programme will lead to a disjointed and inconsistent service. This needs immediate attention.

9.2. Local Offer Database

As children and young people move through their lives they will need access to a variety of services, especially with the promotion of personalisation and personal budgets. Therefore a seamless system with facility to move between children, adults and other universal services will be most beneficial to users. Capacity to ensure this information is complete and accurate is needed.

9.3. Implementation of EHCP process

There are capacity issues across partner's services to meet the demands of the increase in requests for statutory assessment at the same time as transitioning over 1000 statements and LDAs. Review of processes and timelines and engagement across agencies will be required to ensure that children and families receive an effective and timely service.

9.4. Preparation for adulthood

Implications of the Care Act 2014 on systems, structures, ways of working and budgets needs planning carefully to reduce the risks implicit in delivering a new system. Meeting new statutory duties at a time of budget pressures makes the planned implementation a high priority. Ensuring a streamline transition for young people eligible to access services will need to be planned in the context of the new 0-25 duties of the Children and Families Act. Planning is also needed for young people who will not meet the thresholds to ensure the Local Offer is clear and accessible.

9.5. Health

Recruitment to some health professions, for example occupational health and the capacity to meet the assessment requirements and fulfil programmes outlined in EHCPs has been problematic. Once the health team within SENDIS is up to full capacity it is hoped some of these issues will be mitigated.

10 BACKGROUND PAPERS

By way of web-links

Children & Families Act 2014 (Part 3)

SEN Travel and Assistance policy (Merton)

Requesting a Personal Budget (pages 178 – 184 from the SEND Code of Practice)

Home to School travel and transport statutory guidance (DFE)

Section 508A (1), of the Education Act 1996) notes

Personal Budgets Pilot Policy Statement (Merton Local Offer)

Care Act (http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

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Committee: Health and Wellbeing Bard

Date: 28 September 2015

Agenda item:

Wards: All wards

Subject: Draft Children and Young People's Plan 2016/19

Lead officer: Paul Ballatt, Assistant Director Commissioning, Strategy and Performance, Children Schools and Families Department

Lead members: Councillor Maxi Martin; Councillor Martin Whelton.

Forward Plan reference number: n/a

Contact officer: Naheed Chaudhry, Service Manager Policy, Planning and Performance

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Recommendations: That the Health and Wellbeing Board

A. Comment on the draft Children and Young People's Plan 2016/19 as attached in Appendix A

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Attached in Appendix A is a first draft of the refreshed Children and Young Peoples Plan 2016/19 presented to partners for discussion prior to a final draft being signed off by the Childrens Trust in November 2015.

2 DETAILS

2.1. Merton's Children and Young People's Plan (CYPP) is commissioned and monitored by the Children's Trust. Partners have made good progress in delivering key actions outlined within the current plan 2013/16 which has been reported to the Children's Trust and Merton Partnership in updates and performance reports.

2.2. Earlier this year the Children's Trust agreed to refresh the CYPP with the following approach:

- ✓ Building on progress made in current plan
- ✓ Analysing current and emerging issues impacting on children's services
- ✓ Re-affirming shared ambition and values
- ✓ Retaining focus on vulnerable groups guided by needs analysis, review of customer feedback 'user voice' and staff feedback

2.3. The CYPP to date has been more than a vision statement, it has summarised the actions to be taken to meet key priorities. Our latest CYPP is underpinned by specific strategies and business plans to manage delivery on a day to day basis, thus helping staff to understand how their work fits into the bigger picture. In other words, our CYPP therefore remains a 'Plan of Plans'

2.4. While earlier versions of our CYPP included actions for delivering services to all children, young people and families in the borough, our current CYPP is more targeted, reaffirming our determination to support those facing specific challenges, and to 'narrow the gap' in outcomes which exists between these children and their peers.

2.5. Our 2016/19 CYPP as presented in appendix A identifies six key priorities;

- Children in need of early help and those subject to the effects of disadvantage
- Safeguarding children and young people
- Looked after children and care leavers
- Narrowing the gap in educational outcomes and opportunity
- Engage and Enable young people to better outcomes
- Children with special educational needs and disabilities

2.6. These priorities were identified following;

- Multi-agency task and finishing group workshop discussions
- Staff and management forums
- Review of Children's Trust single agency plans and strategies
- Review of resident/customer data and performance information
- Review of key themes from 'user voice' feedback

3 ALTERNATIVE OPTIONS

3.1. The Childrens Trust agreed in December 2014 to retain a Children and Young Peoples plan to support partnership working, a shared vision and accountability. We have the flexibility to tailor arrangements to meet our own circumstances and organise our own planning and commissioning priorities.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The following consultation has been undertaken or is scheduled.

Consultation	Date	Status
Staff Forum	10 March 2015	Completed
CYPP Working Group workshop 1	15 April 2015	Completed
Voluntary Sector engagement: Involve	15 July 2015	Completed
CYPP Working Group workshop 2	3 September 2015	Completed
DMT Continuous Improvement Board	7 September 2015	Completed
Joint CSF Senior Leadership Team (JSLT)	15 September 2015	Completed
MSCB Policy subgroup (consult by email)	7 Sept to 16 Sept 2015	Completed
Childrens Trust – First draft	18 September 2015	Scheduled
MSCB Board	22 September 2015	Scheduled
Merton Partnership Executive Board	22 September 2015	Scheduled
Health and Wellbeing Board	29 September 2015	Scheduled
Childrens Trust - Final Sign off	6 November 2015	Scheduled

4.2. The draft CYPP 2016/19 has been authored by Paul Ballatt Assistant Director of Commissioning, Strategy and Performance and Naheed Chaudhry Service Manager Policy, Planning and Performance Merton Council on behalf of the Childrens Trust.

4.3. The following agency representatives have contributed to the task and finish group workshops. **Merton Child and Adolescent Mental Health Services,** Donna Hayward-Sussex, Nicholas Wilson, **Merton Clinical Commissioning Group,** Maria

Ellery, Mari Longhurst, **Merton Council Children, Schools and Families Department:** Paul Bailey, Liz Broughton, Sarah Daly, Allison Jones Aneesa Kaprie, Tom Procter, Kate Saksena, Keith Shipman, Leanne Wallder, **Merton Police,** Mark Lawrence, David Palmer, **Merton Public Health,** Hilina Asrress, Julia Groom, **Merton Voluntary and Community Sector,** Khadiru Mahdi, Merton Voluntary Sector Council, Andrew Whittington, Merton Mencap , Maureen Bailey, Inner Strength Network, **Sutton and Merton Community Services,** Fiona Pendleton.

5 TIMETABLE

5.1. The Childrens Trust is scheduled to 'sign off' a final draft of the CYPP on 6 November 2015.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. All priories and actions identified in the draft Children and Young Peoples Plan derive from single agency plans and strategies.

6.2. These commitments are based on the financial envelope known to agencies at the time their plans were written and may therefore be subject to change in a climate of economic uncertainty.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. The Government withdrew the statutory guidance to Children's Trusts to produce a Children and Young Peoples Plan in October 2010. The Merton Partnership is still required to have specific arrangements in place for co-operation to improve children's well-being however we are no longer required to produce a specific plan.

7.2. The Section 10 duty to co-operate remains and continues to apply to local authorities and the other bodies who remain listed in section 10(4) of the Children Act 2004.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. None for the purpose of this report

9 CRIME AND DISORDER IMPLICATIONS

9.1. None for the purposes of this report

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None for the purposes of this report

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Appendix A: Draft Children and Young Peoples Plan 2016/19.

12 BACKGROUND PAPERS

12.1. Merton's Children and Young Peoples Plan 2013/16 http://www.merton.gov.uk/council/plansandpolicies/cypplan.htm

12.2. The Children's Trust Board (Children and Young People's Plan) Revocation Regulation 2010. http://www.legislation.gov.uk/uksi/2010/2129/made

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Draft

Children and Young People's Plan 2016-19

Context

Introduction

The Children and Young People's Plan (CYPP) is a multi-agency plan of plans which underpin Merton's Community Plan.

It sets out how agencies in Merton collectively deliver the borough's priorities for children, young people and their families and particularly to those who are vulnerable to poorer outcomes than their peers.

TO BE DRAFTED…….

- *CYPP is a Plan of plans drawing together key priorities from other plans/strategies for children and young people to be delivered collectively by the Childrens Trust.*
- *Focus on targeted intervention and most vulnerable groups*

The national and local context

Since publishing our last Children and Young People's Plan in 2012 we have managed ongoing change on a national and local level. This plan is written within a context of greater national expectations, local demographic changes with an increasing population, further reducing budgets and increasing government scrutiny.

The global financial crisis of 2009 led to a programme of austerity and deficit reduction, consequently children's services have operated within a context of unprecedented funding pressures.

Alongside the financial challenges, we have also managed widespread public sector reforms. Nationally, Professor Eileen Munro (2012) led an independent review into how agencies worked together to safeguard children and young people. The review concluded that child protection had lost its focus on the needs and experiences of children and its publication led to a programme of reform of local safeguarding governance and practice.

The revised Public Law Outline 2013 highlighted the need for faster care proceedings leading to permanence for vulnerable children, with a particular focus on adoption.

Educational reforms have led to greater school autonomy, with the creation of academies and free schools and a drive to improve standards. The introduction of the Pupil Premium has offered schools additional resources to help narrow the attainment gaps between disadvantaged pupils and their peers.

With the raising of the participation age from 2013, local authorities are now also expected to work with schools, colleges and employers to promote participation in education, employment or training for all 16 and 17 year olds.

A greater focus on early intervention has resulted in initiatives such as 'free childcare for vulnerable 2 year olds' and funding for targeted holistic family interventions for 'Troubled Families' vulnerable to criminal and anti-social behaviour, poor mental health, unemployment, school absence and the Family Nurse Partnership.

In healthcare, Clinical Commissioning Groups have been established and are now responsible for commissioning local health provision (2014). The Public Health function has transferred to Local Authorities. Strategic multi-agency Health and Wellbeing Boards have been established, supported by strengthened Joint Strategic Needs Assessments (JSNA) and local voluntary sector led 'Health watch'. These reforms promote whole systems thinking and a greater focus on jointly informed local commissioning.

Finally the Children and Families Act 2014 legislated for a complete review of the needs of children with special educational needs and disabilities, requiring the implementation of a Local Offer and new multi-disciplinary Education, Health and Care Plans replacing the old SEN statement.

Within the context of these legislative and regulatory changes, our local knowledge, needs analysis and collective understanding, we have recognised that we need to continue to focus on the most vulnerable groups within our population, securing improved outcomes for these young people and narrowing outcome gaps.

Our focus on the most vulnerable groups is rooted within a clear evidence base. It is not rhetoric that poverty, ethnicity, gender, social care vulnerability, and special educational need are linked to poorer life outcomes. The following are national facts which have informed our priorities.

- ‘The attainment gap between rich and poor which opens up before children start school, is visible during the infant years and increases over time’ (White Paper, The importance of teaching, 2010)
- Pupils entitled to free school meals are only half as likely to achieve five good GCSEs as their peers’ (White Paper, The importance of teaching, 2010)
- 32 per cent of looked after children do not get any GCSEs and a further 24 per cent achieve fewer than five GSCEs, this is around seven times higher than for children on average (Monitoring poverty and social exclusion, Joseph Rowntree Foundation, 2010)
- 33 per cent of carer leavers are not in education, employment or training (DfE, 2011)
- A particular vulnerable group is children who are eligible for free school meals (FSM), especially white British boys
- Of those pupils known to be eligible for FSM there are variations in achievement by gender and ethnicity
- It is estimated that the current generation of 16 to 18 year olds who are NEET (not in education, employment or training) will cost society £31 billion during their life time, or £4.6 billion annually (No Excuses: A Review of Educational Exclusion, Centre for Social Justice, 2011)
- There is a proven correlation between illiteracy, innumeracy and offending. Before custody 53% of male offenders and 71% of female offenders have no qualifications whatsoever’ (Factsheet Education in Prisons Civitas: Institute for the study of Civic Society, 2010)
- Young people of today will be parents of the future therefore improving their life chances is not only important for breaking the cycle of poverty but also for reducing the likelihood of their children being in poverty, with ill health and/or not achieving their educational potential.

Our Children and Young People’s Plan is therefore focused on the following six priorities:

- Children in need of early help and those subject to the effects of disadvantage
- Children requiring effective, timely and targeted safeguarding
- Children looked after and care leavers
- Narrowing the gap in educational outcomes and opportunity
- Engage and enable young people to better outcomes
- Children with special educational needs and disabilities

Within each of the following chapters we describe our policy position, the data which informs our understanding, some of our successes to date, our future actions, the impact we hope these actions will have and how we will measure our progress.

Ways of working

There is a strong ethos of working together in Merton to achieve the best outcomes for children and young people. The partnership landscape is well established, with strong commitment from partner organisations. (NB to be redrawn)

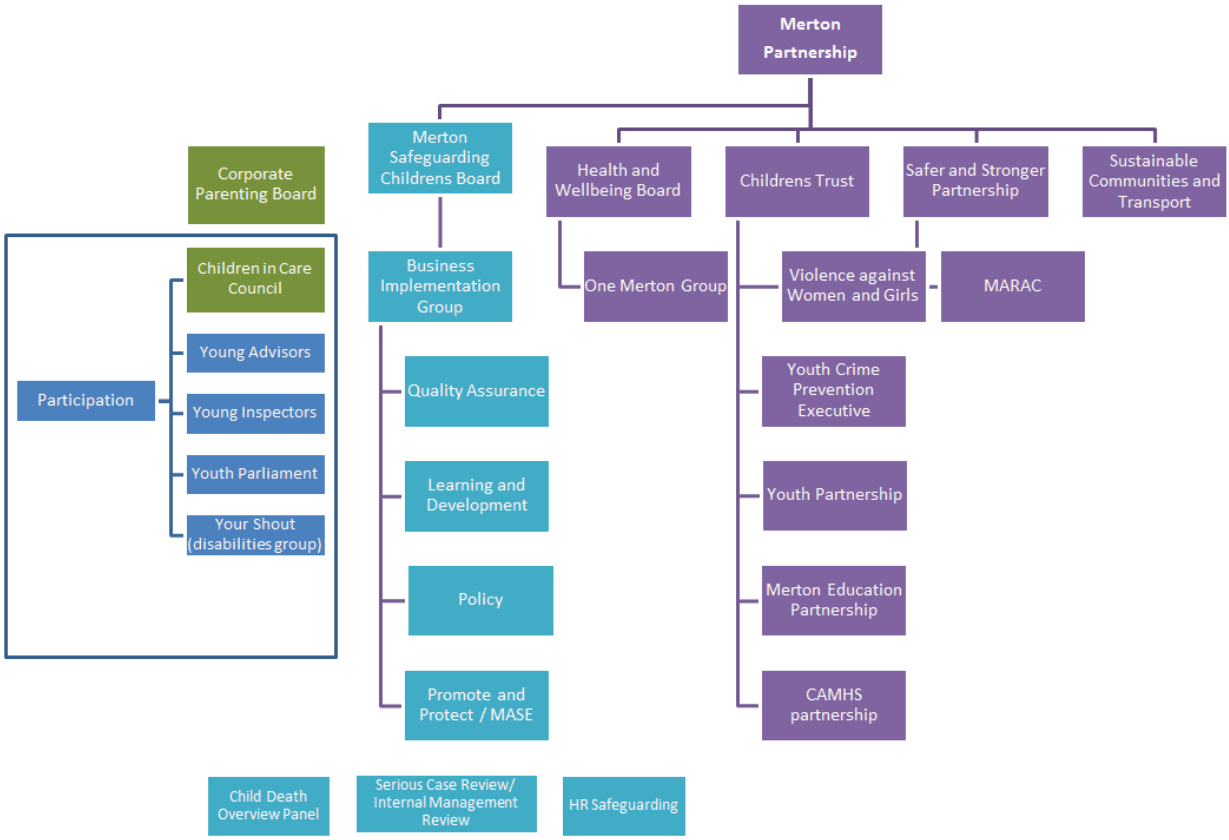


Figure X: Merton Partnership structure relating to children as at June 2015

Merton's Children's Trust Board and the Merton Safeguarding Children's Board are committed to working in the following ways to achieve the strategic outcomes in this plan:

- Keeping children and young people at the heart of our work.
- Equality, equity, inclusion and valuing diversity – judged on our impact on the most vulnerable.
- Local accountability and partnership.
- Making a difference – quality assurance and continuous improvement
- Promoting a learning culture
- Promoting a culture that values children and young people.

Performance management and governance

Merton's Children's Trust brings together services in the borough to focus on improving outcomes for all children and young people. Key partners of the trust are:

- Merton Council and Cabinet Member for Children's Services
- Merton Clinical Commissioning Group (CCG), Public Health and health providers
- Merton Borough Police
- Merton Voluntary Service Council, representing the voluntary and community sector
- Primary, secondary and special schools in Merton
- South Thames College

Representatives from all these organisations make up the Merton Children's Trust Board which will keep a strategic oversight of the plan. Each organisation has agreed to be responsible for implementing the Children and Young People's Plan.

The Children's Trust Board will monitor this plan against a combination of the 'What will we do? (action plan) ' and the 'Key representative performance indicators' sections detailed in each chapter of this plan with progress reports submitted to the board.

Finally, we will continue to consult and engage children, young people and their families by implementing our User Voice Strategy. Maintaining an ongoing dialogue with service users, parents, carers (including young carers), professionals and advocates will be vital in driving improvement, ensuring challenge and accountability, and ensuring that our priorities remain relevant.

Understanding need

The Children and Young People's Plan has been informed by a wide range of information, including demographic data, performance information and service users' views. The section below provides a brief overview of the key messages.

Borough profile - Merton the Place

- Merton is an outer London borough situated to the south west of central London.
- Merton covers 14.7 square miles and is home to 200,543 people of which 47,499 are children and young people. The number of 0-19 year olds is forecast to increase by 3,180 (7%) by 2017, within which we forecast a 20% increase of children aged 5 to 9 (2,270).
- We have a younger population than the England average and have seen a 39% net increase of births over the last ten years (2,535 births in 2002 rising to 3,521 in 2010). The birth rate reduced in 2012/13 and again slightly in 2013/14 suggesting that the rate is stabilising. However the last ten years alongside other demographic factors has placed additional demand on all children's services.
- Predominantly suburban in character, Merton has three main town centres: Wimbledon, Mitcham and Morden, with high levels of commuter flows in and out of central London.
- Census 2011 data estimated that 40.1% of the population is from black and minority ethnic (BME) groups, with the range across schools being 32% to 91%.
- There are over 121 languages spoken in Merton's 43 primary schools, eight secondary schools, three special schools, one Pupil Referral Unit and 11 children's centres. The borough has concentrations of Urdu speaking communities, Sri Lankan, South African and Polish residents. The most prominent first languages for pupils apart from English are Tamil 5.9%, Urdu 5.9% and Polish 4.5%.
- 100% of children's centres have been judged as good or outstanding and 83% of schools are judged as good or outstanding.
- Our post 16 offer is delivered by South Thames College and a number of schools sixth forms and post 16 training providers.
- Seven libraries provide internet access, summer reading schemes and homework clubs as well as traditional book, CD, DVD and video lending. Three leisure centres and youth partnerships provide a wide range of facilities and participation activities in Mitcham, Morden and Wimbledon. Merton also boast 65 parks and open spaces (including Wimbledon and Mitcham commons), 28 conservation areas, 11 nature reserves and 17 allotment sites.
- Merton is consistently amongst the top four safest boroughs in London which is a tribute to the excellent partnerships between the council and Metropolitan Police.

According to the 2010 Index of Multiple Deprivation, Merton is the fourth least deprived of the 33 London boroughs. Nationally the borough is ranked 208 out of 326, where 1 is the most deprived. This overall lack of deprivation does, however, hide stark inequalities in the borough between deprived wards in the east of the borough (Mitcham) and the more affluent wards in the west (Wimbledon).

Our most deprived wards according to the Indices of Deprivation Affecting Children are Ravensbury, Cricket Green, Lavender Fields, Figgie's Marsh, Longthornton and Pollards Hill. These wards are also home to the majority of children and families supported by Childrens Social Care services.

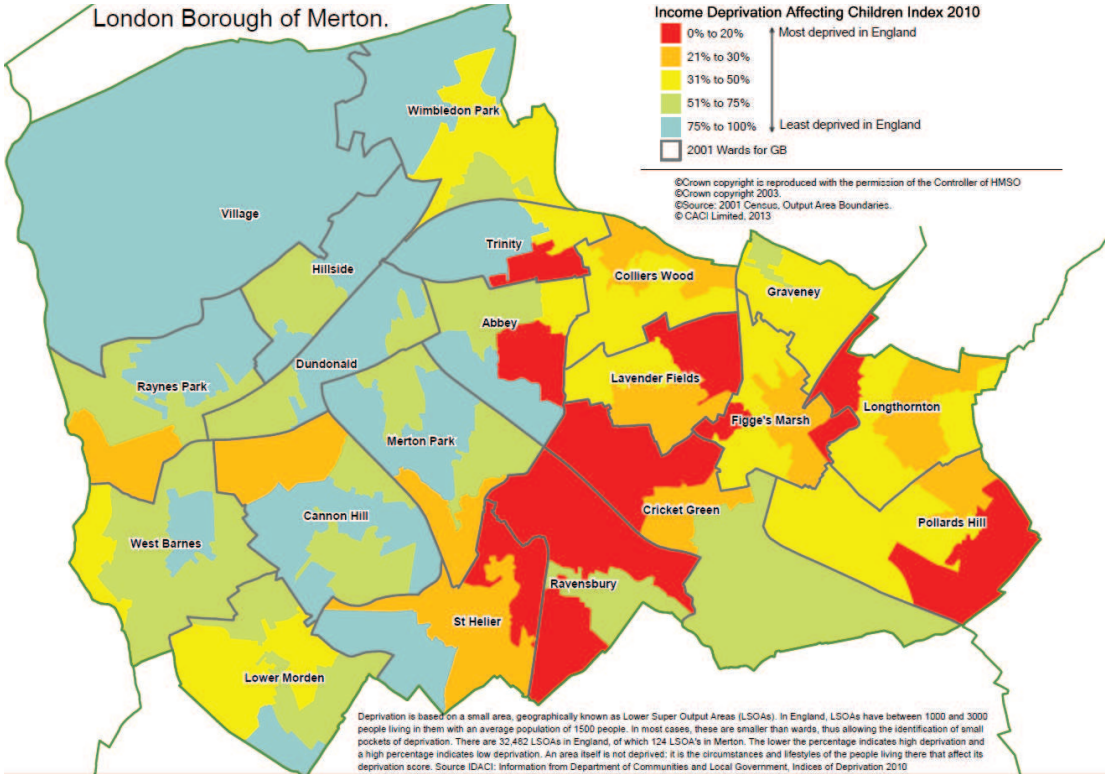
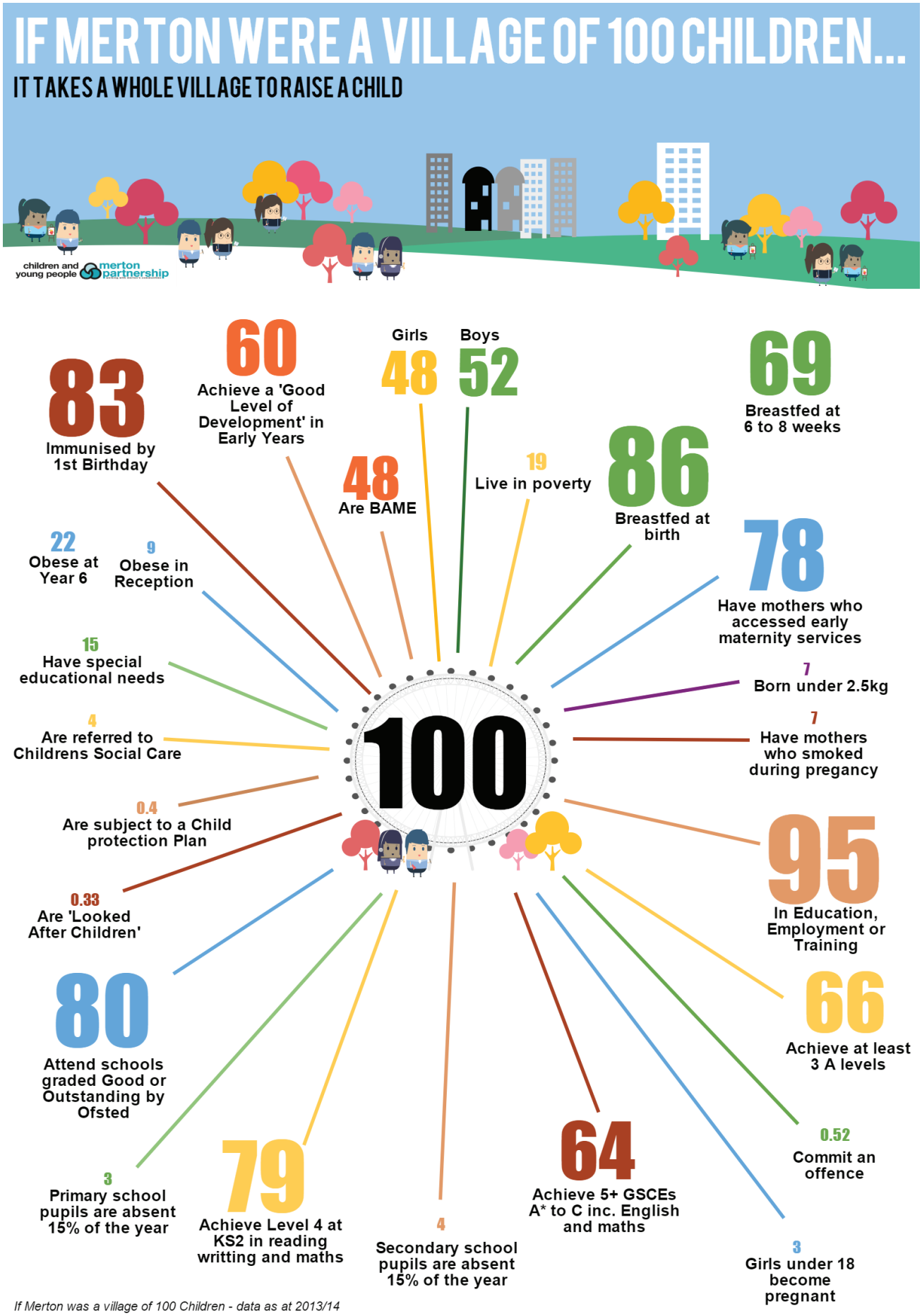


Figure X: Income of deprivation affective children (2010) in Merton by ward.

The following statistics highlight the inequalities between the east and the west of the borough.

- Median household income is £34,461 per annum. However, it is estimated that 27% of those employed living in the east of the borough earn under £20,000.
- The east of the borough has much higher levels of serious illness and early deaths from illnesses such cancer and heart disease.
- Life expectancy for men in the most deprived 10% of the borough which is in the east is 77.20 years whilst for the least deprived 10% living in the west it is 83 years
- Merton has 39 areas which are amongst the 30% most deprived areas across England for children (39 Super Output Areas).
- 45% of Merton school pupils are living in an area of deprivation (30% most deprived, IDACI 2010).
- Although unemployment in the borough is below the national average, it rises significantly in some of the eastern wards, and 63% of all benefit claimants live in the east of the borough.
- Since 2010 we have seen an increase of 23% (2014) of children who are eligible for free school meals.

Merton is, therefore, a borough of contrasts. Bridging the gap between the east and the west of the borough is the main theme of the Merton Community Plan and as such a key driver for our Children and Young People's Plan.



If Merton was a village of 100 Children - data as at 2013/14

Priority area 1: Deliver early help and improve outcomes for those subject to the effects of disadvantage

Why do we need to focus on this?

Early help is provided at different levels of our Child and Wellbeing Model and in Merton we use the C4EO definition:

> *Intervening early and as soon as possible to tackle emerging problems for children, young people and families….early help can take place early in a child's life or early in the development of a problem….effective early help prevents escalation of need and reduces severity of problems…early help can be provided to individual families, particular vulnerable groups or whole populations (C4eo 2012)*

Conscious of language across our partnership we agree that the term 'Early Help' is often used interchangeably and as reference to 'Early Intervention and Prevention', 'Early Support' and 'Early Years'.

Our focus is on working to create and deliver clear plans, often as multi-disciplinary services, which improve outcomes for children and reduce the escalation of need.

We understand that providing early help as soon as a problem emerges is more effective and potentially less expensive in promoting the welfare of children, we agree that:

- identifying and assessing problems at an early stage increases the chances of their effects being minimised or eliminated.
- good support in early years is a determinant of good outcomes and improved life chances.
- being alert and responding early to the key determinants of child protection in families – e.g. adult mental health, domestic violence and substance misuse – can prevent more intrusive interventions later

(Allen (2011); Field (2010); Tickell (2011); Munro (2011) et al)

Early help involves a broad range of multi-agency services and support. The physical and mental wellbeing of children and young people is incredibly important to them having a good quality of life, and good chances in adulthood.

We know that parents, children, and young people make a whole range of decisions that affect their life chance now and in the future. We know that parental capacity is key to good early life outcomes.

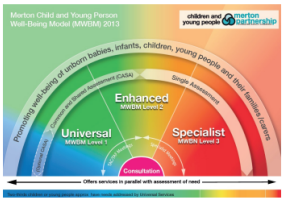
Having a good enough place to live, and the financial resources to manage, are an important part of children and young people being able to succeed in life. Without secure housing and financial stability families can find it hard to prioritise other things in life, and if the most basic of needs aren't met we have a very limited foundation to build on improving children and young people outcomes.

EARLY HELP

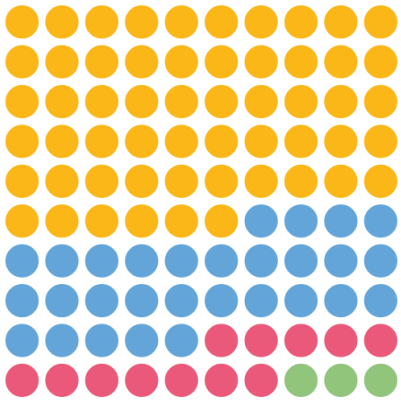
Improving outcomes for those subject to the effects of disadvantage

Early help is provided at different levels of our Child and Young Person Well Being Model, in Merton we believe in the C4EO definition:

Intervening early and as soon as possible to tackle emerging problems for children, young people and families….early help can take place early in a child's life or early in the development of a problem….effective early help prevents escalation of need and reduces severity of problems…early help can be provided to individual families, particular vulnerable groups or whole populations (C4EO 2012)



COMMON AND SHARED ASSESSMENTS



Early years (56%)
Primary school (29%)
Secondary school (12%)
16+ (3%)

2000

Trained CASA professionals

EARLY YEARS

78% of users of children's centres live in areas of deprivation (2014/15)

60% of all children achieve a Good Level of Development at Early Years Foundation Stage (2013/14)

44% of Free School Meal children achieve a Good Level of Development at Early Years Foundation Stage (2013/14)

6 to 8 weeks

Mothers breast feeding at 6 to 8 weeks 69% (2014/15)

MMR1 coverage Age 2, 84% (2014/15)
MMR2 coverage Age 5, 76% (2014/15)

Childhood obesity
Reception 21% (2013/14)
by Year 6, 36% (2013/14)

75% of parents referred complete 'Parenting programme' courses. (2014/15)

STEPPING UP AND DOWN IN NEED

escalating need

de-escalating need

For 80% of families early help works, they have no contact with children's social care for at least 6 months after attending a parenting programme (2013/14)

100%

370 Troubled Families turned around 2011 to 2015, now 378 more to support

Figure X: Merton intelligence profile: Early Help

What have been our key successes to date?

Since our last CYPP we have…

- Revised our Child and Young Person Wellbeing Model including implementing a new CASA model and tools with significant partnership engagement and consultation.
- Commissioned more targeted early intervention and prevention services, including services for families experiencing domestic violence and parental mental health issues and those requiring family support; services for young runaways and young people at risk of sexual exploitation; and services to support children with disabilities and young carers.
- Targeted the take-up of Children's Centre services to families from deprived areas in the borough, now making up 77% of all users.
- Turned around 100% (370) of high need 'troubled families' between 2011 and 2015. Merton was one of the first local authorities in the country to be selected by the DCLG to pilot the Expanded Programme for phase two of the programme.
- Troubled Families programme awarded national Compact Engagement award (November 2014).
- Implemented a project which has increased Pupil Premium income for Merton's schools.
- Forty four per cent of Free School Meal (FSM) children achieved a 'good level of development' (GLD) in the Early Years Foundation Stage (EYFS) 2013/14, a 10% increase on 2012/13.
- Improved breastfeeding and immunisation rates; reduced levels of excess weight and obesity in pre-school children and reduced levels of teenage pregnancies
- Established a Family Nurse Partnership and a commitment to maintain the programme over the next three years.

Our user voice activity told us….	… so we did…
Families who use children's centres in one locality said "We want more groups, often it is too busy and we cannot get in".	We have changed the way that this locality offered groups so that families can attend at least one extra session per week, in addition to targeted sessions. This year 78% of families in deprived areas accessed children's centres.
Parents said that the benefits of the free childcare that they receive for their eligible two year old includes making new friends, improving language development, reading, improved behaviour, increased confidence, and toilet training.	To encourage further take-up of the offer we produced a video with parents about the benefits of free childcare for eligible 2 year olds; take up has increased over the year 2014/15.

What will we do?

We want partner agencies to continue to lead on Common and Shared Assessments (CASA) and Teams Around the Child, and our early help commissioned services to be more sharply targeted at those families most at risk of poorer outcomes.

- We will remain committed to our multi-agency Merton Child and Young Person Wellbeing Model and continue to deliver CASA training and development across agencies to provide early help for all aspects of life. (MSCB Training programme)
- We will continue to apply and develop impact measures for early help services and use learning to inform future commissioning plans (Joint Commissioning Service Plan)

Positive early attachment, bonding and resilience have long-term benefits and it is during the early years that we develop our lifestyle habits for later years. We want parents to have increased confidence and skills in living sustainable healthy lives.

- We will continue to deliver effective, impactful and evidence based parenting programmes, targeted where necessary to support family and child development. We will focus on those families who are hard to engage (Early Help Strategy)
- We will continue to offer families support via the Local Area Network (LAN) in which a lead practitioner works with the family and other professionals to coordinate a package of support based around the family's individual needs. (Early Years Partnership)

Developing children's language from the earliest possible moment is the most significant of all interventions in narrowing the gap. 'The attainment gap between rich and poor which opens up before children start school, is visible during the infant years and increases over time' (White Paper, The importance of Teaching, 2010)

- We will focus on improving the early years development scores " Good Level of Development' where we are below national (Merton's Equalities and Community Cohesion Action Plan)
- We will continue to focus on attracting families from the target areas to engage with a wide range of Children Centres services including access to play and stay and early education groups, job club, child health services, midwifery and antenatal as well as targeted home visiting services. (Early Years Partnership)
- We will continue to support the roll our free child care hours in line with National policy expectations. (Early Years Partnership)
- We will increase levels of school readiness in young children (Health and Wellbeing Strategy)

Despite improvement, Merton's immunisation rates are below recommended levels and inequalities in immunisation uptake persist among poorer families. Obesity levels for children aged 4-5 have improved and are in line with national averages, but we have not sufficiently impacted on levels of obesity for children aged 10-11.

- We will complete joint commissioning of the new community health services for children and young people including health visiting, school nursing and therapies ensuring mobilisation in line with Clinical Commissioning Group and Local Authority priorities (CCG Operational Plan and Commissioning intentions)
- We will engage GP practices in strategies to increase uptake and coverage of childhood immunisations. (Health and Wellbeing Strategy)
- We will increase parental access to and awareness of immunisations. (Health and Wellbeing Strategy)
- We will re procure weight management services for children with an even greater focus on prevention. (Health and Wellbeing Strategy)

We are committed to improving access for children and young people to child and adolescent mental health services (CAMHS) and to continue to develop pathways to timely services for our more vulnerable young people.

- We will refresh Merton's CAMHS Strategy with an emphasis on promoting resilience and early intervention as well as providing care for the most vulnerable (CAMHS Transformation Programme)
- We will introduce a CAMHS 'Single Point of Access', strengthening information sharing with Merton's MASH (CAMHS Transformation Programme)

We want to build on the success of our Transforming Families service and find ways of sustaining this model in the longer term. We recognise the importance of disposable income to families and we want to provide more parents with support to meet their needs around employment, benefits and housing.

- We will continue to deliver the targeted Transforming Families programme to 'turn around' the lives of families with parental mental health, employability and school attendance needs. (CSF, Family and Adolescent Service Plan)
- We will continue to deliver employability programmes in our Children's Centres. (Early Years Partnership)
- We will work with partners to reduce JSA claimants and getting more of our residents into work. (Health and Wellbeing Strategy)
- We will commission specific training and development for lone parents and carers and the long term unemployed (Economic Development Strategy)
- We will support the regeneration of Pollards Hill and Phipps Bridge Estate (Circle Housing Regeneration Plan)

Key representative performance indicators

Deliver early help and improve outcomes for those subject to the effects of disadvantage	*2013-14 Outturn*	*2014-15 Outturn*	*National Benchmark*
Percentage of parents referred completing 'parenting programmes'	*85%*	*75%*	*n/a*
Percentage of mothers breast feeding at 6 to 8 weeks	*69%*	*68%*	*n/a*
Percentage of 0-4 year olds from areas of deprivation (IDACI 30%) accessing Children's Centre services (estimated Census 2011 population)	*78%*	*78%*	*n/a*
Number of two year olds accessing 'Free child places"	*613*	*917*	*n/a*
Percentage achieving 'A Good Level of Development' at Early Years Foundation Stage (4 to 5 year olds)	*46% (AY 2012/13)*	*60% (AY 2013/14)*	*60% (2013/14)*
Percentage of Free School Meals cohort achieving 'A Good Level of Development' at Early Years Foundation Stage Profile (4 to 5 year olds)	*33% (AY 2012/13)*	*44% (AY 2013/14)*	*45% (2013/14)*
Percentage of MMR1 coverage: 1 dose of MMR by age 2 years	*83.5%*	*84.1%*	*n/a*
Percentage of MMR2 coverage: 2 doses of MMR by age 5 years	*72%*	*76%*	*n/a*
Percentage of excess weight in children age 4-5 years (overweight and obesity)	*21% (AY 2012/13)*	*20.9% (AY 2013/14)*	*n/a*
Percentage of excess weight in children aged 10-11 years (overweight and obesity)	*35% (AY 2012/13)*	*36.4% (AY 2013/14)*	*n/a*
Numbers of families engaged and 'Turned around' in the Transforming families programme (National Troubled Families programme)	*173*	*370 (100% Turned around)*	*99% 'Turned around'*

Priority area 2: Safeguarding children and young people

Why do we need to focus on this?

Maintaining robust safeguarding arrangements is at the core of our activity. At our last Safeguarding and Looked after Children inspection in January 2012 Ofsted graded us as Good on all measures. Inspectors noted that "the council, its partners and elected members in Merton have identified and secured demonstrable improvements to services, which are contributing to improving outcomes for children and young people".

Merton has sustained a journey of continuous improvement, which where possible has been embedded into a 'business as usual' approach. We have a long established Children and Young People Well Being Model which reflects how local services provide support for children along a continuum of need supported by "Universal, Enhanced and Specialist" level services.

Merton's referral rate reflects a similar trend to London and National benchmarks, increasing from 351.5 in 2012/13 to 386.5 per 10,000 in 2013/14. Merton's children in need rate per 10,000 (2013/14, 355.1) is lower than the London average 367 but higher than the National 346.4, we remain close to our statistical neighbours (2013/14). Our CIN rate has increased over a number of years alongside our population changes from 171.0 in 2008/9, 276.8 in 2009/10, 288.3 in 2010/11, 371.3 in 2011/12, 336.8 in 2012/13 and 355.1 in 2013/14.

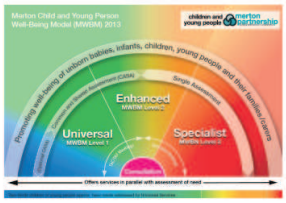
Rates of children subject to a child protection plan in Merton (40.3 2013/14) are similar to national (42.1) and London (37.4). As at the end of 2013/14 11.3% of children became subject of a child protection plan for a second or subsequent time, this is lower than the national (15.5%) and London (13%) averages (2013/14). Our developing use of "Signs of Safety" is providing a useful tool for working with families as well as enabling active discussion about practice and continuous professional development.

One of the key features and enablers of progress has been the strong partnership that exists across a wide range of children's services agencies at strategic and operational levels. We have strengthened the governance of safeguarding services provided by the Merton Safeguarding Children Board but remain ambitious to use performance management and quality assurance to further improve practice in line with our ambitions and expectations.

The council and partner agencies implemented an effective Multi Agency Safeguarding Hub (MASH) in line with national expectations. In the context of increasing pressure on specialist services, however, we need to review its functioning and ensure that the multi-agency capacity in the MASH is best utilised to identify and respond to safeguarding concerns.

The Merton Children and Young People Well Being Model reflects how local services provide support for children along a continuum of need supported by "Universal, Enhanced and Specialist" level services.

We want to ensure that children and families receive the right intervention from the right agencies, continuing to work across the partnership to minimise harm to children and young people.



RATE PER 10,000

386 Referrals of which 80% lead to the provision of social care services

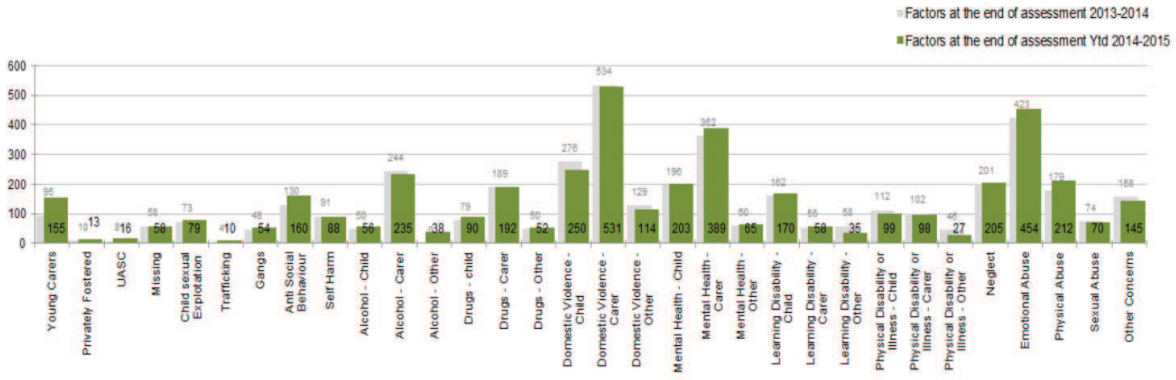
336 Single Assessments

131 Section 47 enquiries

CHILDREN IN NEED OF HELP AND PROTECTION

Merton's children in need rate per 10,000 (2013/14, 355.1) is lower than the London average 367 but higher than the National 346.4, we remain close to our statistical neighbours (2013/14).

FACTORS IDENTIFIED AT THE END OF SINGLE ASSESSMENTS



CHILD PROTECTION

182 PLANS

40 children per 10,000 are subject of a child protection plan (National 42)

3% remain on a child protecion plan for 2 years or more (National 2%)

11% are subject for a second or subsequent plan (National 15%)

Rate per 10,000 - emotional abuse 21, neglect 9, physical abuse 3, sexual abuse 3

EDUCATIONAL OUTCOMES

46% CIN achieving at least level 4 at KS2 in reading, writing and maths (National 46%)

22% CIN achieve 5+A*-C grades at GCSE including English and maths (National 15%)

14% CIN persistently absent from school (National 13%)

5% CIN have at least 1 fixed term exclusion (National 7%)

Figure X: Merton intelligence profile: Safeguarding

What have been our key successes to date?

Since our last CYPP we have…

- Further developed the MSCB governance role and function
- Appointed a robust independent chair of the MSCB
- Reviewed the operation of the Board and sub-groups, establishing a new 'business implementation group'
- Strengthened multi-agency performance management via implementation of a new MSCB dataset
- Further developed and implemented our multi-agency Quality Assurance Framework with more routine case auditing; more robust section 11 assessments for safeguarding services and annual partner quality assurance and challenge meetings
- Undertaken self-evaluation and peer review of our response to child sexual exploitation and implemented a new strategy
- Reviewed and implemented a new Missing Children Strategy
- Responded to the 'Prevent' agenda through provision of guidance to parents and schools, and training for staff across partner agencies
- Implemented a successful recruitment and retention strategy for social work staff leading to reduced levels of agency staff and positive feedback from social workers about caseloads, supervision and learning and development opportunities

Our user voice activity told us….	… so we did…
A child on a 'child protection plan' was supported by our commissioned advocacy service to say how they wanted their family situation to be improved.	We fed back this information to the family and other professionals via key case meetings. There is now improved communication and support within the family, and the child's school attendance and punctuality has improved.
Our Young Inspectors said that they wanted to influence those who plan and deliver services which safeguard children and young people.	Young Inspectors chaired the 2015 Merton Safeguarding Children's Board (MSCB) Conference, and key presentations were delivered by pupils from local schools. Young people gave their views on children's safeguarding services to key managers and practitioners.

What will we do?

The Merton Children Safeguarding Board has identified the following key priorities:

- Maintaining the strongest focus on front line practice. (MSCB Business Plan)
- Developing a strategic multi-agency response to the issue of neglect. (MSCB Business Plan)
- Maintaining strategic oversight of specific cohorts of children including those at risk of child sexual exploitation, violence against women and girls, missing young people, children missing education, those supported by the Prevent strategy and young carers. (MSCB Business Plan & Community Safety Strategic Assessment 2015-16)
- Safeguarding children and young people with complex needs (MSCB Business Plan and SEND Single Improvement Plan)

Merton's MASH has a key role in ensuring that children and young people receive the right intervention at the right time. It needs to ensure that there is a prompt and appropriate safeguarding response where necessary and that children and young people can access pathways to support at 'children in need' level and early help support if they have lower level needs.

- We will review the functioning of the MASH in the context of our Children and Young People Wellbeing Model to ensure the appropriate differentiation of response to children and young people's needs. (MSCB Business Plan & Enhanced integrated 0 – 5 service provision in Merton plans)
- We will ensure collaboration between Merton's MASH and CAMHS services in the establishment of a co-located CAMHS Single Point of Access (CAMHS Transformation Programme)

Focusing on front line practice;

- We will focus on front line practice and learn from multiagency auditing and management reviews where required. (MSCB Business Plan)
- We will continue to roll out the 'Signs of Safety' model in safeguarding work to strengthen direct work with families. (Local Authority Childrens Social Care)
- We will continue to ensure high quality learning and development opportunities are available through our MSCB training offer (MSCB Training Programme & Workforce development strategy)
- We will build on our work to implement the London Training Evaluation Impact Framework (incorporated in London Child Protection Procedures) to understand if our learning offer is working (MSCB Training Programme)
- The council will maintain its social work recruitment and retention activity to minimise use of agency staff and ensure newly qualified social workers are inducted, supported and supervised appropriately (Local Authority Childrens Social Care)

'Neglect is the most common form of child abuse in the UK today. Neglect is the most frequent reason for a child protection referral, and it features in 60 per cent of serious case reviews into the death or serious injury of a child.' (Action for Children, March 2014). We want to improve our strategic and operational response to this issue and maintain a robust focus on other key safeguarding themes.

- We will develop a 'neglect strategy' so that there is a robust approach to identifying and intervening in cases of neglect. (MSCB Business Plan)
- We will maintain conspicuous care and strategic oversight of children at risk of child sexual exploitation, violence against women and girls, FGM, missing children and young people, children missing education, those supported by the Prevent strategy, those with complex needs and LASPO. (MSCB Business Plan)

Key representative performance indicators

Safeguarding children and young people	2013-14 Outturn	2014-15 Outturn	National Benchmark
Number of MASH initial contacts received	4574	4,613	n/a
Percentage of Single Assessments completed within statutory requirements of 45 days	81%	91%	82% (2013/14)
Percentage of quorate attendance at Child Protection Conferences	93%	91%	n/a
Child protection plan rate per 10,000		42	37
Number of Children subject of a Child Protection Plan (as at 31 March)	188	172	n/a
Number of family groups subject of a child protection plans		86	n/a
Percentage of child protection cases which were reviewed within required timescale (cases open three months or more)	93%	93%	94% (2013/14)
Percentage of Children subject of a Child Protection Plan who had a four weekly visit on time	84%	92%	n/a
Percentage of Children who became subject to a Child Protection Plan for second or subsequent time	12%	17%	15.8% (2013/14)
Percentage of reports to the Local Authority Designated Officer (LADO) within one working day (Working Together 2014/15 requirement)	45%	42%	n/a

Priority area 3: Children looked after and care leavers

Why do we need to focus on this?

We have a longstanding approach to preventing children becoming looked after but when children do need to come into care we want to ensure that care proceedings are timely and that our care plans appropriately safeguard children and support decisions around permanency which are in the best interests of each child. We are committed to ensuring all our looked after children and care leavers are given every opportunity to experience a safe, healthy and happy life in which they achieve their potential. We will make every effort to ensure they are able to grow up in a stable and supportive environment with a sense of belonging. Our role as corporate parents is significant and far reaching and we exercise this with commitment and accountability. Through this we consistently strive for all our young people to reach their potential, develop into independent, self-confident adults and enjoy their place in society.

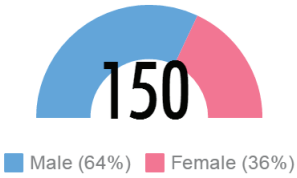
Merton's looked after children rate per 10,000 remains within a range expected of local authorities with statistically similar population, although our actual numbers have been steadily rising from a low of 96 (2006/7) to 150 (2013/14). Reasons for this increase include the impact of national awareness of children's safeguarding, an increasing local birth rate and more general demographic changes.

Merton's services for children looked after and care leavers were rated 'good' in the 2012 Ofsted Safeguarding and Looked After Children inspection. Fostering and Adoption services were also rated good by Ofsted in 2012 and 2013.

The Government has been clear in its drive to improve services and outcomes for looked after children, with revised statutory guidance that sets out the need to address the problem of delays in achieving permanency for children. The Family Justice Review and the revised Public Law Outline has aimed to dramatically speed up care proceedings, including a time limit of 26 weeks within which all, bar exceptional cases, must be completed. In response, we have redesigned our looked after children and permanency services to deliver permanency more quickly. We have also established an 'Edge of Care and Rehabilitation' panel to ensure that any decision to accommodate a child or young person between the ages of 0-16 is reviewed and a robust care plan put in place that has a focus on short and long term care planning.

We are determined to find the most appropriate care for our looked after children using family and friends; in-house foster carers, Independent Fostering Agencies (IFAs) or residential placements. By involving our partners we ensure coordinated wrap-around services are provided so that our children maintain healthy development, are safe both in and out of the home, achieve at school, are involved in out-of school activities and develop skills for independence.

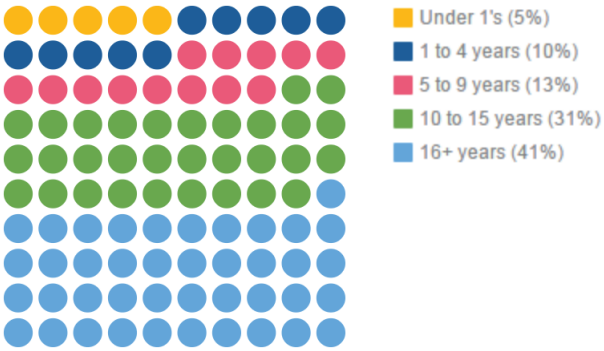
Children often enter the care system with a poorer level of physical and mental health than their peers, and their longer-term outcomes remain worse. Nationally two thirds of looked after children have at least one physical health complaint, and nearly half have a mental health disorder. Health outcomes for Merton looked after children are better than the national average and these are underpinned by good support from health partners with good levels of routine health surveillance and access to specialist provision where necessary.



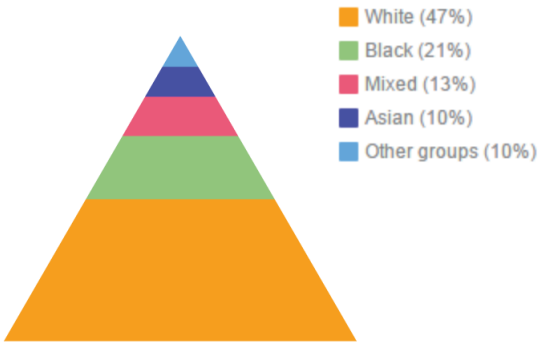
33 CHILDREN PER 10,000 BECOME LOOKED AFTER

Merton's looked after children rate per 10,000 remains within a range expected of local authorities with a statistically similar population. Our actual numbers have risen from a low of 96 (2006/7) to 150 (2013/14). Reasons for this increase include the impact of national awareness of children's safeguarding, an increasing local birth rate and more general demographic changes.

AGE



ETHNICITY



CARE AND PERMANANCE

40 weeks

Care and Supervision application average duration 2014/15

12% move placements 3 or more times (National 11%)

66% were in the same placement for two years or more (National 68%)

689 days

Adopted in 689 days compared to 981 three years ago

HEALTH

95% immunised (National 83%)

8% substance misuse (National 4%)

95% Annual health check (National 87%)

83% Annual dental check (National 82%)

EDUCATION

67% achieve Level 4 at KS2 in reading, writing and maths (National R63%, W59%. M55%)

23% obtain 5 GCSEs A* - C including English and maths (National 15%)

3% are absent from school (National 4%)

47% are in education employment or training (National 45%)

Figure X: Merton intelligence profile: Looked After Children, 2013/14

What have been our key successes to date?

Since our last CYPP…

- Merton's overall services for children looked after and care leavers were rated 'good' by Ofsted in spring 2012
- Merton's Fostering Agency was rated Good by Ofsted in 2012 and Merton's Adoption Agency was rated Good by Ofsted in 2013
- We have developed the role and function of the Corporate Parenting Board, now chaired by the Chief Executive.
- We refreshed our Looked after Children strategy and launched a new Care Leavers strategy in 2014.
- We improved the timeliness of our court proceedings from 72 weeks in 2011/12 to 40 weeks in 2014/15 (Merton 2014/15, CAFCASS).
- We have reduced the time between children entering care and being adopted.
- We have established an Edge of Care and Rehabilitation panel to strengthen management overview and decision-making for LAC
- We have researched placement stability to better inform our placement sufficiency assessment
- Co-developed with the Children in Care Council, we launched our LAC and Care Leavers Pledge
- We have revived our Children in Care Council and progressed our LAC Participation Strategy

Our user voice activity told us….	… so we did…
Our Children in Care Council said they wanted better information about their rights, services and participation opportunities.	We refreshed and reissued the 'LAC Pack' including information about participating in and Chairing LAC review, how to access an advocate, and how to give feedback or make a complaint.
Looked after children said that they wanted to be involved in the training and recruitment of foster carers.	Young people now run and facilitate foster carer preparation meetings to share their experiences of being looked after. Carers report that having an increased understanding of what it is like to be in care has developed their practice.

What will we do?

To improve timeliness of care proceedings a revised Public Law Outline introduced in April 2014 set out streamlined case management procedures for dealing with care proceedings.

- We will develop clear processes which ensure that as much activity as possible is undertaken in advance of proceedings. This includes robust care planning, the coordination of viability assessments, expert assessments and parenting assessments. (Looked After Children Strategy)

We are committed to achieving permanency for our looked after children in the shortest possible time. There are a range of permanent care options which can be considered to meet this commitment.

- We will ensure that all options for permanency for children requiring a placement outside of their own immediate family are considered, including for those with the most complex needs, regardless of the impact on our performance scorecard (Looked After Children Strategy)
- We will continue to work closely with the South West London Adoption Consortium (SWLAC) to ensure that we are pooling resources and subsequently securing best matches. (Looked After Children Strategy)
- We will continue to improve the timeliness of good quality matches for children for whom permanency is the plan. Including improving permanency planning for children aged 6+.(Looked After Children Strategy)

We want to improve placement choice and stability. This entails expanding our range of placement options and identifying the right placement for a child as early in their care journey as possible. Our annual LAC Sufficiency Strategy supports us to target our placement commissioning and procurement.

- We will continue to undertake work to understand our looked after children in order to inform our commissioning activity for suitable and sufficient places. (Looked After Children Sufficiency Statement)
- We will maintain conspicuous management oversight of all cohort so that vulnerable placements can be identified and greater support provided to young people and placements. (Looked After Children Strategy)
- We will continue to focus on recruiting more in-house fostercarers to enable us to minimise use of IFA placements. (Looked After Children Sufficiency Statement)
- We will explore the commissioning of a small local children's home for adolescents. (Looked After Children Sufficiency Statement)

We want to improve educational outcomes for our looked after children. Nationally only 15% of looked after children achieved 5 good GCSEs including maths and English in 2012-13. Our performance in Merton was 23%, better than national but still not good enough.

- The Virtual School will continue to work with Early Years Specialists, carers and settings to develop robust early years PEPs for our younger LAC (Looked After Children Strategy, Virtual School)
- We will extend the Designated Teacher network to include all schools, colleges and commissioned Alternative Providers to enhance support for Merton Looked After Children and Care Leavers (Looked After Children Strategy, Virtual School)
- We will continue to improve pathway planning by ensuring earlier support for transition to education, training or employment at the end of Year 11 and beyond. (Looked After Children Strategy)

We want to improve health outcomes for Looked After Children. Children often enter the care system with a poorer level of physical and mental health than their peers, and their

longer-term outcomes remain worse. Nationally two thirds of looked after children have at least one physical health complaint, and nearly half have a mental health disorder

- We will continue to use LAC annual health assessments and statutory reviews to ensure that the child's health needs are being met and to escalate matters of concern to appropriate services. (Looked After Children Strategy, LAC Nurse)
- We will ensure the timely referral of LAC with substance misuse issues to the commissioned 'risk and resilience' service, and ensure social worker monitoring of engagement with the service of all LAC requiring interventions. (Looked After Children Strategy)
- We will complete the re-commissioning of the specialist CAMHS service for LAC designed to provide consultation to social work staff and carers and direct interventions with young people. (Looked After Children Strategy, CAMHS)
- We will continue to promote completion of the Strengths and Difficulties Questionnaire (SDQ) for all LAC and to ensure that this is an integral part of the annual LAC Health review for over 5 year olds. (Health and Wellbeing Strategy)

We want our looked after children and care leavers to shape and influence the services they receive, and to see their views reflected in our strategies and plans. Social workers and carers are also expected to support looked after children to access and benefit from hobbies, leisure, cultural and sporting activities.

- We will continue to commission an independent advocacy service for children looked after by the local authority and ensure that our IRO service consults appropriately with young people during the statutory review process, providing robust challenge to practice as necessary (Looked After Children Strategy)
- We will continue to encourage participation in the Children in Care council and ensure regular engagement with the Corporate Parenting Board and key decision-makers (User Voice Strategy)
- We will continue to create a range of opportunities for appropriate formal and informal 'participation' and engagement for our looked after children, including for example coffee meetings, fun activities and surveys. (User Voice Strategy)
- Social workers, carers and the Virtual School will continue to promote and facilitate young people's participation in a wide range of interests and hobbies through our care planning process (Looked After Children Strategy)

We want to continue to improve the support we provide to young people as they prepare to leave care and establish themselves independently. Nationally 33% of care leavers are not in education, employment or training (DfE, 2011) and we are determined to better this performance.

- We will review the 'My Guide to Independence' on a bi-annual basis with members of the Children in Care Council (Looked After Children Strategy)
- We will embed the joint working protocol with Mitcham Job Centre Plus to promote better access for care leavers to employment and training opportunities (Looked After Children Strategy)
- We will continue to support the local 'Aim Higher' project encouraging children to aspire to a university education. (Looked After Children Strategy, Virtual School)
- We will continue to deliver apprenticeships specifically for our Looked After Children each year. (Looked After Children Strategy)
- We will review the protocol and guidance for transitions to adult mental health and develop mental health provision for care leavers (Care Leavers Strategy)
- We will develop housing pathways/options and guidance and deliver a broader menu of housing options for our care leavers, including encouraging our care leavers to opt into 'Staying Put'. (Care Leavers Strategy)

Key representative performance indicators

Looked After Children	2013-14 Outturn	2014-15 Outturn	National Benchmark
Time taken to deliver care proceedings in line with the Public Law Outline 26 week expectations (CAFCASS)	63 Q1 2013	24 weeks Q4 2015	37 weeks (2013/14)
Number of Looked After Children	150	157	n/a
Rate per 10,000 of Looked After Children			
Percentage of Looked After Children in external foster care agencies	50%	42%	38% (2013/14)
Number of 'In-house' foster carers recruited	15	10	n/a
Percentage of Looked After Children cases reviewed within timescales	97%	95%	n/a
Percentage of Looked After Children annual Health Assessments completed within timescale	95%	94%	87% (2013/14)
Percentage of Initial Personal Education Plans completed within timescales	83%	93%	n/a
LAC achieved 5 GCSEs including maths and English		21%	
Numbers of children who become Looked After due to a remand	14	6	n/a
Percentage of Care Leavers in education, employment or training (EET) (19 year olds)	43%	41%	34% (2013/14)
Number of Looked After Children adopted or receiving a Special Guardianship Order	15	16	n/a
Placement stability performance (3 moves or more) in line with national average or better.	12.7%,		11%
Placement length (2 years or more) in line with national average or better.	Merton three year rolling average 66%		National average 68% (2011 to 2013)
Emotional and behavioural health SDQ score (strengths and difficulties questionnaire) Merton's average score 12.3, national benchmark 13.9 (2013/14)	Merton's average score 12.3		

Priority area 4: Closing the gap in educational outcomes and opportunity

Why do we need to focus on this?

High quality education motivates children and young people to learn, develops their skills and gives them a foundation of knowledge and understanding on which they can build throughout the rest of their lives. National education policy puts significant weight on the role of individual settings, children centres, schools and colleges to provide the best possible opportunities for children and young people. Standards are high in Merton with 83% of schools (2013/14) and 100% of children's centres rated good or outstanding by Ofsted.

However we have a role in identifying those who might not receive or be able to benefit from our universal offer and ensuring a high quality local children's centre, school and further education offer for those performing behind their peers. Our education priority therefore focuses on closing the gap in outcomes and opportunities.

'The attainment gap between rich and poor which opens up before children start school, is visible during the infant years and increases over time' (White Paper, The importance of teaching, 2010). We need to focus on the access to children's centres specifically for those children from areas of deprivation and those eligible for the free early years offer for two year olds.

Nationally, pupils entitled to free school meals are only half as likely to achieve five good GCSEs as their peers' (White Paper, The importance of teaching, 2010). In Merton at KS4 46% of FSM pupils achieved five A* to C including English and maths in 2013/14, compared to the national equivalent 37% and the average of all peers at 64%. This gap is prevalent at KS2 also, in that 70% of FSM pupils achieved KS2 Level 4 in reading, writing and maths, compared to the national equivalent 67% and the average of all peers at 79%.

Behaviour in Merton schools remains good, with attendance levels improved and fixed term secondary school exclusions decreased. However, we are ambitious to achieve further improvement in these key areas.

Spending time not in employment, education or training (NEET) has been shown to have a detrimental effect on physical and mental health as well as an increased likelihood of unemployment, low wages, and low quality work later on in life. Being NEET can also have an impact on unhealthy behaviours and involvement in crime. These negative health effects do not occur equally across the population, as the chance of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement and school experiences. Being NEET therefore occurs disproportionately amongst those already experiencing other sources of disadvantage. As we respond to the challenges of the raising of the participation age (RPA), we need to focus specifically on those young people more vulnerable to being NEET.

The council has a statutory duty to provide a school place for every child whose parent or carer requests one. After an unprecedented increase in the early years (0-3 years) and primary school (4-11 years) child population in the 2010s, the projections are for the number of pupils in this sector is to plateau from 2020 to 2030. The increase in primary school population starts to reach secondary school from 2015/16 and this will require substantial increase in the secondary school estate.

EDUCATION

Closing the gap in educational outcomes and opportunity

ALL CHILDREN AND YOUNG PEOPLE

EYFS
60% Good Level of Development at Early years foundation stage (National 60%)

KS2
79% Level 4+ KS2 reading, writing and maths (National 79%)

GCSE
64% 5+ A* to C GCSEs inc English and maths (National 53%)

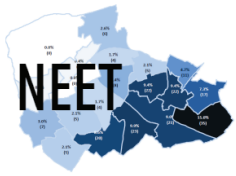
NEET
95.4% in employment, education or training (National 94.7%)

DISADVANTAGED

EYFS
44% of PP Good Level of Development at Early years foundation stage (National 45%)

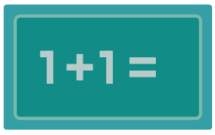
KS2
70% PP Level 4+ KS2 reading, writing and maths (National 67%)

GCSE
46% 5+ A* to C GCSEs inc English and maths (National 37%)

NEET

Prevalence of NEET across Merton

'The attainment gap between rich and poor which opens up before children start school, is visible during the infant years and increases over time' (White Paper, The importance of teaching, 2010).

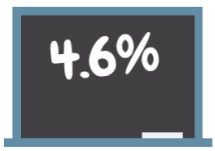
We need to continue to focus on narrowing the gap.



It is estimated that the current generation of 16 to 18 year olds who are NEET will cost society £31 billion during their life time, or £4.6 billion annually (No excuses a review of educational exclusion, Centre for Social Justice, 2011)

2% primary school persistent absence (National 1.9%)

20 primary schools expanded since 2010/11



4.6% secondary school persistent absence (National 5.3%)

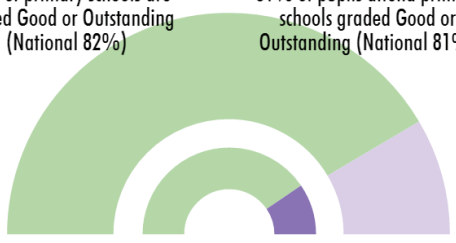
An esimated 2000 secondary school places needed from 2015/16 onwards

OFSTED

Standards are high in Merton 83% of schools (2013/14) and 100% of children's centres are graded Good or Outstanding by Ofsted

83% of primary schools are graded Good or Outstanding (National 82%)

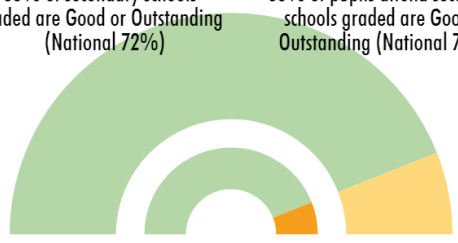
81% of pupils attend primary schools graded Good or Outstanding (National 81%)



Primary

88% of secondary schools graded are Good or Outstanding (National 72%)

88% of pupils attend secondary schools graded are Good or Outstanding (National 74%)



Secondary

Figure X: Merton intelligence profile: Education, 2013/14

What have been our key successes to date?

Since our last CYPP we have…

- Rolled-out free 2-year old childcare offer to disadvantaged groups, exceeding expectation and delivering 917 free child care places significantly exceeding the target of 705 (2013/14)
- Performance at Key Stage 2, reading, writing and maths combined at level 4 and above has increased to 79%. This is equal to the national average.
- At Key Stage 2, we are closing the gap between disadvantaged pupils and others, reducing the gap for attainment by 8% on 2012. (2013/14 X%)
- GCSE performance is above the national average, with 64.2% of pupils achieving 5+A*-C including English and maths, ranking Merton 16th nationally.
- We have implemented a more robust multi-agency Children Missing Education Strategy
- Reducing persistent absenteeism (PA) has been a key focus for the borough. Targeted work with schools and pupils has resulted in significant reduction in these rates which are now below national average.
- Fixed term secondary school exclusions have decreased from 8.15% to 5.31%..
- Permanent exclusions have decreased substantially in 2013/14 to 7 permanent exclusions from 12 in 2012/13. All permanent exclusions were pupils of secondary school age.
- We have implemented our alternative education strategy, improving the commissioning and quality assurance of this provision.
- Implemented NEET reduction strategy, 94% of Merton's 16-17 year olds are participating in education and training (2013/14). This proportion places Merton in the top quintile nationally.
- Merton's rate of apprenticeships is increasing but remains below national levels
- The council has met the increasing demand for primary school places over the last few years through expansion of over 20 primary schools. Additional capacity in SEN provision, both in mainstream and special schools has also been provided

Our user voice activity told us….	… so we did…
Pupils identified the type of teaching and learning approaches that they enjoy and the importance of giving regular feedback to pupils about progress made and areas for improvement.	Pupil voice has been incorporated into school improvement reviews and action plans which have led to developments in practice in schools.
Young people supported by our NEET prevention service said that family therapy has helped them to overcome barriers to accessing opportunities.	We have recruited an additional family therapist to the team to increase our capacity to deliver therapy to more families, and to help them to lift the barriers to accessing education, training and employment.

What will we do?

'The attainment gap between rich and poor which opens up before children start school, is visible during the infant years and increases over time' (White Paper, The Importance of Teaching, 2010)

- We will continue to roll out the strategy for funded childcare places for eligible 2 year olds ensuring take up at good and outstanding settings. (Early Years Partnership Plan)

Pupils entitled to free school meals are only half as likely to achieve five good GCSEs as their peers' (White Paper, The importance of teaching, 2010). Of those pupils known to be eligible for FSM there are variations in achievement by gender and ethnicity.

- We will continue to support and challenge schools and governors to use Pupil Premium, sports fund and Y7 catch up to raise pupil achievement. (Merton School Improvement Service – April 2016)

We have a role in identifying those who might not receive or be able to benefit from our universal offer and ensuring high quality local provision for those performing behind their peers

- We will manage the commissioning of KS4 EAL provision for in-year applicants to support them into appropriate full-time education. (Commissioning Team – July 2015)
- We will continue to support and challenge schools over attendance and especially the Children Missing Education (CME) programme and multi-agency approaches to improving PA on a case by case basis. (Merton School Improvement Service – Ongoing)
- We will continue to deliver a strategy to provide increased, timely access to good quality and appropriate alternative education for learners of compulsory school age. (Commissioning Team – September 2015)

It is estimated that the current generation of 16 to 18 year olds who are NEET will cost society £31 billion during their life time, or £4.6 billion annually (No Excuses: A Review of Educational Exclusion, Centre for Social Justice, 2011)

- We will continue to track and support young people 17 – 19 and target prevention through school based NEET prevention workers. (School Standards report 2013/14)
- We will continue to strengthen partnership arrangements e.g. with employers and work based learning providers to expand pathways and opportunities for young people including apprenticeships and make those apprenticeships more accessible. (School Standards report 2013/14)

The significant increase seen in Merton's primary school population starts to reach secondary school from 2015/16 and this will require substantial increase in the secondary school estate. We also need to provide additional places in local SEN provision. We need to ensure that in-year applications for school places, particularly for vulnerable pupils, are dealt with efficiently and fairly.

- We will deliver our secondary school places strategy by supporting the establishment of the new Harris Wimbledon Free School and through expansion of existing secondary schools in the east of the borough. (Contracts and School Organisation Service Plan 2015-16)
- We will deliver schemes to expand specialist provision and keep under review the need for additional special education provision, submitting bids as appropriate for capital resources. (Contracts and School Organisation Service Plan 2015-16)
- We will work with all secondary schools to agree a fair distribution of in-year secondary admissions and timely responses to applications and continue to operate

an effective Fair Access Protocol so that vulnerable children are placed in school as quickly as possible. (Contracts and School Organisation Service Plan 2015-16)

Key representative performance indicators

Education and Youth Inclusion	2013-14 Outturn	2014-15 Outturn	National Benchmark
Percentage of all Children's Centres graded good or outstanding by Ofsted inspections	100%	100%	69%
Percentage of Nursery Pupils (3 and 4 year olds) in Primary Schools graded good or outstanding by Ofsted	new	82%	n/a
Percentage of all Schools graded good or outstanding by Ofsted inspections	87%	85%	79%
Percentage of all Pupils in Schools graded good or outstanding by Ofsted	new	84%	86%
Percentage of Primary school attendance (all schools Inc. academies 2 and a half terms)	95.6% (AY 2012/13)	96.2% (AY 2013/14)	96.2% (AY 2013/14)
Percentage of Secondary school attendance (all schools Inc. academies 2 and a half terms)	94.4% (AY 2012/13)	95.2% (AY 2013/14)	94.9% (AY 2013/14)
Percentage of Children achieving Level Four in reading, writing and maths at Key Stage 2	78% (AY 2012/13)	79% (AY 2013/14)	79% (AY 2013/14)
Percentage of Young People achieving 5 or more GCSE grades A* to C including English & maths	62.6% (AY 2012/13)	64.2% (AY 2013/14)	53.4% (AY 2013/14)
Percentage of Secondary school pupils subject of a fixed term exclusion (percentage of pupils on roll)	8.15% (AY 2012/13)	6.89% (AY 2013/14)	6.62% (AY 2013/14)
Numbers of Secondary school permanent exclusions	11(AY 2012/13)	7 (AY 2013/14)	n/a
Numbers of young people in alternative education	163 (AY 2012/13)	173 (AY 2013/14)	n/a
Percentage of Young People aged 16-18 Not in Employment, Education or Training (NEET)	4%	4.6%	5.30%
Percentage of Young People aged 16 - 18 who's NEET status is "Not Known"	9.8%	12.4%	9.20%
Percentage of surplus places at Reception year	3.75%	1.10%	n/a
Parentage of surplus places at Secondary school Year 7 (Inc. Academies)	12.34%	11.32%	n/a

Priority area 5: Engage and enable young people to better outcomes

Why do we need to focus on this?

There is often significant peer pressure affecting children and young people, to enter into activities that may not keep them safe, or maximise their potential. We want to divert our young people from these risks and engage them in positive activities to enable better outcomes.

We want to continue to ensure a diverse and sustainable universal youth offer through the Merton Youth Partnership - currently delivered across three hubs: Mitcham, Morden and Wimbledon. In addition the offer includes borough wide services such as the Duke of Edinburgh Awards and MAGIC (Disability Youth Club). Our detached youth provision, now part of the integrated 'risk and resilience' service, will continue to target engagement with more vulnerable young people.

We want our pupils in schools to feel happy. Our anti-bullying strategy work has continued in schools and the Young Residents Survey saw a fall in concerns around bullying from 29% to 25% in line with London. And for the 3rd year running concern about the behaviour of other children stabilised at 25% in line with last year which had seen a significant fall.

We want to divert young people from youth offending, associations with gangs or radicalised extremist behaviour. We received good feedback following our Home Office Peer Review on 'Gang Youth and Violence' in March 2013: "the review team found a number of examples where Merton had moved quickly as a partnership to nullify threats. Engagement with most partners is generally strong, especially with local schools and the voluntary and community sector (VCS)."

Merton's levels of serious youth violence is amongst the lowest in London, however our partnership remains committed to continuing to work together to reduce any youth crime.

We want to increase young people's engagement in diversionary activities that support the reduction in the use of substances and promote positive health choices, through early intervention, prevention and substance misuse treatment for young people aged 24 and under.

We want to support our young people through provision of effective mental health services. Forty four per cent of our primary schools and 25% of secondary schools buy into the Merton TAMHS (Targeted Mental Health in Schools) Service and 83% of mainstream schools fund further provision.

ENGAGE AND ENABLE

Positive lifes choices and better outcomes for Young People

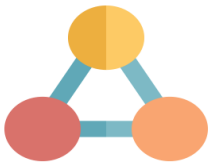
OUR YOUNG PEOPLE

We want to engage our young people to positive activities. We want our young people to make positive life choices which result in better outcomes.

Teenage pregnancy conception rate 22.2 per 1000 (National 30.7) (2013)

MERTON YOUTH PARTNERSHIP

A diverse and sustainable youth offer through the Merton Youth Partnership since 2011/12



Wimbledon

Morden

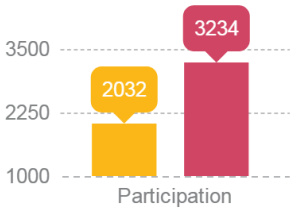
Mitcham

Home Office Peer Review on 'Gang and Youth Violence' March 2013.

"the review team found a number of examples where Merton had moved quickly as a partnership to nullify threats. Engagement with most partners is generally strong, especially with local schools and the voluntary and community sector (VCS)".

Number of young people engaged in positive youth service provision increased.

2032 2013/14 to 3234 in 2014/15



YOUTH JUSTICE

Merton's levels of serious youth violence is amongst the lowest in London, however our partnership remains committed to continuing to work together to reduce any youth crime.

Reduction: 60 First Time Entrants in 2014/15 from 188 in 2009/10

Re offending rate 1.11 per 1000 (National 1.10) (2014/15)

Custodial sentences of all court disposals rate per 1000 0.24 (National 0.51) (2014/15)

90% of young people supervised by the YOT are in Education, Employment or Training

There is a proven correlation between illiteracy, innumeracy and offending. Before custody 53% of male offenders and 71% of female offenders have no qualifications whatsoever' (Factsheet Education in Prisons Civitas: Institute for the study of Civic Society, 2010)

Young Residents Survey saw a fall in concerns around bullying from 29% to 25% in line with London – and for the 3rd year running

HEALTH

44% of our primary schools and 25% of secondary schools buy into the Merton TAMHS Service and 83% of mainstream schools fund further provision.

72% of young people are seen by CAMHS within 8 weeks of their referral (2014/15)

Figure X: Merton intelligence profile: Engage and enable

What have been our key successes to date?

Since our last CYPP we have…

- Continued to improve outcomes for young people in the youth justice system particularly in relation to a reduction of First Time Entrants, Re-offending and custodial sentences. Merton's youth justice service is one of London's top ten performing teams.
- The Short Quality Inspection (SQS) by Her Majesty's Inspectorate of Probation in September 2013 demonstrated a marked improvement in our youth justice casework.
- Assessments in relation to risk and safeguarding have been strengthened in the youth justice service following the SQS
- Implemented plans for new LAPSO and Youth Remand Orders
- Implemented ending gangs and serious youth violence peer review action plan following a good peer review to further improve our impact
- Progressed transformation of our universal youth services offer, establishing our new youth provision model through working closely with the voluntary sector
- Commissioned a new integrated 'risk and resilience' service for young people, delivering combined detached youth work, substance misuse and teenage pregnancy services.
- Established a Family Nurse Partnership and a commitment to maintain the programme over the next three years.

Our user voice activity told us….	… so we did…
Families supported by our Transforming Families (TF) Team said they want regular visits from an employment advisor at home, to help them into paid employment.	We increased the capacity of our seconded Job Centre Plus worker to offer more outreach advice and guidance. At the end of this year 88% of families who were part of the TF programme had been 'turned around'.
Our young advisors said that they wanted to take part in the re-commissioning of services.	We trained a group of young people to evaluate provider bids of the new risk and resilience service which integrates substance misuse, detached youth and sexual health promotion.

What will we do?

We want to divert young people from youth offending and from associations with gangs or radicalised extremist behaviour.

- We will continue to work in partnerships to support vulnerable young people to prevent offending and re-offending through a range of programmes; a 'scaled approach' with differing levels of intervention.(Youth Justice Service)
- We will work as a partnership to ensure early intervention with individuals identified as being at risk of progression towards offending as part of a group or gang. .(Youth Justice Service)
- We will support victims of youth crime through restorative justice interventions.(Youth Justice Service)
- We will work with all partners to identify and address radicalised behaviour at the earliest stage – collectively working towards delivering our Prevent agenda. .(MSCB Business Plan)

We want to increase young people's engagement in diversionary activities that support the reduction in the use of substances, and promote sexual health and positive health choices.
We want to provide young people with appropriate mental health support.

- We will ensure that our young people have timely access to substance misuse and sexual health advice and/or referrals for specialist services and will deliver risk and resilience education via targeted workshops in schools and youth provision (Merton Youth Partnership)
- We will offer diversionary activities as part of the risk and resilience building programme aimed at young people aged 24 and under (Merton Youth Partnership)
- We will provide tailored one to one support/treatment interventions with a specialist substance misuse practitioner when needed (Risk and Resilience Service)
- We will ensure that our refreshed CAMHS strategy provides models of delivery which engage young people (Local Authority and CAMHS)
- We will continue to deliver a Family Nurse Partnership for the next three years.

We want all young people to be prepared for the world of work to enable them to maximise their potential

- We will review the provision of careers advice and guidance across Merton's secondary school sector. (Raising the Participation Age Partnership)
- We will continue to deliver our NEET strategy with resources focused on engaging with more vulnerable young people. (Raising the Participation Age Partnership)
- We will build the capacity in our Post 16 sector to ensure that Merton's young people have choices (Raising the Participation Age Partnership)

We want our young people to have access to a good range of positive activities

- We will continue to seek alternative funding sources to support the diversity and sustainability of our universal youth offer via the Merton Youth Partnership. (Merton Youth Partnership and Education Inclusion)

Key representative performance indicators

Engage and enable Young People positive outcomes	2013-14 Outturn	2014-15 Outturn	National Benchmark
Percentage of Young People aged 16-18 Not in Employment, Education or Training (NEET)	4%	4.6%	5.30%
Percentage of Young People aged 16 - 18 who's NEET status is "Not Known"	9.8%	12.4%	9.20%
Number of young people engaging in positive youth service participation	2032	3234	n/a
Number of first time entrance into Youth Justice System aged 10 to 17 (cumulative)	88	60	n/a
Rate of proven re-offending by young people in the youth justice system	1.1	1.05	1.04 (2013)
Number of young people engaging in positive youth service participation	2032	3234	n/a
Number of first time entrance into Youth Justice System aged 10 to 17 (cumulative)	88	60	n/a
Rate of proven re-offending by young people in the youth justice system	1.1	1.05	1.04 (2013)
Percentage of young people requiring a First CAMHS assessment seen within 8 weeks of referral	51%	72%	n/a
Teenage Pregnancy conception rate per 1000 (under 18 years) (Average data 18 months in arrears)	26.3 per 10,000 in 2012	22.2 per 10,000 in 2013	30.7 per 10,000 (2011)

Priority area 6: Children with special educational needs and disabilities (SENDIS)

Why do we need to focus on this?

The SEND reforms introduced by the Children and Families Act 2014 are a significant set of cultural and systematic changes which are designed to improve outcomes for children and young people with SEN or disability (SEND). We are committed to working with children, young people and parents to improve outcomes for individual children and young people, and strategically to ensuring that operational arrangements and services better reflect needs.

In Merton 15% (January 2015) of pupils were identified as having special educational needs compared to 18.7% nationally (2012/13). Nationally boys are two and a half times more likely to have statements of SEN at primary school than girls, and nearly three times more likely to have statements at secondary school. In Merton 70% of all statements are for boys and 30% are for girls (January 2015). In addition, looked after children are three and a half times more likely to have special educational needs, and over ten times more likely to have statements of SEN.

Children and young people with SEN do less well than their peers at school and college. Nationally pupils with SEN are more likely to have higher levels of absence from school and more likely to be excluded from school. At Key Stage 2 in 2013/14, 23% of pupils with statements of SEN achieved the Level 4 in reading writing and maths compared to 15% nationally and to 79% of pupils with no SEN. Between Key Stage 2 and Key Stage 4 27% made expected progress in English compared to 28% nationally, but only 17% made expected progress in maths compared to 19% nationally. At Key Stage 4 8% achieved five good GCSE's A* to C, including English and maths which is in line with the national average.

Young people with SEN are twice as likely to be out of education, training and employment than their peers. Employment outcomes for people with SEN and disabilities are also poor. In 2012, 46% of disabled people were in employment, compared to 76% of non-disabled people. In addition, employment rates for those with significant learning difficulties are much worse, with some evidence suggesting this to be as low as 7%.

Supporting independence improves outcomes and deploys resources more effectively: The National Audit Office estimated that the cost to the public purse of supporting a person with a moderate learning disability through adult life (16–64) is £2–3 million. Equipping a young person with the skills to live in semi-independent rather than fully supported housing could, in addition to quality-of-life improvements, reduce these lifetime support costs by around £1m. Supporting one person with a learning disability into employment could, in addition to improving their independence and self-esteem, reduce lifetime costs to the public purse by around £170,000. Adult care costs for those with learning difficulties and/or disabilities are second only to the costs of supporting the elderly (£5.19bn compared to £8.79bn, 2012-13)

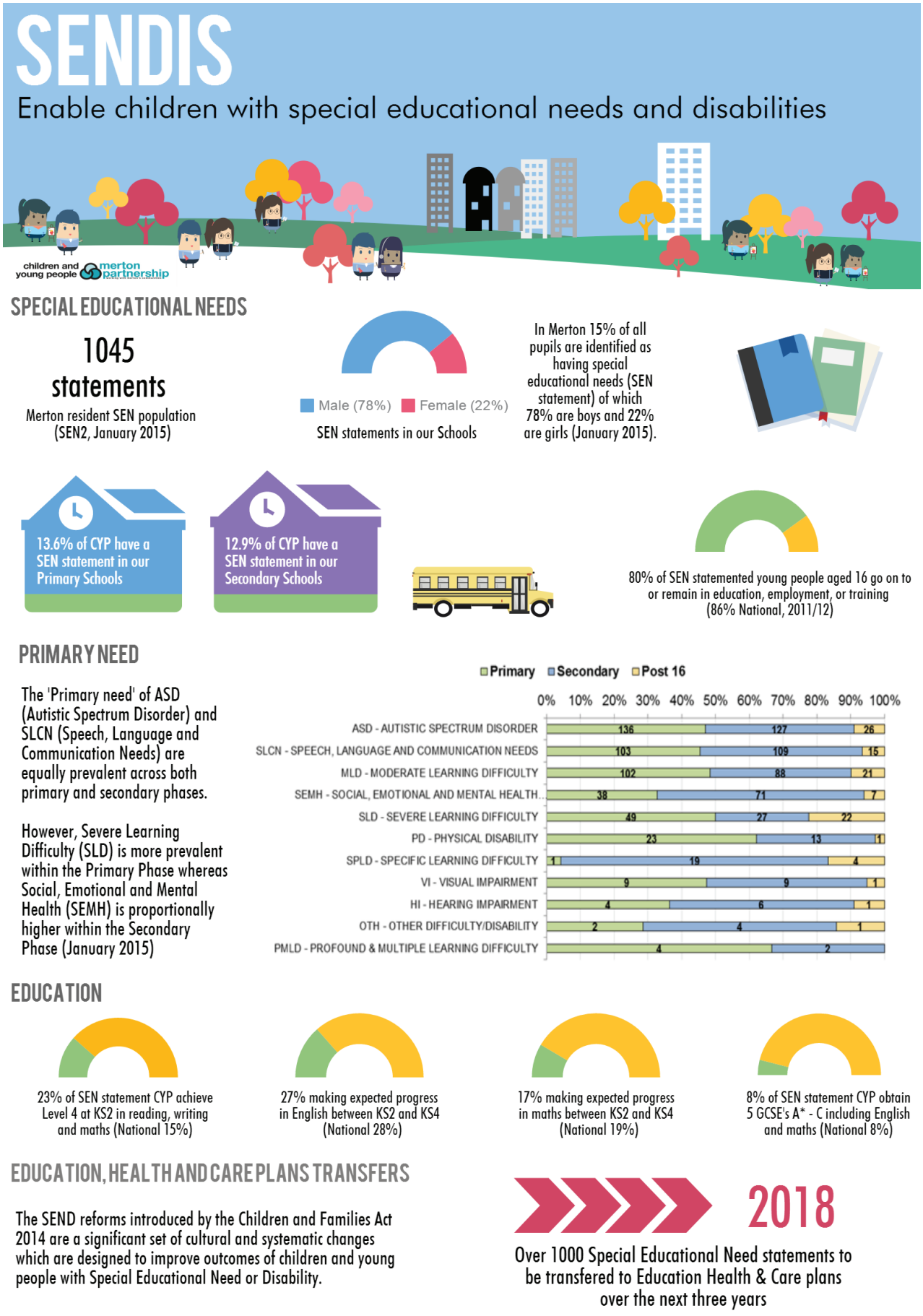


Figure X: Merton intelligence profile: Special Educational Needs and Disabilities

What have been our key successes to date?

Since our last CYPP we have…

- Planned for and begun implementation of the major change programme arising from the Children and Families Act 2014
- Published our first 'local offer' for children with SEN and disabilities and their families
- Implemented Education, Health & Social Care planning for children with SEN and disabilities
- Introduced co-located health practitioners into our integrated service for Children with SEN and disabilities
- Re-negotiated 'tripartite' funding arrangements for children with the most complex needs
- Begun rollout of personal budgets for children with EHC plans
- Strengthened focus on safeguarding in casework with children with disabilities
- Established additional SEN capacity in mainstream and special schools
- Established Melrose school/SMART Centre partnership model

Our user voice activity told us….	… so we did…
Families with children with disabilities were consulted on the local authority's roll out of the Children and Families Act, they said 'we only wanted to give information about our circumstances once and care plans must be more person focused'.	Our EHC plans are more person centred, facilitate family involvement, only require information to be given once, and are outcomes focussed – 'looking ahead', rather than just listing needs and provision.
Families were also consulted on the 'Local offer' – the requirement to publish information about services for children with SEN and disabilities.	They said that they feel that the local authority has meaningfully involved them and listened to their views from an early stage, using their ideas and views to inform developments.

What will we do?

We will work together to commission services which deliver integrated support for children and young people with SEN and disabilities aged 0-25.

- We will review and refresh our overarching SEN Strategy. (Local Authority)
- We will review our commissioning strategy for services for children with disabilities and their families including short breaks. (SEND Single Improvement Plan)
- We will map 16 – 25 SEN provision and support the market to develop routes to employability and social skills development for young adults with disabilities (SEND Single Improvement Plan)
- We will continue to co-produce and improve our published local offer of services and provision available. (SEND Single Improvement Plan)
- We will strengthen the role of parents and carers in the governance of children's services by appointing to membership of the Children's Trust Board. (Childrens Trust Executive, AD Education)
- We will continue to consult children, young people and their parents as key stakeholders in the development of services for children with SEN and disabilities and their families.(User Voice Strategy)

We will embed our approach to integrated Education, Health and Care (EHC) assessment and planning for children and young people with SEN and disabilities aged 0-25.

- We will provide further development opportunities to the multi-disciplinary team to support the major cultural and practice changes needed to fully implement the requirements of the Children and Families Act. (SEND Single Improvement Plan)
- We will deliver EHC plans within the required time limits. (SEND Single Improvement Plan)
- We will continue to transfer old SEN statements into new EHC plans in line with our transfer strategy (SEND Single Improvement Plan)
- We will continue to develop our approach to personal budgets and will offer the option of personal budgets within the EHC planning process. (SEND Single Improvement Plan)
- We will work with Adult Social Care services to review transitions arrangements in response to the Children and Families Act and Care Act requirements (SEND Single Improvement Plan)

We will support the early identification of children and young people with SEN, particularly at key points such as in the early years, through the progress check at age 2, the integrated health check and through the healthy child programme.

- We will embed Portage/children with complex needs services, improve services delivered from Children's Centres for families with children with complex needs and improve parenting offer for families with children with specialist/complex needs. (Early Years, Childcare and Children's Centres Service Plan – March 2016)
- We will implement the new Code of Practice for the delivery of 2, 3 and 4 year old education with an improved focus on supporting the narrowing the gap agenda and raising learning outcomes so children are ready for school. (Early Years, Childcare and Children's Centre Service – April 15)

Key representative performance indicators

Children with Special Educational Needs (SEN) and disabilities	2013-14 Outturn	2014-15 Outturn	National Benchmark
Number of residents with an SEN statement		1045	n/a
Number of new SEN Statements/Education Health and Care Plans (EHCP) issued (in and out of Borough)	153	170	n/a
Percentage of all SEN statements issued in 26 weeks (without exceptions)	92%	96% (Q3)	93%
Percentage of all SEN statements issued in 26 weeks (with and without exceptions)	87%	92% (Q3)	86%
Percentage of new Education Health and Care Plans issued within 20 weeks	100%	Due Jan 2016	61.50%

Children and Young People Plan 2016 - Matrix

The CYPP is a plan of plans which sets the context to support and deliver improved outcomes for children, young people and their families. As a Childrens Trust all of our strategies and plans combined together deliver our vision, the below matrix presents how they all link in.

	SHORT to MEDIUM TERM PRIORITIES					
	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Priority 6
	Deliver early help and improve outcomes for those subject to the effects of disadvantage	Deliver effective, timely and targeted safeguarding	Enable looked after and care leavers	Close the gap in educational outcomes and economic opportunity	Divert and deter Children and Young People to enable better outcomes	Enable children with special educational needs and disabilities
Merton Health and Well-Being Strategy 2017/18 Creating the place for the good life	✓			✓	✓	
Merton CCG Operational Plan and Commissioning Intentions 2014-16	✓	✓	✓		✓	✓
South West London 5 year Strategic Plan	✓					✓
4,5,6 Model - Health visitors	✓					
Breast Feeding Action Plan 2015/16	✓					
Merton Children Safeguarding Board priorities 2015–17	✓	✓	✓	✓	✓	✓
Community Safety Strategic Assessment 2015-16		✓				
LBM Young Persons' Substance Misuse and Teenage Pregnancy	✓				✓	
School Places Strategy				✓		
User Voice Strategy	✓	✓	✓	✓	✓	✓
Merton Education Partnership – The education network	✓			✓		
Enhancing integrated 0-5 service provision in Merton	✓	✓				
Merton's Employment and Skills	✓		✓	✓	✓	
SEND Single Improvement Plan	✓	✓		✓		✓
Volunteering Strategy	✓				✓	
Children Missing Education Annual Review December 2014		✓		✓		
Merton Council LAC Strategy 2015-18.			✓	✓	✓	✓
Merton Council Care Leavers Strategy 2015-18			✓		✓	✓
Workforce Development Strategy 2013-15		✓		✓		
LBM Family Poverty Strategy 2011-15	✓			✓		
Welfare Reform and Financial Resilience	✓					
MSCB and Children's Trust Young Carers Strategy 2013-16	✓	✓	✓			
Children Schools and Families priorities (Service Plans)	✓	✓	✓	✓	✓	✓

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Committee: Health and Wellbeing Board

Date:

Agenda item: CAMH Transformation Plans

Wards: ALL

Subject:

Lead officer:

Lead member:

Forward Plan reference number:

Contact officer: Mari Longhurst (MCCG)

Recommendations:

A. To nominate a representative from the Health and Wellbeing Board to sign off the Local CAMH Strategy and Transformation Plan. This is required to be the Chair of the HWB, DCS or DPH.

B.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to outline assurance requirements to enable allocation of CAMH Transformation monies and to request the Health and Well Being Board (as part of those requirements) to nominate a representative to sign off our local submission.

1.2 Future in Mind (2015) represents the work of an all party taskforce, setting out the case for change in the organisation and provision of mental health services for children and young people across the country. The report sets out an ambition for improved public awareness and understanding of mental health issues, timely access to mental health support for those who need it and improved access and support for the most vulnerable groups.

1.3 Within the autumn statement (Dec 2014) and Budget (March 2015) announcements were made of extra funding to transform mental health services for children and young people; aligning spend with the recommendations within the review and the Five Year Forward View (NHSE Oct 2014).

1.4 The guidance requires CCGs to work with all local partners to develop an agreed transformation plan

1.5 The guidance also requires that Transformation Plans are signed off by the Health and Wellbeing Board, and where this is not possible due to the timeframe and timing of meetings, that a representative from the HWBB (Director of Children's Services, the Director of Public Health or Lead Member for children Services) be nominated to take responsibility for signing off the plan.

1.6 Merton CCG has been working with local partners to develop the Local CAMH Strategy following a CAMHS Health Needs Assessment and Service Review in June 2015. This has formed the priorities within the transformation plan.

2.0 BACKGROUND

2.1 Future in Mind published in March 2015 by the Department of Health and NHS England (NHSE) represents the work of an all party taskforce, setting out the case for change in the organisation and provision of mental health services for children and young people across the country. The report sets out an ambition for improved public awareness and understanding of mental health issues, timely access to mental health support for those who need it and improved access and support for the most vulnerable groups. The whole systems approach to mental health and well-being is centered on five themes;

- Promoting resilience, prevention and early intervention
- Improving access to effective support in a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

2.2 Additional monies for the transformation were announced in the autumn statement (2014) and budget (2015), and guidance for the development of local partnership plans to inform system-wide transformation were published by NHSE in August 2015.

2.3 Local Transformation Plans are required to cover the full spectrum of service provision and address the needs of all children and young people including the most vulnerable, making it easier for them to access the support they need when and where they need it

2.4 The national ambition is to achieve transformation by 2020.

2.5 Merton has a recently established CAMH Partnership Board with membership from a range of partners and membership is currently being sought to include our local Community and Voluntary Sector and Schools.

2.6 The CAMH Partnership Board commissioned a CAMH Needs Assessment and Service Review in the spring (2015) to inform the development of the next CAMH Strategy.

2.7 The Partnership Board has clear Terms of Reference and a clear reporting line to the Merton Children's Trust Board and key links to the Merton Safeguarding Children Board and Health and Wellbeing Board.

2.7 The CAMH Strategy, currently in draft form, has been written in-line with the Future in Mind recommendations and the recommendations that came out of our local review.

2.8 The Transformation Plan will be populated from the priorities identified within the new Strategy.

3.0 DETAILS

3.1 NHSE published their national guidance in August 2015 for the implementation of these recommendations, key points to note include:

- The CCG will be submitting the Plan and associated documentation on behalf of the local Health and Wellbeing Board and wider partners.
- The plan will need to demonstrate compliance with the core principles and ambition described in *Future in Mind* and in the subsequent NHSE guidance;
- Sign off by the local Health and Wellbeing Board, NHS England Specialised Commissioning team and CCG are mandatory and required before monies will be released.
- Submission of the transformation plan is required to NHSE on 16 October 2015

3.2 The CCG will be required to submit progress to NHS on the delivery of the local transformation plans which is in line with their assurance framework.

The key assurances NHSE will seek nationally are that:

- Local Transformation Plans are published and made widely available;
- Children, young people, those who care for them and all local partners have been involved in developing the Plans;
- The additional money is being spent for the purposes intended;
- Locally determined KPIs are being met.

4.0 ALTERNATIVE OPTIONS

4.1 None

5.0 CONSULTATION UNDERTAKEN OR PROPOSED

5.1 Consultation has taken place prior to the development of the strategy through the CAMH Service Review and Health Needs Assessment for Merton.

5.2 Consultation was undertaken with stakeholders and professionals working with children and young people and specifically with children, young people and parents/carers.

5.3 Consultation was undertaken through 1:1 interviews, group discussion, forums and online surveys. On going involvement of children and young people is a key component of the strategy going forward.

6.0 TIMETABLE

6.1 Submission of Local Transformation Plan to NHS England is 16 October 2015

7.0 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1 If guidance is not followed, monies to improve CAMH will not be allocated

7.2 Merton CCG has been allocated initially £106,586 to start planning and improving eating disorders based on the recent publication of Access and Waiting Time Standard.

7.3 Following the submission on the transformation plan in October 2015 and NHS England being assured the CCG will be allocated a further £266,785 in 2015/16. Recurrent funding for CAMHS including the monies for Eating Disorders will be £373,380.

8.0 LEGAL AND STATUTORY IMPLICATIONS

8.1 None

9.0 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1 Equalities impact will be undertaken as part of the Strategy development to minimise any negative impact on any of our children and young people and to ensure that we are providing the best services we can, fairly, to those who need them.

10.0 CRIME AND DISORDER IMPLICATIONS

10.1 None

11.0 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1 None

12.0 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Local Transformation Plans for Children and Young People's Mental Wellbeing; NHS England, August 2015 http://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf
- Future in Mind; Promoting, Protecting and Improving Our Children and Young People's Mental Health And Wellbeing; Department of Health, NHS England, March 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

13.0 BACKGROUND PAPERS

NHS
Merton
Clinical Commissioning Group

Report to the Merton Clinical Reference Group

Date of Meeting: 16th September 2015

Agenda No: **Attachment No:**

Report Author: Hilina Asrress	**Lead Director: Dr Kay Eilbert/Fiona White**

Executive Summary: The attached paper provides the local picture around childhood immunisations. It details current performance, ongoing initiatives and plans for the future. The key messages are that:

- Childhood immunisations have historically been low in Merton but improvements have been made recently
- London Borough of Merton Overview and Scrutiny (O&S) committee completed a review and its report sets out recommendations on how the borough's partners can make further improvements in performance
- A local Immunisations Steering group will be re-established with representation from NHS England, Public Health, Merton CCG, SMCS and other partners (first meeting to take place in October/November). The group will lead the work around improving childhood immunisations locally
- A draft action plan has been developed between NHS England (Commissioners of immunisations) and Merton Public Health in partnership with the Clinical Director for Maternity and Children. The plan incorporates the O&S report recommendations (see Appendix 2). This will be taken to the local immunisations steering group for review and agreement
- Performance will be reported regularly through the GP locality meetings and a quarterly report will go to the Joint Commissioning Board and to the Public Health Board

Recommendation(s):
Members of the CRG are asked to discuss and note the content of the paper and actions to improve immunisations uptake in Merton.

Committees which have previously discussed/agreed the report:
N/A

Financial Implications:
N/A

How has the Patient voice been considered in development of this paper:
N/A

Other Implications:
N/A

Equality Analysis:
N/A

Information Privacy Issues:
N/A

Communication Plan:
N/A

1. Purpose of the Report

This paper is to update the CRG on the current Merton position in terms of the Childhood Immunisations Programme.

2. Background/Introduction

After clean water, vaccination is the most effective public health intervention for saving lives and promoting good health. Historically, Merton's childhood immunisations uptake has been lower than London and England averages. The World Health Organisation (WHO) sets a target of 95% coverage for all childhood immunisations but Merton has been far from this target.

Changes in commissioning arrangements for immunisation came into effect on 1st April 2013 as a result of the Health and Social Care Act 2012. The overall roles and responsibilities of the different organisations are as follows:

- **The Department of Health** will continue to have overall responsibility for immunisation policy, securing the necessary funding and supporting implementation of new vaccination programmes;

- **Public Health England** will be responsible for buying, storing and distributing vaccines, holding coverage and surveillance data, communication, and providing expert analysis and advice (including through the Joint Committee for Vaccination and Immunisation) at a national level and, through the PHE Centres, supporting the area teams of the NHS Commissioning Board;

- **NHS England** will be responsible for commissioning all national immunisation programmes from local providers in line with agreed service specifications. This will be done through Screening and Immunisation Teams which have NHS England and PHE staff working together, and are based within the 27 area teams;

Local Authority
Local Government (through Director of Public Health) will have a duty to ensure plans are in place to protect their population by providing independent scrutiny of the plans of NHS England and other organisations.

- **Providers of immunisation services, such as GPs and school nurses** will continue to deliver immunisation programmes following national schedules.

Further direction is available in guidance published in May 2013 (click on pdf link below).

National Frame &
local op model Imms&

3. Current Performance

Table 1 provides the latest Q4, 2014/15 data compared to Q4, 2013/14 performance for a selected number of immunisations indicators. Out of the 6 indicators shown, 5 of the indicators have shown improvements from the same period the previous year. A similar trend can be seen when comparing the quarterly 2014/15 performance with quarterly 2013/14 date.

Table 1: Latest Q4 COVER data

	Diphtheria, Tetanus, Polio Pertussis, Haemophilus influenza type b (DTaP/IPV/Hib) Age 1	Men C booster Age 2	MMR1 Age 2	Pneumococcal infection (PCV booster) Age 2	Diptheria, Tetanus, Polio, Pertussis (DTaP/IPV – pre school booster) Age 5	MMR2 Age 5
Merton Q4 14/15	93.6%	84.7%	85.8%	85.7%	65.8%	75.6%
Merton Q4 13/14	89.3%	83%	84.9%	83.9	67.3	74.1
London average Q4 13/14	89.8%	Not available	87.5%	86.3%	79.3%	80.7%
Q4 Merton 14/15 compared to Q4 Merton 13/14	↑ 4.3%	↑ 1.7%	↑ 0.9%	↑ 1.8%	↓ 1.5%	↑ 1.5%

Source: NHS England COVER Q4 2013/1 & HSCIC Q4 2013/14 data

Appendix 1 provides 2014/15 annual GP level performance for MMR2 and Pre-school booster vaccinations, where performance in Merton is lower compared to other immunisations and the London average.

The overall 2014/15 performance for Merton, London, England and other boroughs will be published at the end of September 2015. The Merton annual data will be reviewed against the London and England average as well as geographical and statistical neighbours and the previous annual performance.

4. Actions taken to date

A number of actions have been undertaken to improve childhood immunisations performance in the past year.

4.1. Overview and Scrutiny Report

In response to poor performance on childhood immunisations, London Borough of Merton's Overview and Scrutiny Committee requested a review of childhood immunisations locally with the support of The Centre for Public Scrutiny and partners input.

Partners with an interest and responsibility around immunisations were brought together to discuss the issues which were impacting on the uptake of immunisations. This then formed the basis of a report and recommendations (click on the link below).

Imms Scrutiny report FINAL.docx

The task group identified a number of important factors that contribute to improving uptake rates. These include;

- An effective local co-ordination group must be in place which has commitment from the key partners who deliver immunisations. The group should identify clear objectives and develop an action plan to improve take-up.
- Immunisation data must be updated in a timely way to ensure that the key agencies have the latest immunisation figures.
- The local co-ordination group should develop projects to identify and provide support to the groups who are least likely to immunise.
- Finding innovative ways to embed key immunisation messages within the community is the best way to improve take-up.
- The immunisations schedule is complex and changes regularly therefore it is important to ensure that parents and guardians are able to access support and reassurance when they need it.

The Overview and Scrutiny task group made a number of recommendations to address these issues and agreed to continue to raise the profile of this important issue locally.

4.2. Draft Immunisations Action Plan

An Immunisations Steering group which was chaired by Public Health had previously been in place to coordinate work to improve immunisations uptake. This group will be re-established to ensure there is a coordinated approach to improving immunisations uptake with key partners. This is also in line with the recommendations of the Overview and Scrutiny report. The objectives of the steering group are to bring partners together to coordinate initiatives to improve local rates. The group will be led by NHS England as Commissioner of childhood immunisations locally and will bring partners such as Merton CCG, Public Health, Children, Schools and Families (CSF) and Public Health England colleagues together. The first meeting will be scheduled for October/Early November.

A draft action plan has been developed between NHS England (Commissioners of immunisations) and Merton Public Health in partnership with the Clinical Director for Maternity and Children. The plan incorporates the O&S report recommendations (see Appendix 2). This will be reviewed by the wider local immunisations steering group.

4.3. Additional actions taken

4.3.1. Improving childhood immunisations has been identified as one of the outcomes in the refreshed Health and Well-being Strategy (2015-2018) under Theme 1 (Best Start in Life), with MMR 2 as the chosen indicator which will be monitored to track progress

4.3.2. NHS England have reviewed recent data to identify the 10 GP Practices with the highest proportion of unimmunised children. NHS England will be visiting all 10 GP Practices by March 2016 offering support and advice on how rates can be improved and sharing best practice.

4.3.3. Public Health England and NHS England have provided information and advice to GP Practices on changes in the immunisations schedule and provided online training for professionals and also 2 day training for new GP Practice immunisers.

4.3.4. Public Health provides quarterly immunisations data by GP Practice to locality meetings and has provided a Top Tips list of advice for GPs to improve immunisation rates.

4.3.5. Public Health uses local media such as My Merton (magazine which goes out to households in the borough) to remind families of the need to keep children up to date with immunisation schedules.

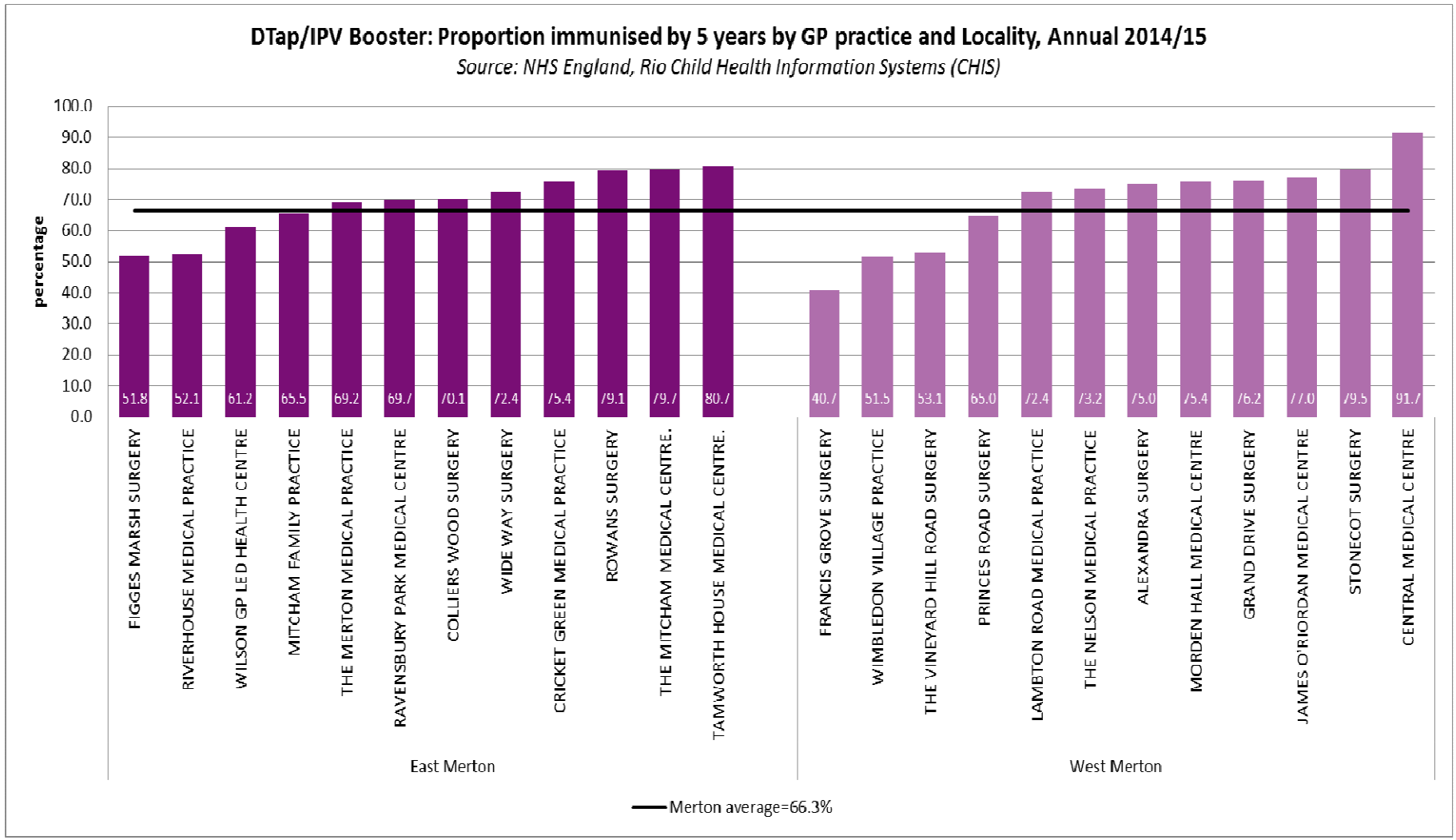
4.3.6. The Community Service Procurement service specifications for Health Visiting and School Nursing include and reinforce the need to promote immunisations and check immunisations status of children at appropriate times and signpost families. They include specific Key Performance Indicators to measure this. For example, School Nursing undertake health assessments for reception year children, including immunisation status. Where early years immunisations are not complete, a letter is sent to parents.

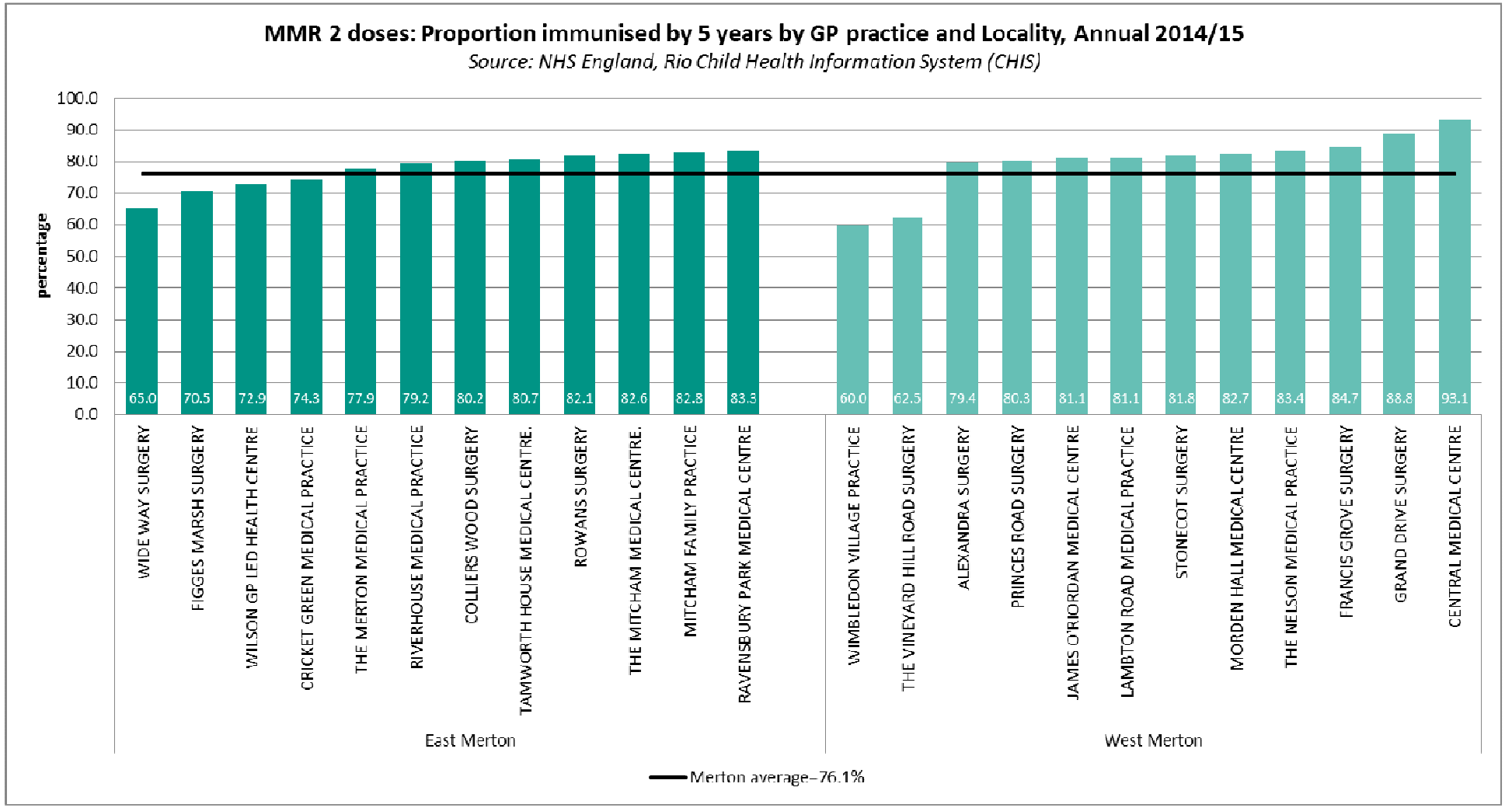
4.3.7. A GP Practice leads Flu update organised by the Clinical Director for Children was delivered in September 2015 with input from Public Health England, LBM Public Health and other key partners. For children this includes the requirements in the new flu season to immunise all 2, 3 and 4 year olds in the borough) by GP Practices.

5. Conclusion

Together with the actions that have been taken to date and the actions planned within the coming year, it is anticipated that improvements in performance shall be made and children and the community will be better protected from infectious diseases.

Appendix 1:
Pre-School Booster




MMR 2 doses: Proportion immunised by 5 years by GP practice and Locality, Annual 2014/15
Source: NHS England, Rio Child Health Information System (CHIS)
percentage
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
65.0
70.5
72.9
74.3
77.9
79.2
80.2
80.7
82.1
82.6
82.8
83.3
60.0
62.5
79.4
80.3
81.1
81.1
81.8
82.7
83.4
84.7
88.8
93.1
WIDE WAY SURGERY
FIGGES MARSH SURGERY
WILSON GP LED HEALTH CENTRE
CRICKET GREEN MEDICAL PRACTICE
THE MERTON MEDICAL PRACTICE
RIVERHOUSE MEDICAL PRACTICE
COLLIERS WOOD SURGERY
TAMWORTH HOUSE MEDICAL CENTRE.
ROWANS SURGERY
THE MITCHAM MEDICAL CENTRE.
MITCHAM FAMILY PRACTICE
RAVENSBURY PARK MEDICAL CENTRE
WIMBLEDON VILLAGE PRACTICE
THE VINEYARD HILL ROAD SURGERY
ALEXANDRA SURGERY
PRINCES ROAD SURGERY
JAMES O'RIORDAN MEDICAL CENTRE
LAMBTON ROAD MEDICAL PRACTICE
STONECOT SURGERY
MORDEN HALL MEDICAL CENTRE
THE NELSON MEDICAL PRACTICE
FRANCIS GROVE SURGERY
GRAND DRIVE SURGERY
CENTRAL MEDICAL CENTRE
East Merton
West Merton
Merton average–76.1%

Appendix 2:

Merton Childhood Immunisation Action Plan 2015/16

Background:

- Achieving high levels of immunisation coverage in London remains challenging. In Merton, immunisation uptake rates are similar to rest of London boroughs.
- This action plan has been developed as part of NHS England's ongoing work to improve immunisation coverage in London working with Merton Public Health and local partners. It consists of 2 sections and each section outlines ways in which partner organisations could contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in Merton. This is in recognition of the key elements and partnerships that are essential to the delivery of an effective, equitable and quality assured immunisation service.
- The 2015/16 Merton Immunisation Action Plan is underpinned by NHS England's immunisation strategic objectives which are:
    1. To achieve improved immunisation coverage across London (including Merton).
    2. To reduce inequalities in immunisation uptake between GP Practices, wards and population groups
    3. To improve patient choice and access to immunisations across London (including Merton)
- Merton's Health and Well-being Strategy 2015 – 2018 also identifies Childhood Immunisations as one of its key priority areas under the 'Best Start in Life' theme with MMR2 chosen as the indicator which will be monitored to track progress.
- This action plan includes recommendations from a London Borough of Merton Overview and Scrutiny report which was recently undertaken focussing on childhood immunisations

- This action plan outlines ways in which partner organisations can contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in Merton. This is in recognition that working in partnerships is essential to the delivery of an effective, equitable and quality assured immunisation service.

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
ommissioning nd Performance anagement	Improvement in the recording of immunisation data. All practices are instructed to use QMS Practice Focus was operational with all clinical systems.	COVER submissions reflect an increase in recorded immunisation coverage rates.	1. Ensure Merton GP Practices enter data for every patient immunised in a timely manner 2. Continue to encourage all practices to use agreed Read	End of Q1 2015/16	**CHIS** – for childhood immunisations **NHSE** in discussion with GP practices for other immunisations	• May not be possible to put an electronic solution in place for practices whose clinical system is not compatible with QMS Practice Focus, may need to revert to a manual system. • Practices experience problems submitting data automatically	
		100% of children who persistently miss GP immunisation appointments actively followed up to ensure they are up to date with immunisations	1. Encourage GP practices to directly contact children missing immunisations on Timely manner (call and recall)	End of Q3 2015/16	NHSE strategic lead **CHIS** operational lead in discussion with GPs (provider) **CHIS** operational lead in discussion with school nursing (provider)	• GP practices/CCG may not see the benefit of the call and recall system. • GPs may not prioritise immunisation	
	Reduce the variation in	Improved immunisation	1. Identify practices with	End of Q4	NHSE	• GP practices may not record	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
	immunisation performance between best performing and worst performing GPs.	data quality resulting in accurate reporting of immunisation coverage and improved GP understanding of current coverage issues and value of immunisation; leading to improvement in immunisation coverage in line with Merton trajectories	the highest number of unimmunised children. 2. Work with these practices to improve, either by cleansing lists or call/recall. 3. Identify what works in the best performing practices and share; work with poor performing practices in troubleshooting the barriers to increasing uptake. 4. CCG to support NHSE attending one Council of members meeting to cover actions 1-3. 5. Share Unify immunisation performance directly with practices (YHC)	2015/16		the data accurately. • GP may not buy in to strategy of identifying practices where efficient intervention can take place. • CCG will encourage GP practices to agree on the plan and monitor the data on monthly basis.	
	Performance data by GP practices provided direcly to GPs, LBM and to CCG locality meetings on a regular basis	Accurate reporting of immunisation coverage for Merton	1. 6 weeks prior to the final COVER submission, CHIS will be requested to send provisional aggregated data to	End of Q2 2015/16	CHIS/NHSE	• Practices not receiving their own data • Send practices their performance prior to final cover data submission and	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
	Children moving in/out of Merton are managed effectively to ensure they do not miss out on public health interventions		NHSE Commissioner. 2. Movers in/movers out Standard Operating Procedure devised and operated. 3. Merton Immunisation Group will discuss every six months. More regular discussion will be initiated by NHSE if required.			after	
			1.				
	To facilitate measurable improvements in quality and performance for Merton immunisation services through bringing people together	Improved immunisations uptake in Merton	1. Continue with Immunisation network meetings. 2. NHS England to liaise with CCGs, LA, Primary care commissioners and PHE. 3. Facilitate NHSE attendance at Practice Manager's and Practice Nurse's forums to encourage sharing of good	Ongoing	NHSE	• NHSE plan to present papers and feed back to group in timely manner.	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
			practice between practices.				
	Continue to provide targeted BCG from provider until new commissioning arrangements for universal BCG programme are in place	100% of babies offered BCG immunisation at birth	1. Monitor BCG data	Sept 2015	NHSE \ CCG	• Vaccine supply. • The provider not delivering the service. • New commissioning arrangements not being explored and finalised • NHSE regularly monitor the uptake and keep informed of PHE vaccine supply issues.	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
	NHSE commissioned Flu and Pertussis vaccinations delivered and promoted throughout primary care providers	Increase in reported rates of flu and pertussis vaccination coverage amongst pregnant women, and flu vaccination across named at risk and universal groups	1. Work with GP practices to improve flu vaccine uptake. 2. Commission the flu pharmacy scheme to improve access (subject to findings from the economic evaluation of the flu pharmacy initiative). 3. Commission maternity services to offer the flu and pertussis vaccinations to pregnant women	End of Q1 2015/16	NHSE	• NHSE doesn't communicate winter strategy in timely manner • NHSE will inform all stakeholders of any delays • Providers feel ill-equipped to respond to queries regarding vaccine efficacy • NHSE to ensure that PHE communication material is distributed in a timely manner.	
	Messages around childhood immunisations are delivered through Health Champions working in the community and targeted at groups who are not being immunised	Information on the importance of childhood immunisations is disseminated throughout the community and more families seek to ensure their children's immunisations are up to date	1. Ensure Health Champions deliver immunisations messages within their communities 2. Public health team seek to develop health champion roles in communities where immunisation rates are the lowest where possible.	April 2016	LBM	• Insufficient funding to recruit more health champions in areas where immunisations rates are lower • Use existing Health champions to cover some areas where immunisation rates are low	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
	School entry packs include information promoting childhood immunisations and importance of being up to date on the schedule	Those who may have missed certain immunisations will be reminded to attend their GP and get children immunised, increasing uptake	Public health team to ensure that information on immunisations will be part of school entry packs and asked within the school entry health review, using the review as an opportunity to identify those unimmunised, promote immunisations uptake and signpost to child's GP.	January 2016	LBM	• Not enough leaflets available for all school entry packs. Need to work with NHSE to ensure there is enough	
	All immunisers have had their annual refresher training and all new immunisers have completed the mandatory 2 day course	Merton population will receive high quality and safe immunisation services as delivered by a competent and knowledgeable workforce.	1. NHSE to work with PHE and LETB to secure and commission immunisation training modules. 2. CCG to encourage practices and other providers to ensure all staff undertaking immunising have current training	End of Q2 2015/16	NHSE\CCG\ PHE	• Immunisation training not being delivered. • Work with Merton CCG and LA to locally deliver in house immunisations training tailored to the needs of Merton nurses.	
ommunication Health care	Information relating to immunisation	Improved communications with all	1. NHSE, LA, CCG and PHE will liaise to	Ongoing First audit	NHSE	• Delay in NHSE communicating winter strategy	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
rofessionals and ublic), and takeholder ngagement	programmes is disseminated to all key stakeholders (e.g. changes to the schedule and introduction of new programmes).	stake holders.	develop communication and cascade plan	to be completed by end October 2015	LA and CCG will advise NHSE on key local stakeholders	in timely manner. This may is dependent on strategic partners on a National level publishing policy and recommendations.	
	Performance data shared with Merton CCG and LA quarterly	All key players are up-to-date on performance information within the borough and able to use this information to inform their own delivery practices.	1. Work with CCG to identify immunisation leads in practices 2. Supply performance data to partners (including CCG and LA) in timely manner Offer support to providers should they wish to audit data flow.	Ongoing	NHSE	• Delay in data sharing. • Queries regarding quality of data. • Sharing the data in timely manner may be difficult	
	Flu, shingles and pneumococcal vaccinations (for targeted cohorts) are promoted in all care homes and included as a requirement in LA contracts with providers of social care services.	Contributes to increased uptake of winter vaccination within these populations (workers and clients).	1. Leaflets promoting immunisations are included in flu information packs. 2. Immunisations are promoted to care homes.	Sep 2015	NHSE lead – including provision of leaflets, policy etc. PHE to advise on content LA to design cascade of information to nursing homes (including local	• Information is not provided in a timely manner. • NHSE communicate winter strategy to all stake holders by end of Q1 2015/16.	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
					IMPACT team), and revise contracts		
	All registered child care providers, nurseries and preschools promote and check immunisation status of the children enrolled.	Increased numbers of children who have completed the childhood immunisation programme by age 5.	1. LA and NHSE to work with childcare providers to reinforce the message to parents of the importance of complete immunisation by age 5 (before starting school).	March 2016	LA/ CHIS	• Lack of understanding and buy in from childcare managers and providers • Regular information sessions through existing communication mechanisms used by LA.	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
Page 87	Children's Centres engaged in promoting immunisations and vaccinations for families.	Greater awareness about the immunisation life course.	1. Information sessions on immunisation; staff trained to provide information with parent/baby groups and other users. 2. Inclusion of immunisation information in child checks/baby weighing clinics. 3. Measured by survey of children centre staff at end of the year. 4. Continue contract between Royal Marsden and Children's Centres on vaccine promotion, including the distribution of leaflets to centres	March 2016	NHSE Royal Marsden hospital and 'Achieving for Children' (LA-Merton) operational leaf	• Immunisation not a priority for children's centres. • Availability of training the benefits of immunisation.	

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
	Identify relevant recommendations from the NHS Southwest London *Childhood Immunisations and Vaccinations 2013* report on Immunisations and implement locally to improve immunisations rates	Increased immunisations uptake	Review the recommendations in the NHS Southwest London report and decide what would be appropriate to take forward	Identify areas by December 2015	Immunisations Group	• Time constraints to be able to review recommendations and implement Ensure time is dedicated to discussing this on the agenda	
	Ensure Health Visitors are checking and promoting immunisations with families during contacts including health reviews and baby clinics	Families reminded to immunise their children at different opportunities by Health Visitors and increase in uptake	Public Health Team to ensure that role of health visitors in delivering information on immunisations is specified and strengthened in the commissioning arrangements.	April 2016	LA	• Contact with families may not be used to promote immunisations Monitor performance indicators around checking immunisations status at reviews	
	Using technology to ensure families are reminded about getting children immunised	Increased immunisations uptake	Conduct a audit of GP's who use a text messaging service and ask them to include information on immunisations. Explore future options for expanding the text messaging service	March 2016	Merton CCG, LA & NHSE		

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
	Information regarding vaccination available at housing offices and local newsletter to communities through the Merton Equalities and Engagement Team	Greater awareness about the immunisation life course, and where to access immunisations.	1. Liaise with Local Authority Housing and communications departments to include immunisation leaflet/advert in housing pack	March 2016	LA	• Do new residents receive "welcome pack"? • Need to get buy-in from housing and communications department.	
ssurance	Timely and comprehensive reporting of current immunisation issues in Merton	Merton locality assured about immunisation coverage and uptake and of plans to increase coverage, commissioning arrangements, and on responses to quality issues.	NHSE to provide comprehensive report on immunisation to the Merton Health and Wellbeing Board **(annually)** NHSE to coordinate local Immunisation Group meetings**)** Coverage and uptake data supplied to LA and CCG **quarterly**	Ongoing	NHSE	• NHSE unable to provide reports	G
	Quality: Incident and serious incident reporting and support	All serious incidents and near misses investigated and	Support providers in dealing with incidents	Ongoing	NHSE		

ey Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion and mitigation of risk	RAG
		lessons learned and shared. Minimise serious incidents	Seek assurance from providers about implementation of lessons learnt from incidents				

pp

Committee: Health and Wellbeing Board

Date: 29th September 2015

Agenda item:

Wards: ALL

Subject: Improving the uptake of immunisations in the 0-5 age group - task group report.

Lead officer: Stella Akintan, Scrutiny Officer

Lead member: Councillor Brenda Fraser, Chair of the immunisations task group

Contact officer: Stella Akintan, stella.akintan@merton.gov.uk; 020 8545 3390

Recommendations:

A. That Health and Wellbeing Board considers and endorses the recommendations arising from the scrutiny review on improving the uptake of immunisations in the 0-5 age group attached at **Appendix 1.**

B. That the Health and Wellbeing Board agrees to the implementation of the recommendations, by means of an action plan to be drawn up by officers and relevant partners.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This is a report and recommendations arising from a scrutiny review of improving the uptake of immunisations in the 0-5 age group. The work came about as the result of a successful application to the Centre for Public Scrutiny who offered councils five free days support from an expert advisor to support a scrutiny task group on immunisations. The review was sponsored by Sanofi Pasteur, although they did not have any direct involvement in the work.

1.2. The Health and Wellbeing Board has been asked to consider this report and recommendations. The report will then go to Cabinet for final agreement.

2 DETAILS

2.1. In 2012/13 Sutton and Merton Primary Care Trust reported the lowest childhood immunisation rates in in the Capital, with very few GP practices reaching the World Health Organisation targets of 95%.

2.2. The task group agreed to focus on immunisations for the 0-5 years in recognition that this is the most challenging area and one which a scrutiny review could have a significant impact.

2.3. The evidence highlights that immunisations in the early years from 0-5 had the lowest take up rates and this group along with the over 65s, are the most vulnerable to communicable diseases. A significant number of vaccinations are required during the early years which may contribute to the challenges in this area. Evidence shows that if people do not begin the process of immunising their children in the early years; they are less likely to have the booster injections.

2.4. It was also recognised that the child population is expanding, with changing demographics, which makes this a more pertinent area to review. Immunisations at the school age years have the benefit of a structure of the school system which can create 'captive audiences' and help to boost rates.

3 ALTERNATIVE OPTIONS

The Overview and Scrutiny Commission can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

Cabinet is constitutionally required to receive, consider and respond to scrutiny recommendations within two months of receiving them at a meeting.

3.1. Cabinet is not, however, required to agree and implement recommendations from Overview and Scrutiny. Cabinet could agree to implement some, or none, of the recommendations made in the scrutiny review final report.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Health and Wellbeing Board will be consulted at the meeting

5 TIMETABLE

5.1. The Health and Wellbeing Board is asked to refer the report to Cabinet for consideration and response.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None relating to this covering report

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Scrutiny review report - Improving the uptake of Immunisations in the 0-5 age group

12 BACKGROUND PAPERS

12.1. .

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Improving the uptake of Immunisations in the 0-5 age group

Overview and Scrutiny Report

Task group membership
Councillor Brenda Fraser (Chair)
Councillor Joan Henry
Councillor James Holmes
Councillor Brian Lewis-Lavender
Councillor Katy Neep
Councillor Marsie Skeete
Councillor Linda Taylor

Scrutiny support:
Stella Akintan, Scrutiny Officer
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This review work is part of a collaborative project between the Centre for Public Scrutiny and Sanofi Pasteur MSD. Sanofi Pasteur MSD has provided funding to The Centre for Public Scrutiny to enable them to offer consultancy from their Expert Advisory Team to the London Borough of Merton. Sanofi Pasteur MSD has not attended the scrutiny stakeholder events and has had no input into the creation of this report.

Table of contents

Foreword by the Task Group Chair

Immunisation plays a really important role in keeping our nation healthy. It is a preventive measure especially for young children, as it attributes resistance to specific infections.

We need to continue the fight against infectious disease, most have been eradicated but others are reportedly making a comeback, which can cause severe trauma to the lives of families. It is therefore, important to establish clear routines in immunisation procedures. Pregnant women, parents and guardians must be given information so that they can make informed choices regarding immunisation.

We also need to ensure we meet the World Health Organisation target as a lapse in take-up not only cause an increase in the different illnesses, but also takes a long time for protection to be re-established in communities.

We are grateful to all our witnesses, Dr Kay Eilbert, Director of Public Health, as well as the public health team, our advisor from the Centre for Public Scrutiny and our Scrutiny Officer, Stella Akintan, who has tirelessly investigated and sought those in the community with responsibility for this area of health to share experiences and to promise commitment to this project.

Although we have completed the review, this is not the end. We will ensure, by continuing investigation and dialogue that our voice is heard and the children of Merton as well as the wider community reap the benefit of this work.

Councillor Brenda Fraser

Executive Summary

This task group considered the important issue of how to improve the take-up of immunisations amongst the 0-5 age group. This issue was very pertinent in Merton given that Sutton and Merton Primary Care Trust reported the lowest immunisations rates in London in 2012/13.

The task group met with a wide range of witnesses including; NHS England, Director of Public Health, Public Health England, parents, early years staff, Merton Clinical Commissioning Group and Sutton and Merton Community Services.

The task group identified a number of important factors that will contribute to improving take-up rates. These include;

- An effective local co-ordination group must be in place which has commitment from the key partners who deliver immunisations. The group should identify clear objectives and develop an action plan to improve take-up.
- Immunisation data must be updated in a timely way to ensure that the key agencies have the latest immunisation figures.
- The local co-ordination group should develop projects to identify and provide support to the groups who are least likely to immunise.
- Finding innovative ways to embed key immunisation messages within the community is the best way to improve take-up.
- The immunisations schedule is complex and changes regularly therefore it is important to ensure that parents and guardians are able to access support and reassurance when they need it.

The task group made a number of recommendations to address these issues and agreed to continue to raise the profile of this important issue locally.

Introduction

1. Immunisation has been hailed as one of the greatest successes of the public health movement in eradicating the infectious diseases that ravaged Britain three hundred years ago. Sustaining take up of immunisations is important; the World Health Organisation has set a target of 95% of the population to be vaccinated as high levels of herd immunity are needed to reduce the possibility of the diseases spreading between people.

2. Whilst the majority of people do immunise their children, the challenge of modern times is to successfully target those who face a complex range of barriers and do not complete the immunisation schedule. Also, many people have not been exposed to the effects of the polio, whooping cough, smallpox and other infectious diseases their children are being vaccinated against, therefore the benefits may not be obvious.

3. In 2012-13, Sutton and Merton Primary Care Trust reported the lowest childhood immunisation rates in the Capital, with very few local GP practices reaching the World Health Organisation target. When the Centre for Public Scrutiny sought local authorities to conduct a review of immunisations it was an opportunity for scrutiny to consider this long standing issue and look at how to increase the uptake of immunisations across the borough.

4. Merton also had a new intake of politicians following the 2014 local election. This review presented an opportunity for them as well as our existing members to benefit from the support of an expert advisor from the Centre for Public Scrutiny.

Summary of Recommendations

1. NHS England, Merton Clinical Commissioning Group, Sutton and Merton Community Services and the Local Authority develop a joint working protocol including development of a joint action plan setting out frequency of meetings and priority actions to improve the take up of immunisations. Ensure the group leads on embedding immunisations messages in all nurseries, children's centres and early years' services in Merton.

2. The group should review the recommendations in the NHS Southwest London report *Childhood Immunisations and Vaccinations 2013* and decide what would be appropriate to take forward.

3. The group should report to the Health and Wellbeing Board on an annual basis and report their progress to the Overview and Scrutiny Commission on a six monthly basis until the Commission are satisfied that this work has been taken forward and that further improvements in immunisations have been made.

4. The task group chair to champion improving immunisation rates and raise the profile of this issue in appropriate forums.

5. That health champions deliver immunisations messages within their communities and public health team seek to develop health champion roles in communities where immunisation rates are the lowest where possible.

6. That the Public Health Team ensures that the role of health visitors in delivering information on immunisations is specified and strengthened in the commissioning arrangements.

7. Public Health Merton to work with Merton Clinical Commissioning Group to conduct an audit of GPs on the 'top tips' sheet including checking which practices use the text messaging service. Merton Clinical Commissioning Group and Public Health Team to explore future options for expanding the text messaging service.

8. Public health team to ensure that information on immunisations will be part of school entry packs and asked within the school entry health review, using the review as an opportunity to identify those unimmunised, promote immunisations uptake and signpost to child's GP.

9. Public health team should take every care to ensure that the immunisation data received from Public Health England is accurate

Key lines of enquiry

A. To review the local arrangements and responsibilities for immunisations.

B. To review arrangements for oversight, co-ordination and monitoring of immunisation services.

C. To review which groups least are likely to immunise and how is this being addressed locally.

D. To review the barriers and challenges experienced by parents in dealing with immunisations.

E. Review the measures in place to address parents' concerns around immunisations.

F. To review the opportunities for partnerships between organisations that work directly with parents and communities and the health services to involve parents.

Background

10. The Merton Joint Strategic Needs Assessment states that immunisation is the most cost effective health measure after clean water in saving lives and maintaining health. It is also an important efficiency measure in avoiding the high costs of hospital admissions.

11. This is demonstrated by a report from Sanofi Pasteur MSD [1] on the economic value of vaccine which highlighted that in Europe the cost of a measles treatment in hospital is approximately £180-£414 compared to 15-84 pence as the cost of being vaccinated against the disease.

12. At the time of writing this report the council is refreshing its Health and Wellbeing Strategy, one of the priorities is 'Giving every child a healthy start'. This is in recognition that if a child has a strong foundation it will benefit them for the rest of their life. The Strategy is seeking to increase immunisation rates recognising they are a form early intervention which prevent illness and disease. The task group are pleased that the recommendations arising from this scrutiny review will inform the work in helping to improve immunisations rates. The Strategy will focus on improving the take up of MMR2 at age five. This indicator will be taken as proxy for improvement in uptake across all childhood immunisations, and not an indication that these are the only immunisations to be improved.

[1] [1] The Economic Value of Vaccination, Sanofi Pasteur MSD, 2011.

Why focus childhood immunisations?

13. The task group considered a review on immunisations across three main areas; children up to the age of five years, school age children and young adults. After looking at the evidence and discussions with experts in the field, the task group agreed to focus on immunisations for the 0-5 years in recognition that this is the most challenging area and one where a scrutiny review could have a significant impact.

14. The evidence highlights that immunisations in the early years from 0-5 had the lowest take-up rates and this group along with the over 65s, are the most vulnerable to communicable diseases. A significant number of vaccinations are required during the early years which may contribute to the challenges in this area. Evidence shows that if people do not begin the process of immunising their children from birth; they are less likely to have the booster injections and complete the immunisations schedule.

15. It was also recognised that the child population is expanding, with changing demographics, which makes this a more pertinent area to review. Immunisations at the school age years are less of a challenge as they have the benefit of the structure of the school system which can help to boost rates.

Landscape for the delivery of immunisations

16. The commissioning of immunisations service has undergone significant changes since April 2013, responsibility has moved from the Primary Care Trust to NHS England who commission services from primary care and other community providers such as school nursing teams. NHS England also monitors and support providers' performance. Improving Immunisation Rates is the responsibility of the London Immunisation Programme Board who develop strategies to increase rates. A quality improvement board has been established in South London.

17. Merton Clinical Commissioning Group has a duty to deliver quality improvement for the immunisations services delivered in GP practices. As part of this, they work with individual practices to improve coverage and include information on immunisations within their programme of engagement and outreach work. The surgeries are responsible for delivering the childhood routine immunisation schedule.

18. Local authorities have a general duty to improve the health and wellbeing of their populations within their public health role. They also have an explicit

'assurance role' in which the Director of Public Health must have oversight of the immunisations and screening process and be satisfied that the system is operating effectively. The public heath team works with the three GP localities in Merton to share best practice to improve performance.

19. Sutton and Merton Community Services are responsible for managing the central data recording systems. From April 2016, the potential delivery of school based immunisations and possibly 3-5% of the preschool immunisations. These contracts are due to be finalised after April 2016.

Immunisation rates in Merton

20. There has been a significant shift in the data on immunisation rates during the course of the review. The task group were initially presented with figures showing Merton with the lowest rates in London; however when the task group met with NHS England they were informed a number of measures were put in place to address this. NHS England focussed on a data extraction project, which electronically extracts immunisations from GP systems and puts them directly into RIO via an interface. This improves data collection and measurement of data quality.

21. The task group were told that it led to significant improvements in the data, for example on the 12 months Hib MenC MMR vaccine, Merton is at 92%. The London average is 90% placing Merton second place in South West London in the Cohort of Vaccinations Evaluation Rapidly (COVER).

22. NHS England said there has been steady progress in the last eighteen months. Merton Immunisations were at 65% and had increased to 80%, which places Merton second in South West London. Merton is in the top three in South West London for MMR booster. The gap has also greatly reduced on the pre-school booster.

23. Following questions from the task group NHS England accepted that improvement in immunisation figures was largely due to improving the data rather than improving uptake. Approximately 15% could be attributed to data collection and 2-3% on improving take-up rates.

Current work to improve the take up of immunisations

24. NHS England policy is to make 'every contact count' and maximise every opportunity to share important messages around immunisations. Therefore

they conduct a range of outreach activities such as work with women in mosques. They also engage with a wide range of partners such as local authorities on health promotion, Public Health England on national aspects of this work.

25. NHS England is developing a programme with GP surgeries to identify and provide targeted support for the groups who are not getting their children immunised. The work will have a very specific scope, the aim is to localise these services which could lead to at 3-5% increase in uptake, which would take the borough above the national average.

26. Merton Public Health Team has produced a local public health guide, which includes the immunisations schedule. Community health champions have recently been trained and can play a role in promoting immunisations messages. This new voluntary role will enable the health champions to work within their own communities and mobilise people around health and exercise. It may also include a focus on immunisations.

27. There are also a range of measures in place to support GP surgeries. The public health team have been attending Merton's three GP locality meetings to provide comparative data on immunisation rates. Public Health Merton have also developed a list of top ten tips in regards to good practice on immunisations which is shared with GP practices.

28. Merton Clinical Commissioning Group work with GP practices to improve uptake. For example practice managers can play an important role in helping patients to complete the immunisations schedule, therefore practice managers from high performing GP practices go to under-performing practices to provide support.

Stakeholder event

29. The task group held a session in the local community to provide an opportunity for all those with an interest in this area to contribute to the review. There was representation from Parents, Merton Clinical Commissioning Group, NHS England, Merton Early Years social work teams and councillors. Attendees engaged in a candid discussion about immunisations in Merton and highlighted there are no quick fix solutions to the problems as many are deeply rooted issues linked to disadvantage, exclusion and wider health inequalities.

30. Another key area to emerge from the discussion was the need to work in partnership to improve uptake of immunisations. The term partnership was

perceived as one which is often used loosely without giving due consideration to accountability, responsibility and commitment to achieving the shared aims and objectives. The stakeholders challenged this review to ensure that a genuine partnership approach was put in place.

Why do people not immunise?

31. Drawing from a wide range of sources, including evidence from the stakeholder event and findings from the NHS Southwest London report, the task group were able to build up a local picture of the factors which inhibit people from immunising their children in Merton:

I. Families who need extra support: such parents with mental health problems.

II. Larger families are less likely to immunise and or get top up boosters for younger siblings.

III. People new to the UK who are not familiar with the immunisations schedule.

IV. People who are not registered with a GP and lack contact with health professionals.

V. Employment issues may make it difficult for parents to take time off work to take children for GP appointment and transport issues may have a similar impact.

VI. Complexity of the immunisations schedule.

The task groups findings and recommendations fall into the following areas:

Local Co-ordination

32. Since the changes in structure in April 2013, resulting in more organisations contributing to the provision of immunisation services, the task group are concerned that the service has become fractured in that no organisation is taking responsibility for leading and guiding the overall process.

33. This became apparent when one of the first pieces of evidence to emerge was a report by NHS Southwest London on improving the uptake of

Childhood Immunisations in Sutton and Merton. This report had seemingly been lost in the transition from the Primary Care Trust to NHS England. The local partners the task group met with were not aware of the report. The task group didn't find any evidence of individual or organisation responsibility for the work, nor had any of the recommendations been taken forward.

34. The task group believes that given the complex nature of the new structure, in which there are different responsibilities as well as overlap between the organisations, partnership working is the only context in which a successful immunisations programme can be delivered.

35. The task group found that there needs to be more clarity around roles and responsibilities. For example during the meetings with the lead organisations it was apparent that it is unclear who would be financially responsible for running an immunisation campaign should the task group wish recommend this approach. NHS England has the commissioning responsibility and states there is no budget for health promotion work. The public health team in the local authority has an assurance role around immunisations and although it has a general duty to improve the health of its communities, the task group were told they would be very hard pressed to use their limited resources to pay for specific immunisations campaigns.

36. NHS England clearly stated to the task group that partnership working across multiple agencies is the best way to achieve improvements in immunisations. The task group understood that a local co-ordination group did exist in the past and had developed an action plan; however this has not met for some time and a covered both Sutton and Merton. The task group believes a Merton only group needs to be established.

37. The task group met with all the key partners; Merton Clinical Commissioning Group, NHS England South London Team, Sutton and Merton Community Services and Public Health Merton. They all agreed that local co-ordination was necessary and that they will commit to working together, sign a Memorandum of Understanding and develop an action plan to improve immunisations uptake in Merton. The task group understand that this has happened in other boroughs and is essential for increasing uptake of immunisations. NHS England has provided a draft Memorandum of Understanding which can be adapted for the local co-ordination group, this has been attached at **Appendix A**

38. Progress with the action plan should be reported to the Health and Wellbeing Board on a quarterly basis to ensure that the Board has a role in overseeing the work, providing advice and guidance to ensure that the strategic links are made with all relevant services across the borough. Reporting to the Board which is decision making and has membership from a range of partners will also help to keep this work high profile, so other local partners will know what

is happening with Immunisations.

39. It is also important that scrutiny maintains its usual oversight of task group reviews by reporting to the Overview and Scrutiny Commission on a six monthly basis until the Commission are satisfied that the recommendations have been implemented. The task group chair can also play an important on-going role in championing this work and raising the profile of improving immunisation take up in appropriate forums.

Recommendations

1. NHS England, Merton Clinical Commissioning Group, Sutton and Merton Community Services and the Local Authority develop a joint working protocol including development of a joint action plan setting out frequency of meetings and priority actions to improve the take up of immunisations. Ensure the group leads on embedding immunisations messages in all nurseries, children's centres and Early Years' services in Merton.

2. The group should review the recommendations in the NHS Southwest London report *Childhood Immunisations and Vaccinations*, 2013 and decide what would be appropriate to take forward.

3. The group should report to the Health and Wellbeing Board on an annual basis and report their progress to the Overview and Scrutiny Commission on a six monthly basis until the Commission are satisfied that this work has been taken forward and that further improvements in immunisations have been made.

4. The task group chair to champion improving immunisation rates and raise the profile of this issue in appropriate forums.

Health inequalities and immunisation take up

40. As with other London boroughs, Merton is working hard to reduce the health inequalities that exist between the wealthier and economically deprived areas, in this case the east and west of the borough. The Health and Wellbeing Strategy has a range of initiatives to provide support to those within the poorest communities.

41. The task group wanted to understand the link between health inequalities and immunisation take up rates. The public health team looked at take up rates between the East and West of the borough and found little difference between the two. However the task group believe there is a wider link between immunisations and vulnerable people, as many of the groups who have been identified as less likely to immunise their children and are those who are more likely to face health inequalities. This includes people who do not come into regular contact with health professionals, find it difficult to navigate the health

system and be proactive in managing their health schedule. The task group therefore believes that improving take up of immunisations should be an integral part of the health inequalities work streams even if the current take up rates figures may not reflect this as a problem.

42. The council has recruited and trained volunteer health champions who are representatives of their own communities and therefore well placed to deliver health messages and support within their own communities. The task group believe that they can play an important role in delivering immunisation messages and would like to see this incorporated into the role.

Recommendation

5. That health champions deliver immunisations messages within their communities and the public health team seek to develop health champion roles in communities where immunisation rates are the lowest, where possible.

Strategies to improve take up

43. Throughout the course of this work, the task group has come across good practice ideas to improve immunisation take up across the borough. Many of these were centred on widening access to GPs, improving call and recall systems as well as targeted support for seldom heard groups. Public Health England told us that one-off campaigns were likely to have limited impact, and would only be effective while the campaign was being run. Information leaflets can be useful to an extent. The most effective way to improve take up is to embed continuous, sustained messages within the community.

Health visitors

44. Health visiting services will transfer from NHS England to the local authority in October 2015. Health visitors play a crucial role in signposting people to services and ensuring that important messages on immunisations are given to parents. This is a good opportunity to review the role of health visitors to engage in meaningful dialogue with parents about the importance of immunisations and this should be reflected in all commissioning arrangements.

45. A report by the London Assembly entitled ' Still Missing the Point'[2] highlighted the impact of the reduction in health visitors in recent years as well as the increasing pressures on workloads, reducing the ability of these frontline workers to carry important immunisations messages. This was reiterated by the NHS South West London Childhood Immunisations and Vaccinations report which found that some health visitors may not feel confident to answer questions from parents about immunisations.

[2] Still Missing the Point Infant Immunisation in London. London Assembly, September 2007

Recommendation

6. That the public health team ensures that the role of health visitors in delivering information on immunisations is specified and strengthened in the commissioning arrangements.

Immunisation process in GP surgeries

46. Many people find the immunisation schedule complex and that it changes regularly, therefore they rely on appointment reminders. GP surgeries use a wide range of initiatives including sending text messages, letters and emails. Surgeries have different approaches to ensuring their patients are vaccinated, therefore not all Merton residents benefit from a reminder service. We received evidence that a central appointment system is a good way of improving the uptake of immunisations to ensure that all patients across Merton receive a consistent service.

47. The importance of flexibility and accessibility was also put forward as important to raise immunisations rates. Access to appointments at GP surgeries posed a challenge for some parents and they needed more information about accessing the out of hour's service.

Recommendation

7. Public Health Merton to work with Merton Clinical Commissioning Group to conduct an audit of GPs on the 'top tips' sheet, including checking which practices use the text messaging service. Merton Clinical Commissioning Group and Public Health Team to explore future options for expanding the text messaging service

Data issues

48. Accurate data was raised as a problem during our stakeholder event and all the witnesses the task group met with confirmed that it is a major issue. It was reported that recorded figures may not reflect the true picture as there is a time delay in data being received and recorded.

49. Accurate recording of those who have had their vaccination is important in understanding local immunisations rates. The collection pathway needs to be rigorous to ensure that vaccinations take place at the right time, patient records are kept up to date, and people's medical records follow them promptly when they move. This requires firstly the accurate coding of the vaccines given by the practice nurses, SMCS investigate non compatible codes on data transfer and relate these back to the practices. The process requires co-ordination of three organisations; GP practices who gather the information from vaccinations that take place at their practice, the information

is then passed to Sutton and Merton Community Services, who record it on the Child Health Information System. This which incorporates the child health records department and hold clinical records on all children and young people who upload the information into a software programme called RIO. The information is then passed to NHS England. The Missing the Point report identified significant problems with RIO system including its ability to make appointments automatically or recall children who have missed appointments or allow data sharing across clinical commissioning groups. RIO can schedule this but SMCS are not commissioned by MCCG to do this for their practices.

50. The highly mobile population in London is an issue in keeping patient lists up to date. Both for patients leaving or moving into the borough and for those newly arrived in the UK. NHS England also reports that there is a 20-40% annual turnover on GP patient lists which affects the accuracy denominator for COVER submissions, which can for example affect the denominator resulting in a lower percentage uptake.

51. Our witnesses told us that those who have the highest immunisation rates may be as a result of robust data systems rather than because they have managed to improve take-up rates amongst seldom heard groups. It was also reported that 2 or 3 children per practice can have an impact on the data.

52. In 2013, when Sutton and Merton recorded the lowest immunisations rates in the country, The then Director of Public Health in Sutton, reflected that this must be an issue of inaccurate data as if this was an accurate figure the area would be vulnerable to a rise in infectious diseases, when in reality, there had only been one recorded case of measles[3]

53. Public Health England also confirmed that at present there is no evidence to suggest a sustainable outbreak of measles is likely in Merton.

54. The Population Health Practitioner Lead - South London told the task group that when NHS England took over the commissioning of immunisations they were aware of the poor uptake COVER rates in Sutton and Merton and a number of measures were put in place to address this. The main focus of the work is a data linkage project which improves the efficient and accuracy of GP uploads to the RIO database

55. Sutton and Merton Community Services told us that data extraction has improved over the last year, however mobility of families is a problem. Some

[3] London Borough of Sutton Press office, June 2013.
http://www.sutton.gov.uk/suttonpress/index.aspx?articleid=17690

data systems across London are sharing information across borough boundaries. They look forward to this being spread across London. The current system is reliant upon people being registered with a GP practice and people updating the system in a timely way.

Embedding important messages within the community

56. Embedding consistent messages within the community is the best way to get important information messages to parents. Public Health England said it is difficult to change behaviour and to show that new initiatives have made a difference. The statistics have not substantially changed over the last 20 years despite various initiatives. Therefore any new initiative needs to be sustainable.

57. The NHS South West London childhood immunisations report has suggested a robust campaign to inform parents about the dangers of not immunising children is needed. While there is likely to be some merit in that approach, this task group has found that embedding sustainable regular messages amongst key professionals within the community is likely to have more impact.

58. The NHS South West London childhood immunisations report highlights that many parents would like to have the opportunity to discuss details on immunisations with key professionals. While it may not be possible to sit down and discuss this at length with a GP, frontline health workers can play an important role and could be empowered to visit voluntary and community sector organisations to deliver important health messages. The task group support this approach and believe that networking in small groups will have impact in delivering immunisations messages.

59. We need a mechanism to ensure that important messages are fed back to co-ordinating groups so they understand what the issues are and can respond to them.

60. Participants at the stakeholder group also suggested that useful information on immunisations could be provided to pregnant women.

61. The World Health Organisation hold ‘Child Immunisations Week’ the public health team support this locally by providing information in children’s centres and advertising in My Merton. Similarly when Public Health England held a MMR top up campaign aimed at older children the public health team supported this locally.

Early Years

62. The Stakeholder event highlighted the significant opportunities to embed immunisations messages within the early year's services. A representative from a local nursery told the task group that immunisation information was not widely available at their local nursery and people were not asked about the vaccinations registration forms. The task group were told that early years is the most challenging area to co-ordinate immunisations.

63. Task group members felt that information should be made available in nurseries and children's centres: including information introductory pack at nursery, letter in all reception and nursery starter packs.

64. Some task group members asked if the government had considered making immunisations as an essential requirement for entrance into primary school to help prevent the spread of infection. Public Health England, highlighted this is a discussion to be held at the national level however in United States where immunisations are mandatory, the take up rates are similar to ours in the UK.

65. Task group members also considered the role schools play in determining immunisation history. They were told that the London Borough of Sutton send a letter to parents asking them to ensure they are up to date with immunisations before starting school. Task Group members felt that a similar approach should be adopted in Merton.

Recommendation

8. Public health team to ensure that information on immunisations will be part of school entry packs and asked within the school entry health review, using the review as an opportunity to identify those unimmunised, promote immunisations uptake and signpost to child's GP.

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NHS Commissioning Board

Memorandum of Understanding (MOU) for Quality Improvement Immunisation programme between NHS England, Clinical Commissioning Group, Public Health England and Local Authority

THE NHS CONSTITUTION
the NHS belongs to us all

Memorandum of Understanding (MOU) for Quality Improvement Immunisation programme between NHS England, Clinical Commissioning Group, Public Health England and Local Authority

Date	
Audience	NHS England, Public Health England HPU director, Clinical Commissioning Group Immunisation Lead, Local Authority Immunisation lead
Copy	CCG Chief Operating Officers, Public Health England Area Director, Local Authority Director of Public Health
Description	This document sets out the roles and responsibilities of a quality improvement Immunisation programme between NHS England, Public Health England, Clinical Commissioning Groups and Local Authority.
Cross Reference	
Action Required	**NHS England Health of Public Health, Public Health England Directors, Clinical Commissioning Group COO and Local Authority DPH to sign a formal agreement taking**
Contact Details	

MOU between

NHS England *[insert name of NHS England]* and

Clinical Commissioning Group *[insert name of CCG lead]*

And Public Health England *[insert name of PHE lead]* and

Local Authority *[insert name of LA lead]*

1. Introduction

This memorandum of understanding (MOU) sets out the agreed contribution to quality improvement programmes between:

a. NHS England (London Region) Public Health and Health in Justice department and

b. The following partners:.

- ***[Insert name of CCG(s)]***
- ***[Insert name of LA(s)]***
- ***[Insert name of PHE HPU region(s)]***
- ***[Insert name of Provider Organisation(s)]***
- ***[Insert name of other parties where applicable]***

2. Key principles

a. NHS England as the commissioner of immunisation services is working in partnership with key other organisations to improve the quality of the immunisation programme

b. The quality improvement programme is a holistic approach to a particular identified issue(s) that needs addressing to improve the quality of the immunisation programme.

c. The quality improvement programme must have a positive impact to improve the accuracy of data or improve the uptake of vaccine preventable diseases as per the UK national schedule or improve the efficiency of the programme without a detrimental effect on the quality of the programme or a combination of the above.

d. Each partner within the quality improvement programme contributes equally to the programme.

3. Partner's quality improvement programme roles

NHS England is expected to:

a. Identify the quality improvement programme

b. Call the appropriate partners together

c. Lead the quality improvement programme

d. Have overall responsibility for evaluating and reporting of the quality improvement programme.

Public Health England is expected to:

a. Provide expert advice on the quality improvement project and any implications this may have on the immunisation schedule
b. Hold the data older and ensures that data is monitored and shared where requested.
c. Assesses the request of data within the Information Governance framework and provides advice on its appropriateness of data to be shared with partners

Clinical Commissioning Groups are expected to:

a. Be a conduit of providing information to GP Surgeries
b. Provide access to clinical networks
c. Provide peer support
d. Provide peer challenge
e. Be a central point of communication

Local Authorities are expected to:

a. Provide challenge on the quality improvement project process
b. Provide local intelligence where available and appropriate
c. Take the lead on the delivery of Health Promotion activities where appropriate

4. Data Sharing Principle between partners

As a part of the quality improvement programme, data will be shared with the group that may not yet be in public domain. This sharing is necessary to facilitate the work of the group and should be seen as for management purposes. The data is not provided to be used outside of the remit of the group, nor should it be published or shared with others without the explicit consent of the data owner.

This memorandum of understanding will start on [insert date] and be subjected to a three monthly review until the quality improvement programme is finished.

Sign Date Sign Date

_ _

[insert name of NHS England Lead]
[title of lead officer]

[insert name of LA Immunisation Lead]
[title of lead officer]

Sign Date Sign Date

_ _

[insert name of Public Health England Lead]
[title of lead officer]

[insert name of CCG Lead]
[title of lead officer]

Sign Date

_ _

[insert names & titles of all / any officers from other providers]

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Committee: Health and Wellbeing Board

Date:

Agenda item: Quality Premium

Wards:

Subject: Merton CCG Quality Premium

Lead officer: Adam Doyle, Chief Officer

Lead member: David Freeman, Director of Commissioning & Planning

Forward Plan reference number:

Contact officer: Murrae Tolson, Head of Health Systems and Performance Merton CCG

Recommendations:

A. The Health and Wellbeing Board is asked to note the details 2015/16 Quality Premium for Merton Clinical Commissioning Group

B. Agree the measures recommended by NHS Merton CCG Executive Committee and Clinical Reference Group for inclusion in the 2015/16 Quality Premium.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of the report is to share and agree with the Health and Wellbeing Board the details of the 2015/16 Quality Premium indicators for NHS Merton CCG.

2. BACKGROUND

a) Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), NHS England has the power to make payments to CCGs to reflect the quality of services that they commission.

b) The Quality Premium is intended to reward CCGs for improvements in the quality of services they commission and for associated improvements in health outcomes and in reducing health inequalities.

c) The Quality Premium guidance for 2015/16, published on 27 April 2015 (full guidance at http://www.england.nhs.uk/ccg-ois/qual-prem/) is comprised of six elements:

- Reducing premature mortality
- Urgent and emergency care
- Mental health
- Improving antibiotic prescribing
- Local measure 1
- Local measure 2

d) CCGs do have some choice in the composition of the metrics for Urgent and emergency care, Mental Health and the two Local measures. CCGs are required to agree the recommended measures chosen with their Health and Wellbeing Board.

e) The Quality Premium is worth approximately £1m to Merton CCG.

f) Reductions to the Quality Premium award are made for failure of each constitutional standard (18 wk Referral to Treatment, A&E 4 hr wait, Cancer 2ww, Ambulance 8 mins)

3 DETAILS

3.1. The following demonstrates a breakdown of the financial value attributed to components of the 2015/16 Quality Premium:

- Reducing potential years of lives lost - 10%
- Urgent and emergency care (two measures) - 15% each
- Mental health - 30%
- Improving antibiotic prescribing - 10%
- Local measure 1 - 10%
- Local measure 2 - 10%

3.2. For 2015/16, NHS Merton CCG Executive Committee and Clinical Reference Group have recommended the following quality premium measures:

a) Reduced premature mortality

b) Urgent and emergency care (two measures):

   i. Reduction in avoidable emergency admissions

   ii. Increase the number of non-elective admitted patients discharged at weekends or bank holiday

c) Reduction number of people with severe Mental Health illness who are currently smokers

d) Improving antibiotic prescribing in primary and secondary care

e) Two local measures, based on local priorities:

   iii. Increase the number of people diagnosed with type 2 diabetes accessing structured education

   iv. Improve diabetes diagnosis rates

3.3. The maximum quality premium payment for the CCG is expressed as £5 per head of registered population.

3.4. For each measure where the quality threshold is achieved, the CCG will be eligible for the indicated percentage of the overall funding available to it.

3.5. Where the CCG does not deliver the 4 NHS Constitution standards, a reduction for each relevant NHS Constitution measure is made to the quality premium payment:

NHS Constitution requirement	Reduction to Quality Premium
Maximum 18 weeks from referral to treatment, comprising: ▪ 90% Completed Admitted standard; each standard, ▪ 95% Completed Non-admitted standard; separately ▪ 92% Incomplete standard.	30% total, (comprising 10% for each standard, separately assessed)
Maximum four hour waits in A&E departments-95% standard	30%
Maximum 14 day wait from an urgent GP referral for suspected cancer-93% standard	20%
Maximum 8 minutes responses for Category A (Red 1) ambulance calls-75% standard	20%

3.6. Full details of the Quality Premium including definitions of all measures can be found at http://www.england.nhs.uk/ccg-ois/qual-prem/

4 ALTERNATIVE OPTIONS

Options Considered:

4.1. Urgent and emergency care

4.1.1 There is a menu of measures for CCGs to choose from locally. The menu is overall worth 30 per cent of the quality premium. CCGs, can decide whether to select one, several or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

a) Reduction in composite measure of avoidable emergency admissions
b) Reduction in delayed transfers of care which are an NHS responsibility
c) Increase in non-elective patients being discharged at weekends or B/H

4.1.2 NHS Merton CCG's Executive Committee and Clinical Reference Group considered the options and have recommended option a and c (in bold), worth 15% each of the total 30% of this category.

4.2. Mental Health

4.2.1 There is a menu of measures for CCGs to choose from locally. The menu is overall worth 30 per cent of the quality premium. CCGs, can decide whether to select one, several or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

a) Reduction in the number of breaches of the 4 hour A&E target for those with mental health-related needs, together with a defined improvement in the coding of patients attending A&E

b) Reduction in the number of people with severe mental illness who are currently smokers

c) Increase in the proportion of adults in contact with secondary mental health services who are in paid employment

d) Improvement in the health related quality of life for people with a long term mental health condition

4.2.2 NHS Merton CCG's Executive Committee and Clinical Reference Group considered the options and have recommended option b (in bold), for the total 30% of this category.

4.3. Local Measures

4.3.1 CCGs must choose 2 local measures, worth 10% each (20% in total). These should reflect local priorities identified in joint health and wellbeing strategies. They should be based on indicators from the CCG Outcomes Indicator Set (attached as Appendix A) unless it is agreed that no indicators on this list are appropriate for measuring improvement in the identified local priorities.

4.3.2 NHS Merton CCG's Executive Committee and Clinical Reference Group considered the options and have recommended two indicators (in bold below) that support "improving functional ability in people with long-term conditions", and will measure the success of programmes to redesign pathways and processes for diabetes management:

a) Increase the number of people diagnosed with type 2 diabetes accessing structured education

b) Improve diabetes diagnosis rates

4.3.1 These priorities reflect the CCG's focus on improving long term conditions management in this area in 2015/16.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. A consultation on the Quality Premium measures was undertaken at the Merton CCG Clinical Reference Group and Executive Management Forums in April and May

5.2. Further consultations were undertaken directly with CCGs Pathway Clinical Leads to determine local priority measures.

6 TIMETABLE

6.1. The quality premium is paid to CCGs in 2016/17, to reflect the quality of the health services commissioned by them in 2015/16. This will be based on measures that cover a combination of national and local priorities described above.

6.2. CCGs will be advised of the level of their quality premium award early in quarter 3 in the 2016/17 financial year

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The maximum financial value of the Quality Premium is £5 per head of weighted registered population, if all Quality Premium measures and all Constitution standards are met.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. Not applicable

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. None of specific note

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. Being managed as part of each measure deliverable

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix A CCG Outcome Indicator Set

13 BACKGROUND PAPERS

13.1. Quality Premium: 2015/16 guidance for CCGs (http://www.england.nhs.uk/ccg-ois/qual-prem/)

14. OFFICER CONTACT

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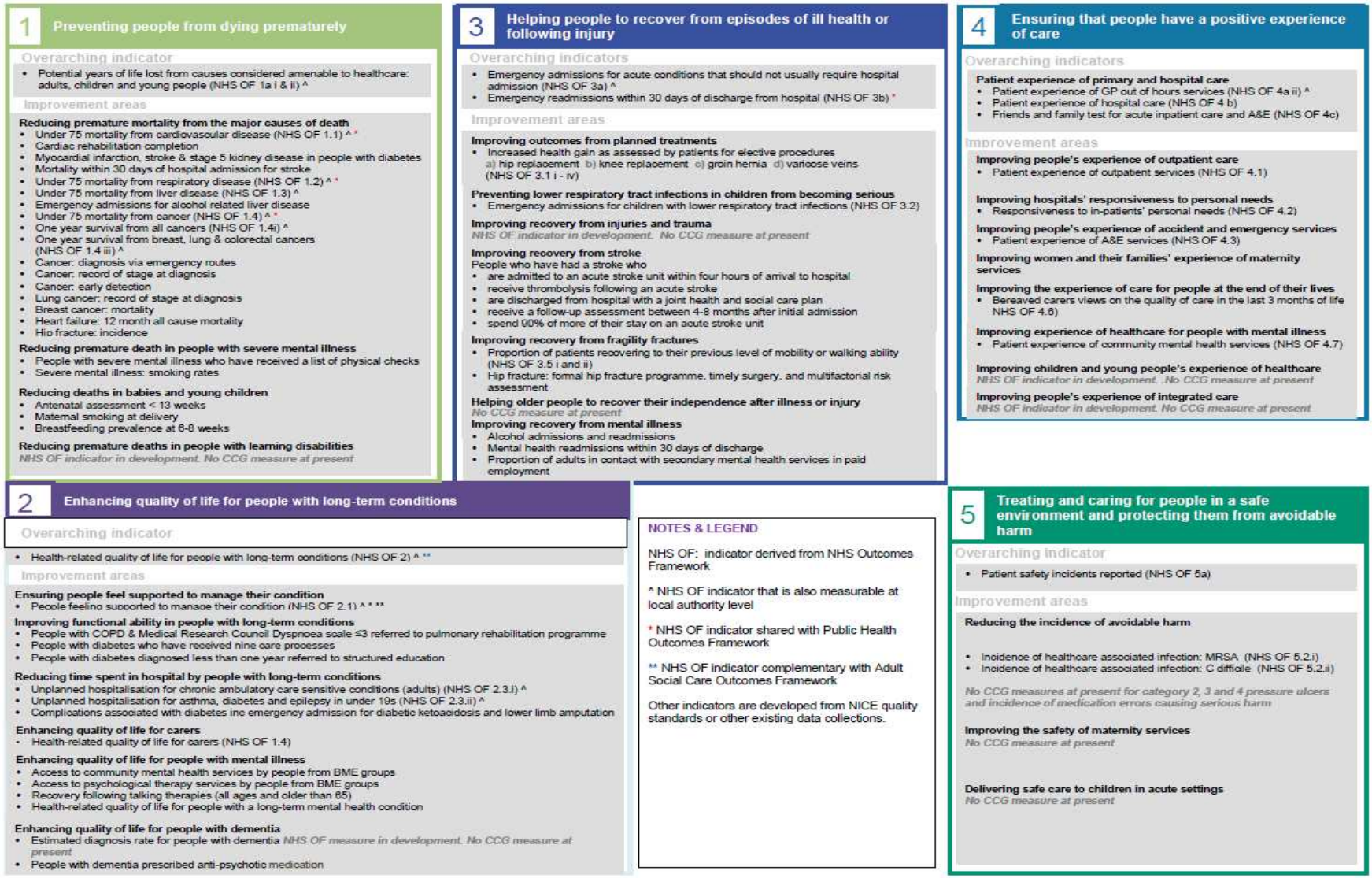
Appendix A: CCG Outcome Indicator Set

http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-at-a-glance.pdf
http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-tech-guid.pdf



1 Preventing people from dying prematurely

Overarching indicator

- Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a i & ii) ^

Improvement areas

Reducing premature mortality from the major causes of death
- Under 75 mortality from cardiovascular disease (NHS OF 1.1) ^ *
- Cardiac rehabilitation completion
- Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
- Mortality within 30 days of hospital admission for stroke
- Under 75 mortality from respiratory disease (NHS OF 1.2) ^ *
- Under 75 mortality from liver disease (NHS OF 1.3) ^
- Emergency admissions for alcohol related liver disease
- Under 75 mortality from cancer (NHS OF 1.4) ^ *
- One year survival from all cancers (NHS OF 1.4i) ^
- One year survival from breast, lung & colorectal cancers (NHS OF 1.4 iii) ^
- Cancer: diagnosis via emergency routes
- Cancer: record of stage at diagnosis
- Cancer: early detection
- Lung cancer: record of stage at diagnosis
- Breast cancer: mortality
- Heart failure: 12 month all cause mortality
- Hip fracture: incidence

Reducing premature death in people with severe mental illness
- People with severe mental illness who have received a list of physical checks
- Severe mental illness: smoking rates

Reducing deaths in babies and young children
- Antenatal assessment < 13 weeks
- Maternal smoking at delivery
- Breastfeeding prevalence at 6-8 weeks

Reducing premature deaths in people with learning disabilities
NHS OF indicator in development. No CCG measure at present

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

- Health-related quality of life for people with long-term conditions (NHS OF 2) ^ **

Improvement areas

Ensuring people feel supported to manage their condition
- People feeling supported to manage their condition (NHS OF 2.1) ^ * **

Improving functional ability in people with long-term conditions
- People with COPD & Medical Research Council Dyspnoea scale ≤3 referred to pulmonary rehabilitation programme
- People with diabetes who have received nine care processes
- People with diabetes diagnosed less than one year referred to structured education

Reducing time spent in hospital by people with long-term conditions
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i) ^
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHS OF 2.3.ii) ^
- Complications associated with diabetes inc emergency admission for diabetic ketoacidosis and lower limb amputation

Enhancing quality of life for carers
- Health-related quality of life for carers (NHS OF 1.4)

Enhancing quality of life for people with mental illness
- Access to community mental health services by people from BME groups
- Access to psychological therapy services by people from BME groups
- Recovery following talking therapies (all ages and older than 65)
- Health-related quality of life for people with a long-term mental health condition

Enhancing quality of life for people with dementia
- Estimated diagnosis rate for people with dementia *NHS OF measure in development. No CCG measure at present*
- People with dementia prescribed anti-psychotic medication

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

- Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a) ^
- Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b) *

Improvement areas

Improving outcomes from planned treatments
- Increased health gain as assessed by patients for elective procedures a) hip replacement b) knee replacement c) groin hernia d) varicose veins (NHS OF 3.1 i - iv)

Preventing lower respiratory tract infections in children from becoming serious
- Emergency admissions for children with lower respiratory tract infections (NHS OF 3.2)

Improving recovery from injuries and trauma
NHS OF indicator in development. No CCG measure at present

Improving recovery from stroke
People who have had a stroke who
- are admitted to an acute stroke unit within four hours of arrival to hospital
- receive thrombolysis following an acute stroke
- are discharged from hospital with a joint health and social care plan
- receive a follow-up assessment between 4-8 months after initial admission
- spend 90% of more of their stay on an acute stroke unit

Improving recovery from fragility fractures
- Proportion of patients recovering to their previous level of mobility or walking ability (NHS OF 3.5 i and ii)
- Hip fracture: formal hip fracture programme, timely surgery, and multifactorial risk assessment

Helping older people to recover their independence after illness or injury
No CCG measure at present

Improving recovery from mental illness
- Alcohol admissions and readmissions
- Mental health readmissions within 30 days of discharge
- Proportion of adults in contact with secondary mental health services in paid employment

4 Ensuring that people have a positive experience of care

Overarching indicators

Patient experience of primary and hospital care
- Patient experience of GP out of hours services (NHS OF 4a ii) ^
- Patient experience of hospital care (NHS OF 4 b)
- Friends and family test for acute inpatient care and A&E (NHS OF 4c)

Improvement areas

Improving people's experience of outpatient care
- Patient experience of outpatient services (NHS OF 4.1)

Improving hospitals' responsiveness to personal needs
- Responsiveness to in-patients' personal needs (NHS OF 4.2)

Improving people's experience of accident and emergency services
- Patient experience of A&E services (NHS OF 4.3)

Improving women and their families' experience of maternity services

Improving the experience of care for people at the end of their lives
- Bereaved carers views on the quality of care in the last 3 months of life NHS OF 4.6)

Improving experience of healthcare for people with mental illness
- Patient experience of community mental health services (NHS OF 4.7)

Improving children and young people's experience of healthcare
NHS OF indicator in development. .No CCG measure at present

Improving people's experience of integrated care
NHS OF indicator in development. No CCG measure at present

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicator

- Patient safety incidents reported (NHS OF 5a)

Improvement areas

Reducing the incidence of avoidable harm
- Incidence of healthcare associated infection: MRSA (NHS OF 5.2.i)
- Incidence of healthcare associated infection: C difficile (NHS OF 5.2.ii)

No CCG measures at present for category 2, 3 and 4 pressure ulcers and incidence of medication errors causing serious harm

Improving the safety of maternity services
No CCG measure at present

Delivering safe care to children in acute settings
No CCG measure at present

NOTES & LEGEND

NHS OF: indicator derived from NHS Outcomes Framework

^ NHS OF indicator that is also measurable at local authority level

* NHS OF indicator shared with Public Health Outcomes Framework

** NHS OF indicator complementary with Adult Social Care Outcomes Framework

Other indicators are developed from NICE quality standards or other existing data collections.

Committee: Health and Wellbeing Board

Date: 29 September 2015

Agenda item:

Wards: All

Subject: Proactive GP Pilot and Award

Lead officer: Dr Kay Eilbert, Director of Public Health

Lead member: Councillor Caroline Cooper Marbiah, Cabinet Member for Adult Social Care and Health

Forward Plan reference number:

Contact officer: Dr Kay Eilbert

Recommendations: To agree the Proactive GP Health and Wellbeing Board Award and note and support the development of the Proactive GP Practice Merton pilot.

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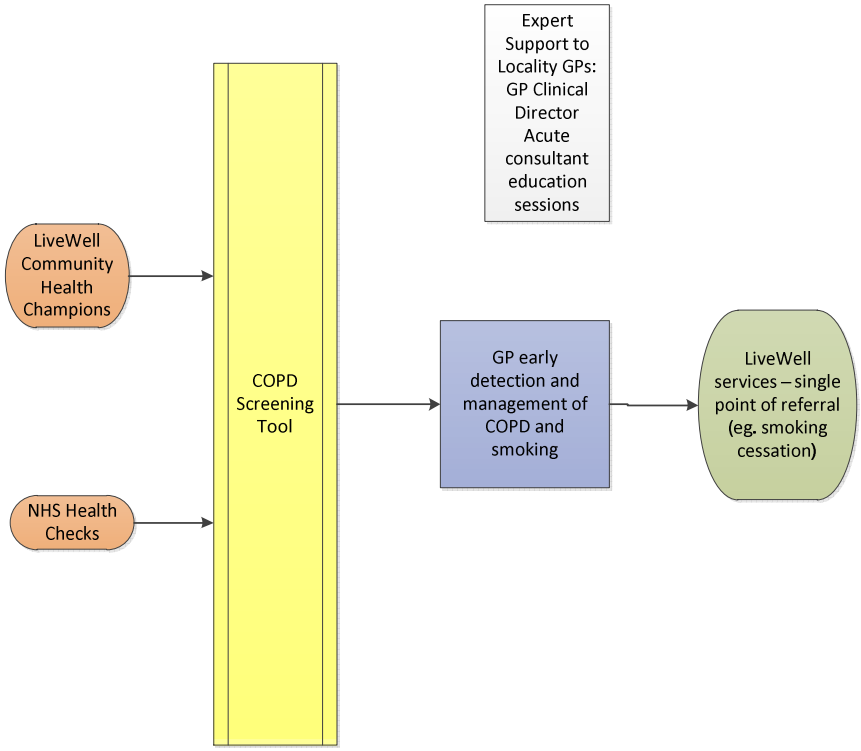
1. Purpose of report and executive summary

1.1 The purpose of this paper is to provide a brief on the Proactive GP pilot and the proposal to gain agreement from the Health and Wellbeing Board to develop a HWB board sponsored award recognising achievement within the scheme.

1.2 Merton's Proactive GP Pilot project works within existing resources to embed prevention in GP practices and tackle health inequalities within hard to reach communities. The project links GP practices to Community Health Champions who screen group members for early diagnosis of long-term conditions in the more deprived east of Merton involving a partnership of the Council, Merton Clinical Commissioning Group, GP practices in East Merton and the voluntary sector Health Champions.

2. Background

2.1 The scheme brings together an integrated pathway across prevention and early detection. See Figure 1 below. It joins together primary care and Public Health through our Livewell Community Health champions who work in part to encourage their members to take up preventive screening opportunities such as NHS Health Checks. Community health champions will be trained to use a screening tool for Chronic Obstructive Pulmonary Disease or COPD and to refer patients identified at risk to their GP.



2.2 GPs then carry out a COPD assessment. At the same time or through the NHS Health Check, they will determine the smoking status of the patient and refer smokers either to a GP practice staff member trained as a smoking advisor or refer smokers into the Livewell Stop Smoking service.

3. Details

Merton Pilot

3.1 The pilot works within existing resources through a partnership to engage with Health Champions in east Merton, where residents suffer higher levels of long-term conditions initially targeting smoking and COPD. Partners include:

- Merton Voluntary Services Council – working with community groups to identify and support community health champions
- Merton Clinical Commissioning Group – providing expertise and support to GP practices through its GP Clinical Director for Keeping Healthy and Well
- LBM Public Health providing a literature review of best practice, support to design of the initiative and monitoring data.

3.2 Health Champions are trained, volunteer members of community groups who encourage their members to take up healthier lifestyles and preventive screening opportunities such as NHS Health Checks.

As part of the pilot community Health Champions are trained to use a screening tool for COPD and to refer patients identified at risk to their GP who will carry out a COPD assessment. GP practices refer known smokers to an embedded smoking cessation service provided on site.

3.3 Participating GP practices share results and experience among themselves to improve early detection and management of COPD. A kite mark scheme is under development.

Health and Wellbeing Board award

3.4 It is proposed that the Health and Wellbeing Board agree a HWB board-sponsored award that recognises achievement within the Proactive GP scheme for both GPs and Community Health Champions. If agreed, Public health will work with partners and LBM communication team to develop the award and public celebration of the winners.

4. Next steps

Should the pilot be successful, a second phase is currently being designed to work on other prevention (e.g., diet and exercise) and early detection (e.g., diabetes) initiatives, as well as to be expanded across the whole borough.

5. Alternative options

None for the purpose of this report

6. Consultation undertaken or proposed

Local consultation has included a discussion with relevant GP Clinical Directors, GP lead for East Merton, and GP Board Member with Public Health, where participants agreed to develop the pilot further, starting with smoking and COPD, along with NHS Health Checks, which include smoking status. An initial presentation was made at the October meeting of the East Merton locality.

7. Timetable

An initial launch of the Proactive GP Practice pilot was held in September.

8. Financial, resource and property implications

None for the purpose of this report.

9. Legal and statutory implications

None for the purpose of this report

10. Human rights, equalities and community cohesion implications

The Proactive GP Practice pilot is targeted at addressing health inequalities.

11. Crime and Disorder implications

None for the purpose of this report

12. Risk management and health and safety implications

None for the purpose of this report

Appendices – the following documents are to be published with this report and form part of the report

None

Background papers

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Committee: Health and Wellbeing Board

Date: 29 September 2015

Agenda item:

Wards: All

Subject: HWBB Systems Leadership Support

Lead officer: Dr Kay Eilbert, Director of Public Health

Lead member: Councillor Caroline Cooper Marbiah, Cabinet Member for Adult Social Care and Health

Forward Plan reference number:

Contact officer: Clarissa Larsen

Recommendations: To agree to and participate in the systems leadership support funded by London Councils.

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1. Purpose of report and executive summary

1.1 The purpose of this paper is to provide an outline of the proposed systems leadership support for the HWBB funded by London Councils.

2. Background

2.1 The HWBB was successful in its application for development funding of £6K from London Councils to support continued work towards integration. This work will build on the outcomes of the HWBBs development with OPM earlier this year reflecting on the challenges currently faced and considering better ways of shared working.

3. Details

. 3.1 The aim of this development work is
Building on previous work, to develop stronger relationships and trust among Board members, laying the foundation for more robust integration work

Starting with the agreed Health and Wellbeing Strategy, its aim to address health inequalities between the east and west of the borough provides an important shared topic for the basis of this development work.

Within 'Theme 2 Good Health' of the Strategy, there is an outcome for 'a model of care for east Merton (that) embeds prevention and delivers early detection of disease through integrated health and social care'. This provides an opportunity to engage all members of the Health and Wellbeing Board in how we, as partners, can work to greatest effect in the development of this model of care in east Merton

3.2 Details of the work are yet to be finalised and might include:-

- Creating a shared understanding of what might be possible for people and communities in East Merton.
- Reflecting on the relationships of trust and ways of working between us.
- Identifying ways we might take action together now to achieve a model of greater integration.

3.3 Systems leadership is the suggested approach to achieve this. By definition integrated models of care will require the collaborative efforts of many of us at different places in the Merton system, at different levels, and leadership that crosses boundaries and extends us beyond the usual limits of our formal responsibilities and authority.

3.4 It is proposed to engage a facilitator skilled in systems leadership to support us in having these conversations. It is envisaged that facilitation would initially involve 1:1 interviews with board members through October/ November followed by a facilitated session following the meeting of the HWBB 24 November.

4. Future Meetings of HWBB

4.1 Democratic Services will shortly be contacting members to agree dates for future meetings. It has been suggested that future HWBB meetings could be held in the morning or later in the afternoon. The likely dates for forthcoming meetings are 26 January and 22 March 2016.

5. Next steps

With the agreement of the HWBB, the systems leadership work will commence in October. Democratic Services will contact members with future meeting dates and times.

6. Alternative options

None for the purpose of this report

7. Consultation undertaken or proposed

None for the purpose of this report

8. Timetable

All work is to be completed within the current financial year.

9. Financial, resource and property implications

Funding for the development work was secured from London Councils.

10. Legal and statutory implications

None for the purpose of this report

11. Human rights, equalities and community cohesion implications

The work is targeted at addressing health inequalities.

12. Crime and Disorder implications

None for the purpose of this report

13. Risk management and health and safety implications

None for the purpose of this report

Appendices – the following documents are to be published with this report and form part of the report

None

Background papers