Merton Council
Health and Wellbeing Board

Date: **29 November 2016**

Time: **3.00 pm**

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

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

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
- Tobin Byers (Chair)
- Katy Neep
- Gilli Lewis-Lavender

Council Officers (non-voting)
- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Environment and Regeneration
- Director of Public Health

Statutory representatives
- Four representatives of Merton Clinical Commissioning Group
- Chair of Healthwatch

Non statutory representatives
- One representative of Merton Voluntary Services Council
- One representative of the Community Engagement Network

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
4 OCTOBER 2016

(3.00 pm - 4.30 pm)

PRESENT Councillor Tobin Byers (Chair), and Cabinet Member for Adult Social Care and Health
Councillor Katy Neep - Cabinet Member for Children's Services
Simon Williams- Director of Community and Housing
Yvette Stanley - Director of Children Schools and Families
Chris Lee - Director of Environment and Regeneration
Dr Dagmar Zeuner-Director of Public Health LBM
Adam Doyle– Chief Officer Merton CCG
Karen Parsons- Accountable Officer Merton CCG
Dr Doug Hing – CCG Clinical Director for the East Merton Model of Health and Wellbeing, had been looking at the new East Merton Model
Brian Dillon-Chair of Merton Healthwatch,
Khadiru Mahdi – Chief Executive Merton Voluntary Service Council,

ALSO PRESENT Erin Cowhig Croft – Merton Healthwatch
Lisa Jewell – Democratic Services

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies were received from:

Dr Andrew Murray – Vice Chair HWBB and Clinical Chair of Merton CCG
Dr Karen Worthington - Clinical Director for Transforming Primary Care and East Merton Locality Lead

Dave Curtis – Manager Merton Healthwatch. Replaced by Erin Cowhig Croft

Councillor Gilli Lewis Lavender
Melanie Monaghan, Community Engagement Network

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

No declarations of pecuniary interest were received

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the last public meeting 19 April 2016 were agreed as a correct record

4 WELCOME AND INTRODUCTIONS (Agenda Item 4)

The Chair thanked Councillor Cooper-Marbiah for her all her work as the previous Chair of the HWBB

The Chair thanked Adam Doyle for all his work with Merton CCG for the Health of the Borough and wished him luck in his new role.

The Chair then asked Board members to introduce themselves and state one thing they had done recently in support of the goals of the HWBB

Councillor Tobin Byers had presented a Healthier Catering Certificate at Pollards Hill Community Centre – small changes to diet could have a huge impact to health

Dagmar Zeuner –had been working on actions to reduce Childhood Obesity' and Social Prescribing.

Brian Dillan had attended a South West London/St Georges Mental Health Trust meeting that reminded him that Healthwatch needed to give more attention to mental health issues, particularly in childhood.

Erin Cowhig Croft –had a meeting with Merton Youth Parliament regarding mental health.

Khadiru Mahdi – had been working on the Social Prescribing pilot project

Dr Doug Hing had been looking at the new East Merton Model

Adam Doyle – Chief Officer Merton CCG - reported that childhood obesity and social prescribing'.are now agreed by the Governing Body as part of the Merton CCG Plan. Also enjoyed community conversations with the Polish community.

Karen Parsons - Accountable Officer Merton CCG, had been developing objectives in health and care for the 'One Merton Model'

Yvette Stanley - Director of Children Schools and Families, had been working with the CCG and public health to commission a new health provider for early years.

Karen Parsons - Accountable Officer Merton CCG, had been developing objectives in health and care for the One Merton Model and taking part in community conversations.

Yvette Stanley - Director of Children Schools and Families, had been working with the CCG and public health to embed CLCH in early years.

Chris Lee - Director of Environment and Regeneration, had been developing policy around diesel vehicles which had a big impact on health issues. A policy would go to Cabinet suggesting that the polluter pays, and to encourage less polluting cars or no car at all.

Simon Williams - Director of Community and Housing, had been looking at welfare reforms and how to mitigate their impact

Councillor Katy Neep - Cabinet Member for Children's Services had been looking at the impact of built environment on health and having conversations with Housing Associations

Councillor Tobin Byers reflected that we are all working towards shared objectives.

5 SUSTAINABILITY AND TRANSFORMATION PLAN (Agenda Item 5)

The Chief Officer of Merton CCG gave a verbal update on the progress of the STP (Sustainability and Transformation Plan). Following publication of the NHS Five Year Forward View (5YFV) in 2015, all regions (or'footprints') of the NHS in England are required to publish Sustainability and Transformation Plans (STPs) setting out how they will meet the challenges set out in the 5YFV and deliver high quality, sustainable services for their populations in the years ahead.
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STPs are intended to be developed through a partnership of NHS commissioners and providers, working with their local authorities. This is a significant change to previous NHS change programmes, which have been commissioner-led.

The South West London STP is currently going through the final stage of drafting. An initial submission was made to NHS England in June 2016, in line with national requirements. The final draft – which will remain an iterative document for discussion with local stakeholders and the public – will be submitted on 21 October2016 and will be more specific on details such as financial modelling.

STPs are a real partnership between commissioners and providers, working with their local authorities. There is a small leadership team:
Kathryn Magson – SRO for STP and Chief Accountable Officer for Richmond CCG
John Goulston – Provider Lead – Chief Executive of Croydon NHS Hospitals Trust
Kath Cawley – STP Programme Director
Ged Curran – Local Authority Lead and Chief Executive of the London Borough of Merton.

The programme has eight clinical working groups, covering different clinical areas, all of which include more than one patient and public representative

The draft STP contains the following:

- A whole system approach based on collaboration between and across commissioners, providers and local authorities
- More care delivered outside hospital in community settings
- An expansion/transformation of primary care
- Proactive, preventative care based on keeping people well and early intervention
- Parity of esteem for mental and physical healthcare

- The need to consider the best configuration of our acute hospitals and of specialised services in south London.

In May 2016 the South West London footprint wrote to over 1000 local organisations to share the emerging thinking and asking for feedback.

The Chair asked for more detail on the collaborative model and engagement with the voluntary sector, when the plan will be ready for public consultation and the reconfiguration of the CCG The Chief Officer replied that

- The CCG engaged with the voluntary sector all the time on a variety of topics including integrated care and out of hospital services.
- The restructure of local CCGs will result in The London Boroughs of Merton, Kingston, Richmond and Wandsworth (with Sutton to join in 2018) sharing one Accountable Officer from 2017, whilst very senior officers manage local commissioning and local issues. The Accountable Officer will deal with NHS England.

The Chief Executive of Merton MVSC suggested that the voluntary sector could have been involved more in the process to date. The CCG Chief Officer acknowledged that the pace had been tight and said he would take this back to the team.

The Chair asked the Board to note that this different approach to the STP has resulted in more involvement by LBM in issues such as out of hospital services.

6 LOCAL INTEGRATION OF HEALTH AND SOCIAL CARE (Agenda Item 6)

The Director of Community and Housing presented his report on Local integration of health and social care . The integration work to date in 2016/17 has focussed on creating a shared vision of integrated health and social care provision between social care teams, community health services, voluntary services and the Merton GP federation. The Board noted that the key priority for local integration 2016/17 was to reduce:

1. Permanent admissions to residential care homes
2. Unscheduled admission of vulnerable people to hospital.
3. Delayed transfers of care

The Director of Children Schools and Families explained how her department was integrating health and social care services for children:

- co-location in early years care and health partnership
- children with complex needs were placed in expanded special schools
- meeting the needs of the most vulnerable children was co-located in the Civic Centre

The Board discussed the metrics presented in the report and noted that delayed transfers of care were increased last year, the main reason for this was the problems of providing home care at short notice. Figures for non- elective hospital admissions

were also increased but it is difficult to prevent admissions as it can be a multi-factorial issue. Merton's figures were still in the top percentile across the Country, although they are not as good as they were three years ago.

The Chief Officer of Merton CCG said he felt that the Merton health and care system had coped well within constraints. All agreed that early intervention and prevention were key.

RESOLVED

The HWBB noted the paper and requested a further report in six months to monitor progress

7 EAST MERTON MODEL OF HEALTH AND WELLBEING (Agenda Item 7)

The Director of Public Health introduced this joint report of LBM Public Health and Merton CCG, and asked Board members to note that the report that gave detail on the progress of the East Merton Model of Health and Wellbeing (EMMoHWB). The report details the implementation of the Model in East Merton which centres on the redevelopment of the Wilson Hospital into an extended health and community campus co-designed by the local community and clinicians, and co-managed and co-owned in the longer term.

Dr Zeuner then continued to talk about the Health and Wellbeing Board's delivery priorities for 2016/17; preventing and reducing childhood obesity and the social prescribing pilot. The Board discussed the social prescribing pilot and noted the importance of collaboration, voluntary sector and community involvement and the role of the navigators in the project. The terminology 'social prescribing' was questioned.

The Board noted that Dr Andrew Murray, Clinical Chair of the CCG, had added Childhood Obesity to the next Practice Leads meeting, and that Merton is one of 11 London Boroughs to sign up to the 'Great Weight Debate'

The Chair thanked the Director of Public Health for her infectious enthusiasm on this work.

RESOLVED

That the Board members:

1. Considered the report on progress of the East Merton Model of Health & Wellbeing (EMMoHWB), and the Health & Wellbeing Board priorities for 2016/17 relating to preventing childhood obesity, and social prescribing.
2. Continue to champion the EMMoHWB and promote priority areas with their constituencies.

3. Engage in the further development and refinement of the EMMoHWB programme and projects as they progress.

8 HEALTH AND WELLBEING FORWARD PLAN AND WAYS OF WORKING (Agenda Item 8)

Board members noted the different approach taken recently to the structure of HWBB meetings and also the forward plan of items to come to HWBB.
Members agreed that recent seminars were valuable and have resulted in an increase in the quality of discussions at HWBB, better working together and an increase in understanding of crosscutting portfolios.

Board members concurred that they need to continue to challenge and ask each other to deliver what we agree on.

The Chair then asked all board members to commit to an action they would take that would benefit Health and Wellbeing in the Borough before the next meeting:

Councillor Tobin Byers will meet with the Chair of Merton HealthWatch to discuss Mental Health and how HWBB can work in this area

Simon Williams will be meeting CLCH (Central London Community Healthcare NHS Trust) to shape work going forward and inform governance structure.

Yvette Stanley will be working on the regional offer on families drugs and alcohol care and the regional proposal for a child sexual abuse house.

Chris Lee would be meeting with the Director of Public Health to discuss actions to reduce childhood obesity.

Councillor Katy Neep would be engaging with the business community and housing to embed health issues and to bring the Great Weight Debate to employees and parents. Conversations with young people about planning their own mental health support with tripadvisor style feedback.

Adam Doyle would be chairing a stocktaking meeting on the EMMoHWB before moving on to his new role.

Karen Parsons would be continuing the community conversations, and working with the Director of Public Health to appoint a project lead.

Dr Doug Hing would be working on a clear plan for social prescribing and also keeping the encouragement and momentum for community engagement going.

Khadiru Mahdi would be working on recruiting the social prescribing officer. and talking to CCG regarding the STP

Brian Dillon would be working with the CCG to understand their processes.

Dagmar Zeuner would be working with CCG and voluntary sector to knit it all together, including recruiting a Manager for the Wilson Campus.

RESOLVED

That the HWBB:

1. agree the HWB forward plan 2016/17
2. consider new and engaging ways of working at HWB meetings

9 UPDATE ON IMPLEMENTATION OF THE CHILDREN AND FAMILIES ACT 2014 PART 3 (Agenda Item 9)

The Board noted that this report had already been considered by the Children's Trust Board, parents of children with complex needs present at this meeting were positive about the transformation process.

RESOLVED

That the HWBB notes:

1. the progress made in implementation of the Children & Families Act 2014 Part 3.
2. considers the risk implications outlined in Section 9 of the report.

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Committee: Health and Wellbeing Board

Date: 29 November 2016

Strategic Item

Wards: All

Subject: Safeguarding Children Board (MSCB) Annual Report

Lead officer: Yvette Stanley, Director of Children's Schools & Families

Lead member: Cllr Katy Neep, Cabinet Member for Children's Services

Contact officer: Paul Angeli, Assistant Director for Children's Social Care and Youth Inclusion

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Recommendations:

A. To note the MSCB's annual report

B. For the Heath and Well-Being Board to continue to contribute to the Board's priorities and to ensure that safeguarding children is a golden thread that is maintain through all the work of the Health and Well-being Board.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To ensure that HWBB are sighted on the statutory Safeguarding Children Board's annual report and that all departments continue to work together to ensure children and young people in Merton are effectively safeguarded.

2 DETAILS

2.1 The MSCB annual report is produced on behalf of the safeguarding partnership involving all key agencies and supports the council and the Chair of the MSCB in assuring local arrangements.

3 ALTERNATIVE OPTIONS

3.1 None

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1 All key agencies contributed.

5 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

5.1 The MSCB budget and expenditure is covered in the annual report.

The Health and Well-Being Board may wish to consider how it uses its influence to ensure that

6 LEGAL AND STATUTORY IMPLICATIONS

6.1 It is a statutory responsibility to have an annual report and for it to be published.

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

7.1 Safeguarding vulnerable children and young people and vulnerable adults as parents strengthens families and communities.

8 CRIME AND DISORDER IMPLICATIONS

8.1 There is a considerable volume of child protection activity which relates to domestic violence, substance misuse and anti-social behaviour. Systemic work with families can break generational cycles as well as improving outcomes for individual children.

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

9.1 The work covered in the report is high risk and considerable attention and efforts are made to mitigate and reduce risk in a challenge context for many of our families.

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

Appendix 1: MSCB Annual Report Executive Summary
Appendix 2: Annual report of the Merton Safeguarding Children Board 2015/16
http://www.merton.gov.uk/mscb_annual_report_2015-2016_web_version.pdf

11 BACKGROUND PAPERS:

Appendix 1 EXECUTIVE SUMMARY

The MSCB works to ensure that:

Everyone in Merton does Everything they can to ensure that Every Child is ***Safe, Supported and Successful.***

Working Together 2015, chapter 3 requires the Chair of a LSCB to publish an Annual Report of its work. The report should be a "rigorous and transparent assessment of the effectiveness and performance of local services." The report covers the period from April 2015 through to March 2016.

2015-2016 has been a challenging year for the MSCB yet the Board has continued to rise to meet these challenges. Our challenges have included anticipating the pending Wood review of LSCB's which may mean significant changes in the way LSCBs do their work in the future.

The Board's strengths are identified

- Senior representation and engagement from agencies
- A strong performance focus including the annual QA process
- Annual conference and comprehensive training programme.
- An improved connection between the Board and frontline practitioners which has and will continue to improve; this includes the Board's responsiveness to and influence on multi-agency frontline practice.

Areas for continued development include

- Partners in the Health economy do not make a proportionate contribution to the work of the Board; the same is with the Metropolitan Police Service.
- The Board needs to continue to improve its visibility and its impact on front line practice.
- The Board also needs to continue to improve its connections with BAME communities, faith groups and voluntary organisations.
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- The Board also needs to continue to improve its connections with BAME communities, faith groups and voluntary organisations

Our agreed areas of focus during 2015-2016 included:

- Building on the annual QA meetings and multi-agency auditing to further strengthen peer challenge;
- Implementing new sub Board structures with a stronger QA Sub-Group;
- Reviewing our Board infrastructure to support the Board's extended role under Working Together 2015;
- Ensuring we maintain our focus on the voice of the child;
- Learning the lessons of SCRs nationally and from our local SCR and any learning reviews;
- Strengthening our links with the adult safeguarding Board; and
- Ensuring we are sighted on the issues for looked after children placed in our borough by other local authorities as well as maintaining our focus on Merton Looked After Children (LAC).

The Annual Reports provides information regarding the Board's progress in achieving these priorities. At its annual Away Day in March, the Board reviewed its performance against these agreed priorities and set priorities for 2016-2018. These priorities involve a broad spectrum of services proactively safeguarding children and being aware how housing, employment, adult physical and mental health issues impact on the prevalence of the trigger trio. The Board's agreed priorities for 2016-2018 are as follows:

1. Think Family – supporting our most vulnerable families by addressing the trigger trio and supporting parents with learning difficulties or learning disabilities.
2. Supporting vulnerable adolescents – especially young people who are at risk of child sexual exploitation (CSE), serious crime, youth violence or involvement in gang activity.
3. Early Help – reviewing our early help in the light of changes in local providers and agencies and with changing levels of resources available we want to ensure our model continues to be fit for purpose.

Merton
Safeguarding
Children Board

Annual report of the

Merton Safeguarding Children Board 2015/16

Contents

1.0
Chair's Introduction

2015-2016 has been a challenging year for the MSCB yet the Board has continued to rise to meet these challenges. Our challenges have included anticipating the pending Wood review of LSCB's which may mean significant changes in the way LSCBs do their work in the future.

At the end of the business year, in March 2015, the Board appointed a new Business and Development Manager, Paul Bailey. In order to ensure that Paul had a seamless induction we ensured that he was supported by the outgoing Business Manager for the first 6 months of his appointment.

MSCB, like other LSCBs, operates in the context of shrinking resources and expanding expectations and commitments. We have worked hard with partners to prioritise where limited resources can be targeted in order to have the maximum impact on the quality of safeguarding across the system. In October 2015, the MSCB commissioned a Serious Case Review (SCR), following an incident in which a young person who was known to Merton services, experienced significant harm as a result of being attacked by a parent with a mental health condition. This review is still in process and we are learning the lessons from this case.

The Board also took the decision to commission a Learning and Improvement Review (LiR) into a case of long-term neglect. This case did not meet the statutory threshold for a SCR; however, the Board considered that there was significant learning for the multi-agency safeguarding system in this case.

The Board remains committed to continuous improvement and in common with all LSCBs faces many challenges ahead, including the challenge for all partners of delivering high quality services within the context of increasing demand and reduced resources. However, this report demonstrates how much can be achieved when we work together, both as individual agencies and in partnership with each other. This report shows that the work that has been done in revising the constitution of the Board and having a more robust and rigorous focus on quality assurance is now embedded and is continuing to improve the way that the young and children are protected and their well-being is promoted.

The Board's strengths are identified as:

- Senior representation and engagement from agencies
- A strong performance focus including the annual QA process
- Annual conference and comprehensive training programme
- An improved connection between the Board and frontline practitioners which has and will continue to improve; this includes the Board's responsiveness to and influence on multi-agency frontline practice

Our agreed areas of focus during 2015-2016 included:

- Building on the annual QA meetings and multi-agency auditing to further strengthen peer challenge;
- Implementing new sub Board structures[1] with a stronger QA Sub-Group;
- Reviewing our Board infrastructure to support the Board's extended role under Working Together 2015;
- Ensuring we maintain our focus on the voice of the child;
- Learning the lessons of SCRs nationally and from our local SCR and any learning reviews;
- Strengthening our links with the adult safeguarding Board; and
- Ensuring we are sighted on the issues for looked after children placed in our borough by others as well as maintaining our focus on Merton LAC.

[1] See Appendix 3: MSCB Structure

The focus of MSCB was to continue to drive through and embed the changes made as a result of the revised constitution and ensuring that the Board is able to maximise its impact. The questions that the Board is continuously seeking to answer are:

- Is there evidence that the right standards, policies, guidance, procedures, protocols are in place?
- Is there good evidence that these are being implemented and applied consistently?
- What impact/difference does this make in keeping Merton children and young people safe from harm and ensuring that their well-being is supported?

This report shows how the work we are doing as the MSCB seeks to answer these questions. The vision of the MSCB is that all Merton's children and young people are *Safeguarded, Supported and Successful.*

I am a member of the London Group of Local Children's Safeguarding Board Chairs. As a group of chairs we are disappointed that the Metropolitan Police continues to choose to fund partnership safeguarding in London 45% less than all the other large urban Metropolitan Police Forces in England[2]. Safeguarding is a complicated and demanding partnership arrangement that needs appropriate resourcing if it is to be effective. If LSCBs are to be able to carry out their statutory duties they need proper support.

The guidelines which we adhere to (Working Together 2015) makes it clear that funding arrangements for Safeguarding should not fall disproportionately and unfairly on one or more partner to the benefit of others. In London this burden does fall unfairly on Local Authorities because the Metropolitan Police does not provide rational or reasonable levels of funding to local safeguarding boards.

The Safeguarding structures in London are due to change in the next two years. When they do there will still be a need to resource whatever arrangements are put in place. The Police are a key partner in the future arrangements for safeguarding and we ask that the Metropolitan Police and The Mayor's Office for Policing and Crime increase their funding to a level which is fair to the other partners and which will assist in keeping London's children safe.

Finally I would like to thank all of the MSCB partner agencies for their hard work and continued commitment to making a difference for Merton's children, young people and their families.

Keith Makin
MSCB Chair
July 2016

[2] Average of Manchester, Merseyside, West Yorkshire and West Midlands £510:10,000 population compared to Met Police £281:10,000 population

2.0
Progress of MSCB Business Plan 2015–16

The MSCB is a statutory body established under Section 13 of the Children Act 2004 and the statutory guidance in Chapter 3 of Working Together 2015. The Independent Chair of the MSCB is Keith Makin.

The objectives of the Board as defined by statute are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes[3].

The MSCB has a well established Business planning process, with the Business Plan receiving regular scrutiny at each meeting of the Board's Business Implementation Group. The last update received by the Board at its annual Away Day in March 2015 is attached as an appendix.

Key areas of focus in the Board's Business Plan between April 2015 and March 2016 have been:

- Quality Assurance – Multi-Agencies Audits/ Learning reviews/Front line practice
- To maintain strategic oversight of CSE including e-safety, missing young people, young people missing from education
- To have a strategic multi-agency response to the issue of neglect
- Female Genital Mutilation (FGM) Prevention
- The Children's and Families Act 2014, Supporting Children and Young People with Complex Needs and Legal Aid, Sentencing and Punishment of Offenders (LASPO)
- Ensure that there is a strategic focus on and all children are safeguarded from radicalisation and violent extremism
- MSCB Governance: implement the revision of the MSCB Governance, Structure and Board Business Processes
- Engage with Faith and Black, Asian or Minorities Ethnic (BAME) Communities on Safeguarding Issues

At its annual Away Day in March, the Board reviewed its performance against its agreed priorities and set priorities for 2016-2018. The Board's agreed priorities for 2016-2018 are as follows:

1. **Think Family** – supporting our most vulnerable families by addressing the 'trigger trio'[4] and supporting parents with learning difficulties or learning disabilities.

2. **Supporting vulnerable adolescents** – especially young people who are at risk of child sexual exploitation (CSE), serious crime, youth violence or involvement in gang activity.

3. **Early Help** – reviewing our early help in the light of changes in local providers and agencies and with changing levels of resources available we want to ensure our model continues to be fit for purpose.

These priorities are outlined in detail in section 11 of this report and the Business Plan is included as appendix 1.

[3] Children Act 2004 Section 14

[4] The 'trigger trio', also known as the 'toxic trio', has been used to describe the issues of domestic violence, mental ill health and substance misuse which have been identified as common features of families where harm to women and children has occurred. They are viewed as indicators of increased risk.

3.0
Key Achievements and Challenges for the MSCB 2015 to 2016

The key achievements of the Board during this period are detailed as follows:

3.0.1. Quality Assurance – Multi-agency Audits/ Learning reviews/Front line practice

The MSCB is continuing to improve its effectiveness at monitoring the performance of each agency against national, regional and local Key Performance Indicators (KPIs). One of the Board's quality assurance priorities for 2015/2016 was to have in place a performance management dataset that included national, regional (London-wide) and local key safeguarding performance indicators. It was important that this was a multi-agency dataset which included Children's Social Care, Education, Health, the Police. The Board now has in place a robust performance dataset that provides the Board with a clear overview of safeguarding practice in each agency with commentary which services to provide the Board with good assurance with regards to the quality of safeguarding practice across the safeguarding system. Performance data is reviewed each quarter by the Board's Quality Assurance (QA) Sub-Group. The QA Sub-Group highlights performance issues at Board meetings and at the Board's Business Implementation Group (BIG) meeting.

The Board has completed 4 themed multi agency audits. The themes for each multi-agency audit are as follows:

- Child Sexual Exploitation February to April 2015
- Domestic violence and the effectiveness of core groups in April 2015
- Neglect in June 2015
- Inter-generational abuse and repeat plans August 2015

In addition this, the Board conducted multi-agency case audits of two cases that were escalated to the Board for review. The findings of each audit is analysed by a multi-agency panel of Senior Managers and Safeguarding Leads. These findings are then organised into key learning themes and are disseminated to Senior Managers and frontline practitioners by a series of briefings.

3.0.2 The Board's second priority was to maintain strategic oversight of CSE including e-safety, missing young people, young people missing from education

The there is a full report of the Board's strategic management of CSE which is covered in this report in detail under section 4.3. We are pleased to note that over the last year we have seen a 47% increase in CSE related referrals. This indicates that practitioners are more aware of CSE as a specific form of sexual abuse and are improving in their recognition and referral of CSE. There is a very strong offer of support to young people at risk of CSE and for those who have been victims of this form of sexual abuse.

3.0.3 To have a strategic multi-agency response to the issue of neglect

At its Away Day in March 2015, the Board established a task and finish group, monitored by the Policy Sub-Group, to produce a multi-agency strategy to address the issue of neglect. The task and finish group completed its work and a draft neglect strategy and its implementation plan were approved by the Board in September 2015. In order to establish a baseline measurement of multi-agency performance in relation to cases of neglect, the Quality Assurance Sub-Group commissioned an audit on the theme of neglect in June 2015. The Board will revisit this theme in 2017 in order to ascertain the impact of the strategy on multi-agency practice. The Board is assured that there is a continuously improving understanding of the issue of neglect and its impact within the MSCB Partnership.

3.0.4 To introduce a multi-agency strategy to prevent Female Genital Mutilation (FGM)

The Board is committed to addressing the issue FGM. The Board commissioned a task and finish group to develop a strategic response and to develop a multi-agency FGM Strategy.

Goals of Merton Safeguarding Children Board's FGM Strategy are as follows:

- To create community awareness and to engage with local communities on the prevention of FGM
- To ensure that all multi-agency partners are aware of their statutory responsibilities and are fulfilling them.
- To ensure that there are safe pathways to protect women and girls who have had or who are at risk of FGM
- To provide multi-agency guidance for local safeguarding partners and an effective safeguarding response to the issue of FGM
- To ensure that services are in place to optimise future reproduction and sexual function, psychological health and better quality of life for survivors of FGM

The FGM Strategy and its implementation plan were approved by the Board in March 2016; this is being monitored by the Board's Policy Sub-Group (see also section 4.6 in this report).

3.0.5 The Children's and Families Act 2014, Supporting Children and Young People with Complex Needs and LASPO

The implementation of the major changes arising from the Children and Families Act 2014 relating to education, health and care planning for children with Special Educational Need (SEN) and disabilities remain on-going. With engagement of partners from the NHS, community organisations and parents/carers, we have established an integrated Education Health and Care service and published our Local Offer. We are now focusing on embedding new procedures and ways of collaborative working which will support more integrated planning and more effective working with this group of children, young people and their families.

After a period of employing interim staff, in 2015 we were successful in recruiting a social care qualified Head of Service. We have also appointed a permanent and appropriately skilled team manager to the social work team within SENDIS, thus strengthening social work management and oversight in the service following a diagnostic audit of Children With Disabilities (CWD) casework.

3.0.6 The Board also wanted to ensure that there is a strategic focus on and all children are safeguarded from radicalisation and violent extremism

The Board commissioned a task and finish group to prepare practice guidance for professionals working with children who were vulnerable to messages of violent extremism and radicalisation. The task and finish group completed its working in May 2015 and presented the draft guidance and information for parents and carers, which would be made available to parents via schools and online, in May 2015. The guidance and information for parents were approved by the Board.

In addition to the practice guidance and information for parents, 459 CSF staff members have attended PREVENT[5] training (this figure does not include staff in Merton's schools who have also been trained in PREVENT). There are two further sessions arranged for 2nd November and we hope to have covered the whole department by this point. There is now a greater awareness of PREVENT and radicalisation across the children's workforce. This training is being rolled out to all Merton schools (see also section 4.5 in this report).

[5] Prevent is part of the Government's counter-terrorism strategy; represented by the 4 Ps: **Pursue:** to stop terrorist attacks; **Prevent:** to stop people, becoming terrorists or supporting terrorism; **Protect:** to strengthen our protection against a terrorist attack; and **Prepare:** to mitigate the impact of a terrorist attack. CONTEST: The United Kingdom's Strategy for Countering Terrorism, July 2011

MSCB Governance: implement the revision of the MSCB Governance, Structure and Board Business Processes

The Board revised its constitution in 2014 and again in 2015 in the light of the revised Working Together 2015. In 2015-2016, the focus of the Board was to embed these changes. There continues to be strong multi-agency representation on the Board and its Sub-Groups. The Business Implementation Group is working effectively to ensure that the Board's Business Plan is implemented and that there is a clear line of sight and action between the Business Plan and the work of the Sub-Groups.

The Board has strengthened the representation of Education representatives on the Board: the Board has representation from the primary, secondary, special and FE sectors; in addition, the Assistant Director responsible for Education and Senior Managers within Education Department serve on the Board. The Board has continued to improve its inter-face with schools and the Board's Business and Development Manager attends the termly Designated Safeguarding Leads meeting; this enables to Board to give and receive key safeguarding messages relevant to education.

In terms of the impact of these changes, the Board continues to be positioned as a stronger enquirer into the quality of safeguarding practice and the work being done by partners to promote the welfare of children and young people. The Board is increasingly able drive improvements in the quality of safeguarding practice through a more streamlined and focused Performance Dataset. The Board has in place a culture of robust challenge across the partnership; this is evidenced through our annual Quality Assurance and Peer Challenge process and the Board's risk and challenge log.

3.0.8 Engage with Faith and BAME Communities on Safeguarding Issues

The Board continues to work to engage with Faith Groups and BAME Communities on safeguarding issues; for example, the Board Business and Development Manger attends Standing Advisory Council on Religious Education (SACRE) and the Joint Consultative Committee (JCC) with Ethnic Minorities and the Merton Voluntary Service Council's Safeguarding Leads meeting. The Board has also consulted with a range of community groups especially with regards to its FGM Strategy. There remains more work to be done to engage with Faith and BAME communities.

3.0.9 Other Achievements

The Board has also developed the following initiatives, Guidance, Policies, and Protocols:

- Established the Violence Against Women and Girls (VAWG) Group in partnership with Merton Safer and Stronger to oversee Multi-Agency Risk Assessment Conference (MARAC) and VAWG related activities
- Revised its Constitution including the revision of the terms of reference for all Sub-Groups
- Re-issued our Information Sharing Protocol
- Revised the Performance Dataset
- Revised the Learning and Improvement Framework
- Re-issued the Safer Recruitment Strategy
- Revised the Participation Strategy
- Prepared Guidance for working with children and young people who are vulnerable to the messages of radicalisation and extremism and prepared advice for parents and carers which was approved by the Board in May 2015
- The Board developed a Communication Strategy which was approved at its meeting in January 2015 which is being implemented

3.1 The challenges for the Board

Whilst the Board has made great strides in embedding improvements in its constitution, we are not complacent and we have a number of key challenges; these are described as follows:

3.1.1 Responding to the Wood Review

The Wood Review and the Government's response outline significant changes in the way that LSCB's operate. This presents the Board with an opportunity to review the nature and effectiveness of it partnership and priorities. These discussions are on-going and it will be some time before primary legislation is enacted to create a new statutory framework for LSCBs, however the Board is committed to staying ahead of the curve by considering the shape of the kind of partnership which will continue to drive improvements in the quality of safeguarding practice in Merton.

3.1.2 Continuing to Demonstrate Impact by Improving Links with Frontline Practice

The Board continues to work hard to ensure that there is a clear line of sight between the Board's priorities and improvements in the quality of frontline practice. To support this aim the Board has engaged in a range of activities to strengthen the link between the Board and frontline practice. For example, the Board provides a presentation at each Corporate Induction so that new members of Council staff are aware of their safeguarding responsibilities, are introduced to the Board's key policies, the MSCB's multi-agency training programme and developments in policies. In addition to this, the Board contributes to the induction of all new social workers by providing an overview of the Board at initial induction and a more detailed workshop about the work of the Board, our priorities and presenting learning from LiRs and SCRs. The Board also provides a termly briefing to all Merton Schools' Designated Safeguarding Leads these briefings include updates on the Board's key policies including introducing new policies, strategies and protocols; highlighting the MSCB's multi-agency training programme, we also present information on learning coming out of multi-agency audits, LiRs and SCRs. Finally, the Board has improved its links with the Merton Voluntary Service Council, which represents voluntary sector organisations and groups, by attending the meeting of voluntary sector's Designated Safeguarding Leads meetings; the Board also meets with the VAWG Practitioner's Group. This remains an area for continuous improvement.

3.1.3 Safeguarding In the Context of Increasing Demand and Limited Resource

Like many other LSCBs the Board is operating within the context of our current economic climate and trying to manage the difficult balance between rising public and government expectations of the Board and finite resources. The Board is currently in discussions with partners regarding the parity of contributions to the Board and how resources could be best targeted to maximise the impact of the work of the Board.

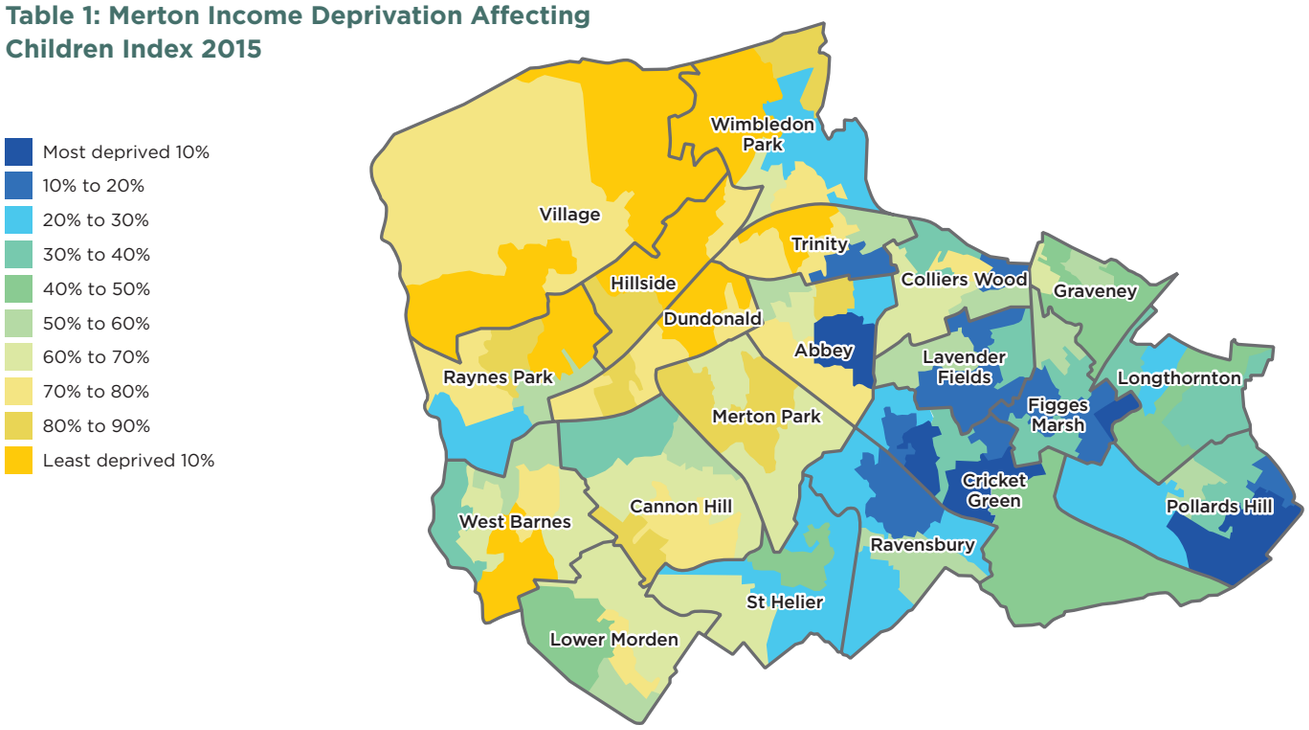
4.0
Local context and need of the childhood population for Merton[6]

4.1 Merton the place

Merton is an outer London borough situated in south west London, covering 14.7 square miles. Merton has a total population of 200,543 including 47,499 children and young people aged 0-19 (Census 2011) this is predicted to increase by between 3% and 6% by 2020, based respectively on the GLA population projections for its Strategic Housing Land Availability Assessment (SHLAA), and its alternative Trend forecasts, which take additional factors into account. Between 2011 and 2020 we can estimate the population of Primary School children aged between 5 and 10 will have increased by 21%, Secondary School aged children aged 11 to 15 will have increased by 11%. Merton has a younger population than the England average. Historically there was a 40% net increase in births from 2,535 in 2002 to a peak of 3507 in 2012 and approximated at 3178 by 2020. This historical increase in births in Merton, together with other demographic factors such as migration of families into the borough, has already created the need for more school places, put pressure on early years and pre-school services, children's social care and early intervention.

Predominantly suburban in character, Merton is divided into 20 wards and has three main town centres; Wimbledon, Mitcham and Morden. A characteristic of the borough is the difference between the more deprived east (Mitcham/Morden) and the more affluent west (Wimbledon). There are a number of pockets of deprivation within the borough mainly in the eastern wards and some smaller pockets in the central wards. These wards are characterised by multiple deprivation, with high scores on income deprivation, unemployment and limited educational attainment. Merton has 39 Super Output Areas which are amongst the 30% most deprived areas across England for children. This means 45% of Merton school pupils are living in an area of deprivation (30% most deprived, IDACI 2015). Since 2010 we have seen an increase of 31% of children who are eligible for free school meals (FSM) (2010, 2881 FSM, 2015, 3796 FSM children).

Table 1: Merton Income Deprivation Affecting Children Index 2015



[6] Statistical information regarding the demographic profile of the Borough is based on the 2011 Census.

Thirty five per cent of Merton's total population is Black, Asian or Minority Ethnic (BAME) – this is expected to increase further to 39% by 2017. Pupils in Merton schools are more diverse still, with 66% from BAME communities, 42% with a first language which is not English, speaking over 124 languages (2015). 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 5.7%, Urdu 5.8% and Polish 5.7%.

The number of pupils with SEN is also increasing, with EHC plans rising from 668 in January 2011 to 880 in January 2015 (an increase of 32%).

There has also been a similar rise in pupils with School Action Plus cohorts in primary schools from 737 in Jan 2011 to 814 in January 2014 (+10%).

4.2 Merton's Children in Need, Children with a Protection Plan and those Looked After

4.2.1 Children In Need

Merton's Children in Need (CIN) rate per 10,000 (2014-2015, 335.8) is lower than the London average (367) and broadly in line with the National average (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. See table 2 below:

Table 2: Increases in CIN rate between 2008 and 2014

Year	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
CIN Rate	171.0	276.8	288.3	371.3	336.8	355.1

Table 3: Children subject to a child protection plan

4.2.2 Children Subject to a Child Protection Plan

Rates of Children subject of a child protection plan in Merton (2014/15, 38.5) are similar to London (37.4) and national (42.1). As at the end of 2014/15 16.4% of children became subject of a child protection plan for a second or subsequent time, this in line with the increasing national benchmark (15.5%) and London (13%) averages (2013/14).

Nationally 4.5% (2013/14) of children were subject of a child protection plan lasting two years or more, in Merton this was 4.3% (2014/15) relating to 10 children.

4.2.3 Looked After Children

As at 31st March 2016 there were 163 Looked After Children (LAC) in Merton. In addition Merton has 142 young people aged 18-27 years accessing leaving care services, making Merton a corporate parent to over 305 vulnerable children and young people.

Merton's LAC rate per 10,000 of the population was 36 in March 2016. The DfE statistical release will not be available until September and therefore at this time we are not in the position to provide comparator statistics for 2015-16. However the data from 2014-15 is set out in the table below and indicates that Merton's LAC population was low in comparison to our statistical neighbours (it is unlikely that this position will change significantly when the comparator data is released).

Table 4: Looked after children by 10,000 population

As highlighted in previous reports the age profile of our looked after child cohort varies from the national picture with Merton caring for a large number of older children aged 16 and over. In Merton 40% of our looked after children are aged 16 and 17 compared to 22% nationally (2015). On review of this cohort we can see that a significant number of these young people are entering care late in adolescence due to the following reasons:

- Young people presenting as an unaccompanied asylum seeking child (UASC)
- Young people presenting as homeless and meeting threshold to be accommodated under Section 20 Children Act 1989
- Young people being remanded to the care of the Local Authority

On 31st March 2016 63% of the LAC population were male and 37% were female. This is in line previous years and does reflect the national picture reported in 2015. The breakdown of the age/gender data highlights that our older LAC cohort is significantly over-represented by males. This reflects the fact that the majority of UASC and Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) referrals received relate to males.

The majority of looked after children in Merton are from a white background (47%) which is broadly in line with the general resident population (55%). As in previous years, there are fewer Asian or Asian British LAC (7%) than the Merton population (20%). Mixed ethnic backgrounds, Black or Black British heritage and 'other ethnic groups' have looked after children populations greater than the resident population.

4.2.3.i Looked After Child Priorities for 2015-16

Specific areas of focus for us in the year 2015-16 were placement stability, participation in reviews and care leavers. As a result of targeted improvement plans being implemented we have managed to make improvements in all three areas as evidenced below.

LAC Priority Area 1: Placement Stability

In April 2015 we undertook a detailed analysis of LAC stability and the resulting report identified key messages in relation to what we do well, what our challenges are and such what we could do better. An improvement plan was put in place focusing on the following areas:

- The quality of placement referrals
- Closer scrutiny of fragile placements
- Scrutiny of children experiencing moves
- Increased placement choice

To ensure an improved offer to our looked after children we also established the LAC Permanence Team in October 2015. Whilst the review of placement stability both locally and nationally identified a number of factors were contributing to a lack of stability it was also apparent that changes of social worker had been a contributing factor.

Table 5: Difference in Ethnic Group of Looked After Children from the Merton Resident Population

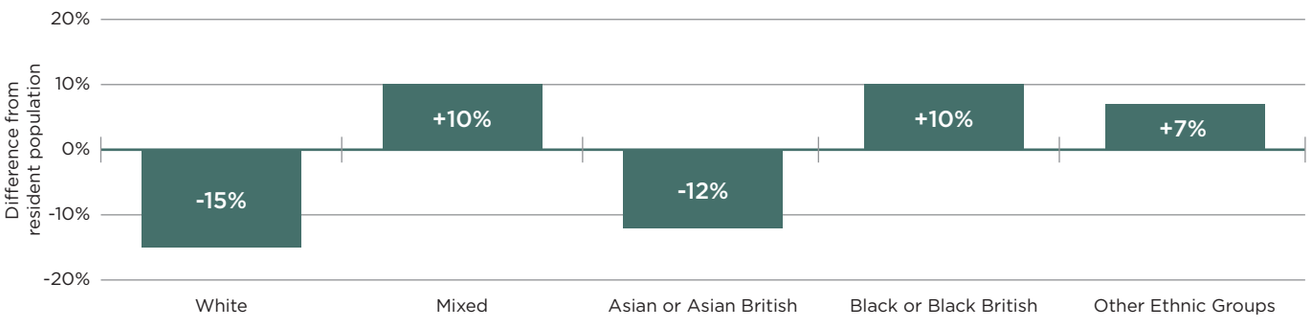


Table 6: Percentage of Looked After Children with Stability in their placement

	2011 (31st March)	**2012** (31st March)	**2013** (31st March)	**2014** (31st March)	**2015** (31st March)	**2016** (31st March)
Merton	67%	68%	64%	55%	46%	67%
National	68%	68%	67%	67%	67%	not available

Source: SSDA 903
Note: The percentage of Children Looked After aged under 16 at 31st March who had been looked after continuously for at least 2.5 years, who were living in the same placement for at least 2 years, or are placed for adoption and their adoptive placement together with their previous placement last for at least 2 years.

The development of the team has allowed the practitioners to focus on the specific needs of the looked after children with whom they are working and to embed a model of relationship based practice supporting children, their carers and their families. Initial feedback in respect of this team has been positive and we are in the process of undertaking a consultation/feedback exercise so that we can more formally evidence the impact of the team.

To support the relationship based/systemic approach we have also integrated a CAMHS Team within the service.

As a result of this we have seen improved stability for those children who have been looked after for more than 2.5 years, and we are now in line with the 2015 national average rate of 67%.

The percentage of children experiencing 3 or more placement moves in the year has remained stable at 14% (this is in line with the 2015 national average of 10%).

LAC Priority Area 2: Participation in LAC Reviews

The 'Voice of the Child' has been highlighted as a priority area in all Children's Social Care Service Plans 2015-16, and a key time for looked after children to participate is at their LAC Review. In July 2015 we developed an improvement plan which was put in place focusing on the following areas:

- Scrutiny on data quality
- Clarification of roles and responsibilities
- Promotion of the advocacy service

As part of the participation improvement plan we have also been working on a specific project to consult on and appraise the current review meeting process. Between September 2015 and December 2015 the IRO service worked with the Participation Apprentice in undertaking a number of consultation activities with young people. These included:

- Workshop with representatives at the Children in Care Council (attended by 13 young people)
- Workshop half day for younger children (attended by 15 children)
- Survey of experiences of children and young people who participated in a survey of LAC reviews

The key messages being fed back from these consultations were that children and young people wanted to be able to choose the venue for their LAC review and for the meeting to be held at a time convenient to them. There was also a request for children and young people to be more involved in the planning for the meetings so that there were child centred and strengths focused.

The children and young people stated that:

- They often don't know who is coming to the review and would like to more involved in agreeing who should attend.
- They wanted to meet the IRO prior to the LAC review meeting so that the ITO could get to know the young people rather than judge them on what they had read 'we aren't always as we appear on paper'.
- They wanted more forward looking reviews; they felt that all too often the reviews focused on the past.

The IRO Team are now looking to adopt a good practice model which has been successfully piloted by the Participation Service in Sheffield. This model will support children and young people to feel that they are at the centre of the review meeting and have a strong influence in the shaping of their care plan.

As a result of the focus in this area we have seen children and young people's participation in LAC reviews rise from 79% in 2014-15 to 96% in 2015-16.

LAC Priority Area 3: Care Leavers

Children's Social Care has a range of duties and powers to provide after care advice and assistance to care leavers. Good corporate parents will provide young people with help and support to access education, employment and training opportunities and to find accommodation suitable to meet their needs.

In 2015 we produced a Care Leaver Strategy which set out our aspirations to improve outcomes for young people accessing support as care leavers.

The strategy is supported by regular themed meetings of the Care Leaver Task Force.

The work in this area is measured against specific performance indicators in respect of a specific cohort of young people (those aged 19-21 years) in the following areas:

- In touch
- NEET (Not in Education, Employment or Training)
- Living in suitable accommodation

The 14+ Team work hard to maintain positive relationships and contact with all young people in the service and there is a practice standard in place to ensure that all care leavers are visited at least every 2 months. In addition to the statutory visits the team have also looked at more informal ways to support contact with their young people through informal drop in sessions at a local coffee shop and programmes such as the Independent Living Skills Workshops. As a result of this we have seen an improvement in performance in this area as set out in the table below.

The number of care leavers who are not engaged in education, employment or training has become an area of focus for us as we have seen a year on year decline in performance in this area. As part of the Care Leaver Task Force we have reviewed the intervention resource in this area and a NEET/EET worker has been recruited to the Virtual School to work solely with the care leaver cohort. We have also developed links with colleagues in Environment and Regeneration, in order to ensure that the care leaver cohort are a priority area for focus in respect of apprenticeship schemes and 'readiness for work' programmes.

Table 8: Care Leavers in Touch

	2014-15		2015-16	
Merton	**Number**	**%**	**Number**	**%**
Yes	72	77%	132	89%
No	9	10%	3	2%
Service No Longer Required	7	8%	3	2%
Young Person Refuses Contact	3	3%	7	5%
Young Person Returned Home	2	2%	3	2%

Table 9: Percentage of Care Leavers in Education, Employment or Training

	2012 (31st March)	**2013** (31st March)	**2014** (31st March)	**2015** (31st March)	**2016** (31st March)
Merton	70.6%	60.0%	47.0%	44.1%	64.5%
National	58%	58%	45%	48%	not available

Source: SSDA 903
Note: In 2014 the DfE extended the care leaver cohort to include 20 and 21 year olds. As a result the figures for 2012-2013 include only to 19 year olds whilst the figures for 2014 - 2016 include Care Leavers of all ages.

As a result of this increased focus and additional resource we have seen some improvement in respect of outcomes for young people in this area.

Whilst we have made improvements it will be important to maintain an area of focus to ensure that we are providing all young people with appropriate levels of support in this area. Many of the young people who are not engaged in employment, training or education have a high level of additional need in respect of their emotional wellbeing and would benefit from a robust level of 1:1 support prior to them being considered for readiness to work programmes (this is being considered as part of the Task Force work).

The legal framework for care leavers aims to ensure that they receive the right support and services in their transition to adulthood, including access to accommodation. Our performance in this area is measured against whether or not accommodation is considered suitable.

The improvement in performance in this area reflects both the fact that we are in touch with more of our care leavers and the work that has been undertaken with colleagues in our Access to Recourses Team and Housing Service.

We remain fully committed to achieving timely permanency for all our children.

4.3 Children at Risk of Sexual Exploitation

Tackling the issue of Child Sexual Exploitation (CSE) continues to be a priority for the MSCB. The strategic intent of the Board is to clearly identify victims and perpetrators of CSE; to ensure that victims receive appropriate support and that the perpetrators of this crime are disrupted and prosecuted; the Board also aims to monitor closely each young person at risk of CSE and to ensure that support is provided to prevent CSE.

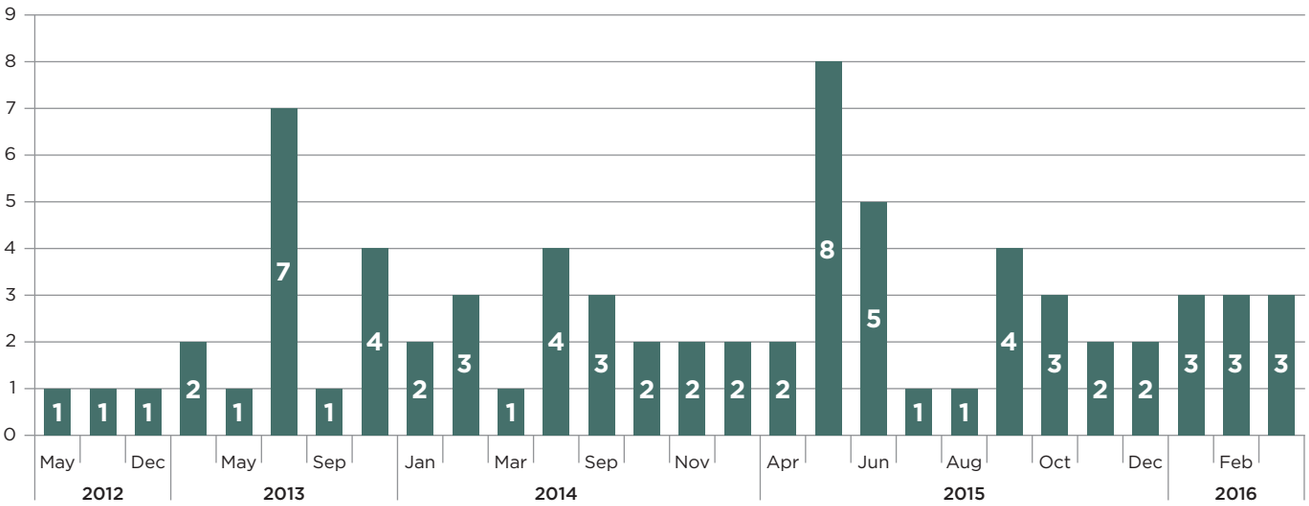
Merton Safeguarding Children's Board's CSE strategy was launched in 2013 and refreshed in 2015 supported by intelligence from our Joint Strategic Needs Assessment and 2014 peer review on CSE. Our Strategy provides clear and practical guidance for social workers and other practitioners dealing with cases where there is suspected and confirmed child/young person sexual exploitation.

Table 10: Percentage of Care Leavers in Suitable Accommodation

	2012 (31st March)	**2013** (31st March)	**2014** (31st March)	**2015** (31st March)	**2016** (31st March)
Merton	88%	85%	66%	76%	95%
National	88%	88%	78%	81%	Not available

Source: SSDA 903
Note: In 2014 the DfE extended the care leaver cohort to include 20 and 21 year olds. As a result the figures for 2012-2013 include only to 19 year olds whilst the figures for 2014 - 2016 include Care Leavers of all ages.

Graph 1: Referral to MASE Panel 2012-2016



The Promote and Protect Young People (PPYP) strategic group, a Sub-Group of the MSCB, is chaired by the Head of Family and Adolescent Services (FAS). The PYPPS has an annual action plan that is regularly monitored by the MSCB. This thematic group also maintains oversight of other vulnerable groups such as those missing from home or care so that we can triangulate information across groups both strategically and operationally. PPYP oversees three multi agency panels where information is shared and considered.

- Multi Agency Sexual Exploitation Panel (MASE), is chaired by a DCI from the Metropolitan Police
- Missing from Home or Care Panel (Multi agency representation), chaired by the Head of Looked After Children
- Children Missing Education Panel (Multi agency representation – chaired by Head of School Inclusion

The PPYPS group has a broad multi-agency membership including representation from: Children's Social Care including the MASH and the 14+ Looked After Team, Police (Missing Persons Officer and borough Police), Primary Health (Designated Safeguarding Nurse), Education Welfare, Youth Offending Service, Pupil Referral Unit, Barnardo's, Jigsaw4U and Catch22.

In 2015 we have been involved with a London Wide process for reviewing CSE across London. In February 2016 our MASE arrangements were reviewed externally and we have taken on board the findings of this review which have encouraged our MASE to operate a more strategic overview of CSE in the borough. Lessons from these peer and external reviews have been shared at PYPP.

Merton had 25 referrals to our Multi Agency Sexual Exploitation Panel (MASE) on average in the past 3 years. There has been a year on year increase to MASE following significant awareness raising activity.

In 2015-16, 37 young people were referred to panel. The majority of those referred are children/young people aged 13 to 16 girls (with a concentration on the 14 and 15 year olds) and White British. Merton MASE manages oversight of a small yet complex cohort of children; we have identified an overlap between children at risk/subject to sexual exploitation and those missing from home and care. Although the correlation with Children Missing from Education (CME) is not so evident, there are still some young people in both cohorts.

As can be seen from Graph 1 above the number of referrals to MASE has increased over the past 3 years as awareness has been raised of CSE and the operation of the panel. As at the 31st March 2016 there were 25 children open to the PPYP/MASE panel, 3 of which were judged to be high risk.

At the most recent MASE meeting of these 25 young people 3 were considered to be high risk, 6 medium and 16 low. The remaining 'on ice' cases represents those cases having been previously judged at risk of CSE that show no current indication but are scheduled for review before being considered for closure. There are currently 50 cases 'on ice' – on ice means that the case is inactive in relation to CSE and young people are being supported via targeted and universal services. The most recent dashboard of March 31st 2016 shows relatively high numbers of 14 and 15 year olds at risk of CSE and the prevalence of White/British victims.

Of the 75 children open to MASE since 2012, 16 have been LAC during the period they were open and 8 young people were subject to Child Protection Plans.

All 25 children open to MASE are or have been open to Children's Social Care and Youth Inclusion at some stage. Of those currently open to MASE:

- 3 of the children were male
- 4 children are subject to a child protection plan
- 6 young people are looked after young people
- 1 child is both Looked After and currently also subject to a Child protection Plan

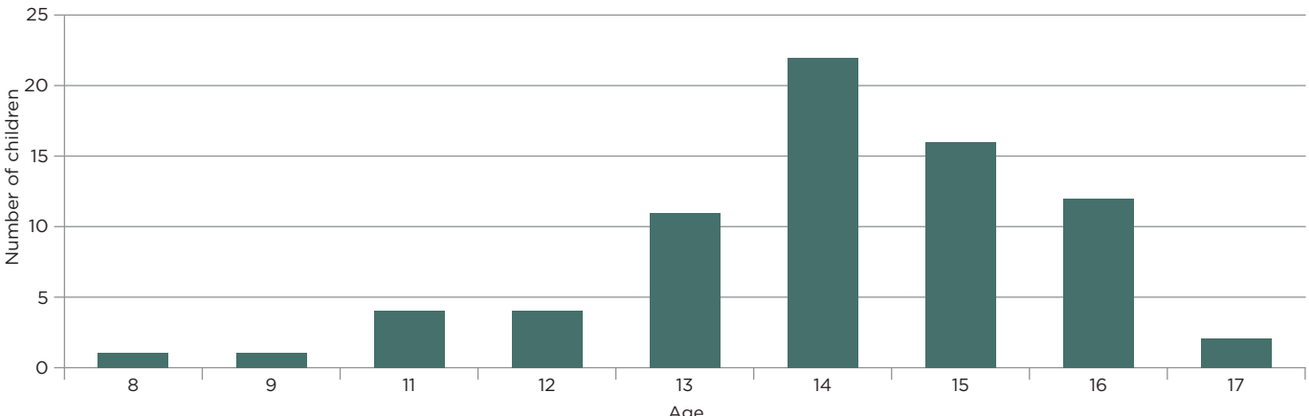
The breakdown of ethnicity shows a prominence of White/British or White background. The age distribution shows 7 or 28% of young people referred for possible CSE are aged 13 and under currently and this is a concern. Many of the young people including this younger cohort have been identified because of concerns around use of social media and the internet. The majority at 10 or 40% were aged 14 at the time of referral.

4.3.1 CSE and Looked After Children

We have several young people who are in the at risk cohort who may be missing from care and the Jigsaw4U[7] project works with these young people. All young people who were LAC and living in the borough were referred to Jigsaw4U. The project will also work with a small number of young people who are Merton LAC but placed outside of the borough. At present there are two children who are being worked with in this way. Furthermore we have also offered Return Home Interviews to 51 individuals, relating to 89 missing episodes to young people who are at risk through running away who are placed in Merton but may be looked after by another local authority. In 2015/16 interviews were taken up by 5 young people and further support offered to two of these individuals. Currently, there are 6 out of 25 (16 out of 50 on ice) cases that are or have been LAC.

[7] Jigsaw4U is a charity that provides a wide variety of services across five London Boroughs including advocacy, work with young runaways, young victims of crime, mentoring and other services.

Graph 2: Age Profile of Young People referred to MASE Panel 2012-2015



Due to our concerns about a cohort of children who go missing who are other local authorities LAC we have established a process with the Police to review this under our new joint protocol. Where our concerns are particularly acute we write to the Local Authority concerned. Data from our missing children dataset indicate that there are a small number of children who go missing regularly. In 2015-16 this has mainly been from Croydon, Sutton and Wandsworth who are neighbouring boroughs. We are currently working with the provider to improve equity of service to Merton young people placed out of borough and to ensure young people placed in Merton by other local authorities can access appropriate support.

4.3.2 CSE and Out of Borough LAC Cases

We have placed young people away from the borough because of our concerns about Looked After Children. For some young people placements away from their home community are a key part of the care plan as a result of anti-social behaviour/risk taking behaviours. For some the needs of the young people are such that they require specialist placements which are not available in Merton or surrounding boroughs. For all children being placed outside of the borough the DCS is required to sign off agreement for the placement. Care plans for these children and young people are reviewed to ensure that where possible young people are supported to return to their home community at the earliest opportunity.

The recent monitoring meeting tracked the progress of 6 current cases where there are known or suspected concerns for sexual exploitation and set out below are some of the key characteristics.

- All of the cases are of young girls; 2 aged 13 2 aged 15 and 3 aged 17 and 1 aged 18.
- 2 of the young girls were at risk of peer related sexual exploitation; 6 were at risk of sexual exploitation by an older male.
- 2 of the young people had been made the subject of full Care Order's linked to their CSE vulnerability and the remaining 5 were accommodated under Section 20 of the Children Act 1989, that is to say with parental agreement.
- No significance could be assigned to the ethnicity of alleged perpetrator in the cohort. For the victims ethnicity was spread: 5 White/British; 1 White/Other; 1 Black/African; 1 Black/Caribbean and White/British.
- In terms of proximity of placement to Merton 2 of the 8 cases are placed in excess of 20 miles from Merton.

One young person was placed briefly in secure as a result of concerns about child sexual exploitation but we have commissioned specialist placement support for the young person as the apparent risks substantially lessened.

4.3.3 Summary Activity During 2015 and 2016:

- Refreshed and re-launched strategy, protocol and tools in March 2015.
- Increased identification of young people at risk, including more males, referred to and discussed at MASE
- Developed a JSNA CSE chapter February 2015
- Delivered CSE champions in Secondary Schools and within Health agencies
- Undertaken extensive awareness raising including; jointly delivering a CSE briefing with Barnardo's to 30+ Foster carers in September 2015 and ongoing development for Primary and Secondary schools including training to Heads
- Strengthened PPYP links to children missing from home, care and education
- Continued work with Redthread in St George's Hospital in relation to young people who have presented with injuries from knife/gunshots and CSE/Sexual injuries. New screening process in place between local Sexual Health GUM clinics and Social Care
- MOPAC funded Young Women and Girls Worker in place – with complex caseload of very vulnerable young women
- MOPAC funded Gangs worker who works towards the main objective of disrupting gang related activity (including CSE)
- Development of Gangs and CSE victims and perpetrator mapping which includes cross-border activity
- Ongoing strengthening of 'Multi Agency Missing from Care and Home Panel' supported by a 'Missing dataset' which identifies other vulnerabilities including CSE and CME.
- Policies and procedures are in place to deliver a well-coordinated response to children who are reported as missing from home or care (refreshed in April 2016).
- Independent organisation (Jigsaw4U) commissioned to work as part of a wider interagency team to provide practical and emotional support and prevent/reduce episodes of going missing. Jigsaw4U also provide 'return home interviews'.
- With regards to children/YP known to Children's Social Care, case management of CIN/CP CYP missing from home is improving and recording and case management of Looked after Children missing or absent has improved over the last 12 to 18 months.
- All in-house foster carers have received 'missing and absent' procedure training.
- 'Children Missing' policies and procedures are checked as part of the placement commissioning process. Agency foster carers and residential placements are required to report missing episodes in a timely way to the Council and Police and are required to support the Council to implement safety plans.
- Strengthened the partnership approach of the multi-disciplinary Hard to Place and CME Panels
- Implemented a Chronic Absence Project in response to an SCR finding with a focus on pupils with chronic absence pre-transition to secondary school. Undertook a post implementation impact review to take forward the learning
- CME/Pupil Absence protocols between Education and Social Care services have been strengthened with regular reporting to CSF Continuous Improvement Board.
- Briefings provided to Primary and Secondary School head Teachers on safeguarding risks associated with absence from school and reinforced as appropriate in termly designated teachers' events.
- Specific guidance provided to schools on forced marriage, female genital mutilation, child trafficking and Prevent.
- Developed a Schools and Early Years settings safeguarding audit tool and guidance.
- Adopted a vigilant approach to the quality of alternative education provision in the borough and the identification and notification of unregistered schools.

- Education Welfare Service supports the home education process where families opt to educate children other than at school (EOTAS). Action is taken by the authority in relation to unregistered schools, we are activity monitoring and liaising with Ofsted where necessary
- Establishment of a dedicated CSE Police team with the Merton arm of the Metropolitan Police

4.4 Children Missing from Home and School

Merton operates a Children Missing Education Panel. The purpose of the panel is as follows:

- To maintain a record of all pupils in Merton recognised as CME
- To provide a multi-agency panel to assess cases and to decide on most appropriate course of action to return pupils to education
- To safeguard pupils who are missing from education
- To consider whether cases need to be referred to Merton's Fair Access Panel
- The Panel also looks at high level non attendees and where home education has been judged to be unsatisfactory

The Panel discussed between 180 and 200 cases per academic year between 2009/10 and 2012/13 in 2014/15 academic year this number has risen to 249 (38% increase), we have understood contributing reasons to be increased awareness in agencies of CME and some additionality due to population growth (higher grow of SEN cases in line with SEN population). Please refer to the CME Annual review for a full analysis.

- Merton LAC can be referred to the panel if they have poor attendance, need a change of school or a permanent school place is not yet available. Other Boroughs LAC who are placed in Merton, may be referred to the panel if they are not yet in a school or have poor attendance. A total of 34 Looked after Children were discussed at panel in 2014/15 of which 16 were Merton LAC. Of the 16 Merton LAC seven were off roll none were of primary school age, nine were at risk of becoming CME but remained on roll.
- During 2014/15, 65 children with statements of SEN or EHC plans were discussed at the panel. Of these 16 were CME off roll and 49 were at risk of CME but remained on roll.
- For pupils who leave school and have no forwarding school address Education Welfare follow up cases on S2S. A high use of S2S is encouraged by Merton with an improved clean up rate from 66% in 2012/13 to 98% in 2014/15. We have also refreshed our off roll notification process.

An Inclusion Officer sits on both CME and MASE panels to ensure effective information sharing. In 2014/15 we had 7 cases across the panels.

The Head of Education Welfare and Head of the Virtual School attend the Missing panel. The CME database is checked to ensure that all Missing / CME cases are flagged and advise social workers of issues related to Education that may reduce any risk from missing from Care and Home. Any issues related to Missing are therefore flagged at CME panel accordingly.

4.5 Prevent

Merton is not considered by the Home Office to be a priority Prevent borough. Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. Channel referrals have been relatively low but as Prevent awareness increases the borough has seen an increase in the number of Channel referrals being made.

When referrals are made an initial assessment is conducted by the Metropolitan Police Service's Prevent Engagement Officer who undertakes low level intelligence gathering and contacts the subject to have a discussion. Often the referrals do not become formal Channel cases because they are assessed as not being a threat from a Prevent perspective. Most of the people referred have some form of mental illness and have been referred on to mental health teams in order to get the appropriate support from mental health practitioners.

Merton's Safeguarding Children Board has developed 'Guidance for working with children and young people who are vulnerable to the messages of radicalisation and extremism'.

This guidance was approved by the Board in May 2015 and developed in the context of the Government's overarching counter-terrorism strategy 'CONTEST' and the 'Prevent Strategy' which was developed in 2011 to respond to the threat of extremist activity; the Counter Terrorism and Security Act 2015, which places the Prevent Strategy onto a statutory footing. In addition, the document is also informed by Working Together to Safeguard Children 2015 and the Pan London Child Protection Protocols for safeguarding, to ensure that it implements good and best practice in safeguarding vulnerable children and young people.

As part of our work to raise awareness and support parents and carers on this issue, the Board has developed advice for parents and carers, on Keeping children and young people safe against radicalisation and extremism. Following approval by the Board, this information was distributed to all secondary and primary schools, as well as to special schools and Pupil Referral Units (PRUs) and has been made available online and in local libraries.

As noted earlier in this report, 459 CSF staff members have attended PREVENT Training[8]. There are two further sessions arranged for 2nd November and we hope to have covered the whole department by this point. There is now a greater awareness of PREVENT and radicalisation across the children's workforce. This training is being rolled out to all Merton schools.

In 2015-2016 Merton Children's Social Care had 3 cases where radicalisation and violent extremism was a feature.

4.6 Female Genital Mutilation

The Board now has in place a robust FGM Strategy and implementation plan. In 2015-2016 Children's Social Care dealt with 8 cases of FGM. Merton has had its first FGM Protection Order. This case was an excellent example of effective multi-agency practice between Children's Social Care, Health services and the Police.

[8] This figure does not include staff in Merton's schools who have also been trained in PREVENT.

5.0
Statutory and Legislative Context

Merton Safeguarding Children Board (MSCB) is the Local Safeguarding Children Board for Merton.

Local Safeguarding Children Boards (LSCBs) have a range of roles and statutory functions.

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board for their area and specifies the organisations and individuals (other than the local authority) that the Secretary of State may prescribe in regulations that should be represented on LSCBs.

Children Act 2004 Section 14 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

The LSCB is not an operational body and has no direct responsibility for the provision of services to children, families or adults. Its responsibilities are strategic planning, co-ordination, advisory, policy, guidance, setting of standards and monitoring. It can commission multi-agency training but is not required to do so.

The delivery of services to children, families and adults is the responsibility of the commissioning and provider agencies, the **Partners**, not the LSCB itself.

Regulation 5 of the **Local Safeguarding Children Boards Regulations 2006** sets out LSCB duties as:

5.1 (a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

5.1 (b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

5.1 (c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve

5.1 (d) participating in the planning of services for children

Regulation 5 (2) relates to the LSCB Serious Case Reviews function and regulation 6 relates to the LSCB Child Death functions.

Regulation 5 (3) offers that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

These duties are further clarified in the statutory guidance: *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2015, Chapter 3* (WT 2015)

LSCB duties are specified in WT 2015, Chapters 3, 4 and 5, with a responsibility to have oversight of single agency and multi-agency safeguarding and promotion of children's welfare (under Children Act 2004, section 11, see the footnote on page 33) as set out in WT chapters 1 and 2.

6.0
MSCB Inter-relationships and Influence with other Key Partners

The Board has a rolling 24-month Business Plan, to be refreshed each March for the business year starting each April. The update of the MSCB Business Plan for 2016-2018, agreed by the Board in June 2016, is attached as Appendix 1. The Business Plan outlines the Board's priorities for 2016-2018 and was agreed by the Board at its annual Away Day in March 2016. Priority items can be added within the year.

The MSCB meets three times per year in half-day business meetings; and in a Business Planning Away Day once per year, in March. The Business Implementation Group of the Board meets four times per year. The progress of the actions agreed in the Business Plan is reviewed at each meeting. Each Sub-Group has an agreed Work Plan and each Sub-Group reports to the MSCB biannually.

Membership[9] of the Board includes the following statutory partners:

- The Metropolitan Police Service, Borough Commander;
- The National Probation Service and London Community Rehabilitation Companies;
- The Youth Offending Team;
- NHS England and Merton Clinical Commissioning Groups including representation from commissioned Health Services;
- CAFCASS;
- Membership of the Board also includes
- Assistant Director of Children's Social Care and Youth Inclusion
- Assistant Director of Education
- The Director of Public Health, Merton
- Representation from the Voluntary and Community Sector
- Adult Social Care
- Representatives from Housing, including Housing Associations

There is also strong partnership and influence between the MSCB and the following strategic partnerships and their Sub-Groups:

- The Health and Well-Being Board
- The Corporate Parenting Board
- The Children's Trust
- The Safer and Stronger Partnership

[9] The structure and membership of the Board is included in this report as Appendices 3 and 4.

7.0 MSCB Sub-Groups

7.1 Quality Assurance Sub-Group

The purpose of the Quality Assurance (QA) Sub-Group is to ensure children and young people are safeguarded and protected by overseeing the quality of single and multi-agency work carried out in partnership across the children and young people sector.

The QA Sub-Group undertook the following activities in 2015-2016

- Completed 4 themed multi agency audits. The themes for each multi-agency audit are as follows:
  - Child Sexual Exploitation February to April 2015
  - Domestic violence and the effectiveness of core groups in April 2015
  - Neglect in June 2015
  - Inter-generational abuse and repeat plans August 2015
- Reviewed the MSCB's Multi-agency Performance Dataset
- Monitored learning from SCRs, LiRs,
- Disseminated learning from multi-agency audits

7.2 Promote and Protect Young People Sub-Group

The Promote and Protect Young People (PPYP) Sub-Group met 7 times in 2015-2016. The purpose of the PPYP is to take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted; concentrating on extra-familial abuse where there is risk of abuse outside the family. PPYP is responsible for policies relating to issues like CSE, children missing from home, care or education, child on child abuse, other forms of exploitation (such as radicalisation), e-safety, trafficking, abuse by those in a position of trust or in institutions – including faith organisations and community organisations; and policies and procedures in relation to allegations against those in a position of trust (Local Authority Designated Officer [LADO] referrals).

In 2015-2016 PPYP undertook the following pieces of work on behalf of the Board:

- Completed Guidance for Professionals Working with Children and Young People who May Be Vulnerable to the Messages of Radicalisation and Violent Extremism
- Advice for Parents and Carers on Preventing Radicalisation and Violent Extremism
- Oversaw the work the MASE Panel and Persons of Concern Panel
- Monitored and ensured the implementation of the CSE Action Plan
- Ensured the delivery of the CSE Awareness Events across the Borough

7.3 Learning and Development Sub-Group

The purpose of the Learning and Development Sub-Group is to take the overall lead responsibility, on behalf of the MSCB, to ensure that there are effective arrangements in place so that the multi-agency workforce is up to date in knowledge and skills for safeguarding children and promoting their welfare. The Learning and Development Sub-Group also plans and delivers the Joint MSCB/CSC/CSF Multi-Agency Annual Conference for practitioners and managers. The aim of the conference is to increase awareness developments in safeguarding and to engage in dialogue with frontline practice. We also aim, where possible, to involve children and young people.

7.3.1 MSCB Joint Conference With Children's Social Care and Children's Schools and Families Department

As noted above, the Learning and Development Sub-Group takes a lead on delivering the Board's Joint Annual Conference. The theme of the conference for 2015-2016 was The Shared Journey to the Finish Line: Children's and Adults Services Working Together. The event was held at Epsom Race Course and featured keynote addresses from Hugh Constant,

Practice Development Manager for the Social Care Institute for Excellence and Dr Ruth Allen, Director of Social Work at South West London and St. George's Mental Health NHS Trust and Research Fellow at St George's University of London. The conference also included workshops on Family Group Conferencing, Substance Misuse, Mental Ill-Health, Learning Disability, Young Carers and Transitions from Children's to Adult Services. The event was attended by 107 professionals and was well received by attendees.

7.3.2 MSCB Training

At the beginning of the financial year 2015-2016, the MSCB published the yearly programme advertising 63 separate training events.

In the course of the year we added a further 27 events and cancelled 16 which meant that we run a total of 75 training events, attended by 1370 multi-agency professionals. The previous year the courses run were 95 and the attendance 1403.

The annual conference on 2nd March was attended by 107 professionals.

Table 11 below offers a quick overview of the training activities throughout the year, including cancellations of courses (mostly related to poor uptake) and new courses added to the programme.

MSCB, in line with other London LSCBs, have adopted the Evaluation Training Impact format, through which we attempt to capture the impact of training immediately after the event, and then 6-8 weeks later to measure impact. This is done through survey monkey.

Data on each individual event is available on our database and reviewed to consider lessons for any repeat of that session.

The Learning and Development (L&D) Sub-Group decided to identify a selection of courses that were repeated over the year and so produced a valid sample, and which sat within the MSCB priorities, and make a deeper analysis in relation to:

- Improved knowledge,
- Improved skills,
- Trainers' skills and
- Emerging recurrent themes in response to the following questions:
  - What difference do you think this training will make to your work with children, young people and their families?
  - How has attending this training impacted on your colleagues/team/service? Please give at least 2 examples.
  - How has your implementation of the learning from the training has contributed to improved outcomes for children, young people and their families/carers? Please provide at least 2 examples.

Table 11: MSCB Training for 2015-2016

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Planned events	2	8	8	5	0	5	6	7	3	6	8	5	63
Added events			4			3	4	5	2	5	2	2	27
Cancelled events	1	3	0				3	2	3	2	1	1	16
Actual events	1	5	12	5		8	8	10	2	9	9	6	75
Actual number of attendees	**10**	**61**	**160**	**73**	**0**	**105**	**172**	**173**	**21**	**134**	**128**	**333**	**1370**

Impact with participants is good. Reach has been consistent and the continued take up in the voluntary sector is pleasing.

The L&D Sub-Group has realised however that the reach of key messages from the Board needs to go much wider in the workforce as is evidenced by Prevent training this year which via police and LA trainers has been delivered to a much wider workforce. It has been agreed that the key messages from the Sub-Group will be cascaded by the members of the L&D Sub to their individual agencies through existing briefing and training channels – i.e. within Health Trusts, at Designed Safeguarding Leads events. This will include key messages around MSCB policies and messages from QA Sub-Group. In is anticipated that the reach in 2016 – 2017 will be even greater.

The low take up of some courses also needs to be considered by the Board. The Sub-Group is considering the question of does the MSCB need to run a narrower range, but more often, keep the breadth or focus on key change issues.

7.3.3 E-Learning

3,087 Course licences were allocated with 2,094 passes. These figures are broken down as follows:

- Awareness of Child Abuse and Neglect 2,542 allocated with 1,793 passes
- Safeguarding Children Refresher Training 491 allocated and 281 passes
- Child Development or Early Child Development 20 allocated with 6 passes

The total number of licences applied for has increased considerably; with allocations more than doubling from September 2015. However, the figures indicate that a significant number of professionals do not complete the programme/ course once applied for. The Sub-Group to consider effective promotion of e-learning through cascade and supporting each agency to monitor and improve the courses completed by their members of staff.

The Sub-Group has focused on the following areas:

1. Ensuring that MSCB training is relevant to the needs of the workforce. The Sub-Group's has employed a range of strategies to conduct needs analysis with limited responses. The decision was therefore taken to focus on developments in legislation and policy, nationally and through the policy development work of the MSCB and to ensure that learning from the work of Sub-Groups such as, PPYP, Policy and QA, informed the training offer so that learning issues from QA audits, LIRs, SCRs, etc., and the dissemination and implementation of MSCB policies, protocols, guidance, etc.

2. The quality assurance of training. The Learning and Development Sub-Group is striving to increase the monitoring and evaluation of the quality and impact of training delivered by 'in-house' and external trainers. As part of this work, the Sub-Group takes the lead in quality assuring training by attending courses and providing feedback. The MSCB quality assured 4 courses this year.

7.4. Policy Sub-Group

The Policy Sub-Group, formerly the Policy and Communication Sub-Group, revised its terms of reference in December 2014. As a result, the functions of this Sub-Group are focused on policies and procedures and not communication. The revised terms of reference were approved by the MSCB in March 2015. Under the revised terms of reference, the purpose of the Policy Sub-Group is to take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency guidance, policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted. The Policy Sub-Group also has lead responsibility for policies in relation to safeguarding children from harm and neglect within their families or substitute families. This includes core early intervention and child protection procedures and looked after children procedures; private fostering; the Sub-Group also leads on specialist areas such as parental mental ill-health, parental alcohol and substance abuse,

and parental disabilities; FGM, cultural-based abuse and so-called 'honour' violence.

In 2015-2016 the Policy Sub-Group drafted or refreshed the following policies/strategies/ protocols for approval by the Board

- The FGM Strategy
- The Neglect Strategy
- Children Missing Education Policy
- Reviewed the VAWG Strategy on behalf of the Board

7.5 CDOP

The Merton Child Death Overview Panel is shared with the London Borough of Sutton. The arrangements in place in Sutton and Merton to respond to and review child deaths in their borough include:

- A review of all child deaths (under 18 years, excluding those babies who are stillborn) in the LSCB area undertaken by a panel (Para 5.8–5.9); and
- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child (Para 5.12–5.20).

36 Cases reviewed and completed by the CDOP during the period 1st April 2015 to 31st March 2016. 15 Cases were from Merton and 21 Cases from Sutton.

From 1 April 2015 to 31 March 2016, there were 28 child deaths reported to the Sutton and Merton CDOP. 16 deaths were of children resident in Sutton and 12 in Merton.

In 2015-16 there were no out of borough deaths of Sutton or Merton children.

There were four CDOP meetings held in 2015–2016 and 36 cases reviewed in total, as per the breakdown in Table 2 below. The number in brackets beside the number of cases reviewed indicates in which year the child died: (13) for a child death from 1st April 2013 – 31st March 2014 (14) for a child death from 1st April 2014 – 31st March 2015, and (15) for a child death that was reviewed in April 2015- to March 2016 year.

There were 9 unexpected deaths in Sutton and Merton in the 2015-2016 CDOP year. Nine rapid response meetings were held. Where a rapid response meeting was held, 1 case was referred to Merton Safeguarding Children's Board for consideration as a learning review. The case currently awaits the Coroner's Inquest and review.

There were 8 neonatal deaths reviewed in this period. Of these none had modifiable factors identified. Half of these children died on the neonatal unit. Three babies died in the delivery suite and one died in paediatric intensive care, three of eight babies were under 23 weeks gestation. Mental health concerns were identified with three families and one set of parents were consanguineous. In all eight cases no recommendations were made by the Panel.

No cases reviewed this year have been classified as Sudden Unexpected Death in an infant for Merton.

There were 14 deaths classified as "expected" reviewed in this period, all of which were considered to have "no modifiable factors". In 1 case, the parents are consanguineous and declined genetic testing antenatally. There were 3 sets of twins. One sibling survived of IVF Twins. Eight children had life limiting conditions. No recommendation was made in any of these cases.

7.6 Youth Crime Executive Board (YCEB)

The YCEB is chaired by the Director of Childrens, Schools and Families Services and the vice chair is the Chief Inspector of the Metropolitan Police (Merton). The YCEB is the governance structure for Merton in relation to the work of the Youth Justice/Offending Team (YOT), including the Youth Justice Annual Plan, performance and Quality Assurance. It also oversees the partnership response to Serious Youth Violence, Gangs and Troubled Families (known locally

as Transforming Families) (TF). Membership includes Children's Schools and Families (CSF): Children's Social Care (CSC); Youth Justice; LAC, Education Inclusion, Police, Probation and the Clinical Commissioning Group (CCG). The YCEB reports to the MSCB and the Safer and Stronger Partnership reviews the performance of the partnership, the Youth Justice Service as well as wider youth crime issues.

The YCEB's key priorities over the past year have involved maintaining and monitoring the strong performance of the YOT (particularly in relation to the reduction of First Time Entrants into the Youth Justice System and the sustaining of low numbers for young people who are sentenced to custody); delivering and extending the TF programme and reducing the levels of serious youth violence and gang activity in the borough. The YCEB also seeks to ensure that key partnership work continues which ensures that the key aim of the Crime and Disorder Act (1998) is achieved which is to prevent offending and re-offending in young people. We have also been overseeing the impact of the C&F Act of 2012 in relation to the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) requirements. The introduction of this Act means that when a young person is remanded to custody for an offence, they become LAC.

Family and Adolescent Services is a strand within Social Care ,Youth Inclusion and CSC that delivers a range of government prescribed and legislated functions to children at risk of harm, children in care, care leavers and young offenders, as well as wider services for families. A number of the interventions are targeted with the aim of providing an intervention before problems escalate within a family or that of a young person. This involves working closely with schools, academies, the Police and the Education Welfare Service. This work has included contributing to the CSF Equalities Action plan and actions are now in place to ensure that young people from deprived wards in the borough are supported. An example of this work is the Performance Reward Grant (PRG) Phipps Bridge (ward) work, which is focused on reaching and supporting young men from Black, Asian and minority ethnic (BAME) and White working class backgrounds.

As part of our commitment to continuous improvement, the YCEB monitors the Youth Justice Team's Improvement and Development Plan, which was written before and updated after a successful inspection by Her Majesty's Inspectorate of Probation in 2013. This Short Quality Screening concluded that Merton's Youth Justice Team had made "important changes" when compared to the inspection which took place in 2011.

The improvement and development work includes the consistent use of auditing and the closer scrutiny of cases during the supervision process. We have also enhanced the quality assurance process within the YOT which includes adhering to the management auditing timetable and the use of thematic audits. All key documents, such as Pre-Sentence Reports, are quality assured, 'gate-kept' and monitored prior to presentation at court and there are regular reviews of work. There is evidence that Merton's low custody rates are influenced by thorough assessments and specific interventions which are presented as robust alternatives to custody. Feedback from the local youth court has consistently shown that the quality of Merton's Pre-Sentence Reports are strong and there have been a number of reports commended in recent times.

The YCEB remains committed to the core value of ensuring the voice of the child (VOC) and that this is captured and acted upon. The Online Viewpoint Questionnaire is completed with young people and Merton has exceeded the required target. In addition to this, Youth Board Panels, comprising of young people, meet regularly with the FAS Manager and YOT manager. Feedback is received from young people and suggestions for change are acted upon in order to ensure that the service provided is in line with the needs of the young people that it works with.

The YCEB continues to focus on the Ending Serious Youth Violence (ESYV) agenda. The objective is to target more high risk offenders and Merton joined the Home Office's 'Ending Serious Youth Violence' programme in 2013. We recognise that a multi-agency approach is essential in tackling this issue. Subsequently, we continue to work closely with key partners such as the Police, CSF, Education, Health and the Voluntary sector. The MOPAC funded Gangs Worker continues to provide support to young men vulnerable to being caught up in gang-related crime and anti-social behaviour. Also a gangs' matrix has been developed between the Police and Family and Adolescent Services and assists with the review of cases at the Youth Offender Management Panel (YOMP). This year saw the launch of the MOPAC Projects and Gangs Multi-agency Panel (MOPAC/GMAP), in conjunction with CSF and the Police, which strengthens this work and focussing further on gangs nominals and those relevant young people who are transitioning into adulthood with significant concerns in this regard. The YCEB assists with the reviewing and monitoring of these essential pieces of work.

Assessment Intervention and Moving on (AIM) training has been delivered to CSC and members of the Youth Inclusion Team in order to support assessments, interventions and practice with young people who display sexually harmful behaviour. The Assessment Planning Panel (APP) has been launched and it will help plan treatment and support packages for young people who display sexually harmful behaviour. The YCEB also has oversight of this significant work and agenda, which is significant because sexual offences are one of the few types of offences which have seen an increase in London in recent years.

Merton CSF also focuses on the Child Sexual Exploitation agenda especially with regards to reducing the vulnerability of children and young people. This is done through the work of the Multi-Agency Sexual Exploitation (MASE) Panel and the Youth Offender Management Panel (YOMP). A MOPAC funded Young Women and Girls Worker helps support some of the most vulnerable young women in the borough who are affected by this area via criminal and/or gang links. The YCEB also has oversight of this significant work.

The YCEB and its oversight have proved highly effective in Merton, particularly in the past year. Indeed, despite significant challenges, where levels of youth violence saw an increase of more than 15% across London and despite Merton being bordered by boroughs with some of the highest levels of youth crime and violence in London (e.g. Lambeth and Croydon), Merton's performance in relation to the agenda has been strong. For instance, Merton's First Time Entrants figures are well below the London, National and YOT comparison data with a 9.7% reduction for the year. Similarly impressive is the fact that Merton has some of the lowest levels of young people sentenced to custodial sentences and of serious youth violence prevalence in London.

7.7 Violence Against Women and Girls (VAWG) Sub-Group

The Merton VAWG Strategic Board meets four times per year. The VAWG Board's strategic aims are to engender an integrated, evidence-based and outcomes-focused approach to tackling all forms of VAWG across the borough. Over the next four years the partnership will foster and develop an approach which coordinates strategic and operational planning alongside activity from a wide range of partners involved in addressing VAWG issues.

The strategic aims promote closer coordination in the areas of identification and reporting of VAWG, strategic planning, commissioning, delivery of interventions and services alongside monitoring of outputs and outcomes. In so doing, they strive to create effective and efficient responses to VAWG. We aim to meet the needs of all those who are victims/survivors and/or perpetrators of VAWG, as well as those who are at risk of the same.

The strategic aims outline four priority areas in tackling VAWG and domestic abuse, which are:

1. Providing accessible, evidence-based, holistic support to people who have experienced or are at risk of VAWG.

2. Implementing effective systems and interventions for working with perpetrators.

3. Fostering an integrated and coordinated approach to tackling VAWG.

4. In order to deliver the four strategic aims this action plan is split into to four priority themes;

    1. Coordination: to develop a coordinated multi-agency approach by ensuring that the response to VAWG is shared by all stakeholders, embedded into service plans and coordinated effectively.

    2. Prevention: to change attitudes and prevent violence by raising awareness through campaigns; safeguarding and educating children and young people; early identification, intervention and training.

    3. Provision: to improve provision and specialist support services which are essential in enabling people to end violence in their lives and recover from the damaging effects of abuse by providing a range of services to meet the needs of victims and survivors; practical and emotional support, emergency and acute services; access to legal advice and support, refuge and safe accommodation.

    4. Protection: to provide effective response to perpetrators outside of and within the criminal justice system through effective investigation; prosecution; victim support and protection; perpetrator interventions.

7.8 MASH Strategic Board

The purpose of the MASH Strategic Board (MSB) is outlined as follows:

- To provide assurance to the MASH Leadership Group
- To review the performance of MASH against individual agency Performance Framework and MASH Performance Framework
- To Review the function of the hub
- To identify future development/changes for the hub

The MSB meets each month and membership of the Board includes:

- Merton Adult Services
- Merton Borough Police
- Merton CSF: Children's Social Care, Education & Early Years
- Merton CCG, Commissioner of community health services
- Merton Housing Services

The MSB is accountable to the MSCB. An annual report will be submitted and presented to the MSCB and the MASH Group by the Chair who shall brings to the attention of the Board and the MASH Leadership Group issues relating to performance, the future direction of the MASH, operations, issues, blockages etc.

7.9 Structure and Effectiveness of the MSCB

In 2014-2015 the Board undertook a review of its structure and constitution. The focus of this review was to streamline the work of the Board for increased effectiveness (see appendix 3). These changes were embedded in 2015-2016 and there is evidence that these changes beginning to pay dividends in terms of the Board's increased effectiveness and impact.

The Board has 100% compliance with its section 11 process for statutory agencies. This was supported by a rigorous Peer Review and Challenge process to which challenged each agency to demonstrate their effectiveness in safeguarding and promoting the welfare of children locally.

The MSCB has clear thresholds which are clearly understood throughout the safeguarding system. This is known locally as the Merton Well-Being Model and Common And Shared Assessment).

The MSCB has a robust Multi-Agency Training programme which works to ensure that the multi-agency children's workforce has access to high quality, multi-agency training. This programme is evaluated as being very good by the members of staff attending courses.

The Board is assured by partner agencies regarding their recruitment and supervision of persons who work with children as part of our Section 11 process. There are arrangements in place for the LADO and there has been a significant increase in LADO referrals and consultation in 2015-2016. The Board also receives the private fostering annual report in January each year.

The Board works in cooperation with neighbouring children's services including peer review; joint services with Sutton, contributing to SCRs and learning (Croydon, Wandsworth, Kingston and Sutton).

The Board communicates with persons and bodies including schools, parents, educational settings, temples, churches, Mosques, other voluntary organisations, health providers and a range of other statutory and voluntary services by telephone, online, in person, through conferences, events, briefings etc. regarding safeguarding. The Board elicits feedback on its communication to ensure that this is effective.

The Board also quality assures the quality of safeguarding and promotion of children's welfare, through the monitoring of key performance data; multi-agency, single agency audits ensuring that the learning from audits and other quality assurance activity is cascaded across the children's safeguarding system.

The Board contributes to the planning of services for children in highlighting priorities for service delivery and service design. For example, the Board's Annual Business Plan is informed by the Joint Needs Strategic Assessment.

Since the last inspection (January 2012), the MSCB has:

- 7 serious incident notifications have been submitted to Ofsted by the MSCB
- completed one SCR (TS)
- The MSCB are currently conducting a SCR(Child B)
- The MSCB have completed 2 learning and improvement reviews (Child J and Baby PP)
- The MSCB are currently undertaking 1 learning and improvement review (Child C)

7.10 MSCB Budget

The MSCB has an agreed budget and all agencies contribute. Its income for 2015/16 was £228,470. The MSCB Budget for 2015-2016 is detailed as follows:

Brought forward from 2014-2015	£18,642
Income for 2015-2016	
Agency Contributions	
CAFCASS	£550
London CRC	£1,000
London Probation Service	£1,000
London Borough of Merton	£142,030
Merton CCG	£35,000
Metropolitan Police	£5,000
Sub-total	**£184,580**
London Borough of Merton Baseline supplement[10]	£43,890
Total	**£228,470**

Expenditure	
Staffing	£144,170
Premises	£2000
Supplies and Services	£80,460
Transport	£1,840
Totals	**£228,470**
Brought forward from 2015-2016	£0.00

[10] In 2015-2016, the MSCB Expenditure exceeded income from Agency contributions; LB Merton therefore supplemented the MSCB Budget.

8.0
Sub-Group Task and Finish Group Summary Reports/Effectiveness

8.1 Prevent Task and Finish Group

The MSCB appointed a task and finish Group to review Merton's response to radicalisation and extremism and to develop some guidance for those working with children and young people who are vulnerable to the messages of radicalisation and extremism. This guidance was developed in the context of the Government's overarching counter-terrorism strategy 'CONTEST' and the 'Prevent Strategy' and the Counter Terrorism and Security Act 2015. The group has completed its work and has prepared guidance for professionals and advice to parents and carers which were approved by the Board May 2015.

8.2 FGM Task and Finish Group

Public Health reported to the Board in September 2015 regarding FGM in Merton. Under the oversight of the Policy Sub-Group, the FGM task and finish Group were re-launched and commissioned to a draft strategy an FGM strategy that would be presented to the Board for approval in March 2016. The Strategy and its implementation plan were approved by the Board.

8.3 Neglect Task and Finish Group

A task and finish Group was also appointed to develop a strategic multi-agency response to the issue of neglect in March 2015. The Group reviewed data sources for monitoring neglect by child and by family, reviewing thresholds especially with regards to chronic neglect, exploring the issue of parental capacity, motivation and ability to sustain positive change with regard to providing good enough care, reviewing knowledge and skills across the CSF and proposing a draft MSCB strategy for tackling neglect: including parenting support and early intervention, health, education (across early years, primary and secondary phases) early help (CASA), MASH, CIN and CPP. As a result a MSCB's Multi-Agency Neglect Strategy and its implementation plan was approved by the Board in September 2015. We want to ensure that all people, including managers and practitioners, who come into contact with children and young people who may be at risk are able to

1. Identify children at risk of neglect at the earliest opportunity; in order to reduce the numbers of children experiencing neglect;

2. Respond promptly and effectively to address the underlying factors;

3. Maintain our focus on the experiences of children;

4. Minimise the long term effects of childhood neglect and provide therapeutic support to overcome these;

5. To ensure that the importance of neglect and its incidence is recognised by all partners in the strategic planning and service design.

We want to ensure that there is seamless provision of help and support for children, young people and their families across thresholds and pathways for help. We will do this by:

- Ensuring early help and identification regarding neglect are specifically covered within Partners' 'early help' protocols and procedures
- Ensuring that there is a joint working protocol with adult services that is effective
- Tasking the Policy Sub-Group with working with the Children's Trust to review the Early Help Strategy to ensure that it is explicit about identifying and responding to childhood neglect
- Working closely with the Health and Well Being Board, the Safeguarding Adult Board and Commissioners in order to highlight the impact neglect can have on the wellbeing and safety of children

8.4 The Performance Management Dataset

The Board commissioned a task and finish group to review the MSCB's Performance Management Dataset. At the time the Board's Performance Dataset was unwieldy, characterised by being data rich and poor on analysis – the dataset comprised over 300 separate lines of multi-agency performance data. The task and finish group was tasked to reduce the KPIs and bring them in line with the DfE's Children's Safeguarding Performance Information Framework, published in January 2015. The revised Performance Management Dataset was approved by the Board in May 2015.

8.5 The Self-Harm Task and Finish Group

The Board also commissioned a task and finish group to draft a self harm protocol. The purpose of the protocol is to support all professionals working with children and young people (0 -18 in Merton) and to support young people in order to reduce self-harm incidents by:

- Supporting agencies to timely manage self-harm as it arises
- Improving the response on presentation, disclosure or suspected signs of self-harm
- Improving the quality of support, advice and guidance offered by all workers who work with children and young people

The protocol is due to be approved by the Board in June 2016.

8.6 Learning & Improvement Reviews and Serious Case Reviews

A Serious Case Review is a case where the abuse or neglect of a child is suspected and ether the child has died or has been seriously harmed and there is cause for concern regarding how professionals and organisations have worked together to safeguard the child. The purpose of an SCR is to seek to understand what happened and why it happened in the context of local safeguarding systems rather than solely the actions of individuals relating to a single case. SCRs are an opportunity for multi-agency learning rather than blame. In 2015-2016 the MSCB commissioned a SCR. This SCR is referred to as Child B. This SCR is still in process and it is hoped that the report will be ready for publication in October 2016.

The Board also commissioned a Learning and Improvement Review (LiR). This LiR is referred to as Baby C. This case did not meet the statutory threshold for a SCR but the Board considered that there was significant learning from this case which would provide a 'window' into the multi-agency safeguarding system. It is expected that the LiR will be completed in November 2016

The key learning points emerging from the SCR:

- Information sharing between agencies
- The effectiveness of multi-agency working
- Domestic abuse (especially understanding of violence with the context of mental health), substance misuse and mental health – the need of updated protocols and to ensure that these are followed
- Whole family assessments (especially the role of men within families)
- Use of written agreements especially with regard to mental capacity and poor mental health (monitoring and contingency planning)
- Effective use of escalation within the safeguarding system
- Management oversight and supervision
- Multi-agency management of incidents of self-harm
- The need to overcome errors in things such as rule of optimism (believing that things are alright despite evidence to the contrary) and confirmation bias (accepting only evidence which confirms professional assumptions)

The key learning from the LiR include:

- Recognition of safeguarding concerns:
- Understanding parental mental capacity and how learning difficult impact on parenting
- The importance of bruising to pre-mobile babies, as an indication of Non-Accidental Injury (NAI)
- The need to recognise significant weight loss in babies as a possible indication of neglect
- 'Trigger trio': depression; poor mental health, drug and alcohol abuse and in domestic abuse and the risks these pose to children
- Impact of learning disability on parenting capacity: the need for this to be sufficiently recognised or assessed?
- The voice of the child and consider their experience in the home environment

9.0
Agency Effectiveness in Safeguarding – reports for each key agency drawing on Section 11 and QA and Challenge Meetings

9.1.1 Section 11

The Board holds partners to account through its Section 11 Quality Assurance and Peer Challenge Process. The Board also receives annual reports from the Children's Trust, the VAWG Group and Public Health[11].

The Board Section 11 process is robust and provides good assurance regarding the quality of partners' commitment and prioritisation of safeguarding. All agencies support the work of the Board by attending and contributing at Board meetings and meetings of the Board's Sub-Group. The Quality Assurance and Challenge Meetings for 2015-2016 were arranged as follows:

1. Children, Schools and Families (24 June 2015)
2. Health Services (24 June 2015)
3. Police, Probation and Community Safety (30 June 2015)
4. Community and Housing Services (30 June 2015)
5. Adult Social Care (19 August 2015)
6. Mental Health Services including CAMHs (17 November 2015)

These Challenge meetings included a review of Section 11 Compliance, analysis and discussion of each agencies' self-review of work to safeguard children during April 2013–March 2014; including relevant agency data showing impact of safeguarding children from the agency's perspective, the agency's performance against the MSCB dataset and key performance indicators. The Challenge meetings also considered each agency's implementation of learning from the TS SCR. Each agency was also asked to comment on its compliance to relevant safeguarding legislation and statutory guidance including Working Together 2015 and Keeping Children Safe in Education 2015.

[11] Evidence includes minutes of Board Meetings, the notes of the Section 11 Challenge Meetings, Section 11 Returns, QA Minutes, notes of multi-agency audits, the Board's Business Plan.

Twenty two Agencies/organisations completed twenty three self evaluation forms (the Metropolitan Police provided two Section 11 self-audits for CAIT and Borough Command)

These are detailed as follows:

1. CAFCASS
2. Carers Support Merton
3. LBM Adult Social Care
4. LBM Children, Schools and Families (including Children's Social Care)
5. LBM Safer Merton
6. LBM Early Intervention and Prevention
7. LBM Early Years
8. LBM Education Inclusion
9. LBM Housing Needs
10. LBM Youth Justice
11. London Community Rehabilitation Company Probation
12. Merton Voluntary Service Council
13. MPS Borough-wide Command
14. MPS Child Abuse Investigation Team
15. National Probation Service
16. NHS Community Health, Royal Marsden
17. NHS – Epsom and St Helier
18. NHS – Merton Clinical Commissioning Group
19. NHS – South West London and St George's Mental Health Trust
20. NHS – St George's Trust
21. Public Health
22. Parkside Hospital

Overall good progress is being made in meeting the section 11 standards. Agencies were asked to submit additional evidence and this evidence was reviewed and challenged in the Challenge Meetings.

National or regional services (such as, CAFCASS and Probation) submitted more 'global' self-assessments were asked to ensure that there is an addendum which gives assurance for Merton.

A challenge across a number of agencies was demonstrating how the views of service users were being taken into consideration in service design and service planning – although on challenge it was noted that more consultation and involvement with young people was being done than had been described in the self-evaluations.

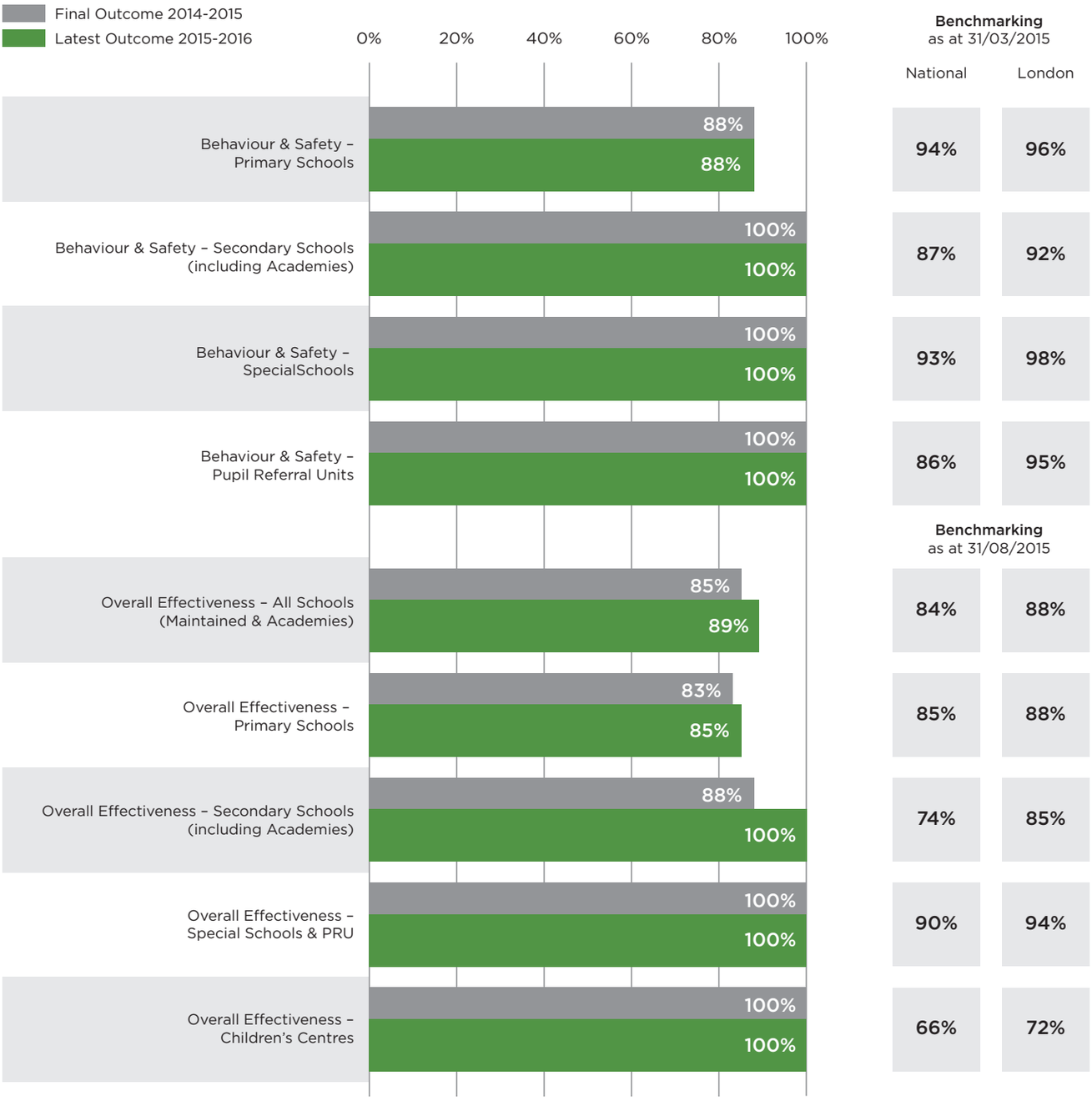
Schools were not asked specifically to complete a section 11 audit in this round. A safeguarding systems audit for each school had been undertaken in the Autumn term 2014 and reported to the MSCB In January 2015. This was repeated in the Autumn term 2015. This will be reported to the MSCB. In this round of audits the Local Authority and other Agencies' support to schools and involvement of schools in the MSCB was reviewed.

Agencies where offering services to children and young people was not a core task, were seen to have greater challenges in meeting the standards – it was agreed that the MSCB would offer them more assistance to understand and make arrangements to meet the standards, where necessary.

It was agreed that the Peer Challenge was helpful and that it was valuable to involve a Lay Member, where possible. The involvement of Commissioners was also seen as helpful as it enabled the Chair and the Director of Children, Schools and Families to challenge commissioned services regarding improving the quality of their safeguarding practice.

9.1.2 Schools

Ofsted inspection outcomes rated Good or Outstanding



Merton Schools contributed to the Section 11 audit and formed part of the CSF Section 11 return.

9.2 CSF department

CSF department completed section 11 audits for CSC; Early Years; the Youth Service, Education Inclusion and the FAS (including Youth Justice).

We have evolved our structures to deliver to larger numbers of children and young people and meet the challenges of a range of initiatives. We have increased our number of social workers, provided reasonable caseloads and continue to focus on reducing agency rates. We will maintain our sharp focus on this going forward.

There has been a very challenging recruitment and retention context nationally, in London and particularly for SW London. Despite these challenges Merton has appointed 50+ permanent social workers since Jan 2015. We have endeavoured to maintain good quality of recruits and despite the challenges have rejected a number of candidates post references over the same period.

We have a recruitment and retention action plan and will continue to maintain our focus generally but will also focus on specific hotspot recruitment areas such as: Children With Disabilities, MASH, Quality Assurance (QA). We now have a strong pipeline of student social workers including Frontline colleagues and a sufficient flow of ASYEs. We will continue to maintain our strong focus on this work.

Our professional development activity and strengthened approach to QA, combined with active performance management, are increasingly enabling the challenge and support for improving practice. We want to ensure that all practitioners are supported and work to the highest levels of competence in line with our ambitions and expectations; we both invest in the development of our workers and tackle underperformance. Our developing use of "Signs of Safety" and motivational interviewing techniques are providing useful tools for working with families and adolescents as well as enabling active discussion with regard to pedagogy and practice. This work will need to be sustained going forward.

The implementation of the major changes arising from the Children and Families Act 2014 relating to education, health and care planning for children with SEN and disabilities remain on-going. With strong engagement of partners from the NHS, community organisations sectors and parents/carers, we have established an integrated Education Health and Care service and published our Local Offer. We are now focusing on embedding new procedures and ways of collaborative working which will support more integrated planning and more effective working with this group of children, young people and their families.

To deliver our shared ambitions we will continue to provide leadership and governance through our MSCB partnership identifying and addressing our priorities for improvement. To support us in this we will utilise our anticipated new casework system to further develop our use of data both for identifying underperformance at a case, team or service level as well as for the development, commissioning and prioritisation of services. We will use our continuous improvement agenda to deliver sustained improvements where issues are identified and to maintain our ambitions for all our services to be good or better.

As we start 2016-2017 with a more stable workforce we expect to accelerate the pace of our improvements and will also be looking to implement improvements from a recent external review of our MASH as well as plans to review our Children and Young Persons Well-Being Model, the step up, step down process and the continuum of specialist, enhanced and wider services for children and families in line with the emerging MSCB priorities 2016-2017.

9.3 Acute Trusts

Merton does not have an acute trust located in the Borough however there is an effective relationship with acute trusts in the neighbouring boroughs of Sutton, Wandsworth, Croydon, Lambeth and Kingston

9.3.1 Sutton and Merton Community Health Service and the Royal Marsden Trust

The Trust and the service provider completed a Section 11 Self-audit and attended Quality Assurance Challenge meetings, which gave the Board assurance that the Trust is fulfilling its statutory duties under Section 11 of the Children Act 2004.

9.3.2 SW London & St George's Mental Health Trust

South West London and St George's Mental Health Trust completed Section 11 Self-audit; this was undertaken at a time of considerable organisational change due to a major transformation programme.

9.3.3 Epsom and St Helier NHS Trust

The Trust and the service provider completed a Section 11 Self-audit and attended Quality Assurance Challenge meetings, which gave the Board assurance that the Trust is fulfilling its statutory duties under Section 11 of the Children Act 2004.

9.3.4 NHS Merton Clinical Commissioning Group (CCG)

The Merton CCG has completed a Section 11 Self-audit and has attended Quality Assurance and Challenge meetings which gave the Board assurance that the CCG is fulfilling it statutory responsibilities under Section 11 of the children Act 2004.

9.3.5 St George's Hospital NHS Trust

The Trust completed a safeguarding survey as part of their Section 11 submission to the Board. The Trust also provided a range of supplementary evidence which gave the Board assurance that the Trust was fulfilling its statutory responsibilities in relation to Section 11 of the Children Act 2004.

9.3.6 Central London Community Healthcare NHS Trust

The Trust was awarded the community health care contract from the first of April 2016. The trust completed their Section 11 submission to the Board for 2016. The Trust also provided supplementary evidence which gave the Board assurance that the Trust was fulfilling its statutory responsibilities in relation to Section 11 of the Children Act 2004.

9.3.7 Public Health

The Director of Public Health sits on the Board and is a strong partner. The Director of Children, Schools and Families is also a member of the Health and Well-being Board. The JSNA also informs the priorities of the Board's Bi-Annual Business Plan. Public Health completed a Section 11 Self-audit that gave the Board assurance that the Public Health is fulfilling its statutory responsibilities in relation to Section 11 of the Children Act 2004.

9.4 Community and Housing Dept. - London Borough of Merton

Community and Housing Department completed Section 11 Audits for Public Health, Adult Social Care and Housing and participated in the Quality Assurance Challenge Meetings. Representatives of the Housing Needs team and the Safeguarding Manager of Circle Anglia, Merton's largest housing provider attends meeting of the Board

9.5 Corporate Service – HR – London Borough of Merton

A section 11 audit of the council's safer recruitment and employment practices was undertaken. The council has also re-issued advice to schools in the period covering revisions to the vetting and barring arrangements and on the new DfE guidance on disqualification by association.

9.5 Metropolitan Police/Probation/Cafcass

Regional Section 11 returns have been completed by all three organisations. The Metropolitan Police have completed returns for the Borough Command and CAIT. The police have included local information and analysis.

10.0
Views of Children and Young People and the Community

Merton's Children's Trust User Voice Strategy implements one of the core ambitions of Merton's Children's Trust and the MSCB namely, demonstrating that the views and ambitions of children and young people have informed and improved our service offer.

The strategy is also part of the Children's Trust's implementation of key legislation, policy and guidance: The Children Act 1989 and 2004 recognises children as citizens with the right to be heard and requires that when working with children in need, their wishes and feelings should be ascertained and used to inform making decisions. The Children and Families Act 2014 section 19 requires that children, young people and families should be involved in decision making at every level of the system. And, Working Together 2015 states that one of the key principles for effective safeguarding arrangements in a local area is to take a child centred approach: 'for services to be effective they should be based on a clear understanding of the needs and views of children'.

Merton's Children and Young People's Plan 2016-19 identifies priority areas of work to close gaps and improve outcomes for Merton's most vulnerable groups. This year, we can report on user voice activity which has involved each of the vulnerable cohorts including: those in need of early help; children in need of help and protection; looked after children and care leavers; children with special educational needs and disabilities; those at risk of disengaging from school and beyond; and those at risk of offending.

This year we have ensured that children and young people's views are central to decisions about their care. A very high proportion of visits (94%) and reviews (100%) for children subject to a child protection plan, and reviews (99%) for those who are looked after have been conducted within timescales with 90% CYP participation at LAC reviews.

In order to ensure that the views of children, with all levels of ability, and their families inform the CP process social workers have been trained in the child/ family centred Signs of Safety approach, and have also been trained in gathering the views, wishes and feelings of children with disabilities/ communication difficulties. In addition we have continued to support children and young people to participate in CP Conferences either by attending, or through an independent advocate.

Ninety per cent of LAC participated in their LAC review either through attendance, completion of consultation papers, or through an advocate (for additional information on LAC participation see section 4.2.3.i of this report).

Providing opportunities for children and young people to influence key decision makers

Through a range of forums and groups including the Children in Care Council, Merton Youth Parliament, Young inspectors, the Your Shout Group for learning disabled young people and school councils, Merton's young people's voices have informed and impacted on a broad range of issues which affect young people's lives including:

- review and refresh of licensing policy in town centres,
- feedback to Transport for London on the accessible transport for disabled people,
- the new 'Child House' support model for those affected by sexual abuse,
- LAC placements and Care leavers accommodation
- school reviews and improvement plans,
- Youth Generator funding for young people's activities,
- Merton's Child and Adolescent Mental Health Service Strategy (CAMHS),
- the Anti-Bullying Operational Group refreshed action plan,
- support for young LGBT people,
- and recruitment to senior positions in schools and children's services.

Merton's service user forums and target cohorts have been supported to feedback on the quality of our offer to them, and to effect positive improvements to our service provision. Notable examples include:

Children in need of help and protection – user views on the experience of our Social Work Intervention service is used to inform quarterly improvement plans for the service. Views of a number of children, who have used the commissioned service for missing children, have been used to inform recommendations for the Police service and the Home Office as featured in the HMIC report Missing Children: who cares? Feedback from users of our Contact Service has informed recommendations for improvements to the service including improved information about and scheduling of contact, and increased options for contact arrangements with older teenagers.

Feedback from parents of children with Special Educational Needs and Disabilities (SEND) shows that our Information and Advice Support Service for SEND is invaluable for helping families through the EHCP process and preventing tribunals. Young people were consulted and contributed to the 'look and feel' of the refreshed Family Services Directory which includes Merton's 'Local Offer'.

Other vulnerable cohorts of Young People:

- As a result of feedback from young people in the Youth Justice System, workers, in their sessions with young people, have increased their to focus on the needs of the young person, identifying the skills they need and signposting to local projects that can help build these skills.
- Feedback from the forum for young people who are supported by the Education, Training and Employment team highlights that staff have an increased understanding that user views are key to ensuring that assessments and plans are as comprehensive as possible.
- In response to feedback from parents involved in the Transforming Families programme practitioners are now revisiting the 'family plan' at more regular intervals so that families are fully aware of targets and expectations.

11.0
Conclusions and Priorities for 2016–18 Business Years

The Board is on a journey of continuous improvement; seeking to sharpen our focus and streamline our processes so that we are increasingly able to fulfil our statutory responsibilities in relation to safeguarding children and young people and promoting their welfare.

In 2015-2016 we embedded the processes agreed in the revised constitution of the Board in 2014-2015. As a result the Board has continued to be rigorous in its work. Our partnership is mature and robust and is characterised by respectful challenge and accountability. The Sub-Groups are purposeful and targeted on delivering on the Board's agreed priorities. The Board's Performance Dataset allows the Board to analyse trends and identify risk or gaps as well as prioritise areas for development.

At the Board's Annual Away Day it was agreed that the Board would focus on fewer priorities whilst continuing to deliver on a range of key 'Business a Usual' safeguarding issues. In agreeing the Board's priorities for 2016-2018, there was a robust discussion with presentations from partner agencies on their agency's strategic priorities. Members of the Board then agreed the following priorities for the next 24 months:

1. **Think Family – to support children and adults in our most vulnerable families to reduce risk and ensure improved outcomes. Signs of vulnerability include**

The MSCB wants to ensure that our partnerships continue enable the most vulnerable families to be supported; so vulnerable parents are supported to care for their children and children are in turn supported to thrive and achieve their potential. Evidence from local and national research tells us that our most vulnerable parents/families are those who:

- Experience poor mental health,
- Struggle with substance misuse,
- Are affected by domestic abuse,
- Parents with learning difficulties or learning disabilities that may affect their ability to respond to the changing needs of their children

The evidence nationally and locally also shows that vulnerable families are best supported when there is effective joint working between adult and children facing services. When professionals understand the underlying causes of issues like neglect and other form of abuse and offer effective support early before these problems get worse.

2. **Supporting Vulnerable Adolescents – adolescence is a time of significant change for all young people.**

We know that, for some young people, adolescence is a time of particular vulnerability. We are determined to support adolescents who are at risk of:

- Child Sexual Exploitation (CSE),
- Children who go missing from home/ school/care
- Children and young people who are at risk radicalisation and violent extremism,
- Children at risk of serious youth violence and gangs
- Self-harm and poor mental health
- Suicide

3. **Early Help – To develop an early help system that is responsive and effectively prevents escalation of concerns.**

Merton has had a long-established child and YP Well Being Model which we last reviewed in 2013. With changes in local providers and agencies and with changing levels of resources available we need to ensure our Model continues to be fit for purpose. The evidence shows that timely and purposeful help or intervention at all stages of a child or young person's journey is the most effective way improving impact and outcomes for vulnerable children, young people and families. As part of our review we will:

- Take forward the learning from our recent MASH review
- Consider the interface between our MASH and EH arrangements
- Review our service offer at all levels of the Model and Engage partners in discussion on thresholds, Step-Up Step Down processes and the tools to support early help assessment CASA and intervention (Signs of Safety/signs of well being)
- Review our partnership quality assurance of EH

This Business Plan contains the MSCB priority actions. The on-going work of the MSCB and its Sub-Groups and Task Groups continues alongside it and will be incorporated into the Sub-Groups' annual work plans and reporting cycle to the MSCB.

The MSCB continues to work to drive improvements in the quality of safeguarding practice in Merton. The partnership remains strong and is well positioned to meet the challenges ahead.

Appendix 1
Merton Safeguarding Children Board Business Plan 2016–18

Progress of this Plan will be updated monthly & monitored at each MSCB Meeting. Approved by Business Implementation Group.

Introduction

Merton Safeguarding Children Board aims to ensure that local services work knowledgeably, effectively and together to safeguard children and young people and to support their parents.

As part of our continuous improvement approach the Board has identified some key development priorities for 2016/17. These link with our business as usual work plan undertaken by the MSCB and its Sub-Groups. Alongside these priorities we are also is seeking to improve our Quality Assurance and Learning and Improvement System to ensure that there is clear understanding of the complexity of work to protect children at the frontline. The Board continues to seek to improve its links to practitioners and their managers as part of our quality assurance processes to inform service improvement and development as well as maintaining our strong focus on the Voice of the Child/Young person.

Priorities for this business year are:

1. **Think Family – to support children and adults in our most vulnerable families to reduce risk and ensure improved outcomes. Signs of vulnerability include:**

Following on from our successful 2015/16 annual conference in partnership with adult services, the MSCB wants to ensure that our partnerships enable the most vulnerable families to be supported; that vulnerable parents are supported to care for their children and children are in turn supported to thrive and achieve their potential. Evidence from local and national research tells us that our most vulnerable parents/families are those who:

- Experience poor mental health,
- Struggle with substance misuse,
- Are affected by domestic abuse,
- Parents with learning difficulties that may affect their ability to respond to the changing needs of their children

The evidence nationally and locally also shows that vulnerable families are best supported when there is effective joint working between adult and children facing services. When professionals understand the underlying causes of issues like neglect and other form of abuse and offer effective support early before these problems get worse.

2. Supporting Vulnerable Adolescents – adolescence is a time of significant change for all young people.

We know that, for some young people, adolescence is a time of particular vulnerability. We are determined to support adolescents who are at risk of:

- Child Sexual Exploitation (CSE)
- Children who go missing from home/ school/care
- Children and young people who are at risk radicalisation and violent extremism
- Children at risk of serious youth violence and gangs
- Self-harm and poor mental health
- Suicide

3. Early Help – To develop an early help system that is responsive and effectively prevents escalation of concerns.

Merton has had a long-established child and YP Well Being Model which we last reviewed in 2013. With changes in local providers and agencies and with changing levels of resources available we need to ensure our Model continues to be fit for purpose. The evidence shows that timely and purposeful help or intervention at all stages of a child or young person's journey is the most effective way improving impact and outcomes for vulnerable children, young people and families.

As part of our review we will:

- Take forward the learning from our recent MASH review
- Consider the interface between our MASH and EH arrangements
- Review our service offer at all levels of the Model and Engage partners in discussion on thresholds, Step-Up Step Down processes and the tools to support early help assessment CASA and intervention (Signs of Safety/signs of well being)
- Review our partnership quality assurance of EH

This Business Plan contains the MSCB priority actions. The on-going work of the MSCB and its Sub-Groups and Task Groups continues alongside it and will be incorporated into the Sub-Groups' annual work plans and reporting cycle to the MSCB.

New priorities may be added during the year, including any identified risks which will be monitored in the confidential risk log below.

The Plan will be updated and presented to each MSCB meeting by the Board Manager for monitoring and exception reporting.

Objectives		Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
1. Think Family – looking beyond symptoms and supporting families with particular vulnerabilities					
1.1	For the Board to continue to be assured that there are robust and effective strategies, procedures, protocols in place in relation to safeguarding children in cases where parental mental health is a significant factor.	To further clarify the reciprocal responsibilities of the Community Mental Health Team (CMHT) and associated Mental Health Services, and the Children's Social Care Service in relation to those adults who are parents and who have mental health needs, in order to achieve the dual outcome of supporting them as parents whilst ensuring their children's welfare is safeguarded.	To review and refresh the Joint Protocol between Children's Social Care and Adult Mental Health Services. To incorporate the lessons from the Child B SCR into the protocol.	Policy Sub-Group With SAB	Sept 16
1.2	To continue Work With the VAWG Board to review and refresh the Domestic Abuse (DA) Protocol to increase professional awareness and capacity to effectively intervene in cases of domestic abuse.	For the Board continue to seek assurance that there continues to be clear multi-agency guidance on DA and an effective multi-agency response to DA cases and to be assured that this guidance is being following in practice.	To review and refresh protocol with appropriate assessment tools to ensure that our response to cases of DA is consistent and effective.	Policy Sub-Group and VAWG	Jan 17
1.3	The Board will review its guidance to professionals regarding parental substance misuse.	There is a clear and thorough understanding of parental substance misuse and there a joint protocols and procedure in place to ensure effective intervention in cases where parental substance misuse is a feature.	The Board will review its guidance to professionals regarding parental substance misuse.	Policy Sub-Group Adults Safeguarding Board	Nov 16
1.4	Merton Safeguarding Children Board, (MSCB), is committed to reducing the incidence of childhood neglect within the borough. This is a key priority for the Board.	To continue demonstrate improved awareness and understanding of neglect across the partnership in order to ensure that agencies are responding promptly and effectively to address neglect and its underlying factors.	To continue to ensure that the neglect strategy and its implementation is quality assured so that there is a clear view of the MSCB's performance in: 1. Identifying children at risk of neglect 2. Intervention at the earliest opportunity 3. Reducing the actual numbers of children experiencing neglect	Policy Sub-Group QA Sub-Group Learning and Development Sub-Group	Jan 17

Objectives		Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
1.5	The MSCB is assured that the multi-agency **Female Genital Mutilation (FGM) Strategy** is being implemented and young people at risk of FGM are being identified and supported.	To continue to seek assurance that there is professional and community awareness of the issues of FGM. The young people at risk of FGM are identified and supported.	Improve professional awareness of FGM as safeguarding issue by providing training on FGM and Briefings on the Strategy. Ensure that each agency has a plan in place to raise awareness of FGM as a safeguarding issue.	Policy Sub-Group CT/PB/LR QA Sub-Group	On-going at each Policy Sub-Group Mar 17
1.6	To ensure that children and young people continue to be protected from radicalisation and violent extremism.	For the Board to seek continued assured of robust arrangements in relation to PREVENT and radicalisation.	To update the multi-agency guidance and information for parents.	PPYP and Prevent Multi-Agency Partnership Board	On-going by PPYP Sub-Group
1.7	For the Board to continue to seek assurance regarding the quality of frontline practice through themed multi-agency audits.	For the Board to confirm the quality of frontline practice through 3 themed multi-agency audits – highlighting areas of good practice and areas for improvement.	To conduct 3 themed multi-agency audits. To disseminate the learning from audits, LiRs and SCRs.	Quality Assurance Sub-Group Learning and Development Sub-Group	Termly Termly
1.8	To explore the use and application of Signs of Safety and Signs of well-being across partner agencies as part of the review of the Merton Well-Being Model.	To continue to review the range of tools and approaches being used to support children and families in Early Help so that there continues to be consistency of approach through the safeguarding system.	To provide Multi-agency training to DSLs, Health Visitors, School Nurses, Police Officers in Schools and those who attend CP conferences.	Police Education Health Providers Signs of Safety project team	Mar 18
2.1	The Board to continue to be assured that there remains conspicuous oversight of all young people at risk of CSE and to improve the identification and support of young people who are victims of CSE.	To clearly identify victims and perpetrators of CSE; to ensure that victims receive appropriate support and the perpetrators are disrupted and prosecuted; to monitor closely each young person at risk of CSE and to ensure that support is provided to prevent CSE.	To undertake further data analysis to inform strategic planning and inform future CSE/CM Multi-Agency data set.	MASE and PPYP Sub-Groups	On-going at each PPYP Sub-Group
2.2	To continue to seek assurance that all agencies are aware of their roles in prevention and intervention in CSE.	To continue to increase awareness of agencies' roles in effective intervention in relation to CSE.	To provide information for the public including parents on CSE and its risks. To ensure that universal information is available. Specialist and targeted services to ensure parents of YP at risk of CSE can access information and support.	PPYP Sub-Group CSF CSC	Nov 16

Objectives		Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
2.3	To maintain strategic oversight of missing young people in Merton.	Maintain and strengthen oversight of missing young people in Merton.	To incorporate operational and strategic oversight of Young people missing from Home/Care/School in to MASE monthly panel.	CSC & YI, CSE Lead and CA and SD CSC & YI, CSE Lead TBC and Sarah Daly	On-going at each PPYP Sub-Group
2.4	To maintain strategic oversight of LAC placed outside of the borough.	To have oversight of LAC placed out borough.	To use the CSE dataset and the MASE panel and the CME panel to ensure patterns of absence are analysed for risk of CSE as well potential neglect.	CSC & YI SD and CB	On-going at each PPYP Sub-Group
2.5	The Board will continue to seek assurance that is a joined up approach to issues affecting vulnerable young people especially young people at risk from gangs and serious youth violence.	To be assured that there are appropriate policies and procedures in place to ensure that children and young people are safe using the knowledge and expertise of multi-agency partners and mapping systems.	For the MSCB and YCEB to confirm arrangements to address Serious Youth Violence and Gang-related Crime.	PPYP	Sept 16
2.6	To explore the practicability of Transitions Protocol with Adult Social Care to ensure that vulnerable young adults are protected.	Ideally to have in place an agreed protocol that allows both children's and adult services to support vulnerable young people who are 18-24 years old who are not LAC or do not meet the criteria of the Mental Capacity Act 2005.	A Task and Finish Group to draft an protocol that is agreed by the MSCB and the SAB.	A Task and Finish group from both MSCB and SAB	March 17
2.7	The Board will continue to seek to ensure that young people's voices and experiences are heard and reflected in the work of the MSCB.	For the Board to ensure that young people and their views remain at the centre of the Board's work.	To deliver the joint-research project with Southbank University. To develop a youth facing webpage. For members of the Board to meet with groups of young people 3 times per year.	PPYP PB/MSCB	July 16

Objectives		Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
3.1	The Board will oversee the review of the MWBM.	Through the review The Board will seek assurance that thresholds are clearly understood across the safeguarding system.	To review the CASA and MWBM, to ensure that thresholds are clearly understood and effectively applied.	QA Sub-Group	March 17
3.2	The Board will oversee the implementation of our MASH Action Plan.	Insert some of the key deliverables from the action plan.	To monitor the implementation of the MASH review action plan.	QA Sub-Group/ MASH Strategic Board	
3.3	The Board will oversee the review of the service offer in early help.	To ensure that there are clear procedures in place for stepping cases down from CSC into universal and targeted services.	The Board will agree Step-Up -Step Down/ Arrangements between Children's Social Care (statutory) and Early Help (EH) children's services in Merton. To engage partners in discussion on thresholds.	QA Sub-Group Multi-Agency Partners	March 17
3.4	The Board will approve an escalation protocol so that all professional within the multi-agency system have a framework for resolving professional differences in a timely way so that children are effectively safeguarded.	The process for escalation is clear at every level and accords to the London Child Protection Procedures.	To review the Board's escalation procedure in accordance with local needs and the London Child Protection Procedures.	Policy Sub-Group	June 16
3.5	The Board will review the multi-agency partnership Quality Assurance of Early Help to ensure its effectiveness.	For the Board to have assurance of the quality of the early help offer across the partnership.	The Board to undertake a review of the early help offer.	QA Sub-Group and multi-agency partners	
3.6	The Board will continue to seek assurance that the commissioning of early help provision accords with the MSCB's Priorities.	The Board is assured the provision and referral pathways are clearly understood and accords with the Board's agreed priorities.	Map the early help offer and quality assurance arrangements.	QA Sub-Group	March 17

Appendix 2
Merton Safeguarding Context and Performance Summary

This section reviews trends and progress with safeguarding children with high levels of vulnerability. This includes children who need to be supported by a child protection plan and those who need to be in the care of the local authority to keep them safe. It also looks at other cohorts of children and young who have been identified as a priority by the MSCB.

Children in Need

The number of children in need at 31 March decreased this year. There were 1,544 children in need at 31 March 2015 which is a decrease of 4% from 1,603 last year. This follows the national trend where there has been a decrease of 2% on last year, yet London has seen a rise of 3%.

There was a decrease in the rate of children in need per 10,000 in the population from 355.1 in 2014 to 338.3 in 2015. This is in line with national (337.3). There is considerable variability in the rates of children in need between Merton's statistical neighbours and London local authorities. Merton is 7th in comparison with the ten statistical neighbours, 13th amongst London's 33 local authorities.

The number of children in need episodes starting in the year has decreased by 23% in Merton, 6% nationally from last year to 2014-15.

Episodes of need are lasting longer in Merton than nationally and in London, of the episodes ending in the year 28.4% lasted a year or more compared to national 21.3%.

'Abuse or neglect' is the most common primary need at first assessment in Merton but with 40% of the children in need at the 31st March this is below London and national proportions. Nationally and in Merton, 'Family dysfunction' is the second most common need, yet Merton (24%) exceeds London (14%) and national (18%) percentages.

The gender gap of children in need has widened on 2014 with 54% are male, 45% are female and 1% are unborn or of unknown gender.

The age split of children in need also remains similar to previous years. The largest age group is those aged 10-15 years accounting for 30% of children in need; 24% are under 5 years of age. Merton has a larger proportion of children in the older age range and fewer under 5 than nationally and this is mirrored in the comparison with the Merton resident population.

The proportion of children in need with a disability has increased over the last four years although numbers remain stable.

Children from a White or White British and an Asian or Asian British ethnic origin are underrepresented in the Children in Need cohort in comparison with the Merton resident population.

Referrals

Referrals have dropped this year after a larger than usual increase last year. This follows the national trend. There were 1,477 referrals in the year ending 31 March 2015 – down by 15% from 1,745 in 2013-14. Merton has the lowest rate of referral per 10,000 of its population in comparison with its ten statistical neighbours and is 5th of the 33 London boroughs.

As a proportion of all referrals: 4.1% require no further action after initial consideration, below national 13.8%, London 6.9% placing Merton in the middle rank amongst its statistical neighbours and London boroughs; 22.5% are assessed and then require no further action, in line with national and above London rates; and 13.9% were within 12 months of a previous referral, Merton has the lowest percentage in comparison with its ten statistical neighbours and is 14th of the 33 London boroughs.

The police are the most common source of referral, 32%, followed by schools with 18%, and health services with 14%.

Single Assessments

Merton increased the number of Single Assessments undertaken in 2014-2015 from 1,533 to 1,658. The rate of assessments per 10,000 of its population is below national and London. There is considerable variability in the rates of assessments between Merton's statistical neighbours and London local authorities. Merton is 3rd in comparison with the ten statistical neighbours, 9th amongst London's 33 local authorities.

The majority of assessments were completed in the 31 - 40 day of the assessment (42%), with 90% completed with the statutory 45 days. Merton has the third highest completion rate in 45 days amongst its statistical neighbours and 6th highest in London.

Domestic violence, which includes that aimed at children or other adults in the household, was the most common factor identified, flagged in 71.5% of episodes assessed in the year and with assessment factors recorded. This is substantially higher than the 48.2% reported nationally. This was followed by mental health at 52.1%, which incorporates mental health of the child or other adults in the family/household; this is also higher than the 32.5% nationally.

Section 47 enquiries and initial child protection conferences

The number of section 47 enquiries carried out continues to increase this year resulting in more initial child protection conferences: 648 section 47 enquiries were initiated – an increase of 9% on last year.

There were 267 initial child protection conferences carried out, which is a 12% increase on last year.

Where concerns are substantiated and the child is judged to be at continuing risk of harm then an initial child protection conference should be convened within 15 working days. Merton convened 72.6% within the 15 days, this is below national, yet above the London average.

Child protection plans

Merton has fewer children and a lower rate per 10,000 of the population (38.8) subject of a child protection plan at the 31st March 2015 than London (40.6) or nationally (42.9). Merton is in the middle rank position amongst its statistical neighbours and London boroughs.

The durations of child protection plans that end in the year are greater than London and national averages for plans lasting 3 months or less and 2 years and over.

A higher proportion became the subject of a plan for the second or subsequent time. In 2014-15, 16.4% became the subject of a child protection plan for the second or subsequent time which has been steadily increasing from 7.8% in 2011-12. This follows the national trend. Merton is in line with national.

This year, 91% of child protection plans were reviewed within the required timescales. This is down from 93% last year and is below London and National averages. Whilst this decrease is a trend seen in London and nationally, Merton's percentage is the second lowest amongst its statistical neighbours and fifth lowest in London.

Child seen in accordance with their plan has increased to 71.3% in 2014-15 from last year's 53.5%.

The most common 'initial category of abuse' reported when a child becomes the subject of a plan is neglect at 36.3%, followed by emotional abuse (34.5%).

The gender gap of child protection plans is in line with children in need with 54% are male, 46% are female.

The age split of child protection plan children also remains similar for children in need and looked after children with a larger proportion than the national average in the teen age bands.

Children from a White or White British and an Asian or Asian British ethnic origin are underrepresented in the child protection plan cohort in comparison with the Merton resident population.

Performance table summary

Referrals and Assessments

Referrals and assessments								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Referrals	Number	1527	1372	1745	**1477**	n/a	n/a	n/a
	Rate per 10,000	351.5	311.0	386.5	**323..6**	548.3	477.9	456.0
Referrals where within 12 months of a previous referral	Percentage	17.9%	12%	10.1%	**13.8%**	24.0%	15.9%	16.8%
Referrals which resulted in No Further Action	Number	46	33	35	**61**	n/a	n/a	n/a
	Percentage	3%	2.4%	2%	**4.1%**	13.8%	6.9%	6.4%
Single Assessments completed	Number	n/a	n/a	1533	**1658**	n/a	n/a	n/a
	Rate per 10,000	n/a	n/a	333.2	**363.3**	475.2	442.3	440.4
Percentage of Single Assessments completed within 45 days	Percentage	n/a	n/a	81%	**90%**	82%	80%	82%

Children who need help and protection

Children in Need								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Children starting an episode of need	Number	1323	1222	1407	**1417**	**n/a**	n/a	n/a
	Rate per 10,000	304.5	277.0	311.7	**237.7**	**348.0**	355.5	335.4
Children in need throughout the year	Number	2546	2373	2513	**2517**	**n/a**	n/a	n/a
	Rate per 10,000	586.1	537.9	556.7	**551.5**	**674.4**	702.0	635.2
Children ending an episode of need	Number	933	887	910	**973**	**n/a**	n/a	n/a
	Rate per 10,000	214.8	201.1	201.6	**213.2**	**337.1**	331.4	312.4
Children in need at 31 March	Number	1613	1486	1603	**1545**	**n/a**	n/a	n/a
	Rate per 10,000	371.3	336.8	355.1	**338.3**	**337.3**	370.6	322.8

Children in Need								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Children in need at 31 March, by duration of open cases (3 months or less – 91 days)	Percentage	18.7%	17.4%	19.8%	**15.7%**	**25.2%**	24.0%	25.7%
Children in need at 31 March, by duration of open cases (between 3 and six months-183 days)	Percentage	17.2%	10.6%	17.7%	**14.6%**	**12.4%**	11.8%	12.5%
Children in need at 31 March, by duration of open cases (between six months and one year – 365 days)	Percentage	16.9%	19.4%	20.3%	**16.0%**	**14.9%**	14.7%	15.2%
Children in need at 31 March, by duration of open cases (between one and two years – 730 days)	Percentage	22.8%	21.1%	15.2%	**22%**	**16.1%**	16.6%	16.5%
Children in need at 31 March, by duration of open cases (two years or more)	Percentage	24.5%	31.4%	26.9%	**31.7%**	**31.3%**	33.0%	30.1%

Children in Need - Attainment							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
Children in Need Key Stage 2 – percentage Reading Level 4+	Percentage	Data not available	70.2%	**67%**	**62%**	66.2%	64.5%
Children in Need Key Stage 2 – percentage Maths Level 4+	Percentage	56.7%	57.4%	**65%**	**58%**	63%	62.3%
Children in Need Key Stage 2 – percentage Reading, Writing and Maths Level 4+	Percentage	Data not available	48.9%	**46%**	**46%**	52%	50.6%
Children in Need Key Stage 2 – percentage Grammar, Punctuation and Spelling Level 4+	Percentage	Data not available	53.2%	**56%**	**46%**	52%	50.6%
Children in Need GCSE – percentage 5+ A* to C	Percentage	42.1%	41.5%	**23.4%**	**19.2%**	32.9%	31.2%
Children in Need GCSE – percentage 5+ A* to C including English and Maths	Percentage	15.8%	24.6%	**21.9%**	**15.1%**	19.0%	17.8%
Children in Need KS2-4 – percentage expected progress in English	Percentage	29.6%	30%	**28.1%**	**30.6%**	35.8%	33.4%
Children in Need KS2-4 – percentage expected progress in Maths	Percentage	25.9%	36.7%	**27.1%**	**22.9%**	27.0%	23.5%
Unauthorised absence – percentage sessions missed by Children in Need	Percentage	3%	3.7%	**3.5%**	**3.7%**	3.6%	4.0%
Overall absence – percentage sessions missed by Children in Need	Percentage	8.7%	9.3%	**8.6%**	**9.4%**	8.5%	9.1%
Persistent absence – percentage Children in Need classed as persistent absentees	Percentage	12.4%	14%	**14.7%**	**13.8%**	12.4%	13.4%
Exclusion – percentage of Children in Need with at least one fixed term exclusion	Percentage	7.5%	Data not available	**4.92%**	**6.58%**	6.08%	6.12%

* Absence, Exclusions and Attainment data for Children in Need excludes children who were looked after at any point during the year unless those children were also the subject of a child protection plan (as per data represented in DfE Matrix).

Child protection

Section 47 enquiries and initial child protection conferences								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Children subject to S.47 enquiries which started during the year	Number	318	493	593	**648**	**n/a**	n/a	n/a
	Rate per 10,000	73.3	111.7	131.4	**140.0**	**138.2**	137.0	131.6
Children who were the subject of an initial child protection conference which started during the year	Number	223	177	239	**267**	**n/a**	n/a	n/a
	Rate per 10,000	51.4	40.1	52.9	**58.5**	**61.6**	55.9	54.3

Children who were the subject of a child protection plan								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Child protection plans started in the year	Number	192	160	212	**226**	**n/a**	n/a	n/a
	Rate per 10,000	44.2	36.3	47.0	**49.5**	**53.7**	47.4	45.6
Child protection plans ended in the year	Number	139	171	192	**231**	**n/a**	n/a	n/a
	Rate per 10,000	32.0	38.8	42.5	**50.6**	**52.1**	43.4	41.8
Children subject of a plan as at 31 March	Number	173	162	182	**177**	**n/a**	n/a	n/a
	Rate per 10,000	39.8	36.7	40.3	**38.8**	**42.9**	40.6	38.3
Child protection plans reviewed within the required timescales (cases open 3 months or more)	Number	104	118	131	**106**	**n/a**	n/a	n/a
	Percentage	93.7%	97.5%	92.9%	**91.4%**	**94.0%**	95.7%	97.1%
Child protections plans: child seen every 28 days	Percentage	n/a	n/a	53.5%	**71.3%**	**63.7%**	67.4%	70.2%
Children who became subject of a plan for the second or subsequent time	Percentage	7.8%	10.6%	11.3%	**16.4%**	**16.6%**	13.8%	13.7%
Child protection plans lasting two years or more	Percentage	1.4%	3.5%	3.3%	**4.3%**	**3.7%**	4.4%	3.6%

Progress of children looked after and achieving permanence

Looked After Children								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Children in care throughout the year	Number	210	215	253	**255**	**n/a**	n/a	n/a
	Rate per 10,000	48	48	56	**56**	**n/a**	n/a	n/a
Children in care at 31 March	Number	130	140	150	**157**	**n/a**	n/a	n/a
	Rate per 10,000	30	32	33	**34**	**60**	52	47

Looked After Children – Placements								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
NI 62 – Stability of placements – number of moves	Percentage	14.7%	15.7%	12.7%	**14%**	**10%**	n/a	n/a
NI 63 – Stability of placements – length of placement	Percentage	68%	64%	58%	**45.7%**	**67% (3 year rolling)**	n/a	n/a
LAC Placed over 20 miles away	Percentage	19%	14%	17%	**18%**	**18%**	18%	18%
LAC Placed Out of Borough	Percentage				**65%**	**40%**	63%	56%

Looked After Children – Reviews								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
NI 66 – LAC reviews within timescale	Percentage	95.9%	95.9%	97%	**95%**	**Data not available**	Data not available	Data not available
Children in care participation in reviews	Percentage	79%	88%	87%	**88%**	**Data not available**	Data not available	Data not available

Looked After Children – Health								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Children with Health Surveillance checks up to date	Number	12	12	8	**8**	**n/a**	n/a	n/a
	Percentage	86%	80%	100%	**100%**	**n/a**	n/a	n/a
Children who have had their annual health assessment	Number	70	70	79	**82**	**n/a**	n/a	n/a
	Percentage	83%	82%	95%	**94%**	**89.7%**	90.5%	89.2%
NI 58 – Emotional & behavioural health – Average SDQ score	Score	11.4	14.6	12.3	**14.8**	**13.9**	13.2	13.4
Children who have had their immunisations up to date	Number	76	75	79	**75**	**n/a**	n/a	n/a
	Percentage	90%	88%	95%	**86%**	**87.8%**	85.3%	86.1%
Children who have had their dental checks up to date	Number	83	85	69	**83**	**n/a**	n/a	n/a
	Percentage	99%	100%	83%	**95%**	**85.8%**	89.2%	90%
Children who have been identified as having a substance misuse problem	Percentage	18.9%	10.7%	8.4%	**6%**	**4%**	6%	4%

Looked After Children – Education								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Absence from school of children who have been looked after continuously for at least 12 months	Percentage	5.50	3.90		**Data not available**	**4.40**	4.50	Data not available

Adoption

Adoption						
	Merton Single Year 2012/13	Merton Single Year 2013/14	**Merton Single Year 2014/15**	Merton 3 Year Average 2010/13	Merton 3 Year Average 2011/14	**Merton 3 Year Average 2012/15**
A1 – Average time between a child entering care and moving in with its adoptive family, for children who have been adopted (days)	467.2 days	694.9 days	**362.2 days**	685 days	689 days	**530 days**
A2 – Average time between a local authority receiving court authority to place a child and the local authority deciding on a match to an adoptive family (days)	124.25 days	291.7 days	**129.8 days**	256 days	281 days	**193 days**
A3 – Children who wait less than 20 months between entering care and moving in with their adoptive family (number and %)	23% (3/16)	76% (3/12)	**50% (12/24)**	42%	51%	**44%**
A4 – Adoptions from care (number adopted and percentage leaving care who are adopted)	6% (5/85)	9% (10/107)	**7% (8/116)**	7% (19/272)	8% (24/286)	**7% (23/308)**
A5 – The number of children for whom the permanence decision has changed away from adoption	2	9	**1**	n/a	n/a	**12**
A6 – The percentage of black and minority ethnic children leaving care who are adopted	60% (3/5)	50% (5/10)	**25% (2/8)**	26% (5/19)	42% (10/24)	**42% (8/19)**
A7 – The percentage of children aged 5 or over leaving care who are adopted	0% (0/5)	30% (3/10)	**0% (0/8)**	11% (2/19)	17% (4/24)	**13% (3/23)**
A8 – Average length of care proceedings locally (weeks)	n/a	n/a	**n/a**	65 wks	Source Cafcass (numbers too low)	**Source Cafcass (numbers too low)**
A9 – Number of children awaiting adoption	7	5	**16**	n/a	n/a	**n/a**

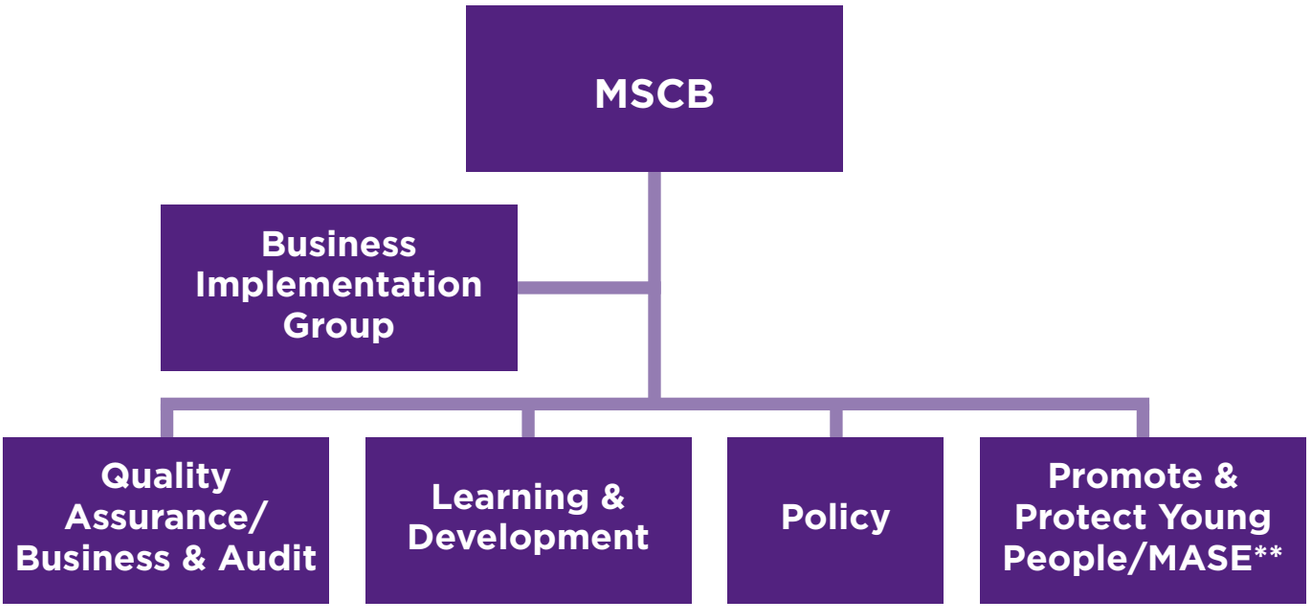
Care leavers

Care leavers								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Total Care leavers	Number	Data not available	Data not available	96	**93**	**n/a**	n/a	n/a
Care Leavers aged 19	Number	Data not available	Data not available	29	**34**	**Data not available**	Data not available	Data not available
	In touch with	Data not available	Data not available	23 (79%)		**Data not available**	Data not available	Data not available
Care Leavers aged 20	Number	Data not available	Data not available	34	**27**	**Data not available**	Data not available	Data not available
	In touch with	Data not available	Data not available	28 (82%)		**Data not available**	Data not available	Data not available
Care Leavers aged 21	Number	Data not available	Data not available	33	**32**	**Data not available**	Data not available	Data not available
	In touch with	Data not available	Data not available	18 (54%)		**Data not available**	Data not available	Data not available
Subtotal Care Leavers aged 19, 20, 21	In touch with	Data not available	Data not available	69 (72%)	**72 (77%)**	**Data not available**	Data not available	Data not available
% of children leaving care over age of 16 who remained looked after until their 18th birthday	Percentage	66.0%	63.0%	65.1%	**80.8%**	**n/a**	n/a	n/a

Care leavers – Accommodation								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
% of young people aged 19, 20 or 21 Care leavers in suitable accommodation	Number	Data not available	Data not available	67.7%	**81.3%**	**80.7%**	83.5%	84.1%
% of young people aged 19 Care leavers in suitable accommodation	Number	88.2%	85.0%	64.3%	**75%**	**83%**	84%	86%
% of young people aged 20 Care leavers in suitable accommodation	Number	Data not available	Data not available	79.4%	**80%**	**82%**	85%	85%
% of young people aged 21 Care leavers in suitable accommodation	Number	Data not available	Data not available	58.1%	**84.4%**	**77%**	81%	82%

Care leavers – Education								
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	**Merton 2014/15**	**National 2014/15**	London 2014/15	Outer London 2014/15
Care leavers aged 19, 20 or 21 not in education, employment or training	Percentage	Data not available	Data not available	48.4%	**44.1%**	39.3%	34.6%	33.1%
Care leavers aged 19 not in education, employment or training	Percentage	17.6%	25.0%	42.9%	**44%**	38%	35%	33%
Care leavers aged 20 not in education, employment or training	Percentage	Data not available	Data not available	55.9%	**32%**	41%	35%	34%
Care leavers aged 21 not in education, employment or training	Percentage	Data not available	Data not available	45.2%	**31%**	39%	35%	32%
Young people aged 19, 20 or 21 who were looked after aged 16 who were in higher education (i.e. beyond A-Level)	Percentage	Data not available	Data not available	11.8%	**7.5%**	6.5%	9.3%	8.3%
Young people aged 19 who were looked after aged 16 who were in higher education (i.e. beyond A-Level)	Percentage	5.9%	10.0%	0.0%	**2.9%**	**5%**	7%	5%
Young people aged 20 who were looked after aged 16 who were in higher education (i.e. studies beyond A-Level)	Percentage	Data not available	Data not available	14.7%	**3.7%**	7%	10%	8%
Young people aged 21 who were looked after aged 16 who were in higher education (i.e. studies beyond A-Level)	Percentage	Data not available	Data not available	19.4%	**15.6%**	7%	11%	11%

Appendix 3
MSCB Structure



** MASE Multi -Agency Sexual Exploitation Group

In addition there are Joint Sub-Groups with Sutton LSCB – namely:

Child Death Overview Panel (CDOP) and the Joint Human Resources Sub-Group
The MSCB will commission Task and Finish Groups as required.

The MSCB Chair may commission a Panel to undertake SCRs or LIRs. (See Appendix Eight)

Reporting
Sub-Groups will routinely report to the MSCB on their work plans as follows; and where required by exception:

Quality Assurance
- Multi-Agency data – quarterly in arrears
- Lessons from quality assurance at each MSCB meeting

Learning and Development
- twice per year

Policy
- twice per year

Promote and Protect Young People
- twice per year
- Quality and aggregated lessons arising from case monitoring in Promote & Protect/MASE meetings will be reported via QA and to the MSCB

Joint HR Sub-Group
- once per year

MASH Strategic Board
- meets monthly

VAWG Board
- The Merton VAWG Strategic Board meets four times per year.

Joint CDOP
- once per year, usually through the draft CDOP Annual Report

The Sub-Groups will work together to ensure that Policy Development and Learning and Development reflect lessons being learned through QA and PPYP.

Appendix 4
Membership

Membership of MSCB has been agreed as follows:

P **Statutory Partner**

S **Statutory Sector Partner**

C **Co-opted**

V **Voting**

PO **Participant Observer**

SA **Statutory Advisor**

A **Advisor**

B **Board support**

Statutory Partners will nominate an agreed senior Agency Deputy who is able to speak and take decisions on their Agency's behalf.

Sector Partners will cover each other and do not require a deputy for their own agency.

Advisers will not have deputies.

Where a Sub-Group Chair is appointed who is not a Board Member they will be co-opted to the Board but will not be a voting member, unless they are deputising for an Agency Member.

	MSCB	
	Independent Chair **Casting Vote**	
P	**Vice Chair to be drawn from the Statutory Members**	
P V	Chief Officer, Merton Clinical Commissioning Group	
P V	NHS England (London)	
P V	Chief Nurse, Central London Community Healthcare Services	
P V	Sutton & Merton Service Director, SW London & St George's MH Trust	
P V	Consultant Child and Adolescent Psychiatrist, SW London & St George's	
P V	St George's Healthcare NHS Trust	
P V	Borough Commander, Met Police	
P V	DCI, Child Abuse Investigation Team, Met Police	
P V	Assistant Chief Officer, London Probation	
P V	Assistant Chief Officer The London Community Rehabilitation Company Limited	
S V	Lay Members (Two)	
S V	Voluntary Sector Agency (Two)	
P V	Director, Children Schools & Families	
P V	Head of CSC & YI, CSF	
P V	Head of Education, CSF	
C V	Director of Public Health Merton, Community & Housing	
C V	Safeguarding Adults Manager, Community & Housing	
C V	Housing Needs Manager, Community & Housing	
P V	Senior Service Manager, CAFCASS	
SV	Head Teacher Primary School 'Rep of Governing Body of a Maintained School	
SV	Special School	
SV	Maintained secondary school	
SV	Representative of the proprietor of a city technology college, a city college for technology or the arts, or an Academy	
SV	Independent Sector School – vacant at Jan 2015	
CV	CP Officer, Merton Priory Homes	
PO	Merton Council Lead Member Children's Services	**Non-voting**
SA	Designated Doctor for Child Protection, Merton CCG	**Non-voting**
SA	Designated Nurse Safeguarding, Merton Clinical Commissioning Group	**Non-voting**
SA	Principal Social Worker	**Non-voting**
P V	Consultant Child and Adolescent Psychiatrist, SW London & St George's	
A	Joint Head of HR Business Partnerships	**Non-voting**
A	Service Manager, Policy, Planning and Performance	**Non-voting**
BS	MSCB Board Development Manager	**Non-voting**
BS	MSCB Administrator/s	**Non-voting**
A	MSCB Training Officer	**Non-voting**

Contact Details

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Committee: Health and Wellbeing Board

Date: 29 November 2016

STRATEGIC ITEM
Wards: All

Subject: The Merton Story- Key health issues in Merton

Lead officer: Dr Dagmar Zeuner, Director of Public Health
Lead member: Cllr Tobin Byers
Contact officer: Dr Amanda Killoran, Public health consultant

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Recommendations:

A. To consider and comment on the Merton Story – Key health issues in Merton (2016)

B. To actively use the Merton Story as a tool to champion the key messages relating to our health and wellbeing ambitions.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The report –*The Merton Story*- provides a snapshot of local needs identified through the Joint Strategic Needs Assessment (JSNA) process, and developed to inform commissioning intentions.

Local authorities and CCGs have equal and joint statutory duties to prepare and publish a joint strategic needs assessment (JSNA) for their area, through the Health and Wellbeing Board. This Merton Story is a summary of the key health issues in Merton, and planned to be updated on an annual basis. It is complemented by a range of other needs assessment documents being produced as part of the JSNA process.

1.2. The Merton Story presents a summary narrative to support our health & wellbeing partnership working and commissioning agendas:

Despite the overall positive position of Merton as a healthy and safe place to live, we have concerns and ambitions relating to:

- *Closing the health divide as part of the growth agenda*
- *Maximising the potential for prevention*
- *Giving every child the best start in life*
- *Promoting independence and recovery*.

1.3. Board members might wish to consider the following questions:

- How might members actively use the Merton Story as a tool to promote the key messages relating to our health and wellbeing ambitions?
- What are members' views on the Merton Story approach-the format of an annual snapshot? How might the format be improved?

The report-The Merton Story- is attached.

The Merton Story – Key Health Issues in Merton

Introduction

Local authorities and CCGs have equal and joint statutory duties to prepare and publish a joint strategic needs assessment (JSNA) for their area, through the Health and Wellbeing Board. The JSNA is the on-going process to describe the current and future health and wellbeing needs of the local population to inform services. It provides a framework for improving local health and wellbeing and addressing inequalities.

This *Merton Story* is a snapshot of the local needs identified through the JSNA process, developed to inform commissioning intentions. This snapshot is planned to be updated on an annual basis. It is complemented by a range of other needs assessment documents being produced as part of the JSNA process.

The Merton Story

Overall Merton is healthy, safe and has strong community assets

The health of people in Merton is generally better than the London and England average. Life expectancy is higher than average and rates of death considered preventable are low. This is largely linked to the lower than average levels of deprivation in Merton. We have a range of community assets that are important to health; there are many green spaces, educational attainment is high and we have high levels of volunteering.

Merton also has a diverse and growing population. Merton's population is projected to increase by 5,000 people between 2015 and 2020. The age profile is predicted to shift –with a notable growth in the proportions under the age of 16 years and those over 50 years old.[1]

Despite this positive picture, there are areas of concern and ambition

Closing the health divide as part of the growth agenda

Significant social inequalities exist within the borough. The eastern half has a younger, poorer and more ethnically mixed population. The western half is whiter, older and richer. Largely as a result, people in East Merton have worse health and shorter lives.[2]

Life Expectancy at birth in Merton is 80.4 years for males and 84.2 years for females. [3] In East Merton life expectancy in men is 78.9 years compared to 81.9 years in West Merton. Women's life expectancy is 83.3 years in the East compared to 85.1 years in West Merton.[4]

There is a gap of 6.8 years in life expectancy for men between the most deprived and least deprived areas in Merton. The gap is 5 years for women.[3]

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[1] GLA population projections 2015 Round. Using Housing-linked projections incorporating data from the 2013 Strategic Housing Land Availability Assessment (SHLAA) using the Capped Household Size projection model

[2] East Merton Health Needs Assessment, January 2014
http://www.merton.gov.uk/east_merton_health_needs_assessment.pdf

[3] Public Health Outcomes Framework (PHOF), PHE, August 2016

[4] Local Health, PHE, November 2016

Premature mortality (deaths under 75 years) is strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts. Of all deaths in East Merton, nearly 2 in 5 deaths were premature. In comparison, in West Merton, just over 1 in 4 deaths were premature.[5]

Marked social inequalities (as highlighted below) are important drivers of the health divide. However Merton's plans for economic growth and regeneration have the potential for improving life chances and securing better health outcomes over time.

- Unemployment claimant rates in Merton are 1.5%; however rates are significantly higher in the East of the borough (2.1%), compared to West Merton (0.8%). Unemployment in East Merton is higher than London (1.8%) and England (1.8%).[4]

- 16% of households are overcrowded in Merton. This is higher in the East (20.4%) than West of Merton (11.1%).[4]

- Merton's social housing stock is amongst the lowest in London at 14%. The London average is 22% with social housing stock as high as over 59% in boroughs like Southwark. The profile of stock differs between owner occupied and social housing in Merton, with 58% of social housing and 63% of private rented homes being flats, compared with only 24% in the owner-occupied sector.[6]

- Overall, Merton has a lower overall crime rate (5.3 total notifiable offences per 1,000 population) compared to London (7.7) (2016). However there are variations-with higher rates of crime in the East (6.5) compared to the West (5.2). Since 2013 there have been year on year increases in total crime rates for London and Merton (although there have been changes in definitions for reporting crime).[7]

- Low income combine with high energy costs is strongly linked to living in homes that are not heated sufficiently (fuel poverty). An estimated 10.6% of household (8384) are fuel poor in Merton, which is similar to London and England (2016). Fuel poverty is more prevalent in inner London boroughs and lessens in outer London.[8] Since 2012 levels of fuel poverty in Merton have increased, and a similar trend is evidence for London as a whole.

Maximising the potential for prevention

The main causes of ill health and premature deaths in Merton are cancer and circulatory disease (including coronary heart disease and stroke). Known risk factors (unhealthy diet, smoking, lack of physical activity, and alcohol) account for around 40% of total ill health. Consequently changing patterns of unhealthy behaviour must be an important focus for prevention efforts. Furthermore, most risk factors are inversely associated with socio-economic conditions.

The numbers of people in Merton with unhealthy behaviours are substantial. This is despite some positive rankings against London and England for these primary risk factors.

[5] Primary Care Mortality Database, 2011-2015

[6] Merton Health & Wellbeing Strategy, 2015/16-2017/18.

[7] Metropolitan Police Service – Crime Mapping 2016

[8] Estimates of sub regional fuel poverty in England, 2014 data, Department of Energy & Climate Change, published 2016.

- 23,500 adults smoke in Merton; representing 14.7% of adults; and 22.5% are routine and manual workers (2015).[3] The level of smoking is not significantly different from London (16.3%) and England (16.9%).[3]

- 46,000 adults are physically inactive, with 28% of adults doing less than 30 minutes of physical activity a week. This level has increased since 2014.[3]

- 94,300 adults are overweight or obese (59% of adults). This is a lower proportion compared to London and England.[3]

Based on modelled data, there is marked variation in patterns of healthy behaviours between East and West Merton. For example 55% of adults (over 16 years) consume 5 or more portions of fruit and vegetables every day. Only 36% of adults have healthy eating patterns in East Merton compared to 44% in West Merton.[9]

An estimated 11.1% of the population use of outdoor space for exercise/health reasons in Merton (2014/15) which is lower than London (12.3%) and England (17.9%).[3] This is despite Merton being one of the greenest boroughs in London with 677ha of public open spaces. Green spaces make up 18% of the borough, compared to the London average of 10%. Merton has over 65 parks and open spaces.[10]

New revised estimates of local alcohol consumption are due to be issued shortly.

The scale of alcohol related harm is significant. In 2014/15 there were 2,926 admission episodes to hospital for alcohol related conditions (broad definition). While the number is substantial, this represents a lower rate of admissions (1,858 per 100,000 population) compared to London (2,157) and for England (2,139).[11] There is a significant variation between the East and West of the borough, with a higher rate of alcohol-related admissions in the East compared to the West.[4]

617 adults were in contact with specialist substance misuse treatment services in 2015/16. 290 (47%) were treated for drug misuse, and 327 (53%) for alcohol. The rate of successful treatment completion for opiate users was 9.4%, with a decline from previous years. 60.2% of alcohol clients completed treatment successfully, a rate higher than the national average (39.2%).

Around 22% of substance misuse clients were treated concurrently for mental illness.

1 in 250 people between the ages of 15-59 years in Merton were diagnosed with HIV. There were 4.21 per 1000 diagnosed in Merton which is lower than London (5.83). In 2015 there were 6,656 HIV testing uptake. HIV testing uptake was higher than both London and England. Merton was the 6th highest of all 32 London boroughs.[15]

[9] Mosaic data tool, Experian
[10] Future Merton, The London Borough of Merton
[11] Local Alcohol Profiles for England (LAPE)

In 2015 screening coverage rates for breast and cervical cancer were both lower than the England average but similar to London. The number of eligible women screened adequately within the previous 3.5 or 5.5 years for cervical screening was 45,876 women (69.9%) in Merton, and the number of eligible women screened adequately within the previous 3 years for breast screening was 12,202 women (68.4%).[3]

Giving every child the best start in life

Most children and young people living in Merton are healthy and have a good start in life. Most experience better health and related outcomes than the London and England average. However not all children enjoy similar positive outcomes. The health divide is evident at the start of life.

'School readiness' is a key measure of a child's development- the percentage of children achieving a good level of development at the age of reception. In 14/15, 67.7% of children living in Merton achieved this standard - which is 1,830 reception children. This is similar to the average for England and London. This was an improvement against the previous 2 years.[3]

However children with free school meal status do less well. In 14/15, 55% of children with free school meal status achieved a good level development, representing a trend of continuous improvement over the past three years. Also, whilst all other pupils have improved, the gap in school readiness between children with free school status and their peers has reduced (to 12.75%). The gap nationally is 18%.

Family context has profound influence on a child's healthy development and life chances. Children living in poor social circumstances are most at risk of poor health outcomes.

While Merton has lower rates of children living in deprived circumstances, numbers remain substantial.

- Around 6,000 children under 16 years in Merton are living in poverty (2013).[3]

- In 2016 there were 165 children in care. This continues the trend of gradual increase since 2012. The rate of children in care (35 per 10,000 children) is significantly lower compared with outer London boroughs (47 per 10,000 children) and England (60 per 10,000 children).[12]

- Parental mental health problems, parental misuse of alcohol and drugs and domestic violence are the most significant risk factors that impact on a child's health and wellbeing. Of the 2,517 children in receipt of services as Child in Need in 2014/15, almost 1,000 of these children were in need due to abuse, neglect or family dysfunction.[12]

There were 1,045 Merton Resident Children with a Statement of special education needs 2015. Numbers have increased significantly over the previous four years; and growing at a faster rate than London, statistical neighbours and national comparators.[13]

[12] Children looked after in England 2015-2016, Department for Education September 2016
[13] Merton JSNA 2014/15

Uptake of childhood immunisations has increased in Merton however, as with most boroughs in London we are below the national target of 95%. MMR for 2 doses at age 5 years in Merton is 80.4% compared to London 81.1% and England 88.6% (2014/15).[3]

4,500 primary school children (aged 4-11) are estimated to be overweight or obese. 1 in 5 entering reception are overweight or obese and this increases to 1 in 3 children leaving primary school in Year 6 who are overweight or obese. Obesity is more common in Black and Minority Ethnic Groups (BAME) and in poorer communities in East Merton.[14]

There has been a general decline in the proportion of 4-5 year olds that are of excess weight, however, a decline among 10-11 year olds is only starting to become evident (2015/16). Despite this recent promising trend, the overall gain in excess weight amongst children between reception and Year 6 remains substantial (an increase of 15.7%).[14]

Since 2006 there has been a decline in under 18s conceptions from 41.1 per 1000 to currently 19.7 per 1000 in 2014.[3] This is lower than London (21.5) and England (22.8). Merton has the 9th lowest numbers of under 18 conceptions in London with 60 cases of teenage pregnancy – just over half of these pregnancies resulted in abortion in 2014.[15] Wards in East Merton have the highest rates of teenage pregnancies compared to the West of Merton.[4]

Alcohol and drug misuse are markers of risky behaviours and vulnerability among young people. Locally in 2015/16 71 young people (under 18s) required access to specialist substance misuse services. This is a decline from previous years, and reflects the national trend of decline in young people entering specialist substance misuse services.[16]

In 2014/15 the Merton rate of child admissions (under 17 year olds) for mental health conditions (122.7 per 100,000 children 0-17 years) was one of the highest against LA nearest neighbours and compared to England (87.4). This equated to 56 young people being admitted. This represents a 'stable' trend of mental health admissions assessed over the last 5 years period, and is similar to the national trend.[17]

Promoting independence and recovery

The population is ageing: the number of people aged 65 or over is projected to increase by 12% (from 24,700 in 2015 to 28,400 in 2025).[1] This further increases the challenge of caring for increasing numbers of people living with multiple long term conditions such as heart disease, diabetes, cancer, mental health conditions, and dementia.

Joined-up care and support helps to deliver better experiences and outcomes for people with multiple long-term conditions and their carers. It also saves money across the health and social care system through a shift to out of hospital services.

An estimated 1,686 older people (65 years and over) have dementia in Merton; and 74.4% have received a formal diagnosis. This represents a higher diagnostic rate compared to London (71.1%), and England (66.4%).[18]

[14] Annual Public Health Report 2016 – Childhood Obesity
[15] Sexual & Reproductive Health Profiles
[16] The National Drugs Treatment Monitoring System (NDTMS)
[17] Children & Young People's Mental Health & Wellbeing Profile, PHE
[18] NHS England April 2016

Recent evidence is emerging that healthy lifestyles such as avoidance of tobacco, alcohol, poor diet and physical inactivity can reduce the risk of dementia.[19]

10,292 people have been recorded with diabetes (2014/15). This equates to 6% of the population, and similar to London (6.1%) and 6.4% England overall. 57.3% of diabetes patients achieved the treatment standard of good blood pressure control. This is significantly lower than the average for London.[20]

There are an estimated 24,000 adults (16-74 years) with common mental health disorders such depression and anxiety (2015), representing 16% of the adult population in Merton. There are 9,754 adults identified with depression by Merton GPs (5.7% of patients).[21] This suggests that a substantial proportion of adults in Merton experiencing common mental health conditions remain undetected. The 5.7% figure is lower compared against England (7.3%) but higher than the London average (5.3%).

Latest data (June 2016), for access to psychology therapies (IAPT) shows, each month, that of those patients completing treatment, 41.9% are moving to recovery. This Merton recovery rate is lower than England (48.8%). In Merton there has been an overall decline in recovery rates, based on trend analysis.[21]

There are around 2,775 adults (aged 18 years and over) in contact with specialist mental health services (205/16). This represents a rate of 1,758 per 100,000 population, and significantly lower than the London average (2,474) and England (2,451).[22]

Merton performs well for providing support to people in the community. In 2015/16, 1,496 people accessing long term community support received self directed support – a rate of almost 100% of users, and higher than local authority compactors and England (87%). In 2015/16 34.3% of service users and 94.1% of carers received a direct payment, against 30.4% and 73.3% (respectively) in the comparator group of local authorities.

Delayed transfer of care from hospital to home is an important measure of the interface between health and social care. 3.6 adults per 100,000 population in Merton experienced a delayed transfer attributable to social care or jointly to social care and the NHS in 2015/16. This is a lower rate compared to England, however higher against comparator authorities.[23] The proportion of older people being offered reablement services, following discharge, is improving (although lower than the England average). With establishment of a new community health provider, joint working between health and social care has a new impetus and is focussed on preventing unnecessary admissions to and supporting recovery on discharge from hospital.

Feeling isolated and lonely has a profound negative effect on physical and mental health and wellbeing. This is particularly important given we have an estimated 5,900 people aged over 75 living alone. Many people who use social care services would like more social contact- with around 40.4% of users reporting that they had as much social contact as they

[19] Health Matters: midlife approach to reduce dementia risk. PHE, 2016
[20] Diabetes Profile, PHE
[21] Common Mental Health Profiles, PHE, June 2016.
[22] Severe Mental Illness Profile, PHE
[23] Adult Social Care Outcomes Framework (ASCOF), 2016

would like (2015/16), and this is significantly lower than the average for England (45.4%), although similar to the average for London.

In 2014/15 were 764 emergency admissions for injuries due to falls among people of aged 65 years & over. Falls are the leading cause of older people being admitted to hospital as an emergency. Having a fall can have a significant negative impact on long terms outcomes for older people. The Merton rate of emergency admissions for injuries due to falls for 65 year olds and over (2,864 per 100,000 population) is significantly higher than for London (2,253) and England (2,125).[3]

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Committee: Health and Wellbeing Board

Date: 29 November 2016

STRATEGIC ITEM
Wards: All

Subject: Health & Wellbeing Strategy 2015-18: Annual report 2016

Lead officer: Dr Dagmar Zeuner, Director of Public Health

Lead member: Cllr Tobin Byers

Contact officer: Dr Amanda Killoran, Public health consultant

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Recommendations:

A. To consider and comment on the progress on implementation of the Health & Wellbeing Strategy 2015-18

B. To continue to champion the implementation of the Health & Wellbeing Strategy and promote the outcomes with their constituencies.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The report provides a summary of progress on implementation of the Merton Health and Wellbeing Strategy 2015-18.

The refresh strategy is providing the opportunity to embed the commitment of the council and partners to reducing health inequalities through improving outcomes across five priority themes:

- Best Start in Life
- Good health
- Life skills, lifelong learning and good work
- Community participation and feel safe
- A good natural and built environment

1.2 The Health & Wellbeing Strategy was agreed by Cabinet for 2015-18 with the initial intention of progress being monitored on a quarterly basis. However many of the outcome indicators require a longer period to register impact and therefore this annual reflection on progress is judged to be more appropriate. The Board is particularly asked to consider whether this approach is helpful.

1.3 This report assesses progress towards achieving agreed outcomes. Overall the assessment shows positive progress across many areas - in line with trajectory to 2018 targets.

There is good evidence of impact across all themes. However in certain areas targets are very ambitious and progress is proving difficult (for example immunisation and fuel poverty). Some areas are at an early stage (such as improving mental health pathways). There are proposed revised outcomes for community safety (relating to alcohol-related crime, and domestic violence) and also prevention of homelessness.

1.4 Board members might wish to consider the following questions:

- How might members continue to support progress towards outcomes in their role as system leaders?
- What are the expectations of the pace of progress towards different outcomes within the difficult financial context? A number of outcomes are linked to major developments and service redesign (such as the East Merton Model of Health & Wellbeing) and outcomes are longer term.
- What are members' views on the format of the report? How might the format be improved? This annual report attempts to be more 'streamlined' and focused on outcomes.
- What specific outcomes might members wish to consider in more detail at future meetings?

The report is attached.

Annual report 2016: Merton Health and Wellbeing Strategy 2015-2018

1. Purpose

The report provides a summary of progress on implementation of the Merton Health and Wellbeing Strategy 2015-2018.

This refresh strategy has the broad goal of achieving a fair share of opportunities for health and wellbeing for all Merton residents. This means that we will halt the rise in the gap in life expectancy between areas within Merton.

The refresh strategy is providing the opportunity to embed the commitment of the council and partners to reducing health inequalities through improving outcomes across five priority themes:

- Best Start in Life
- Good health
- Life skills, lifelong learning and good work
- Community participation and feel safe
- A good natural and built environment.

This report assesses progress towards achieving these outcomes as measured by agreed indicators and targets set out in the delivery plan (following sections covering each theme).

A supplementary report is planned for early next year on measuring 'the gap' in health inequalities over time within Merton, based on a small number of selected high level indicators.

2. Overview of progress

The assessment shows positive progress across many areas in line with trajectory to 2018 targets.

There is good evidence in certain areas of impact on outcomes including

- Reduced average waiting times for local children and adolescent mental health services through the introduction of a Single Point of Access.

- Increased proportion of children with free school meal status achieving a good level of development in early years, and some closing of the gap with their peers.
- Reduced gap between disadvantaged pupils achieving 5 a-c* GCSEs and their peers.
- Increased numbers of residents supported in volunteering through the MVSC activities.
- Improved performance in the offer of reablement to older people, through the introduction of the new reablement service.
- Increased number of residents supported into employment through IT and soft skills training.
- Increased numbers of businesses supported in starting up, and the creation of new jobs.

It is proving difficult to make progress towards outcomes in a number of areas:

- Increasing the proportion of adults who are using outdoor spaces for exercise/health reasons.
- Reducing fuel poverty through promotion of collective energy switching – fuel poverty has increased over the last three years.
- Achieving immunisation targets.

Some programmes of development and redesign are at an early stage and therefore it is too early to assess impact on outcomes- although the trajectory is potentially promising:

- The childhood obesity action plan in reducing the gap between East and West Merton.
- The first phase of development of the East Model of Health and Wellbeing through the redevelopment of the Wilson hospital site.
- Delivery of commissioned adult learning programmes focusing on English for speakers of other languages.
- Introduction of use of Health Impact Assessments as a tool within the planning process.

Assessment of progress towards outcomes is difficult in some areas due the measurement challenges:

- A longer time period is required to assess trends, particularly with respect to indicators relating to health behaviours –smoking, use of outdoor spaces, alcohol-related harm. Year on year changes are subject to variability.

Revised outcomes are proposed in certain areas based on needs analysis and changes in policy context:

- A new outcome for crime reduction to be set in early 2017 based on the Strategic Needs Assessment findings- and responding to alcohol related crime and domestic violence..
- Prevention of homelessness through advice and information (replacing the outcome on Houses of Multiple Occupation)

Theme 1: Best Start in Life: early years development and strong educational achievement

1.1 Outcome: Uptake of childhood immunisation is increased:

- Uptake of childhood immunisations increased in 2014/15, however there has been a slight decrease in 2015/16 for MMR2 by age 5.
- This highlights the need to keep a sharp focus on action to improve immunisation reporting and uptake by NHS England and Merton CCG.
- Merton Childhood Immunisation Steering Group has been re-established with NHS England, MCC and Public Health and the Merton action plan is being refreshed for delivery.
- Overview and Scrutiny report with recommendations on improving childhood immunisations produced and informed the action plan.
- Action to improve immunisation uptake has included:
    - NHS England visited and advised GP practices on improving performance on childhood immunisations and child flu uptake.
    - PHE and NHSE provided training on changes to the immunisations schedule,
    - Health visitors promoted immunisations and signposted families.

1.2 Outcome: Waiting time for children and adolescents to mental health services shortened

- Average waiting time for local Tier 3 CAMHS services has been shortened to 3.3 weeks (Aug 16), from over 10 weeks at baseline (2014/15). This has been achieved through the introduction of a Single Point of Access, launched in Oct 2015.
- However, there is some variance in relation to centralised services and especially neurodevelopmental services where the average wait time is being reported as 8 weeks.
- A comprehensive Health Needs Assessment and Service Review was undertaken in summer 2015 and updated in Autumn 2016 to support the development of the 2017/18 Transformation Plan
- CAMH Strategy 2015-18 in place and informed Year 1 and Year 2 CAMH Transformation action plans which were ratified by NHS England.
- Areas for transformation include improving access to CAMHs, earlier intervention, support for our most vulnerable children and young people and workforce development, including:
    - Investment has been made into Eating Disorder Services, liaison nursing, support for children who have been sexually assaulted.
    - Work is underway improve pathways for children over the age of 5 years with social and communication issues
    - Training needs analysis undertaken and training commissioned, specifically for schools and social workers
    - CAMH Conference held in January 2016 and first CAMH Networking event in November 2016

1.3 Outcome: Childhood obesity is reduced.

- A new approach to childhood obesity is being developed with a focus on a whole systems approach which addressed the underlying environmental causes of childhood obesity - including food and physical environment.
- Childhood obesity Peer Review undertaken in February 2016 as part of a pan-London programme.
- Comprehensive child healthy weight action plan under development and steering group established following recommendations from the peer review.
- Action has included:
    - The targeted Healthy Schools programme in the east of the Borough which supported healthy eating, food growing and physical activity has been completed.
    - Work underway to align Schools to the pan London Healthy Schools programme
    - HENRY (Health, Exercise & Nutrition for the Really Young) training commissioned
    - Healthy Catering Commitment rolled out
    - Pan London Great Weight Debate survey actively promoted

1.4 Outcome: Educational achievement gap in children eligible for pupil premium is reduced.

- The Schools Standards report for academic year 2015/16 will be published in Feb 2017. It is anticipated that this will further decrease the gap in educational achievement.
- Overall the performance of Merton schools judged to be good or better as of December 2015 was 89%. This is an improvement compared to 81% at August 2014.
- 2015 data shows a gap of 23% between disadvantaged pupils achieving 5 A*-C including English and mathematics at GCSE and their peers.
- This is higher than the figure for London, but lower than nationally (21% & 28% respectively). Although not meeting the target of 20%, this is an improvement from 2014 when the gap was 27%

1.5 Outcome: The proportion of children ready for school is increased

- The gap between the percentage of pupil premium children achieving a good level of development in early years has reduced, however 2015/16 data has not yet been published. This national indicator was due to change, but has not done so yet.
- Overall the proportion of children eligible for Free School Meals (FSM) achieving a good level of development (GLD) in early years has increased by 11 percentage points to 55%. Whilst all other pupils have also improved their performance, the gap between these groups has reduced to 12.7%. Nationally, the gap is wider at 18 percentage points.
- Action has included:

- ‘Narrowing the Gap’ project supporting 15 targeted schools to improve performance on good level of development (GLD) at early years.
- Roll out of free 2 year old nursery places offer to disadvantage groups
- Worked with PVI sector to secure 97% of all 2 year places are taken up in Ofsted rated good or above settings
- Targeted the uptake of Children’s Centre services to families from deprived areas in the borough,
- Pathways across Children’s Centres, Family Support, Health Visiting, and other health services are being developed through Early Years Partnership,
- A revised level of support was created in early years settings and Children’s Centres to support families with specific needs.

Outcome Indicator	Baseline	Current	Target	RAG rating	Commentary
The health visiting service provided by CLCH is now co-located in our Children Centres as part of journey to providing integrated, flexible services.					
Immunisation - MMR2 at 5 years	72.2% 2013/14	80.4% (2014/15) 80% (2015/16)	87.6% (2018) National target 95%	R	MMR2 has increased from 72.2% baseline in 2013/14 to 80.4% in 2014/15. However in 2015/16 there has been a slight decrease to 80% (lower thank London – 81.7% and England – 88.2%). This will be a challenging target to meet. The updated childhood Immunisation Action Plan and steering group, will progress work towards reaching target in 2017/18.
Integrated CAMHS pathways in place, reduced waiting times from referral	Baseline wait times >10 weeks No CAMHS Strategy	Average wait time for local Tier 3 service is 3.3 weeks (Aug 16)	Integrated CAMHS pathways embedded and average waiting times from referral < 5 weeks	A	The introduction of the Single Point of Access (Oct 15) has had a positive impact on wait times locally. Some variance in relation to centralised services and especially neurodevelopmental services where the average wait time is being reported as 8 weeks.
Excess weight (overweight and obesity) in 10-11 year olds Excess weight refers to those that are obese	36.4% 2013/14	35.6% (2014/15) 34.7% (2015/16)	35.7%	Achieved HWB target.	Excess weight in 10-11 year olds in Merton has been lower than the London average for the last 8 years, The early signs are that the

and overweight				Proposal to set new target to be achieved by 17/18	level of excess weight in 10-11 year olds is beginning to decrease. The target set reflected the aim to halt and then begin to reduce this upward trend. The overall gain in excess weight between 4-5 year olds and 10-11 year olds in Merton is slowly decreasing (compared to increases seen in London and England) but is however still currently 15.9% Data for 2015/16 showed a reduction in excess weight at age 10/11 years since 2013/14 and has met the H&W target. Proposed to set a new target to be achieved by 17/18.
Gap between % of 10-11 year olds with **obesity** weight between east and west Merton	6.2% 2010/11-2012/13	2011/12-2013/14 - 7.8%	6%	R	There is a higher rate of obesity in the east of the Borough than the west, linked to deprivation. This is measured using data aggregated over 3 years. The gap has widened since the HWBB baseline. Child healthy weight action plan includes focus on whole systems preventative approach, with population wide approaches, targeting the east of the borough, focusing on food and physical environment.
Gap in % children achieving 5 GCSE's A-C including English & Maths between pupil premium children and children not eligible for pupil premium	24.8% (2009/10-2013/14)	2014/15 - 19.8%	20%	G	Data for 2015/16 will be published in the Schools Standards Report in Feb 2017. Indication is that this gap will decrease.
Gap between % of pupil premium children achieving a good level of development in early years	13.1% (2013/14)	2014/15 - 12.7%	A target was not set because nationally the indicator was due to change.	G	The Gap has reduced from baseline. 2014/15. 2015/16 data is not yet published. The measure has not changed and it is proposed that a target should be set based on existing measure.

Theme 2: Good health- focus on prevention, early detection of long term conditions and access to good quality health and social care

2.1 Outcome: A prevention strategy will set the framework to embed prevention into local public policy and make health everyone's business to ensure that every contact counts and that influences on health make a positive impact

- The development of a prevention framework is underway-setting out a whole-systems approach to promoting healthy lifestyles, preventing ill health and reducing health inequalities. The approach is based on employing a combination of programmes and actions at population, community and individual levels- creating opportunities for people to adopt healthy behaviours as part of every day life. The framework will help to clarify roles of partners- across the council, NHS, voluntary and private sectors in the changing financial and commissioning context. It will provide a tool to help integrate prevention within CCG commissioning as well as the Council activities, and also the Sustainability and Transformation Plan.
- Merton Council is participating (as the first London Council) in the LGA's *Health in All Policies* learning initiative to translate its existing commitment into an action plan.

2.2 Outcome: Settings across the borough where people spend their time, including workplaces, schools and high streets are healthier and enable individuals to make healthy choices

- Working in partnership with the Merton Chamber of Commerce, a scope is being developed for a sustainable approach to supporting Merton businesses to enable their staff to lead healthy lifestyles, linked to the GLA's Healthy Workplace Charter which is currently being formally evaluated.
- The Healthy Catering Commitment is being used as the focus for developing a number of healthy high streets in the borough, particularly East Merton. 29 food businesses have been supported in helping their customers consume less saturated fat, less salt, less sugar and have the opportunity to purchase smaller portion sizes
- The revised Statement of Licensing Policy (SLP) was formally adopted by the Council in November 2015 and published in Jan 2016. It included a new Cumulative Impact Zone (CIZ) for Mitcham Town Centre and the surrounding area, focusing on the off sale of alcohol. The review was informed by health analysis. Public Health is further strengthening its approach to support the Licensing Sub-Committee in making informed judgements. It is important to note that this is partially restricted as there is not a public health licensing objective in the Licensing Act 2003.

2.3 Outcome: Adults make healthy lifestyle choices, including taking up clinical prevention services

- As part of the prevention framework, and in response to a challenging budgetary position, a new model for supporting residents to lead healthy lifestyles has been developed that includes digital interventions, promotes self care and delivers targeted support to the most vulnerable.
- A service development and improvement plan is being implemented for the NHS Health Checks programme, with a view to externalise (through a procurement process) the administration, management and delivery of the programme with a new community delivery model in the New Year.

- An ACE Bowel Cancer Screening pilot has been developed, and implemented across all 24 Merton GP Practices. Between October 2015 and Nov 2016, over 3500 non-responders were contacted regarding their bowel cancer screening.
- A range of health facilitation and promotion activities are being delivered to support people with learning disabilities by Community Nurses in LBM Learning Disability service. This includes hospital liaison visits (both planned and unplanned admissions), hospital discharges and follow ups and input to GP work relating to annual health checks and long term conditions. A link work role is undertaken in Residential Homes and supported living homes. Staff also provide health promotion advice and assistance on a variety of lifestyle risks including: obesity, diabetes, smoking and drug and alcohol abuse.
- Work is underway to develop a partnership strategic framework for the prevention substance misuse and related harm- to encompass prevention, treatment, hidden harm to families, community safety, regulatory and enforcement measures. This will guide the current process of redesign of the adult substance misuse service towards a more preventative and recovery based model. This includes review and strengthening of the interface with mental services.

2.4 Outcome: Improving access to Mental Health services through integrated locality working, resulting in improved parity of esteem

- This work is still in early inception, and includes as a starting point, a review of supported accommodation for adult mental health service users.

2.5 Outcome: East Merton Model of Health and Wellbeing – Residents of East Merton have access to a model of care that responds to their health needs, focusing on prevention, early detection and management in primary and community healthcare and multi-disciplinary team working with secondary care

- Extensive work is being taken forward to develop the East Merton Model of Health and Wellbeing and under this overarching umbrella, the re-design and re-development of the Wilson Hospital in East Merton is a starting point, as a health and wellbeing campus consisting of integrated health and community facilities, co-designed and co-owned by the community.
- A series of community conversations were undertaken by members of the Health and Wellbeing Board and others, with communities in East Merton facilitated through community connectors. Three design workshops have been held, that have resulted in invaluable insight into the future design, and mechanisms for co-production.
- Funded by the Merton CCG, a lead officer called the Wilson HWB Campus Development Manager is being recruited to take the work forward on a full-time basis.
- OPE funding was applied for and secured for the Wilson development.
- The project plan, communications plan, governance, funding vehicle, engagement and co-production mechanisms are currently being considered and developed.
- The Proactive GP Pilot has concluded and the evaluation completed. The findings from this pilot will help inform the development of a social prescribing pilot in East Merton.
- The social prescribing pilot is currently being developed through a steering group, starting in two East Merton GP Practices with the view of extending over the 12 months ensuing from the start of the pilot, to a further 3-4 practices. A social prescribing coordinator is being recruited to help implement the approach.

Theme 2: Good health					
Outcome Indicator	**Baseline**	**Current**	**Target**	**RAG rating**	**Commentary**
No. frontline staff trained as health champions within HWB partner organisations	0	107 staff trained against Y1 target - 100 staff trained	TBC	G	Staff trained include 48 who completed the RSPH Understanding Behaviour Changes course, 24 staff in children's centres who completed HENRY training and 35 staff who took part in a course on Making Every Contact Count (MECC).
Number of employers delivering healthy workplace schemes and / or signed up to the London Healthy Workplace Charter	1 employer	35 employers supporting healthy workplaces and 6 receiving formal recognition	50 in total by the end of March 2017.	A	Organisations receiving formal recognition at Commitment level include Merton Council, MVSC, Merton Chamber of Commerce, Merco Medical Recruitment, Peldon Rose, Wimbledon Guild and Turners. Epsom and St Helier have received achievement level recognition.
GLA Healthy Workplace Charter in LBM. • Action plan developed by LBM Workplace Steering Group based around the 8 LHWC themes • Council sickness absence rates	• 'Commitment' level • 9.92 days lost per FTE (2014/5)	• Draft action plan was agreed by CMT on 11th October 2016. • 9.3 days lost per FTE (as at October 16)	• Action plan agreed • 8.0 days lost per FTE[1]	G	The council has reached 'commitment' level in the GLA's London Healthy Workplace Charter framework and CMT have committed to strive for excellence, which fits well with Merton's vision to be London's best council by 2020 and the pilot approach to embed 'health in all policies'.
Statement of Licensing Policy explicitly considers health and wellbeing.	N/A	Achieved.	SLP includes HWB	G	The revised SLP published in Jan 2016 included a new CIZ for Mitcham Town Centre and the surrounding area, focusing on the off sale of alcohol.

[1] The Council's target is 8.0 days per FTE, The CIPD Absence Management Survey, 2013 showed that there was a sickness absence rate of 8.7 days per employee in the whole of the UK Public Sector and 7.2 days in the Private Sector; both have increased since 2012.

Theme 2: Good health					
Outcome Indicator	**Baseline**	**Current**	**Target**	**RAG rating**	**Commentary**
Gap in alcohol-related harm (Standardised Admission Ratio) between east and west	31.7[2]	30.4	TBC (25 by 2018)	Not appropriate	Trend analysis over longer period required.
No eligible food outlets signed up to Healthy Catering Commitments	New audit of HCC outlets against revised criteria. Baseline therefore zero.	29 awarded the Healthier Catering Commitment (July 2015 – November 2016). Further 3 are working towards achieving HCC.	Y1: 20 outlets	G	In year 1 target was exceeded
Proportion of people using outdoor space for exercise / health reasons (PHOF)	15% (Mar 2013-Feb 2014)	11.1% (Mar 2014 to Feb 2015). Fall against a trend of increasing in England. Merton lower than England (17.9%) and London (12.3%).	17/18: 20%	A	This is below the target trajectory People accessing outdoor space for exercise/health reasons has dropped to 11.1% from 15%. Amber rating is because figures are based on small annual survey sample and therefore subject to variability
Smoking prevalence – adults (18+) (PHOF)	2014:12.8% 2013: 12.8%	2015:14.7%	2018: 10.6%	A	Prevalence has increased slightly in 2015 but is still lower than England (16.9%) and London (16.3%). Amber rating is because figures are based on small annual survey sample and therefore subject to variability
Alcohol-related admissions to hospital PHOF	537 (2013/14) 502 (2012/13)	517 (2014/15)	17/18: 458	A	Admissions have fallen slightly in 2014/15 and are still lower than England (641) and London (526). Figures subject to annual variability and therefore further trend analysis required
ACE Pilot developed, implemented and evaluated	N/A	Pilot developed and implemented. (Pilot	15 GP Practices	A	Difficult to assess effect of the ACE pilot due to overall variation in uptake rates

[2] Merton Standardised Admissions Ratio Baseline: East SAR 101.44; West Merton SAR: 69.78

Theme 2: Good health					
Outcome Indicator	**Baseline**	**Current**	**Target**	**RAG rating**	**Commentary**
• Number of GP Practices participating in the pilot • Percentage of patients sent a bowel screening test (FOBT) and did not submit the test, who were engaged through the pilot	N/A N/A	still on). Mid-point evaluation undertaken. 24 out of 24 GP practices participating in the pilot. Approximately 3500 non-responders followed up by practice staff.	80% of patients		over the course of the year, combined with the short-term nature of the data. Some improvements indicated. Impact will be clearer based on full year.
East Merton Model of care developed and plan in place to with resources to deliver actions.	N/A	Progress to timeline	Model of care developed and plan in place with resources to deliver actions	G	Extensive work on first phase of the Development Programme underway.
A range of Health facilitation and promotion activities delivered to support people with learning disabilities	0	4 nurses/ psychotherapists provide this in their individual caseloads.	Range of activities and support in place	G	This is an extensive and specialised service provided by LBM nurses/ psychotherapists. It is difficult to give a definitive number on current caseloads due to the unpredictability of the work. As an indicative example, the community nurse has 180 clients on her list.

Theme 3: Life skills, lifelong learning and good work

3.1 Outcome: The number of Jobseekers Allowance claimants in Mitcham is reduced

- The Economic Wellbeing Group set the target to reduce the number of JSA claimants within the 4 most deprived wards of the borough where unemployment rates continue to remain significantly higher than the borough average. These wards are Cricket Green, Pollards Hill, Lavender Fields and Figgie's Marsh, and are covered by Mitcham Job Centre Plus. Strong links have been developed with the Job Centre Plus and a small reduction in the number of JSA claimants has been achieved – 2.32% of the working population against the baseline of 2.77% (average for the four most deprived wards). The target of 1.7% of the working population by March 2017 is ambitious.

3.2 Outcome: Increase employment by targeting initiatives to improve soft skills and to deliver skills in growth sectors

- The Council commissioned 4 employability programmes to support the hardest to reach residents. (ex-offenders, care leavers, carers, over 50's and long term unemployed). The total number of residents into employment through the four specific programmes is currently 160. The target for 2018 has therefore already been exceeded. Further funding to support employment and skills activities is through a London Councils European Social Fund Operational Programme (ESF). Merton has offered match funding and this programme is now due to commence in January 2017.

3.3 Outcome: Assist business start-ups and growth of existing businesses and enable local unemployed to access the new jobs created

- The Council procured Merton Chamber of Commerce to deliver a three year Merton Business Support Service (MBSS). Over the three year programme the following results have been reported:
    - 545 new jobs created
    - 270 new businesses created
    - 300 jobs safeguarded or attracted as a result of business retention, inward investment, business loans and shopfront grant programme
    - 700 businesses received practical advice and to start-up, develop, grow or survive downturn
    - £130,000 worth business loans made to Merton businesses through the Merton Business Loan scheme, to start-up or expand
    - £900,000 of finance raised to help business to start-up, grow and survive – as a result of the business support and business loans programmes

Merton is the only borough in south London to have experienced employment growth above the London average, in part due to the rise in the creative industries (*South London Sub-regional Transport Plan - 2015 update Sept 2015)*

- Much of the activity to support residents into employment, particularly East Merton and more vulnerable groups is funded through the Economic Development Strategy which was programmed for 2012/13-2015/16 and has now completed until the new programme for 17/18-19/20 is approved. The Economic Well Being sub group of Sustainable Communities and Transport Partnership will continue to bid for funding where possible to support activities that will reduce unemployment and encourage new businesses in Merton.

3.4 Outcome: Bridge the lifelong learning gap in deprived wards and increase access to ESOL (English for Speakers of Other Languages) courses using health themes

- Courses for English for speakers of other languages are mainly being delivered through two commissioned partners – South Thames College and Groundwork London. Enrolments have been steady during the first few months however it is too early to assess progress with respect to target.

Theme 3: Life skills, lifelong learning and good work

Outcome Indicator	Baseline 2015	Current	Target 2018	RAG rating	Commentary
The number of JSA claimants at Mitcham JCP and ESA claimants	Average for deprived wards is 2.77% (NOMIS June 2015)	2.32%	1.7%	A	As at Qtr 2 2016/17 there are 892 JSA claims at Mitcham.JobCentre Plus.
Increase employment by targeting initiatives to improve soft skills and to deliver skills in growth sectors	100 residents in IT and 200 residents in employability skills training	160	+ 150 employed	G	The initial target has been exceeded Reporting on this target beyond 2015/16 will relate to the new ESF London councils' programme
Assist business start-ups and growth of existing businesses and enable local unemployed to access the new jobs created	N/A	**545** new jobs created	+160 jobs	G	The MBSS programme completed in August 2016. A decision has yet to be agreed on whether a new business support programme will be funded through a future Economic Development Strategy
Bridge the lifelong learning gap in deprived wards and increase access to ESOL (English for Speakers of Other Languages) courses using health themes	36% of learners on qualification live in deprived ward. 60 ESOL learners using health themes	New services set up through commissioning model. Significant emphasis placed on ESOL as part of commissioning principles.	40% 240 ESOL learners using health themes	A	Too early to report on outcomes.

Theme 4: Community participation and feeling safe

4.1 Outcome: Number of people engaged in their communities is increased through volunteering

- A new Joint Voluntary and Community Sector and Volunteering Strategy being developed for submission to Merton Partnership and Cabinet in November and December 2016. Draft recommendations to be presented at Merton Partnership Voluntary and Community Sector November Conference
- 2015/16, 904 volunteers received extra support by MVSC's Volunteering Recruitment Team and assisted into volunteering opportunities in their local community. From April 2016, MVSC's LBM funding ceased for Youth Action Programme (disadvantaged 16-18 year olds); Ageing Well Supported Volunteering Programme (disabilities, long term health conditions, mental health issues, long term unemployed); and Merton Library Volunteers recruitment programme. MVSC has gained some external funding to deliver programmes but with a large reduction in capacity of approximately 58%. Revised trajectory is therefore proposed
- 2,800 residents made contact with MVSC (face to face, and via website) (2015/16) to identify volunteering opportunities and approach organisations.
- The new Volunteer Merton online portal launch in April 2016 and over 500 residents have accessed the website and database of 200+ local volunteering roles. These roles provide at least 600 opportunities for people to volunteer.

4.2 Outcome: Sustainable voluntary and community organisations partner with the public sector to strengthen community capacity and cohesion

- A range of capacity building activities (including training, partnership bids and group forums) delivered to support the health agenda, particularly in East Merton. Funding workshops delivery and funding secured to support health activities.

4.3 Outcome: People remain independent or regain independence as far as possible

- A new reablement service has been implemented and has performed well achieving a significant improvement in the proportion of older people who are offered reablement on discharge from hospital. Reablement remains a key short term intervention, and has become increasingly critical to managing hospital discharges

4.4 Outcome: People feel safer through tackling perceptions of crime

- Metropolitan Police (October 2016) reports public confidence is currently at 68% (1% increase) for the borough which is 1% below the Met average. The Met with partners through Local Multi-Agency Problem Solving Panels to put measures in place to improve perceptions of crime and anti-social behaviour (ASB). Maximum use is being made of community messaging and social media to promote perceptions of safety.
    - In 2015-16 the ASB service received 603 contacts. This was an increase on the previous year and a further increase is anticipated for 2016-17. The most common themes being neighbour disputes, street drinking and environmental crime. Merton is now using new legal tools -Community Protection Warnings and potential subsequent court proceedings (introduced in the amended ASB act, 2014). Across

London compliance rates for the warnings are high with a small percentage requiring further enforcement work and amendments to notices.

- Neighbourhood Watch in Merton plays an important role in strengthening community cohesion as well as crime prevention. Currently Merton's Neighbourhood Watch scheme has close to 30,000 individual members covering the equivalent of 35.5% of the borough. Work between Safer Merton is on-going to maximise coverage as well as maintain active and engaged members.
- Clearly the referendum decision for Britain leaving to EU has had implications on levels of hate crime. Post Brexit there was a 50% increase in reports of hate crime in the borough. Wards with the highest level were Cricket Green, Trinity and Merton Park. The lowest were West Barnes, Lavender Fields and Long Thornton. A new Hate Crime prevention strategy, action plan and communications plan is to be developed

4.5 Outcome: Causes of crime addressed through a place based approach focusing on hot spots

- The 2015-16 Community Safety Strategic Assessment identified four wards within the borough with the highest amount of total volume crime. The wards were Cricket Green, Figgie's Marsh, Pollards and Ravensbury. The Community Safety Partnership considered these wards, alongside other priorities, and the decision was made to not undertake any specific work solely on these areas. However, the crimes affecting these areas are all addressed through other areas of Community Safety Partnership work.
- It is proposed that outcome indicators for the H&WB Strategy are revised to reflect the findings of the planned Strategy Assessment early next year, and reflect recent Domestic Violence needs profile, and a focus on alcohol related crime (below).
- Local Alcohol Action Areas (LAAA) – a bid is being submitted to the Home Office for Merton to be part of a new, two year pilot, which works to address crime committed where alcohol is present. This does provide funding but access to the specialist advice and expertise of the Home Office and Public Health England. The bid is based on a partnership approach between businesses, police, public health and Safer Merton with actions focusing on Wimbledon Town Centre and Mitcham Town Centre. Selection is made in December.

Theme 4: Community participation and feeling safe					
Outcome indicator	**Baseline**	**Current**	**Target**	**RAG**	**Comment**
Refresh Merton Partnership Volunteering Strategy for 2015-17	20% of residents report volunteering participation (Resident Survey 2014indicator)	No resident survey 2016	21% from 2015	No data	MVSC delivering against priorities agreed with Merton Council
Residents who require extra support to volunteer e.g. with disabilities, long term health conditions, mental health problems, 16-18 year olds, and the long term unemployed are supported to volunteer	800 residents 2014/5	Target of 900 residents for 2015/16 , 904 residents supported achieved 2016/17 –to date 313 volunteers supported	Suggested revised trajectory for 2016/17: 380 volunteers; 2017/18: 250 volunteers, due to reduced funding and capacity	G	Target exceeded for numbers of residents supporting in volunteering
Residents are able to easily identify volunteer opportunities and approach organisations	1000 residents 2014/5 (MVSC stats)	2015/16: 2,800 residents contacts (face-to-face support & via MVSC website) (target 1,200)	2016/17: target 880 2017/18: proposed target 750	G	Target exceeded New Volunteer Merton online portal established April 2016
Increase in finance levered into Merton for health and wellbeing activities within the voluntary & community sector in the east of the borough	2 workshops £100,000 secured	5 funding workshops delivered £125,000 levered in	Over £300,000 levered in	G	On target
Capacity building across community groups to enable partnership working with public sector on health and wellbeing agenda	N/A	Capacity building activities implemented	Maintained activity	G	Target achieved

Ensuring that the right people receive reablement services (proportion of older people 65+ who were offered a reablement or intermediate serviceBCF & ASCOF indicator	2013/14 1.6% -against comparator LAs of 4.6%	2015/16 4.4% Against comparator LAs 3.9%	TBC	G	Good performance against baseline and comparators
Improve the provision of mental health peer support services for adults- Pilot Project	N/A	Pilot developed and commissioned to Imagine Independence. Pilot is currently underway.	Pilot developed, implemented and evaluated	A	Pilot commenced from October 2016 Amber as early stage
Support older adults to reduce loneliness and isolation, and remain or regain independence: Two year Pilot Merton Befriending Scheme Number of eligible Merton residents with: a) Telephone befriending b) Face to Face Befriending	N/A	127 clients engaged as of July 2016. Next tranche of data due.	At end of year 2 92 telephone clients and 92 face to face clients seen in Pilot	G	There were initial issues including staff changes However the service been able to engage a significant number of clients.
People feel safe through tackling perception of crime	75% respondents 2015	No survey	80% respondent	A	There has been no resident survey for 2016 Met reports 68% public confidence (1% increase) for the borough which is 1% below the Met average.
Causes of crime addressed in three Hotspot areas identified through the vulnerable localities index	Crime rate in identified ward area before intervention	Not progressed due to revised Safer Merton priorities			Proposed revised outcome indicator and target –following report of Strategic Assessment early 2017

Theme 5: A good natural and built environment

Outcome 5.1: Positive health and wellbeing outcomes are embedded within major developments as a condition of granting planning permission in Merton

- Progress is being made to achieve the target that every master plan and significant planning application will have a Health Impact Assessment.
- Future Merton team is carrying out its first Health Impact Assessment for the Estates Local Plan (development planning document), in collaboration with Public Health Merton. The Plan covers the regeneration of the three estates: Eastfields, High Path and Ravensbury. The HIA provides the tool for consideration of health and wellbeing as part of Estates Plan, and how any negative impacts might be mitigated. Key areas will be ensuring the decant process involved in estates regeneration is well managed as well as the health service needs of the population are understood and addressed.
- The Merton Development Control team require HIA's for all major developments in accordance with London Plan policy. A planning policy guidance on HIA's has been prepared which will give further guidance on HIA's for developers and for Development Control.

Outcome 5.2: Fuel poverty is reduced through collective energy switching

- Fuel poverty affects the most vulnerable residents in our communities and can have adverse impacts on their well-being. The high, and rising, cost of energy is a significant contributor to this problem, and collective energy switching can help reduce residents' energy bills – particularly alongside other key approaches such as increasing home energy efficiency.
- In Merton the aim has been to promote and facilitate the Big London Energy Switch in to enable residents, especially those without internet access, to access collective energy switching programmes. The target of increase annually participation of residents has proved extremely difficult to achieve. Our efforts also 'compete' with a range of other initiatives such as the national Uswitch campaign. Vulnerable residents are more likely to have pre-paid meter arrangements and any debt will mean that it is not possible to switch energy supplier.
- Latest figures on levels of fuel poverty show that since 2012 there has been a gradual increase in Merton. An estimated 10.6% of household (8,384) are fuel poor (2014) compared to 8.6% in 2012. The current level of fuel poverty is similar to London and England.

Outcome 5.3: Pollution is reduced through an increased number of trees in parks

- The programme of tree planting is on-going with sustained investment. More trees are planted every year - in part to off-set losses – both in parks and on highways. Trees are also an appreciating asset and natural growth results in increased canopy. A longer time is required to measure accurate tree coverage and assess impact, and not possible at this interim stage.

Outcome 5.4: Homelessness Prevention through appropriate advice and assistance (proposed revised housing outcome)

- Homelessness Prevention is a central plank to the Council's Housing Needs Service and is in accordance with the provisions of the Housing Act 1996 and the associated government code of guidance. Homelessness Prevention prevents admission into temporary accommodation which households have not chosen themselves and instead gives households the opportunities to continue to occupy their homes until they can make a planned move to suitable alternative accommodation and importantly it brings significant benefits to individual health and well being and seeks to improve life chances
- The importance of Homelessness Prevention is currently being reinforced in the proposals by Government to issue guidance on the importance of homeless prevention activities, and linked to the Homelessness Reduction Bill which received its second Reading on the 28 October 2016.

Theme 5: A good natural and built environment					
Outcome indicator	**Baseline**	**Current 2016**	**Target 2017/18**	**RAG rating**	**Commentary**
Undertake Health Impact Assessment	HIA not part of planning processes	HIA of Estates Local Plan by Future Merton working with Public Health	Every significant developments & masterplans have a HIA	G	HIAs introduced into planning system in line with trajectory for 2018
Promote & facilitate the London Energy Switch in Merton	2013/14 Total registrations: 1103 Total switchers: 117	2014/15 Total registrations: 302 Total switchers: 88 (-24% on 2013/14) 2015/16 Total registrations: 385 Total switchers: 74 (-15% on 2013/14) 2016/17 (*to date) Total registrations: 125 Total switchers: 26	Increased participation of 10% annually	R	Proved difficult to achieve target- No dedicated resource to promote uptake; other major collective energy switching schemes; vulnerable groups possible with debt & have prepaid meters have difficulty switching
Increased tree planting & increasing tree canopy cover	5.5% (5.9% to 6.5% (6.9%) tree cover by LBM managed trees and woodland	No interim measurement by aerial photography survey available	3% increase in LBM managed tree canopy cover	G	Interim monitoring not available- However normal annual growth likely to increase canopy coverage
Homelessness Prevention through advice and assistance	450 cases	265 cases	450 cases annual target	G	On track to achieve annual target

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Committee: Health and Wellbeing Board

Date: 29 November 2016

Strategic Item

Wards: All

Subject: South West London Sustainability and Transformation Plan (STP) and St George's Hospital CQC status

Lead officer: Karen Parsons, Chief Officer Merton, CCG

Lead member: Andrew Murray, Chair, Merton CCG

Contact officer: Karen Parsons

Recommendations:

A. To consider and note the report on South West London STP and St George's Hospital CQC status.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The report gives an update on the South West London Sustainability and Transformation Plan (STP) and the CQC status of St George's Hospital

2 DETAILS

2.1 South West London – Sustainability and Transformation Plan (STP)

The 6 CCGs covering the SWL STP footprint are Merton, Wandsworth, Sutton, Croydon, Richmond and Kingston.

The financial challenge collectively across SWL is around £140m a year and projections shows the financial challenge will reach up to £726m by 2020/21 if we do nothing.

The whole of the NHS in South West London has been working together and with local councils to develop a long term plan that will:

- use our money and staff differently to build services around the needs of patients
- invest in more and better services in local communities
- invest in our estates to bring them up to scratch
- try to bring all services up to the standard of the best.

The plan has now been published for discussion. A summary version is also available. A significant STP communications cascade is in progress to share our plan with our key stakeholders across SWL.

The key headline messages in our 5 year plan are:

- We want people-centred services
- We have some excellent services but we know we can do better

- We will invest much more in mental health and services based in the community as this improves outcomes
- We want to help local people live healthier lives
- We need to transform the way we deliver services to make sure people get the best are and taxpayers get value for money
- We have already achieved a lot

For Merton patients it means:

- Reduced variation in the quality and access of services
- More care delivered outside hospital in community settings (key to this is our emerging GP federation, CLCH and primary care localities as part of our primary care strategy)
- An expansion/transformation of primary care (based on GPFV).
- Proactive, preventative care based on keeping people well and early intervention
- Parity of Esteem for mental and physical healthcare
- Consideration of the best configuration of acute hospitals and specialised services in SWL

As part of the emerging STP Commissioner Operating Model, Merton and Wandsworth CCG have started early discussions about working together to deliver services in a more joined up way to support the recovery of St George's Hospital. This will not compromise our position in continuing to develop a more joined up approach to working with Sutton CCG.

Contrary to misleading media coverage, we also wanted to clarify that there are no proposals to close any hospital in South West London. We are suggesting our hospitals will need to work differently, with more clinical networking and possibly one hospital ceasing to provide certain acute services such as A&E, obstetrics and specialist paediatrics. However we have not ruled out retaining these services in all five hospitals. Our plans are still in development and will be subject to much wider discussion - and formal public consultation should we develop firm proposals to change acute hospital services.

2.2 St George's Hospital CQC status

The CQC published their inspection report on St George's University Hospitals NHS Foundation Trust, giving an overall rating of inadequate and has recommended that it is placed in special measures. It was rated 'good' for caring but the team of inspectors found it "inadequate" for being safe and well-led. It was rated "requires improvement" for being effective and responsive.

We are pleased that the report recognises the caring attitude of St George's staff and acknowledges areas of outstanding practice including positive outcomes for renal patients and improvements in maternity care.

We will continue to monitor, seek assurance and work with the trust, NHS England, NHS Improvement and the CQC to support delivery of St George's recovery plans. We hope that this report marks a turning point that will enable the trust to focus on making the significant improvements that are needed.

3 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

3.1. None for the purpose of this report.

4 LEGAL AND STATUTORY IMPLICATIONS

4.1. None for the purpose of this report.

5 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

5.1. None for the purpose of this report.

6 CRIME AND DISORDER IMPLICATIONS

6.1. None for the purpose of this report.

7 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

7.1. None for the purpose of this report.

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

9 BACKGROUND PAPERS

Link to STP:

http://www.swlccgs.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf

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Committee: Health and Wellbeing Board

Date: 29 November 2016

Strategic Item

Wards: All

Subject: Better Care Fund (BCF) Small Grants Programme

Lead officer: Kim Carey, Interim Head of Access & Assessment

Lead member: Cllr Tobin Byers

Contact officer: Sarah Wells, Service Manager

Recommendations:

A. Approval is sought to proceed with the bid to the London BCF Small Grants Programme

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The aim of the small grants programme is to support the implementation of Better Care Plans in London Health and Wellbeing Board areas. Details of the bid are attached at appendix A.

2 BACKGROUND

2.1 Officers have identified a gap in the service provided by the Re-ablement service whereby if an individual has fallen staff from the service are unable to help them up and have to rely on calling an ambulance to assist with this.

2.2 Mascot, which provides 24 hour cover to people registered to use the service, have access to mobile lifting equipment which can be used to right individuals that have fallen and the Small Grants programme provides the opportunity to bid for monies which could be used to purchase two pieces of equipment which can be used by the team.

2.3 Appropriate training will be provided to staff before they are required to use this equipment.

2.4 This bid is in line with the aims of the Better Care Fund and seeks to reduce the number of people admitted to hospital, but also importantly, seeks to reduce demand on an already overstretched ambulance service.

2.5 Bids are invited for up to £5,000 per Health and Wellbeing Board area and the benefits must be clear and measurable. The Council will need to monitor usage of the lifting equipment to justify the expenditure.

2.6 The Programme states that initiatives to support reduction of Delayed Transfers of Care will be given particular priority.

2.7 Expenditure must be planned for completion by **31 March 2017.**

3 DETAILS

3.1 The detailed bid is attached as Appendix A.

4 ALTERNATIVE OPTIONS

4.1 No alternative options are presented for consideration.

5 CONSULTATION UNDERTAKEN OR PROPOSED

N/A

6 TIMETABLE

BIDS NEED TO BE SUBMITTED BY 30TH NOVEMBER 2016

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None; the equipment will not be purchased if the bid is not successful.

8 LEGAL AND STATUTORY IMPLICATIONS

N/A

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

N/A

10 CRIME AND DISORDER IMPLICATIONS

N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

All staff will be appropriately trained in the use of the equipment before it is used.

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

BID ATTACHED AS APPENDIX A.

13 BACKGROUND PAPERS

N/A

Appendix A

London BCF Small Grants Programme

Aim

The aim of this small grants programme is to support the implementation of Better Care Plans in London Health and Wellbeing Board areas.

Criteria

- Bids are invited for **up to £5,000 per Health and Wellbeing Board area**. Health and Wellbeing Board areas can also submit combined bids.
- **The benefits must be clear and measurable**
- **Initiatives to support reduction of Delayed Transfers of Care will be given particular priority**
- Expenditure must be planned for completion by **31 March 2017.**
- Bids with matched local funding are encouraged
- Funding is not available for completed initiatives or initiatives which have already commenced
- Bids must be received by **midnight 30 November 2016**.

Process

A joint NHSE and ADASS panel will review each bid against the criteria. Wherever possible, the outcome will be communicated to HWBs within 10 working days of receipt.

All successful HWBs will be required to provide a completed expenditure form, with evidence of spend and a best practice sharing template. These must be returned within 1 month of the end of the end of the agreed funding period.

For further information or to submit a bid: contact, Jane Hannon, Regional Better Care Manager janehannon@nhs.net, 01138070643.

London BCF Small Grants Programme

Request for funding

Contact information	
Health and Wellbeing Board area	**London borough of Merton**
Contact name	**Sarah Wells**
Email Address	**Sarah.wells@merton.gov.uk**
Telephone Number	**020 8274 5301**

Funding proposal	
Please describe the proposed initiative	To purchase a piece of lifting equipment that can be utilised by the Reablement Service. This piece of equipment known as the Raizer Lifter is portable, light weight and can be used by just one individual. This will enable the social care staff to lift customers off the floor when they have fallen, and resettle them instead of calling the London Ambulance Service. A one off purchase which will support long term savings targets beyond March 2017
How would the funding support implementation of the local Better Care Plan?	Better utilisation of resources. London Ambulance Service (LAS) will not be called out unnecessarily. Unnecessary attendances at A&E will be reduced and in some cases admissions prevented.

What will the benefits be to local health and social care delivery?	Better use of health and social care resources to include: Reduced cost implication for LAS and the acute trust. Reduced demand placed on front line staff in terms of their time, waiting for ambulances. Improved customer satisfaction as individuals often get very distressed when staff call for an ambulance as they don't want to attend A&E.
How will these benefits be measured?	Number of falls and number of times the Raizer is used, which can be equated to: Number of calls to the LAS avoided, saving approximately £150 each time Number of A&E attendances avoided, saving approximately £150 each time These figures are minimal and do not reflect the increasing costs of those customers that get unnecessarily admitted.

London BCF Small Grants Programme

Expenditure monitoring form

Contact information	
Health and Wellbeing Board area(s)	**London Borough of Merton**
Contact name	**Sarah Wells**
Email Address	**Sarah.wells@merton.gov.uk**
Telephone Number	**020 8274 5301**
Value of grant	**Raizer Lifter £2795.00 + VAT £559.00 + Carriage £40.00 (approx)** **Total £3394.00**

Detail of expenditure	Date	Amount
One off purchase	**December 2016**	**£3394.00**
Total		**£3394.00**

The Better Care Fund *Case Study*

CASE STUDY

Region/HWB area: London Borough of Merton

Challenge/Aim of Project:	Action:
Support a fallen customer and resettle them within their own home	Store the Raizer Lifter within the Reablement Service so that staff have around the clock access to it and utilise it as required.
Result (What indicates that your achieving results– Outputs, Outcomes, Impact) : Speedier response to somebody that has fallen Increased referrals to the falls service Numbers of time the equipment is utilised	**Barriers** (Obstacles that prevented you achieving more) :
Success Factor (What must you do to be successful): Staff to be further trained in how to complete an injury check on somebody that has fallen.	**Lessons Learned** (Reflection, the Good the Bad):

Contact Details:

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State of the Art Lifting Chair

Liftup's new and patented emergency lifting chair is a fast and safe solution when a person has fallen and needs help with transfer to either a standing or sitting position.

Equal Opportunities

Every day thousands of elderly and physically challenged people are falling without being able to get up without assistance. The new RAIZER from Liftup can with ease be assembled and operated by only one assistant. The fallen person can be raised in a safe and effortless manner within a few minutes.

Easy Operation

The assistant can safely operate the RAIZER with minimal physical effort while at the same time observing and caring for the fallen by for instance supporting the head of the fallen person when the transfer is in progress. The RAIZER is an optimal solution for personnel in home care as well for ambulance services and all personnel working with handling and transfer of individuals in general. The RAIZER is light and easy to transport. It is carried disassembled to the place where it is to be used. The heaviest part weighs less than 7 kgs and the RAIZER is easily assembled and placed around the fallen individual without strain to neither the fallen person nor the assistant. The RAIZER is battery operated via a handheld remote control.

Safety above all

For a fallen individual it is of utmost importance that there is a feeling of security while the transfer to standing or sitting position is taking place. At all times during the transfer with RAIZER the individual has contact with the floor as well as physical contact and eye contact with the assistant. For the assistant a transfer can be done without any strain to his or her back. The RAIZER can transfer individuals weighing up to 150 kgs. The transfer movement is smooth and protective and as an extra comfort for the users the RAIZER is equipped with a seat belt.

- Mobile chair for transfer from floor to a sitting or standing position
- Safe working load: 150 kgs
- Seat: width 47 cm depth 22cm
- Battery capacity: approx. 100 transfers before charging
- Charger: 12 V or 100-250 VAC
- Assembly prior to operation: max. 3 minutes
- Transport: smart-handle for the seat and carry bag for back-rest and legs
- CE-marking
- Patented

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08/2014

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Committee: Health and Wellbeing Board

Date: 29 November 2016

Item for Information

Wards: All

Subject: Health in All Policies

Lead officer: Simon Williams, Director of Community and Housing

Lead member: Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health

Contact officer: Dr Dagmar Zeuner, Director of Public Health

Recommendations:

A. To note the report to LBM Cabinet on 14 November on Health in All Policies

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To note the report to LBM Cabinet on 14 November on Health in All Policies which is attached as an appendix.

2. TIMETABLE

As set out in the report

3. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None other than time, LGA will support this work.

4. LEGAL AND STATUTORY IMPLICATIONS

None

5. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Health in All Policies is directly concerned with improving health equity.

6. CRIME AND DISORDER IMPLICATIONS

None

7. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

8. APPENDICES

Health in All Policies report to LBM Cabinet 14 November 2016.

9. BACKGROUND PAPERS

None

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Committee: Cabinet

Date: 14 November 2016

Agenda item:

Wards: All

Subject: Health in All Policies

Lead officer: Simon Williams, Director of Community and Housing

Lead member: Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health

Contact officer: Dr Dagmar Zeuner, Director of Public Health

Recommendations:

A. To note the LGA Health in All Policies peer assessment work to date.

B. To agree to receive the final report and action plan for Health in All Policies and support its implementation.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Health in All Policies seeks to embed prevention of ill health and promotion of wellbeing into everything we do as a Council. It offers an opportunity for Merton to take a lead in having a positive impact on health, wherever possible, in all of its policies and services for the benefit of local residents.

1.2. As Merton is the first Council to take part in this LGA programme in London, it will contribute to our aim to be London's best Council by 2020. We also anticipate that the Mayor of London's health inequality strategy will embrace this approach.

1.3. There is potential for a strong mutual benefit from Health in All Policies, across the Council and our partners. We understand that health and health equity are not only important goals in their own right but also prerequisites for achieving other corporate council goals such as educational attainment, employment, safety, sustainability and prosperity.

1.4. Our allocated Health in All Policies peer, Cllr Rory Palmer (Deputy Mayor, Portfolio Holder and Chair of Leicester City Council Health and Wellbeing Board) will attend Cabinet on 14 November. He will set out the work underway, opportunities to share good practice and seek Cabinet's consideration, contribution and agreement to receive the final report and action plan on completion of the peer assessment.

2 DETAILS

2.1. LGA piloted a HIAP programme last year with ten councils nationally. Evaluation was positive but limited funding was made available for 2016/17. Merton was offered a funded place for a self assessment questionnaire and facilitated workshop; the first in London. Success of the self assessment relies upon real involvement and engagement of officers, Councillors and partners. Along with the discussion with Cllr Rory Palmer, Cabinet are asked

to note the HIAP work programme and agree to receive the action plan that results from the work.

2.2. HIAP seeks to embed prevention of ill health and promotion of wellbeing into everything we do as a Council. We believe there is a strong mutual benefit in this, across the Council as a whole and our partners, seeing the opportunities of improving health and wellbeing to a wide range of our corporate objectives: educational attainment, employment, safety, independence and recovery, sustainability and prosperity.

2.3. HIAP links to the Mayor of London's work on Tackling London's Health Inequalities and the pledge of, 'getting to grips with health inequalities .. (and) renewing focus on prevention'. It also links to our work in Merton towards excellence under the London Healthy Workplace Charter.

2.4 HIAP recognises that health and health equity are important goals in their own right, and prerequisites for achieving other goals, for example in Merton, Bridging the Gap between the East and West of the borough. It recognises the varying priorities that are difficult for councils to reconcile and tries to provide a framework to manage these and identify solutions that contribute positively. Health and wellbeing is contingent on so many societal factors under the control of councils, that it lends itself as a marker of good government, where spending can become an investment rather than just an expenditure that needs to be controlled.

2.5 HIAP is about ways of working: systems leadership; building relationships and collaborations across services and partners, for example, between councillors and GPs; making the best informed decisions; and, effective implementation. A HIAP approach aims that each decision seeks the greatest health benefit possible for the investment asking key questions such as 'what will this do for the health and wellbeing of the population?' and 'will this reduce health inequalities locally?'

2.6 Examples can include social value procurement (that considers the impact on health and wellbeing, supports local communities and builds voluntary sector capacity where possible), responding to the Care Act and duty of wellbeing for service users and carers and tools like Health Impact Assessment for planning developments (on which joint work with Planning and Public Health Planning is already underway).

2.7 HIAP offers considerable opportunities, most of which would have not financial implications aside from officer time. It is important to consider any additional bureaucracy versus potential gain but the ambition for HIAP is that it can build on the strong partnerships in Merton and help manage medium and longer term financial pressures and strengthen the council corporately towards 2020.

3. Methodology and timeline

3.1 As part of the HIAP programme the LGA have issued a questionnaire to Council officers and CCG partners identifying existing work and further opportunities to further strengthen and embed prevention.

Two ‘peers’ have been assigned to Merton: Councillor Rory Palmer (Portfolio holder for Adult Social Care, Health Integration and Wellbeing, Chair of the Health and Wellbeing Board and Deputy City Mayor, Leicester City Council) who will attend the Cabinet meeting and Martin Smith (previously Chief Executive of Ealing Council).

3.2 In addition to the discussion at Cabinet, the peers and LGA will conduct stakeholder interviews with key partners (including the voluntary sector, CCG, Police and Fire Borough Commander etc).

This will be followed up by a HIAP workshop for officers in December where the full findings of the peer assessment will be analysed, case studies of good practice will be considered and an action plan drawn up for Merton. The action plan will set out the new collaborative work needed, building on existing initiatives, to achieve the mutual benefits which Health in All Policies can deliver.

3.3 Following completion of the HIAP peer assessment the LGA will write to the Council with their report to which the Council then has the opportunity to respond. The Merton action plan will be built upon the findings of the LGA and the contributions of all participants and partners in the work.

3.4 The below timeline gives a summary.

Timeline	Activity
October 2016	Circulation and completion of self assessment questionnaire to officers and CCG
Oct/Nov 2016	Stakeholder interviews with key partners (voluntary sector, CCG, Police and Fire Borough Commanders etc)
November 2016	HIAP peer visit and report to Cabinet
December 2016	Officer workshop session facilitated by LGA and HIAP peers
January 2017	LGA report received and action plan developed

4. ALTERNATIVE OPTIONS

The LGA has offered to fund the work on HIAP. There is no alternative.

5. CONSULTATION UNDERTAKEN

The HIAP self assessment will involve consultation across the Council and key partners.

6. TIMETABLE

As set out in the report

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None other than time, LGA will support this work.

8. LEGAL AND STATUTORY IMPLICATIONS

None

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Health in All Policies is directly concerned with improving health equity.

10. CRIME AND DISORDER IMPLICATIONS

None

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

12. BACKGROUND PAPERS

None

Department of Health

From David Mowat MP
Parliamentary Under Secretary of State for Community Health and Care

Richmond House
79 Whitehall
London
SW1A 2NS

Dear Health and Wellbeing Board Chairs,

I am writing to you in your capacity as a Health and Wellbeing Board (HWB) Chair to highlight the General Practice Forward View, recognising the important relationship that primary care has with the delivery of local health and wellbeing strategies. This document is part of the future vision for the NHS being developed as part of NHS England's overarching Five Year Forward View.

The role of general practice is central to our health and care system, but we know that pressure on GPs and other general practice staff is increasing. The Government and NHS England have recognised the need for additional support and, on 21st April 2016, NHS England published the GP Forward View. This is a package of support to help get general practice back on its feet, improve patient care and access, and invest in new ways of providing primary care. It sets out that we are investing an extra £2.4 billion a year for general practice services by 2020/21, which represents a 14% increase in real terms. The overall investment includes a £500 million five year Sustainability and Transformation package to support GP practices, which contains measures to help boost the workforce, drive efficiencies in workload and modernise primary care infrastructure and technology.

However, as HWBs will be very well aware, general practice cannot work effectively in isolation, and the GP Forward View looks at general practice's role in relation to the wider system – both how improved integration can provide additional support to general practice and the contribution that general practice staff make on wider social issues. It also highlights the important role that primary care can play in supporting integration across local health and care systems.

We acknowledge that many HWBs are already promoting strong and effective relationships between general practice services and other health, social care, public health and wider local services; and that they recognise the centrality of primary care in integrating their local health and care systems and the need to ensure access to all relevant support services. These links are going to be even more important in the future, and so I am writing to ask all HWBs to review the GP Forward View document and consider what more Boards could do to build effective relationships between primary care and wider local services.

There are many examples of effective collaboration with primary care at a local level, including:

- *Just What the Dr Ordered* (published by the Local Government Association in April 2016) contains case studies on social prescribing from: East Riding of Yorkshire;

Blackburn with Darwen; Knowsley, Halton and St Helen's; Luton; Rotherham; Cotswold; Doncaster; Tower Hamlets; and Forest of Dean: http://www.local.gov.uk/documents/10180/7632544/L16-108+Just+what+the+doctor+ordered+-+social+prescribing+-+a+guide+to+local+authorities/f68612fc-0f86-4d25-aa23-56f4af33671d.

- Northumberland's network of community hubs with strong voluntary, community and faith sector engagement and support planners working with GPs.

- Social prescribing in Gloucestershire: http://www.gloucestershire.gov.uk/extra/CHttpHandler.ashx?id=63219&p=0.

- Wiltshire's community hubs where primary care services are co-located with other services in buildings such as libraries: http://www.wiltshire.gov.uk/hwb-2015-annual-report.pdf.

HWBs will additionally already be engaged in the Sustainability and Transformation Plan (STP) process. As set out in the NHS Shared Planning Guidance, published in December 2015, the success of STPs will depend on having an open, engaging, and iterative process that involves clinicians, patients, carers, citizens, clinicians, local community partners including the independent and voluntary sectors, and local government through, for example, health and wellbeing boards, building on existing plans such as Health and Wellbeing Strategies and Joint Strategic Needs Assessments.

The arm's length bodies responsible for the NHS Five Year Forward View – NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England and the National Institute for Health and Care Excellence – have asked for local engagement plans as part of the Sustainability and Transformation Plan process, building where appropriate on existing engagement through health and wellbeing boards and other local arrangements, including GP services.

In summary, given the potential benefits outlined above, I am asking HWBs to consider how, through their work and specifically through Joint Health and Wellbeing Strategies, they can encourage action to develop and strengthen relationships with general practice services in local areas, in order to generate benefits for the whole system and better outcomes for patients.

Yours faithfully,

DAVID MOWAT

Department of Health

Department for Communities and Local Government

To:
Chief Executives
Directors of Adult Social Services
Local Authorities, England

Copy:
Health and Wellbeing Board Chairs
ADASS National Urgent Care Lead
ADASS Regional Urgent Care Leads
Local Government Association
NHS England Regional Directors
Emergency Care Improvement Cluster Leads

11 November 2016

Dear Colleague

Winter Planning for Adult Social Care and Supporting Delivery into 2017

We know that everyone in the adult social care system has been planning for the winter months alongside their NHS partners and, first of all, we would like to take this opportunity to thank you for all of your efforts.

We also appreciate that the coming months may be challenging, particularly with a long bank holiday weekend over Christmas, and with January and February usually being difficult months as systems manage the impact of high seasonal demand. Given this, we wanted to write to you to outline some practical actions and avenues of support that local authorities could consider to foster resilience over the period.

A&E Delivery Board Plans

Local Authority Chief Executives will have received a copy of a letter sent to Local A&E Delivery Board Chairs on 21st October by NHS England and NHS Improvement about priorities and the assurance of winter plans to manage performance. The letter emphasises the importance of ensuring that social services are fully embedded in on-going discussions and implementation of the five improvement initiatives of the 2016/17 A&E Improvement Plan arrangements. This is extremely welcome and we would ask you to continue to do all you can to support implementation, particularly in relation to reducing delayed transfers of care.

Lessons from 2015/16

Since last winter, we have listened to the views of local government and taken on board some important lessons. We understand that we need to take a proportionate approach and allow local organisations to work together to develop solutions, and that we need to mirror this joint working at national level. That is why we set up the Discharge Board with our partners to co-ordinate a coherent, cross-system approach to improvement. Through the Board, we are working with local government, the NHS and system partners to oversee, coordinate and deliver meaningful approaches to address delays in hospital discharge.

Market Shaping

The Care Act 2015 introduced new duties on local authorities to shape their local market and to ensure that there is a choice of quality providers for all people in their areas, taking account of ensuring sufficient capacity to support safe, prompt hospital discharge. The Department of Health (DH) has worked with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) to produce a wide range of practical approaches to help local authorities to discharge these duties, including work delivered by the Institute of Public Care on best practice in market shaping, and *Commissioning for Better Outcomes*: *a route map*, a practical tool for self-assessment and peer-review developed with the LGA and sector-led improvement:
http://ipc.brookes.ac.uk/what-we-do/market-shaping.html
http://www.local.gov.uk/search?q=commissioning%20for%20better%20outcomes

DH is consolidating all of the advice and guidance on market shaping, commissioning and contingency planning onto a Markets Hub as an on-line resource available on GOV.UK, which should be available later in November.

Sector-Led Improvement

DH has also worked with the LGA and ADASS to put an enhanced sector-led improvement programme in place. We have seen the positive impact of this programme and are very pleased with the support that it is providing – both in individual areas that may be facing significant pressures and in sharing the very best practice. Your Director of Social Care will be aware of the *High Impact Change Model*. It provides practical support options, particularly around patient flow and discharge, and helps to assess how effectively current systems are working:
http://www.local.gov.uk/documents/10180/7058797/Impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc5cd6e3c1a

Since the *High Impact Change Model* was developed, the LGA and ADASS have also worked with the NHS and system partners to produce a range of tools to help local systems, including a series of *Quick Guides* containing practical approaches, case studies and links to useful documents that identify solutions to commonly experienced issues:
http://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx

If your local hospital is part of the Emergency Care Improvement Programme support to address seasonal demand is available through that programme.

Graeme Betts (graemebetts@yahoo.co.uk or 07789 205 201) leads for the LGA on sector-led improvement support for winter pressures. He is supported by regional Care and Health Improvement Advisors and Regional ADASS Urgent Care Leads who are available to provide specific support to local areas.

Region	**Local Government Care and Health Improvement Advisors**	**ADASS Regional Urgent Care Leads**
North	Terry Dafter (North West) terrydafter@me.com 07427 223 383 Sandie Keene (North East) sandiekeene@me.com 07824 512 908 Moira Wilson (Yorkshire and Humberside) moiral.wilson@ntlworld.com 07824 512 908	Dwayne Johnson dwayne.johnson@sefton.gov.uk
London	Adi Cooper dradicooper@gmail.com 07468 511 404	Grainne Siggins grainne.siggins@newham.gov.uk
Midlands and East	Rachel Holynska r.holynska@btinternet.com 07585 328 458 Ian James (West Midlands) jamesian03@btinternet.com 07 817 542 255.	David Stevens david_stevens@sandwell.gov.uk
South East and West	Oliver Mills oasmills@btinternet.com 07881 820 895	Keith Hinkley keith.hinkley@eastsussex.gov.uk

Seasonal Influenza

As we are approaching winter, we would also ask you to consider what steps, including with the independent care sector, you need to take to make sure that all front-line staff are vaccinated against seasonal flu. This will protect them and the vulnerable individuals they care for.

The flu fighter campaign delivered by NHS Employers has resources available on-line to help you plan, deliver and evaluate a flu vaccination campaign targeted at increasing the uptake of the vaccine among health and care workers. You can access and download resources, including posters, screensavers and promotional artwork for free at:
www.nhsemployers.org/flu

Emergency Preparedness

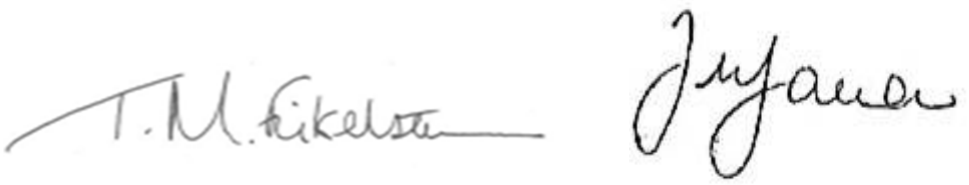
Your local authority should be briefed via your local resilience forum (LRFs) on the wider civil emergency risks you should be planning for this winter. DCLG officials are discussing with LRFs their readiness to respond to severe winter weather and flooding; you may find it helpful to review your own authority's readiness against the check list in the DCLG / Solace Local Authority Preparedness for Civil Emergencies: A Good Practice Guide.

The annual Met Office *Get Ready for Winter* campaign was launched on 7th November, and this year's theme is informal carers: looking out for neighbours, family and those vulnerable to the effects of winter weather. The 2016/17 webpages are available now and can be linked to your emergency planning advice for local businesses and residents, along with details of how your communities can contact you in an emergency.

Conclusion

We appreciate all of the effort going into preparing for winter and the work you are doing with partners on plans and look forward to continuing to work with you.

Yours Sincerely



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TO:
Chairs of Health and Wellbeing Boards
Chief Constables
Police and Crime Commissioners

15 November 2016

Dear All

Police and Crime Commissioners and Health and Wellbeing Boards

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health's public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.

There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: http://www.crisiscareconcordat.org.uk/

- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.

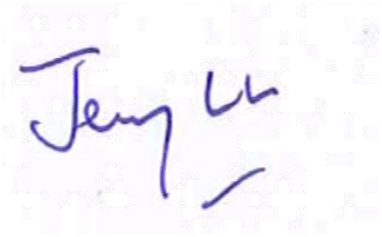
- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.

- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.

- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area's alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.

FOR INFORMATION

Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.



The Rt Hon Amber Rudd MP

The Rt Hon Jeremy Hunt MP

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