Merton Council
Health and Wellbeing Board

Date: **23 June 2015**

Time: **1.00 pm**

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

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

Future meeting dates

FUTURE MEETING DATES

29 September 2015

24 November 2015

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

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

Council Officers (non-voting)

- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Public Health

Statutory representatives

- Four representatives of Merton Clinical Commissioning Group
- Barbara Price, 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
24 MARCH 2015
(13.00 - 14.10)

PRESENT Councillor Caroline Cooper-Marbiah (in the Chair), Eleanor Brown (Chief Officer MCCG), Dave Curtis (HealthWatch), Kay Eilbert, (Director of Public Health), Dr Howard Freeman (Chair of MCCG), Chris Lee (Director of Environment and Regeneration), Councillor Gilli Lewis-Lavender, Khadiru Mahdi (Merton Voluntary Services Council), Councillor Maxi Martin, Yvette Stanley (Director of Children, School and Families), Simon Williams (Director of Community and Housing) and Dr Karen Worthington (MCCG).

Also Present Clarissa Larsen (Health and Wellbeing Board Partnership Manager) and Chris Pedlow (Democratic Services)

1 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 1)

No declarations were received

2 APOLOGIES FOR ABSENCE (Agenda Item 2)

Apologies were received from Adam Doyle (Deputy Chief Officer MCCG) and Melanie Monaghan (Community Engagement Network - Carers Support Merton)

3 MINUTES OF THE MEETING (Agenda Item 3)

The minutes of the Health and Wellbeing Board held on the 27 January 2015 were approved as a correct record.

4 BETTER CARE FUND (Agenda Item 4)

The Director of Community and Housing presented the Better Care Fund (BCF) which provided an update on the implementation of the BCF plan and detailed that the BCF target for Non-Elective Admissions had reduced from 3.5% to 1.41%. In guiding the Board through the report emphasis was given to the update on Holistic Assessment and Rapid Investigation Service (HARI) as detailed in paragraph 3 of the report.

The Board discussed in detail Section 5 and 6 of the report – 'Alignment of Schemes' and 'Objectives of Integration', respectively, especially their relationship and interactions with the Out of Hospital Schemes and the revised versions of the Merton Integration Board.

It was noted that the Board was pleased with the praise received following visits from senior Government officials, as detailed in Section 7 of the report.

RESOLVED

That the Board:

1) notes the progress of with the Better Care Fund plan.

2) agrees of the reduction of the BCF target for Non-Elective Admissions from 3.5% to 1.41% is formally noted, having been transacted outside the meeting cycle for reasons of timing by the Merton Integration Board.

5 MCCG DRAFT OPERATING PLAN REFRESH (Agenda Item 5)

The Chief Officer of the MCCG guided the Board through a presentation which detailed Merton CCG Operating Plan Refresh - 2015/16. During the presentation the Board asked a number of questions on what they had been presented with. Arising from that discussion the Chief Officer of the MCCG agreed to provide Councillors on the Board with a breakdown of the dementia diagnosis across the Borough by ward boundaries.

A copy of the presentation was included as Appendix A to these minutes.

RESOLVED

That the Board noted the presentation on Merton CCG Operating Plan Refresh - 2015/16.

6 HEALTH AND WELLBEING BOARD TERMS OF REFERENCE (Agenda Item 6)

The Director of Public Health presented the report which proposed revised terms of reference for the Board, which aimed to reflect the areas of responsibility and ways of working that governs the Board in the future. It was noted that the basis of the revised terms, had arisen from some slight changes in legislation and guidance also from feedback gained from the Board members themselves following their facilitated development session.

In considering the report the Board were in general support of the proposals. However an amendment was moved by Dr Freeman that the Board chairmanship should move way from being solely chaired by the Cabinet Member for Adult and Social Care. Instead it was proposed to have a co-chair scenario with the current Chair sharing the chairing jointly with the Chief Officer of the MCCG. In putting the amendment forward it was noted that he believed that majority of other Health and Wellbeing Board across London were co-chaired in that way. The amendment was then seconded.

In response to this it was highlighted that as this option had been mooted during the brainstorming session, officers had sought some general advice as to whether it would be possible. The advice received was that constitutionally it was felt unlikely to be possible due to the executive nature of the Board and possibly a change to constitution would be required. However having a named vice chair would certainly be possible. It was suggested that further advice be sought on this matter and the decision over chairmanship be brought back to the next meeting of the Board. Dr Freeman replied that as the amendment had been a moved and seconded, a vote was required and if agreed, unless it was proven to be illegal to have a co-chair then it should occur.

The Board then voted on the amendment which was carried, that subject to any legal reasons to the contrary the Health and Wellbeing Board was to be Co-Chaired by the Cabinet Member for Adult and Social Care and the Chief Officer of the Merton CCG.

RESOLVED

1) That the Board agrees to the proposed new governance arrangements and Terms of Reference for the Health and Wellbeing Board, including that the Board be Co-Chaired by the Cabinet Member for Adult and Social Care and the Chief Officer of the Merton CCG.

2) That the Board agrees to seek approval from Cabinet for the new governance arrangements and Terms of Reference for the Health and Wellbeing Board.

3) That Officers investigate, prior to the report going to Cabinet as to the legality of having Health and Wellbeing Board being Co-Chaired.

Note by the Head of Democracy Services

Following a discussion after the meeting between Officers from the Council and the Merton CCG, it was jointly agreed that it would be more appropriate that the recommendation for Co-Chairing should be the Chair of the CCG rather than the Chief Officer of the Merton CCG. As such the proposal was included in the Health and Wellbeing Board's Terms of Reference that was put before Cabinet for their ratification:

'that, subject to a legal reason to the contrary that the Health and Wellbeing Board was to be Co-Chaired by the Cabinet Member for Adult and Social Care and the Chair of the Merton CCG.'

7 HEALTH AND WELLBEING STRATEGY REFRESH 2015-2018 (Agenda Item 7)

The Director of Public Health presented the report which sought approval for the Chair of the Board to sign off the Health and Wellbeing Strategy 2015-18. In presenting the report it was noted that there were still some minor amendments were required before the strategy would be ready for final sign off and publication. However the final draft would be sent to all board members for comments prior to Chair signing it off on their behalf.

The board confirmed they were happy with the proposed Chair's action to sign off the strategy, as they would be receiving a copy of the final draft also.

RESOLVED

That the Board noted the report and subject to circulation of a final draft strategy to Members of the Health and Wellbeing Board, and agree to Chair's action to sign off the Health and Wellbeing Strategy 2015-18.

8 PHARMACEUTICAL NEEDS ASSESSMENT (Agenda Item 8)

The Board considered the report that sought the adoption and then publication of the Pharmaceutical Needs Assessment. The Board noted paragraph 2.2 which details the key findings of the assessment namely that there appears to no requirements for any additional pharmacies. There was however a gap in provision of the minor ailments service (an enhanced service) on Sundays in the East Merton and West Merton localities.

RESOLVED

That the Health and Wellbeing Board agrees that the completed Pharmaceutical Needs Assessment can be adopted and published in line with the statutory deadline of 1st April 2015.

9 CHARTER FOR HOMELESS HEALTH (Agenda Item 9)

The Board considered the report which sought their agreement to sign up to the Charter for Homeless Health. The Board were pleased to support the principles contained within the Charter as they were fully aware that the effects of being homeless did have a significant impact on those health of the individuals. Therefore the local health service (through the Board) had a responsibility to meet the need of the people who were homeless.

The Board acknowledged that homelessness across London was an issue that needed to be tackled in a cross borough manner and the rising of the new ‘hidden homeless’ should not be forgotten in such work, especially from a health perspective.

It was noted that the One Merton Group had supported the Board signing of the charter.

RESOLVED

The Health and Wellbeing Board agrees to sign the Charter for Homeless Health

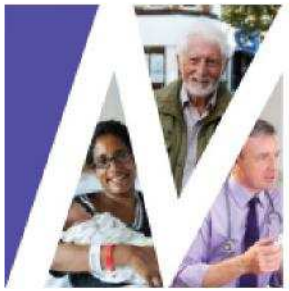
NHS
Merton
Clinical Commissioning Group

Merton CCG Operating Plan Refresh - 2015/16

Eleanor Brown

Chief Officer, MCCG

Merton Health and Wellbeing Board



right care
right place
right time
right outcome

Aim of today

To outline the process undertaken in MCCG to review the NHS England planning guidance, revise our operating plan and implement this in Merton.

Background – 2014/15

- 2014/15 was the first time commissioning organisations within the NHS developed operational plans for two years;
- Plans included financial allocations based on two years;
- Major themes of this were integration with a clear focus on the Better Care Fund (BCF);
- CCGs were required to deliver all constitutional pledges;
- CCGs were required to deliver 15% access target for our IAPT service and 67% dementia diagnosis rate.

High level Achievements – 2014/15

- There was a real clinical drive for change within the organisation – we can still go further;
- A developing staff structure to deliver change;
- Delivered a balanced financial plan which performed well in 2014/15;
- Our Better Care Fund which was a joint initiative with the LA was rated 'one of the five best in the country‘;
- We will have delivered the 15% access target for our IAPT (awaiting validation) service;
- We have gone from a 49.9% dementia diagnosis rate in April 2014 to 65% by year end 2014/15;
- Over 70% of patients at the end of life on Coordinate My Care (CMC) register die in their Preferred Place of Care (PPC).

Investment into Patient Care – 2014/15

- Integrated Locality Teams;
- Dementia nurse – one in each locality;
- Four more intermediate care beds;
- Winter investment into social care to ensure patients are discharged as soon as possible;
- Increased participation in Expert Patients Programme (EPP) – Polish, Tamil;
- Health coaching for Chronic Obstructive Pulmonary Disease (COPD) patients;
- A specific service commissioned for people with Complex Depression and Anxiety (CDA);
- A new Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) service in borough for Merton patients.

Investment into Patient Care – 2014/15

- A new health and social care team working with children;
- Increased paediatric appointments in primary care;
- A new model of care for musculoskeletal patients;
- The Nelson Health Centre built on time and in budget;
- Model of Care developed for East Merton;
- Site selected for East Merton Health Centre;
- Proactive GP pilot in East Merton;
- New obesity service model designed with public health.

Planning Guidance – 2015/16

- Five Year Forward View – October 2014;
- 2015/16 Planning Guidance – December 2014;
- A number of new requirements alongside existing ones - particularly in reference to mental health services.

Merton CCG – Agenda

- London Healthcare Commission
- South West London Commissioning Collaborative (SWLCC)
- Merton Better Healthcare Closer to Home (BHCH)
- New Community Services
- Emerging Federations
- Local Authority financial pressures

Planning Guidance – Areas of Focus, MCCG

- Prevention
- Empowering patients
- Engaging communities
- Models of Care
- Regime
- New deal for Primary Care
- Improving quality and outcomes
- Improving patients' safety
- Meeting NHS Constitutional Standards
- Achieving parity of esteem
- Learning Disabilities
- Information
- Workforce

Operating Plan Refresh 2015/16 - progress

- Operating Plan still based on Joint Strategic Needs Assessment (JSNA), NHSE Guidance and year one Operating Plan;
- All areas of new guidance have been scoped and there is a RAG rating and update on weekly basis to ensure the refresh is on track;
- There are a number of external factors which are out of the CCGs control - DTR and ETO tariff; application of Commissioning for Quality and Innovation (CQUIN) guidance awaited in a number of key areas; current provider financial performance; nil contracts yet signed;
- Awaiting formal feedback from NHS England on draft plan;
- It is therefore difficult to have a clear plan for all investment;
- Financial plan is still draft.

Operating Plan Refresh – revised timeline

- Expected to sign contracts in early April;
- Will submit final plan in early April;
- The narrative will be 'wrapped around' this and will be formally agreed at the MCCG Governing Body meeting, May 28th 2015;
- Plan will be shared at the next HWBB full meeting;
- Investments will be reviewed once the financial position is locked down;
- All Mental Health investments will go ahead immediately -
  - Crisis
  - Improved Home Treatment Teams
  - IAPT – new contract
  - Single point of access for CAMHS
  - Multi Systemic Therapy

Committee: Health and Wellbeing Board

Date: 23 June 2015

Agenda item:

Wards: All

Subject: MSCB Annual Report

Lead officer: Yvette Stanley, Director of Children Schools and Families

Lead member: Councillor Maxi Martin, Cabinet Member for Children's Services

Contact officer: Paul Bailey: Paul.Bailey@Merton.gov.uk

Recommendations:

A. That the report is received by the Health and Wellbeing Board

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The MSCB Annual Report is a key document from the MSCB. The Annual Report aims to give an assessment of the effectiveness of an LSCB; to show the MSCB's awareness of the quality of single agency and multi-agency safeguarding work at the frontline to protect children and young people, and to show the Board understands its local area and needs, how it prioritises and meets its statutory duties and holds its members to account.

1.2 On the evidence set out in this report the MSCB judge its current arrangements to be good, providing reasonable assurance that all partners are doing as much as they can to ensure the safeguarding and safety of children and young people. The Board has worked hard to restructure itself for effectiveness it is hoped that the changes we have made in governance will enable a more robust level of challenge and accountability; the Business Implementation Group will ensure that the Board is more capable of executing its key priorities as well as monitoring and reviewing its effectiveness.

In conclusion the MSCB is compliant with statutory guidance and working well to protect children and young people in the London Borough of Merton.

1.3 Areas which will continue into 2015 include:

The Board is seeking to improve its 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 is seeking to improve its links to practitioners and their managers.

1.4 In reviewing its own effectiveness the Board is seeking to streamline its business processes to ensure SMART working and to prioritise and de-bureaucratise its work streams.

Priorities for the 2015 calendar year are:

- quality assurance and challenge to improve direct safeguarding with children, young people and their parents in all local agencies
- engaging with and listening to children and young people

- continuous learning and feedback
- better understanding of our local needs, including children with particular vulnerabilities**, with particular emphasis on child sexual exploitation (CSE emphasis added Nov 2014)
- greater involvement of schools and early years services as places where children and young people are best safeguarded
- increasing understanding about chronic neglect and working to safeguard children who are particularly vulnerable**
- and better communication to the local community and to practitioners about safeguarding

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

Annual Report of Merton Safeguarding Board 2013/14

** Young people who experience domestic violence, sexual exploitation, parental ill health, neglect, alcohol and substance misuse and abusive cultural practices eg fgm

Annual report of the Merton Safeguarding Children Board

2013/14

Date of publication: December 2014

www.merton.gov.uk/lscb

Lead: Keith Makin, Independent Chair,

MSCB Contact: Business Manager

Contents

1.0 Chair's Introduction

With my appointment as a new Chair and with a new interim Business Manager in place at the start of the 2014/15 municipal year we actively took the decision to delay the production of the 2013-14 report to enable me to review with the Board its effectiveness and to develop, agree and implement changes to the constitution. This work was completed in the autumn 2014 following which this report was completed. It therefore covers the period April 2013 to December 2014. A new Annual Report will be completed at the end of 2015.

I started my role as MSCB Chair in April 2014 with an induction programme which included overseeing the Annual Quality Assurance Review of all SCB agencies Section 11 returns. This was an enormously valuable exercise. The DCS and I met with local heath agencies including the CCG and the acute trusts, with CSF services: children's social care, education, youth justice; with the Police and Safer Merton; with adult services and the Mental Health Trust. We will be taking the learning from this into our QA process for 2015 by including peer challenge in the process.

An early highlight of 2014 was our MSCB conference January 2014 which had a focus on adolescence reflecting some of the issues arising out of our 2013 Serious Case Review. It was an early indication for me of the commitment of local SCB partners and the engagement of the frontline staff across agencies in working together to protect and safeguard young people of all ages.

During 2014 the MSCB and Children's Trust also undertook a self evaluation of our work using the Ofsted Single Inspection Framework. We noted the board strengths as:

- Senior representation and engagement from agencies
- A Lay member and a Young Member linking with the Children in Care Council
- A strong performance focus including the annual QA process
- Financial contributions from all relevant partners
- Annual conference and comprehensive training programme.

Our agreed areas of focus 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 board;
- Reviewing our Board infrastructure to support the board's extended role under Working Together 2013;
- 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 boroughs by others as well as maintaining our focus on Merton LAC.

The national focus on Safeguarding issues has continued throughout the year with the publication of the Rotherham Inquiry into Child Sexual Exploitation and heightened awareness of the Prevent agenda with young people being groomed to participate in wars over seas and terrorist activities at home. We concluded the year by undertaking a self evaluation of our work on Children at Risk of Sexual Exploitation. We also participated in a peer review with our neighbours Sutton, Richmond and Kingston and contributed to a Pan London review overseen by the London Safeguarding Children's Board. The learning from all these processes will inform our 2015 work programme.

To ensure we are driving the changes needed and maximising our impact we concluded 2014 by establishing our Business Improvement Group to oversee the work programme in detail and to provide additional peer challenge. Thus we will start 2015 in a good place to deliver our ambitions for all children and young people, but in particular those who are vulnerable and at risk.

I would like to close by thanking all Merton SCB agencies for their hard work and continued commitment to making a difference for Merton's children.

Keith Makin

MSCB Chair

December 2014

2.0 Progress of MSCB Business Plan 2013 – 14

The MSCB has a well established Business planning process with the plan receiving regular scrutiny at board level. The last update received by the board was in Nov/Dec 2014 and is attached as an appendix.

Key areas of focus in the plan over the period have been:

Priorities for this business year are:

- quality assurance and challenge to improve direct safeguarding with children, young people and their parents in all local agencies,
- engaging with and listening to children and young people,
- continuous learning and feedback,
- better understanding of our local needs, including children with particular vulnerabilities[1], with particular emphasis on child sexual exploitation (CSE emphasis added Nov 2014)
- greater involvement of schools and early years services as places where children and young people are best safeguarded,
- increasing understanding about chronic neglect and working to safeguard children who are particularly vulnerable;
- and better communication to the local community and to practitioners about safeguarding.

3.0 Key Achievements and Challenges for the MSCB 2013 – 14

- The Board has successfully secured senior representation and engagement from all agencies.
- The Board has also reviewed the terms of reference for the QA Sub Group to give it a sharper focus on performance.
- We have been able to appoint a second Lay member and a young member (CICC) for 2015
- The Board continues to maintain a strong performance focus – data set and Chairs QA annual review
- All partners contribute financially to the work of the Board and there is good support from partners on the main Board and with the sub-groups.
- We held our Annual conference in January 2014. The conference challenged participants regarding the learning from SCRs and had a particular focus on neglect and adolescents; cross generational abuse and the impact of parental substance misuse. The event was rated highly with the majority of participants rating the event as excellent.
- Comprehensive work programme and good linkage to Children's Trust and HWBB

[1] *e.g. domestic violence, sexual exploitation, parental mental ill-health, neglect, alcohol and substance misuse, abusive cultural practices,*

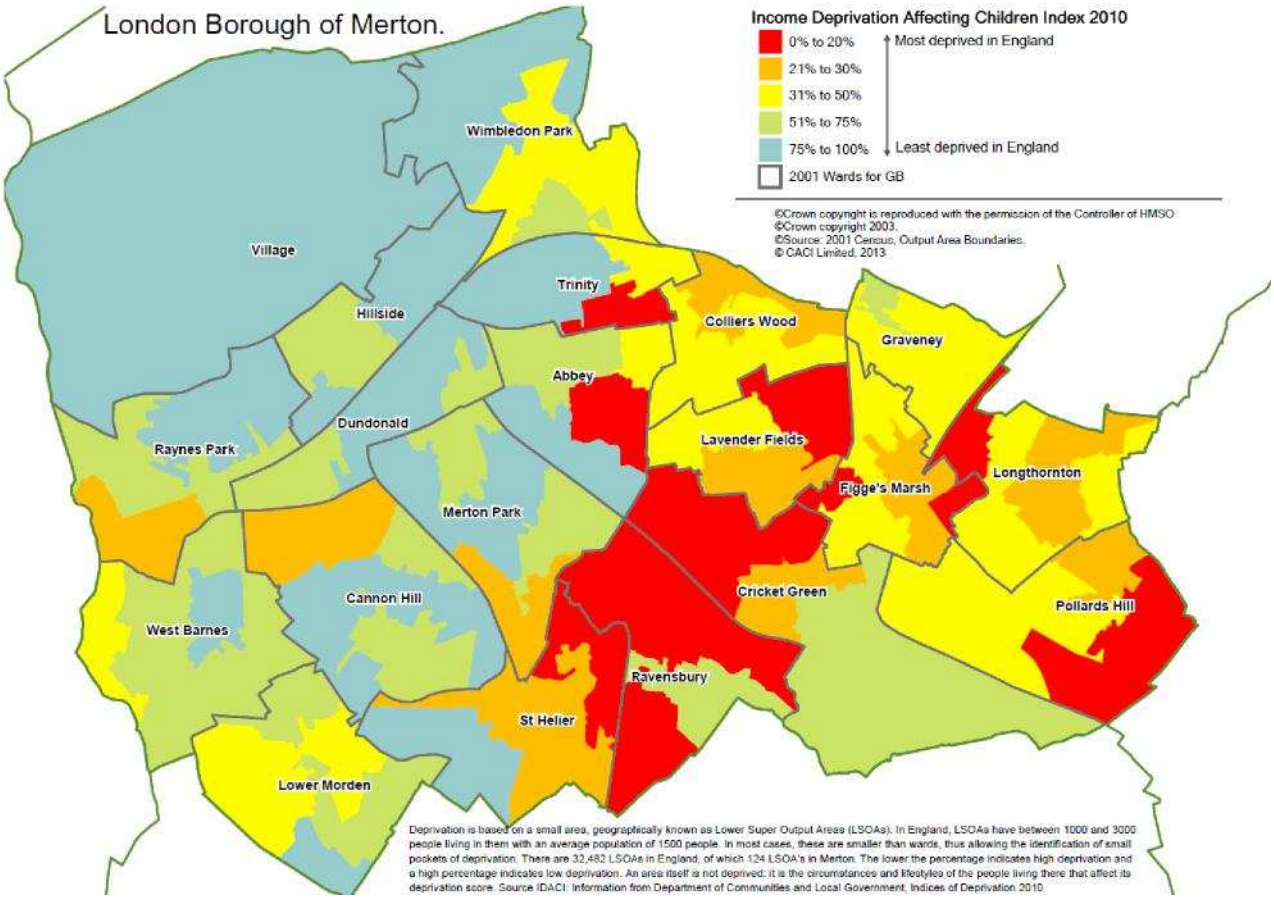
4.0 Local context and need of the childhood population for Merton

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). The number of 0-19 year olds is forecast to increase by 3,180 (7%) by 2017, within which we forecast a 20% increase of children aged 5 to 9 (2,270). We have a younger population than the England average and have seen a 39% net increase of births over the last ten years (2,535 births in 2002 rising to 3,521 in 2010). The birth rate reduced in 2012/13 and again slightly in 2013/14 suggesting that the rate is stabilising. However the last ten years alongside other demographic factors has placed additional demand on all children's services.

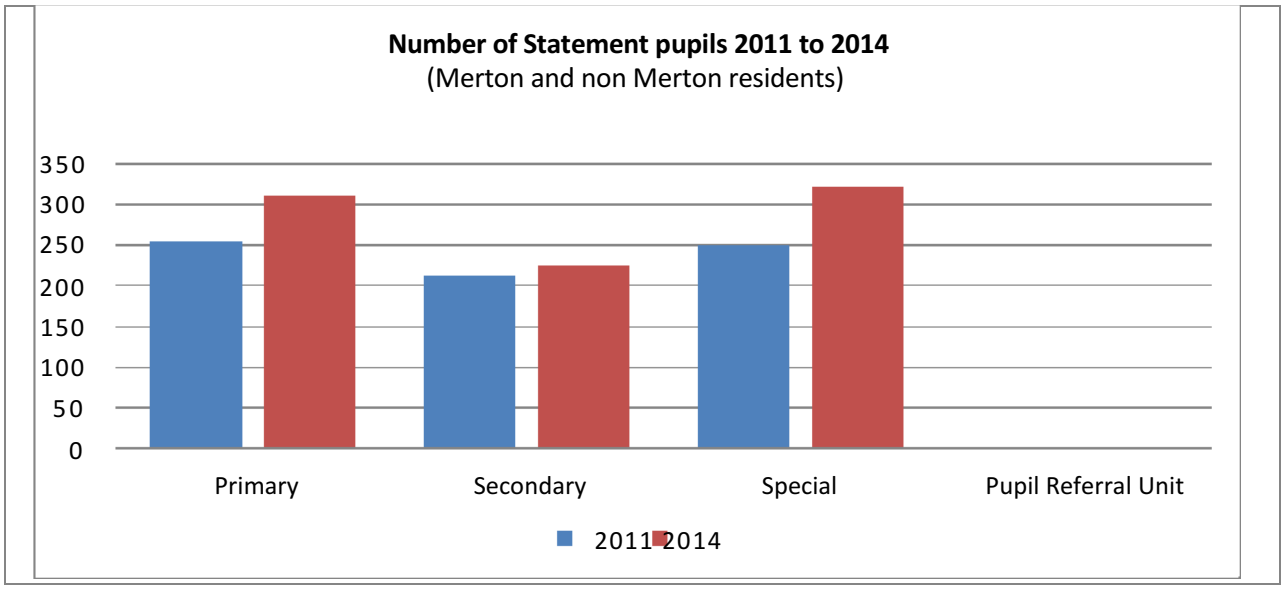
Predominantly suburban in character, Merton is divided into 20 wards and has three main town centres; Wimbledon, Mitcham and Morden. A characteristic of the borough is the difference between the more deprived east (Mitcham/Morden) and the more affluent west (Wimbledon). There are a number of pockets of deprivation within the borough mainly in the eastern wards and some smaller pockets in the central wards. These wards have 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 2010). Since 2010 we have seen an increase of 23% of children who are eligible for free school meals (2010, 2881 FSM children, 2014, 3548 FSM children).

Merton income deprivation affecting children index 2010



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, speaking over 120 languages (2014). The borough has concentrations of Urdu speaking communities, Sri Lankan, South African and Polish residents. The most prominent first languages for pupils apart from English are Tamil 5.9%, Urdu 5.9% and Polish 4.5%.

The number of children with Statements and School Action Plus pupils in Merton schools is also rising. Numbers of SEN Statements in Primary schools has risen from 255 in Jan 2011 to 310 in Jan 2014 (+22%), numbers of SEN Statements in Secondary schools has risen from -212 in Jan 2011 to 224 in Jan 2014 (+6%) and the number of SEN Statements in Special schools has risen from 249 in Jan 2011 to 321 in Jan 2014 (+29%).



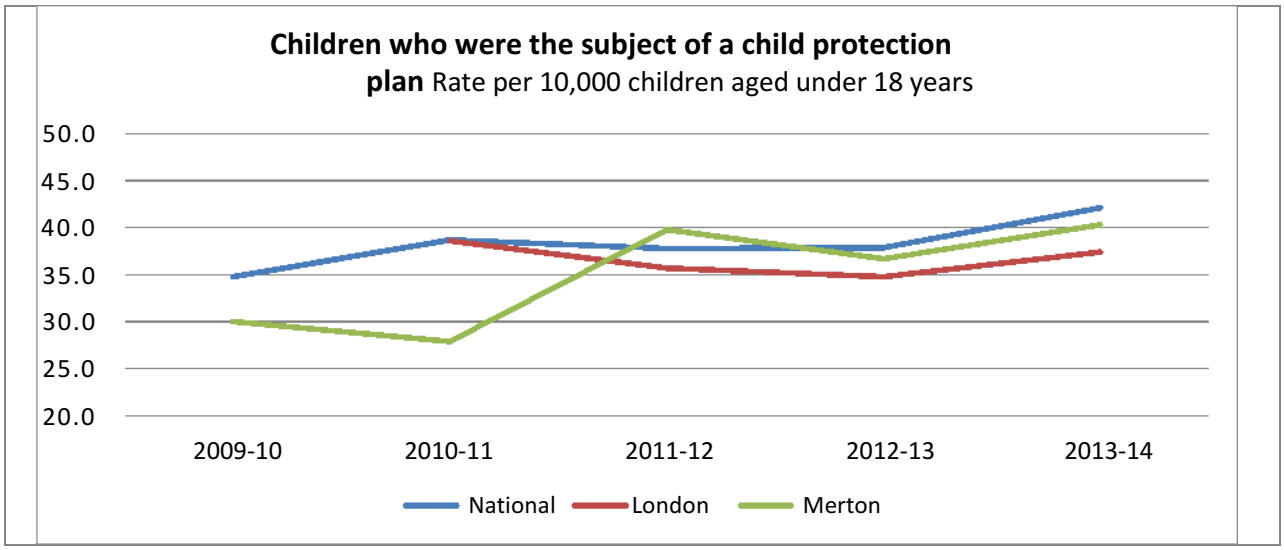
We can also demonstrate a similar rise in pupils with School Action Plus cohorts in primary schools rising from 737 in Jan 2011 to 814 in Jan 2014 (+10%)

4.2 Merton's children in need, children with a protection plan and those looked after

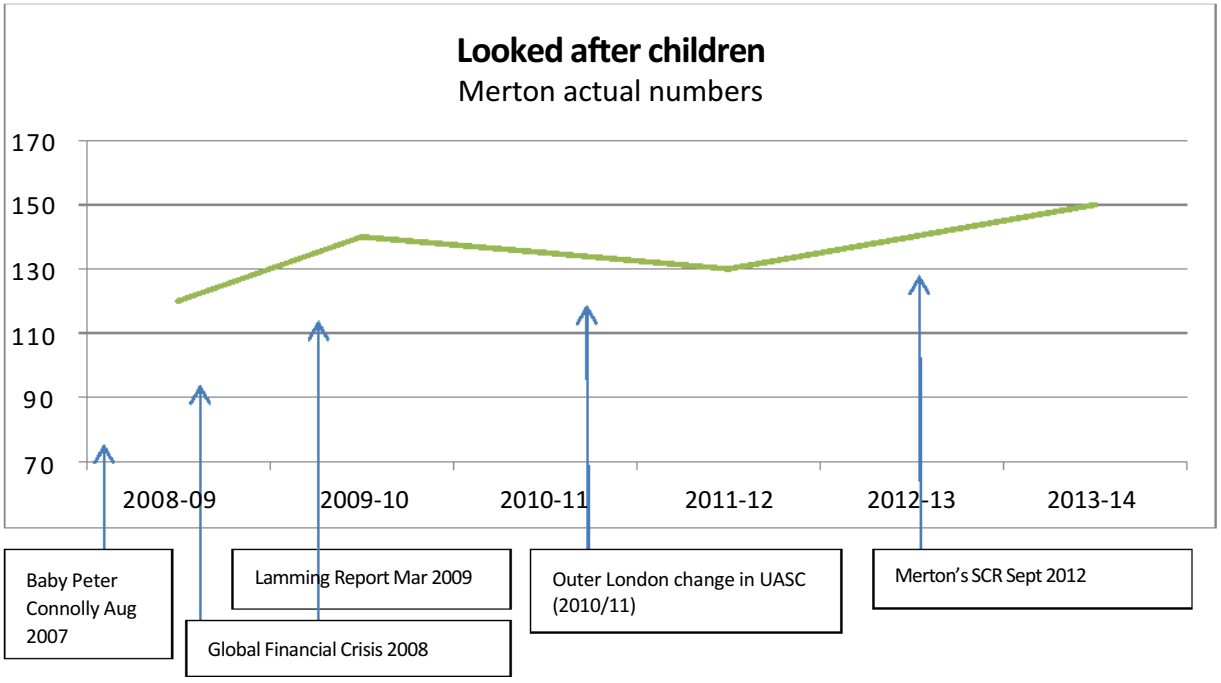
Merton's children in need rate per 10,000 (2013/14, 355.1) is lower than the London average 367. 8 but higher than the National 346.4, we remain close to our statistical neighbours (2013/14). Our CIN rate has increased over a number of years alongside our population changes from 171.0 in 2008/9, 276.8 in 2009/10, 288.3 in 2010/11, 371.3 in 2011/12, 336.8 in 2012/13 and 355.1 in 2013/14.

Rates of Children subject of a child protection plan in Merton (40.3 2013/14) are similar to national (42.1) and London (37.4). As at the end of 2013/14 11.3% of children became subject of a child protection plan for a second or subsequent time, this is lower than the national (15.5%) and London (13%) averages (2013/14).

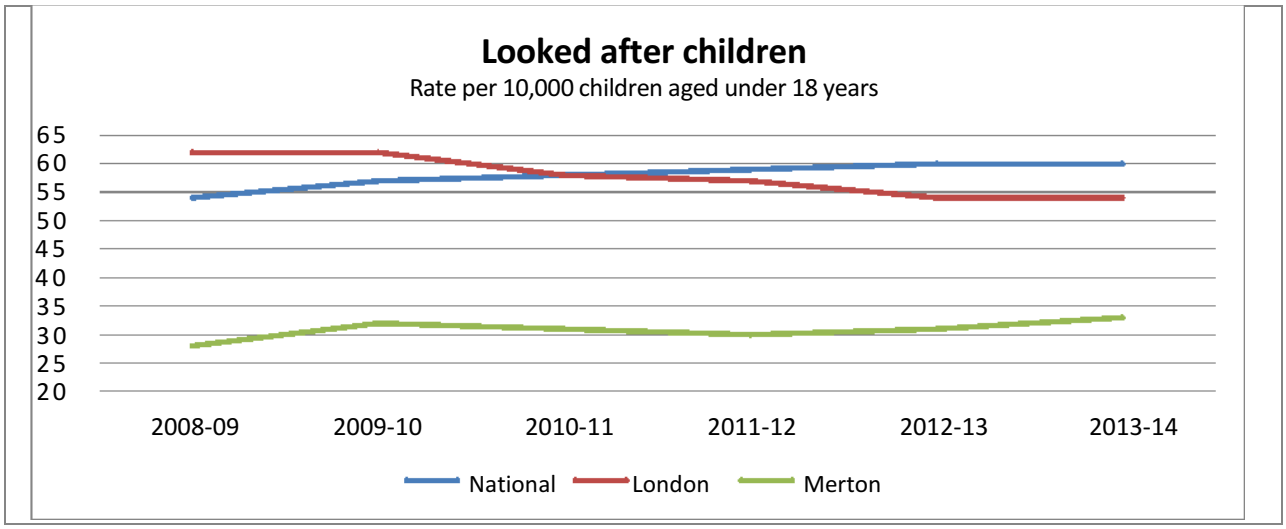
Nationally 4.5% (2013/14) of children were subject of a child protection plan lasting two years or more, in Merton this was 3.3% (2013/14) this relates to 6 children.



Merton's looked after children population in the last ten years has ranged from a low of 96 (2006/7) to 140 (2012/13), rising further to 160(+) during 2013/14 and end the year with 150 children in care. This increase has been reviewed and audited to establish what is behind this trend. There are a number of reasons for this increase including increased national awareness of children's safeguarding, an increasing birth rate and more general demographic changes. Merton has a higher than average profile of looked after children at the older age range, including a significant increase in the numbers of Unaccompanied Asylum Seekers and an increase in young people coming into care through the Southwark Judgement.



Merton's LAC rate per 10,000 remains within the range of its comparable statistical neighbours (2014/15). London's LAC rate per 10,000 ranges from the low 40s to the high 60s. Merton's rate per 10,000 in March 2014 was 33, this remains within the range of our statistical neighbours.



Merton's LAC gender distributions are similar to national averages; we have more LAC boys than girls.

The age profile of children looked after at 31 March in Merton varies from the national norm with Merton caring for a large number of older looked after children aged 16 and over. In Merton 41% of our looked after children are aged 16 and 17 compared to 21% nationally.

Merton has a changing profile of ethnic groups for LAC. The majority of children looked after in Merton are from a white background, this is lower than the general resident population (18%). There are fewer Asian or Asian British than the all persons Merton population also. Mixed ethnic backgrounds, Black or Black British heritage and 'other ethnic groups' have looked after children proportions greater than the resident population. We continue to report an increase in the category of 'other ethnic groups' in 2013 and 2014 circa 80% were known to the authority as Unaccompanied Asylum Seeking Children.

The total number of Children Looked After in Merton during 2013/14 was 253. On 31 March 2014 there were 150 children and young people looked after by Merton (33 rate per 10,000); 83 of these children were looked after for one year or more. Our children have a range of complex needs at the point they become looked after 19% (2014) have SEN statements. Significant numbers of our LAC have experienced mental health and drugs or alcohol abuse issues within their families. We have lower rates of younger children in care and higher rates of older children in care compared to the national. Merton's LAC age profile compared to national is as follows: 1-4 years olds (Merton 10%, National 17%), 5-9 year olds (Merton 13%, National 20%) and for 16+ (Merton 41%, National 21% all 2014).

At 31st March 2014, 53 of 150 looked after children were placed over 5 miles away. Of these 16 were placed 6-10 miles away

- (1/16) placed for adoption.
- (11/16) in foster care (10 agency; 1 in-house).
- (2/16) in children's homes.
- (2/16) in residential accommodation not subject to children homes regulations (supported lodging).

Of our 150 looked after children, 37 were placed over 10 miles away:

- (2/37) placed for adoption.

- (1/37) fostered with a relative or friend.
- (16/37) in foster care (16 agency; 0 in house).
- (9/37) in a children's homes.
- (2/37) in a residential school.
- (1/37) in a YOI or prison.
- (2/37) in NHS/Health Trust or other establishment providing medical or nursing care.
- (1/37) in residential accommodation not subject to children homes regulations (supported lodging).
- (2/37) in secure accommodation.
- (1/37) in a residential care home.

Merton expects the highest standards of care for all our looked after children and we have a policy of not using external placements which are not rated Good or Outstanding by Ofsted. There are no suitable children's homes within Merton which we would choose to use (except for Merton's own respite unit for children with disabilities). There are limited placement options within neighbouring authorities. We use agency carers only when we are unable to place in-house or it is in the best interest of the child both in terms of safeguarding but also in terms of suitability of match. We continue to focus on increasing the numbers of in house foster carers based on our LAC sufficiency needs analysis.

Merton's fostering agency was rated Good by Ofsted in November 2012, inspectors noting that "Children and young people are able to make good progress in relation to their starting points across all aspects of their care and effective arrangements are in place to support this. Children and young people have positive views about their care and their relationships with foster carers".

Merton's adoption agency was inspected in January 2013. Ofsted found that we provided an effective service to all affected by adoption and gave an overall judgement of Good. Inspectors noted that the DfE adoption scorecard published in 2012 highlighted historical poor timeliness issues but found that the authority had worked hard to improve. They recognised that subsequent year on year performance showed substantial improvements across all areas albeit that the impact of the rolling three year data would continue to impact on published performance tables for some time. We recognise the need to maintain our improvement trajectory and continue to act more quickly in our family finding and deliver our action plans to improve permanency and speed up care proceedings. Whilst we have achieved timely and effective placement for many of our children and this is evident in our data, sibling groups tend to take longer as do those with disabilities to secure permanency. Ofsted noted that Adoption is viewed as a positive option for all children needing permanency, whatever their needs or characteristics and that "the lifelong implications of adoption are fully understood and people's needs are catered for, whatever their age".

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

4.3 Children at Risk of Sexual Exploitation

During 2014 Merton undertook a CSE self review of the local arrangements in London to manage Child Sexual Exploitation. We also met with colleagues in Kingston, Sutton and Richmond to undertake a peer review session in early December 2014.

A CSE sub group of the MSCB has been in place following the issuing of guidance around CSE. The MSCB reviewed its CSE arrangements in 2012 putting in place a strategy and strengthening the work of the PPYP in 2013. It established the PPYP as a sub group of the MSCB. The PPYP group has a broad multi-agency membership including representation from: Barnardos, Jigsaw4U, Catch22, Education Welfare, Youth Offending Service, Police

(Missing Persons Officer and the new Central CSE team), Primary Health (School Nursing and Health Visiting), Pupil Referral Unit, MASH and the 14+ Looked After Team. In December 2013 the CSE service was awarded the London Safeguarding Children Award in recognition of the multi-agency work to identify and protect young people at risk of CSE in Merton.

4.4 CSE Cases

The following is a snapshot taken in autumn 2014.

- All 30 CSE cases are or have been open to CSC&YI.
- 1 of the open cases is male.
- 12 cases have been or are subject to a child protection plan.
- 8 cases are looked after young people 7 of which are placed out of Borough
- Ethnicity is broadly in line with the changing demographics in Merton with just over 50% from a White/British or White background
- The age distribution shows 13% of young people referred for possible sexual exploitation are aged 13 and under.
- The majority at 35% were aged 15 at the time of referral.
- Risk factors include 5 cases with drug and alcohol concerns and 6 with mental health issues.
- Routes of victimisation include 6 gang related: 14 older male and 9 victimised through peers and 1 trafficked young person.
- 5 of the cases have been identified as at risk because of images and messages posted on social media.

In 2012-13 123 young people were identified by the MASH and First Response service as being at risk of CSE following assessment. This identification process involved ticking a box that was labelled CSE. Many of the young people who were identified showed some of the indicators that might place them at risk of CSE, others were referred on to the PPYP and others may simply have been younger siblings of older young people who were at risk. While many practitioners have a good understanding of CSE we have recognized that we need to embed the Barnardos risk assessment matrix more formally across our systems to support a more consistent approach to the risk assessment of young people.

The identification of young people at risk of CSE has been supported by the work of Jigsaw4U (since 2009), Barnardos (since 2011) and a specialist Young Women and Girls Worker in the Family and Adolescent service(since 2014), who works with young women in the Borough on the edge of gangs at risk of CSE and those in abusive relationships. These voluntary agencies have both directly supported professionals by providing training and briefings. The vast majority of cases coming to the attention of these commissioned projects have been through the Multi Agency Safeguarding Hub and Children's Social Care.

The full self evaluation will go to the MSCB, Safer and Stronger Exec Board, One Merton Group and other appropriate boards and bodies in January 2015 and will inform MSCB Business Planning 2015/16.

4.5 Children Missing from Home and School

A review of children missing in the Merton between January 2013 and September 2014 has demonstrated that there is a clear connection between those children deemed to be at risk of CSE and being missing from home or Care. Many of the children known to PPYP have been reported missing. The vast majority of children reported as missing were referred to a specialist project Jigsaw 4U. Importantly however, many children known to be at risk from

CSE were not necessarily reported as missing and this reveals the complex causes and indicators of risk in this area. 33% of young people who were at risk of CSE (referred to PPYP) also had missing periods from home or care.

The Jigsaw4u Project Worker plays a significant and important role in safeguarding for young people in Merton who go missing and especially those experiencing sexual exploitation. This includes advocating for a child protection response, providing information to social workers which enables them to form a more coherent picture of what is happening to a young person, helping to locate and safeguard vulnerable young people who are missing. The worker also provides information and intelligence increasing the ability of the multi-agency network including the Police to identify hot spots, potential perpetrators and gangs and through this the worker develops local intelligence links and supports best practice. The report on their activity for the last year shows:

- 75 young people received a service (43 young people had a 1:1 service)
- 56 adults had a service (53 had a 1:1 service)
- 64 independent return interviews conducted
- 282 x 1:1 sessions were delivered to young people
- 156 x 1:1 sessions were delivered to adults
- 48 mediation sessions were delivered
- 2 group work programmes were delivered.
- 86 meetings were attended including Promote and Protect Operational and Strategic Groups, core groups, Sexual Exploitation Strategy Meetings. professionals meetings, LAC reviews.

The London Borough of Merton operates a Children Missing Education panel which reviews young people who have persistent absence –over 85%. This panel meets on a monthly basis and tracks a wide range of children noted to be missing education for a number of potential reasons such as ill health, newly arrived and placement change or disruption. The annual report on CSE shows increasing levels of referral with higher numbers of boys missing 55% than girls 45%. It was also noted that the numbers of looked after children notified to be missing education had also increased. Recent checks of the respective database showed that there were three young people open to the PPYP who had also been referred to the CME panel. The manager of the EWS team and the Schools Inclusion Manager sit on both the CME panel and the PPYP panel.

Young people vulnerable to being out of education, employment or training are also identified and supported by the My Futures team providing systemic interventions and practical support to families and liaising with key professionals addressing concerns such as substance misuse and adolescent mental health.

This will also continue to be a focus for 2015/16.

4.6 Prevent

During 2014 the issue of young people becoming involved in extremist activity has become much more heightened and we will be reviewing our local strategy and policy in early 2015 to respond to the changing legislation and rising concerns.

5.0 Statutory and Legislative Context

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

Local Safeguarding Children Boards (LSCB) 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, 2013*** **(WT 2013)**

LSCB duties are specified in WT 2013, 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) as set out in WT chapters 1 and 2. See appendix for clarification for Agency responsibilities under section 11)

6.0 MSCB Inter-relationships and Influence with other Key Partners

The MSCB has a well established business planning process with the plan receiving regular scrutiny at board level. The last update received by the board was in Nov/Dec 2014 and is attached as an appendix.

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.

During the period covered by this report the QA sub-group has been chaired by the Assistant Director of Children's Social Care and Youth Inclusion and includes representation from relevant agencies. The QA sub group maintains and interrogates the MSCB dataset, monitors serious incidents and responses to local and national issues arising out of SCRs and oversees multi-agency audit activity for the Board. A refreshed MA QA framework was adopted by the Board in March 2013 and has been refined in 2014. We are working together to further strengthen our shared audit programme and to ensure audit informs practice improvement. The data set supports the MSCB in reviewing service access and thresholds as well as caseloads and access to supervision and training.

There has been a renewed focus on the auditing role of the group and meetings are now held on a monthly basis in effect to ensure that the group can effectively undertake auditing. We have planned to undertake 4-5 audits on a bi monthly basis and expect to complete 20 multi agency audits by the end of this year. Since January 2014 the group has undertaken audits on 10 cases and have also received a report regarding 4 multi agency audits completed independently by Cordis Bright in January 2014. The multi agency audits completed by agencies have been undertaken on a thematic basis. So far this year we have reviewed in the initial audit cases of families where domestic violence was present, hard to reach families and those subject to a plan for more than 2 years. The latter theme has been explored alongside the recently reconvened Child Protection Panel which reviews children who have been subject to a plan on more than one occasion or for more than 2 years. Thematic audits for the 2015 include Children with Disabilities and Children living with a parent with mental health problems. The sub group has also agreed that agencies can request specific audits on cases where near misses or particular concerns have arisen around multi agency working. To date none of these have been requested. The reports from audits are collated and disseminated to the training sub group and the policy and communication group if particular training needs, procedural issues or communications are required. The sub group also consider themes arising from discussions about performance.

The group supports and encourages single agency reports being presented and social care and health have provided feedback about internal audits of their activity. These have included the findings of the Cordis Bright audits and the IRO quarterly report.

Evidence of effective multi agency practice has been seen. Challenges to the system have been identified as managing chronic neglect, maintaining an understanding of families' long

term engagement with services and patterns of care, managing very challenging and avoidant families.

The group has reviewed the current performance reports which go to the Board. Proposals to assist the Board in analysing the information will be made following discussions with the Chair. Themes identified to date for further exploration from performance information has been a recent increase in young people presenting at St. George's Hospital with concerns about self harm and the high proportion of children subject of Child Protection Plans under the category of Emotional Abuse. The Cordis Bright multi agency audits raised issues about the need to develop Education and Health Care Plans to continue to strengthen coordination around transitions for young people with disabilities.

The group is strengthening its capacity and feeds back audit findings to the Board throughout the year.

7.2 Promote and Protect Young People Sub-group

The purpose of the Promote and Protect Young People is to act as a multi-agency forum on behalf of the Merton Safeguarding Children Board to respond to the agenda around at risk areas in relation to children and young people in Merton. It also will monitor the effectiveness of the Local Authority response to 'Statutory guidance on children who run away and go missing from home or care' (2009) and the 'Pan London Protocol for Children and Young People abused through Sexual Exploitation'. The sub group also monitors the effectiveness of the inter-agency arrangements for identifying and supporting young runaways; including cases where children and young people may have been trafficked, either from abroad or within the UK and statutory responsibility for Children Missing from Education and statutory guidance.

The PPYP group is co chaired by CSF's principal Social Worker and a Senior Police Officer has a broad multi-agency membership including representation from: Barnardos, Jigsaw4U, Catch22, Education Welfare, Youth Offending Service, Police (Missing Persons Officer and the new Central CSE team), Primary Health (School Nursing and Health Visiting), Pupil Referral Unit, MASH and the 14+ Looked After Team. More detail on the sub group's work on CSE is detailed above. In addition the PPYP oversees the Board's work on missing children.

The Sub Group has had a key role in the MSCB self evaluation of its CSE work and has been reviewing the CSE Strategy and risk assessment tools which were all refreshed during 2014.

The PPYP CSE self-review identified the following strengths:

- The London Borough of Merton has had a standing and functioning Multi Agency Group overseeing CSE in the Borough for some time. The PPYP Operational group was established in autumn 2011, building on the Young Runaways group established in 2009
- There is a great deal of activity to co ordinate and support raised awareness (CSE Champions, Barnardos Team Briefings, MSCB Training programme)
- Our MSCB strategy was developed in 2012 and this was in the process of being refreshed. This has now been completed

- Young People are being identified and appropriately referred to the PPYP and cases are being reviewed on a multi-agency basis through the MASE.
- Direct work is coordinated across agencies with shared information and intelligence.
- Management of children missing from education and home is robust

The CSE self review also identified the following areas for development:

- A performance dataset around CSE is needed
- Benchmarking activity against comparators would assist in assessing prevalence
- The awareness raising strategy could benefit from a developed programme of work
- More work to raise awareness by parents is needed.
- The development of a borough wide risk assessment tool could help to clarify the threshold in this specialist area.

The development areas are being addressed through the CSE action plan. This is monitored by the PPYP at each sub-group meeting.

CSE Champions in schools was identified as a priority and the matter was taken to the secondary heads meeting in June. The CSE champions have now been identified and an induction was delivered in September 2014.

The PPYP also revised its terms of reference which is to be presented to the main Board for approval in January 2015.

7.3 Training Sub Group

The purpose of the Training sub-group is to ensure children and young people are safeguarded and protected by overseeing the training and workforce development undertaken in partnership across the children and young people sector, including the training funded and provided on behalf of the Merton Safeguarding Children Board (MSCB).

The Training Sub Group is now chaired by the Head of Education Inclusion and oversees the development, implementation and review of the MSCB training and development programme. The MSCB and Children's Trust provide a joint Children's Workforce Induction available to all employees and volunteers across partner agencies which cover key issues such as: the Merton C&YP Well Being Model; safeguarding and the MASH; information sharing etc. The MSCB and Children's Social Care Training team run a comprehensive and extremely well evaluated training programme, responsive to the requirements and needs of service providers. During 2012/13 58 MSCB courses were attended by 820 colleagues from across agencies, the average course rating was 3.5. During 2013/14 90 training courses were attended by 1295 staff from across agencies, this year the average course rating was 3.4. An e-learning offer is also available covering generic and specialist areas. In 2014 we are taking part in the pilot Pan-London learning evaluation tool on behalf of the London SCB. Bespoke and targeted training has been provided to follow recommendations in our recent SCR action plan.

7.4 The Policy Sub-Group (formerly Policy and Communications)

The purpose of the Policy sub-group is to encourage and develop effective working relationships between partners in the Merton Safeguarding Children Board (MSCB) working

to safeguard children and young people from harm, including the requirements of *Working Together to Safeguard Children* and other guidance on multi agency working. The subgroup reports and is accountable to MSCB.

The decision was taken during the year to revise the sub-group structure and separate the functions of policy development and communication. This process included revising the current terms of reference and work plan as well as to create a defined core membership. The revised terms of reference is to be presented to the main Board at the meeting on 20th January 2015.

7.5 CDOP

The CDOP covers both Sutton and Merton and is chaired by the Director of Public Health. Over the period the CDOP has worked hard to address a backlog of cases inherited at the point the PCT ceased to exist and is now up to date with current cases going through the system. The CDOP has submitted its annual report to the board.

7.6 Structure and Effectiveness of the MSCB and Key Changes

During 2014 we reviewed our constitution and examined the effectiveness of all our sub groups. As a result we approved a new constitution and a suite of documents strengthening local arrangements:

- The Board adopted an FGM Mission Statement
- A new Learning and Improvement Framework was adopted
- New terms of reference was drafted for all sub-committees
- The multi-agency case work auditing process was refreshed and a new audit tool has been produced and adopted
- The Board has also adopted a new Performance Management Framework with a Challenge Process with the Chair and Agency Leads.
- The Communication Strategy and Participation have both been drafted and are in the process of being reviewed for adoption by the Board.

The board has worked hard to strengthen its effectiveness by appointing a Head Teacher of one of the Secondary Academies; the appointment of a Head Teacher of a Secondary Community School and the appointment of a Head Teacher representing Special Schools. We have also appointed an interim Designated Nursed (two members of the Clinical Commissioning Group both share this role).

The most significant change is that we have established our Business Implementation Group. The Business Implementation Group will co-ordinate, prioritise actions and ensure the coverage of statutory functions & business plan by ensuring governance and connectivity across the Sub Groups and task groups.

The Business Implementation Group will enable commissioning agencies to secure and plan delivery of the total work programme. It will contribute to board and agency self-evaluation and to challenge and improvement priorities.

The Business Implementation Group will report to and be accountable to the MSCB.

The Business Implementation Group Membership

	Business Implementation Group Membership
	Independent Chair
P	**Vice Chair to be drawn from the Statutory Members**
P	Chief Officer, Merton Clinical Commissioning Group
P	Borough Commander, Met Police
P	Assistant Chief Officer, London Probation
S	A Voluntary Sector Agency
S	Lay Member for a year at a time between the two Lay Members
P	Director, Children Schools & Families
P	Head of CSC & YI, CSF
P	Head of Education, CSF
P	Director of Public Health, Merton Council
P	Senior Service Manager, CAFCASS

Sub Group Chairs may be asked to attend the Business Implementation Group if the business of their sub group is on the agenda.

Sub groups are chaired by officers from a range of agencies including Health, Children's Social care, Police, Education and the voluntary sector.

7.7 MSCB Budget

The MSCB has a healthy budget and all agencies contribute. Its income for 2013/14 was £161.000, in 2014/15 the MSCB income is £200,000.

8.0 SubGroup and task and Finish Group Summary Reports / Effectiveness

8.1 HR Sub Group (Joint with Sutton)

The joint sub group has continued to meet and has HR representatives across agencies from both boroughs. It brings together HR professionals to ensure good and best practice is disseminated across all agencies. The sub group produces an annual report for the board.

8.2 Learning & Improvement Reviews and Serious Case Reviews

The MSCB commissioned a Serious Case Review in response to the tragic death of a Merton young person which was published summer 2013. The finding of the Review was that although there were lessons to be learnt and areas in which services could be improved, there was no information known to any agency which would suggest that the young person's life would end as it did, or that indeed she was at any risk of harm. Following careful analysis of the Review report an action plan was established and all agencies have worked together to ensure learning from our collective or individual agency response to the young person during her lifetime informs service improvement. The MSCB has been monitoring the overall SCR action plan and the SCR panel reconvened six months post publication to review progress on the SCR and IMR action plans. Workshops for staff were held on the specific recommendations and our MSCB annual conference 2014 was themed around the issues from this and other published SCRs.

The MSCB contributed to a learning review concerning a Croydon resident who was placed briefly in the borough in temporary accommodation and who subsequently committed murder.

On 25th March 2014 CSF received a serious LADO notification regarding Child J, an 11 year old boy placed in a residential school setting. The LADO notification concerned a deteriorating situation regarding this young person which resulted in an escalation in care management, including the restriction of his movements and the need to provide restraint to prevent harm to Child J and others.

A Merton LADO strategy meeting was held within 24 hours in order to put a plan in place to meet Child J's needs and to protect him from harm. The Surrey LADO was notified, as was Ofsted, whose inspectors visited the school. CSF commissioned an internal management review which was conducted by the Assistant Director of Children, Schools and Families Department, who had no prior involvement with the case, and the MSCB commissioned a Learning and Improvement Review (LIR) which was conducted by Jane Wannacott, who reported her findings in February 2015. The decision to conduct a LIR was reported to the National Panel who endorsed this decision.

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

Section 11

Relevant agencies completed their Section 11 audit tool in 2013 and these were reviewed for the April/May 2014 QA reviews with all agencies undertaken by the Chair and DCS. The Pan London Audit Tool was used for this purpose and then agencies were challenged through the QA process.

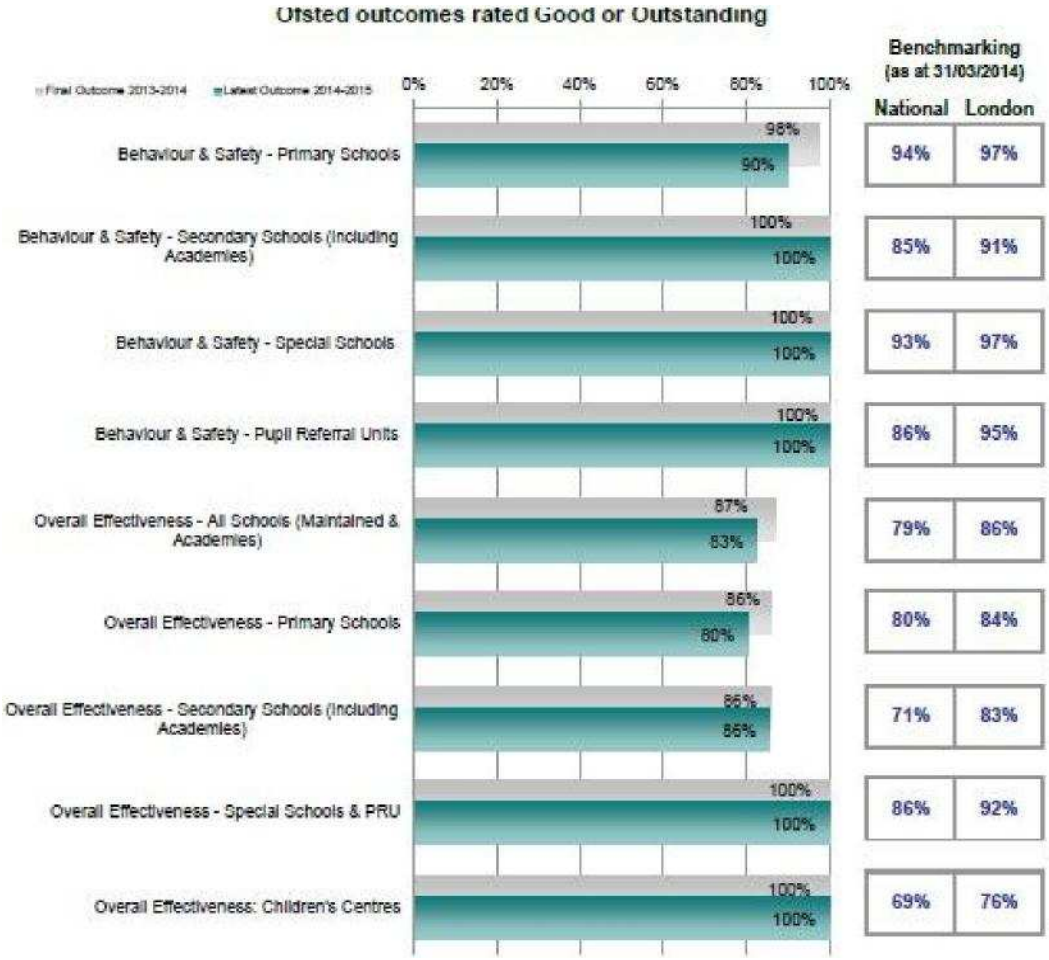
9.1 Schools

During the period covered by the report the LA School Improvement Service has developed, implemented, reviewed and refreshed their Schools' Safeguarding Audit Tool the completion of this complies with the Section 11. Schools make returns to the LA. In addition the LA undertakes safeguarding Reviews of schools at their request or where a specific concern for example a parental complaint or incident has occurred.

The borough has 3 Harris Academies who complete the Harris Foundation Section 11 which meets the required standard. St Mark's Academy completed the council's audit tool. The tool was sent as an example of good practice to independent schools in the area.

School inspections cover safeguarding under behaviour and attendance. The December 2014 Ofsted profile for schools in this area is as follows:

9.1.2 Ofsted inspection outcomes rated Good or Outstanding



9.2 CSF department

CSF department completed section 11 audits for Children's Social Care; Early Years; the Youth Service, Education Inclusion and The Family & Adolescent Service (including Youth Justice.

For 2013 CSF restructured its children's social care to deliver a Multi Agency safeguarding Hub and to implement the new Troubled Families initiative which is called Transforming Families locally. During 2014 Children's Social Care Services reviewed remits and capacity

issues across the teams and are added additional social work staff into the MASH and core social work teams. It also implemented a new caseload policy to ensure fair distribution and manageable workloads across the service. The recruitment and retention of social worker in common with most authorities continues to be challenging and the MSCB and CSF management continue to monitor use of agency staff closely and the department has a proactive recruitment and retention strategy.

The council is in the process of procuring a new social care information system to support good casework practice. The aim is to provide casework staff with a system which is more user friendly than the current system and to enable a more comprehensive dataset (in line with new Annex A) to be inputted and reported both for internal management information and for statutory returns. In the interim period prior to the commissioning of a new system, we are reviewing key business processes and developing a wider set of Business Objects reports for the current Carefirst system.

Following the full review of our early intervention and prevention strategy in 2012/13 the council produced revised structures for children's social care and our enhanced services as well as new commissioning intentions for our EIS commissioned services. A range of services were commissioned externally for 2013-16 with a strong focus on early help/intervention and prevention as well as specialist support for vulnerable groups. Safeguarding is embedded in all specifications as is a strong performance focus on impact and outcomes.

9.3 Acute Trusts

9.3.1 Sutton and Merton Community Health Service

The Royal Marsden and the service provider completed a Section 11 Audit covering all children's community health services including the provision of health services for looked after children and care leavers.

In early 2014 the S&MCHS were commissioned to deliver a family Nurse Partnership providing intensive support to young mums (under 19) who are vulnerable or at risk. The FNP will complete it first annual review in early 2015,

9.3.2 SW London & St George's Mental Health Trust

Whilst the Trust completed their audit it was undertaken at a time of considerable change due to a major transformation programme.

9.4 Community and Housing Dept. - London Borough of Merton

C&H dept. completed S11 audits for Public Health, Adult Social Care and Housing.

9.5 Corporate Service – HR – London Borough of Merton

A section 11 audit of the council's safe 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

The regional organisations submitted the relevant regional Section 11 assessments. For 2015 we will need to make arrangements with the two new probation services that the cover London Borough of Merton.

9.6 Youth Crime Executive Board (YCEB)

The YCEB is chaired by the Director of Children's Services and the vice chair is a Senior Police Officer and is the governance structure for the work of the Youth 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 CSF: CSC; YJ; LAC, Education Inclusion, Police, Probation and the CCG.

The YCEB's key priorities over the last year have been maintaining the performance of the YOT, delivering and extending the TF programme and overseeing serious youth violence work. We have also been overseeing the impact of the C&F Act LASPO requirements.

The Family and Adolescent Service (FAS) was restructured and many key functions have moved across to TF where interventions are targeted before problems escalate within a family. This has involved 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 PRG Phipps Bridge work, which is focused on reaching young men from BAME and White working class backgrounds.

As part of our commitment to continuous improvement, the YCEB commissioned Cordis Bright to provide support and challenge in our ambitions to improve casework. This work includes the consistent use of auditing and the closer scrutiny of cases during the supervision process. Case managers have also had one to one coaching with Cordis Bright. We have also enhanced the quality assurance process with YJS/YOS which includes adhering to the management auditing timetable and the use of thematic audits. All key documents are gate kept and monitored prior to 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.

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 meet regularly with the FAS Manager and YJS manager. Feedback is received from young people and suggestions for change are acted upon. The YJB National Audit by YJS was completed in August 2014 and showed positive results around engagement with young people around frequency of contacts and the timeliness of Referral Order Panels.

The YCEB continues to focus on Ending Serious Youth Violence (ESYV). The objective is to target more high risk offenders. We recognise that a multi-agency approach is essential in tackling this. We are working 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 delivered and assists with reviewing this area of our work.

We use a range of approaches to identify and support vulnerable young people including the use of the 'tightrope assessment approach' and this will be supplemented and strengthened in 2015 by training around the 'signs of safety' approach. AIM training has been delivered to CSC and members of the Youth Inclusion Team. It is hoped that this will support practice with YP who display sexually harmful behaviour. The goal is to equip staff with the ability to carry out robust assessments of young people who display sexually harmful behaviour.

We are also focusing on the Child Sexual Exploitation agenda especially with regards to reducing the vulnerability of young women and girls. This is done through the work of the Multi-Agency Sexual Exploitation (MASE) Panel and the Youth Offender Management Panel (YOMP). In addition to this, a Young Women's worker, funded by MOPAC, received clinical supervision from the Ops manager in YJS.

10 Views of Children and Young People and the Community

The Children's Trusts User Voice Strategy 2014-16 is intended to capture and monitor work undertaken to facilitate service users' influence on service design and continuous improvement. A quarterly report draws together 'user voice' actions identified in Children Schools and Families Level 3 Service Plans and implements quarterly monitoring of progress made against these activities. This process aims to enhance and embed a culture of 'user voice' as central to service planning and delivery, and to support our delivery against five key commitments made in our strategy, as listed below:

We will continue to find engaging ways for children, young people, parents and carers to represent their views, and to consult with our service users and other children and young people on their terms and on familiar territory:

- **Commitment 1** - We will continue to embrace a variety of models of feedback and participation, recognising that one style may not fit all.
- **Commitment 2** - We will continue to develop participation methods for children and young people's views to be more strongly heard in key governance structures such as Merton's Children's Trust and the Local Safeguarding Children Board. We will also publicise routes for feeding issues raised by young people and other service users to decision makers.
- **Commitment 3** - We always try to understand what our feedback is telling us. We will analyse our feedback and consider what we have been told when planning our services to ensure we continuously improve. We will log summaries of our feedback findings and information about our approaches in a central repository for cross departmental use and learning.
- **Commitment 4** - We will, where appropriate, publish our feedback findings in the Young Merton Together online magazine to share our findings with others across the department and local authority, Children's Trust and Local Safeguarding Children's Board.
- **Commitment 5** - We will ensure that services and service users who take part in events or share their views always get feedback about what has happened to their input and any outcome from it.

We have an approach to listening to the views of children and young people, carers, parents and other service users in four key ways:

- **Approach 1** - A 'practice approach' expected of all practitioners and managers which puts children's wishes and feelings at the centre of decision making and planning.
- **Approach 2** - Merton's youth participation promise.
- **Approach 3** - Targeted user feedback.
- **Approach 4** - Complaints and compliments.

Where our children and young people feel they need support to represent their views we provide that support through an independent advocacy service.

Our looked after children continue to be represented by the Children in Care Council (CICC) which is regularly consulted on how to improve the support that looked after children and care leavers receive. The CICC is supported by Merton's Participation Team who reports regularly on its activities, to the Corporate Parenting Group.

We are committed to ensuring that young people have a strong voice in governance structures. We have regularly monthly meetings of the Youth Parliament, discussions at recent meetings have centred on the following issues: a process for feeding back young

people's crime and safety concerns to the Safer Merton Committee; Islam in modern society including a change in attitudes to Muslims since 9/11; ISIS and Save our Girls (Young Girls kidnapped in Nigeria); attending the Children and Young People Scrutiny Panel to discuss e-safety and cyber bullying; and ideas for developing an approach to 'user voice' across the borough. In addition the Youth Conference was delivered by young people in October 2014 and focused on two issues – domestic violence and votes for 16 year olds.

The above provides a sample of User Voice actively, key elements of user voice are reported frequently to the Children's Schools and Families department, the Corporate parenting board, the MSCB and Children's Trust.

11 Conclusions and Priorities for 2013 – 14 Business Year

On the evidence set out in this report we judge our current arrangements to be good, providing reasonable assurance that all partners are doing as much as they can to ensure the safeguarding and safety of children and young people. The Board has worked hard to restructure itself for effectiveness it is hoped that the changes we have made in governance will enable a more robust level of challenge and accountability; the Business Implementation Group will ensure that the Board is more capable of executing its key priorities as well as monitoring and reviewing its effectiveness.

Training levels continue to be good across all agencies and the MSCB ensures an appropriate programme for multi agency training is provided. Learning from Serious Case Reviews and other related activities is an established feature of the partnership.

The commitment of the partnership to continuous improvements continues to be a positive feature and we aim to demonstrate our ability to monitor and challenge performance in the next year.

In conclusion the MSCB is compliant with statutory guidance and working well to protect children and young people in the London Borough of Merton.

Areas which will continue into 2015 include:

The Board is seeking to improve its 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 is seeking to improve its links to practitioners and their managers.

In reviewing its own effectiveness the Board is seeking to streamline its business processes to ensure SMART working and to prioritise and de-bureaucratise its work streams.

Priorities for the 2015 calendar year are:

- quality assurance and challenge to improve direct safeguarding with children, young people and their parents in all local agencies,
- engaging with and listening to children and young people,
- continuous learning and feedback,
- better understanding of our local needs, including children with particular vulnerabilities**, with particular emphasis on child sexual exploitation (CSE emphasis added Nov 2014)
- greater involvement of schools and early years services as places where children and young people are best safeguarded,
- increasing understanding about chronic neglect and working to safeguard children who are particularly vulnerable**;
- and better communication to the local community and to practitioners about safeguarding.

Appendices

Appendix 1: MSCB Business Plan 2014-2016

Merton Safeguarding Children Board

Business Plan 2014 – 16

Agreed 16 September 2014

Progress of this Plan will be updated monthly & monitored at each MSCB Meeting

October 2014

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.

The Board is seeking to improve its 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 is seeking to improve its links to practitioners and their managers.

The Board recognises that Partner agencies have been undergoing their own changes and that the revised governance and implementation of these changes take time but that safeguarding children must remain a priority.

In reviewing its own effectiveness the Board is seeking to streamline its business processes to ensure SMART working and to prioritise and de-bureaucratise its work streams.*

Priorities for this business year are:

- *quality assurance and challenge to improve direct safeguarding with children, young people and their parents in all local agencies,*
- *engaging with and listening to children and young people,*
- *continuous learning and feedback,*
- *better understanding of our local needs, including children with particular vulnerabilities**,*
- *greater involvement of schools and early years services as places where children and young people are best safeguarded,*
- *increasing understanding about chronic neglect and working to safeguard children who are particularly vulnerable**;*
- *and better communication to the local community and to practitioners about safeguarding.*

Keith Makin
Independent Chair, Merton Safeguarding Children Board

**SMART Specific, Measurable, Achievable, Realistic/Resourced & Timely - also Proportionate*
***e.g. domestic violence, sexual exploitation, parental mental ill-health, neglect, alcohol and substance misuse, abusive cultural practices, etc.*

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
1. Embed the revised Learning and Improvement System agreed in July 2014 Implement the revised Performance Management Framework					
1.1	Continue to embed and strengthen multi- agency case auditing	Identify and train auditors to include wider group of agencies	Clarity about the learning and QA process, including the multi-agency workforce	QA SubGroup	Sept 2014
1.2	Ensure Initial CP Conferences are audited within each audit and as a specific focus at least once annually	Revise themed audit schedule and ensure at least one ICPC is audited in each	LSCB will be informed about the quality of ICPCs	QA SubGroup	From Sept 2014 – 5 or 6 audits a year subsequently
1.3	Extend auditing to include the views of practitioners and service users	Agree process for involving practitioners	Better systemic understanding of the complexity fi delivering safeguarding at the frontline	QA SubGroup	Sept 2014
1.3	Deliver Learning &Improvement Feedback Briefings to multi-agency practitioners and first line managers	MSCB to deliver summary feedback workshops on lessons from audits, case reviews locally and wider	Front line staff aware of issue and how to improve practice	LSCB Manager & Training Officer	October - 2 sessions planned
		Cascade materials to be provided for use within agencies	Better staff awareness of local and key lessons	Agencies to release staff and use cascade materials	Termly thereafter
	Use briefing sessions to seek feedback from practitioners	Feedback 'system' issues and practitioner feedback to LSCB	LSCB better informed of frontline issues	Reports to QA & Training SubGroups	Termly

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
1.4	Introduce revised School Safeguarding Audit process (section 11) and establish reporting back to MSCB	School HTs to be consulted on and receive the school self-audits	QA that schools meet the revised guidance	AD Education – Heads, School Improvement & Designated Teachers Group	Autumn Term. QA report to LSCB in Jan 2015
1.5	Develop a multi-agency Performance Framework – to inform MSCB and partners of macro need to aid strategic planning and monitoring	Confirm draft governance processes and ensure multi- agency contribution to quarterly data monitoring	Quality date on incidence, need and service delivery	QA SubGroup	Sept 2014 and quarterly thereafter
1.6	Ensure multi-agency safe recruitment and staff management	LADO review – including resources *Agree local guidance & Audit?* Annual HR SubGroup and LADO reports to MSCB	Staff are aware of expectations about behaviour Safe recruitment guidance and practice is in place Agencies self-audit against agreed standards and report to LSCB LSCB and Partner agencies learn from cases of concern	AD Social Care HR SubGroup HR SubGroup LADO	Sept 2014 HR Nov 2014 LADO July 2015

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
1.7	Continue to improve practice and multi-agency responses to families where there is concern about domestic violence, mental health and/or alcohol or substance mis-use	Ensure priority multi-agency training Undertake multi-agency audits Increase awareness and understanding of complexity	Improved understanding Earlier recognition Effective planning Fewer children affected by	QA SubGroup & Training SubGroup Promote and Protect YP Strategic Group	Reports to LSCB in quarterly meetings
	Ensure agency and multi-agency compliance with safeguarding standards	Continue the monitoring of agency section 11 compliance and actions through biennial section 11 audits and annual Agency QA and Performance Management Challenge Meetings (Peer review) Safeguarding Audits of schools as equivalent to section 11 see 1.4 above to be fed back into the Performance Challenge Meetings in April 2015	An annual overview of Partner Agency safeguarding standards	LSCB Chair Board Manager All Partner agencies	April 2015

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
2.1	Develop a LSCB Participation Strategy for Children and Young People	Review and map current agency systems for consulting children and young people and how safeguarding is and can be woven into that.	A clear mechanism to consult children and young people Understanding of young people's concerns and how to respond to them	*Policy and Communication SubGroup?*	Nov 2014
2.2	Develop a strand for children and young people into the revised Communication Strategy	Review how young people seek to communicate LSCB articles in Young Merton and other publications	Integrated communications strategy	*Policy and Communication SubGroup?*	
2.3	To seek young people's views on safeguarding and on services to increases the LSCB's awareness – particularly in the area of increased vulnerabilities	To explore working with school councils, children in care and young people's groups to facilitate dialogue about the LSCB role and young people's views on	A network of fora where safeguarding can be explored from a young person's perspective and the LSCB can test its relevance to young people	Commission Action Research Project / BASPCAN / South Bank University Children's Social Care	Autumn Term 2014
2.4	To invite young people to be actively involved the LSCB Annual Conference	Invite school councils and youth groups to devise a presentation to the Conference / LSCB	Increased understanding of children and young people's concerns and perspectives on safeguarding	Training SubGroup & CSF Community Sector?	March 2015
2.5	Feedback from young service users on the work undertaken	Involve young people in case auditing See 1.3 above	Increased awareness of young people's views about the services and their quality.	QA SubGroup	Nov 2014

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
3.1	Implement revised guidance for schools: 'Keeping children safe in education', April 2014	LSCB Chair to write to schools & set out LSCB expectations & seek stronger partnership	A strong link between the LSCB and schools	Chair	Sept 2014
3.2	Strengthen school membership of the LSCB and the LSCB involvement in schools' designated persons meetings and HT's meetings	Increase school representation on MSCB LSCB Chair to write to schools & establish a clear relationship with Heads Fora	Increased involvement of Head Teachers in the LSCB, increased understanding of young people's needs	AD Education Chair	Sept 2014
3.3	Review and improve the multi-agency response to Domestic Violence including peer relationships	Agree revised Domestic Violence Strategy	Improved understanding across Partnerships of leadership in DV and protection of children and young people	MSCB	Sept 2014
3.4	Review and agree the multi-agency response to Self-Harm	Agree and implement Self-Harm Protocol	Increased awareness of signs and multi-agency responses	Policy and Communications SubGroup	Nov 2014
3.5	To agree clear multi-agency approach to parental mental-ill health	Agree and implement Mental Health Protocol	Increased awareness and understanding of the impact of mental ill-health on parenting and the inherent risks and interventions	Policy and Communications SubGroup	Nov 2014
3.6	To introduce a multi-agency strategy to prevent Female Genital Mutilation	Agree and implement Female Genital Mutilation Strategy	Increased awareness of Female Genital Mutilation, how to recognise risk and respond sensitively and to prevent it	Policy and Communications SubGroup	March 2015

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
3.7	Ensure multi-agency safe recruitment and staff management	LADO review – including resources Annual HR SubGroup and LADO reports to MSCB	Safe recruitment is embedded into job design, selection, induction and every day staff management and agencies have clear processes to investigate allegations of concern.	AD Social Care HR SubGroup HR SubGroup LADO	Sept 2014 Nov 2014 HR SubGroup Nov 2014 LADO July 2015
3.8	Continue to improve practice and multi-agency responses to families where there is concern about domestic violence, mental health and/or alcohol or substance mis-use	Ensure priority multi-agency training Undertake multi-agency audits Increase awareness and understanding of complexity Practitioners' Forum to be re-launched	Improved understanding Earlier recognition Effective planning Fewer children affected by	QA SubGroup & Training SubGroup Promote and Protect YP Strategic Group	Reports to LSCB in quarterly meetings Jan 2015

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
3.9	Review understanding of chronic neglect, its impact and intervention	Review recent research into neglect and its impact Review local incidence Include in multi-agency briefings Include as a theme in Annual Conference	Better recognition of neglect	Training SubGroup QA SubGroup	Nov 2014 Nov 2014 Mar 2015
3.10	Ensure that there is an agreed and operating escalation process	Draft Escalation Protocol	Greater awareness of how to challenge in case work and escalate when needed	Policy and Communication SubGroup	Nov 2014
	To have a revised MSCB Constitution, Performance Framework, Learning and Improvement System and Training Strategy and to seek Partner commitment to the work of the MSCB.	Confirm Constitution Review, MSCB Membership and structure and processes To review Annual Business Planning and reporting cycle reducing the frequency of reports to meetings	Clarity about roles and responsibility Possible separation of strategy and practice monitoring	MSCB Chair Board Manager All Members	Sept 2014
4.2	Information Sharing Protocol	To review the Information Sharing Protocol in light of changes in partnership structures and commissioning	Clarity about the governance of information sharing at strategic and case levels	Merton Council Board Manager Partner Agencies	Nov 2014

Objectives		Actions	Outcomes	Resources	
				Who? (Work plans etc.)	When?
4.3	To hold an Annual Stakeholders' Conference for practitioners and supervisors to increase awareness of the MSCB role and work programme and to increase the LSCB's awareness of the complexity of work at the frontline, in order to enhance the MSCB's role and inform its future business planning and priorities: Theme – **Learning from and enhancing engagement and practice at the frontline**	Agree themes and structure of the Conference Seek involvement of children and young people Seek involvement of practitioners and supervisors	Greater awareness of principles of engagement in frontline practice Consultation between the LSCB, practitioners and service users	MSCB Business Support team Board Manager	Sept 2014 Conference March 2015

Updated 31 October 2014

Appendix 2: Performance table summary

Children who need help and protection

Referrals and assessments							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
Referrals	Number	1527	1372	**1745**	**n/a**	n/a	n/a
	Rate per 10,000	351.5	311.0	**386.5**	**573.0**	469.6	441.1
Referrals where within 12 months of a previous referral	Percentage	17.9%	12%	**10.1%**	**23.4%**	16.2%	16.7%
Referrals which resulted in No Further Action	Number	46	33	**35**	**n/a**	n/a	n/a
	Percentage	3%	2.4%	**2%**	**14.1%**	8.2%	7.5%
Single Assessments completed	Number	n/a	n/a	**1533**	**n/a**	n/a	n/a
	Rate per 10,000	n/a	n/a	**333.2**	**Data not available**	Data not available	Data not available
Single Assessments completed as a percentage of referrals	Percentage	n/a	n/a	**87.8%**	**Data not available**	Data not available	Data not available
Percentage of Single Assessments completed within 45 days	Percentage	n/a	n/a	**81%**	**82%**	78%	Data not available

Children in Need							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
Children starting an episode of need	Number	1323	1222	**1407**	**n/a**	n/a	n/a
	Rate per 10,000	304.5	277.0	**311.7**	**372.6**	364.0	336.9
Children in need throughout the year	Number	2546	2373	**2513**	**n/a**	n/a	n/a
	Rate per 10,000	586.1	537.9	**556.7**	**680.5**	688.0	610.2
Children ending an episode of need	Number	933	887	**910**	**n/a**	n/a	n/a
	Rate per 10,000	214.8	201.1	**201.6**	**334.6**	320.1	297.4
Children in need at 31 March	Number	1613	1486	**1603**	**n/a**	n/a	n/a
	Rate per 10,000	371.3	336.8	**355.1**	**346.4**	367.8	312.7

Children in Need							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
Children in need at 31 March, by duration of open cases (3 months or less – 91 days)	Percentage	18.7%	17.4%	**19.8%**	**24.8%**	23.7%	24.9%
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%**	**12.2%**	12.3%	13.6%
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%**	**15.8%**	14.9%	15.9%

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%**	**15.1%**	16.2%	15.5%
Children in need at 31 March, by duration of open cases (two years or more)	Percentage	**24.5%**	31.4%	**26.9%**	**31.6%**	33.0%	30.1%

Children in Need – Attainment							
Indicators		Merton 2011-12	**Merton 2012-13**	Merton 2013/14	**National 2012-13**	London 2012/13	Outer London 2012/13
Children in Need Key Stage 2 – percentage Reading Level 4+	Percentage	Data not available	**70.2%**	Data not available	**56.8%**	Data not available	Data not available
Children in Need Key Stage 2 – percentage Maths Level 4+	Percentage	56.7%	**57.4%**	Data not available	**55.7%**	Data not available	Data not available
Children in Need Key Stage 2 – percentage Reading, Writing and Maths level 4+	Percentage	Data not available	**48.9%**	Data not available	**42.3%**	Data not available	Data not available
Children in Need Key Stage 2 – percentage Grammar, Punctuation and Spelling Level 4+	Percentage	Data not available	**53.2%**	Data not available	**40.9%**	Data not available	Data not available
Children in Need GCSE – percentage 5+ A* to C	Percentage	42.1%	**41.5%**	Data not available	**35.3%**	Data not available	Data not available
Children in Need GCSE – percentage 5+ A* to C including English and Maths	Percentage	15.8%	**24.6%**	Data not available	**16.1%**	Data not available	Data not available
Children in Need KS2-4 – percentage expected progress in English	Percentage	29.6%	**30%**	Data not available	**27%**	Data not available	Data not available
Children in Need KS2-4 – percentage expected progress in Maths	Percentage	25.9%	**36.7%**	Data not available	**25.5%**	Data not available	Data not available
Unauthorised absence – percentage sessions missed by Children in Need	Percentage	3%	**3.7%**	Data not available	**3.9%**	Data not available	Data not available
Overall absence – percentage sessions missioned by Children in Need	Percentage	8.7%	**9.3%**	Data not available	**10.4%**	Data not available	Data not available
Persistent absence – percentage Children in Need classed as persistent absentees	Percentage	12.4%	**14%**	Data not available	**15.4%**	Data not available	Data not available
Exclusion – percentage of Children in Need with at least one fixed term exclusion	Percentage	7.5%	**Data not available**	Data not available	**7.8%**	Data not available	Data not available

*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**	**National 2013/14**	London 2013/14	Outer London 2013/14
Children subject to S.47 enquiries which started during the year	Number	318	493	**593**	**n/a**	n/a	n/a
	Rate per 10,000	73.3	111.7	**131.4**	**124.1**	11.9	107.7
Children who were the subject of an initial child protection conference which started during the year	Number	223	177	**239**	**n/a**	n/a	n/a
	Rate per 10,000	51.4	40.1	**52.9**	**56.8**	49.9	48.3

Children who were the subject of a child protection plan							
Indicators		Merton 2011-12	Merton 2012-13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
Child protection plans started in the year	Number	192	160	**212**	**n/a**	n/a	n/a
	Rate per 10,000	44.2	36.3	**47.0**	**52.1**	43.2	41.6
Child protection plans ended in the year	Number	139	171	**192**	**n/a**	n/a	n/a
	Rate per 10,000	32.0	38.8	**42.5**	**47.4**	39.7	37.5
Children subject of a plan as at 31 March	Number	173	162	**182**	**n/a**	n/a	n/a
	Rate per 10,000	39.8	36.7	**40.3**	**42.1**	37.4	35.1
Child protection plans reviewed within the required timescales (cases open 3 months or more)	Number	104	118	**131**	**n/a**	n/a	n/a
	Percentage	93.7%	97.5%	**92.9%**	**94.6%**	97.2%	96.7%
Child protections plans: child seen every 28 days	Percentage	n/a	n/a	**53.5%**	**58.4%**	61.0%	60.8%
Child protections plans: child seen every 35 days	Percentage	n/a	n/a	**77%**	**Data not available**	Data not available	Data not available
Children who became subject of a plan for the second or subsequent time	Percentage	7.8%	10.6%	**11.3%**	**15.8%**	13%	12.5%
Child protection plans lasting two years or more	Percentage	1.4%	3.5%	**3.3%**	**2.6%**	3.6%	3.0%

Progress of children looked after and achieving permanence

Looked After Children							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	**London 2013/14**	**Outer London 2013/14**
Children in care throughout the year	Number	210	215	**253**	**n/a**	n/a	n/a
	Rate per 10,000	48	48	**56**	**n/a**	n/a	n/a
Children in care at 31 March	Number	130	140	**150**	**n/a**	n/a	n/a
	Rate per 10,000	30	32	**33**	**60**	**54**	48

Looked After Children – Placements							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	**London 2013/14**	**Outer London 2013/14**
NI 62 – Stability of placements – number of moves	Percentage	14.7%	15.7%	12.7%	11%	n/a	n/a
NI 63 – Stability of placements – length of placement	Percentage	67.6%	63.9%	**58%**	**68% (3 year rolling)**	n/a	n/a
LAC Placed over 20 miles away	Percentage	19%	14%	**17%**	**17%**	18%	18%

Looked After Children - Reviews							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	**London 2013/14**	**Outer London 2013/14**
NI 66 – LAC reviews within timescale	Percentage	95.9%	95.9%	**97%**	**Data not available**	Data not available	Data not available
Children in care participation in reviews	Percentage	79.4%	88.2%	**87.4%**	**Data not available**	Data not available	Data not available

Looked After Children – Health							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	**London 2013/14**	**Outer London 2013/14**
Children with Health Surveillance checks up to date	Number	12	12	**8**	**n/a**	n/a	n/a
	Percentage	86%	80%	**100%**			
Children who have had their annual health assessment	Number	70	70	**79**	**n/a**	n/a	n/a
	Percentage	83%	82%	**95%**	**87%**	90%	88%
NI 58 - Emotional & behavioural health – Average SDQ score	Score	11.4	14.6	12.3	**13.9**	13.4	13.7
Children who have had their immunisations up to date	Number	76	75	**79**	**n/a**	n/a	n/a
	Percentage	90%	88%	**95%**	**83%**	73%	80%
Children who have had their dental checks up to date	Number	83	85	**69**	**n/a**	n/a	n/a
	Percentage	99%	100%	**83%**	**82%**	88%	87%
Children who have been identified as having a substance misuse problem	Percentage	18.9%	10.7%	**8.4%**	**3.5%**	6.1%	6.2%

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

Adoption

	Merton Single Year 2011-2012	**Merton Single Year 2012-2013**	**Merton Single Year 2013-2014**	**National 3 Year Average 2010-2013**	**Merton 3 Year Average 2010-2013**	**Merton 3 Year Average 2011-2014**
Adoption						
A1 - Average time between a child entering care and moving in with its adoptive family, for children who have been adopted (days)	807 days	467.2 days	694.9 days (8cyp)	647 days	685 days	689 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)	344.1 days	124.25 days	291.7 days (6cyp)	210 days	256 days	281 days
A3 - Children who wait less than 20 months between entering care and moving in with their adoptive family (number and %)	25%	23%.	76%	55%	42%	51%
A4 - Adoptions from care (number adopted and percentage leaving care who are adopted)	7% (9/93)	6% (5/85)	9% (10/107)	13%	7% (19/272)	8% (24/286)
A5 - The number of children for whom the permanence decision has changed away from adoption	3	2	9	n/a	n/a	n/a
A6 - The percentage of black and minority ethnic children leaving care who are adopted	22% (2/9)	60% (3/5)	50% (5/10)	7%	26% (5/19)	42% (10/24)
A7 - The percentage of children aged 5 or over leaving care who are adopted	11% (1/9)	0% (0/5)	30% (3/10)	4%	11% (2/19)	17% (4/24)
A8 - Average length of care proceedings locally (weeks)	n/a	n/a	n/a	51 wks	65 wks	n/a
A9 - Number of children awaiting adoption	3	7	17	6890		

Care leavers

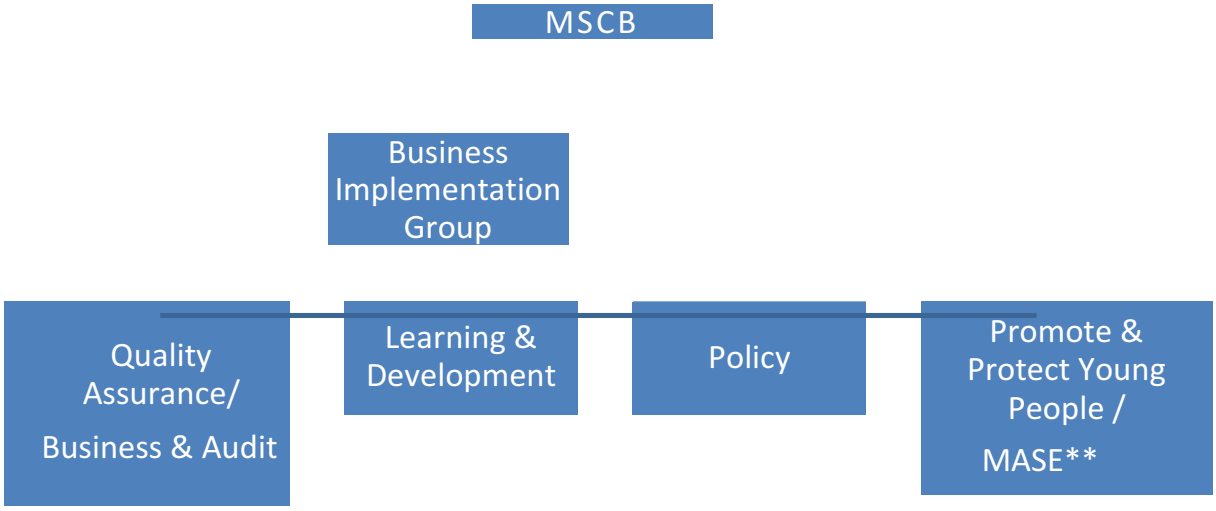
Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	National 2013/14	London 2013/14	Outer London 2013/14
Care leavers							
Total Care leavers	Number	Data not available	Data not available	**96**	**n/a**	n/a	n/a
Care Leavers aged 19	Number	Data not available	Data not available	**29**	**Data not 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**	**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**	**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%)**	**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%**	**68%**	n/a	n/a

Indicators		Merton 2011/12	Merton 2012/13	Merton 2013/14	National 2012/13	London 2012/13	Outer London 2012/13
Care leavers - Accommodation							
% of young people aged 19, 20 or 21 Care leavers in suitable accommodation	Number	Data not available	Data not available	**67.7%**	**Data not available**	Data not available	Data not available
% of young people aged 19 Care leavers in suitable accommodation	Number	88.2%	85.0%	**64.3%**	88%	88%	87%
% of young people aged 20 Care leavers in suitable accommodation	Number	Data not available	Data not available	**79.4%**	**Data not available**	Data not available	Data not available
% of young people aged 21 Care leavers in suitable accommodation	Number	Data not available	Data not available	**58.1%**	**Data not available**	Data not available	Data not available

		Merton 2011-12	Merton 2012-13	Merton 2013/14	National 2012-13	London 2012/13	Outer London 2012/13
Care leavers – Education							
Care leavers aged 19, 20 or 21 not in education, employment or training	Percentage	Data not available	Data not available	**48.4%**	**Data not available**	Data not available	Data not available
Care leavers aged 19 not in education, employment or training	Percentage	17.6%	25.0%	**42.9%**	34%	28%	29%
Care leavers aged 20 not in education, employment or training	Percentage	Data not available	Data not available	**55.9%**	**Data not available**	Data not available	Data not available
Care leavers aged 21 not in education, employment or training	Percentage	Data not available	Data not available	**45.2%**	**Data not available**	Data not available	Data not available
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%**	**Data not available**	Data not available	Data not available

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%**	6%	8%	9%
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%	**Data not available**	Data not available	Data not available
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%	**Data not available**	Data not available	Data not available

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

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

	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, Royal Marsden Hospital, Sutton and Merton Community Health Services
P V	Sutton & Merton Service Director, SW London & St George's MH Trust
P V	Consultant Child and Adolescent Psychiatrist, SW London & St Georges
P V	St George's Healthcare NHS Trust
P V	Director of Nursing, Epsom & St. Helier 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
	Head of Education, CSF

P V	
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 Georges
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**

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.

Contact details

Merton Safeguarding Children Board

9th Floor, Civic Centre

London Road

Morden

SM4 5DX

Tel: 020 8545 4866

Email: mertonlscb@merton.gov.uk

Committee: Health and Wellbeing Board

Date: 23 June 2015

Agenda item:

Wards:

Subject: Information Sharing to Support Children's Safeguarding & Protection

Lead officer: Yvette Stanley, Director of Children, Schools and Families

Lead member: Councillor Maxi Martin, Cabinet Member for Children's Services

Forward Plan reference number:

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

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Recommendations:

A. That all Merton Partnership Board and Sub Board members commit to continuing to ensuring that their agencies are compliant with legislation and good practice.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. To ensure that all Merton Partnership Board and Sub Board members commit to continuing to ensuring that their agencies are compliant with legislation and good practice.

2 DETAILS

2.1. Following on from a series of national child protection cases relating to the sexual exploitation of children and young people (CSE), ministers from a range of departments wrote to the Independent Chairs of Safeguarding Children Boards (SCB), Chief Executives and Directors of Children's Services advising that they would be producing simplified guidance to support information sharing and setting out 5 principles to support this. A copy of their letter is attached as an appendix to this report. The principles they outlined are:

- Integrated working;
- Joint risk assessment;
- A victim focused approach;
- Good leadership and clear governance; and
- Frequent reviews of operations.

2.2. These principles are clearly reflected in our local Children's Trust values:

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

2.3. The Ministerial letter was widely circulated to MSCB statutory partners by the Independent Chair and DCS who, in turn, were asked to cascade it within their organisation. Further the Chair of the MSCB will be holding his annual quality assurance review with all SCB agencies in the coming months and these will include the commitment to the principles and operational arrangements to support them.

2.4. In late 2014 Merton SCB partners undertook a self-evaluation of their work regarding CSE as well as taking part in a sub-regional and pan London review process. The self-evaluation and the action plan has been to the SCB, the Safer and Stronger Executive, the Violence against Women and Girls Board, the One Merton Group (joint planning between LBM and Merton CCG) and LBM's Chief Officer Management Team (CMT). The partnership also marked national CSE awareness day with an all-day event in the Civic Centre attended by in excess of 130 practitioners from across SCB agencies and by councillors from all parties and senior officers.

2.5. At this event we launched our refreshed policy and risk assessment tool. We also heard, very powerfully, from a young woman who had experienced CSE and been supported by our commissioned services, Children's Social Care and our Promote and Protect/MASE arrangements.

2.6. Our commitment on the day was clear:

"In Merton we will not tolerate the sexual exploitation of children. Sex with, or indeed grooming a young person under 16 for sex, is a crime. We will work proactively to identify and respond to the victims of these crimes as the victims they are – even when they do not identify themselves as victims because of the grooming they have experienced. We will work to identify and prosecute perpetrators and to create a climate of zero tolerance."

2.7 Tackling CSE and effective information sharing is an issue for all our strategic partnership boards, with the SCB's role to seek assurance that it is afforded the priority strategically and operationally by all boards. This report is therefore going to each sub board to enable a focus on this important issue and for the boards to each consider their role in creating a zero tolerance borough with regard to CSE and to highlight the principles for effective information sharing to assist in tackling CSE and supporting effective information sharing to protect and safeguard children and young people.

3 ALTERNATIVE OPTIONS

3.1. N/A

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. N/A

5 TIMETABLE

5.1. N/A

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1 N/A

7 LEGAL AND STATUTORY IMPLICATIONS

7.1 The report addresses the delivery of the council and partners' statutory functions to share information to ensure children and young people are safeguarded and protected from harm.

The statutory framework for the duty to co-operate between the Council and its partner agencies is set out in the Children Act 2004. Sections 10, 11 and 12 of the 2004 Act imply powers to share information to improve or promote and safeguard children's welfare.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. Improving children and young people's safeguarding and well-being contributes positively to human rights, equalities and community cohesion.

9 CRIME AND DISORDER IMPLICATIONS

9.1. Improving pupil outcomes reduces crime and disorder.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. The failure to deliver effective safeguarding arrangements places children at risk and prevents their wider well-being.

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

11.1 Appendix 1: Ministerial letter dated 3 March 2015 and response from DCS and MSCB Chair dated 6 March 2015.

12 BACKGROUND PAPERS

12.1. None

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Merton Safeguarding Children Board
Independent Chair – Keith Makin

Email: keith.makin@merton.gov.uk

Children Schools And Families Department
Yvette Stanley - Director

Email: Yvette.stanley@merton.gov.uk

c/o Director's Office
London Borough of Merton
Merton Civic Centre
Morden
Surrey SM4 5DX

6 March 2015

Dear Colleagues,

We attach a joint letter from ministers from a range of portfolios reminding us all of our collective duties to safeguard and protect children and young people including the particular statutory duty to share information.

As Chair of the MSCB and DCS we are absolutely clear that the current legislation expects as well as allows information to be shared if we have a child protection concern. We do, however, welcome the simplified guidance to support this.

There are 5 principles set out in the ministerial letter:

- Integrated working;
- Joint risk assessments;
- A victim focussed approach;
- Good leadership and clear governance; and
- Frequent reviews of operations

These principles are clearly reflected in our local Children's Trust values

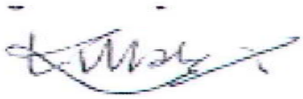
- Keeping the child / young person at the heart of our work;
- Equality, equity, inclusion and valuing diversity — judged on our impact on the most vulnerable;
- Local accountability and partnership;
- Making a difference — quality assurance and continuous improvement;
- Promoting a learning culture;
- Promoting a culture that listens to, responds to and which values children and young people.

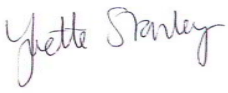
Following the publication of the Jay Report on Children at Risk of Sexual Exploitation in Rotherham the MSCB partners have conducted a self-evaluation and have participated in a regional peer challenge process to ensure that we are clear about our local partnership strengths and areas for improvement in tackling CSE. We have recently agreed a refreshed strategy and risk assessment tool which partner agencies are cascading within their own agencies. Individual agencies offer specific training on safeguarding and CSE and we have an offer in our MSCB programme: *http://www.merton.gov.uk/health-social-careichildren-family-health-social-carefiscbllscbtraining.htm*. We would urge colleagues to ensure that staff and volunteers access the appropriate training.

The MSCB will be holding each other to account in the coming months with regard to each agency's response and our collective action plan. In the meantime our message to frontline practitioners across all agencies is a simple one. In Merton we will not tolerate the sexual exploitation of children. Sex, or indeed grooming a child under 16 for sex, is a crime. We will work proactively to identify and respond to the victims of these crimes as the victims they are — even when they do not identify themselves as victims because of the grooming they have experienced. We will work to identify and prosecute perpetrators and to create a climate of zero tolerance.

We would encourage you to distribute this letter and the ministerial statement widely within your organisation and to join with us on the 18th March — national CSE Awareness Day — in committing to continuing to work in partnership to protect and safeguard our children and young people from sexual exploitation.

Yours sincerely





Keith Makin
Chair of the MSCB

Yvette Stanley
Director of Children, Schools and Families

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3 March 2015

To the Chief Executives of local authorities, Directors of Children's Services, Police and Crime Commissioners, Local Safeguarding Children's Boards, Health and Wellbeing Boards and GPs.

Our joint commitment to share information effectively for the protection of children

Today we have issued the Government's response to the chronic failures to protect children from sexual exploitation in Rotherham, which were the subject of recent reports by Alexis Jay and Louise Casey. The findings of these reports show that organised child sexual exploitation had been happening on a massive scale, over many years. This complete dereliction of duty in safeguarding vulnerable children is shocking. But it is not unique to Rotherham. We must use the tragedies experienced here and elsewhere across the country as opportunities to transform our processes, our ways of working and our cultures to tackle this threat. A key factor in this is sharing information. This letter sets out how and when personal information should be shared.

We all know that decisions to share information, with whom and when, can have a profound impact on a child's life. These decisions enable action to disrupt and deter offenders early on, to protect children from risk and support them to recover from the harm they may have suffered. These decisions can even mean the difference between life and death.

There can be no justification for failing to share information that will allow action to be taken to protect children. We know that skilled frontline staff can be hesitant and uncertain as to when and how they should be sharing information with other agencies. There can be many reasons for that, including a blame culture, bureaucracy and a fear of being challenged. Professional staff need to be able to

make these crucial decisions on a day to day basis. They need clarity and simple guidelines about when and how personal information should be shared.

An overview of the existing legislation and guidance on information sharing is annexed to this letter, together with a summary of our package of cross-Government information sharing guidance which will be published by the end of March 2015. The golden thread throughout all of this is that the duty to safeguard children must be paramount. Let's be absolutely clear - a teenager at risk of child sexual exploitation is a child at risk of significant harm. Nothing should stand in the way of sharing information in relation to child sexual abuse, even where there are issues with consent. The updates we are making to the Working Together to Safeguard Children guidance will be clear on everyone's responsibility in this regard. We will also publish a myth busting guide to help professionals take informed decisions.

Of course, failures to share information are not just due to legal barriers. We, as Secretaries of State, are clear on the need for genuinely integrated multi-agency approaches to underpin information sharing. Local processes or models must ensure that the right input from the right agencies is reflected and considered as part of risk assessments at the right time and in the right way, with jointly agreed and executed actions.

Every agency should commit to this approach. Local areas should consider the following principles for multi-agency working[1]:

- **Integrated working (e.g. co-location)** – Close collaboration in multi-agency working is essential in developing 'real time' risk assessments to enhance decision making. A truly integrated approach helps to break down cultural barriers, leading to greater understanding and mutual respect among different agencies.
- **Joint risk assessments** – these ensure clear and sufficient information about particular cases and joint plans for individual interventions.
- **A victim focused approach –** the needs of the victim must be at the forefront of our approach not systems and processes.
- **Good leadership & clear governance** – strong leadership can often bind different organisations together to develop a shared culture.
- **Frequent review of operations –** to continue to drive improvement of service.

We know that there have been persistent and complex barriers to the effective sharing of information over the course of many years. We also appreciate that implementing the changes outlined in this letter will require sustained efforts at the local level. But it can and must be achieved. As leaders, you are responsible for developing a culture where the interests of the child are put first through championing the appropriate sharing of information and dealing robustly with staff who block, hinder or fail to share.

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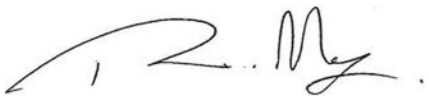
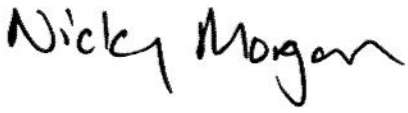
1 Further detail on best practice arrangements can be found in the Multi Agency Working and Information Sharing Project Final Report, July 2014, https://www.gov.uk/government/uploads/system/.../MASH.pdf

We understand that the Information Commissioner is today welcoming our initiative. This is a joint commitment. If there is anything more we can do to support you in achieving the goals set out in this letter please do not hesitate to tell us.

Sincerely

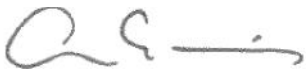


THERESA MAY

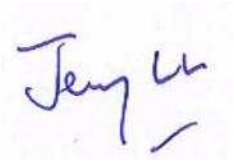


NICKY MORGAN

ERIC PICKLES



CHRIS GRAYLING



JEREMY HUNT

ANNEX

A summary of existing legislation and guidance on information sharing

- The Data Protection Act is the foundation of good information sharing practice. It places duties on organisations and individuals to process personal information fairly and lawfully. The Act is not a barrier to information sharing where a child is at risk.

- The seven Caldicott principles[2] build on this, setting out the approach to the handling of information to protect patient confidentiality. In order to provide effective care for children, information often needs to be shared beyond the normal boundaries of health and social care services. The seventh Caldicott principle makes clear that the duty to share information can be as important as the duty to protect patient confidentiality.

- The Information Commissioner's Office Data Sharing Code of Practice explains how the Data Protection Act 1998 (DPA) applies to the sharing of personal data. It provides helpful checklists for data sharing and advice on privacy impact assessments and data sharing agreements.

- In addition, we are streamlining and simplifying our approach to information sharing. By the end of March 2015, we will publish a comprehensive package of information sharing guidance. The package will include:

    - Her Majesty's Government '*Working Together to Safeguard Children*' statutory guidance which spells out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children; and provides a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

    - *Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers* specifically for all frontline practitioners and senior managers working in child and/or family services who have to make decisions about sharing personal information on a case by case basis. This simplifies current legislation and guidance into six overarching principles, and dispels common information sharing myths.

2 The term Caldicott refers to a review commissioned by the Chief Medical Officer in 1997 on the sharing of patient information in respect of confidentiality. The subsequent Caldicott report recommended key principles for effective sharing and access to patient information.

Merton Health and Wellbeing Board

Subject: Healthy Child 0-5 Years Services

Lead: Dr Kay Eilbert, Director of Public Health

Contact: Julia Groom, Consultant in Public Health

RECOMMENDATIONS:

A. To note progress on the transfer of commissioning responsibilities for Healthy Child 0-5 years services (health visiting) to the London borough of Merton from October 2015.

B. To note progress and consider opportunities for the further development of partnerships and closer integration of Early Years services.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to update the Board on progress on the transfer of commissioning responsibilities for Healthy Child 0-5 years services (health visiting) to the London Borough of Merton from October 2015, and to set out the development of Merton Early Years partnerships.

The Healthy Child Programme is available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. Health visiting services are a key component of the Healthy Child Programme (HCP) 0-5 years and support infants and children to achieve the best possible health outcomes.

The benefits of the transfer have been highlighted as an opportunity to link with wider systems, including early years services and enable integration of children's services. This recognises the huge impact that primary prevention, early identification of need and early intervention have on ensuring positive outcomes for children and young families. Public health services play a key role in ensuring that needs are identified in a timely way and families are supported to access the services they need.

The Department of Health has set out a new Health Visiting '4-5-6' service model which is based on delivery of a 4 tier service, with 5 core health reviews, mandated for a minimum of 18 months, and a focus on 6 high impact areas designed to improve access, experience, outcomes and reduce health inequalities.

From October 2015, local authorities will take over responsibility from NHS England for commissioning public health services for babies and children up to 5 years old. These services include health visiting and the Family Nurse Partnership programme (a targeted service for teenage mothers).

In order to prepare for the transfer of commissioning responsibility, a review of local health visiting services took place in 2014. The review identified a number of strengths, including from the parent survey 89% of parents and

carers rated the service good or very good. The review identified a number of areas for improvement including coverage of the universal Healthy Child Programme which is below 90%. It also identified a range of additional support needs for parents and priorities for professionals.

Overall the following priorities were identified from the service review:

- the need for greater integrated delivery with Early Years/Children's Centres;
- the need to improve communication and information sharing with service users;
- the need to improve communication and information sharing with other services;
- the need to increase efficiency in order to maximise client facing time.

The DH grant allocation for Healthy Child 0-5 services for Merton in 2015/16 (6 months) is £1,476,000, covering both health visiting and Family Nurse Partnership services. There have been ongoing negotiations with the current commissioner, NHS England, to ensure that the service can be delivered effectively within budget and that there will be no cost pressures on LB Merton at point of transfer in October 2015.

In addition to the transfer of commissioning responsibility for Healthy Child 0-5 services, LB Merton is also re-commissioning 0-5 and 5-19 Healthy Child Services as part of a wider re-procurement of community health services in partnership with Merton CCG. Robust specifications for these services were developed as part of the procurement process.

There are significant opportunities for improving outcomes for infants and children in the context of the transfer of commissioning responsibility for healthy child 0-5 services to the local authority and the re-procurement of 0-5 services. A Merton Early Years Partnership has recently been established to strengthen the integrated planning and delivery of core service from pre-conception through to age 5, across health and local authority. The aim of the Partnership is to provide a strategic focus on collaboration and the development of an integrated early years work programme, including the development of effective early years pathways across services, information sharing and a shared outcomes framework.

2 DETAILS

2.1. Background

2.1.1 The importance of giving every child the best start in life and reducing health inequalities throughout life has been highlighted by Sir Michael Marmot[1] and the Chief Medical Officer (CMO)[2]. The Healthy Child Programme is available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. Health visiting services are a key

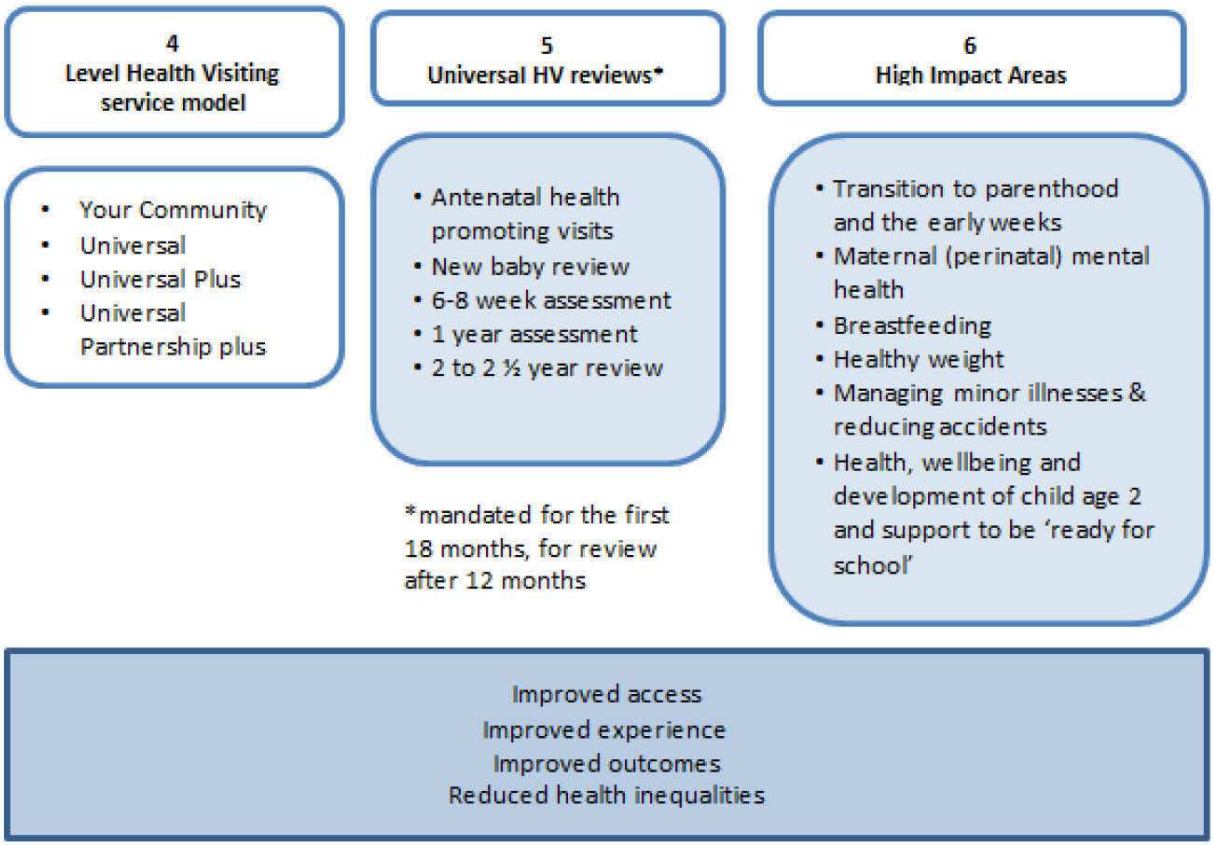
[1] Marmot et al (2010) Fair Society, Healthy Lives; a strategic review of Health inequalities in England

[2] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

component of the Healthy Child Programme (HCP) 0-5 years and support infants and children to achieve the best possible health outcomes.

2.1.2 The health visiting service workforce consists of specialist community public health nurses (SCPHN) and teams who provide expert information, assessments and interventions for babies, children and families including first time mothers and fathers and families with complex needs. Health visitors help to empower parents to make decisions that affect their family's health and wellbeing and their role is central to improving the health outcomes of populations and reducing inequalities. Health Visitors have a significant role in safeguarding children.

2.1.3 There have been changes to both the delivery and commissioning of health visiting services in recent years, including a national 'Call to Action' to increase health visiting numbers. In terms of delivery, the Department of Health have set out a new Health Visiting '4-5-6' service model (set out below and Appendix 1), which is based on delivery of a 4 tier service, with 5 core health reviews, mandated for a minimum of 18 months, and a focus on 6 high impact areas designed to improve access, experience, outcomes and reduce health inequalities.



2.1.4 In terms of commissioning, responsibility for health visiting transferred from PCTs to NHS England in April 2013. However, from October 2015, local authorities will take over responsibility from NHS England for commissioning public health services for babies and children up to 5 years old. These services include health visiting and the Family Nurse Partnership programme (a targeted service for teenage mothers). The transfer will not include Child

Health Information Systems (CHIS) or the 6-8 week GP check (also known as child health surveillance).

2.1.5 This is the final piece in the transfer of wider public health responsibilities to local authorities that took place in April 2013. Public Health already commission healthy child services 5-19 years (school nursing). The benefits of the transfer have been highlighted as an opportunity to link with wider systems, including early years services and enable integration of children's services. This recognises the huge impact that primary prevention, early identification of need and early intervention have on ensuring positive outcomes for children and young families. Public health services play a key role in ensuring that needs are identified in a timely way and families are supported to access the services they need.

Further information is available at:

https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

2.2 Local Context

2.2.1 In Merton health visiting services are provided by Sutton and Merton Community Services (SMCS), Royal Marsden Hospital NHS Foundation Trust. Staff are based at Wimbledon (120 Broadway) and Mitcham (the Wilson) and deliver services in homes, health centres and children's centres. There are approximately 54 whole time equivalent (WTE) staff covering Merton, including a number of shared specialist posts, plus non-caseholding specialists including safeguarding and management posts.

2.2.2 Data on the service is recorded by the Child Health Information Service (CHIS) using the Early Years Minimum Data Set (EYMDS) and includes output data on key health reviews. Outcome data is limited and includes breastfeeding at 6-8 weeks.

2.2.3 The service has been required to implement a number of service changes over the past two years including a move of delivery of services from GP registered to resident population; the introduction of an antenatal review and the re-introduction of a 2-21/2 year health review. Any implications for Merton?

2.2.4 In order to prepare for the transfer of commissioning responsibility, a review of local health visiting services took place in 2014. This included a review of evidence, local needs, workforce and stakeholder engagement. Nearly 400 parents responded to a survey giving their views on services in addition to 2 focus groups. Over 100 professionals responded to a survey, in addition to interviews with 20 professionals.

2.2.5 The review identified a number of strengths including from the parent survey 89% of parents and carers rated the service good or very good. On the whole staff felt proud to work for and value the service, and the service has a low vacancy rate. There is a specialist health visitor for vulnerable families and Teams serving more deprived catchment areas within the South and East of the borough have smaller caseload sizes per WTE health visitor than teams serving less deprived areas.

The service offers a full training programme and 80% of Health Visitor survey respondents reported that they felt supported in their continuing professional development needs. The service has recently introduced an evidence based Standard Operating Procedure which specifies content for all routine client contacts, use is mandatory.

2.2.6 The review identified a number of areas for improvement Coverage of the universal Healthy Child Programme[3] is below 90%. Data from SMCS for 2013/14 showed that only 80% of families are receiving a New Birth Visit by 14 days. This compares to a coverage of approximately 95% in the best performing London boroughs. In LBM 76% of the families who do not receive a visit by 14 days are seen by 21 days. The service is reaching 60% coverage of 1 and 2.5 year check.

2.2.7 Local engagement with parents/carers identified a number of additional support needs including more support with breastfeeding, immunisations, infant feeding and contraceptive advice; 15% of respondents stated they had no extra support needs. Areas cited for improvement were access, information and consistency of service/advice received and continuity of care.

2.2.8 Among wider professional stakeholders there was a widely held perception that population needs within LB Merton had increased because of increased complexity of families (English as an Additional Language families, changes to housing benefit and population churn) and there was a reported increased Universal Partnership Plus need.

2.2.9 Gaps in services were identified by professionals as post-natal depression services, children with additional but not statutory need, breastfeeding support, Health visitor support for children with high level disabilities, support with sleep issues, support with domestic violence issues, low level mental health issues and services to support children with low level behavioural issues. The health visiting service was seen as performing well on safeguarding.

2.2.10 Overall the following priorities were identified from the service review:

- **The need for greater integrated delivery with Early Years/Children's Centres**: the service should work towards a shared vision of integrated service delivery and shared outcomes with Early Years/Children's Centres.
- **The need to improve communication and information sharing with service users**: Local engagement identified that parents/carers would like to have more information about ages and stages of child development to support them in the care of their children; and that they would like to know more about the role of the health visiting services and how services can be accessed.
- **The need to improve communication and information sharing with other services**: robust systems need to be developed in terms of IM&T, information governance and data sharing between health visiting and other early years services.
- **The need to increase efficiency in order to maximise client facing time**: There is a need to maximise capacity for service delivery including adequate

[3] Currently these are a New Birth Visit by 14 days after birth, 6-8 week maternal review, 12 month development review, 2.5 year review and handover to the school nursing service

IT infrastructure to enable mobile working and minimised data management time; delineation of the roles of the early years workforce including health visitors, community nursery nurses, early years family worker, outreach workers and other early years professionals; and prioritisation of elements of early years service delivery and identification of areas for co-delivery with partner agencies.

2.3 Vision for 0-5 services going forward

2.3.1Outcomes from the review led to the following vision for children's public health services:

'Our vision is for the delivery of high quality children's public health services that improve outcomes for children aged 0-5 years in Merton overall and narrow the gap in outcomes for children in more deprived areas, including the east of the borough'. The Service will:

- be responsive to changing local needs; provide innovative, integrated service delivery with early years/children's centres, with health visitors taking a leadership role to supporting families;
- provide an area-based geographical health visiting service structured/co-located in line with local early years settings and children's centres, working together towards shared outcomes and delivering health-led integrated, evidence-based services for children and their families, with a focus on prevention, promotion and early intervention; and
- work collaboratively with other professionals, including GPs/primary care, midwifery services and voluntary sector providers, to ensure seamless care pathways for children and families.

2.4 Transfer of Commissioning Responsibility to LB Merton

2.4.1 The transfer of commissioning responsibility to local authorities requires that some elements of the 0-5 services are delivered in the context of a national standard format to ensure consistent delivery. These include five mandated health checks:

- antenatal health visit,
- new baby review,
- 6-8 week assessments,
- the one year assessment and
- 2 to 2.5 year review.

However, local authorities have the flexibility to ensure that in the context of local needs these universal services support local priorities.

2.4.2 The transfer of responsibility will include funding for 0-5 services which will sit within the overall ring-fenced public health budget. The allocation is based on a Baseline Agreement Exercise, determined on the basis of 'lift and shift' supported by funding adjustments including a minimum floor of £160 per head.

The DH grant allocation for Merton for **2015/16 (for 6 months from October) is £1,476,000** which includes health visiting and Family Nurse Partnership services.

Going forward, 2016/17 allocations will be dependent on the amount of funding announced for public health in the 2015 Spending Review and on the fair shares formula developed following advice from ACRA (the Advisory Committee on Resource Allocation).

2.4.3 There have been ongoing negotiations with the current commissioner, NHS England, to ensure that the service can be delivered effectively within the budget envelope and that there will be no cost pressures on LB Merton at point of transfer in October 2015. NHS England has recognised that there are potential pressures and is working with the provider to ensure these are addressed before transfer.

2.4.4 Estates costs have been identified as a potential pressure. In light of this and to promote greater integration between children's centres and health visiting services, a feasibility study has been commissioned to explore possible co-location of health visiting services with children's centres.

2.4.5 Once LB Merton has had assurances that all measures have been taken to mitigate against cost pressures and that the service will deliver within budget, Cabinet will be asked to authorise the novation of the contract with Royal Marsden to LB Merton on 1st October 2015. If there are any outstanding concerns regarding changes needed to the baseline allocation as a result of local circumstances, DH have confirmed an in-year adjustment process is available to local authorities.

2.5 Re-commissioning of Healthy Child 0-5 services

2.5.1 In addition to the transfer of commissioning responsibility for Healthy Child 0-5 services, LB Merton are also re-commissioning 0-5 and 5-19 Healthy Child Services as part of a wider re-procurement of community health services in partnership with Merton CCG. This is a change from current arrangements, where services are commissioned jointly with LB Sutton, and requires the disaggregation of services which are currently jointly provided for Sutton and Merton by RMH.

2.5.2 In Merton the Invitation to Tender has been issued to potential providers and assessment will take place in July/August 2015, with a view to awarding the contract by October 2015. There will then be a mobilisation period leading up to the contract start date on 1st April 2016.

2.6Merton Early Years Partnership

2.6.1 In light of the recent changes to Healthy Child provision and Early Years services, a Merton Early Years Partnership has recently been established to strengthen the integrated planning and delivery of core services from pre-conception through to age 5, across the NHS and local authority. This brings together partners from Early Years, Public Health, Merton CCG, GP, Community Health Services, Midwifery and voluntary sector. The aim of the Partnership is to provide a strategic focus on collaboration and the development of an integrated early years work programme, including the development of effective early years pathways across services, information sharing and a shared outcomes framework.

The partnership will meet quarterly throughout 2015/16, supported by an Early Years pathway co-ordinator funded by Public Health and will report to the Children's Trust Board.

2.7 Evidence base for Healthy Child 0-5 Services

2.7.1 The current HCP for 0-5 year olds is based on evidence up to 2009. In order to support the transition of commissioning responsibilities to local authorities a rapid review of recent evidence from 2009-2014 has been undertaken by the Department of Health. This covers the following areas: maternal mental health, smoking, drugs and alcohol, intimate partner violence, preparation and support with childbirth and transition to parenthood, attachment, parenting support, keeping safe, nutrition and obesity prevention, oral health and promotion of child development including speech, language and communication. For each area the review summarises latest evidence, implementation and workforce issues. This rapid review of evidence will inform local commissioning and service delivery.

2.7.2 A number of overarching implementation issues and priorities have been highlighted by the Review of Evidence, including:

- the importance of universal assessment points being used as an opportunity to promote wellbeing as well as to identify risk; the use of a partnership model of working; training the workforce to undertake promotional interviews and use standardised assessment tools alongside professional skills; the importance of effective infrastructure arrangements;
- matching needs and services effectively to ensure that the most in needs families benefit; the need to address difficulties in engaging 'hard to reach' families - evidence suggests brief intensive engagement that target both practical and psychological barriers at the point of entry can be effective;
- Working with families and family readiness to change: a partnership model of working is effective – supportive, guiding, motivating, strengths-based and consistent. Evidence also suggests the importance of continuity to build trust.
- Practitioner readiness and motivation to change needs to be addressed when implementing new ways of working. Some local adaptation or co-construction to ensure a programme is delivered in a culturally sensitive way can be effective however if core elements are changed this can lead to suboptimal delivery.

Further details are available at:
https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence

2.8 Next Steps

There are significant opportunities for improving outcomes for infants and children in the context of the transfer of commissioning responsibility for healthy child 0-5 services to the local authority, the re-procurement of 0-5 services and the development of a robust Early Years Partnership. Key next steps include:

- Feasibility study and business care on the re-location of health visiting services – June-July 2015.
- Cabinet authorisation for the novation of the Healthy Child 0-5 service contract to LB Merton –September 2015.
- Transfer of responsibility to Local Authority – October 2015
- Awarding of Community Health Services contract –October 2015
- Mobilisation of 0-5 services–October-March 2016
- Commencement of New Community Services contract –April 2016.

- Development and embedding of integrated Early Years Pathways – by April 2016

3 ALTERNATIVE OPTIONS

3.1. None

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. Consultation was undertaken with parents and professionals as part of the Health Visiting services Review 2014.

5 TIMETABLE

5.1. Commissioning responsibility for Healthy Child 0-5 transfers to LB Merton on 1st October 2015.

6 FINANCIAL OR RESOURCE IMPLICATIONS

6.1. Public health grant allocation of £1,478,000 for 2015/16 (6 months) has been published by Department of Health. The national government recently announced in-year cuts to public health funding of £200m nationally. Until further guidance is issued around local implications, we can only note this as an urgent risk to all public health funds locally.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. LBM Legal services have reviewed the novation of contract documentation and advised that this is acceptable.

The Healthy Child 0-5 Service includes 5 statutory mandated universal health reviews: Antenatal, New Baby, 6-8 weeks, 1 year, 2-11/2 years. These have been mandated for 18 months.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1.

9 CHILDREN & YOUNG PEOPLE'S PLAN IMPLICATIONS

9.1. Healthy Child 0-5 services a key part of the CYP service offer in Merton and will feed into the refresh of the CYPP in 2015.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1.

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

APPENDIX 1: THE '4-5-6' SERVICE MODEL FOR HEALTH VISITING

APPENDIX 2: SUMMARY OF FINDINGS FROM THE HEALTH VISITING SERVICE REVIEW, 2014

Appendix 1. The '4-5-6' Model for Healthy Child 0-5 Years Services

Appendix 2. Summary of Key findings from the Merton Health Visiting Service Review, 2014

The Public Health Team of the London Borough of Merton (LBM) commissioned an external review of Health Visiting (HV) Services within the borough in preparation for the transfer of commissioning responsibilities for these services from NHS England to Local Government in October 2015. The aims of the review were to:

- Understand the role of health visiting services in promoting health and wellbeing in children aged 0-5, including a description of the evidence of effectiveness for different models of service
- Describe health, social care and early years needs and outcomes for children aged 0-5 living within LB Merton
- Map current Health Visiting service provision across Merton against the Healthy Child Programme and National Specification for Health Visiting Services version 6.0
- Map current Health Visitor workforce and activity
- Gain the views and needs from local parents/carers concerning the roles of the Health Visitor service in relation to parenting support and children's health needs
- Integrate the views of the wider health and early years provider communities on the role of Health Visiting teams
- Gain the views of stakeholders on service provision and performance and integration with local authority early years services, taking the findings of the 2013 Early Years Review into account[4]
- Describe strengths of the current service and identify any gaps in service provision both in relation to unmet need and delivery of the Healthy Child Programme, 0-5

Nearly 400 parents responded to a survey giving their views on services in addition to 2 focus groups. Over 100 professionals responded to a survey, in addition to interviews with 20 professionals.

Service Strengths:
The review identified a number of strengths including from the parent survey 89% of parents and carers rated the service good or very good. On the whole staff felt proud to work for and value the service, and the service has a low vacancy rate. There is a specialist health visitor for vulnerable families and Teams serving more deprived catchment areas within the South and East of the borough have smaller caseload sizes per WTE health visitor than teams serving less deprived areas. The service offers a full training programme and 80% of Health Visitor survey respondents reported that they felt supported in their continuing professional development needs. The service has recently introduced an evidence based Standard Operating Procedure which specifies content for all routine client contacts, use is mandatory.

Areas for improvement:
The review identified a number of areas for improvement Coverage of the universal Health Child Programme[5] is below 90%. Data from SMCS for 2013/14 showed that only

[4] Sewell A. The London Borough of Merton Children's Centre and Early Years Review 2013. Anna Sewell Implementation Ltd: September 2013.

80% of families are receiving a New Birth Visit by 14 days. This compares to a overage of approximately 95% in the best performing London boroughs. In LBM 76% of the families who do not receive a visit by 14 days are seen by 21 days. The service is reaching 60% coverage of 1 and 2.5 year check.

Local engagement with parents/carers and wider stakeholders

Local engagement with parents/carers and wider stakeholders identified the following perceived met and unmet needs in Merton:

Parents/Carers:

- From the parent survey 89% of parents and carers rated the service good or very good.
- The top four extra support needs identified were support with breastfeeding, immunisations, infant feeding and contraceptive advice; 15% of respondents stated they had no extra support needs.
- Most parents/carers accessed support for all listed needs from the health visiting service; friends and family were next. Parents also accessed support from children's centres (especially for wider issues such as parenting support and childcare advice) and GPs (contraceptive advice and managing minor illnesses).
- Of those parents who had extra support needs, 70% stated their needs were met by the health visiting service; 19% partly; and 8% said their needs were not met by the health visiting service.
- Areas cited for improvement were access, information and consistency of service/advice received and continuity of care.

Wider professional stakeholders:

- There was a widely held perception that population needs within LB Merton had increased because of increased complexity of families (English as an Additional Language families, changes to housing benefit and population churn).
- Gaps in services were identified as post-natal depression services, children with additional but not statutory need, breastfeeding support, Health visitor support for children with high level disabilities, support with sleep issues, support with domestic violence issues, low level mental health issues and services to support children with low level behavioural issues.
- There was a reported increased Universal Partnership Plus need, but practitioners are very busy with providing Universal services sometimes making it difficult to meet this need.
- The health visiting service was seen as performing well on safeguarding.
- GP surgery practice staff expressed concerns that with health visitors removed from practices the opportunity for ad hoc immunisations would be lost.
- Concern was raised amongst health visiting team members, safeguarding professionals and GPs that the move to corporate caseload holding had negatively impacted on continuity of care for families.

[5] Currently these are a New Birth Visit by 14 days after birth, 6-8 week maternal review, 12 month development review, 2.5 year review and handover to the school nursing service

Overall the following priorities were identified from the service review:

The need for greater integrated delivery with Early Years/Children's Centres: the service should work towards a shared vision of integrated service delivery and shared outcomes with Early Years/Children's Centres in order to deliver the following benefits:

- Reduction in duplication of assessment and intervention activities and reduction in the risk of gaps and children falling through the net.
- A whole family approach: services will be developed around the needs of the child/family/carers.
- Enabling families/carers to receive appropriate care at the appropriate time, including early identification of need and onward referral, which frees up health visitor time to deliver specific health visiting skilled support to focus on families with enhanced health needs.
- Strengthening the strategic leadership role of the health visitor in holistically assessing a child's/family's needs and collaborating with other services to meet those needs to improve outcomes for the child/family.

The need to improve communication and information sharing with service users: Local engagement identified that parents/carers would like to have more information about ages and stages of child development to support them in the care of their children; and that they would like to know more about the role of the health visiting services and how services can be accessed.

The need to improve communication and information sharing with other services: robust systems need to be developed in terms of IM&T, information governance and data sharing between health visiting and other early years services. Information sharing is key to the goal of improving outcomes for all children. Data needs to be shared appropriately and in line with the law, data sharing concerns should not be a barrier to sharing information between professionals where the interests of the child are paramount. Active contact between professionals should ensure strong working relationships and communication. The service should work in partnership with the provider of children's centre services to facilitate the sharing of child led data in a systematic and appropriate way.

The need to increase efficiency in order to maximise client facing time: There is a need to maximise capacity for service delivery including:

- adequate IT infrastructure to enable mobile working and minimised data management time;
- delineation of the roles of the early years workforce including health visitors, community nursery nurses, early years family worker, outreach workers and other early years professionals; and
- prioritisation of elements of early years service delivery and identification of areas for co-delivery with partner agencies.

October 2014

Committee: Health and Wellbeing Board

Date:

Agenda item: Merton CCG 2015/16 Operating Plan

Wards:

Subject: HWB Operating Plan

Lead officer: Adam Doyle, Chief Officer

Lead member:

Forward Plan reference number:

Contact officer: David Freeman, Director of Commissioning and Planning

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Recommendations:

A. To note progress and approve direction of travel

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to update the Health and Wellbeing Board on the 2015/16 operating plan

2 DETAILS

2.1. Merton CCG provided held a seminar with the Health and Wellbeing Board when agreeing its two year operating plan. As part of the panning guidance for 2105/16, a number of key initiatives had to be incorporated into the operating plan. As such Merton CCG completed a refresh to ensure that the plan met the guidance

3 ALTERNATIVE OPTIONS

3.1. Nil of note

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. Merton CCG constantly refreshes it's strategy as part of our wider communications and engagement strategy

5 TIMETABLE

5.1. Nil of note

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. This paper has fully been financially appraised and the CCG financial position is described in detail

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. Merton CCG has had a review of the planning guidance and is confident this refresh meets all the statutory obligations that CCG is required to deliver.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. Nil of note

9 CRIME AND DISORDER IMPLICATIONS

9.1. Nil of note

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. Nil of note

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

Nil of note

12 BACKGROUND PAPERS

12.1. Merton CCG Operating Plan Refresh 2015/16

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

Merton CCG 2015/2016 Operating Plan Refresh

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

18 May 2015

Refresh version 2.4

Foreword

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

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

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

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

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

Signed

Dr Andrew Murray
Clinical Chair

Eleanor Brown
Chief Officer

1. Context

1.1 About Us

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

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

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

1.2 Aims and Ambition

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

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

2. Local and National Priorities

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

2.1 Clinical Leadership

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

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

2.2 Health and Well-being

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

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

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

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

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

2.3 Merton Better Healthcare Closer to Home

2014/15 Achievements

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

The programme has six key delivery objectives:

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

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

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

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

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

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

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

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

2015/16 Plans

The Nelson Health Centre

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

The new centre will offer the following range of services:

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

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

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

Mitcham Health Care Centre and East Merton Model of Care

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

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

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

Key areas for focused engagement with the public will be:

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

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

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

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

Targets and Trajectory

Nelson Health Centre

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

Mitcham

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

Communication and Engagement

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

2.4 Transforming Primary Care

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

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

The specifications include:

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

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

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

2.5 Community Services Procurement

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

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

2.6 SWL Commissioning Collaborative

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

- cancer
- children and young people
- integration

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

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

2.7 Co-commissioning

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

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

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

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

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

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

2.8 Five year Forward View

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

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

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

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

The major parts of this plan include the following:

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

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

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

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

2.9 London Health Commission

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

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

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

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

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

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

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

2.10 Integration Programme – Better Care Fund

2014 Achievements

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

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

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

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

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

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

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

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

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

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

2015/16 Plans

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

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

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

2015/16 Targets and Trajectory

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

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

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

3. Delivery

3.1 CCG Work Programme

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

3.2 Older and Vulnerable Adults

2014/15 Achievements

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

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

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

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

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

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

Supporting Data

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

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

2015/16 Plans

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

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

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

2015/16 Targets and Trajectory

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

3.3 Mental Health

2014/15 Achievements

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

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

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

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

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

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

Supporting Data

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

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

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

2015/16 Plans

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

Specific plans include the following:

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

2015/16 Targets and Trajectory

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

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

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

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

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

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

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

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

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

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

3.4 Children and Maternity Services

3.4.1 Children's Services

2014/15 Achievements

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

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

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

Supporting Data

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

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

2015/16 Plans, Targets and Trajectory

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

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

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

3.4.2 Maternity Services

2014/15 Achievements

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

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

The following improvements have been delivered in 2014/15:

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

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

Supporting Data

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

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

In 2015/16 the CCG will work to deliver:

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

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

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

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

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

2015/16 Targets and Trajectory

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

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

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

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

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

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

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

3.5 Keeping Healthy and Well

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

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

2014/15 Achievements

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

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

Supporting Data

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

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

2015/16 Plans, Targets and Trajectory

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

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

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

3.6 Early Detection and Management

2014/15 Achievements

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

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

Diabetes

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

Coronary Heart Disease

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

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

COPD

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

Cancer

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

Musculoskeletal Service

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

Supporting Data

Since 2013/14 Merton CCG has seen:

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

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

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

2015/16 Plans

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

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

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

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

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

2015/16 Targets and Trajectory

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

3.8 Urgent Care

2014/15 Achievements

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

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

System Resilience

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

Walk-in Centre Services

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

111 Service

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

Winter Schemes (Local Priorities)

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

Communications

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

Supporting Data

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

System Resilience

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

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

Walk-in Centre Services

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

111 Service

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

Winter Schemes (Local Priorities)

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

Communications

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

2015/16 Plans

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

System Resilience

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

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

Walk-in Centre Services

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

111 Service

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

Communications

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

2015/16 Targets and Trajectories

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

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

3.9 Medicines Management

2014 Achievements

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

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

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

Supporting Data

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

2015/16 Plans

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

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

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

2015/16 Targets and Trajectory

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

4. Quality

4.1 Quality and Patient Safety

Achievements 2014/15

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

The definition identifies the three elements of quality as:

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

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

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

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

Priorities for 2015/16

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

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

Improving Patient Safety

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

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

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

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

Priorities for 2015/16

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

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

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

Safeguarding Adults at Risk - Achievement 2014/15

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

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

Priorities for 2015/16

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

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

Safeguarding Children – Achievement 2014/15

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

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

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

Priorities for 2015/15

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

Workforce – Achievement 2014/15

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

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

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

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

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

Priorities for 2015/16

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

4.2 Empowering Patients

NHS Citizen

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

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

Patient Engagement

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

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

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

Priorities in 2015/16

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

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

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

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

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

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

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

Prevention

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

Priorities for PPI within 2015/16

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

Choice

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

Personal Health Budgets

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

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

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

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

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

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

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

Priorities for 2015/16

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

Support for Carers

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

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

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

Priorities for 2015/16

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

4.3 Provider Assurance

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

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

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

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

Priorities for 2015/16

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

4.4 Quality Premium

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

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

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

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

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

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

4.5 CQUINs

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

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

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

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

The acute CQUINs are intended to:

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

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

The community CQUIN is intended to:

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

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

4.6 Equality Objectives

The Equality Act 2010 and Public Sector Equality Duty

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

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

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

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

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

Embedding equality and diversity: Equality Delivery System (EDS2)

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

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

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

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

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

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

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

Implementation plans focus on the CCG taking actions to ensure:

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

Priorities for 2015/16

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

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

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

5. Performance Monitoring and Delivery

5.1 Progress Against 2014/15 Indicators

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

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

This will be reported at year end.

5.2 Outcome Ambitions 2015/16

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

5.3 Performance Standards 2015/16

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

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

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

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

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

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

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

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

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

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

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

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

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

Forecast of Operating Plan Activity

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

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

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

6. Financial Strategy and Financial Plan 2015/16

6.1 The financial resource of our Clinical Commissioning Group will be aligned to support the delivery of our commissioning strategy and strategic programmes that are also aligned with SWL for example:

- Integration – The CCG has increased its investment for the Better Care Fund (BCF) by £3.6m for 2015-16 in addition to the 2014-15 spend. Some of this investment will form part of the pooled funds with Merton LA to deliver social care aspects such as reablement and domiciliary packages. In addition the money will also be used to provide seven-day services across community and social care.

- Out-of-hospital/community-based care – Merton CCG will be opening the Nelson Health centre on 1 April 2015, which will provide outpatient, diagnostics, minor procedures, older people's rehabilitation, mental health and primary care services in one building in the community. The cost of these services is estimated to be circa £6m.

- Mental health – A needs assessment was commissioned by the Merton Health & Well-being Board in 2014-15. As a result of this the CCG will work with Merton Local Authority to meet the recommendations of the report and has also invested in 2014-15 and in 2015-16 (8% more) into mental health services such as:

    - a new complex depression and anxiety service
    - improving access to psychological therapies (IAPT)
    - a Merton-based attention deficit hyperactivity disorder/autism spectrum disorder (ADHD/ASD)
    - single point of access to CAHMs services
    - enhancing the community services e.g. home treatment teams.

The continued identification and delivery of transformational change will ensure that funds invested are targeted at those areas of greatest need and health impact, whilst at the same time ensuring a sustainable financial future. It seeks to ensure value for money and the fair and effective use of resources to improve the health and wellbeing of the community and secure the provision of safe high quality services. It builds on the initial strategic, operational and financial planning that was developed for 2013/14.

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

6.3 The overriding objective of the financial strategy is to maintain, through prudent control, sustainable financial viability in order to enable the CCG to achieve its purpose, goals as well as its statutory and financial duties.

6.4 The purpose of the financial strategy is to:

- monitor and ensure the on-going financial viability of the CCG
- ensure the resource needs of the CCG and potential financial risks are correctly identified

- enable the CCG to make informed decisions on new initiatives, future developments and opportunities
- support the CCG's service strategies through effective and prioritised use of resources and enable service review and redesign
- enable the movement of financial resources to support changing health needs and changes to the delivery of health
- enable the CCG to demonstrate robust financial management and decision making.

Financial plan 2015-16

6.5 Summary Plan

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

Table 1

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

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

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

- Surplus – 1%

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

2014-15 forecast out-turn position

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

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

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

Resource Allocation

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

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

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

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

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

Table 2

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

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

Expenditure planning assumptions

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

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

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

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

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

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

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

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

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

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

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

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

6.23 Local planning assumptions are as follows:

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

Table 3

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

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

Activity assumptions

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

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

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

Cost pressures

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

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

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

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

Investments

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

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

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

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

Table 4

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

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

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

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

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

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

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

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

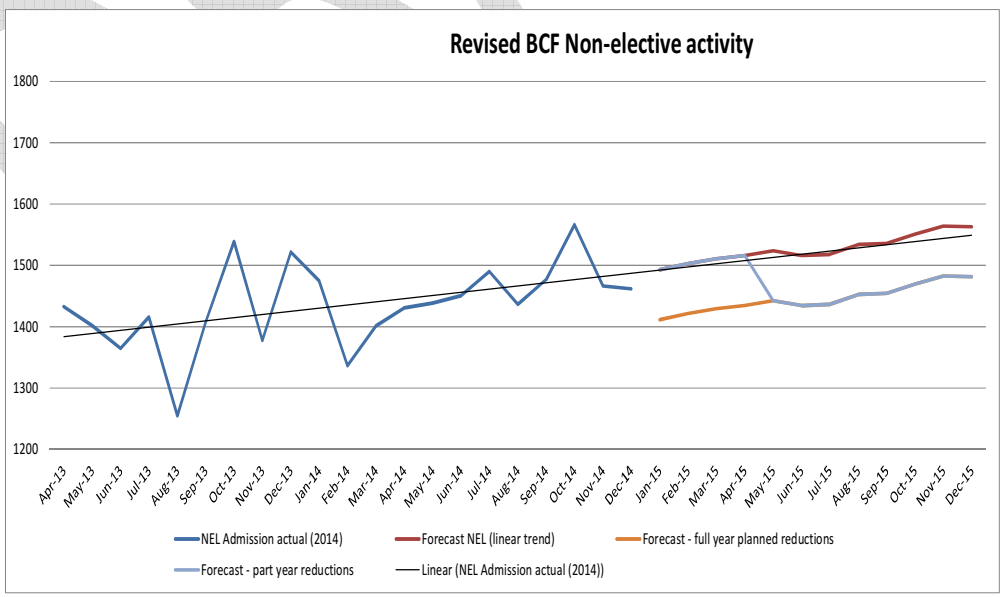
6.38 Since the submission and approval in fact, NELs grew by 4.1% in 2014. Based on a linear trend over the past 18 months, NELs are forecast to increase by 5.2% in 2015.

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

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

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

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



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

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

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

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

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

Non recurrent spend

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

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

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

transformation programmes in line with the London Health recommendations.

QIPP

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

(a) Urgent and intermediate care

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

(b) Planned Care and diagnostics

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

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

(c) Medicines Management

The medicines management workstream consists of two areas:

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

(d) Transactional

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

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

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

Table 5

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

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

Capital plans

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

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

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

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

Statement of Financial Position (SoFP)

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

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

Table 7

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

Cash Plans

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

7. Summary

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

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

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

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

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

Key Strategic Projects

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

Context and scale of the challenge

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

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

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

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

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

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

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

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

CCG Organisational Development Priorities

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

Patient Involvement Priorities

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

SWLCC Priorities

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

Merton BHCH Priorities

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

Better Care Fund Priorities

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

Performance Priorities

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

System Resilience Priorities

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

Our Six Delivery Areas

Older and Vulnerable Adults = SWLCC Integrated Care.

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

Mental Health = SWLCC Mental Health.

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

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

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

Urgent Care = SWLCC Urgent and Emergency Care.

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

Early Detection and Management = SWLCC Planned Care

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

Keeping Healthy and Well = SWLCC Commissioning themes.

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

Primary Care Support and Improvement

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

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

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

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Committee: Health and Wellbeing Board

Date:

Agenda item: Community Services Procurement

Wards:

Subject: Community Services

Lead officer: Adam Doyle, Chief Officer

Lead member:

Forward Plan reference number:

Contact officer: David Freeman, Director of Commissioning and Planning

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Recommendations:

A. To note progress and plan

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to advise the Health and Wellbeing Board on the progress made regarding the procurement of Community Health Services**.**

2. BACKGROUND

The Royal Marsden NHS Foundation Trust is the current provider of community service to the Boroughs of Merton and Sutton. The contract was originally entered into by Sutton and Merton Primary Care Trust in April 2011 for a contract term of 3 years with an option to extend for a further 2 years. The option to extend by two years was exercised and the contract will now expire at the end of March 2016. A full competitive procurement has been undertaken in order to identify and appoint a preferred partner for the provision of community services post March 2016.

This is a major procurement and presents an opportunity to realise a step change in the quality of community services in Merton. This will be a joint procurement by the CCG and the local authority.

It was agree that the wider community services would be procured as one lot and that musculoskeletal services would be procured as a separate lot.

3 DETAILS

3.1. The procurement is currently at tender stage. The PQQ evaluation outcome for both Lots was considered and signed off at the Finance Committee on 12 June, EMT on 13 June and Project Board on 20 May, and the decision was ratified by the Governing Body on 28 May. The successful bidders have been notified that they will progress to the next stage of the process.

3.2. The ITT suite of documents was published on the EU Supply portal as planned on 1 June following sign off by the Project Board on 20 May. Work is now ongoing to confirm the arrangements for the bidder dialogue session (for Lot 1 only) on 30 June and for the evaluation process. The closing date for ITT submissions is 10 July.

3.3. The project is currently on schedule to meet all agreed major milestones.

4 ALTERNATIVE OPTIONS

4.1. Nil of note

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. A number of workshops were held with the public throughout the Autumn, 2014 to discuss the new service model. These workshops built on the wider work that had been carried out regarding the integration agenda

6 TIMETABLE

The high Level milestone plan can be seen below:

Milestone	Date
ITT issued to short listed bidders	1 June 2015
Evaluation period	July and August 2015
Intention to award contract	October 2015
Contract Signature	November 2015
Service commencement	1 April 2016

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The financial impact of the procumbent has been modelled and both commissioning organisation are confident that new service will enable will improve patient outcomes

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The CCG and Local Authority are currently procuring the new services in line with the required legal framework

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. None of specific note

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. Being managed as part of the procurement

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

13 BACKGROUND PAPERS

13.1. Community Services Project Initiation Document – September 2014

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NHS
Merton
Clinical Commissioning Group

Community Services Procurement

Sue Howson

05 September 2014

Project Initiation Document

right care
right place
right time
right outcome

Document Control

Version Control

Version	Date	Issued to:	Author(s)
0.1	05/09/14	Adam Doyle – MCCG Director of Commissioning and Planning	Sue Howson

Change Control

Version	Changes:		Author(s)
0.2			

Contents

Appendices

1 Introduction and Background

1.1 Introduction

1.1.1 The Royal Marsden NHS Foundation Trust is the current provider of community service to the Boroughs of Merton and Sutton. The contract was originally entered into by Sutton and Merton Primary Care Trust in April 2011 for a contract term of 3 years with an option to extend for a further 2 years. The option to extend by two years has been exercised and the contract will now expire at the end of March 2016. A full competitive procurement will need to undertaken in order to identify and appoint a preferred partner for the provision of community services post March 2016.

1.1.2 This is a major procurement and presents an opportunity to realise a step change in the quality of community services in Merton. This will be a joint procurement by the CCG and the local authority.

1.1.3 This Project Initiation Document (PID) sets out the details the scope and objectives of the project, the approach to be followed, governance arrangements and project control processes to be employed to ensure that the project is delivered within allocated resources and timeframe.

1.2 Background

1.2.1 The background to the current community health services contract lies in the national Transforming Community Services process, where PCTs were required to divest themselves of their community services in order to focus on their commissioning responsibilities. The contract was awarded to The Royal Marsden NHS Foundation Trust and the contract began on 1 April 2011. The contract was for three years with the option to extend for two further years.

1.2.2 Following the NHS reorganisation in April 2013 some of the PCT commissioning responsibilities for community services transferred to the local authority and NHS England. This meant that the services within the current contract were, as at April 2014, commissioned by five organisations: Merton CCG, Sutton CCG, LB Merton, LB Sutton and NHS England. NHS England have since exited the current contract on 1 April 2014 leaving four commissioners.

1.2.3 The Figure 1 below shows a summary of the commissioning responsibilities of each of the organisations.

Figure 1. Commissioning responsibilities for community services.

Organisation	Service
CCGs	• Community nursing including night nursing and tissue viability • Specialist nursing – heart failure, respiratory, continence, HIV, Parkinson's Disease • Diabetes service (nursing, dietetics and podiatry) • End of life nursing • Adult rehab services including OPARS, CPAT, neuro rehab and community physiotherapy • Specialist children's services including therapies, SALT and children's specialist nursing • Children's community nursing • Children's safeguarding • Cedar Lodge (children's residential respite and outreach service) • Outpatient physiotherapy and MSK services • Community podiatry • Podiatric surgery • Dysphagia service for people with learning disabilities
Local Authorities	• Falls prevention service • School nursing • Community dietetics (NB tier 3 under discussion around transfer back to CCGs) • Contraceptive and sexual health services
NHS England (excluded from this exercise with the exception of health visiting)	• Health visiting (transfers to local authorities in October 2015 so likely to be part of this procurement exercise) • Family Nurse Partnership • Child health information systems • Immunisations • National screening programmes including diabetic eye screening

1.3 Progress to Date

1.3.1 The contract was originally extended to 1 April 2015 but has since been extended another 12 months to 31st March 2016 to allow adequate time for a full review and redesign of services prior to commencement of the procurement process.

1.3.2 A workshop was held on 14 April 2014 with the co-commissioners (LB Merton, Sutton CCG and LB Sutton), where there was an appetite for dividing the contract into Merton and Sutton. The objective of this decision is to support integration with social care, and to continue and promote joint commissioning with the relevant local authority. The associate commissioners were asked to agree the timescale by 30 May, and to be ready to progress to the next stage by 30 June.

1.3.3 There has been full engagement with the CCG Membership through the Clinical Reference Group (CRG), Locality Group meetings, Practice Leads Forum and Practice Managers' Forum.

1.3.4 In May 2014, the CCG commenced a community services survey with its GP practice membership, the survey closed on Friday 1st August 2014.

1.3.5 All practice staff were invited to respond to the survey which comprised of 49 questions concerning the following community teams and services:

- Community Nursing Team
- Community Prevention of Admission team (CPAT)
- Specialist Nursing Teams
- Community (Tier 3) Diabetes Service
- Community Dietetics
- Adult Therapy Services
- Children and Family Services
- LiveWell
- Family Planning Services
- Check it Out

1.3.6 The results of the survey indicated various degrees of satisfaction with the current service. Specifically, community nursing, specialist nursing and health visiting were rated negatively whilst end of life care was rated as excellent.

1.3.7 [what happened at the July event?]

2 Project Definition and Scope

2.1 Introduction

2.1.1 The overall aim of the project is to ensure that a community service provider is identified and a contract entered into to ensure that there is continuity of community services provision when the contract expires on 31 March 2016.

2.1.2 This section of the document sets out the scope of the project and the outputs to be delivered that will ensure successful delivery of this objective.

2.1.3 The following sections of the document refer to the governance arrangements and controls that will need to be in place to monitor progress and to manage any risks that impact on successful delivery. Whilst this sets out the scope and deliverables of the MCCG and LBM teams it must be remembered that the success of the project is reliant upon the partnership working between MCCG and other key stakeholders.

2.2 Project Scope

2.2.1 It is important at the outset of the project that the scope is defined and, of equal importance, that it is agreed what is out of scope. This does not mean that the scope cannot change during the project but this will need to be agreed by the Project Board and any resource implications of this change in scope acknowledged. For example, a change in scope may

result in a requirement for additional funding, project team resource or an extension to the project timeline.

In Scope

2.2.2 The current scope assumes that the project team will manage the procurement of the community services for both MCCG and LBM.

2.2.3 The scope for the delivery of the project involves:

- The disaggregation of the current community services contract resulting in the separation of staff and budgets at a borough level;
- The preparation of a business case to support additional investment in community services highlighting the key benefits to be realised by the investment;
- The management of the procurement process from the initial approach to the market through to the appointment of the preferred partner.

Out of Scope

- The project will not engage in any business as usual (BAU) activities associated with the current community service provision under the current contract.

2.3 Project Objectives and Expected Benefits

2.3.1 The objectives of the project are to:

- Ensure that the approach to the market is robust and attracts significant interest from potential bidders;
- Ensure that the procurement process is robust and follows the principles of equality of treatment, non-discrimination, proportionality and transparency;
- Ensure that the constitution of the evaluation team is robust and that they are adequately trained;
- Successfully procure and appoint a community provider to commence services by April 2016

2.3.2 The MCCG are committed to realising a real step change in the quality of, and access to, community services. The CCG also acknowledge that in order to achieve the range of benefits to which they aspire additional investment will be required. A business case will be developed to support this investment and as part of that process a benefits realisation workshop will be held.

2.4 Deliverables

2.4.1 The key deliverables from the project will be:

- The disaggregation of the community service contract to establish a borough based workforce and commissioning budget;

- A business case setting out the case for additional investment in community services to deliver improvements in clinical outcomes;
- Production of all tender documentation to include Clinical Service Specifications, Pre-qualification Questionnaire, Invitation to Tender (ITT) or Invitation to Participate in Dialogue (ITPD) and contract documentation; and
- Final report detailing the procurement process, the outcome of the bid evaluation and a recommendation for contract award.

2.5 Constraints

2.5.1 The two key constraints to the successful delivery of the project are:

- The availability and capacity of the MCCG commissioning team to engage in the procurement process; and
- Adequate time to ensure that the procurement process can be completed to allow for a substantial mobilisation period of no less than 6 months prior to service commencement.

2.5.2 Whilst Project Management support will be provided to manage the project there will be significant time commitments required from the CCG commissioning team and clinical leads. This will involve the development of the service specifications and the engagement in the evaluation process leading up to the appointment of the preferred partner. The timing and level of input will vary depending upon the preferred procurement route e.g. a restricted procedure will require more input prior to advertising the scheme to the market whilst competitive dialogue requires more input once three bidders have been selected to enter into the dialogue. A full resource plan will be developed to support the preferred procurement route once this decision has been made.

2.5.3 The deliverables identified above will require significant work to be undertaken prior to the scheme being advertised and the procurement process being commenced. The current timescales indicate that the scheme will be advertised in January which provides a challenging timescale to complete the disaggregation of the services, establish the TUPE implications and to write and gain approval of a business case for the proposed additional investment in the community services contract.

2.6 Dependencies

2.6.1 The dependencies can be divided into two groups, those that are internal to the project, for example one working group's progress is influenced by that of another, and those that are external but that could influence the project scope, timeline or cost.

Internal

2.6.2 The key dependency for the project is that all working groups will need to have completed their work programme to enable the tender to be advertised. This will need to be managed through strong internal project management.

External

2.6.3 There is a dependency with the current co-commissioners with regard to the completion of the disaggregation process. This will have an impact on the identification of the quantum of TUPE transfers, the information of which is required as part of the Invitation to Tender documentation.

3 Governance Arrangements

3.1 Introduction

3.1.1 This chapter outlines a proposed project management structure and the processes that need to be in place to ensure that the project delivers the appointment of a preferred provider for the community services by October 2015 in readiness for service commencement in April 2016.

3.1.2 The ultimate decision making forum for decisions within the remit of the CCG will be the MCCG Governing Body.

3.2 Roles and Responsibilities

Senior Responsible Owner

3.2.1 The MCCG Assistant Director of Commissioning and Planning is the Senior Responsible Officer (SRO) for the Community Services Procurement project and is accountable to the Governing Body for the successful delivery of the project. The SRO is supported by an experienced team of project managers who will oversee the inputs required to deliver the project to the agreed timescale, budget and quality standards.

3.2.2 The SRO is owner of the overall business change and risk management process. The SRO is responsible for ensuring that:

- The project meets its objectives and delivers the anticipated benefits;
- The projects is managed effectively in the context of a clear business focus in terms of meeting the CCG's aims and objectives; and
- That the project is delivered within the agreed resource and financial parameters.

Project Director

3.2.3 The Project Director is responsible for the overall integrity and coherence of the project, and will develop and maintain the environment to support successful delivery. The high level responsibilities are highlighted below:

- Planning and designing the project in accordance with the Project Plan and proactively monitoring its overall progress;
- Defining the project specific governance arrangements;

- Managing the project's budget on behalf of the SRO;
- Facilitating the appointment of individuals to the project delivery teams;
- Ensuring that the deliverables are of the appropriate quality, delivered on time, within the agreed budget and in accordance with the Project governance arrangements;
- Ensuring that there is efficient allocation of resources and skills
- Managing third party contributions to the project
- Managing project specific communications with stakeholders
- Managing risks to the project's successful outcome
- Initiating extra activities and other management interventions wherever gaps in the project are identified or issues arise
- Reporting progress of the project at regular intervals to both the SRO and the Project Board.

3.2.4 The Project Director reports directly to the SRO.

Project Managers

3.2.5 Two Project Managers will be appointed to work with the Project Director and be responsible for the day to day delivery of the project, managing the outputs from the project working groups.

3.2.6 The high level responsibilities of the Project Managers are to:

- Provide Project Management support to the working group leads;
- Report to the Project Director on progress against the project plan;
- Take responsibility for specific deliverables and tasks as identified by the Project Director; and
- Identify any risks that are detrimental to successful delivery of the project.

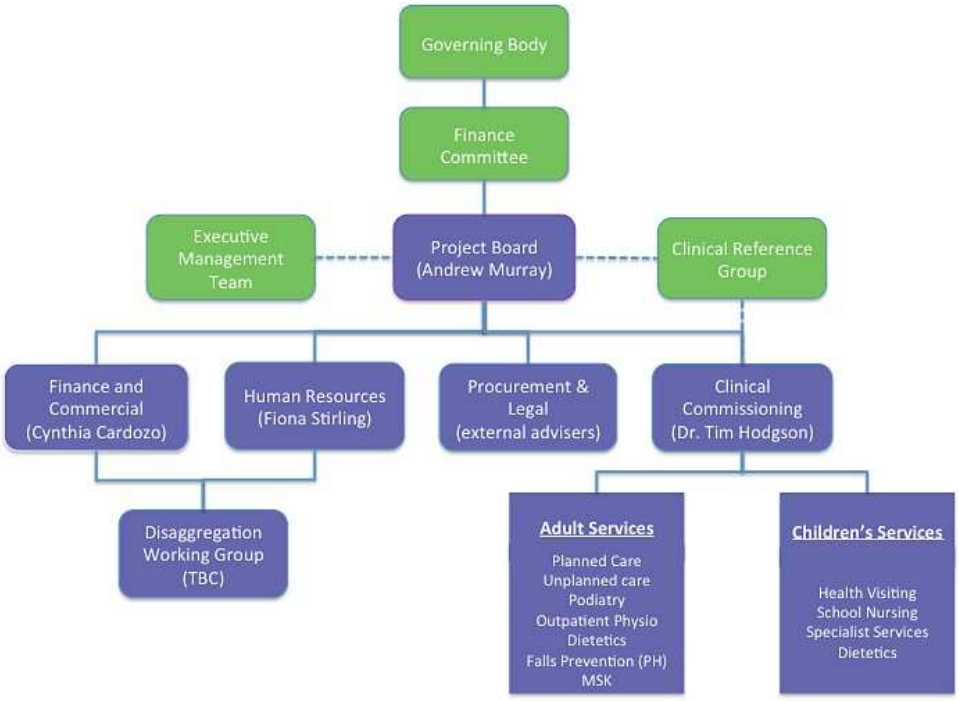
3.2.7 The Project Managers report directly to the Project Director.

3.3 Project Management Structure

3.3.1 The project management structure is consistent with the principles in the Office of Government Commerce "Managing Successful Programmes and Projects". The project structure is designed to manage the delivery of the specified outcomes and will integrate with the CCG governance structure for approvals and strategic direction when required.

3.3.2 The following figure sets out the proposed project structure.

Figure 2. Project Management Structure



Project Board

3.3.3 A Project Board will be established to take responsibility for overseeing the delivery of the Community Service Procurement project. It will report to the MCCG Finance Committee on progress, any significant risks to delivery and for approval purposes.

3.3.4 The Project Board will be chaired by Andrew Murray, the clinical lead for XXXXXX.

3.3.5 The Project Board will have delegated authority from the MCCG Finance Committee to oversee and ensure delivery of the project in line with the agreed deliverables and timescales. Its role is to ensure that resources are made available to deliver the project and that the project management arrangements are robust. It will form the main decision making forum and provide direction and advice to the Project Director on issues outside their level of authority.

3.3.6 The Project Board will monitor progress against time, budget and quality and authorise actions to address any deviation from the agreed plan.

3.3.7 The Project Board will meet on a monthly basis. Draft Terms of Reference and membership of the Project Board are attached at **Appendix A**.

Working Groups

3.3.8 Responsibility for key deliverables will be delegated by the Project Board to subject specific Working Groups. Membership of these work-streams will be chosen specifically to ensure that the requisite expertise is present to deliver the quality of output required.

3.3.9 The project Working Groups will be responsible for delivering of key outputs, as defined by the Project Board, and will report progress on an agreed basis depending upon the status of the Working Group in the project timeline. They will be constituted where necessary to deal with specific deliverables, risks or issues as they become apparent throughout the course of project delivery and discontinued once the allocated work is complete.

3.3.10 At the outset of the project four working groups will be established. Each group will have be responsible for the delivery of key outputs at specific times of the project. The membership of the procurement evaluation team will be drawn from these groups. The following sets out the high level responsibilities and deliverables for each Working Group.

Finance and Commercial

3.3.11 This Working Group will be chaired by the MCCG Chief Financial Officer and will be responsible for all financial input into the project. This will include:

- The disaggregation of the current community services contract;
- Input into the business case for additional investment and establishing the contract value for the procured services;
- Agreeing the contracting model with commissioning team: and
- The design of the financial and commercial evaluation methodology and associated documentation for the tender documentation;

Human Resources (HR)

3.3.12 The HR Working Group will be chaired by the CSU HR Manager allocated to the CCG. The group will specifically be responsible for:

- Providing the HR support to the disaggregation process ensuring that Employment Law, specifically TUPE, is adhered to: and
- Input into the development of the tender documentation.

Procurement and Legal

3.3.13 The Procurement and Legal workstream will be chaired by the Procurement Adviser (yet to be confirmed). This group will be responsible for the delivery of:

- The procurement and tender documentation at all stages of the process and will review all documentation prior to release for approval by the Project Board;

- The design, organisation and management of all bidder events;
- The contract documentation (NHS Standard Contract) for inclusion in the tender pack;
- Management of the evaluation process; and
- Production and review of the final recommendation report

Clinical Commissioning

3.3.14 The clinical commissioning group will be chaired by Dr Tim Hodgson.

3.3.15 The role of the group is to oversee and manage the delivery of the clinical service specifications to the required standard for the inclusion in the Invitation to Tender. The level of detail required in the service specifications will be dependant upon the preferred procurement route.

3.3.16 The Clinical Commissioning Working Group will oversee two main streams of work; Adult Services and Children's Services. These two work streams will have focus groups working on the individual service lines.

3.3.17 Members of this Working Group will play a significant role in the evaluation process and the competitive dialogue process with should this be the preferred option for procurement.

3.4 Project Resources

3.4.1 This is a complex project to be delivered in a within an agreed timescale with limited contingency with regard to the timeline. It is therefore essential that the project be adequately resourced from the outset to ensure successful delivery. The figure below sets out the proposed resource plan for the core project team.

Figure 3. Resource Plan

3.4.2 There will also be significant input required from the MCCG commissioning team and clinical leads throughout the process. The input will vary at different stage of the process and is dependent upon the chosen procurement route. This resource requirement will be calculated and profiled once the procurement route has been agreed.

4 Project Controls

4.1 Controls

4.1.1 Project controls will be established primarily around a comprehensive, regular and effective reporting system. The following table outlines the key areas of project control.

Figure 4. Project Controls

Control	Responsibility	Frequency
Maintaining the risks and issues log	Project Manager, with assistance from Working Group Leads	On-going – monthly reporting to Project Board
Tracking expenditure against budget	Project Director with assistance from Project Manager	On-going – monthly reporting to Project Board
Tracking progress against project plan	Project Manager, with assistance from Working Group Leads	On-going – monthly reporting to Project Board
Authority to approve change	Project Board	On-going – to be reported to SRO and MCCG Finance Committee
Maintaining on-line filing system for key project documentation	Project Manager and Working Group Leads	On-going
Signing off deliverables	SRO and Project Board	When deliverable is ready
Signing off project completion / contract award	Project Board, MCCG Finance Committee, MCCG Governing Body	End of project

4.2 Risk Management

4.2.1 Risk management is an integral part of the MCCG project management approach. At the outset of the project a risk workshop will be scheduled to identify any key project risks. These will be logged on the project specific risk and issues register. Each working group will also be required to identify, assess, log and manage any risks specific to their work programme. Any significant risks from the working groups will be captured on the project risk register.

4.2.2 Reporting of significant risks will be managed through the project reporting mechanisms and will be a standing item on all project agendas. If the Project Board cannot deal with the risk, they will ensure that it is escalated within the governance structure to the level most appropriate to manage the risk or provide instruction to the Project Board.

4.2.3 All new risks and issues will be identified by the Working Groups or the project team and registered on the risks and issues log and discussed at the next available Project Board meeting. Validation and acceptance onto the Risks and Issues log will be the responsibility of the Project Team and will be ratified at the next project Board meeting.

4.2.4 All risks and issues will have a management plan developed, agreed and a named person identified and held accountable for managing the risk/issue. This person will be considered best able to manage the risk due to their requisite skill set and competencies.

4.2.5 The Risks and Issues log will be updated on an on-going basis and formally validated monthly by the Project Board.

4.3 Reporting

4.3.1 The outline responsibilities for timescales for project reporting are summarised in the following table.

Figure 5. Reporting

Report	Prepared By	Purpose	Timescale for Completion
Project Highlight Report	Project Director	To update the Project Board on the progress of the project and the overall progress against the project plan. To highlight any significant risks and issues that will impact on successful delivery	A week in advance of the Project Board meeting
Working Group progress report	Working Group Leads	Provides commentary on activities and milestones completed in the previous month and planned for the following month. Provides commentary on key risks and issues and how these are being managed. The content of these reports will inform the Project Highlight Report	Three days in advance of the Project Highlight Report

4.3.2 The template for the Project Highlight report is presented in **Appendix B**.

4.4 Timetable

4.4.1 The table below presents an outline programme for the procurement of the community services. This timetable is subject to change depending upon the chosen procurement route. The timetable below assumes a restricted process.

Task	Timeline
Project Start-up	September 2014
Consultation period	Aug – October 2014
Develop Service Specifications	Oct – November 2014
Market Engagement Event	December 2014
Sign off Service Specifications by EMT	December 2014
Sign off Service Specifications by CRG	January 2015
Approval by Governing Body to proceed to advert	January 2015
Advert placed on Supply2Health and OJEU websites	February 2015
Issue PQQ	March 2015
Issue ITT to short listed parties	April 2015
Tender submissions returned	June 2015
Evaluation Period	July – August 2015
Preferred Bidder approved by Governing Body	September 2015
Contract award following 2 week standstill period	October 2015
Mobilisation Period	Oct 2015 – Mar 2016
Service Commencement	April 2016

Committee: Health and Wellbeing Board

Date: 23 June 2015

Wards: All

Subject: Merton Health and Wellbeing Strategy 2015-18

Lead officer: Kay Eilbert, Director of Public Health

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

Contact officer: Clarissa Larsen, Health and Wellbeing Board Partnership Manager

Recommendations:

1. To receive the refreshed Merton Health and Wellbeing Strategy 2015-18

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report outlines the Health and Wellbeing Strategy 2015-18 and presents a one page summary for information and circulation.

2 DETAILS

2.1 Members of the Board will recall that they discussed the direction of the refreshed Strategy at the development session in January and again at the informal seminar in March. It was agreed that the Strategy should be more focussed on fewer outcomes with a clear delivery plan.

2.3 The Health and Wellbeing Strategy 2015-18 prioritises the most significant influences on health as well as good health. Our vision is:

A fair share of opportunities for health and wellbeing for all Merton residents.

This means we will halt the rise in the gap in life expectancy between areas within Merton.

2.4 The Strategy has five key priorities which together create a place for a good life in Merton:

Theme 1	Best start in life – early years development and strong educational achievement.
Theme 2	Good health – focus on prevention, early detection of long-term conditions and access to good quality health and social care
Theme 3	Life skills, lifelong learning and good work
Theme 4	Community participation and feeling safe
Theme 5	A good natural and built environment

2.5 Each theme sets out a number of outcomes with three year targets. The draft delivery plan details actions against each outcome, with baselines, one year

targets, lead officer and governance lead. The Delivery Plan 2015/16 will be available online and the link will be circulated with the minutes of this meeting.

The Health and Wellbeing Strategy 2015-18 has been circulated to members of the Health and Wellbeing Board and a printed version will be available at the meeting.

2.6 Following comment and agreement by the Health and Wellbeing Board and Merton Council Cabinet, the Health and Wellbeing Strategy was launched at the Mitcham Fair on 13 June. A one page summary of the Strategy was circulated at the event which will also be distributed at the meeting. Partners are encouraged to share and promote this summary as widely as possible, within their own organisations and with contacts.

2.7 NEXT STEPS

Each of the priorities will report on progress to the Health and Wellbeing Board and this reporting schedule will be included in the forward plan. The Delivery Plan will be updated on an annual basis.

3 ALTERNATIVE OPTIONS

3.1. It is a statutory requirement for all Health and Wellbeing Boards to produce a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment and wider data

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. A consultation event was organised by Healthwatch for the refresh of the Health and Wellbeing Strategy. Health and Wellbeing Board partners have been closely involved in the development of the Strategy.

5 TIMETABLE

5.1. The Health and Wellbeing Strategy will run to 2018 with the Delivery Plan being updated on an annual basis.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. The Health and Wellbeing Board is supported by the Public Health team

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. The Health and Wellbeing Board is a statutory committee of the Council and must deliver a Joint Strategic Needs Assessment, a Health and Wellbeing Strategy and integration of health and social care

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. The Health and Wellbeing Board has prioritised health inequalities within Merton

9 CRIME AND DISORDER IMPLICATIONS

9.1. One of the themes of the health and wellbeing strategy – Community Participation and Feeling Safe involves a focus on crime and perceptions of crime, especially in the more deprived part of the borough.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

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

None

12 BACKGROUND PAPERS

12.1. None

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Committee: Health and Wellbeing Board

Date: 23 June 2015

Agenda item:

Wards: All

Subject: Public Health – Two Years On

Lead officer: Dr Kay Eilbert, Director of Public Health

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

Contact officer: Clarissa Larsen, Partnership Manager Health and Wellbeing Board

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Recommendations:

To note the work of Public Health and progress made two years into its transition to the local authority.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out the work of the Public Health team and partners in the first two years following transition to Merton Council

DETAILS

2.1 Background

2.1.1 LBM Public Health has had an exciting and productive two years, building commitment from partners and its own capacity. Our approach to health and wellbeing in Merton is taken from a model that estimates that seventy to eighty percent of what creates health lies outside healthcare services. Early child development, education, income and the physical environment, including the built environment contribute to creating health. This demonstrates the key role that local government has to influence health.

2.1.2 The 2010 Health and Social Care Act set out five statutory public health services:

- Sexual health – e.g., Genito-urinary medicine (GUM), family planning, HIV prevention services
- National Child Measurement Programme – BMI measurement at reception and Year 6 by School Nurses
- NHS Health Checks – check-ups for adults 40 to74 every 5 years delivered in primary care
- Support to clinical commissioning groups - up to 40% of Public Health staff capacity to support local CCG commissioning. In Merton, this is delivered through staff support to five of the six CCG priority workstreams (Keeping Healthy and Well, Children, Early Detection and Management of Long-term Conditions, Mental Health and Older People).

- Assuring protection of the public's health – while Public Health England leads this, local public health must assure robust delivery of immunisations, screening and pandemic flu plans, for example.

2.1.3 In addition, local Public Health is required to

- Produce an annual update of the local Joint Strategic Needs Assessment (JSNA)
- Produce an independent annual Public Health Report by the Director of Public Health
- Support the Health and Wellbeing Board and help produce a health and wellbeing strategy that guides local commissioning of services

2.1.4 Public Health teams in local government are expected to champion health and reducing health inequalities across the whole of the local authority's business, promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed. This latter is delivered through close work with Public Health England London and participating in the Merton Borough Resilience Forum where a Flu Pandemic plan has been agreed and will be tested over the Summer 2015. In addition, PHE London is invited periodically to LBM adult social care and health scrutiny to update on the immunisations and screening programmes.

2.2 LBM Public Health

2.2.1 LBM Public Health received a ring-fenced grant of £8.9m in 2013-2014, increased to £9.2m in 2014-15. Because there will be no further increases in the future, this calls for continual review of services to identify quality improvements and efficiencies due to pressures on the public health budget where clinical services experience increasing demand.

2.2.2 From April 2013 to present, in addition to ensuring delivery of the statutory services, we said we would focus on

- Understanding the services we inherited from Sutton & Merton PCT through reviews
- Investing in increased Public Health capacity
- Influencing partners and investing in addressing health inequalities and prevention, focusing on settings where resources have a larger impact

2.3 What We Have Achieved

2.3.1 Public Health has worked collaboratively, both across the Council and with our partners to deliver change that focuses on embedding prevention and addressing health inequalities, as well as encouraging a public health approach starting with a needs analysis and embedding best practice across robust pathways.

2.3.2 We focused the first two years of public health in LBM to

- review all services that the Council inherited from Sutton & Merton PCT. These reviews will be complete end June when the Livewell review will be complete. We have used this improved understanding of all services to set out robust KPIs to performance manage these services and to inform specifications for the public health services (school nursing, CASH-family planning, and the forthcoming health visiting services) within the community health services re-procurement by Merton CCG on our behalf. Two services—community dietetics and falls prevention—are being included in the MCCG-LBM Section 75 agreement.
- increase the Public Health capacity from 7 to 13 staff (including transfer of a manager for substance misuse from within the Council). This was completed at the end of September 2014, when the Public Health team started providing a basic public health service. We increase our capacity by being a training site for Public Health trainees and for community dieticians.
- put in place a programme of prevention initiatives that focus on working in settings (e.g., schools, workplace, high street, housing estates) and address health inequalities across Merton either through influence or direct commissioning.

2.4 London Borough of Merton

2.4.1 Children and Young People

A Public Health-Children Schools and Families group ensured that Public Health support to CSF early years and young people progressed effectively. The Consultant in Public Health and the Public Health Principal designed and supported implementation of a number of public health initiatives. They supported the MCCG GP clinical director and workstream focusing on children, providing expert input to the re-procurement of the community health services and to the transfer of health visiting from NHS England. Specific initiatives include

- A review of the National Child Measurement Programme, one of the Public Health statutory services and delivered by School Nurses, provided the information to establish improved KPIs and to develop a robust specification for re-procurement of the service.
- A review of the early years' agenda led to development of best practice in children's centres (Early Years Pathways, Mental Health Post). Pathway development is well underway to ensure a robust pathway and good communication between professionals who deal with young children—maternity, health visitors, children's centres and GPs, with a link to school nurses.
- A review of the Health Visiting service informed ongoing work to ensure an effective transfer of health visiting service from NHS England to LBM Public Health in October 2015.
- Development of Healthy School programmes in two school clusters in the more deprived east of Merton, including work with Dig Merton to introduce food growing to children.

- Alive N Kicking – programme for children and their families, identified through NCMP
- Reviews of CAMHS and Looked After children are ongoing

School nursing and health visiting services are within the community health services being procured in partnership with Merton CCG for April 2016.

2.4.2 Adults and Older People

Our consultant in Public Health for Adults and Older People and the Public Health Principal support three of the six priority workstreams for Merton CCG; i.e., Early detection and management, mental health and older people. An important product involved the mental health needs assessment, completed on behalf of both the CCG and the Council. This will be the basis of a discussion to prioritise the CCG mental health work programme going forward. Specific initiatives include

- Adult Mental Health Needs Assessment
- Ongoing work with adult social care involves review and development of best practice mental health peer support
- NHS Health Checks – IT procurement
- Befriending scheme through lead Age UK
- Falls and neurological needs assessments

2.4.3 Influences on Health

LBM Public Health now works across Council influences on health, including

- A Responsible Authorities Group established by Public Health to develop strategic responses and to identify common areas of interest, including
    - responding regularly to licensing and development control applications and agreeing conditions with applicants
    - working with the Licensing Committee and officers to refresh the statement of licensing policy
    - working with local and national planning colleagues to develop a tool setting out key points in the planning process for Public Health involvement and identification of potential to work across planning and licensing functions with Public Health
- Health impact assessments – although agreement to embed this across the Council did not move forward, HIAs are now ongoing with the regeneration team for three regeneration schemes.
- London Workplace Charter – in collaboration with HR, LBM achieved commitment level. A healthy workplace scheme is being designed for staff and will include Health Champions, frontline training for brief advice and signposting, as well as review of the physical environment (e.g. student dietitians review catering offer on-site). StepJockey has been operating in the Council since the repairs to the lifts started.
- Merton Adult Education delivers English for Speakers of Other Languages (ESOL) courses based on health messages

- Libraries staff and volunteers have been trained as Health Champions to provide frontline brief advice and signposting to lifestyle services
- Public Health will support a healthy catering officer in Environmental Health and a school travel post
- Work with Sports and Leisure through additional green gyms; a scheme to train physical activity champions is being designed
- Agreement to work with litter enforcement officers to offer cancellation of litter fines for smokers who attend Stop Smoking services and quit smoking
- Work with Sustainable Communities and Transport through the work agenda (discussed below under Pollards Hill pilot) and the Sustainable Merton partnership through DigMerton support to Healthy Schools
- Work with LBM Scrutiny Panels to increase attention to public health and prevention. Invitation to Scrutiny Commission in July to begin dialogue about how their areas of work influence health and increasing their consideration of health impacts in their areas of work

2.4.4 Sexual Health

Sexual health is one of the statutory Public Health services provided by local government. The Genito-Urinary Medicine (GUM) services are open-access sexual health services provided by hospitals. Because they are open access, this presents a risk to the LBM Public Health budget since it is difficult to predict use of the services. Other sexual health services commissioned by Public Health include CASH-family planning (a block contract within community health services), condom distribution and HIV prevention (commissioned both pan London and locally). Achievements include

- Contraceptive and Sexual Heath Review – to examine the options for reducing the budget risk in the open access GUM services. The sexual health commissioner worked to put in place a variety of mechanisms, including
    - Agreed associate commissioner status with main providers
    - Work with London Directors of Public Health will lead to a pan-London (22 boroughs have signed up to date, including Merton) tariff regime, as well as a procurement process, both of which increase individual commissioner's influence over providers. Following this agreement, work is proceeding to develop the processes that will oversee this, which will culminate in negotiations/agreement with the main sexual health providers in London
- GettingItOn services for young people
- Pilot HIV testing in selected GP surgeries
- Early medical admissions HIV testing at St Hellier
- HIV home sampling

2.5 Merton CCG

- The DPH is a member of the strategic Executive Management Team and of the MCCG Board.

- Public Health support to five of the six MCCG priority workstreams (Children and Maternity, Keeping Healthy and Well, Early Detection, Mental Health and Older People) with Public Health funding of three of these posts.
- This work is covered by a memorandum of Understanding and an agreed annual work plan.
- Building on the priority given to Keeping Healthy and Well by Merton CCG, work with CCG colleagues to develop NHS required prevention work through, for example, joint weight management and alcohol pathway work.
- A health needs assessment for residents in the more deprived wards of Merton resulted in agreement to develop a model of care for the younger, more deprived and ethnically diverse residents. Partners for this work include MCCG, primary care providers, LBM Public Health, LBM Adult social care, and the voluntary sector. A draft model should be ready by end November.
- This model of care will most likely be informed by an ongoing Public Health sponsored Proactive GP pilot in East Merton, which focuses on prevention and early detection in primary care to reduce health inequalities, embed prevention and link primary care to our community health champion scheme.

2.6 Other partners

- MVSC supports our community Health Champion initiative- volunteers from community groups are trained to Royal Society of Public Health NVQ2 level to deliver brief advice and signposting to members of their groups. A My Health Guide was created to support Health Champions and to provide opportunities for people to make a pledge for a chosen lifestyle change.
- The Fire Brigade staff were trained to embed prevention (smoking and alcohol, the largest causes of fires) in their frontline work to install fire alarms
- Merton Chamber of Commerce has been commissioned to provide a sustainable healthy workplace outreach service to small and medium size enterprises.
- A pilot of the refreshed Health and Wellbeing Strategy – Merton the Place for a Good Life -- is being designed for Pollards Hill, in collaboration with Commonside Community Development Trust, Phoenix residents association and residents. Starting with a Living Street Audit to identify assets and issues, efforts are now ongoing to seek support/interest from local residents to guide further development

2.7 Public Health has supported the Health and Wellbeing Board to

- Develop a rolling programme to deliver an updated Joint Strategic Needs Assessment with a series of supporting needs assessments
- Refresh the Health and Wellbeing strategy – Merton the Place for a Good Life
- Secure funding for review and development of the Board, with a proposal for further support under consideration by London Councils
- Broaden the scope of the Board by gaining agreement to expand the agenda to include the wider influences on health and membership to include the

Director of Environment and Regeneration, who manages many of the services that influence health

- Agree establishment of Public Health Board as sub-group of HWB Board to influence the HWBB partnership and oversee Public Health programme
- Complete a statutory Pharmaceutical Needs Assessment, setting out the market for new pharmacies in Merton and recommending opportunities for embedding prevention in local pharmacies

NEXT STEPS

2.8 Public Health Prevention Services for Procurement 2015-16

2.8.1 Weight management and alcohol services represent the largest part of the underspend in the Public Health budget.

Livewell provides Stop Smoking services, as well as support to people who wish to change a lifestyle behaviour. The service is well liked by providers and is currently under review following a LB Sutton Public Health decision not to continue joint commissioning past April 2016. This presents an opportunity to create a one-stop referral service for lifestyle interventions, along with weight management. Consideration will be given to inclusion of alcohol services.

2.8.2 In 2015-16 we are working to develop seamless pathways from prevention through to treatment/rehabilitation, in partnership with MCCG for both weight management and alcohol services. For weight management, LBM Public Health will begin procurement of Public Health Tier 1 and 2 services and Tier 3 on behalf of MCCG, along with a one-stop service from June 2015. We are currently negotiating with MCCG to develop a similar joint pathway for alcohol, as Tier 4 alcohol rehab services are commissioned by the CCG. While a study was completed on an alcohol pathway, we are further ahead with weight management work but will examine the potential to include alcohol in the one-stop service.

2.8.3 We are bringing together our work across lifestyle behaviours, including diet, exercise, smoking, and alcohol to create coordinated pathways that address not only individual lifestyle behaviours, but also provision in the built environment or in our high streets to make the healthy option the easy choice. Our food work adopts a broad approach, starting with a Merton Food Summit in April to bring together organisations that deliver some aspect of the food agenda. We are exploring how Public Health can best work with Council officers who deliver services that influence health, including examples mentioned above such as healthy catering and policy levers. We are undertaking an audit of physical activity opportunities in Merton to create options (in addition to leisure centres) for people using our Tier 2 weight management service. We commissioned social marketing to understand better why our smoking quit rate is declining, similar to a trend across the country.

2.8.4 The DPH is the London DsPH lead for alcohol and works with a Healthy High Street group to commission support to this agenda, as well as to identify areas of common interest across our boroughs, as well as developing effective advocacy at the national level. We are awaiting feedback from a list of 'asks' sought by the group on increased control over their local high streets and are beginning to examine potential for a London pilot for alcohol minimum unit pricing for interested boroughs.

5. ALTERNATIVE OPTIONS

None for the purpose of this report

6. TIMETABLE

As set out in the report

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report. **.**

8. LEGAL AND STATUTORY IMPLICATIONS

None for the purpose of this report.

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

A core aim of Public Health is to address health inequalities.

10. CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

12. Appendix
None

13. Background Papers
None

14. Officer Contact
Clarissa Larsen, Health and Wellbeing Board Partnership Manager
Clarissa.larsen@merton.gov.uk

Committee: Health and Wellbeing Board

Date:

Agenda item:

Wards: All

Subject: Healthwatch Merton Update June 2015

Lead officer: Dave Curtis – Healthwatch Merton Manager

Lead member: Barbara Price – Healthwatch lead Trustee for MVSC

Forward Plan reference number:

Contact officer: Dave Curtis – Healthwatch Merton Manager

Recommendations:

A. That the Board note the progress made by Healthwatch Merton.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the report is to update the Board on the progress to date and the on-going developments within the Healthwatch service for Merton.

2 DETAILS

2.1. The Health and Social Care Act 2012 included a requirement on local authorities to establish a local Healthwatch in their area. This duty replaced the duty to establish a Local Involvement Network (LINk) from 1 April 2013.

2.2. As previously reported to the Board on 23 April 2013, Merton Voluntary Service Council (MVSC) was awarded the contract to deliver Healthwatch Merton in March 2013. A two-year contract was agreed with an option to extend for a third and then a fourth year. MVSC has been given the extension of a third year being the year 2015/2016.

2.3. Appendix 1 shows the workstreams established for 2015/16 with provisional timings.

2.4. Appendix 2 gives a current update on Healthwatch Merton activities and recent developments

2.5. Appendix 3 and 4 relate to Healthwatch Merton Governance changes and the new Healthwatch Merton Operational Committee.

3 ALTERNATIVE OPTIONS

3.1. No alternative options are suggested.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. Review of all feedback and intelligence during 2014/15 used to inform an online/offline survey to help set the workstreams for 2015/16.

5 TIMETABLE

5.1. The provisional timetable for the workstreams is set out in Appendix 1.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. The contract for Healthwatch Merton will be £125,085 in 2015/16. Financial monitoring against this will be provided to the Council.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. Provision of an effective Healthwatch Merton is a statutory requirement under the Health and Social Care Act 2012.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. Healthwatch Merton is subject to MVSC's Equalities Policy. The contract requires Healthwatch Merton to monitor use of the service and report this to the Council.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. Healthwatch Merton is subject to MVSC's Health and Safety Policies.

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

Appendix 1 – Healthwatch Merton Workstreams Programme for 2015 - 2016

Appendix 2 – Healthwatch Merton Update report

Appendix 3 – Revised HWM GOVERNANCE STRUCTURE diagram

Appendix 4 – ToR HWM Operational Committee

12 BACKGROUND PAPERS

12.1. Health and Social Care Act 2012.

Healthwatch Merton update

Name: David Curtis

Position: Healthwatch Manager
Period Covered: Mid Feb 2015 – May 2015

Update:

Staff appointment - Jade Fairfax, HWM new information and outreach officer
Volunteer appointment - Brian Dillon, HWM New independent Chair

Monitoring and Reporting:
- Report as required to the Health and Wellbeing Board.
- Report as required to Board of Trustees
- Annual Report in full draft stage for 2014/2015

Publicity:
Website: Ongoing – Volunteer opportunities posted - Local signposting - News stories - Events updated – website and social media kept relevant and up to date - regular tweets

Newsletters: First electronic newsletters produced and disseminate plus additional e-bulletins as required for specific events

External: Events, Meetings and Public Engagement opportunities attended, member of and present at:

Boards/Committees/ Meetings
New: SWL Primary Care Co-commissioning Joint Committee

Health and Wellbeing Board; Kingston Hospital Healthwatch network; SWLSTG Foundation Trust Steering Committee Meeting; St Georges Stakeholder Steering Group; South west London Patient and Public Engagement Steering Group; BHCH programme Board; Adult Safeguarding Board; The Merton Model Group; Community Services Procurement Board; South West London Collaborative Commissioning;

HWM Events/Meetings and Public Engagement

- 20th May 15 – Healthwatch Merton, Feedback and the Future event. Shared overview of work done in the last 12 months and launched our workstreams for the coming year

Partnership work:

New:
- Primary Care and Out of Hospital briefing
- SWL Primary Care Co-commissioning Joint Committee
- Quality Account Priorities/proposed stakeholder session - St Georges
- CAMHS Needs Assessment & Review (Task and finish Group)

Existing:
- Integration project team – health and social care (MCCG and Merton Council)
- South West London Local Healthwatch Forum Meeting
- Mitcham Project board
- HWE Developing HW standards
- Community Services Procurement Project Board Meeting

Workstreams 2015/2016:
Over the last 12 months Healthwatch Merton has been busy gathering people's views on health and social care in the borough – a survey was also conducted and completed by 314 local people. These have been identified for 2015/16 using feedback and intelligence gathered since April 2014.

Locally Directed
- Older People: Engagement work to identify areas within this we should focus on:
- 1 focused workshop
- Develop work plan
- Deliver work plan

- A&E & Urgent care services: Engagement work to identify areas within this we should focus on:
- 1 focused workshop
- Develop work plan
- Deliver work plan

Operational
- Children and Young People: Develop our Children and Young People function

Top Down
- Integration: Watching brief on integration and lead on patient public engagement

Existing
- GP Services: Promote findings directly with GP surgeries, Review HWM GP Services Impact.
- Hospital: Inpatient/ Outpatient, Finish report

Volunteers:
New:
x1 Engagement and Outreach/ Research and Policy Volunteer
Currently have:
x1 Research and Policy Volunteer

Governance:
Healthwatch Merton has listened to and reviewed the views/opinions raised on its governance structure over the last year and made proposed changes to MVSC board of trustees that would be achievable within the contractual arrangements. These were recently approved. We now have a Healthwatch Merton Operational Committee (HWMOC). The HWMOC will be a sub-committee in the MVSC governance arrangements to lead on the strategic development of Healthwatch Merton and oversee its operations on behalf of MVSC Board of Trustees and will be independently chaired.

HWMOC (Healthwatch Merton Operational Committee) has held its first meeting in May 2015 which was extremely productive. We are still recruiting to vacant positions.

We have new independent Chair – Brian Dillon. He has already chaired the first HWMOC and beginning to take on other responsibilities relevant to position i.e. Governor for St Georges.

London Borough of Merton have confirmed this year's funding 2015/16 which will be the same as level as 2014/2015 of £125,085.

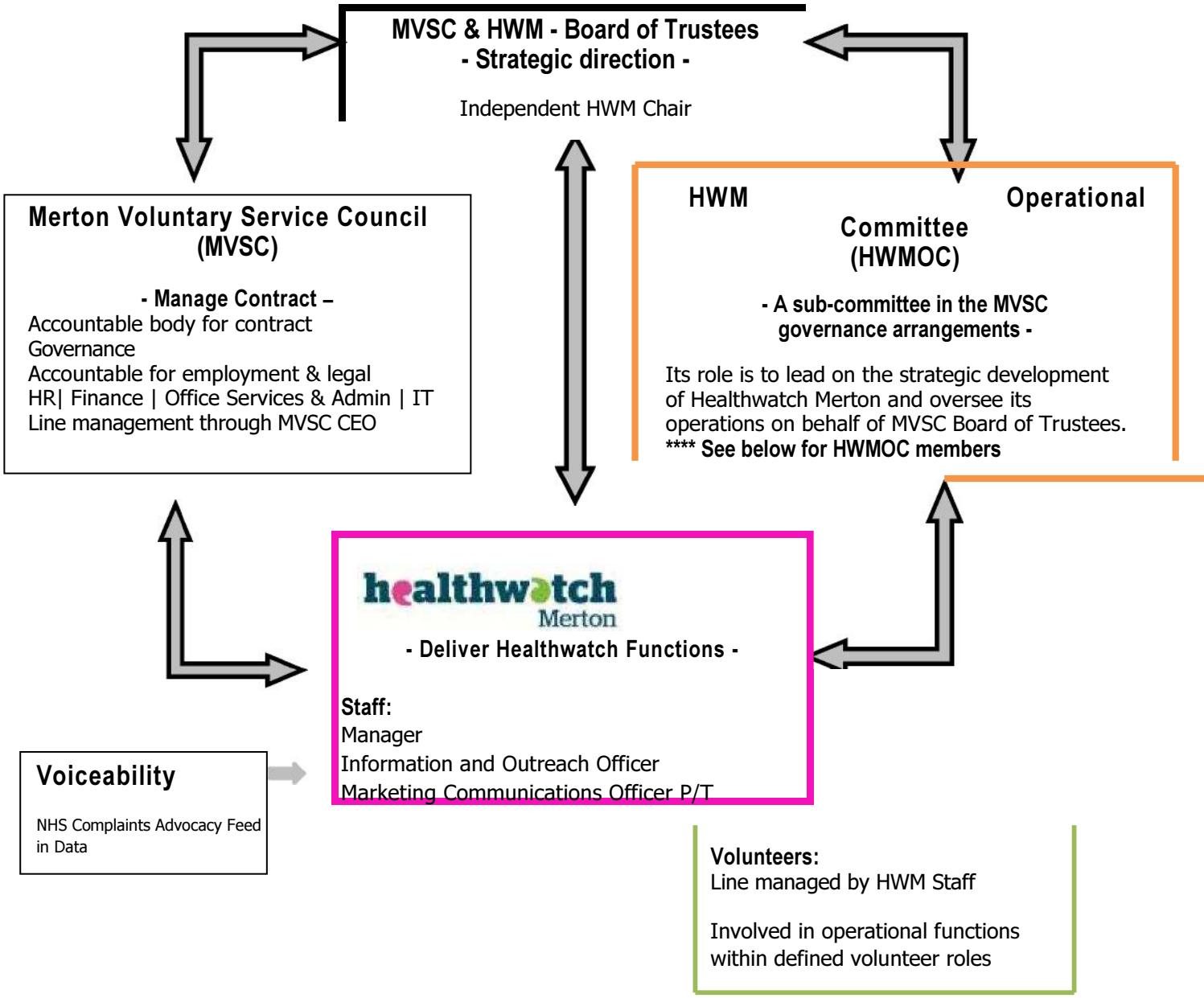
Healthwatch Merton Workstreams Programme Report

Workstream	Evidence	What We Do	How We Will Do It	Who Will be Involved	Next Step
Locally Directed					
Older People	From our Workstream survey and listening events	Engagement work to identify areas within this we should focus on: • 1 focused workshop • Develop work plan • Start Delivery of work plan	Engagement and work plan development – Share plan	HWM team Patients Voluntary and community organisations Public	Workshop May – July 2015 Develop work plan August 2015 Start work September 2015 – March 2016
A&E and Urgent care services	From our Workstream survey and listening events	Engagement work to identify areas within this we should focus on: • 1 focused workshop • Develop work plan • Start Delivery of work plan	Engagement and work plan development – Share plan	HWM team Patients Voluntary and community organisations Public	Workshop May – July 2015 Develop work plan August 2015 Start work September 2015 – March 2016
Operational					
Children and Young People	HWM resources still mainly directed on **Adult** Health and Social Care areas	Develop our Children and Young People function	Work with Children and Young people Groups/ forums to develop clear plan	HWM Manager Youth Partnership VCM young people Youth Parliament Young Advisors	May – July 2015 Implement plan once agreed

Top Down					
Integration	Largest reform of health and social care – still ongoing	Watching brief on integration and lead on patient public engagement	'Integration' Project meetings Continue to hold events to engage patients and public to feed directly into 'Integration' developments and progression On-going information and communication using HWM channels and bulletins	HWM Manager HWM team Integration Project Voluntary and community organisations Patients Service users Public Carers	Ongoing May 2015 – March 2016
Existing					
GP Services		Promote findings directly with GP surgeries Review HWM GP Services Impact	Meet with all practices Survey and engagement with patients, GP's and MCCG	HWM team Volunteers HWM team Volunteers	Sept 2015 Dec 2015
Hospital: Inpatient/ Outpatient		Finalise Report	Online and share widely	HWM team	June 2015

Healthwatch Merton
www.healthwatchmerton.co.uk 020 8685 2282 info@healthwatchmerton.co.uk

GOVERNANCE STRUCTURE



**** HWMOC members:

Chair of HWMOC will be the HWM Independent Chair

Representation of at least 1 trustee appointed by the MVSC board and no more than 3 MVSC trustees

HWM Manager

4 places on the HWMOC are allocated to representatives from Merton's voluntary, community and faith organisations selected through an open nomination process.

4 places on HWMOC are allocated to residents of Merton selected through an open recruitment process.

The MVSC CEO will sit on the committee as an advisor - without voting rights.

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Healthwatch Merton Operational Committee

Committee Purpose

Healthwatch Merton Operational Committee (HWMOC) will be a sub-committee in the MVSC governance arrangements.

Its role will be to lead on the strategic development of Healthwatch Merton and oversee its operations on behalf of MVSC Board of Trustees.

Terms of Reference:

1. Composition and attendees

- HWMOC will be chaired by selected Independent Chair appointed by the trustees of MVSC
- HWMOC shall have representation of at least 1 trustee appointed by the MVSC board and no more than 3 MVSC trustees
- 4 places on the HWMOC are allocated to representatives from Merton's voluntary, community and faith organisations selected through an open nomination process.
- 4 places on HWMOC are allocated to residents of Merton selected through an open recruitment process.
- The MVSC CEO will sit on the committee as an advisor but without voting rights.

2. Terms of Office

- The Independent Chair will be a 2 year appointment with the possibility of a one year extension at the discretion of the MVSC Board.
- MVSC trustee representatives will be reviewed and nominated annually.
- The resident representatives shall be 2 year appointments with the possibility of a one year extension at the discretion of the Independent Chair and ratified by the MVSC Board.

3. Reporting

- HWMOC reports directly to the MVSC Board, supported by the HWM team.
- HWMOC must provide written reports on work profile, activity, outputs and outcomes at least four times a year to the MVSC board of trustees.
- HWMOC must be mindful of the contract targets with the LB Merton and ensure that capacity is considered when developing work programmes.
- Contract compliance with regard to the LB Merton funding must be paramount in all considerations of the group.

4. Quorum

- A quorum shall consist of five members of HWMOC.

5. Decision Making

- HWMOC will operate under an evidence based decision making approach
- All decisions and recommendations to the MVSC Board must be on a majority vote
- In the case of a hung decision the Chair has the casting vote

- All strategic decisions about annual work programmes, campaigns, resources, consultancy and appointments to HWMOC must be ratified by the MVSC Board of Trustees
- The Terms of Reference of HWMOC are set and agreed by the MVSC Board and form part of our contractual arrangements with the London Borough of Merton. They are therefore not open to review or amendment by HWMOC.

6. Meeting Frequency

- HWMOC will meet six times a year.
- Meetings shall be timetabled to be three weeks before an MVSC board meeting wherever possible to ensure effective reporting.

7. Performance Review

- The trustees and CEO of MVSC will review the performance of HWMOC every six months with the Independent Chair in the first year.
- Thereafter HWMOC performance will be reviewed annually.

8. Dissolution

- MVSC trustees reserve the right (as the contracted organisation) to dissolve HWMOC if it is not felt to be working in the best interests of patients, carers, service users, residents and the wider voluntary and community sector.

Overall responsibility

Take delegated responsibility on behalf of the board of trustees for ensuring effective strategic development and improving governance.

Main duties

- To consider and make recommendations to the board on all matters relating to HWM (to include determining and making recommendations on the appropriate governance structures)
- To consider and develop the strategic direction of HWM.
- To consider and make recommendations concerning the function of HWM in relation to influence, engagement, volunteering and information.
- To act as champions for HWM and where appropriate liaise with key stakeholder groups.
- To establish critical success factors for HWM.
- To consider and advise the board on the most appropriate model of representation for HWM.
- To keep informed of developments in good practice and changes in policy and legislation in relation to health and social care.
- Members of HWMOC to attend meetings, representing HWM where appropriate and within capacity
- Work within a code of practice and Nolan Principles (The seven Principles of Public Life. These being: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.)

Committee: Health and Wellbeing Board

Date: 23 June 2015

Agenda item:

Wards: All

Subject: Proposal for Health and Wellbeing Board Vice Chair

Lead officer: Simon Williams Director of Community and Housing / Kay Eilbert, Director of Public Health

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

Forward Plan reference number:

Contact officer: Clarissa Larsen, Partnership Manager Health and Wellbeing Board

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Recommendations:

To agree the Chair of Merton Clinical Commissioning Group as Vice Chair of Merton Health and Wellbeing Board

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents a proposal for the Chair of Merton Clinical Commissioning Group to become the Vice Chair of the Health and Wellbeing Board.

DETAILS

2.1 Background

2.1.1 Health and Wellbeing Boards are nearly two years into their statutory role as a committee of the Council and, as constituted in Merton, a sub committee of Cabinet.

2.2 Chairing Arrangements

2.2.1 The Health and Wellbeing Board is currently chaired by the Cabinet Member for Adult Social Care and Health.

2.2.2 At the Health and Wellbeing Board on 24 March a motion was made by Howard Freeman, Chair of Merton Clinical Commissioning Group (since retired):

subject to a legal reason to the contrary that the Health and Wellbeing Board was to be co-chaired by the Cabinet Member for Adult and Social Care and the Chief Officer of the Merton CCG

2.2.3 Advice on Merton Health and Wellbeing Board Constitution

As requested by the Board the Council's Monitoring Officer – Paul Evans (Assistant Director of Corporate Governance) has examined the legality of the Boards proposals for Co-chairing. Below set out are his findings:

'The Health and Social Care Act 2012 gives Health and Wellbeing Boards statutory duties to encourage integrated working between health and social care commissioners and to exercise functions of a local authority and its partner clinical commissioning groups.

Merton Council decided on 27 March 2013 that the council's health and wellbeing functions are an executive function and therefore, the responsibility for decision making is through the Leader and his Cabinet. The Leader has delegated the responsibility for this role to the Cabinet Member for Adult and Social Care, who is also the Chair of the Board.

Merton's Constitution, in its Cabinet Procedure Rules on sub delegation (Part 4D paragraph 1 (2) (a)) does not allow for further delegation by the Cabinet Member to a non-Cabinet member, which would be the case if the chair was co-chaired with the proposed Chair of the Merton CCG.

In addition, the Local Government Act 1972, Schedule 12, paragraph 39 (2) provides that in the case of an equality of votes, the person presiding at the meeting (the chair) has a second or casting vote. By having a co-chair it is not possible to meet this legal requirement.

Based on the above principles I find that the Board's proposal for co-chairing is unconstitutional. It would, however, be appropriate for a non-Cabinet Member to be the Board's Deputy Chair.

I would suggest that a change be made to the constitution to include the Health and Wellbeing Board's terms of reference.'

2.2.4 Available information, from the work conducted by Shared Intelligence in 2014 for London Councils, shows that across London the majority of Health and Wellbeing Boards have a Vice Chair most from their local Clinical Commissioning Group. One London borough has a co-chairing arrangement with the CCG. Ten Boards do not have a vice chair.

2.2.5 The Merton Health and Wellbeing Board has worked effectively on a consensus basis since being established. A Peer Challenge in 2013 praised the partnership work between members of the Board. Whilst a co-chairing arrangement is not constitutionally legal in Merton, it is recognised that having the CCG as Vice Chair would be a positive development.

2.2.6 It is therefore proposed that the Chair of the CCG, Dr Andrew Murray, be agreed as Vice Chair of Merton Health and Wellbeing Board.

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3. NEXT STEPS

Following agreement by the Health and Wellbeing Board the new Vice Chair will be included in the Health and Wellbeing Board's revised Terms of Reference which will be reported to the Council's Cabinet for agreement.

4. Consultation Undertaken

None for the purpose of this report.

5. ALTERNATIVE OPTIONS

It is a statutory requirement that all local authorities have a Health and Wellbeing Board as a committee of the Council.

6. TIMETABLE

None for the purpose of this report.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report.

8. LEGAL AND STATUTORY IMPLICATIONS

It is a statutory requirement for all local authorities to have a Health and Wellbeing Board as a committee of the Council.

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

A core aim of the Health and Wellbeing Board is to address health inequalities.

10. CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

12. Appendix

None

13. Background Papers

Merton Health and Wellbeing Board Terms of Reference

14. Officer Contact

Clarissa Larsen, Health and Wellbeing Board Partnership Manager
Clarissa.larsen@merton.gov.uk

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Committee: Health and Wellbeing Board

Date: 23 June 2015

Agenda item:

Wards: All

Subject: South West London Joint Committee Nomination

Lead officer: Dr Kay Eilbert, Director of Public Health

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

Contact officer: Clarissa Larsen, Partnership Manager Health and Wellbeing Board

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Recommendations:

To agree the nomination of a representative of Merton Health and Wellbeing Board to attend the South West London Joint Committee

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To agree the nomination of a representative of the Health and Wellbeing Board to attend the South West London Joint Committee

2. DETAILS

2.1 From 1st April 2015, the six south west London Clinical Commissioning Groups (CCGs) took on the responsibility of commissioning Primary Care services together, alongside NHS England, as part of a Primary Care joint co-commissioning arrangement. Co-commissioning is intended to give local clinicians and local communities more influence over how primary care services are developed.

2.2 A South West London Joint Committee is being set up top to oversee the joint commissioning function. More detailed work is continuing to take place with CCGs, NHS England (London) and Local Authority colleagues to establish how the joint committee will work in practice.

2.3 A request was received in April for a representative of Merton Health and Wellbeing Board to take part in this Committee. In the transferral from NHS England to CCGs it is possible that conflicts of interest may arise between a CCG with GP membership and contracting of local services. This South West London Joint Committee has been proposed to reduce/remove this risk.

2.4 Separately to the request to Health and Wellbeing Boards, one representative has also been requested from each borough's Healthwatch and relevant Local Medical Committee to attend the SWL Joint Committee.

3. NEXT STEPS

Following nomination and agreement the Merton Health and Wellbeing Board representative will attend the South West London Joint Committee and report back as necessary.

4. Consultation Undertaken

None for the purpose of this report.

5. ALTERNATIVE OPTIONS

None for the purpose of this report

6. TIMETABLE

None for the purpose of this report.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report. **.**

8. LEGAL AND STATUTORY IMPLICATIONS

None for the purpose of this report.

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None for the purpose of this report.

10. CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

12. Appendix

None

13. Background Papers

None

14. Officer Contact

Clarissa Larsen, Health and Wellbeing Board Partnership Manager
Clarissa.larsen@merton.gov.uk