Merton Council
Health and Wellbeing Board

Date: **24 November 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

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Agreed Dates:
26 January 2016 3pm-5pm
19 April 2016 1pm-3pm
Provisional Dates subject to Council Approval all 3pm-5pm:
28 June 2016, 4 October 2016, 29 November 2016,
24 January 2017, 28 March 2017

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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All minutes are draft until agreed at the next meeting of the committee/panel. To find out the date of the next meeting please check the calendar of events at your local library or online at www.merton.gov.uk/committee.

HEALTH AND WELLBEING BOARD
29 SEPTEMBER 2015
(13.00 - 14.15)

PRESENT Councillor Caroline Cooper-Marbiah (in the Chair), Dr Andrew Murray, Kay Eilbert, Yvette Stanley, Adam Doyle, Dr Karen Worthington and Melanie Monaghan

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

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies were received from:
Councillors Maxi Martin and Gilli Lewis-Lavender
Simon Williams – Director of Community and Housing
Chris Lee – Director of Environment and Regeneration
David Freeman – Director of Commissioning, Merton CCG
Khadri Mahdi – Chief Executive Merton Voluntary Services Group

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

No declarations of interest were made

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the Health and Wellbeing Board held on the 23 June 2015 were approved as a correct record

4 CHILDREN AND FAMILIES' ACT (Agenda Item 4)

Jane McSherry, Assistant Director of Education presented the report on the progress of the implementation of the Children and Families Act 2014 Part 3; the Special Educational Needs (SEN) and disabilities elements of the reforms.
She guided the Board through the sections of the report; programme governance, the local offer, Education Health & Care (EHC) Assessment and Planning, Preparation for Adulthood, Personal Budgets, Joint commissioning, Health and the final section on Risk Management implications.

The Board asked questions regarding Risk Management and how risks could be managed. The Board noted that capacity issues would be reviewed. Anecdotal evidence suggested that Merton was doing as well, if not better than other authorities with implementing this transformation. It was also noted that a rolling training programme was required to ensure that all staff were fully trained.

RESOLVED

That the Health and Wellbeing Board

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

5 CHILDREN AND YOUNG PEOPLE'S PLAN (Agenda Item 5)

Naheed Chaudry, Service Manager Policy, Policy and Performance presented the report on the Draft Children and Young People's Plan 2016/19. This is a multi agency plan which underpins Merton's Community Plan and is commissioned and monitored by the Children's Trust. It sets out how agencies in Merton collectively deliver the borough's priorities for children and young people, and focuses on targeted intervention for the most vulnerable groups.

Any comments that members have can be made by email to Naheed. Kay Eilbert requested a bullet point on prevention. Yvette Stanley noted that the Merton C&YP Well Being Model which underpins all our work is a preventative model and that this needed to be added to the forward by way of context. Melanie Monaghan suggested further mention of housing could be included.

Links to the Health and Wellbeing Strategy were discussed and the need for the Health and Wellbeing Board to articulate the influences on wellbeing.

RESOLVED

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

6 CAMHS TRANSFORMATION PLAN (Agenda Item 6)

The Chief Officer of Merton CCG presented the report on the CAMH Transformation Plan which will cover the full spectrum of service provision and address the needs of all children and young people making it easier for them to access CAMH services and support

The report outlined the NHSE guidance for the Transformation Plan which requires that the Plan is signed off by the HWB or a representative of the Board. The board agreed that the Director of Children Schools and Families would undertake this role in consultation with the HWBB Chair and the Director of Public Health.

RESOLVED

1. To nominate the Director of Children Schools and Families in consultation with the HWBB Chair and the Director of Public Health to sign off the Local CAMH Strategy and Transformation Plan.

7 SCRUTINY TASK GROUP FINAL REPORT - IMPROVING THE UPTAKE OF IMMUNISATIONS IN 0-5 AGE GROUP (Agenda Item 7a)

Councillor James Holmes presented the report as a member of the Immunisations Task Group. Councillor Holmes explained that the task group was a cross-party group that examined the important subject of how to improve the take-up of immunisations amongst the 0-5 age group in the borough. The group received expert advice and officer guidance. Many of the people consulted expressed the view that they were pleased to have the opportunity to talk about this subject.

Board members noted the Childhood immunisation paper report to the Clinical Reference Group that set out a comprehensive action plan to deliver the scrutiny review recommendations

Board members noted that issues of access to services affected. It was noted that GPs continued to be the main deliverer of immunisations and that whilst schools could not require children to be immunised they were an important partner in improving uptake.

In accepting the recommendations of the Task Group, the HWBB suggested that the future report to HWBB be timed to match other report cycles. The HWBB heard that there were volunteers, working with families in the community, who were well placed to become health champions and deliver the immunisation message

RESOLVED

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

2. That the Health and Wellbeing Board agrees to the implementation of the recommendations, as set out in the action plan presented to the Board.

8 CHILDHOOD IMMUNISATIONS PAPER - REPORT TO THE CLINICAL REFERENCE GROUP (Agenda Item 7)

The Health and Wellbeing Board noted the Childhood Immunisation Paper – Report to the Clinical Reference Group.

9 MERTON CCG QUALITY PREMIUM (Agenda Item 8)

The Chief Officer of the CCG presented the report and explained that the Quality Premium is a financial reward paid to CCGs by NHS England for improvements in the quality of the services they commission and for associated improvements in health outcomes and in reducing health inequalities. The quality Premiums are judged across six areas and the CCG have some choice in the measures within Urgent and Emergency Care, Mental Health and the two local measures. CCGs are required to agree the recommended measures with their Health and Wellbeing Board.

Yvette Stanley highlighted the link between adult mental health and adult diabetes and school attendance as our CAP project had shown a high prevalence of these

issues in the parents of school non-attenders, as showing the cross cutting nature of these issues. Melanie Monaghan echoed this saying that diabetes often occurs alongside other long term conditions.

RESOLVED

1. The Health and Wellbeing Board is asked to note the details 2015/16 Quality Premium for Merton Clinical Commissioning Group
2. Agree the measures recommended by NHS Merton CCG Executive Committee and Clinical Reference Group for inclusion in the 2015/16 Quality Premium.

10 PROACTIVE GP PRACTICE (Agenda Item 9)

The Director of Public Health presented the report on the Proactive GP Pilot and Award. She explained that the GP Pilot project was already operating, in East Merton, in partnership with Health Champions on smoking cessation and screening for COPD (Chronic Obstructive Pulmonary Disease). Most of the 9 practices in East Merton locality have signed up and efforts are underway to recruit all practices to the pilot.

Dr Karen Worthington said that the pilot was providing a strong route to smoking cessation. The Chair of Merton CCG asked what was planned to encourage GP practices to sign up and The Director of Public health explained that where necessary training will be provided on site. Melanie Monaghan and the Director of Public Health agreed to talk, outside of the meeting, about how carers' roles could be better identified by GPs. The Awards would recognise achievement within the proactive GP scheme for both GPs and Community Health Champions.

RESOLVED

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

11 HEALTH AND WELLBEING BOARD SYSTEMS LEADERSHIP SUPPORT (Agenda Item 10)

The Director of Public Health presented the report which requested the Board's agreement to the proposed systems leadership support for the HWB, which is to be funded by £6K from London Councils. Board members noted that they would be asked to participate in this development work which would use the East Merton Model of Care as a starting point. The report proposed that a specialist consultant be engaged to facilitate this work to conduct interviews with HWBB members and feedback to the next HWBB on 24 November.

Future meetings – discussion of time of day. The board were asked to consider the possibility of moving the HWB meetings to either a morning or afternoon. Members agreed that a 3pm start would be acceptable.

(NOTE: 24 November meeting to start at 1pm as this date has already been publicised on website.)

RESOLVED

That the Health and Wellbeing Board:

1. agrees to and participate in the systems leadership support funded by London Councils.

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Committee: Health and Wellbeing Board

Date: 24 November 2015

Wards: All

Subject: MSCB Annual Report 2015

Lead officer: Yvette Stanley

Lead member: Councillor Maxi Martin

Contact officer: Paul Bailey, MSCB Business Manger

Recommendations:

A. The Health and Wellbeing Board is asked to consider the MSCBs annual report and comment as appropriate.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The Merton Safeguarding Children Board's Annual Report is a statutory requirement under Working Together 2015; Chapter 3, paragraphs 16-17 which provides that

> 16. The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.47 The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.
>
> 17. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period (see chapters 4 and 5).

On the evidence set out in this report we judge MSCBs current safeguarding arrangements to be effective. We are strengthening the Board's ability to enquire into and challenge frontline practice with children, young people and families through the work of the Quality Assurance Sub-Group; through single and multi-agency case audits, we are growing in our understanding of the intended and actual impact of safeguarding practice. Through the Section 11 and quality assurance challenge process we have been able to hold partners to account so that they provide the Board with assurance regarding the quality of safeguarding across the system. Learning from audits LIRs, SCRs etc., is fed back to the front line through training, briefings, conferences and other learning events. Attendance levels at training are good and continue to improve.

The Board has a good understanding of early help and child protection thresholds and ensures that children, young people and their families get right level of help at a time when this help is needed and that frontline practitioners are supported in using their professional judgment when working with families.

The Board has prioritised the safeguarding of children from CSE, exploitation through radicalisation and extremism, and FGM. With regard to CSE, robust strategic and operational measures are in place to ensure that the MSCB has a strong grasp of this issue and that children at risk are identified, supported and monitored to ensure that risks are reduced and

the activities of perpetrators are disrupted and, where there has been an offence, there are persecutions.

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.

Priorities for the 2015 calendar year are:

1. To evidence Board impact through Quality Assurance – Multi-Agency Audits/Learning reviews/Front line practice
2. To maintain strategic oversight of CSE including e-safety, missing young people, young people missing from education
3. To have a strategic multi-agency response to the issue of neglect
4. To have a strategic response to the prevention of Female Genital Mutilation (FGM)
5. The Children and Families Act 2014, Supporting Children and Young People with Complex Needs and LASPO
6. Ensure that there is a strategic focus on and all children are safeguarded from radicalisation and violent extremism
7. MSCB Governance: Implement the revision of the MSCB Governance, Structure and Board Business Processes
8. Engage with Faith and BAME Communities on Safeguarding issues

2 DETAILS

2.1. It is a statutory requirement for all Safeguarding Children Boards to produce an annual report each calendar year. This report details the progress the MSCB is making on delivering its Working Together 2015 and other statutory duties.

3 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

3.1. Information on the SCB budget is included in the report.

4 LEGAL AND STATUTORY IMPLICATIONS

4.1. SCBs must have an Independent Chair and must produce an annual report.

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

Appendix 1 - MSCB annual report 2014/15

6 BACKGROUND PAPERS

6.1. None applicable

Merton
Safeguarding
Children Board

Annual report of the

Merton Safeguarding Children Board 2014/15

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1.0 Chair's Introduction

It has been over a year since my appointment as the Independent Chair. The decision was taken by the Board to delay the publication of the report for 2013-2014 in order to enable me to review with the Board its effectiveness and to develop, agree and implement changes to the constitution. This report will overlap, in part, with the MSCB Annual Report for 2013-2014.

There remains much to do and there are many challenges ahead, including the challenge of delivering high quality services within the context of reduced resources, however, this report demonstrates how much can be achieved when we work together, both as individual agencies and in partnership. The report shows that the work that has been done in revising the constitution of the Board and having a more robust and rigorous focus on quality assurance is improving the way that the young and children are protected and their well-being is safeguarded.

A highlight of 2014-2015 was The Joint MSCB/ Children's Social Care/Children Schools and Families Conference held on the 5th March 2015, which had a focus on hearing the voices of children and young people. The theme for the Conference was *'W T F' – Working the Frontline* and the event focused on enhancing children and young people's participation. The event featured delightful presentations from children and young people from Merton primary and secondary schools and was chaired by representatives of Merton's Youth Parliament. This event was attended by 120 practitioners and managers from a range of multi-agency settings and was rated as very good.

In November 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[1] with a stronger QA Sub-Group;
- 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.

[1] Children Act 2004 Section 14

The national attention on safeguarding issues has continued throughout the year with the publication of the Rotherham Inquiry into Child Sexual Exploitation (CSE) and heightened awareness of the Prevent agenda with young people being groomed to participate in wars overseas and terrorist activities at home. Towards the end of this reporting period, in March 2015, the MSCB appointed a new permanent Business Manager.

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

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

This report shows how the work we are doing as the MSCB seeks to answer these questions.

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, young people and their families.

Keith Makin
MSCB Chair
July 2015

2.0
Progress of MSCB Business Plan 2014 – 15

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

The objectives of the Board as defined by statute are:

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

(b) to ensure the effectiveness of what is done by each such person or body for those purposes[2].

[2] Children Act 2004 Section 14

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

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

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

3.0
Key Achievements and Challenges for the MSCB 2014 – 15

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

3.1.1 Appointment of a Permanent Board Manager.

The Board was able to appoint a new permanent Business Manager who started in on 2nd March 2015. The Board also ensured that there was an effective handover process in order to secure a robust induction and transition process.

3.1.2 Learning and Improvement.

The Board has sought to embed and disseminate learning from Serious Case Reviews and Learning and Improvement Reviews (LIRs), by conducting regular briefings and learning events. These are aimed at keeping frontline staff and their managers informed on recent developments in relevant safeguarding topics (national and local policies, research, etc.), feedback from local learning (including audits and case reviews) as well as maintaining an open dialogue between practitioners and the Board; the Board has held two such events since Autumn 2014. The Board has signed off the Child J LIR with a briefing event delivered to Managers and frontline practitioners across the children's workforce.

3.1.3 The Annual Conference.

The Board held a very successful Joint Annual Conference. The theme for the Conference was *'W T F' – Working the Frontline* and the event focused on enhancing children and young people's participation. The event featured keynote speeches from Professor Jan Horwath and Dr Alan Cooklin as well as delightful presentations from children and young People from Merton primary and secondary schools and was chaired by representatives of Merton's Youth Parliament. The Conference was attended by 120 practitioners and managers from a range of multi-agency settings and was rated as being very good.

3.1.4 Quality Assurance.

The Board has streamlined and embedded its multi-agency quality assurance process and delivered multi-agency audits.

Building on the experience of 2012-2013, the Board has improved the level of rigour in its QA Challenge process and conducted 5 challenge meetings across the MSCB Agency partnerships, to review each agency's compliance with Section 11 of the Children Act 2004. The Board used this process to hold partners to account regarding their work to ensure the safeguarding of children and young people, including, each agency's self-review of its work to safeguard children during period, April 2013 – March 2014. The Board asked each agency to provide relevant data, demonstrating impact of safeguarding activity from the agency's perspective, asking each agency to demonstrate its learning and improvement with regards to safeguarding (Agency and Multi-Agency Learning and Development; take up of MSCB Training/ Briefings). This includes implementing learning from SCRs, LIRs or Sudden Untoward Incidents, agency performance regarding the safeguarding of Care Leavers and Looked After Children (LAC), each agency was asked to provide an update of its work in relation to CSE and its work in relation to implementing statutory and other guidance.

The Board has also revised its Performance Dataset to ensure that our performance data is rich in both content and analysis.

3.1.5 Work on CSE.

In the autumn of 2014, the Board led a multi-agency challenge process to assess local agency understanding of and compliance with the findings of the Rotherham Inquiry. This was peer reviewed by other LSCBs. The MSCB's arrangements were found to be appropriate its CSE action plan was updated to implement the findings of this review. The Board held a National CSE Awareness Day on 18th March 2015. At this event, the Board re-launched its refreshed CSE Strategy, CSE Protocol and CSE Procedure. We have also established CSE champions in schools and Health. The event was attended by 101 participants from a range of agencies and partners including Children's Social Care (CSC), Education, Youth Services, Health, Probation, the Police and a number of Voluntary Organisations. The event also included the voice of a young person, by means of audio recording, who had experienced CSE; sharing with professionals her experience of the safeguarding process and what she felt would be helpful in supporting young people experiencing CSE. This was very powerful and well-received by participants.

3.1.6 The Business Implementation Group (BIG)

The Board established the BIG Sub-Group. The purpose of the BIG is to coordinate and prioritise key actions, to ensure coverage of the statutory functions of the Board and to monitor the implementation of the Board's Business Plan. The BIG also ensures that there is connectivity across the Sub-Groups and Task and Finish Groups. The BIG held its first meeting in February 2015 and will meet 4 times throughout each MSCB Business Year (March 15 to April 16).

3.1.7 Other Achievements

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

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

3.2 The challenges for the Board

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

3.2.1 Consistency and membership

The Board has generally good membership and attendance, however, the representation of secondary education needs to be strengthened on the Board. The Board has taken action to address this by a adding this to our risk register; the Chair has enlisted the support of the Assistant Director of Education and is arranging a series of meetings with Secondary Head Teachers in order to secure their full commitment and representation on the Board.

3.2.2 Demonstrating Impact by Improving Links with Frontline Practice

The Board is also seeking to demonstrate its impact by improving the inter-face between the Board and frontline practice. The Board is addressing this challenge through events such as the annual conference and termly practitioner briefings, feeding back learning from multi-agency audits; in addition we are improving our communication by reviewing the MSCB Website, contributing to workforce wide publications such as Young Merton and the development of an Escalation Protocol that will enable frontline practitioners to bring cases to the attention of the MSCB for audit.

3.2.3 Strengthening our ability to listen to children and take their views into consideration

The Board is always seeking to strengthen our ability to listen to children and take their views into consideration. The Board has developed a Children and Young People's Participation Strategy in partnership with Children's Schools Families (CSF) Department and the Children's Trust, which is due to be approved by the BIG in May 2015.

The Board has also commissioned research from London South Bank University (LSBU) on the theme Help Keep Us Safe. This is a collaborative, consultative project which is proposed between LSBU and MSCB. The project will consult young people who are at risk and/or have used Merton Safeguarding Services, using questionnaires, focus groups and semi-structured interviews.

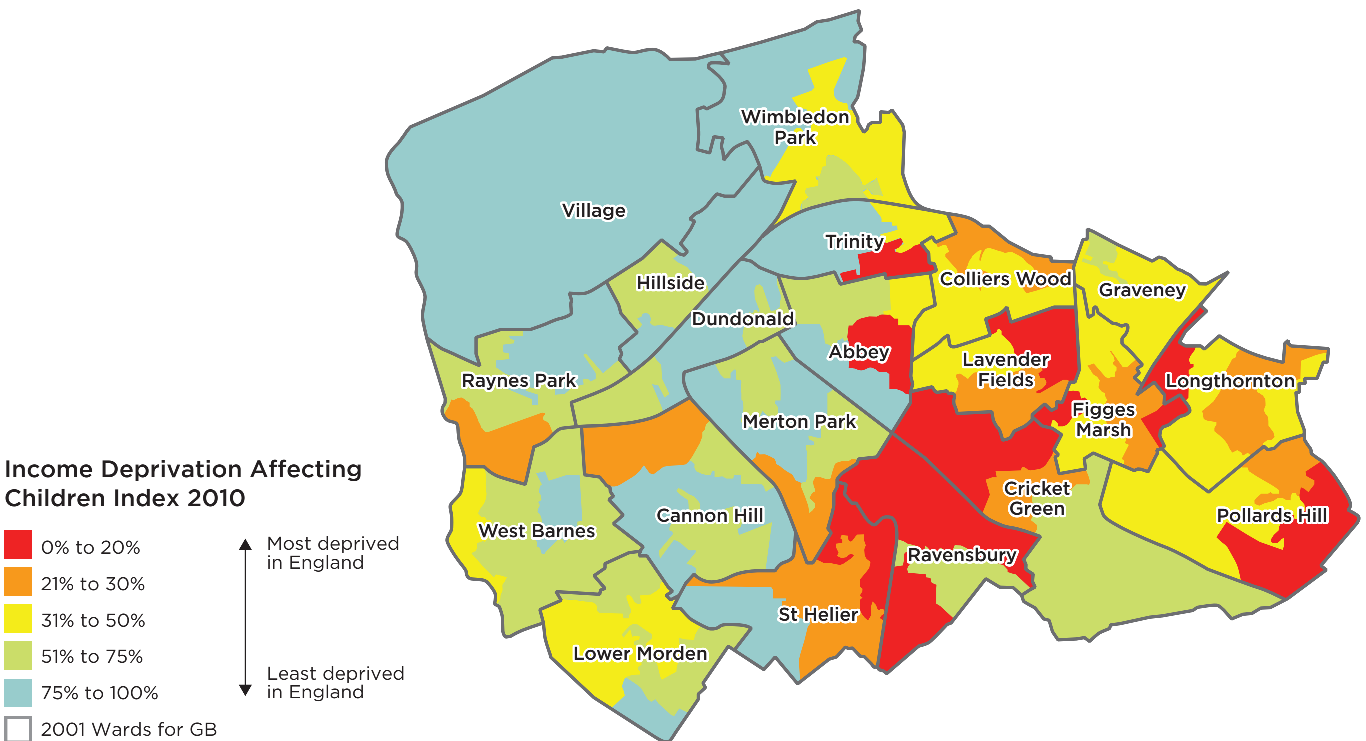
The data gathered will be used to provide a contemporary knowledge-base of current risk issues in the area and to consider how young people want Merton children's services to work with them to best ensure their on-going safety. The project will also include the participation of young people in the design and analysis of questionnaires.

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.

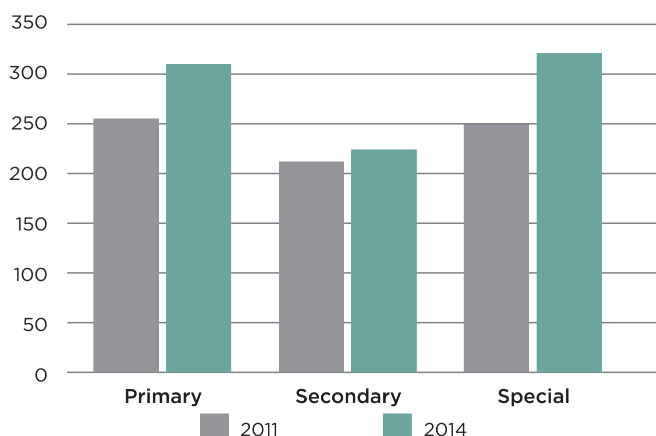
Predominantly suburban in character, Merton is divided into 20 wards and has three main town centres; Wimbledon, Mitcham and Morden. A characteristic of the borough is the difference between the more deprived east (Mitcham/Morden) and the more affluent west (Wimbledon). There are a number of pockets 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[4] 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 31% of children who are eligible for free school meals (2010, 2881 FSM children, 2015, 3796 FSM children).



[4] Super Output Areas are a geographical area for the collection and publication of small area statistics.

Thirty five per cent of Merton's total population is Black, Asian or Minority ethnic (BAME) this is expected to increase further to 39% by 2017. Pupils in Merton schools are more diverse still, with 66% from BAME communities, 42% with a first language which is not English, speaking over 124 languages (2015). The borough has concentrations of Urdu speaking communities, Sri Lankan, South African and Polish residents. The most prominent first languages for pupils apart from English are Tamil 5.7%, Urdu 5.8% and Polish 5.7%.

The number of pupils with Special Educational Needs is also rising, with SEN statements/EHC plans rising from 668 in January 2011 to 880 in January 2015 an increase of 32%).



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 (2014/15, 335.8) is lower than the London average (367) and broadly in line with the National average (346.4), we remain close to our statistical neighbours (2013/14). Our CIN rate has increased over a number of years alongside our population changes 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 (2014/15, 38.5) are similar to London (37.4) and national (42.1). As at the end of 2014/15 16.4% of children became subject of a child protection plan for a second or subsequent time, this in line with the increasing national benchmark (15.5%) and London (13%) averages (2013/14).

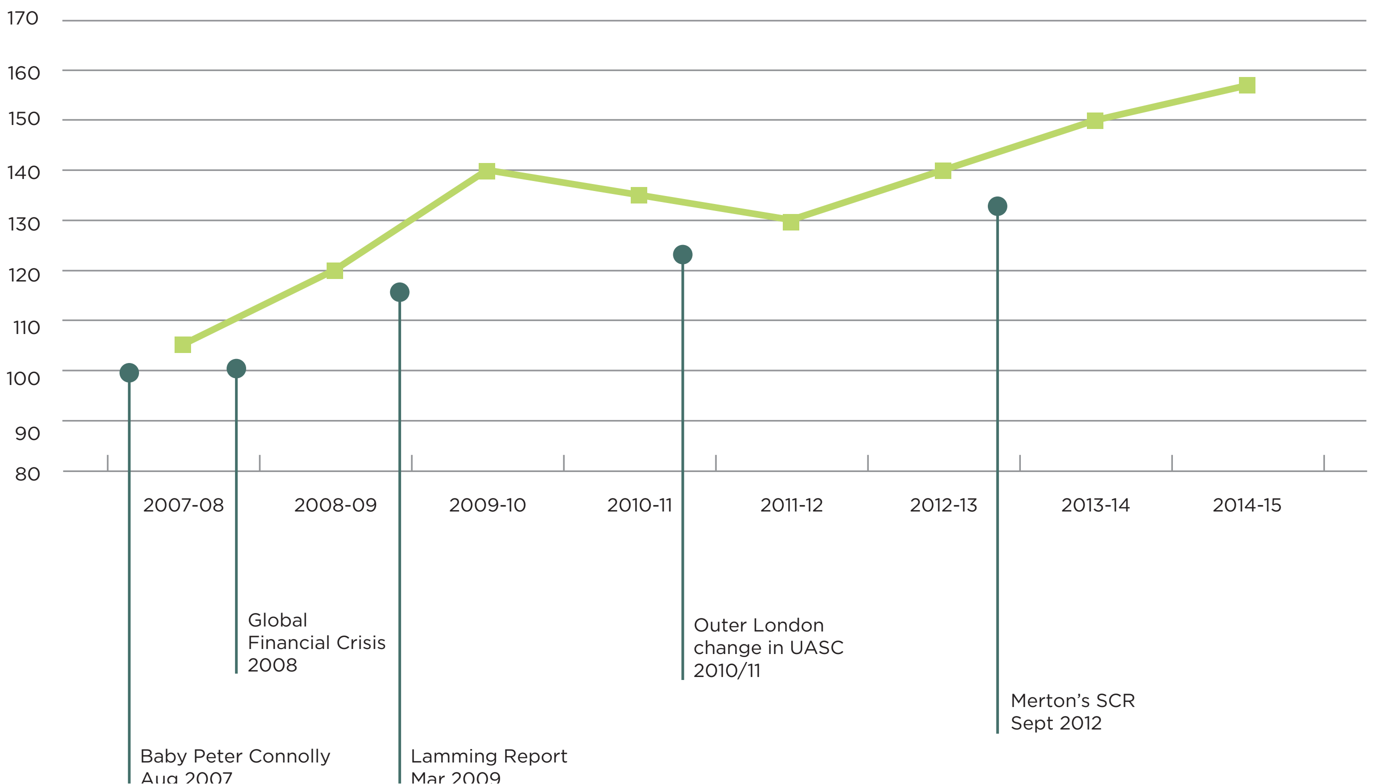
Nationally 4.5% (2013/14) of children were subject of a child protection plan lasting two years or more, in Merton this was 4.3% (2014/15) relating to 10 children.

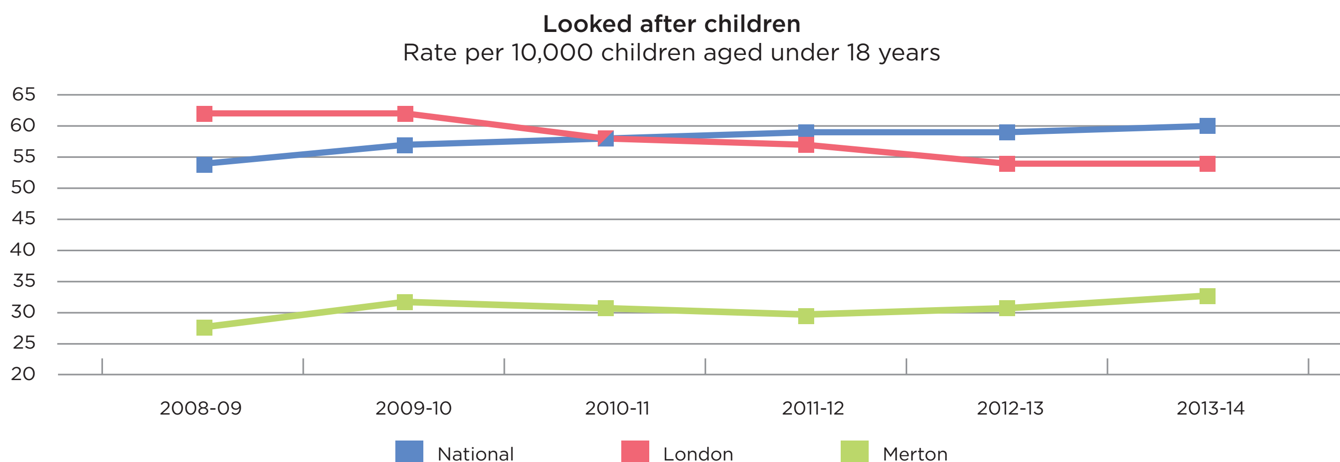
Merton's looked after children population in the last ten years has ranged from a low of 96 (2006/7) to 157 (2014/15), rising to 160(+) during 2013/14. This increase has been reviewed and audited to establish what is behind this trend. There are a number of reasons for this increase including increased 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, 32 during 2014/15.

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 34 (2014/15), this remains within the range of our statistical neighbours 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 24% are aged 10 – 15 and 23% are aged 16 and over.

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 (48% 2014/15). There are fewer Asian or Asian British (8%) than the all persons Merton population. Mixed ethnic backgrounds, Black or Black British heritage and 'other ethnic groups' have looked after children in greater proportions than the resident population. We continue to report an increase in the category of 'other ethnic groups', the majority of which are known to the authority as Unaccompanied Asylum Seeking Children.





The total number of Children Looked After in Merton during 2014/15 was 255. On 31 March 2015 there were 157 children and young people looked after by Merton (34 rate per 10,000); 87 of these children were looked after for one year or more. We have lower rates of younger children in care and higher rates of older children in care compared to the national averages.

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 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." [5]

The total number of Children Looked After in Merton at any time 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).

[5] Inspection Report: London Borough of Merton Fostering Services, 20/11/2012, © Crown copyright 2012

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'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." [6]

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

[6] Inspection Report: London Borough of Merton Adoption Service, 01/02/2013, © Crown copyright 2013

4.3 Children at Risk of Sexual Exploitation

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

During 2014 Merton undertook a CSE self review of the local arrangements to manage Child Sexual Exploitation. We also met with colleagues in Kingston, Sutton and Richmond to submit to a peer review in early December 2014. This was part of a pan-London review of CSE. Merton's arrangements to address CSE were found to be appropriate. The findings from this process contributed to the MSCB's CSE action plan.

CSE is a priority for the Promote and Protect Young People (PPYP) Sub-Group of the MSCB. 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, Primary Health (School Nursing and Health Visiting), Pupil Referral Unit, MASH and the 14+ Looked After Team.

In February 2015, the MSCB approved the refreshed CSE Strategy and Protocol which was formally launched on National CSE Awareness day in March 2015. As noted above, the event was attended by 101 professionals and frontline practitioners from a range of agencies including Children's Specialist Services, Health, the Police, Youth Services and Voluntary Organisations. The protocol sets out local guidance on the identification and referral of CSE concerns utilizing the screening and risk assessment tool which has also been reviewed and updated.

The work across the Borough and partnership has continued to improve practitioner awareness and skills in identifying and referring CSE concerns. The Multi-Agency Sexual Exploitation (MASE) Panel continues to meet on a monthly basis and cases are routinely reviewed to ensure effective multi-agency collaboration, planning and intervention.

Other activities to raise awareness of CSE included:

- CSE and e-safety briefings to 100+ staff at the Merton Council Staff Annual Conference.
- 50 staff attended the first two of an ongoing monthly programme of CSE briefings to multi-agency staff focusing on identification and referral pathways.
- Over 100 staff attended the National CSE Awareness day event in March 2015.
- Over 2,500 students and staff from across MSCB agencies, attended CSE focused assemblies for National Awareness day.
- Leaflets on CSE were distributed to local businesses as part of Metropolitan Police's Operation Makesafe launch.
- The MSCB Multi-agency Training programme offers training for frontline practitioners and mangers on CSE two times per year. The evaluation of this training includes workers commenting on how this training has improved/affected their practice in this area.
- There has been single agency training to police officers and social workers and specialist awareness raising training is being delivered by health safeguarding leads across key elements of the health economy.

Number of Young People Identified

For the year 2014-15 there were 56 cases open to the PPYP/MASE panel; 13 of which were judged to be High risk. We are working with neighbouring Boroughs to share information, expertise and data to improve our benchmarking. At the most recent MASE meeting 17 young people were reviewed 7 were identified as being at a high risk of CSE; 8 medium and 2 as low. The remaining 'on ice' cases represents those cases having been previously judged at risk of CSE that show no current indication of risk but are scheduled for review before being considered for closure. There are currently 30 cases 'on ice'.

Of the Open cases, 7 are assessed as High risk: 8 as Medium risk and 2 as Low risk. The CSE Strategy and Protocol in Merton incorporates the refreshed screening and risk assessment tool developed by Steven Rimmer and Birmingham LSCB.

4.4 CSE Cases

- All 30 cases are or have been open to Children's Social Care and Youth Inclusion.
- 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 is aged 13 and under.
- 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.

4.5 Children Missing from Home and School

In 2014/15 the Jigsaw4u project received 158 referrals and worked with 126 families. This is consistent with the previous year when 169 new referrals were received. Of these families, 27 (21%) were families previously known to the service, 70 were first time runaways and there were 17 repeat runaways on average each quarter. In this time period 64 young runaways were recorded as a Looked After Child and 32 were known to social care. An average of 27.2% engagement in the service was achieved over the year. While this may seem low, this should be read in the context of the high numbers of young people going missing only once that do not go on to receive an in-depth service.

As part of the National CSE Awareness Day campaign, schools in Merton conducted whole school assemblies. This included a specialist workshop and extensive PHSE briefings with a focus on CSE. CSE champions have reported that over 2,500 students and staff attended the focused events across all Secondary Schools across the LA. The campaign was well received by students and staff alike and as a result of our auditing we are especially aware that this work needs to be effectively targeted to our most vulnerable students in Specialist Education and Additionally Resourced Provision.

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 MASE panel 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 Sub-Group.

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.

4.6 Prevent [7]

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.

Merton is not considered by the Home Office to be a priority Prevent borough. Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. Channel referrals have been relatively low but as Prevent awareness increases the borough has seen an increase in the number of channel referrals being made. In 2014/15, 6 referrals were made, 2 of which became formal channel cases with interventions satisfactorily put in place (both have now been exited from the programme). None of the channel referrals involved children and young people.

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

Merton's Safeguarding Children Board has developed *'Guidance for working with children and young people who are vulnerable to the messages of radicalisation and extremism'*. This guidance was developed in the context of the Government's overarching counter-terrorism strategy *'CONTEST'* and the *'Prevent Strategy'* which was developed in 2011 to respond to the threat of extremist activity; the *Counter Terrorism and Security Act 2015* has recently been passed, which places the Prevent Strategy onto a statutory footing. In addition the document is informed by *Working Together to Safeguard Children 2015* and the *Pan London Child Protection Protocols for safeguarding*, to ensure that it implements good and best practice in safeguarding vulnerable children and young people. This guidance is due to be approved by the Board in May 2015.

As part of our work to raise awareness and support parents and carers on this issue, the Board has developed guidance for parents and carers, on *Keeping children and young people safe against radicalisation and extremism*. Subject to approval by the Board, this information will be distributed to all secondary and primary schools, as well as to special schools and PRUs and will be available online and in local libraries.

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

5.0
Statutory and Legislative Context

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

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

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

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

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

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

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

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

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

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

- (i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- (ii) training of persons who work with children or in services affecting the safety and welfare of children;
- (iii) recruitment and supervision of persons who work with children;
- (iv) investigation of allegations concerning persons who work with children;
- (v) safety and welfare of children who are privately fostered;

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

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

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

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

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

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

LSCB duties are specified in WT 2015, Chapters 3, 4 and 5, with a responsibility to have oversight of single agency and multi-agency safeguarding and promotion of children's welfare (under Children Act 2004, section 11, see the footnote on page 31) as set out in WT chapters 1 and 2.

6.0
MSCB Inter-relationships and Influence with other Key Partners

The Board has a rolling 24-month Business Plan, to be refreshed each March for the business year starting each April. The update of the MSCB Business Plan for 2014-2015, agreed by the Board in June 2015, is attached as Appendix 1. The Business Plan outlines the Board's priorities for 2015-2017 and was agreed by the Board at its annual Away Day in March 2015. Priority items can be added within the year.

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

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 including, Health, Child and Adolescent Mental Health, the Police, Children's Social Care, Education etc. 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. The Quality Assurance Sub-Group operates with the MSCB's Learning and Improvement System, agreed by the Board in July 2014 and the Board's Performance Management Framework agreed by the Board in September 2014.

In the period covered by this report, the QA Sub-Group (both Business and Audit) has met 9 times. The QA Sub-Group (Business) met to consider business items such as the MSCB performance data and to monitor learning from SCRs and LIRs and to review the work being done to safeguard children on 5 occasions. The QA Sub-Group (Audit) met on 6 occasions. These audits focused on a variety of safeguarding themes including, CSE, the effective working of Core Groups, etc. Each case is reviewed by a group of Senior Managers from a range of agencies in the MSCB partnership including Health, Mental Health Services, the Police, Children's Social Care and colleagues from Early Help and Education. Each case is used to provide a window into Merton's safeguarding system and allows the Board to be assured regarding the quality of safeguarding practice and to identify gaps and areas for improvement. Each case is assessed to see if learning from SCRs and LIRs is being implemented across the system. The learning from these audits is fed back to staff through MSCB briefings and through summary reports on each audit process. We are working together to further strengthen our shared audit programme and to ensure audit informs practice improvement. The children's safeguarding performance dataset supports the MSCB in reviewing service access and thresholds as well as caseloads and access to supervision and training.

7.2 Promote and Protect Young People Sub-Group

The Promote and Protect Young People (PPYP) Sub-Group met 5 times in 2014-2015. The purpose of the PPYP is to take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted; *concentrating* ***extra-familial*** abuse where there is *risk of abuse outside the family*. PPYP is responsible for policies relating to issues like CSE, children missing from home, care or education, child on child abuse, other forms of exploitation (such as radicalization), e-safety, trafficking, abuse by those in a position of trust or in institutions – including faith organisations and community organisations; and policies and procedures in relation to allegations against those in a position of trust (LADO referrals).

PPYP also takes the lead responsibility for the MSCB's CSE Strategy, Procedures and Action Plan. This includes the direct management of the Multi-Agency Sexual Exploitation (MASE) Panel, which tracks and advises the multi-agency professional teams responsible for young people who are identified at serious risk of harm from sexual exploitation and/or who are at risk from going missing from time to time[8]. PPYP also oversees the work of the Person's of Concern Group which meets in order to identify, monitor and disrupt the activities of individual or groups who pose a risk of CSE. The PPYP refreshed the MSCB's CSE Protocol and CSE Strategy which was approved by the Board in February and re-launched as part of the CSE National

[8] MASE Panels have their own Terms of Reference agreed across London

Awareness Day. The Board continues to monitor Looked After Children identified as being at risk of CSE who are place outside of the Borough of Merton.

This year PPYP oversaw the work of the Prevent Task and Finish Group which produced Guidance for professionals working with children and young People who are vulnerable to the messages of radicalisation and extremism. This guidance is to be presented to the Board for approval in May 2015. Similarly, the Task and Finish Group produced Advice to Parents and Carers regarding keeping children and young people safe from radicalisation and extremism of all forms; this advice will also be presented to the Board for approval in May 2015.

7.3 Learning and Development Sub Group

The purpose of the Learning and Development Sub-Group is to take overall lead responsibility on behalf of the MSCB, to ensure that there are effective arrangements to inform and keep up-to-date the multi-agency and multi-disciplinary workforce in knowledge and skills for safeguarding children and promoting their welfare. The Learning and Development Sub-Group also plans and delivers the Joint MSCB/CSC/CSF Multi-Agency Annual Conference for practitioners and managers to increase awareness and dialogue with frontline practice and to ensure that young people are involved in commissioning and delivery.

The Learning and Development Sub-Group revised its terms of reference which was approved by the MSCB in March 2015.

New to 2014 has also been the introduction of termly Multi-Agency Briefings. These are aimed at keeping frontline staff and their managers informed on up-to-date a range of legislative and good practice developments in safeguarding (including national and local policies, research, etc.). These briefings also provide feedback from local learning (e.g. audits and case reviews) as well as at maintaining an open dialogue between practitioners and the Board.

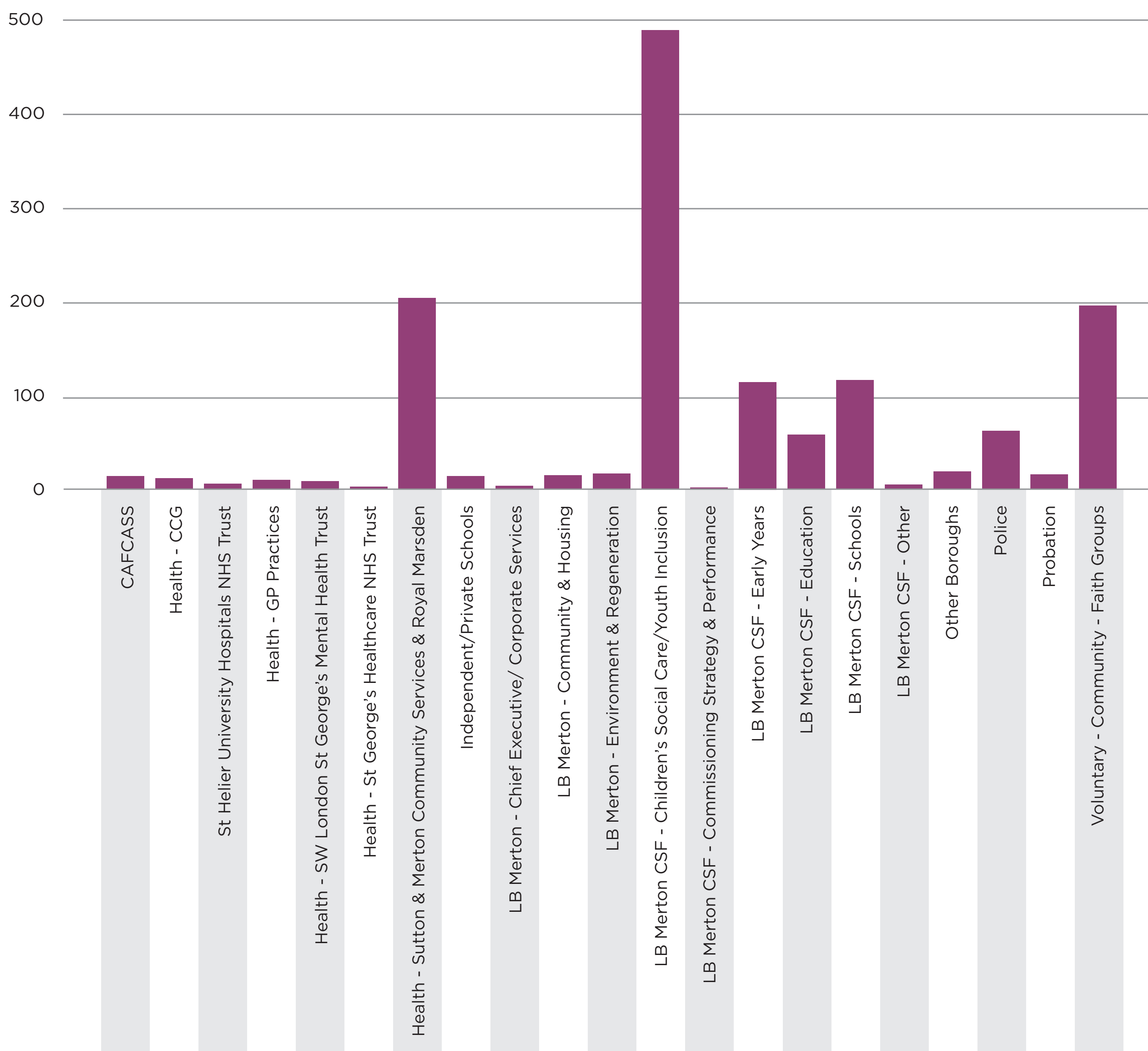
7.3.1 MSCB Joint Conference With Children's Social Care

The Joint MSCB/CSC/CSF Conference was held on 5th March 2015, at Epsom Race Course. The Conference theme was, *'W T F' – Working the Frontline* and the Conference focused on enhancing children and young people's participation. The guest speakers at the conference were Professor Jan Horwath and Dr Alan Cooklin who delivered the keynote speeches. The event included presentations from children and young people from Merton primary and secondary schools on online safety and the Rights of the Child. A range of workshops were held on a variety of topics, including, CSE, Young Women and Relationships, Communicating with Disabled Children, etc.

The Conference was attended by 120 practitioners and managers from multi-agency settings and was highly rated by all attendees.

7.3.2 MSCB Training

From April to 31st 2014 to March 2015, the MSCB has run a total of 95 training events attended by 1403 multi-agency professionals (the totals for April 13- March 14 were 90 courses attended by 1295 staff). The table below provides a breakdown of attendance by each agency.



7.3.3 E-Learning

Merton SCB partners have made much better use of their e-learning licence allocation since September 2013, and even more so over the last 3 months - 322 passes in the year to September 2014 and a further 181 to December 2014, compared with only 192 passes in the previous 18 months March 2012 to September 2013. Value for money (VFM) is much improved, with the cost per licence passed being £21.74 for the year to September.

The Sub-Group has focused on the following areas:

1. Ensuring that MSCB training is relevant to the needs of the workforce. The Sub-Group's has employed a range of strategies to conduct needs analysis with limited responses. The decision was therefore taken to focus on developments in legislation and policy, nationally and through the policy development work of the MSCB and to ensure that learning from the work of Sub-Groups such as, PPYP, Policy and QA, informed the training offer so that learning issues from QA audits, LIRs, SCRs, etc., and the dissemination and implementation of MSCB policies, protocols, guidance, etc.
2. The quality assurance of training. The Learning and Development Sub-Group is striving to increase the monitoring and evaluation of the quality and impact of training delivered by 'in-house' and external trainers. As part of this work, the Sub-Group takes the lead in quality assuring training by attending courses and providing feedback. The MSCB quality assured 4 courses this year.

7.4. Policy Sub-Group

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

The Policy Sub-Group has approved the MSCB statement on FGM and is overseeing the development of strategic response to this issue. It is hoped that there will be guidance and procedures issued to professionals working with children and young people at risk of FGM. The Sub-Group has also commissioned a Multi-Agency Task and Finish Group to develop a strategic response to the issue of neglect.

7.5 CDOP

There were 6 CDOP meetings held in 2014 – 2015 and 29 cases reviewed in total. In the year from 1 April 2014 to 31 March 2015, there were 32 child deaths reported to the Sutton and Merton CDOP. 30 deaths were of residents of Sutton and Merton; 2 were out of borough deaths, 1 Greenwich child who was resident with a young mother in foster care died in Merton; 1 Sutton child died out of borough.

The CDOP reports that there have no SUDI cases reviewed this year. In 2013-14, 7 SUDI deaths were reviewed. Safer sleeping messages constantly have to be reinforced not only to mothers, but to other members of the family such as fathers, grandparents and carers.

There was 1 case escalated from the CDOP to the MSCB. This was the case of a child who died in 2012. The circumstances were that this child died in nursery provision as a result of suffocating on a cube of jelly that was stuck in

the child's throat. The child was not previously known to children's social care. The matter was referred to Ofsted who agreed with the MSCB's decision not to convene a Serious Case Review (SCR). Ofsted subsequently included this issue in their bulletin to local authorities and the Health and Safety Executive reported on the incident. It was concluded that there was no further role for the MSCB.

7.6 Youth Crime Executive Board (YCEB)

The YCEB is chaired by the Director of Childrens, Schools and Families Services and the vice chair is the Chief Inspector of the Metropolitan Police (Merton). The YCEB is the governance structure for Merton in relation to the work of the Youth Justice/Offending Team (YOT), including the Youth Justice Annual Plan, performance and quality assurance. It also oversees the partnership response to Serious Youth Violence, Gangs and Troubled Families (known locally as Transforming Families) (TF). Membership includes CSF, CSC; Youth Justice; Looked After Children (LAC), Education Inclusion, Police, Probation and the Central Commissioning Group (CCG). The YCEB reports to the MSCB and the Safer and Stronger Partnership reviews the performance of the partnership, the Youth Justice Service as well as wider youth crime issues.

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

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

As part of our commitment to continuous improvement, the YCEB monitors the Youth Justice Team's Improvement and Development Plan, which was written before and (updated) after a successful inspection by Her Majesty's Inspectorate of Probation in 2013. The Short Quality Screening concluded that Merton's Youth Justice Team had made "important changes" when compared to the inspection which took place in 2011. The improvement and development work includes the consistent use of auditing and the closer scrutiny of cases during the supervision process. We have also enhanced the quality assurance process within the YOT which includes adhering to the management auditing timetable and the use of thematic audits. All key documents are 'gate kept' and monitored prior to presentation at court and there are regular reviews of work. There is evidence that Merton's low custody rates are influenced by thorough assessments and specific interventions which are presented as robust alternatives to custody.

The YCEB remains committed to the core value of ensuring the voice of the child (VOC) and that this is captured and acted upon. The Online Viewpoint Questionnaire is completed with young people and Merton has exceeded the required target. In addition to this, Youth Board Panels, comprising of young people, meet regularly

with the FAS Manager and YOT manager. Feedback is received from young people and suggestions for change are acted upon. The YCEB continues to focus on the Ending Serious Youth Violence (ESYV) agenda. The objective is to target more high risk offenders and Merton joined the Home Office's 'Ending Serious Youth Violence' programme in 2013. We recognise that a multi-agency approach is essential in tackling this issue. Subsequently, we continue to work closely with key partners such as the Police, CSF, Education, Health and the Voluntary sector. The MOPAC[9] funded Gangs Worker continues to provide support to young men vulnerable to being caught up in gang-related crime and anti-social behaviour. Also a gangs' matrix has been developed between the Police and FAS and assists with the review of cases at the Youth Offender Management Panel (YOMP).The YCEB assists with the reviewing and monitoring of these essential pieces of work.

Assessment Intervention and Moving on (AIM) training has been delivered to CSC and members of the Youth Inclusion Team in order to support assessments, interventions and practice with young people who display sexually harmful behaviour. The Assessment Planning Panel (APP) has been launched and it will help plan treatment and support packages for young people who display sexually harmful behaviour. The YCEB also has oversight of this significant work and agenda.

Merton CSF also focuses on the CSE 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). A MOPAC funded Young Women and Girls Worker helps support some of the most vulnerable young women in the borough who are affected by this area. The YCEB also has oversight of this significant work.

[9] MOPAC stands for Mayor's Office for Policing And Crime

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

This Sub-Group reports to the Safer and Stronger Partnership and includes attendance by CSF, CSC, Adult Social Care, the CSE lead, Safer Merton, Public Health, the Police and the Voluntary and Community Sector. The VAWG oversees a wide range of issues including domestic violence (DV), CSE, prostitution, trafficking, girls and gangs. It also considers DV involving persons of all genders and sexualities. The VAWG was established in mid 2014-2015 and has met 3 times during this period.

A Task and Finish Group was established to review and advise, regarding an appropriate performance framework for the VAWG. In addition, the VAWG reviewed the performance metrics for the MARAC[10]. The VAWG will be conducting a self-evaluation of the MARAC during 2015-2016.

[10] MARAC is A Multi Agency Risk Assessment Conference (**MARAC**) is a local, multi agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

7.8 Structure and Effectiveness of the MSCB and Key Changes

During 2014/15 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-Groups
- The multi-agency case work auditing process was refreshed and a new audit tool has been produced and adopted
- The Board has revised its Performance Management Framework with a streamlined dataset.
- A Communication Strategy and a Participation Strategy have both been adopted 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 Nurse (two members of the Clinical Commissioning Group share this role). The Board has also appointed a second lay member.

The Board's Business Implementation Group was established towards the end of 2014. The Business Implementation Group meets 4 times per year and co-ordinates, prioritises actions and ensures the coverage of statutory functions and the MSCB business plan by ensuring governance and connectivity across the Sub Groups and task groups.

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 Senior Officers from a range of agencies including Health, Children's Social care, Police, and Education.

7.9 MSCB Budget

The MSCB has a healthy budget and all agencies contribute. Its income for 2013/14 was £213,852. The MSCB Budget for 2014-2015 is detailed as follows:

Brought forward from 2013-2014	£11,502
Income for 2014-2015	
Agency Contributions	
CAFCASS	£550
London CRC	£1,000
London Probation Service	£1,000
London Borough of Merton	£106,240
Merton CCG	£35,000
Metropolitan Police	£5,000
Sub- total	**£148,790**
London Borough of Merton Baseline supplement[11]	£53,060
Other income	£500
Total	**£213,852**

Expenditure	
Staffing	£82,544
Premises	£2,992
Supplies and Services	£108,257
Transport	£1,417
Totals	**£195,210**
Brought forward from 2014-2015	£18,642

[11] In 2014-2015, the MSCB expenditure exceeded income from Agency contributes; LB Merton therefore supplemented the MSCB budget.

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

8.1 Prevent Task and Finish Group

As reported under 7.2, the MSCB appointed a Task and Finish Group to review Merton's response to radicalisation and extremism and to develop some guidance for those working with children and young people who are vulnerable to the messages of radicalisation and extremism. This guidance is being developed in the context of the Government's overarching counter-terrorism strategy ***'CONTEST'*** and the ***'Prevent Strategy'*** and the forth-coming ***Counter Terrorism and Security Act 2015***. The group has completed its work and has prepared guidance for professionals and advice to parents and carers which will be submitted to the Board for approval and adoption when it meets in May 2015.

8.2 Neglect Task and Finish Group

A Task and Finish Group was appointed to develop a strategic multi-agency response to the issue of neglect at the Board's Annual Away Day in March 2015. The key responsibilities of the Group include reviewing data sources for monitoring neglect by child and by family, reviewing thresholds especially with regards to chronic neglect, exploring the issue of parental capacity, motivation and ability to sustain positive change with regard to providing good enough care, reviewing knowledge and skills across the CSF and proposing a draft MSCB strategy for tackling neglect: including parenting support and early intervention, health, education (across early years, primary and secondary phases) early help (CASA), MASH, CIN and CPP. It is anticipated that this Group will report to the Board in September 2015.

8.3 Performance Management Task and Finish Group

The MSCB appointed a Task and Finish Group to review the MSCB's Performance Management Dataset to ensure that there was an appropriate balance between the quality of data and the quality of analysis. The Task and Finish Group completed its work and the proposed revised Performance Dataset was finalised in March and is due to be presented for approval at the Board's BIG meeting in May 2015. The revised performance monitor consists of 27 indicators included within the new national policy framework[12] and a number of proposed local performance indicators to support further contextualisation. The revised monitor aims to provide a stronger safeguarding-led narrative in relation to the 'child's journey', starting with the pathways (e.g. Initial contacts and referrals), the assessments used to determine risk (e.g. single assessments and Initial Child Protection Conferences) and the use of specialist interventions (e.g. Child Protection Plans).

[12] The Children's Safeguarding Performance Information Framework, January 2015, Crown Copyright

8.4 Learning & Improvement Reviews and Serious Case Reviews

A Serious Incident (SI) occurred in November 2014 and was referred to the MSCB through the Quality Assurance Sub Group in December 2014; this was then passed on to the MSCB Chair who convened a case meeting. At the meeting held on the January 2015, The MSCB considered that although there was significant harm to a child, the criteria for a SCR were not met. The incident was notified to Ofsted in February 2015.

In considering if the criteria for a SCR were met, the Panel agreed that there were lessons which could be learned from the case. The hospital had already initiated a SI review and it was agreed that other agencies could learn from their response and communication following the discovery of the injuries. The MSCB Chair agreed to commission a multi-agency LIR. The Chair wrote to agencies January 2015 asking them to undertake an IMR and forward this to the Board by the end of February. When the reports were received a case panel was convened to consider lessons to be learned. The MSCB is in the process of concluding this review.

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 in relation to this young person; this 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 LIR which was conducted by Jane Wonnacott, 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 Challenge Meetings

9.1 Section 11

One of the key tools for understanding and demonstrating the effectiveness of safeguarding is the Annual Section 11 audit. Section 11 of The Children Act 2004 places a duty on LSCBs to ensure that organisations have appropriate safeguarding arrangements in place.

Agencies completed their returns during April and May 2014 and there were a series of Quality Assurance and Challenge meetings in June and July 2014. The meetings were led by the Independent Chair of the MSCB and the Director for CSFs. The purpose of these meetings was to monitor agency compliance with Section 11 standards and key MSCB actions, to note key challenges and to consider priorities for the MSCB Business Plan. The Quality Assurance and Challenge Meetings for 2014-2015 were arranged as follows:

1. Children, Schools and Families (4 June 2014)
2. Health Services (10 and 18 June 2014)
3. Police, Probation and Community Safety (18 June 2014)
4. Voluntary and Community Sector (18 June 2014)
5. Community and Housing Services (1 July 2014)
6. Mental Health Services including CAMHs (2 July 2014)

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

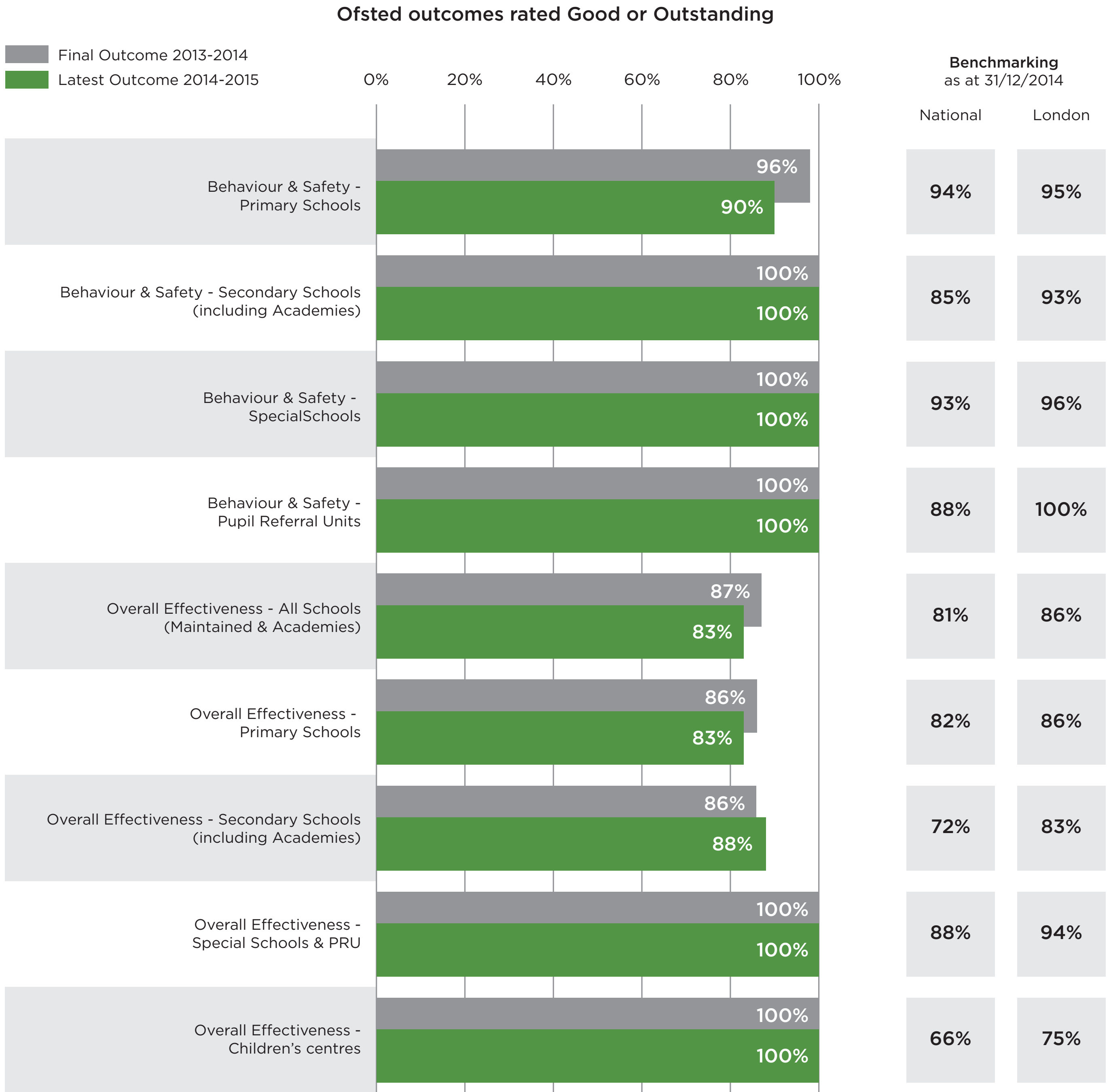
As a result of this process the Board was able to hold partners to account regarding their work to safeguard the well-being of children and young people, to assure itself that each partner is achieving the 8 safeguarding standards outlined Working Together and the pan-London Audit Tool[13]. The QA Challenge meetings also ensures that the Section 11 process is not simply a paper exercise and agencies' self-audit is tested through questioning and challenge.

The returns from statutory partners indicate full compliance on 90% of the safeguarding standards and clear plans to take action on identified areas for improvement.

[13] Section 11 Standards include: a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services; 2. arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);.3.a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively; 4. appropriate supervision and support for staff, including undertaking safeguarding training: 5. employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role; 6. staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; 7. and all professionals should have regular reviews of their own practice to ensure they improve over time; and; 8. There is effective Information Sharing between agencies

9.1.1 Schools

9.1.2 Ofsted inspection outcomes rated Good or Outstanding



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

9.2 CSF department

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

During 2014 CSC services reviewed remits and capacity issues across the teams and have 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 workers 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 has procured a new social care information system to support good casework practice which will be implemented in 2015/16. The aim is to provide casework staff with a system which is more user friendly for frontline practitioners 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 service improvement planning and for statutory returns.

Following the full review of our early intervention and prevention strategy in 2012/13 the council produced revised structures for CSC 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 and the Royal Marsden Trust

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

9.3.2 SW London & St George's Mental Health Trust

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

9.3.3 Epsom and St Helier NHS Trust

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

9.3.4 NHS Merton Clinical Commissioning Group (CCG)

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

9.3.5 St George's Hospital NHS Trust

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

9.3.6 Public Health

Public Health completed a Section 11 Self-audit that gave the Board assurance that the Public Health is fulfilling its statutory responsibilities in relation to Section 11 of the Children Act 2004.

9.4 Community and Housing Dept. - London Borough of Merton

Community and Housing Department completed Section 11 Audits for Public Health, Adult Social Care and Housing and participated in the Quality Assurance Challenge Meetings.

9.5 Corporate Service – HR – London Borough of Merton

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

9.6 Metropolitan Police/Probation/Cafcass

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

10.0 Views of Children and Young People and the Community

In 2014 Merton's Children's Trust launched a User Voice Strategy to further implement one of the eight core values of the Children and Young People's Plan, which highlights the importance we give to listening and responding to our children, young people and service users:

"We listen, respond to and value our children and young people. Children and young people have rights to participate in decisions affecting their lives and participation provides opportunities for them to develop important life skills. Services should not only listen but should help children and young people shape services they receive. We should also canvas and respond to the views of parents and carers".

Our ambitions are in line with and underpinned by key legislation, policy and regular guidance. The Children Act 1989 and 2004 for England and Wales recognises children as citizens with the right to be heard. The Act made it a legal requirement for the views of children to be taken into account in any court decisions affecting them. The Children Act 2004 (section 53) amends sections 17, 20 and 47 of the Children Act 1989. It requires that when working with children in need, their wishes and feelings should be ascertained and used to inform making decisions. Working Together 2015 states that one of the key principles for effective safeguarding arrangements in a local area is to take a child centred approach: 'for services to be effective they should be based on a clear understanding of the needs and views of children'. In addition the document is clear that assessing need and providing help should focus on 'the needs and views of the child'. Ofsted Joining the dots (March 2015) highlighted that 'Senior leaders in [Good and Outstanding] authorities sought feedback from a variety of sources including children and families, staff and partners. Leaders in these authorities kept a relentless focus on demonstrating how they were improving outcomes for all the children who received the services. They saw gathering feedback as a crucial element in driving forward such improvements.

Our User Voice Strategy provides a framework by which we capture and monitor feedback to influence service design, delivery and continuous improvement. The Children, Schools and Families Department deliver this through an annual programme of user voice activity embedded within our service planning process. This report summarises some of our key successes in including children and young people's voices in our daily practice and service improvements and how we have delivered our five User Voice Strategy commitments.

Commitment ONE - Gathering feedback through a variety of models.

We have continued to embrace a variety of models of feedback and participation, recognising that one style may not fit all, during the year we have identified and embedded four key ways in which we approach listening to the views of children and young people, and families:

- An ongoing 'practice approach' expected of all practitioners and managers to put children's wishes and feelings at the centre of decision making and planning.
- Continuing to deliver Merton's youth participation promise.
- Bespoke targeted user feedback sought from vulnerable groups.
- Ongoing management oversight to learn from complaints and compliments.

Commitment TWO - Providing opportunities for children and young people to influence key decision makers.

We have continued to develop participation methods for children and young people's views to be heard in key governance structures, including influencing the work programme of the Merton's Children's Trust, Local Safeguarding Children Board and Member Scrutiny Panels. Merton's Annual Young Resident (2014) demonstrates that we are doing this well as 47% of young people feel involved in decision making, significantly better than the London average of 31%.

Commitment THREE - Understand what our feedback is telling us to continuously improve services.

We have a long history of reviewing feedback at a local level to influence operational delivery. During 2014/15 we have reviewed what the feedback is telling us at a strategic level quarterly and shared this analysis across the Children's Schools and Families department and wider Childrens Trust to inform service improvement.

Commitment FOUR - Publish and share our feedback findings across the children's workforce.

We have where appropriate, published our feedback findings in Young Merton Together the Childrens Trust professionals e-magazine published five times a year receiving 52,000 hits by 1000 readers over the year. We have shared user voice findings with staff and partners at Staff Forums, Merton's Childrens Trust, MSCB and Corporate Parenting meetings.

Commitment FIVE - Demonstrate to those who participate in user voice activity the impact of their involvement.

We have, where possible, fed back to participants who share their views, what has happened as a result of their input. Merton's Annual Young Residents' Survey (2014) demonstrates that we are doing this well and that young people feel their input is valued with 57% reporting that they feel listened to 'a great deal or to some extent'; better than the London average of 47%.

As noted under 3.2.3, the Board has commissioned a research project with LSBU which focuses on listening to and learning from children and young people's experiences of the safeguarding system here in Merton. It is hoped that one of the outcomes of this research is that we will be more responsive to the expressed needs of children and young people.

Our goal is to make sure that we continue to listen and learn from the complaints and compliments we receive and to use this process to ensure that there is continuous improvement in our services to our young people.

11.0
Conclusions and Priorities for 2015 – 17 Business Year

2014-2015 has been a year of change and consolidation for the Board. We have fully revised the constitution of the Board and renewed the Terms of Reference for each Sub-Group. The purpose of these changes has been to improve the effectiveness of the Board. We will continue embed these changes and there is evidence of effectiveness in the breadth and depth of the work of the Board.

On the evidence set out in this report we judge MSCB's current safeguarding arrangements to be effective. We are strengthening the Board's ability to enquire into and challenge frontline practice with children, young people and families through the work of the Quality Assurance Sub-Group; through single and multi-agency case audits, we are growing in our understanding of the intended and actual impact of safeguarding practice. Through the Section 11 and quality assurance challenge process we have been able to hold partners to account so that they provide the Board with assurance regarding the quality of safeguarding across the system. Learning from audits LIRs, SCRs etc., is fed back to the front line through training, briefings, conferences and other learning events. Attendance levels at training are good and continue to improve.

The Board has a good understanding of early help and child protection thresholds and ensures that children, young people and their families get right level of help at a time when this help is needed and that frontline practitioners are supported in using their professional judgment when working with families.

The Board has streamlined its performance dataset so that we have the right level of information with commentary from partners so that the Board is able to be rigorous and robust in its analysis of its performance. The work of the Board is also informed by Joint Strategic Needs Assessment (JSNA) which provides the Board with an overview of local needs so we are able to prioritise our work.

Our Section 11 and quality assurance and challenge process ensures that safeguarding is a priority for all of our statutory partners, who have all completed Section 11 self-audit and participated in the challenge process.

The Board has prioritised the safeguarding of children from CSE, exploitation through radicalisation and extremism, and FGM. With regard to CSE, robust strategic and operational measures are in place to ensure that the MSCB has a strong grasp of this issue and that children at risk are identified, supported and monitored to ensure that risks are reduced and the activities of perpetrators are disrupted and, where there has been an offence, there are persecutions.

The MSCB continues to play an active and influential role in the planning of services for children using its role as a scrutiniser of safeguarding to inform and influence the planning priorities across strategic partnerships such as the Health and Well-Being Board, YCEB, the Safer and Stronger Partnership, Adult Social Care and Children's Social Care.

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.

Priorities for the 2015 calendar year are:

1. To evidence Board impact through Quality Assurance – Multi-Agency Audits/Learning reviews/Front line practice
2. To maintain strategic oversight of CSE including e-safety, missing young people, young people missing from education
3. To have a strategic multi-agency response to the issue of neglect
4. To have a strategic response to the prevention of Female Genital Mutilation (FGM)
5. The Children and Families Act 2014, Supporting Children and Young People with Complex Needs and LASPO
6. Ensure that there is a strategic focus on and all children are safeguarded from radicalisation and violent extremism
7. MSCB Governance: Implement the revision of the MSCB Governance, Structure and Board Business Processes
8. Engage with Faith and BAME Communities on Safeguarding issues

Appendix 1
Merton Safeguarding Children Board Business Plan 2015–17

Progress of this Plan will be updated monthly & monitored at each MSCB Meeting.
Approved by Business Implementation Group 12th May 2015.

	Objectives	Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
1.	**To evidence Board impact through Quality Assurance – Multi-Agency Audits/Learning reviews/Front line practice**				
1.1	To have a robust dataset that enables the MS CB to have a strategic oversight of key performance data	For MSCB to have a robust dataset which gives a strategic overview of multi-agency performance in relation to the safeguarding of children. To have a revised dataset for 1st quarter plus commentary.	To implement the revised core multi-agency dataset reporting for 1st quarter data	NC and PB	BIG May 15
1.2	To review annual safeguarding performance dataset for MSCB and the annual report	To provide an annual summary of safeguarding dataset for MSCB and annual report	To complete annual review of safeguarding performance dataset for 2014-15	All agencies led by PB and NC	April 15
1.3	To quality assure multi-agency safeguarding practice	To be assured of the quality of multi-agency frontline practice	To conduct 4 multi-agency themed case audits and to report findings	PA to lead, with QA Sub	Quarterly and an annual report to MSCB
1.3	To ensure compliance under Section 11 of the Children's Act 2004	Annual report from each key agency	To have an overview of the quality of single agency safeguarding work through annual agency reports to sub group including audits	All agencies undertake audits as required within their service areas	Annually and as required i.e. 31/05/2015
1.4	To ensure learning from SCRs and LIRs is disseminated and applied	A regular report on progress of actions an regarding LIRs and learning from SCRs	To monitor actions from case reviews, LIR and SCRs	All led by QA Sub-group	Quarterly reviewed at each BIG
1.5	To ensure that there is a clearly understood process for escalating cases to the QA Sub-group	A review of the process for escalating cases to the sub-group. Greater awareness of how to challenge case work decisions and escalate cases when needed.	To ensure that cases where there are difficulties in multi-agency working are reviewed and lessons learned. To agree how the London CP Procedures will be localised and to ensure that practitioners and agencies are aware of the key contacts for implementing them.	PA/PB	June 15

Objectives		Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
2. Strategic oversight of CSE including e-safety, missing young people, young people missing from education					
2.1	To ensure that there is oversight of all young people at risk of CSE and to improve the identification and support of young people who are victims of CSE.	To clearly identify victims and perpetrators of CSE; to ensure that victims receive appropriate support and the perpetrators are disrupted and prosecuted; to monitor closely each young person at risk of CSE and to ensure that support is provided to prevent CSE.	To undertake further data analysis to inform strategic planning and inform future CSE/CM Multi-Agency data set	MASE and PPYP Sub-groups	At each PPYP Sub-group
2.2	To ensure that all agencies are aware of their roles in prevention and intervention in CSE.	To increase awareness of agencies' roles in effective intervention in relation to CSE.	To provide information for the public including parents on CSE and its risks. To ensure that universal information is available. Specialist and targeted services to ensure parents of YP at risk of CSE can access information and support.	PPYP Sub-group CSF LH	On going, monitored at each PPYP Sub group meeting.
2.3	To ensure that CCG has clear oversight of health providers' performance with regard to CSE.	To strengthen CCG's overview of the performance of the local health economy with regard to CSE.	CCG to review QA processes and contractual requirements so that the MSCB is assured of the effectiveness of performance with regard to CSE.	CCG Director QA Lynn Street	
2.4	To maintain strategic oversight of missing young people in Merton.	Maintain and strengthen robust oversight of missing young people in Merton.	To incorporate operational and strategic oversight of young people missing from Home/Care/School in to MASE monthly panel.	CSC & YI, CSE Lead and LH CSC & YI, CSE Lead LH and Sarah Daly	Mar-Apr 15 Monthly
2.5	To maintain strategic oversight of LAC placed outside of the borough.	To have robust oversight of LAC placed out borough.	To establish a mechanism to share data across the CSE MASE panel and the Chronic Attendance Project to ensure patterns of absence are analysed for risk of CSE as well potential neglect.	LH, CSC & YI	Mar to Jul 15

	Objectives	Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
2.6	To maintain strategic oversight of LAC from other boroughs placed in Merton.	To have robust oversight of the LAC of other boroughs placed in Merton.	To incorporate operational and strategic oversight of Young people missing from Home/Care/School in to MASE monthly panel. To establish mechanism to share data across the CSE MASE panel and the Chronic Attendance project to ensure patterns of absence are analysed for risk of CSE as well potential neglect. To train CAT project staff in awareness and referral pathways for possible CSE. To provide quarterly update to Corporate Parenting Panel and annual summary report.	CSC & YI, CSE Lead and LH PPYP	Mar-Apr 15 May 15
2.7	To ensure a strategic focus on the voices of vulnerable and at risk young people.	To maintain strong focus on voice of the child strategically and operationally.	To engage in a Research Project with Southbank University. To agree scope and methodology of research project to gather evidence of young people's experience of child protection system including young people's exposure to sexual exploitation.	PB, LH, LSBU	
3.	**Strategic multi-agency response to the issue of neglect**				
3.1	To have a strategic multi-agency response to the issue of neglect.	To agree a Merton neglect strategy so that there is a robust approach to identifying and intervening in neglect.	To form task and finish group to research best practice and to propose a strategy for MSCB on neglect.	Led by PB	22 Sept 15
4.	**Strategic response to the prevention of Female Genital Mutilation (FGM)**				
4.1	To introduce a multi-agency strategy to prevent FGM.	Agree and implement FGM Strategy.	To increase awareness of FGM; how to recognise risk and respond sensitively and to prevent it.	Policy SubGroup	March 2016
5.	**Supporting Children and Young People with Complex Needs and LASPO**				
5.1	To ensure that MSCB partners are aware of their responsibilities under the 2014 Act.	To ensure that MSCB are aware of the key changes.	To deliver a briefing on the main changes and the impact of the Act.	To ensure that MSCB partners are aware of their re-onsibilities under the 2014 Act.	To ensure that MSCB are aware of the key changes.

	Objectives	Outcomes	Actions	Resources	
				Who? (Work plans etc.)	When?
6.	**Strategic focus on ensuring that all children are safeguarded from radicalisation and violent extremism**				
6.1	To ensure that MSCB has strategic oversight in relation to the safeguarding and well-being of children and young people vulnerable to the messages of radicalisation and extremism, with regard to the Prevent and Channel strategy.	To have a Merton guidance, policy and protocols to safeguard the well-being being of children and young people vulnerable to the messages of radicalisation and extremism.	For a task and finish group to prepare a draft Prevent Strategy. The MSCB to approve and adopt guidance to safeguard the well-being being of children and young people vulnerable to the messages of radicalisation and extremism.	Prevent Task and Finish Group PPYP Sub-group and BIG	12 May 15
6.2	To have strategic oversight on the multi-agency implementation of the Prevent and Channel strategy.	To ensure that the implementation of the Prevent Strategy is monitored.	To monitor the implementation of the Prevent strategy through the PPYP Sub-group	PPYP Sub-group	BIG May 15 and Annually
7.	**Implement the revision of the MSCB Governance, Structure and Board Business Processes**				
7.1	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 Forum.	Increase the involvement of Head Teachers in the LSCB, increased understanding of young people's needs.	AD Education Chair	Sept 15
7.2	To undertake a review of all agreed MSCB policies, protocols and procedures.	To ensure that all MSCB policies are reviewed and up-to-date.	Increase the involvement of Head Teachers in the LSCB, increased understanding of young people's needs.	Policy Sub-committee	Sept 15
8.	**Engage with Faith and BAME Communities on Safeguarding issues**				
8.1	Develop a list of individuals and groups who can provide advice on faith/culture, with a view to improving the understanding of safeguarding in BAME communities.	MSCB to have a list of trusted advisers from faith and BAME communities who can advise the Board on relevant community issues.	To map faith and BAME communities. To meet with key leaders in faith and BAME communities.	Board Manager	Jan 16

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 – Health							
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

Adoption						
	Merton Single Year 2011-12	Merton Single Year 2012-13	Merton Single Year 2013-14	National 3 Year Average 2010-13	Merton 3 Year Average 2010-13	Merton 3 Year Average 2010-13
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

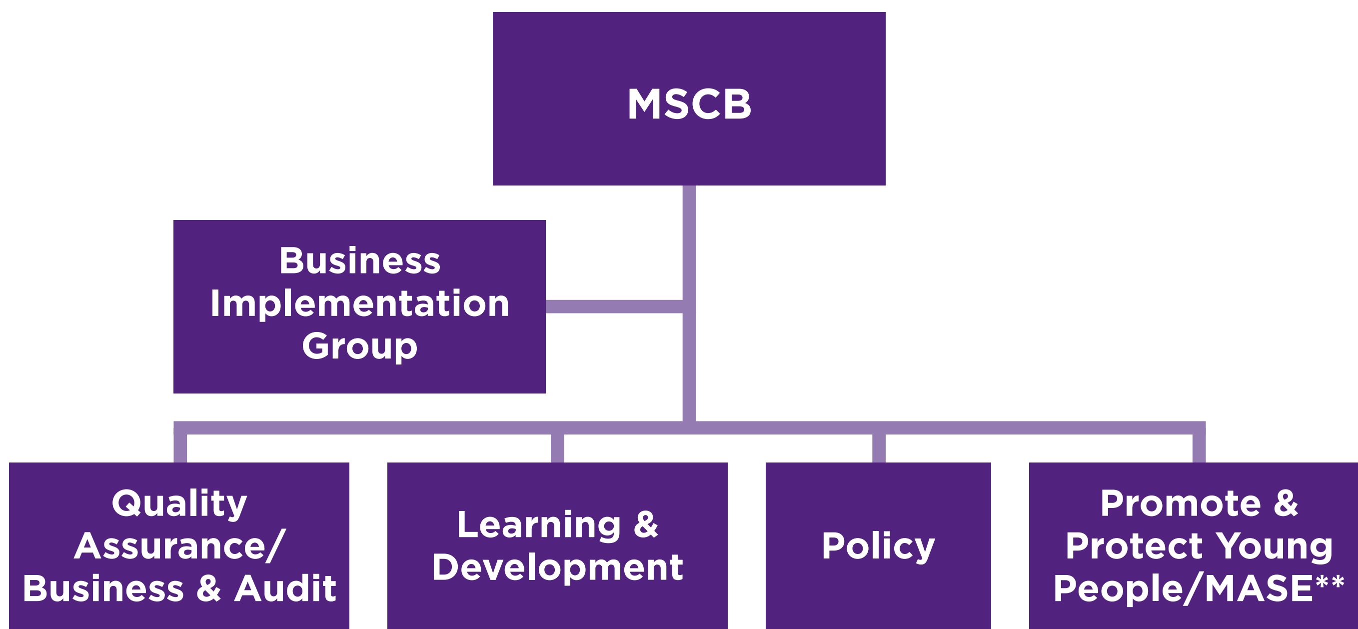
Care leavers							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
Total Care leavers	Number	Data not available	Data not available	**96**	**n/a**	n/a	n/a
Care Leavers aged 19	Number	Data not available	Data not available	**29**	**Data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

Care leavers - Accommodation							
Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2013/14**	London 2013/14	Outer London 2013/14
% 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

Care leavers - Education

Indicators		Merton 2011/12	Merton 2012/13	**Merton 2013/14**	**National 2012/13**	London 2012/13	Outer London 2012/13
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**

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

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

Advisers will not have deputies.

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

	MSCB	
	Independent Chair **Casting Vote**	
P	**Vice Chair to be drawn from the Statutory Members**	
P V	Chief Officer, Merton Clinical Commissioning Group	
P V	NHS England (London)	
P V	Chief Nurse, 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	
P V	Head of Education, CSF	
C V	Director of Public Health Merton, Community & Housing	
C V	Safeguarding Adults Manager, Community & Housing	
C V	Housing Needs Manager, Community & Housing	
P V	Senior Service Manager, CAFCASS	
SV	Head Teacher Primary School 'Rep of Governing Body of a Maintained School	
SV	Special School	
SV	Maintained secondary school	
SV	Representative of the proprietor of a city technology college, a city college for technology or the arts, or an Academy	
SV	Independent Sector School – vacant at Jan 2015	
CV	CP Officer, Merton Priory Homes	
PO	Merton Council Lead Member Children's Services	**Non-voting**
SA	Designated Doctor for Child Protection, Merton CCG	**Non-voting**
SA	Designated Nurse Safeguarding, Merton Clinical Commissioning Group	**Non-voting**
SA	Principal Social Worker	**Non-voting**
P V	Consultant Child and Adolescent Psychiatrist, SW London & St 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**

Contact Details

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Tel: 020 8545 4866

Email: mertonlscb@merton.gov.uk

Committee: Health and Wellbeing Board

Date: 24/11/2015

Wards: All

Subject: Adult Social Care (ASC) Local Account 2013-15

Lead officer: **Simon Williams (Director Community & Housing LBM)**

Lead member: **Councillor Caroline Cooper-Marbiah**

Contact officer: **Shamal Vincent – Acting Performance Manager Adult Social Care**

Recommendations:

A. For Information and comment

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This is the fourth year Merton has produced an Adult Social Care 'Local Account'. and it is for 2013/14 and 2014/15. Usually we produce one every year. The reason for producing a two year report is that nationally we have seen some extensive changes in the system for data collection and we wanted to ensure that comparative information was valid.

The report is a quality self-assessment published by the council and includes details about outcomes achieved for our service users, compares performance with other local authorities and provides customer case studies.

2. BACKGROUND

The coalition government has taken a different emphasis from the previous government on the way that performance management operates in Local Government. The Local Government Group has been lobbying for a sector led approach to assessment and peer review, and this has appeared in government thinking and policy. The coalition government has in effect abolished these layers of inspection and indicators, replacing them with a new regime that is encapsulated within 'Transparency in outcomes: a framework for quality in adult social care'.

The revised performance framework includes peer reviews, and an annual statement on outcomes and priorities called a Local Account. The Director of Adult Social Care has asked that this Local Account be presented to the Health and Wellbeing board for comment.

3. DETAILS

There is an expectation that there will be user involvement, and although there are suggestions on what might constitute some core elements of a Local Account, there is no prescribed content or process. The local account is intended to let residents know how well adult social care has performed, and is an opportunity for

Councils to make more information available to their residents on their successes, challenges and priorities. The local account is aimed at everyone who is interested in the quality of adult social care including service users, carers, residents and people working in Merton.

4. ALTERNATIVE OPTIONS

N/A

5. CONSULTATION UNDERTAKEN OR PROPOSED

A Short survey will be available for feedback and will inform further improvements to the report in future years.

6. TIMETABLE

This Local Account will be published on intranet and internet from end of November and the feedback survey will be open until end of March 2016.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

N/A

8. LEGAL AND STATUTORY IMPLICATIONS

N/A

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

N/A

10. CRIME AND DISORDER IMPLICATIONS

N/A

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A

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

Adult Social Care Local Account 2013-15

13. BACKGROUND PAPERS

N/A

MERTON COUNCIL

Adult Social Care
Local Account

How we have delivered Adult Social Care Services

During 2013 to 2015

London Borough of Merton

London Road
Morden
SM4 5DX
www.merton.gov.uk

merton

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Foreword

Cabinet Member for Adult Social Care (ASC) and Health

Caroline Cooper-Marbiah

"Welcome to Merton's fourth Local Account. May I take this opportunity of introducing myself to those of you I haven't met yet as the Cabinet Member for social care services and for health, and as the Chair of the Health and Wellbeing Board. I have held these roles since May 2014. I have been really impressed by the commitment to supporting people in need that I see constantly, whether it's from carers and family members, care providers, or other staff working across health and social care. My ambition is to work with this commitment and to continue to achieve the best possible outcomes for local people, albeit within a reducing budget.

I am pleased to be able to report on progress in several areas. We have recently refreshed our Health and Wellbeing Strategy and this gives a chance to see how all services and organisations can work together to promote people's wellbeing. We have increased the integration of health and social care services, in particular the formation of integrated locality teams for older people, underpinned by an agreement over how we use money together in the Better Care Fund. Our outcomes for customers, as measured in our performance figures, have in general help up or even improved. We won a national award for innovation in 2014 for our work in supporting people to use direct payments. Our Ageing Well strategy with the voluntary sector is producing some really good outcomes through working differently.

I am committed to being transparent with our customers and residents about how we are doing, and so I do hope that you will find this Local Account informative."

Director of Community and Housing

Simon Williams

"Welcome to this Local Account. This is for two years, 2013/14 and 2014/15. Usually we produce one every year. The reason is that nationally we have seen some extensive changes in the system for data collection and we wanted to ensure that comparative information was valid.

We continue to use our value based approach to using money (summarised on Page 9) as a framework for the local account and indeed our general approach in difficult financial times. The performance data shows that generally we have done reasonably well in terms of outcomes for our customers and customer satisfaction with our services, but we know that there are specific areas where we would like to do better: for example including carers in discussions about people they care for, carers having as much social contact as they would like, and looking at why our use of residential care for working age adults has grown.

We value the partnerships in place to achieve good outcomes. We have made progress in our work with NHS partners in having a more joined up approach for older people. We have a long standing formal partnership with our Mental Health Trust. We work closely with the voluntary sector to look at how together we can find the best ways of supporting people to stay at home. I would also like to take this opportunity of thanking my own staff for their commitment to doing the best we can for our customers at a time when we have less money to spend.

We are following our usual practice of publishing a large amount of data, as we know that many readers find this helpful. We do our best to make the data as user friendly as possible. Please continue to let us know whether we can improve this."

What is a local account?

What can you find inside our local account?

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Performance and Quality Assurance

A local account is an annual statement that all councils who provide adult social care services are encouraged to produce as part of the Local Government Association's (LGA) programme called 'Towards Excellence in Adult Social Care' (TEASC). This is a sector-led initiative that builds on the self-assessment and improvement work already carried out by councils. Local accounts are a means of reporting back to local people on performance and are a useful way of informing self- improvement activity locally.

The 2013-15 local account explains how much the council spends on Adult Social Care, what it spends money on and what it is doing along with its future plans for improvement. It also represents a quality self-assessment and includes details about outcomes achieved for our service users, compares performance with other local authorities and provides customer case studies. We believe this account provides a meaningful way of reporting the quality of Adult Social Care Services in Merton.

Taking a closer look

Key facts about Merton

What can you find inside our local account?

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Deprivation of Liberty Safeguards (DoLS)

Performance and Quality Assurance

You can find out more information on POPPI and PANSI data from

… about the people

Merton is an outer London borough situated to the south west of central London.

Based on the Greater London Authority (GLA) trend-based projections, Merton's population is projected to increase by 13,245 people between 2014 and 2020.

A further forecast indicates that there will be an increase of over 2,100 people (9.2%) in the over 65 age group.

English, Polish and Tamil are the three most spoken languages in Merton and more than a half of the population are Christian and over one fifth have no religion.

The BAME* population in Merton represents just over one third of the borough's population which is less than the London average.

Merton borough within London

Around one fifth of Merton's population is single and nearly a quarter are married; with similar proportions for both males and females.

Those who are unemployed are distinctly concentrated towards the eastern parts of Merton and those who are self-employed are concentrated towards the western parts of the borough.

**Black, Asian & Minority Ethnic (BAME)*

… about the future with POPPI and PANSI

POPPI (Projecting Older People Population Information) and PANSI (Projecting Adult Needs and Service Information) are tools developed by the Institute of Public Care that project population information for older people and adults with needs. According to POPPI and PANSI information produced in November 2014 it is predicted that the number of older people will increase from 24,800 to 27,500 by 2020 and the number of older people predicted to have dementia will also increase from 1,749 to 2,017.

The number of adults between the ages of 18 and 64 that will have a moderate to severe learning disability is also predicted to increase from 764 in 2014 to 815 by 2020.

About Merton Adult Social Care

What else can you find inside our local account?

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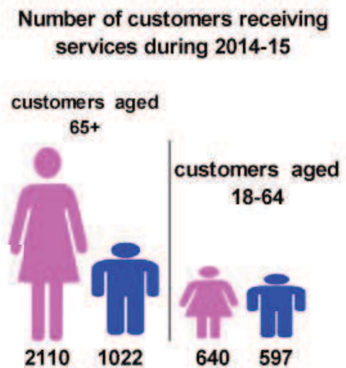
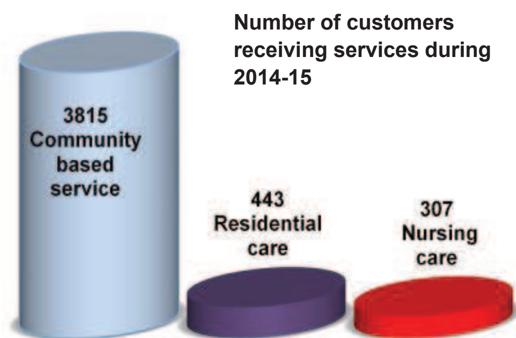
Performance and Quality Assurance

The Community and Housing department, led by the Director Simon Williams, is responsible for housing needs, adult social care, libraries and heritage, adult education. During each year Adult Social Care provides services to approximately over 4000 people.





NB: The total people figures in this graph include some double-counting as some customers have moved between different services in the same year (e.g. move from community-based to residential care).

Our Adults Social Care service has enabled all customers requesting and/or requiring assessment to be supported through the self- directed support process. The overall aim of the assessment is to meet the identified needs of eligible individuals by supporting them to make cost effective choices to maintain their independence, support them to remain at home and maintain and improve their safety and quality of life.

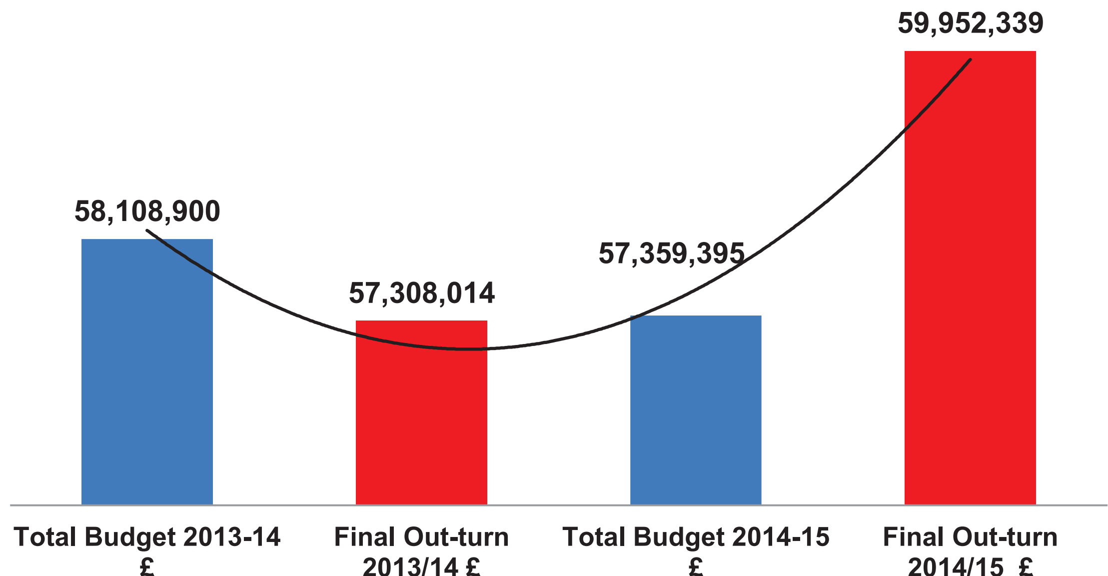
Merton has welcomed opportunities for external challenge. It was part of the pilot programme for peer reviews for Health and Wellbeing Boards in 2013. It had a peer review for commissioning, as part of the London wide review programme, in 2013. It has had an externally supported self-assessment on its use of resources in 2013. As it becomes harder to find the savings needed to deliver quality services with less money, such external challenge and learning from best practice is increasingly important.

Adult Social Care Budget Position

The National Benchmarking data on average cost of social care packages can be found in the **Performance & Quality Assurance** section of this local account.

Merton spent around 38% of its budget on Adult Social Care (ASC) during 2014-15, its gross budget for ASC was £70.2m and the net budget was £53.4m. The national benchmarking data published in 2014 shows that Merton is a low spending council overall and its actual expenditure on ASC is correspondingly low. The following table shows the **Adult Social Care's final spend against its budget during 2013 to 2015:**

Service	Total Budget 2013-14 £	Final Out-turn 2013/14 £	Variance £	Total Budget 2014-15 £	Final Out-turn 2014/15 £	Variance £
Older People	19,866,010	18,684,800	-1,181,210	18,202,170	19,048,887	846,717
Learning Disability	17,282,960	18,056,122	773,162	17,059,760	19,279,873	2,220,113
Physical & Sensory	4,875,590	4,645,935	-229,655	5,883,225	5,732,993	(150,232)
Mental Health	3,627,260	3,547,387	-79,873	3,723,810	3,757,196	33,386
Service Strategy	395,910	525,812	129,902	397,220	397,176	(44)
Support Services	405,710	238,817	-166,893	101,250	(87,773)	(189,023)
No recourse to public funds	267,850	183,526	-84,324	184,630	191,103	6,473
Other	228,610	377,028	148,418	370,070	416,212	46,142
Supporting People	2,356,410	2,373,850	17,440	2,391,760	2,251,069	(140,691)
Concessionary Fares & Taxicard	8,802,590	8,674,737	-127,853	9,045,500	8,965,603	(79,897)
Grand Total	**58,108,900**	**57,308,014**	**-800,886**	**57,359,395**	**59,952,339**	**2,592,944**



Adult Social Care Budget Position

Customers receiving services during the year by Client Group	2013-14	2014-15	Average % *(Out of all customers receiving services during 2013-2015)*
Older People (65+)	3023	3003	**69%**
Adults with Physical & Sensory Disabilities	622	601	**14%**
Adults with learning disabilities	516	518	**12%**
Adults with mental health needs	260	247	**6%**
Total	**4421**	**4369**	**100%**

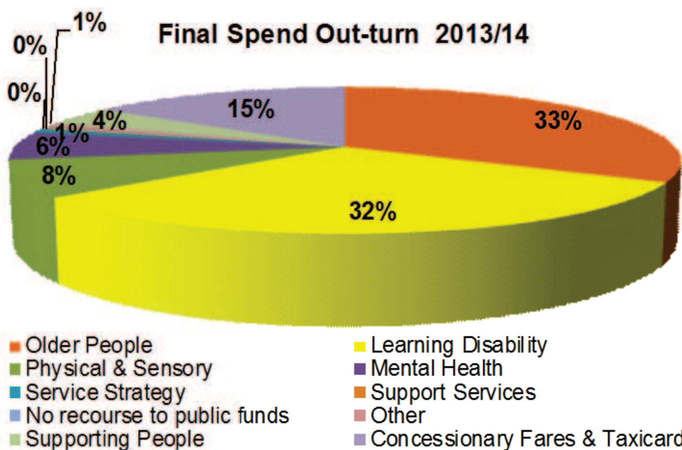
NB: The services counted in this table are residential care, nursing care, meals, days care, home care, transport, equipment, direct payments and other services.

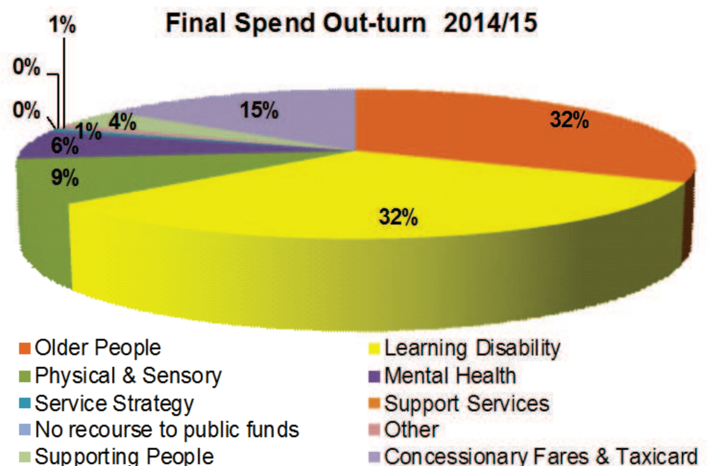
Key Points:

'Customers receiving services during the year by Client Group' table shows that Older People represent the highest proportion followed by Physical Disability, Learning Disability and Mental Health.

The spend information below for 2013 to 2015 is showing that Older people and Leaning disability take up the highest proportion of the budget.

The following graphs will show the percentage of spend by service for 2013-14 and 2014-15





Efficiency Framework; a whole system approach:

What are the key areas of our Efficiency Framework?

Prevention

Recovery

Long term Support

Efficient Process

Partnership

Contributions

In 2010 the Social Care "Efficiency Framework" was developed by Directors of Adult Social Care (ADASS) and brought together by Simon Williams the Director of Merton's Community and Housing service. The framework provides guidance, identifies performance measures and offers approaches to efficient delivery of services. This approach helps councils to use their resources in the most effective way possible and is particularly relevant set against the current economic climate. The six key areas within the Efficiency Framework are:

Prevention	Recovery	Long Term Support
I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage any risks.	When I initially need health or social care, I am enabled to achieve as full a recovery as possible and any crises are managed in a way which maximises my chances of staying at home.	If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review.
Efficient Process	**Partnership**	**Contributions**
The processes to deliver these outcomes are designed to minimise waste, which is anything that does not add value to what I need.	The organisations that support me work together to achieve these outcomes. These organisations include health and social care, other functions in statutory bodies such as councils or government agencies, and the independent sector.	I and others who support me are expected and enabled to make a fair contribution to this support. These contributions may be financial according to my means, informal care and support from those close to me or from volunteers, or from me playing my own part in achieving these outcomes.

This framework has proved locally to be an effective way of designing services, and has been broadly supported by local service users and carers. The headings in the framework will be used to describe local initiatives.

Prevention/Promoting Independence

What is Prevention?

I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage any risks.

Adult Social care has focused on prevention and promoting independence through various initiatives. We believe community involvement and voluntary action are essential to the quality of life in Merton, and we know the voluntary and community sector make a valuable contribution to the borough's economic, environmental and social development.

The Merton Compact is a partnership agreement between local public bodies and the voluntary and community sector to improve their relationships and provide a framework within which the sectors can understand what to expect from each other. The 'Compact' is a national framework for how councils should work with the voluntary sector.

Some key initiatives focusing on Prevention/Promoting Independence:

Commissioning of Merton-i, an interactive information and advice portal, jointly managed with the voluntary sector, designed to enable people to find information and arrange their own support where appropriate. If you would like further information about the services we provide, please click on the link below or copy the link to your internet browser: http://merton-i.merton.gov.uk/kb5/merton/asch/home.page

You can find more details on Prevention/ Promoting independence on the following pages….

A re-focussing of prevention for older people through Ageing Well, a programme involving around 30 local authorities in which Merton participated. This re-focussing was based on achievement of outcomes for which there is evidence that they prevent or delay the need to use formal care.

New initiatives for people with dementia: Merton has commissioned the Dementia Hub with the Alzheimers Society as its provider partner, with a significantly improved environment largely funded by the Department of Health and offering immediate access to support for those with a diagnosis of dementia. The Hub has attracted national attention.

MASCOT Telecare helps to provide safety, security and well-being, enabling people to live independently in their own homes. The service is available 24 hours a day, every day of the year and uses simple technology linked to our own response centre.

The launch of Disabled Go, a guide to local public spaces for disabled people.

Ageing Well Programme

Prevention/Promoting Independence

Efficiency Framework

What is Prevention?

I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage any risks.

The Adult Social Care Ageing Well Programme was launched on 30 April 2013. The key features of the programme are:

Enabling people to live for longer in their own homes and delaying or reducing spend on Council funded social care.

Based on the evidence of triggers that cause people to go into care homes – such as incontinence, dementia, isolation, loss of mobility, and depression/anxiety.

It is outcomes-focused and takes an asset based approach.

Building social connectedness - instead of relying on services which keep older people segregated from others, it actively encourages people to mix.

Promotion of stronger local neighbourhoods and putting older people in touch with local people and opportunities.

Its effectiveness will be measured by a set of metrics - a combination of inputs by voluntary groups, individuals or objective assessment of “wellbeing” among older people against certain key factors and whether the services are actually having a “preventive” effect.

Cross-borough coverage for outcomes, whether by one organisation or through collaboration between organisations.

Consultations with older people on what they actually want.

The services funded by the Ageing Well Programme include:

Age UK Merton – Life after Stroke; continence awareness and support service

Carers Support Merton - Neighbourhood peer support groups/ networks; self-financed activities for carers as respite; Carry on caring workshops; emotional support and coaching

Merton & Morden Guild of Social Service Fit for Life' exercise programme; falls prevention programme; opportunities for volunteering

Merton Community Transport - Volunteer community car service

Merton Mencap – ‘Evolutions’ support service for non-FACs eligible people with autism; activities club and carers community advice service

Merton Vision - Buddying programme, emotional support and counselling, training to use equipment

Volunteer Centre Merton - Supported Volunteering Programme for mental health service users and people with learning, physical or sensory disabilities

Wimbledon Guild of Social Welfare - Community coaching sessions; menu of services; informal drop-in café

Merton Voluntary Service Council

Prevention/Promoting Independence

Efficiency Framework

What is Prevention?

I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage any risks.

*To find out more about **MVSC** go to:* www.mvsc.co.uk

Merton Voluntary Service Council works to support enable and champion the voluntary, community and faith sectors in Merton. Since 2014 Volunteer Centre Merton has been part of MVSC. They support enable and champion the sector in a number of ways:

Practical support to voluntary, community and faith organisations (VCFOs): Providing for the basic needs of VCFOs through information and advice, training, and access to practical resources such as IT/internet, desk space and equipment loan.

Liaison, advocacy and joint working: Acting as and facilitating the voluntary, community and faith sector's (VCFSs) voice with the public and private sectors and funders, and within the sector itself; playing a key role in bringing together VCFOs to work for their mutual benefit; accessing new funding for the VCFS and supporting joint working between sectors.

Development: Identifying new social and community needs; initiating new groups and/or providing support and facilities to strengthen existing groups by advising on a range of management and governance issues, including financial management and fundraising.

Standard setting: Setting and raising standards in the VCFS in general and in particular promoting quality management systems such as PQASSO (Practical Quality Assurance System for Small Organisations) and IIP (Investors for People) and financial management systems such as the Charity Commission SORP (Statements of Recommended Practice) and applicable accounting standards.

Strategic partnership working: Developing the VCFS's roles in strategic partnerships; representing the VCFS's interests by taking a lead role in partnerships with the public and private sector in Merton and externally.

Fund management: Managing and administering funds and acting as Lead and Accountable Body on local, regional, national or international programmes where there is a clear benefit for the VCFS in Merton.

Encourage, support and develop volunteering and voluntary and community action: Enhance the recruitment, promotion and management of volunteers in Merton. Raise awareness of volunteering, gain recognition for the contribution of volunteers and highlight issues affecting volunteers. Deliver good practice support for organisations and provide information, advice and training. Support people involved in community development in local communities and estates.

Dementia - Prevention/Promoting Independence

Efficiency Framework

The Merton Dementia Hub is a 'one stop' shop providing integrated care for people affected by dementia within the community, representing a new solution to integrating dementia services. The Hub is a unique community service for people with dementia, their family and carers at any stage in their journey, providing access to different health and social care professionals all under one roof.

The Alzheimer's Society has been commissioned to provide services at the Hub and around the borough and having access to everything in one place helps both people with dementia, carers and professionals. People are welcome to drop into the Hub at any time as there will always be a Dementia Support Worker available to talk to them. The Dementia Hub is managed by the Alzheimer's Society alongside the L B of Merton and in collaboration with the CCG, Mental Health Trust and a variety of other partners, provides a wide range of services including:

- Memory, assessment, and follow up Clinics
- Dementia Adviser (DA)
- Dementia Support Workers (DSW)
- Connecting BME Communities Worker
- Peer support groups for people with dementia
- Peer support groups for carers
- Carers' Information and Support Programme (CrISP)
- Information and Support Programme for people with dementia (LAD)
- Falls prevention exercises classes
- Dementia Cafes at the Hub and around the borough
- Singing for the Brain
- A variety of activity groups for people with dementia and carers
- Dementia workshops for professionals/voluntary organisations
- Access to services such as dentistry, chiropody, reflexology, audiology, etc.
- Rolling programme of health and alternative health services as identified by our users.
- Hub tours and dementia friends sessions

As the dementia specialists, we involve service users at every stage of service provision and they lead the discussion around what services are of greatest benefit. Our emphasis on recording these viewpoints means the services introduced and the ones we are planning to introduce directly reflect the wishes of local users.

Going forward we plan to continue to raise awareness of dementia around the borough and help people affected by dementia, professionals and members of the public to recognise that it really is possible to live well with dementia. Ensure that every person newly diagnosed has the opportunity to meet with a Dementia Adviser or Dementia Support Worker (who can see people in their own homes). We are planning to start up a new dementia café in Wimbledon and we are working with the new Community Dementia Nurses to provide Cognitive Stimulation Workshops at the Hub. We also plan to continue with our dementia friends and awareness raising sessions at the Hub and around the borough.

Sarah Waller CBE, Programme Director of the Kings Fund, Enhancing The Healing Environment said:
'The Merton Dementia Hub is an exemplar showing how local partnerships and an enthusiastic team can deliver a wide range of information and support.'

For more information contact:
Merton Dementia Hub
67 Whitford Gardens
Mitcham, Surrey, CR4 4AA
Monday to Friday, 9.00 am - 5.00 pm
T: 020 8687 0922
E: merton@alzheimers.org.uk

Carers Support Merton

Efficiency Framework

Prevention/Promoting Independence

Carers Support Merton improves the quality of life for unpaid carers who live or support a person living in the London Borough of Merton. We are a local organisation providing individual and family support to anyone who has caring responsibilities.

Carers often have to learn new skills, cope with new challenges in their lives and gain access to services they have never used before. **We are here to help carers sustain their role and we specialise in offering responsive, confidential and flexible support for carers** to negotiate the complex and changing world of public and health services, equip themselves and plan for the future.

Our Adult Carers services include:

- Information
- Advice
- Advocacy
- Training
- Emotional Support; Counselling
- Telephone Support Service
- Help with Benefits Claims and Appeals, Finances and Debts
- Remaining in Employment; Carers Rights
- Access to Carers Assessments
- Wellbeing, Social and Therapies Programmes
- Managing Long Term Health Conditions
- Advance Care Plans; Lasting Power of Attorney
- Deputyship and Wills
- Referral for Befriending or Bereavement Support
- Participation and Volunteering

Contact details: Email: info@csmerton.org www.csmerton.org

Our Ageing Well Programme, funded by London Borough of Merton, promotes choice and control, autonomy and resilience for carers as well as connectedness to each other and within their own communities. Our *Carry On Caring* programme offers training and advice. Carers can participate in our *Stay Well, Stay Active, Stay Connected* and *Time for You* programmes, our peer and neighbourhood networks, or use our *telephone support* and *counselling* services.

Who will benefit?

Anyone who is an adult or young adult (18+) caring for/impacted by supporting an adult with a disability, learning disability, dementia, mental health issue, serious illness or long term health condition.

How quickly will a carer be contacted?

We will normally make initial contact within one week, often within one or two days.

What does the service cost?

The service is free for carers. There are suggested donations for some services e.g. Counselling and Therapies. Some (voluntary) recreational activities may incur a cost which we endeavour to keep as low as possible.

Who can refer?

Carers and their families may simply call or email us. All organisations/professionals both statutory and voluntary. Referring agencies MUST HAVE CONSENT from the carer. Email is preferred: please provide the full name, address, telephone and contact details of the carer; their age or D.O.B, if possible and a brief description of their circumstances – e.g. 'caring for her father who has dementia'. Any further information you can provide is always helpful. Referrals by telephone or letter also accepted. Professionals should make us aware of any Risk Assessment issues. It is helpful to know if there are children or young carers involved. Core hours 10.00 am – 4.00 pm with additional hours most days.

Carers Support Merton

Prevention/ Promoting Independence

Efficiency Framework

Support to carers with Carers' Discretionary Payment Budget

Carers' Discretionary Payment Budget provides an easily accessible budget source of funds to allow for the provision of those services for carers that are not usually considered appropriate when sourced from the community care budget. A total of just over £30,000 was assigned for 2012-13 with a limit of £100.00 set per carer. We may contribute up to £100.00 toward an appropriate service in one application, or we may consider two or more applications over the year, provided the ceiling of £100.00 is not breached. This grant is to benefit the informal carers who are assessed under the legislative framework of the Carers and Disabled Children's Act 2000.

Merton fund Carers Support Merton to administrate the Carers' Discretionary Payment and to provide services to carers directly.

Carers Support Merton Contact details:
Email: info@csmerton.org
www.csmerton.org

A Case Study
Naturally our casework with carers, delivered by experienced Assessment and Support workers in the Adults' Service, continues to be a core part of what we do. For example, following a referral by the Alzheimer's Society, one of our home visits revealed multiple health, hygiene and continence problems that were affecting both the carer (the older of two siblings) and his brother, who had dementia. We were able to arrange for an urgent GP visit for antibiotics and a chiropody appointment; a cleaning and laundry service from Age UK Merton and support from *In Control*, their Continence Advice Service. We also contacted Merton Adult Social Care, who sent out forms to claim financial assistance, and we helped the carer to complete these. These measures helped to avert a crisis which could have led to hospitalisation or residential care for both brothers.

Mascot Telecare

Prevention/Promoting Independence

Efficiency Framework

Website:

www.mascot-telecare.org.uk

Email:
mascot@merton.gov.uk

Telephone:

020 8274 5940

Telecare Solutions

A selection of sensors available:

- Flood detector
- Smoke detector
- Watch
- Fall detector
- Carbon Monoxide Detector
- Bed/Chair Occupancy Sensors
- Bogus Call Button
- Property Exit Sensors
- Temperature Extremes Sensor
- Movement Detector
- Key Safe

MASCOT Telecare helps to provide safety, security and well-being, enabling people to live independently in their own homes. The service is available 24 hours a day, every day of the year, uses simple technology linked to our own response centre.

Case study:

Mrs T is a 68 year old lady who is speech & hearing impaired, has severe epilepsy, a mild learning disability, poor mobility due to left side paralysis, is also blind in one eye and has asthma. MASCOT is her first contact as she has no carers or relatives. This lady is sociable and keen to live independently in the community. She has frequent epileptic seizures and injury falls which are responded to appropriately. She has fallen from a ladder trying to replace a clock battery and now relies upon the helping hand service to carry out such tasks. We have also liaised with her housing association and other external agencies when there has been a communication issue. She embraces a dialogue with staff keeping them up to date with her social activities. Over a 6 month period, we have had 318 calls.

Mascot Telecare

Prevention/Promoting Independence

Efficiency Framework

Handyman Scheme
Deals with on average 30 tasks per month – for example:

- Changing light bulbs
- Replacing curtain tracks
- Putting up shelves
- Repairing Locks
- Replacing tap washers
- Repairing furniture
- Replacing seals around baths and worktops

Warm Homes Health Scheme:

- Check thermostats set correctly
- Bleeding radiators
- Check timers set correctly for on and off periods of boilers
- Supplying and fitting spy holes and door chains.

The MASCOT service continues to expand as technology advances and more and more telecare services become available. We are committed to actively promoting these additional services to our customers and healthcare professionals within Merton and are confident that we always get the best value as we tailor appropriate telecare products for our customers.

Installer and Handyman Service

In October 2014, Mascot employed two full time alarm installers who additionally provide a free handyperson services available to all our MASCOT customers.

As well as being able to provide supplemental resource to the mobile response officers, Andrew and Chris install the MASCOT alarm systems within customers' homes. In addition they are able to install smoke alarms, carbon monoxide alarms, bed sensors, pill dispensers, etc. Maintaining the equipment also falls within their remit – an essential part of the service.

"It can be extremely busy at times. One minute you're installing an alarm and the next you are being asked to go and assist the mobile response officers to help someone that has fallen over".

Warm Homes Healthy People Scheme

MASCOT also advises customers about the Warm Homes Healthy People Scheme that Merton Council is now providing. This additional service is designed to help older adults in their homes to feel warmer and safer.

Customers receiving a service from MASCOT each year:

2013-2014	2014-2015
1549	1601

Recovery

What is Recovery?

When I initially need health or social care, I am enabled to achieve as full a recovery as possible and any crises are managed in a way which maximises my chances of staying at home.

Some of the key Services helping recovery are:

MASCOT

Merton's in house Reablement service

Equipment and adaptations

You can find more details about these services on the following pages...

The recovery model in Merton involves two primary aims. The first aim is to prevent admission to hospital, nursing or residential care by offering short term, focussed support when people face a potential crisis. This may relate to an individual's 'long term condition' or be as a result of a significant change of social circumstance.

The second aim of the model is to provide an effective, multi-disciplinary reablement service at the point of hospital discharge.

The council offers reablement wherever appropriate to all those approaching Adult Social Care for help, and to those being discharged from hospital, as part of an overall aim to promote independence. We do not commit to long-term support without first checking that maximum recovery has been achieved. This strategy is resulting in reductions in the numbers of people receiving long-term support at home (and/or reductions in the size of their packages), and is proving cost-effective once the costs of the reablement intervention are taken into account.

Some key services helping recovery are:

MASCOT continues to reach a growing number of people and equipment is increasingly offered as a solution to promote independence. Examples are Just Checking, a cost effective way of assessing the level of someone's mobility within their own home, and devices to manage gas and water in the event of taps being left on.

Merton's in-house reablement service has been restructured to offer a clearer focus on recovery programmes for those who can most benefit, and led by occupational therapists and physiotherapists.

Equipment and adaptations for people in their own homes continues to play a vital role. Equipment is largely procured from the Croydon Equipment Solutions (CES) and has offered reductions in cost and faster delivery times.

Reablement Service

Recovery

Efficiency Framework

Merton Council applies a promoting independence approach to adults accessing Social Care, which provides local residents with an opportunity to maintain or regain their independence and continue to actively participate in their local community. Central to this approach is the Merton Reablement Service, which is community based and offers a short term intensive support package. The service facilitates an individual in their own home to regain their confidence and level of independence in their activities of daily living, which may be personal, domestic or social.

The benefits that can be achieved include:

- Improving quality of life
- Keeping and regaining essential life skills
- Regaining or increasing confidence
- Increasing people's choice and autonomy
- Enabling people to remain living at home
- Enabling people to remain as active members of the local community
- Maintaining and/or increasing independence, reducing the need for on-going care and support.

Typically, the Reablement Service is for adults who have either lost or are losing the ability to care for themselves, but who have the desire and ability to engage in a Reablement programme following:

- An admission to hospital
- A bout of ill health
- A fall or other incident that triggers a loss of confidence
- A feeling of increased frailty resulting in a loss of confidence
- A change in circumstance such as the death of a spouse/main provider/carer

However, this is by no means exhaustive and any enquiries are welcomed .

What do we mean by promoting independence?

The council role is to intervene when we have to, but not in a way which makes people dependent on our services. We seek to find other practical solutions, for instance:

- People using their own skills and assets and being resilient in finding solutions in their own lives.
- Regaining as much independence as possible if they have a crisis/illness.
- Family members, with help, supporting their own family members.
- Communities, including neighbours, supporting their vulnerable members.
- Voluntary and faith sectors supporting individuals.
- If customers come out of hospital we will re-able where we need to and support people to regain independence as far as possible.
- Using technology where we can.
- Keeping ongoing support under review.

Reablement Case Study

Recovery

Efficiency Framework

What is Recovery?

When I initially need health or social care, I am enabled to achieve as full a recovery as possible and any crises are managed in a way which maximises my chances of staying at home.

Some of the key services helping recovery are:

MASCOT

Merton's in house Reablement service

Equipment and adaptation

Ms. J. is an 83 year old lady who received an individualised programme from the Adult Social Care Reablement Team (Merton Independent Living & Engagement Team) that was cost-saving and allowed her to remain at home.

Ms. J. who suffers with leg oedema had a fall in January and was admitted to Hospital with a badly injured shoulder and leg. She was discharged home with a package of care consisting of 4 calls a day to support her with personal care, toileting, medications and meal preparation. Ms. J. also required a zimmer frame to help her mobilise safely around the house.

Following a progressive recovery, it was felt that the best aid towards Ms. J. regaining her independence was through support from the Merton Reablement service. Over a five week programme, Ms. J. developed the strength and confidence to start caring for herself and was soon able to walk around the house unaccompanied. After the first week she was able to take her own medications and to use a journal to record this.

Ms. J's recovery didn't come without its challenges. With partial sight and some memory issues even the smallest task presented difficulties. She was really anxious especially while mobilising until she got to know the carers. She also had Occupational Therapy adaptations in the shower, which helped Ms. J. with her independence and confidence levels. Ms. J. was a very determined lady who fought every obstacle that came her way, and with our support following her accident was soon able to resume living at home independently.

Merton Occupational Therapy Service

Efficiency Framework

Recovery

What do the OT Service provide?

Occupational Therapy supports people to optimise their potential and to engage in a range of meaningful activities.

The London Borough of Merton's Occupational Therapy (OT) service is consciously embracing the Personalisation agenda and the new Care Act legislation.

The philosophy of Occupational Therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in e.g. working, learning, playing, caring and interacting with others. Being deprived of or having limited access to occupation can affect physical and mental health.

Case Study:

Mr B has restricted mobility and has received disability benefits for about 10 years. As his main carer, his wife regularly has to reposition him during the night, leaving them both sleep deprived. In addition Mr B has depression, feeling that he cannot 'provide' for his family or be part of normal family life, including accompanying them on outings, holidays etc.

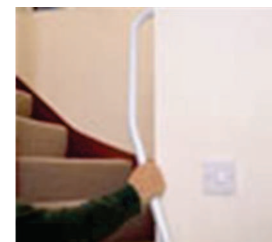
The Occupational Therapist assessed Mr B's needs and worked with him and his wife to identify options that would improve his wellbeing and independence and provide him with options to engage with the community, as well as reducing stress on Mrs B, the main carer.

Mr B was referred to the District Nurses who, following assessment, supplied a profiling bed which gave Mr B more independence and an improved sleep pattern for him and his wife.

Mr B was supported to choose a suitable trailer for taking his mobility scooter on outings which allowed him to access the community and take part in family outings.

Under Direct Payment the services of a visiting personal assistant were engaged which now provides some regular respite for Mrs B.

Mrs B was referred to the Social Work department for a carer's assessment in her own right.



Personalisation for Occupational Therapists (OTs) in social care means:

Understanding and acknowledging the social model of disability; providing choice, control and a person centred approach to assessment/review and delivery of support and services.

Considering environmental barriers as disabling factors in people's lives and seeking to remove these barriers through inclusive and flexible building design and strategic planning.

Optimising potential for independence through the use of adaptive techniques.

Emphasising the promotion of self-reliance and personal and community resources.

Ensuring that people have access to information and advice to make informed decisions about the support they need.

Long Term Support

Efficiency Framework

What is Long term Support?

If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review.

Where people require continued long term support Merton provides value for money and offers all eligible customers personal budgets. This can be by having a Direct Payment or a service set up and organised by the Council.

Personal budgets are made available to everyone needing long term support. Merton has pioneered the use of pre-paid cards as a cost effective and efficient way of managing this area, along with Merton Managed Accounts to offer money management for those requiring it: This area won the Local Government Chronicle award for Innovation in 2014.

Merton aims to support as many people as possible in the community and in their own homes. This is achieved by using technology such as care alarms and sensors, a range of accommodation options such as Supported Living, Shared Lives and Extra Care Supported Housing, and equipment and adaptations within people's homes. Where people's needs are at a higher level, residential and nursing care is provided.

Long Term support challenges:

In 2012 Merton awarded contracts to preferred home care providers through a framework contract, which remains in place despite the pressure on fees. Merton is now working with providers to move to a more outcome based approach.

Merton's use of residential care homes has declined, whereas use of nursing homes has slightly increased. Accessing local nursing home care has become an increasing challenge. Quality of care in these homes remains a focus, and Merton Seniors Forum has led an important initiative in this area, through recruiting and training volunteers to act as Dignity in Care Champions in local homes.

Many London boroughs are experiencing a shortage of capacity and demands for steeply increased fees from independent service providers. Merton is no exception to this trend even though we have very successfully managed our care markets in terms of value for money over the last 6 years. These pressures are especially evident in the commissioning of domiciliary care and bed based care for older people. We are building more strategic partnerships with our market providers and voluntary organisations to shape a strategic response to these new market realities. Together we are designing, building and delivering more efficient, effective and customer focused health and care solutions for the people of Merton.

Direct payments

Long Term Support

Efficiency Framework

What is Long term Support?

If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review.

You can find out more information about our direct payment service on: *http://www.merton.gov.uk/health-social-care/adult-social-care/directpayments.htm*

Where people require continued long term support Merton provides value for money and offers all eligible customers personal budgets. This can be by having a Direct Payment or a service set up and organised by the Council.

If you qualify for help from social services following a needs assessment, you can choose to receive payments from us (called 'direct payments') to buy the services you need to meet your needs. This is instead of receiving the services direct from the council.

Many people who use direct payments find they have more choice, control and flexibility. They are also responsible for accounting for how the money is spent. A direct payment cannot affect social security benefits nor be classed as taxable income. There is no maximum or minimum level to a direct payment, but it must be cost-effective and must be enough to purchase support of a quality acceptable to the local authority. We also offer Merton Managed accounts and pre-paid cards.

What is a Pre-Paid card?

If you receive direct payments from Merton Council to pay for your community care services, you will be given a pre-paid card. You can use this like a debit card, to pay for the agreed goods and services you use to meet your social care needs.

More information can be found on: http://www.merton.gov.uk/health-social-care/adult-social-care/directpayments.htm

What is a Merton Managed Account?

A Merton Managed Account (MMA) is a new service available from Merton council. The service is an option for all Adult Social Care customers, including those who do not receive financial support towards their care needs from the council; we call these individuals ‘self funders’. In 2014 Merton Managed Accounts won the Local Government Chronicle award for Innovation.

The service is designed to assist customers who receive their personal budget (social care funds) as a Direct Payment, but who need or choose to have support managing the financial aspects of their personal budget.
More information about Merton Managed Account can be found on:

http://www.merton.gov.uk/health-social-care/adult-social-care/directpayments/merton-managed-accounts-pre-paid-cards.htm

Long Term Support – Case study

Efficiency Framework

What is Long term Support?

If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review.

Case Study:

Ms M has a learning disability and until recently lived at home with family members. She was assisted by social work staff from Merton Council to move into a Supported Living Scheme in the Borough as she wanted to increase her independence.

Ms M has recently moved to a new flat in a brand new Supported Living Scheme. The scheme was constructed by a local housing association and is staffed by support workers from the Council's Supported Living Team. Ms M has been sorting out her new flat and has told staff that it is good. Friends living in the scheme come and visit her in her flat. She is also looking forward to meeting new people who move into the other flats in the scheme. There are staff on duty during the day and at night and Ms M receives assistance to carry out daily living tasks such as support with her money so that she can do her shopping. She also attends day opportunities and evening activities.

Ms M receives support with her washing and cleaning but has told staff that she needs less support now because her independence is increasing. She has had support with travel training so that she can travel on her own to her job.

Process

What is Efficient Process?

The processes to deliver these outcomes are designed to minimise waste, which is anything that does not add value to what I need.

Merton’s overall processes have been looked at under the ‘Lean’ principles to end or minimise anything which does not add value to the outcome for our service users.

The brokerage service was launched in 2012, offering a way of accessing the market in a way that secures best available value for money at acceptable quality. This change to process has been all the more essential as it has become harder to find care at the prices which Merton pays and as the pressures have increased especially in terms of the dependency levels of those being discharged from hospital. We are considering how this can be best positioned for those who fund their own care.

Merton’s safeguarding function has managed significantly increased volumes of referrals in recent years, as people become more aware of the issue. In order to ensure a degree of independent oversight, the directors for adult social care for Kingston and Merton chair each other’s Safeguarding Adult Boards on a reciprocal basis.

A major development in this area has been an increased recognition of self neglect as a safeguarding issue, which in Merton was accepted as a criterion for a safeguarding intervention before this was enshrined in statue under the Care Act. In this area there has been some specific work in the area of hoarding, where people may put themselves and others at significant risk: Merton with its partners has developed a shared protocol which has enabled successful interventions to take place and which has attracted national attention for its pioneering nature.

The Deprivation of Liberty Safeguards and the subsequent case law has significantly increased the work load to assess people who lack capacity in care home and hospitals. It has also increased the work load for those living in the community who lack capacity to ensure that their care plan are in their best interest and are the least restrictive option.

The information system in use forms a significant proportion of process time, and Merton is in the process of changing to a new system for both children’s and adult social care. The system is called Mosaic and is due to go live in 2015. Changing systems is a very significant change process, but we expect as a result to see reduced time spent on data inputting and therefore more time available to be spent with customers, which will in turn support more flexible working.

Partnership

What is Partnership?

The organisations that support me work together to achieve these outcomes. These organisations include health and social care, other functions in statutory bodies such as councils or government agencies, and the independent sector.

In 2012/13 our partnership work with the voluntary sector was recognised in national awards for Compact working.

In February 2013 Merton hosted an event for all local NHS organisations (CCG [Clinical Commissioning Group] 3 acute Trusts, the community provider Trust, and the mental health Trust) where the integration programme for older people and people with long term conditions was launched. 4 strategic outcomes were agreed:

1. An improvement in satisfaction levels among customers
2. A reduction in emergency admissions to acute hospitals
3. A reduction in lengths of stay in acute hospitals
4. A reduction in admissions to care homes

This programme is based on two main areas:

- Proactive care management, where social care workers, community health workers and primary care workers work together in three geographical locality teams, offering integrated assessments and case management.
- Reactive response services, especially focused around avoiding hospital admissions and facilitating hospital discharge.

The programme turned out to anticipate the central government initiative of the Better Care Fund (BCF), where across England local partners were required to produce a plan to use a pooled budget to achieve similar outcomes and especially a reduction in admissions to hospitals. Merton's plan was judged one of the five best in the country, and the local arrangements have been praised by visiting senior civil servants and government ministers.

At the same time our pre-existing partnership arrangements for learning disabilities and mental health have remained effective and been refreshed through a formal review of the Section 75 agreements.

Outcomes achieved with the voluntary sector task group

- A transfer of management of small grants for carers to Carers Support Merton, which has levered in external funding to supplement what the council spends
- A change in the pathway for those who get a visual impairment diagnosis, so that they get more rapid support from the voluntary sector
- The launch of the community fund to support local voluntary group endeavours
- Transfer of management of certain assets to the voluntary sector
- The ageing well programme for prevention
- A reduction in transport costs

Better Care Fund (BCF)

Partnership

Efficiency Framework

What is the Better Care Fund?

The Better Care Fund was announced by the Government in the June 2013 to support integrated health and social care by creating a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

In the autumn of 2013 each of the 151 Health and Wellbeing Board areas in England were required to produce a BCF Plan. The BCF Plan for Merton was developed to build on the Integration Programme's work schemes and strategic outcomes and was signed off by the Merton Health and Well Being Board as part of the re-submission process in September 2014.

The project infrastructure established to deliver this work includes the Integration Board, a multi-agency group co-chaired by the Clinical Commissioning Group (CCG) and London Borough of Merton, which includes the three local acute trusts, the local mental health trust, community services and representation from the voluntary sector. The same agencies are represented within the Merton Model Development Group which is the key implementation group responsible for delivery of this work. The implementation model includes both reactive and proactive work streams.

Outcomes achieved through the Merton Model Development Group

Within our pro-active work stream:

- Integrated Locality Teams have now been established to support people in their own homes.
- Support for those people at risk of admission to hospital through care planning, multi-disciplinary discussion and use of a key worker.
- Additional skills and support have been added to these teams including the Health Liaison Social Workers as well as more recently, community dementia nurses, enabling closer links with mental health services and the voluntary sector, including the Dementia Hub where the London Borough of Merton was nominated for two Local Government Chronicle Awards.
- Development of the HARI service which provides holistic assessment and rapid investigation for complex patients. This service started offering routine appointments in April in the new developed Nelson Health Centre and will be expanded to support urgent assessment through the recruitment of an interface geriatrician.

For the reactive work stream:

- A crisis team has been established within community services to offer 7 day crisis support to support admission prevention.
- Additional Intermediate Care Bed capacity has also been commissioned to enable more people to be supported out of hospital.
- Community in reach services and a social worker are now based at St George's to help support discharges 7 days a week.
- The Reablement team was restructured to support the delivery of reablement services.

Contributions

What do we mean by Contribution?

I and others who support me are expected and enabled to make a fair contribution to this support. These contributions may be financial according to my means, informal care and support from those close to me or from volunteers, or from me playing my own part in achieving these outcomes.

Everyone should be able to, and is expected to contribute to their care whether it is in kind or financial. Merton adult social care has a clear, fairer contributions policy which expects users to pay for services if they can afford to do so, including from appropriate benefits. The council's charging policy has remained relatively unchanged, recognising that in comparison with many councils Merton already receives a comparatively high contribution level through charges. The charging consultation group has continued to meet in order to listen to customer experience and make changes where required.

The self-directed support process is also clear about the contribution in kind expected from the customer and any informal carers and family members.

Support from the Voluntary Service and Carers

There has been a re-launch of the volunteering strategy, with Merton Voluntary Service Council taking lead responsibility for implementation, which has included a merger with Volunteer Centre Merton in order to offer one place to support volunteering. The strategy has been the subject of regular reports to the Overview and Scrutiny Commission. Volunteering is playing an increasingly effective role in areas such as day opportunities, befriending, working with people on a short term basis in order to help them work out the right support for them, and informal get-togethers.

The contribution of carers continues to be seen as vital, and more investment went into Carers Support Merton under Ageing Well in order to promote a single place for carers to get information and support, supplemented by more specialist support in certain key areas.

healthwatch
Merton

Healthwatch are here to:

Gather the views and experiences of local people on the way services are delivered and have the power to enter and view adult health and social care services to get a feel for how they are delivering.

Help you to shape and improve the services you use. We do this by influencing the way services are designed and delivered based on evidence gained from you.

Engage with people in our locality. We want to hear from people across every part of the community - so if you haven't met us yet, please get in touch.

Keep you up to date with our work through newsletters and updates. To sign up to the mailing list visit www.healtwatchmerton.co.uk

Provide information and signposting about local health and social care services.

Influence how services are set up and commissioned by having a seat on the local Health and Wellbeing Board.

Pass information and recommendations to other local Healthwatch, Healthwatch England and the Care Quality Commission.

Healthwatch is the consumer champion for health and social care in England. Here to give children, young people and adults a powerful voice – making sure their views and experiences are heard by those who run, plan and regulate health and social care services.

By making sure the views and experiences of all people who use services are taken into account, we can help make services better now and in the future. Healthwatch actively seeks views from all sections of the community, especially from those who sometimes struggle to be heard and not just from those who shout the loudest. We also encourage health and social care providers, regulators and planners to hear directly from people themselves.

What do we do?

Healthwatch Merton works to help local people get the best out of their local health and social care services. Whether it's improving them today or helping shape them for tomorrow. It's all about voices being able to influence the delivery and design of local services, not just for people who need to use them now, but anyone who might need to in future.

Healthwatch Merton will play a role nationally through Healthwatch England and at a local level as one of the 152 community focused local Healthwatch. Together we form the Healthwatch network, working closely to ensure consumers' views are represented nationally and locally

Merton Council awarded the Healthwatch Merton contract to MVSC because of their excellent local knowledge. MVSC is based in the borough and already engage on a daily basis with the many diverse communities in Merton. Their experience and knowledge about health and social care services working within Merton is also another strong quality.

Web: www.healthwatchmerton.co.uk

Email: info@healthwatchmerton.co.uk

Tel: 0208 685 2282

Safeguarding

Safeguarding Performance data

Health and Social Care Information Centre (HSCIC) collects data on safeguarding from each local authority, further details are available in the Performance & Quality Assurance section of our Local Account

The introduction of the Care Act sets out for the first time a legal framework for safeguarding adults with Safeguarding Adults Boards becoming statutory. Local Authorities, the NHS and the police will be core members of Safeguarding Adults Boards and are already key partners on Merton's Safeguarding Adult's Partnership Board. The Safeguarding Adults Partnership Board is a group of people who meet four times a year to ensure that Adult Safeguarding is delivered effectively. The Board comprises of senior lead managers from all key partner agencies.

Merton has a reciprocal arrangement with the Royal borough of Kingston for the chairing of the safeguarding boards. This means that the director of Kingston chairs Merton board and the director of Merton chairs Kingston Boards. These arrangements allow a level of independent scrutiny. We will be reviewing this arrangement in the latter part of 2015.

Views of our key partners

"The Care Act places a duty for agencies to work together hence working in partnership has never been so important. The demands being placed upon those engaged in safeguarding adults continues to push the boundaries of our capacity to deliver a professional and caring service without additional funding. Within this operating environment I am immensely proud of the positive contributions to improving people's lives being made by all agencies in Merton. I am very aware of how the lives of carers and service users are affected each day when dealing with families and friends." **Sue Redmond (Chair of Merton Safeguarding Adults Partnership Board)**

"St Georges University Hospitals Foundation Trust is an active member of the Merton Safeguarding Board and is committed to providing safe and dignified care to Merton residents who use our services. We continue to have good working relationships with Merton social services and with our other partner agencies in respect of reporting and investigating allegations of abuse and neglect. All staff receive level 1 training in adult safeguarding and we have a dedicated safeguarding lead nurse for adults in addition to 2 learning disability nurses and a clinical nurse specialist for domestic abuse within the safeguarding team who can provide support and advice to some of our most vulnerable clients." **David Flood (Safeguarding Lead - St Georges Hospital trust)**

Deprivation of Liberty Safeguards (DoLS)

Where can I find more Performance data on DoLS?

Health and Social Care Information Centre (HSCIC) collects data on safeguarding from each local authority, further details are available in the Performance & Quality Assurance section of our Local Account

Deprivation of Liberty Safeguards (DoLs) were introduced in England and Wales in April 2009 as part of the Mental Capacity Act 2005. The aim of DoLs is to provide protection for vulnerable people who are accommodated in hospitals or care homes in circumstances that amount to a deprivation of their liberty and, who lack the capacity to consent to the care or treatment they required.

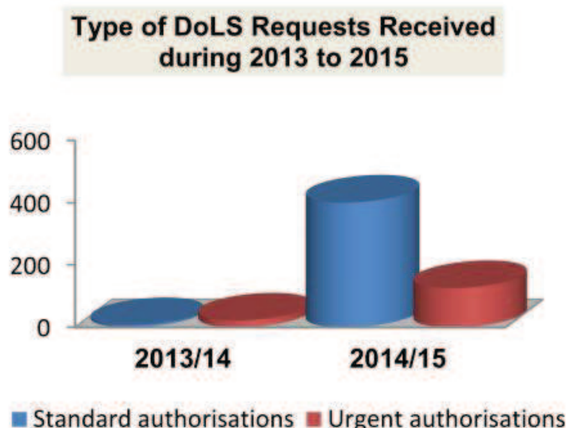
Since March 2014, the threshold for a Deprivation of Liberty has changed following the Cheshire West Supreme Court Judgement. The threshold is now significantly lower, which means that an increasing number of people accommodated in care homes and hospitals will now come under the remit: If the person is not free to leave, and under continuous supervision and control.

DoLs statistics for 2013 to 2015

Since 1st April 2013 to 31st March 2014 Merton received 29 DoLs requests and during the same period in 2014/15 we received 527 DoLs requests. This shows that we received nearly 500 more request during 2014/15 compared to 2013/14.

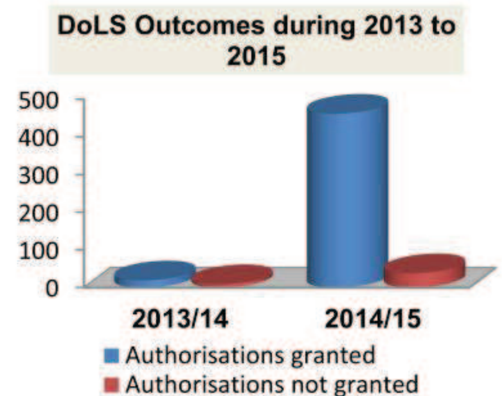
DoLs Requests Received

The chart below shows the amount of DoLs requests received and if they were standard or urgent.



DoLs Outcomes

The chart below shows the amount of DoLs that have been authorised and declined.



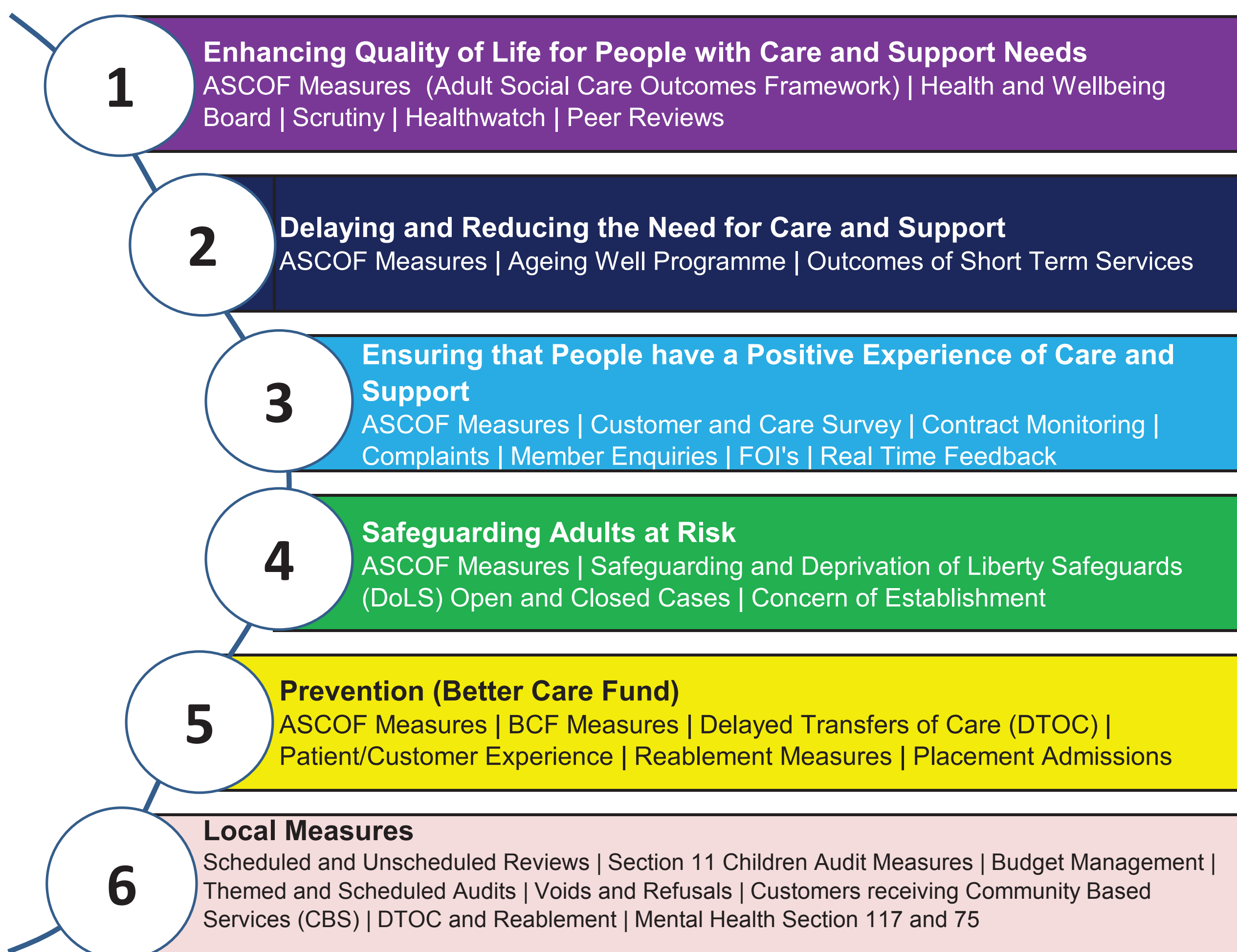
Performance and Quality Assurance (PQA)

What are the key areas covered in this section?

- National Performance Measures
- Benchmarking data
- Local Measures
- Cases file Audits
- Local Customer Satisfaction Surveys and more…..

In Merton we see quality assurance as a fundamental part of the relationship between adult social care and its customers. We aim to provide a high quality and responsive service based on positive outcomes. In order to understand quality as defined by our customers we have been working on implementing a quality assurance process that ensures that customers" views feed in to our process.   We also need to ensure that the process allows for internal challenge of ourselves and the organisations we work with. This will ensure that we continually improve and deliver better outcomes for our customers.

In 2014 we launched a new Performance and Quality Assurance Framework, with six key domains and overseen by a quality board. The aspiration is to get more feedback in real time from customers about their experience of support, alongside the usual performance metrics. The six key areas within the Performance and Quality Assurance Framework are:



Summary of Performance from 2013 to 2015

Key Achievements on Adult Social Care Outcome Framework (ASCOF) Measures against our Comparator Group Average (CGA)

- The proportion of people / carers using social care who receive self-directed support have significantly increased from 2013 to 2014-15 and we are well above our CGA.
- Noticeable increases in direct payments for both carers and people since 2013 and we are significantly higher than our CGA.
- Long-term support of older adults (aged 65 and over) met by admission to residential and nursing care homes is considerably lower than our CGA.
- Delayed transfers of care from hospital are significantly lower than our CGA.
- We have the lowest delayed transfers of care from hospital, which are attributable to adult social care compared to England and our comparators.
- The proportion of older people (65 and over) who were offered reablement services following discharge from hospital is considerably higher than our CGA.
- The proportion of adults in contact with secondary mental health services in paid employment is noticeably higher than our comparators.
- The proportion of adults with learning disabilities who live in their own home or with their family is higher than our CGA.
- The overall satisfaction of people who use services with their care and support is higher than our CGA.
- The overall satisfaction of carers with social services is also higher than our CGA.
- The proportion of social care-related quality of life score is higher than our CGA.
- The proportion of people who use services who find it easy to find information about support is higher than our CGA.
- The proportion of carers who find it easy to find information about support is significantly higher than our CGA.
- The proportion of people who use services who feel safe is higher than our CGA.

Further details on ASCOF measures and comparator group can be found on the following pages of this local account.

Key Achievements on Local Measures:

- The number of carers receiving an assessment and/or services saw a slight decrease in quarter three of 2014-15 but is now steadily increasing.
- The percentage of adults receiving long-term community based services is also steadily increasing.
- The time taken to authorise service agreements has seen a gradual decline over the last year.
- While the number of safeguarding referrals has seen a sudden increase, the number of investigations that this has led to has remained about the same.

Key areas for improvement on (ASCOF) measures against our Comparator Group Average (CGA)

- The proportion of adults with learning disabilities in paid employment is significantly lower than our CGA.
- The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services is marginally lower than our CGA.
- The proportion of carers who reported that they had as much social contact as they like is lower than our CGA.
- We are lower than our CGA on 'The proportion of carers who report that they have been included or consulted in discussion'.
- We are slightly lower than our CGA on 'The proportion of people who use services who say that those services have made them feel safe and secure'.

National Benchmarking Measures (ASCOF)

The ASCOF performance measures are divided into four domains.

Domain 1

Enhancing the quality of life for people with care and support needs.

Domain 2

Delaying and reducing the need for care and support.

Domain 3

Ensuring people have a positive experience of care and support.

Domain 4

Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

hscic Health & Social Care Information Centre

Adult Social Care Outcomes Framework

Source: (Adult Social Care Outcomes Framework (ASCOF) Handbook of Definitions 2014 Prepared by the Department of Health)

The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

The purpose of the ASCOF is three-fold:

- Locally, the ASCOF supports councils to improve the quality of care and support. By providing robust, nationally comparable information on the outcomes and experiences of local people, the ASCOF supports meaningful comparisons between councils helping to identify priorities for local improvements and stimulating the sharing of learning and best practice.
- The ASCOF fosters greater transparency in the delivery of adult social care, supporting local people to hold their council to account for the quality of the services they provide. A key mechanism for this is through councils' local accounts, where the ASCOF is already being used as a robust evidence base to support councils; reporting of their progress and priorities to local people: and,
- Nationally, the ASCOF measures the performance of the adult social care system as a whole and its success in delivering high-quality, personalised care and support. The framework will support Ministers in discharging their accountability to the public and Parliament for the adult social care system and will inform and support national policy development.

Performance against the ASCOF, at both the national and individual council level, will be published by the Health and Social Care Information Centre (HSCIC), and the Department will also release an annual commentary on the national picture.

Click *www.hscic.gov.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF* to visit the HSCIC webpage relating to ASCOF with links to additional information including published reports.

The following pages show the council's performance against the ASCOF measures in the years since 2012, together with a comparison of how Merton is performing against other councils within our Comparator Group. The councils within our Comparator Group include Bexley, Brent, Croydon, Ealing, Enfield, Greenwich, Harrow, Hounslow, Kingston-upon-Thames, Lewisham, Redbridge, Richmond-upon-Thames, Sutton, Waltham Forest and Wandsworth.

National Benchmarking Data

Performance

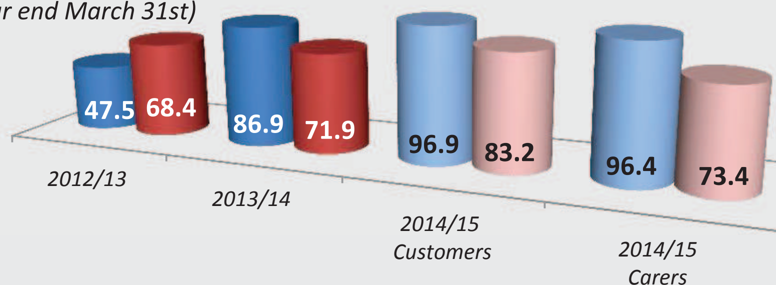
ASCOF DOMAIN 1	Enhancing quality of life for people with care and support needs

People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. People are able to find employment when they want, maintain a family and social life and contribute to community life and avoid loneliness or isolation. Carers can balance their caring roles and maintain their desired quality of life. To view the 'ASCOF: Handbook of Definitions' visit ***www.hscic.gov.uk***

Measure	2012/13	2013/14	2014/15
1A - Social care-related quality of life *(Source: 'Personal Social Services Adult Social Care Survey', HSCIC)*	17.9 CGA 18.4	18.8 CGA 18.6	18.7 CGA 18.5
1B - Proportion of people who use services who have control over their daily life *(Source: 'Personal Social Services Adult Social Care Survey', HSCIC)*	68.4 CGA 71.7	73.7 CGA 73.1	69.1 CGA 70.8
1C - (1a) Proportion of adults receiving self-directed support *(Snapshot data at the year end March 31st)*	47.5 CGA 68.4	86.9 CGA 71.9	96.9 CGA 83.2
1C - (1b) Proportion of carers receiving self-directed support *(Data during the year to March 31st)*			96.4 CGA 73.4

1C - Proportion of people using social care who receive self-directed support

(Snapshot data at the year end March 31st)



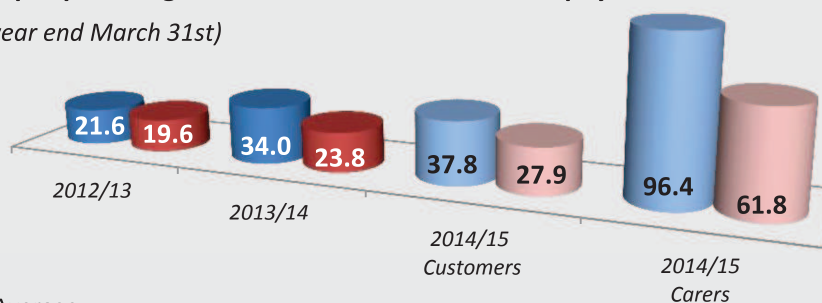
■ Merton
■ Comparator Group Average

NOTE: *This measure originally combined data for both adults and carers until 2014/15 when they were reported separately.*

Measure	2012/13	2013/14	2014/15
1C - (2a) Proportion of adults receiving direct payments *(Snapshot data at the year end March 31st)*	21.6 CGA 19.6	34.0 CGA 23.8	37.8 CGA 27.9
1C - (2b) Proportion of carers receiving direct payments for support direct to carer *(Data during the year to March 31st)*			96.4 CGA 61.8

1C(2) - Proportion of people using social care who receive direct payments

(Snapshot data at the year end March 31st)



■ Merton
■ Comparator Group Average

NOTE: *This measure originally combined data for both adults and carers until 2014/15 when they were reported separately.*

CGA = Comparator Group Average | GREEN = Merton performing above average (CGA) | RED = Merton performing below average (CGA)

National Benchmarking Data

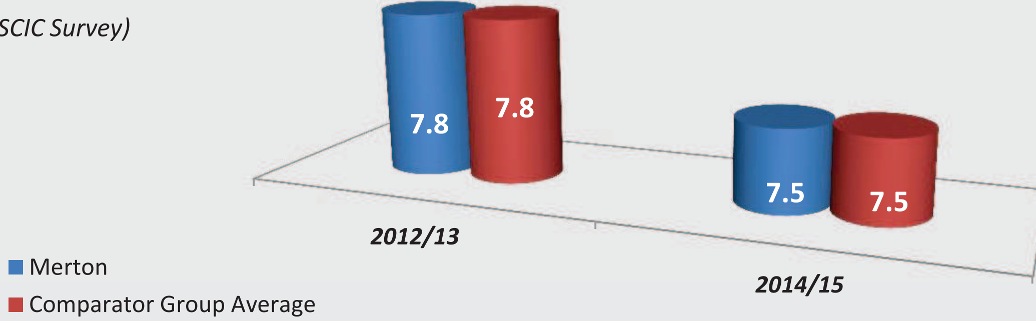
Performance

ASCOF DOMAIN 1	Enhancing quality of life for people with care and support needs

Measure	2012/13	2013/14	2014/15
1D - Carer-reported quality of life *(Source: 'Personal Social Services Survey of Adult Carers in England', HSCIC)*	7.8 CGA 7.8	N/A	7.5 CGA 7.5

1D - Carer-reported quality of life

(HSCIC Survey)

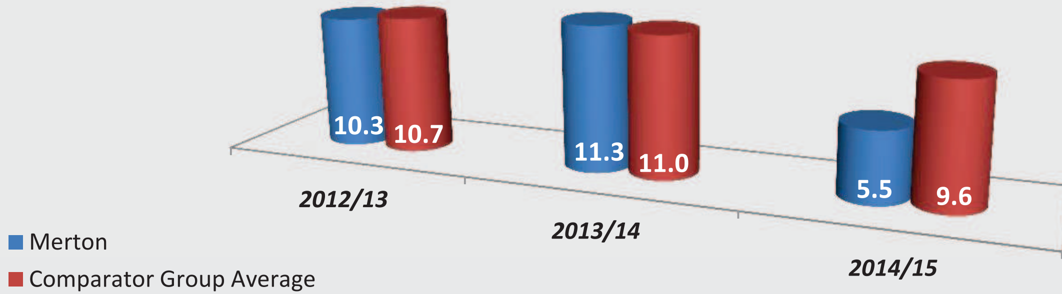


NOTE: *The survey of carers is conducted every two years and therefore not required for 2013/14.*

NOTE: *This measure is a culmination of responses from six questions within the survey. For more info visit* ***www.hscic.gov.uk***

Measure	2012/13	2013/14	2014/15
1E - Proportion of adults with learning disabilities in paid employment *(Data during the year to March 31st)*	10.3 CGA 10.7	11.3 CGA 11.0	5.5 CGA 9.6

1E - Proportion of adults with learning disabilities in paid employment



Measure	2012/13	2013/14	2014/15
1F - Proportion of adults in contact with secondary mental health services in paid employment	11.2 CGA 7.9	9.2 CGA 6.4	9.6 CGA 6.6
1G - Proportion of adults with learning disabilities who live in their own home or with their family *(Data during the year to March 31st)*	73.4 CGA 69.8	70.4 CGA 71.6	74.5 CGA 67.5
1H - Proportion of adults in contact with secondary mental health services who live independently, with or without support	76.9 CGA 79.7	82.1 CGA 78.9	86.9 CGA 79.7
1I - (1) Proportion of people who use services, who reported that they had as much social contact as they would like *(Source: '… Survey of Adult Carers in England')*	Not Available	43.9 CGA 41.0	45.1 CGA 42.2
1I - (2) Proportion of carers, who reported that they had as much social contact as they would like *(Source: 'Personal Social Services Survey of Adult Carers in England', HSCIC)*	Not Available	Not Available	31.5 CGA 34.6

CGA = Comparator Group Average | GREEN = Merton performing above average (CGA) | RED = Merton performing below average (CGA)

National Benchmarking Data

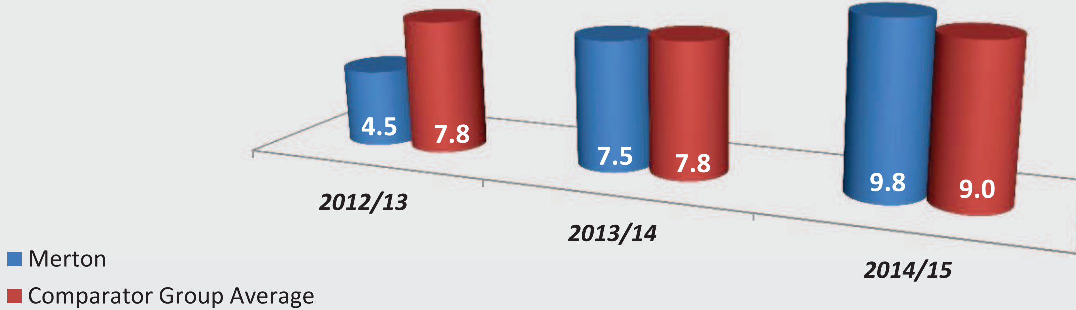
Performance

ASCOF DOMAIN 2	Delaying and reducing the need for care and support

When people develop care needs, the support they receive takes place in the most appropriate setting and enables then to regain their independence. Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

Measure	2012/13	2013/14	2014/15
2A - (1) Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 *(a lower figure is favourable)*	4.5 CGA 7.8	7.5 CGA 7.5	9.8 CGA 9.0

2A - (1) Permanent admissions (18-64 years old) to residential and nursing care homes

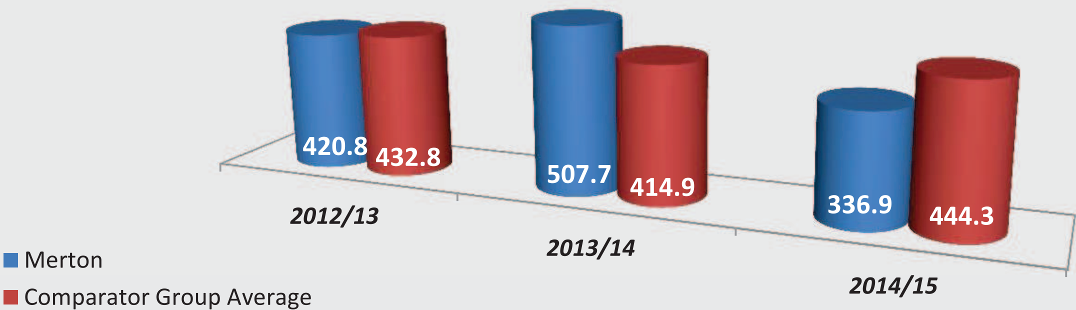


***NOTE:** The definition of this measure has changed for 2014/15.*

***NOTE:** A lower figure is favourable.*

Measure	2012/13	2013/14	2014/15
2A - (2) Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 *(a lower figure is favourable)*	420.8 CGA 432.8	507.7 CGA 414.9	336.9 CGA 444.3

2A - (2) Permanent admissions (over 65 years) to residential and nursing care homes



***NOTE:** The definition of this measure has changed for 2014/15.*

***NOTE:** A lower figure is favourable.*

Measure	2012/13	2013/14	2014/15
2B - (1) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement services (effectiveness of the service)	84.4 CGA 84.2	83.3 CGA 86.8	81.2 CGA 84.9
2B - (2) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)	1.0 CGA 4.3	1.6 CGA 4.6	5.4 CGA 3.9
2C - (1) Delayed transfers of care from hospital per 100,000 population *(a lower figure is favourable)*	2.5 CGA 6.1	2.7 CGA 6.7	4.4 CGA 7.2
2C - (2) Delayed transfers of care from hospital, that are attributable to social care or jointly with the NHS, per 100,000 population *(a lower figure is favourable)*	0.7 CGA 1.9	0.0 CGA 2.0	0.7 CGA 2.3
2D Proportion of those that received a short term service during the year where the sequel to service was either no ongoing support or support of a lower level	Not Available	Not Available	73.7 CGA 67.6

CGA = Comparator Group Average | GREEN = Merton performing above average (CGA) | RED = Merton performing below average (CGA)

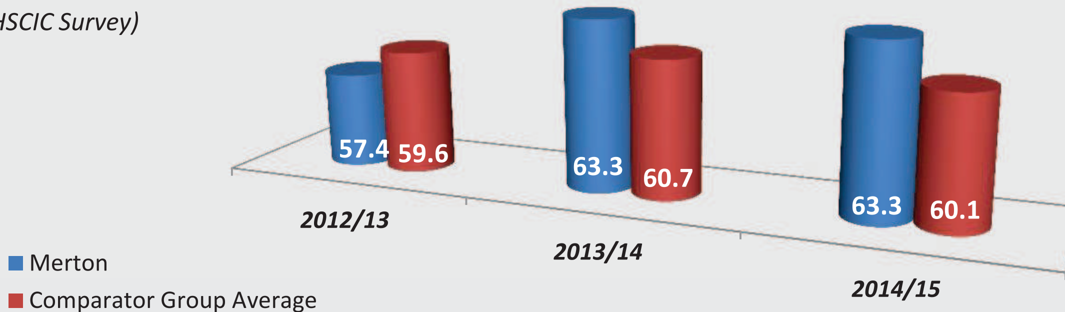
National Benchmarking Data

Performance

ASCOF DOMAIN 3	Ensuring people have a positive experience of care and support

People who use social care and carers are satisfied with their experience of care and support services. Carers feel that they are respected as equal partners throughout the care process. People know what choices are available to them locally, what they are entitled to, and who to contact when they need help. To view the 'ASCOF: Handbook of Definitions' visit **www.hscic.gov.uk**

Measure	2012/13	2013/14	2014/15
3A - Overall satisfaction of people who use services with their care and support *(Source: 'Personal Social Services Adult Social Care Survey', HSCIC)*	57.4 CGA 59.6	63.3 CGA 60.7	63.3 CGA 60.1



Measure	2012/13	2013/14	2014/15
3B - Overall satisfaction of carers with social services *(Source: 'Personal Social Services Survey of Adult Carers in England', HSCIC)*	36.5 CGA 35.5	Not Applicable[1]	35.7 CGA 34.3
3C - Proportion of carers who report that they have been included or consulted in discussion about the person they care for *(Source: 'Personal Social Services Survey of Adult Carers in England', HSCIC)*	71.1 CGA 66.9	Not Applicable[1]	58.1 CGA 64.9
3D - (1) Proportion of people who use services, who find it easy to find information about support[2] *(Source: 'Personal Social Services Adult Social Care Survey', HSCIC)*	71.8 CGA 68.7	78.6 CGA 73.1	75.1 CGA 73.4
3D - (2) Proportion of carers who find it easy to find information about support[2] *(Source: 'Personal Social Services Survey of Adult Carers in England', HSCIC)*		Not Applicable[1]	71.4 CGA 62.4

[1] *Carer Survey conducted every two years therefore information not available for each year.*

[2] *From 2013/14 the ASCOF 3D measure was separated into services users and carers.*

CGA = Comparator Group Average | GREEN = Merton performing above average (CGA) | RED = Merton performing below average (CGA)

National Benchmarking Data

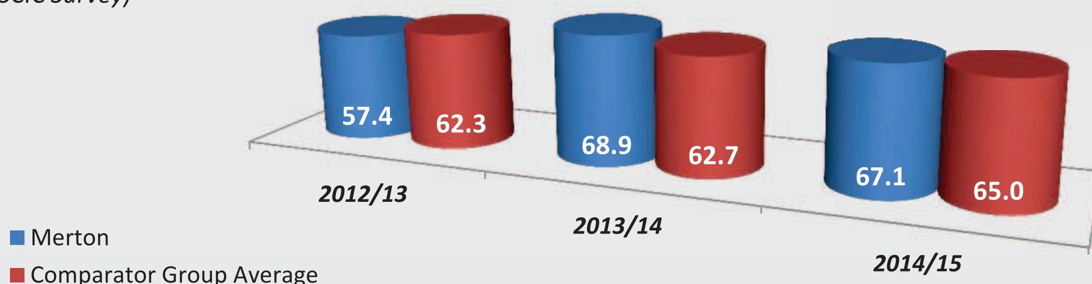
Performance

ASCOF DOMAIN 4	Safeguarding people whose circumstances make them vulnerable and protecting them from avoidable harm

Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injury. People are supported to plan ahead and have the freedom to manage risks in the way that they wish. To view the 'ASCOF: Handbook of Definitions' visit ***www.hscic.gov.uk***

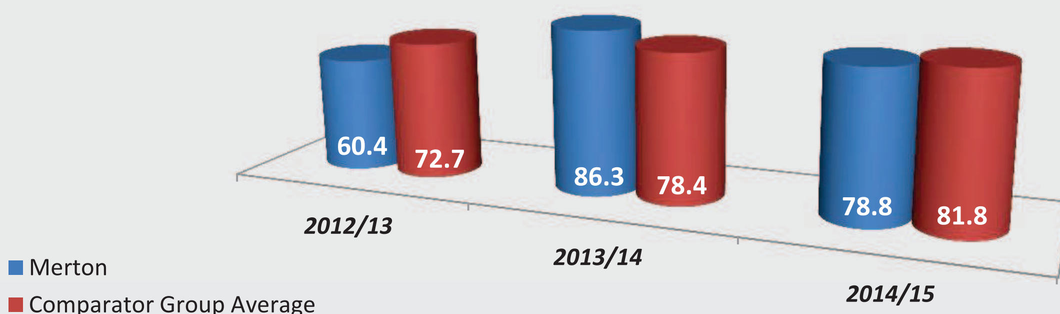
4A - Proportion of people who use services who feel safe
(Source: 'Personal Social Services Adult Social Care Survey', HSCIC)

2012/13	2013/14	2014/15
57.4	68.9	67.1
CGA 62.3	CGA 62.7	CGA 65.0



4B - Proportion of people who use services who say that those services have made them feel safe and secure
(Source: 'Personal Social Services Adult Social Care Survey', HSCIC)

2012/13	2013/14	2014/15
60.4	86.3	78.8
CGA 72.7	CGA 78.4	CGA 81.8



CGA = Comparator Group Average | GREEN = Merton performing above average (CGA) | RED = Merton performing below average (CGA)

National Benchmarking Data - Safeguarding Adults

Performance

Councils with Adult Social Services Responsibilities (also known as CASSR) are required to complete the Safeguarding Adults Return (SAR) and submit this each year to the Health and Social Care Information Centre (HSCIC). **The tables below show SAR data from 2013/14.**

NOTE: The SAR data for 2014/15 was not available at the time of producing this Local Account but can be accessed and viewed via the HSCIC website by following this link.
http://www.hscic.gov.uk/datacollections/sar

CGA = Comparator Group Average

Individual or organisation believed to be source of risk, by type of abuse	*Social care support or service paid, contracted or commissioned*		*Other: Known to individual*		*Other: Unknown /stranger*	
Physical	**40**	CGA 41	**45**	CGA 64	**5**	CGA 24
Sexual	**10**	CGA 4	**10**	CGA 14	**0**	CGA 7
Psychological / emotional	**15**	CGA 24	**25**	CGA 48	**5**	CGA 14
Financial and material	**25**	CGA 28	**30**	CGA 50	**5**	CGA 23
Neglect and acts of omission	**75**	CGA 89	**75**	CGA 44	**5**	CGA 31
Discriminatory	**0**	CGA 1	**0**	CGA 1	**0**	CGA 1
Institutional	**5**	CGA 6	**10**	CGA 2	**0**	CGA 2

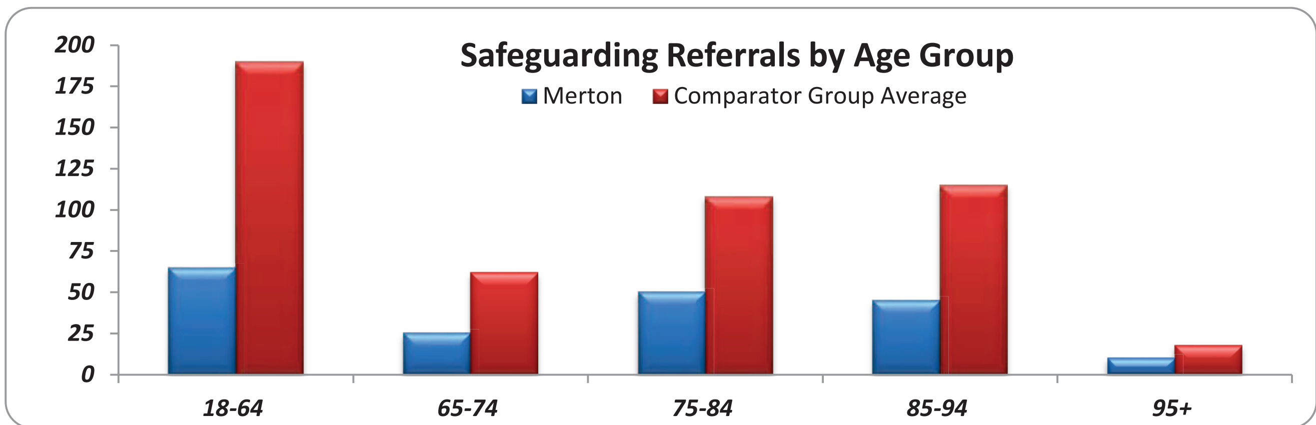
CGA = Comparator Group Average

Individual or organisation believed to be source of risk, by conclusion	*Social care support or service paid, contracted or commissioned*		*Other: Known to individual*		*Other: Unknown /stranger*	
1 - Substantiated - fully	**35**	CGA 50	**30**	CGA 55	**0**	CGA 30
2 - Substantiated - partially	**20**	CGA 17	**25**	CGA 14	**5**	CGA 5
3 - Inconclusive	**25**	CGA 32	**25**	CGA 36	**5**	CGA 22
4 - Not substantiated	**55**	CGA 58	**65**	CGA 60	**5**	CGA 32
5 - Investigation ceased at individual's request	**0**	CGA 5	**0**	CGA 9	**0**	CGA 3

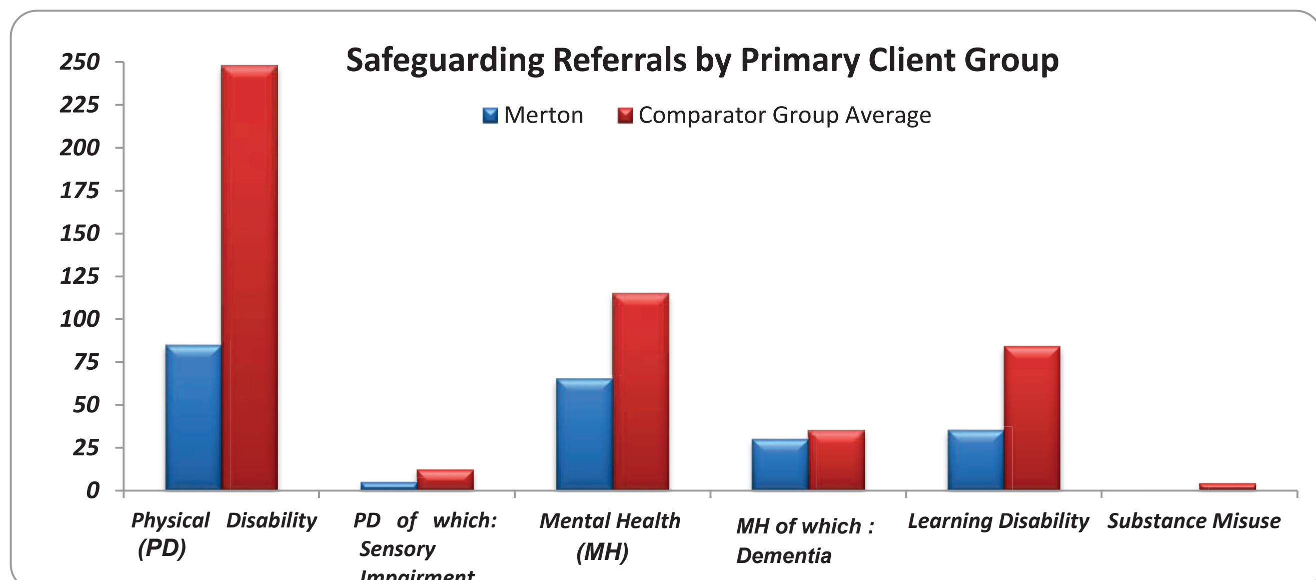
National Benchmarking Data - Safeguarding Adults

Performance

Safeguarding referrals by age	18-64	65-74	75-84	85-94	95+
Numbers of individuals for whom a safeguarding referral has been made within the borough of Merton	65	25	50	45	10
Numbers of individuals for whom a safeguarding referral has been made within the boroughs of Merton's Comparator Group	190	62	108	115	18



Safeguarding referrals by primary client group	Physical Disability (PD)	PD of which: Sensory Impairment	Mental Health (MH)	MH of which : Dementia	Learning Disability	Substance Misuse
Numbers of individuals for whom a safeguarding referral has been made within the borough of Merton	85	5	65	30	35	0
Numbers of individuals for whom a safeguarding referral has been made within the boroughs of Merton's Comparator Group	248	12	115	35	84	4



National Benchmarking Data - Deprivation of Liberty Safeguards (DoLS)

Summary from Health and Social Care Information Centre

Since 2009, care homes and hospitals have had to seek authorisation from their Local Authority if they need to deprive an individual who lacks capacity of their liberty as part of their care and/or treatment. The Health and Social Care Information Centre (HSCIC) currently collects data from Councils with Adult Social Services Responsibilities (CASSRs or councils) on Deprivation of Liberty Safeguards (DoLS) at case level on an annual basis. This information is then published in the annual report 'Mental Capacity Act, 2005, Deprivation of Liberty Safeguards'.

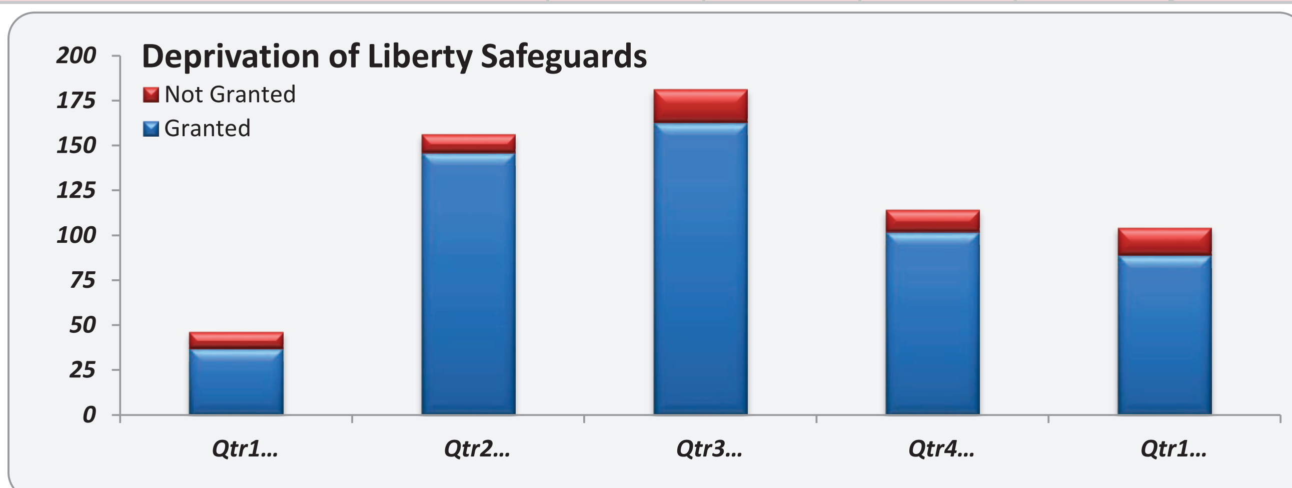
Supreme Court judgments handed down on 19 March 2014 have led to a substantial increase in the volume of Deprivation of Liberty Safeguards (DoLS) applications received by councils. As a result, a temporary, voluntary, data collection has been introduced to cover the period 1 April 2014 – 30 September 2015. This quarterly collection enables stakeholders to monitor the scale of the Supreme Court judgments' impact on councils in a timely manner, and allows for any increase in the number of DoLS applications to be quantified and evidenced.
You can access the data on a quarterly basis from Health & Social Care Information Centre – click on this link to access the full report:

http://www.hscic.gov.uk/article/2021/Website-Search?productid=18380&q=dols+2015-15&sort=Relevance&size=10&page=1&area=both#top

The table below shows the summary of the report published by Health & Social Care Information Centre with our comparator average figures:

CGA = Comparator Group Average

Outcome of applications	*Qtr1 2014/15*	*Qtr2 2014/15*	*Qtr3 2014/15*	*Qtr4 2014/15*	*Qtr1 2015/16*
Number of applications received during the quarter	**46** CGA **73**	**156** CGA **122**	**181** CGA **153**	**139** CGA **151**	**142** CGA **162**
Of those applications how many were granted	**37** CGA **67**	**146** CGA **94**	**163** CGA **88**	**102** CGA **78**	**89** CGA **69**
Of those applications how many were not granted	**9** CGA **10**	**10** CGA **17**	**18** CGA **15**	**12** CGA **23**	**15** CGA **31**



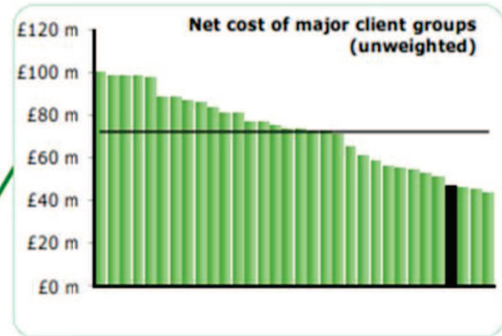
National Benchmarking data

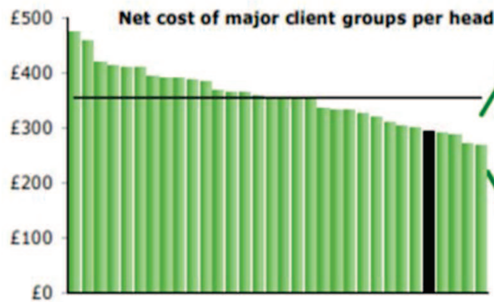
We will update with 2014-15 data once it is published by CIPFA

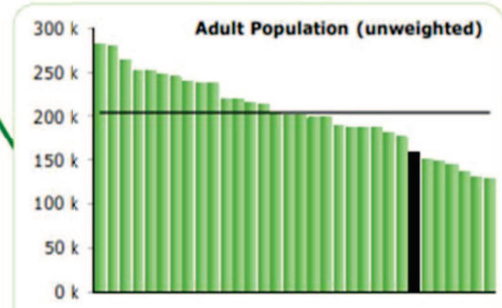
Costs of Adult Social Care Services:

The following graphs show how our costs of services compare to other statistically similar boroughs in 2013-14. (The average cost of the service is worked out by dividing the number of customers by the amount of money spent per day, week, etc.)

Overall Summary
Net Expenditure per Head
2013/14







The two charts marked unweighted are given here to help members understand the relative size of authorities. As most of our analysis shows unit costs, or other ratios, the size of the authority is usually not apparent.

Adult Population (18+) 158 k

	Net Expenditure	£'million	£/head	Avg
A	Service Strategy	0.3	£1.90	£2.78
B,E,F,G	Major Client Groups	46.5	£293.79	£355.19
H	Asylum Seekers	0.2	£1.16	£0.66
J	Other Adult Services	1.8	£11.29	£9.66
K	**Total Adult Services**	**48.8**	**£308.14**	**£368.29**

Graph Source: CIPFA Social Care Benchmarking
(CIPFA: Chartered Institute of Public Finance & Accountancy)

Key points:

- Merton spends less per head of population than average.
- Merton is a smaller authority than average.

National Benchmarking data

Costs of Adult Social Care Services

How Merton compares on net spend on specific care groups or settings
(net means including the income we get from charges and other sources)

Services for Adults - Summary
Net Expenditure per Head, 2013/14

Key points:

Merton spends less per head of population than average.

Merton is a smaller authority than average.

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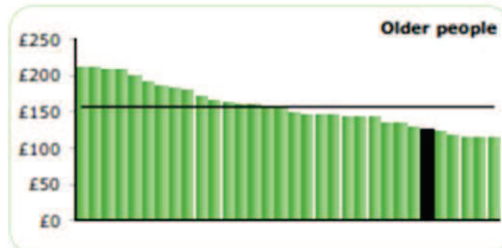
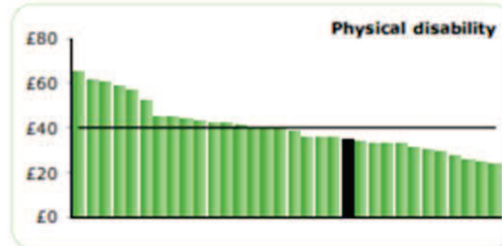
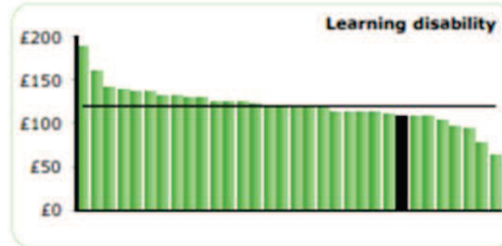
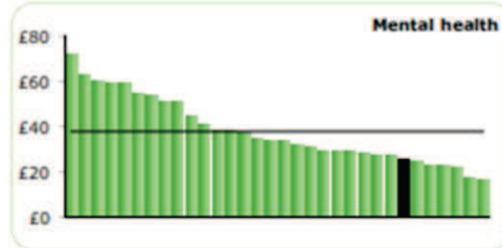
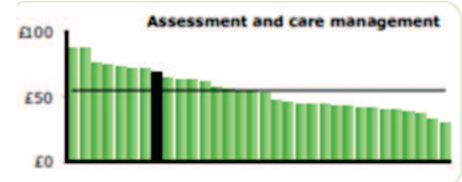
We will update this page with 2014-15 data once it is available from CIPFA.

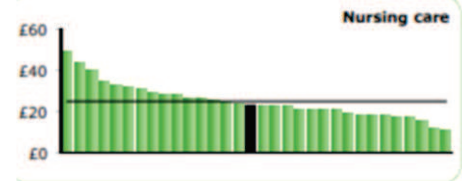


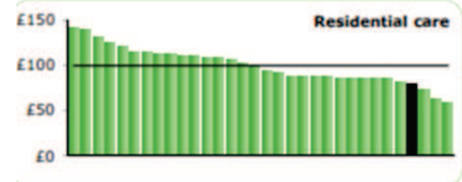


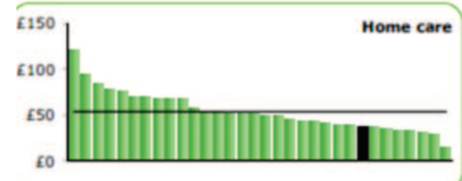












Adult Population (18+) 158 k

	Net Expenditure	£'m	Exp/head	Avg
B	Older people	19.8	£125	*£157*
E	Physical disability	5.5	£35	*£40*
F	Learning disability	17.2	£109	*£120*
G	Mental health	4.0	£25	*£38*
Total		**46.5**	**£294**	***£355***

	Net Expenditure	£'m	Exp/head	Avg
1	Ass. & care mgt.	11.0	£69	*£55*
2.1	Nursing care	3.7	£23	*£25*
2.2	Residential care	12.5	£79	*£99*
4	Sup. & other accom..	1.9	£12	*£30*
5	*Home care**	5.9	£37	*£54*
6	*Day care/services**	4.6	£29	*£29*
7	Fairer charging	8.6	£54	*£74*
8	Direct payments	4.5	£28	*£33*
9-11	Other services	3.3	£21	*£29*
13	Supporting people	1.2	£7	*£9*
Total		**46.5**	**£294**	***£355***

**Home Care/Day Care figures are gross with respect to client contributions, but all other income is netted off.*

Source: CIPFA Social Care Benchmarking based on PSSEx1 Report 2013-14 Final
(CIPFA : Chartered Institute of Public Finance & Accountancy)

Costs of Adult Social Care Services

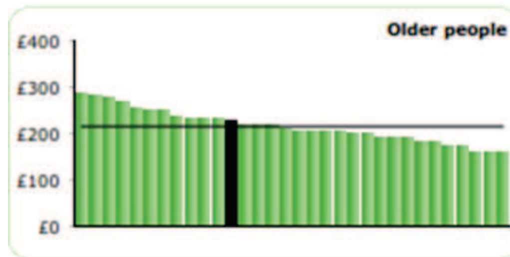
How Merton compares on net spend on specific care groups or settings

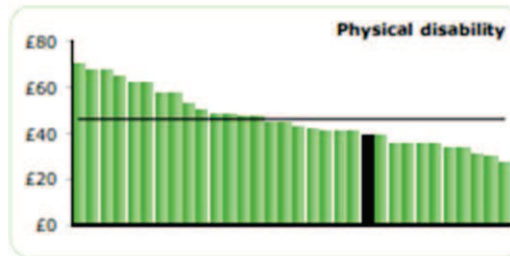
(net means including the income we get from charges and other sources)

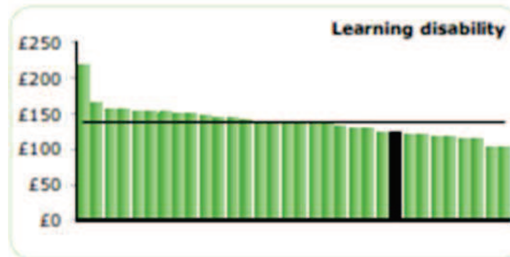
We will update this page with 2014-15 data once it is available from CIPFA.

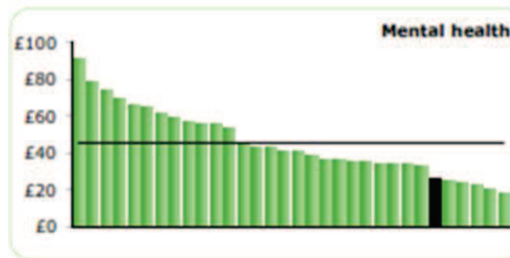
Services for Adults - Summary

Gross Expenditure per Head, 2013/14









Adult Population (18+) 158 k

	Gross Expenditure	£'m	Exp/head	*Avg*
B	Older people	35.8	£226	*£215*
E	Physical disability	6.2	£39	*£46*
F	Learning disability	19.7	£125	*£137*
G	Mental health	4.2	£27	*£45*
Total		**65.9**	**£417**	***£444***

Source: CIPFA Social Care Benchmarking based on PSSEx1 Report 2013-14 Final

(CIPFA: Chartered Institute of Public Finance & Accountancy)

National Benchmarking data

We will update this page with 2014-15 data once it is available from CIPFA.

Costs of Adult Social Care Services

Service Strategy	Cost (£'k)	Clients	£/head	£/client	Clients/pop.
Older People	19,774	1,596	£125	£12,392	10.1
Physical Disability	5,503	289	£35	£19,040	1.8
Learning Disability	17,208	414	£109	£41,575	2.6
Mental Health	4,007	66	£25	£60,712	0.4
Total	**46,492**	**2,365**	**£294**	**£19,661**	**14.9**

Adult Population (18+) 158 k

Group Averages:

Service Strategy	£/head	£/client	Clients/pop.
Older People	*£157*	*£16,057*	*10.0*
Physical Disability	*£40*	*£20,389*	*2.0*
Learning Disability	*£120*	*£47,267*	*2.6*
Mental Health	*£38*	*£41,472*	*1.2*
Total	***£355***	***£22,867***	***15.8***

Client figures: *calculated from PSS Ex1 Activity sheet for the following clients: Nursing Care, Residential Care, Home Care, Day Care, Meal & Direct Payments*
Please see client group reports for further detail.

Source: CIPFA Social Care Benchmarking based on PSSEx1 Report 2013-14 Final
(CIPFA : Chartered Institute of Public Finance & Accountancy)

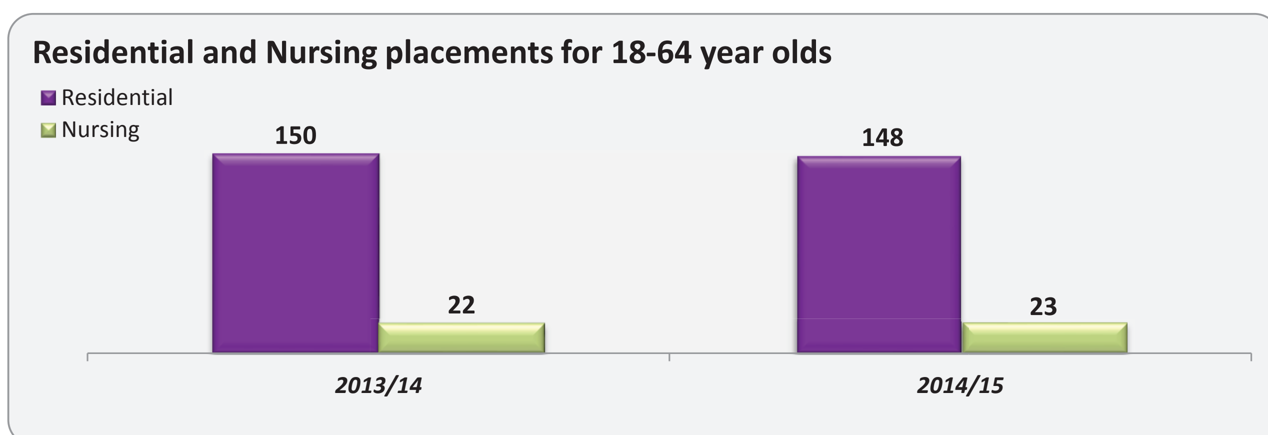
Local Performance Report

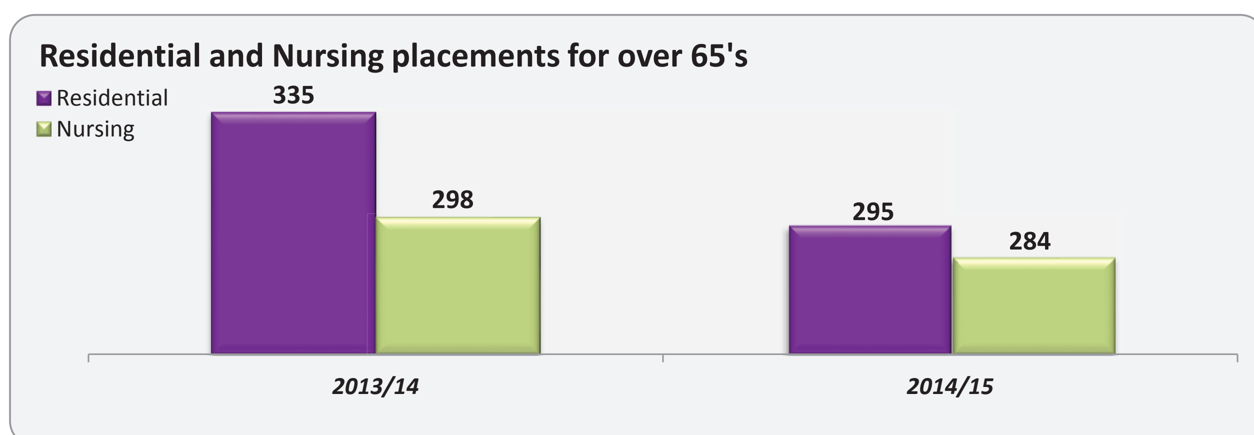
The local performance report forms part of our Performance and Quality Assurance Framework. We monitor activities and volumes of Adult Social Care data and local measures on a monthly, quarterly and yearly basis.

In this Local Account the local performance reporting is split into yearly and quarterly reports. The quarterly reporting section will be updated on a quarterly basis.

Yearly Monitoring data

	18-64		*65+*	
Services	*2013/14*	*2014/15*	*2013/14*	*2014/15*
Residential placements made during the year	150	148	335	295
Nursing placements made during the year	22	23	298	284

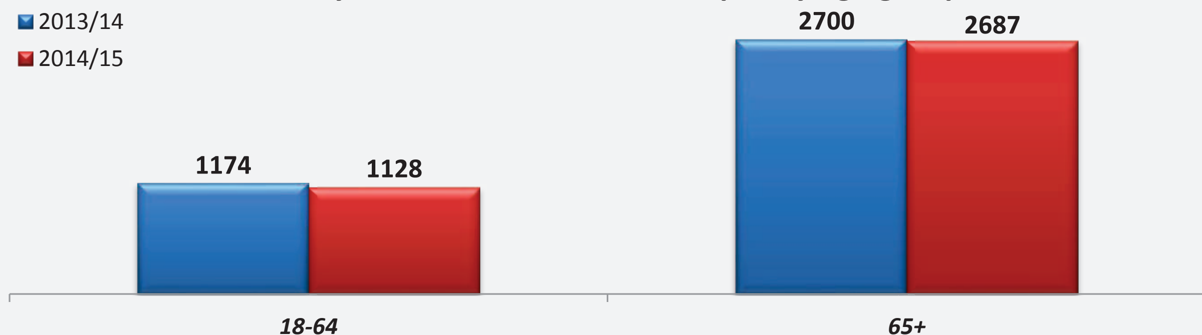


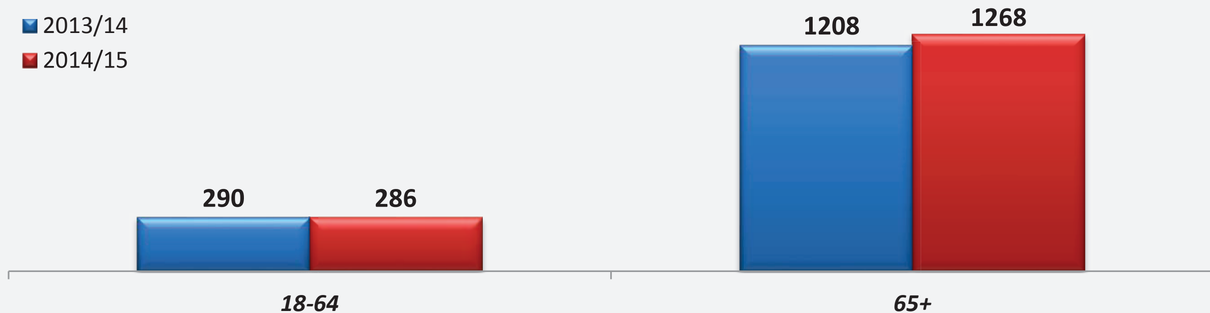


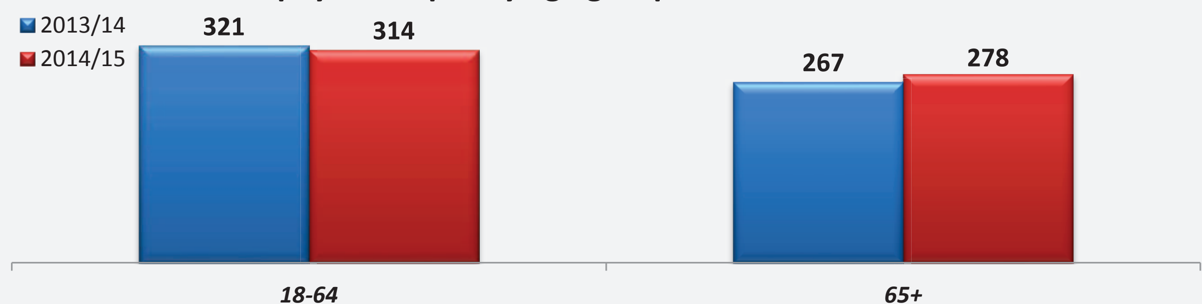
Local Performance Report

Yearly Monitoring data

	2013/14		2014/15	
Community Based Services[1]	18-64	65+	18-64	65+
The total number of adults receiving Community Based Services during the year	1174	2700	1128	2687
The number of adults receiving domiciliary care services during the year	290	1208	286	1268
The number of adults receiving direct payments during the year	321	267	314	278





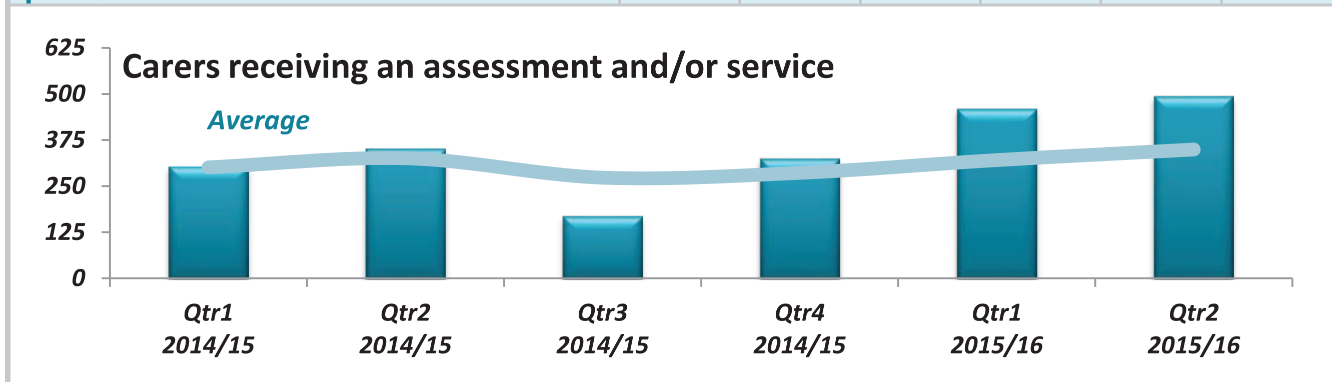


[1] *Community Based Services included in the graph are temporary residential and nursing placements, domiciliary care, day care, transport, equipment and direct payments.*

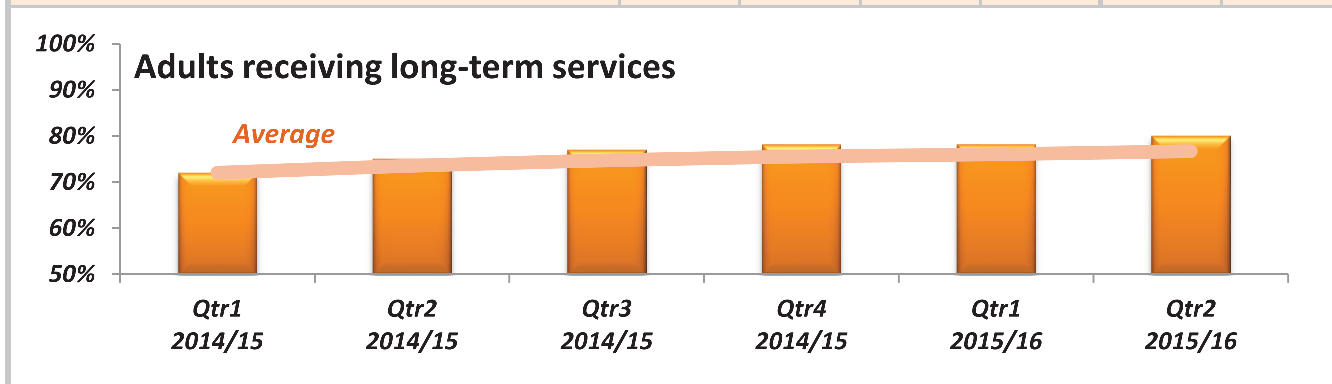
Local Performance Report

Quarterly Monitoring data

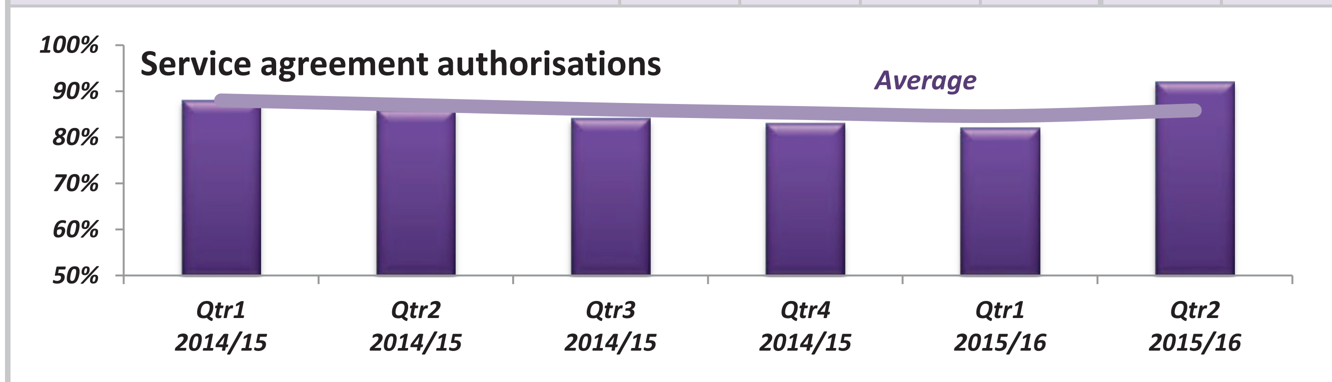
Number of carers receiving an assessment, services and/or information and advice for each quarter	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16
	301	350	168	325	459	493



Percentage of adults receiving long term community based services from all adults receiving long term services	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16
	72%	75%	77%	78%	78%	80%



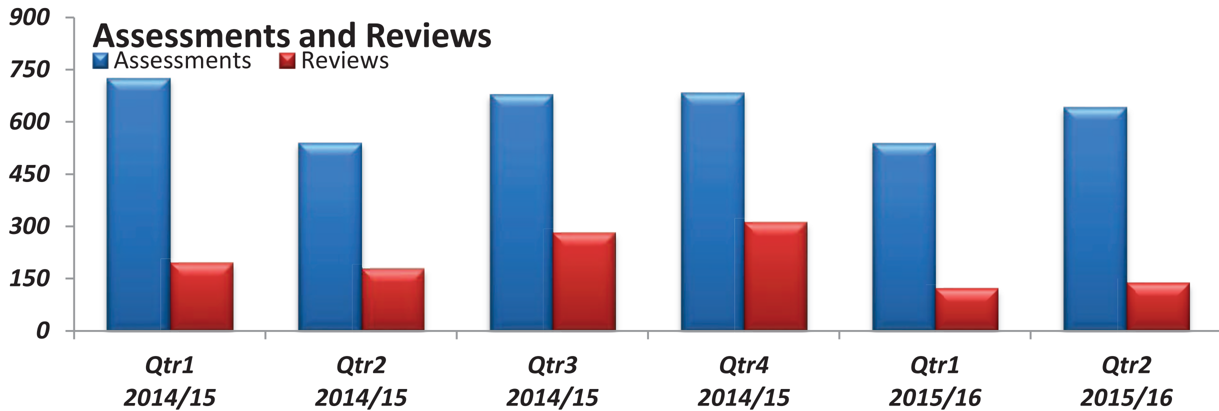
Percentage of service agreement authorisations completed within five days for each quarter	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16
	88%	86%	84%	83%	82%	92%



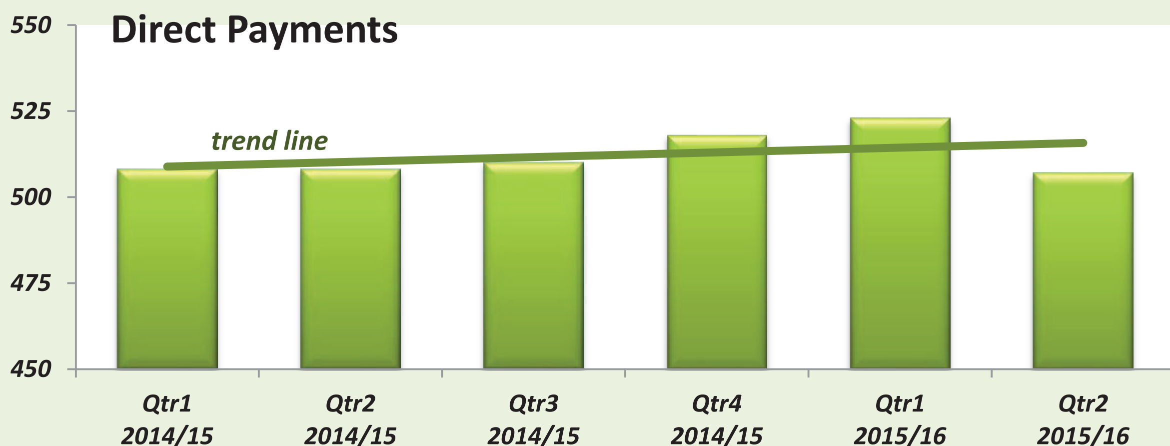
Local Performance Report

Quarterly Monitoring data

Assessments and Reviews	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16
Number of assessments completed *(quarterly snapshot)*	**725**	**539**	**678**	**683**	**538**	**642**
Number of reviews completed *(quarterly snapshot)*	**195**	**179**	**281**	**311**	**121**	**138**

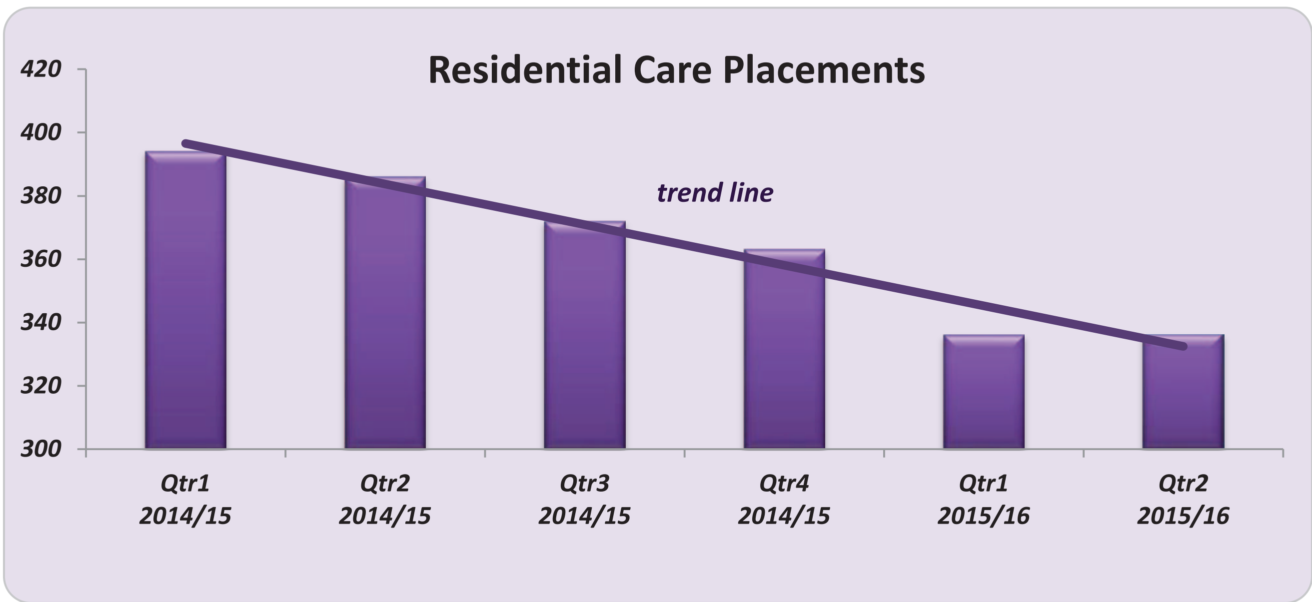


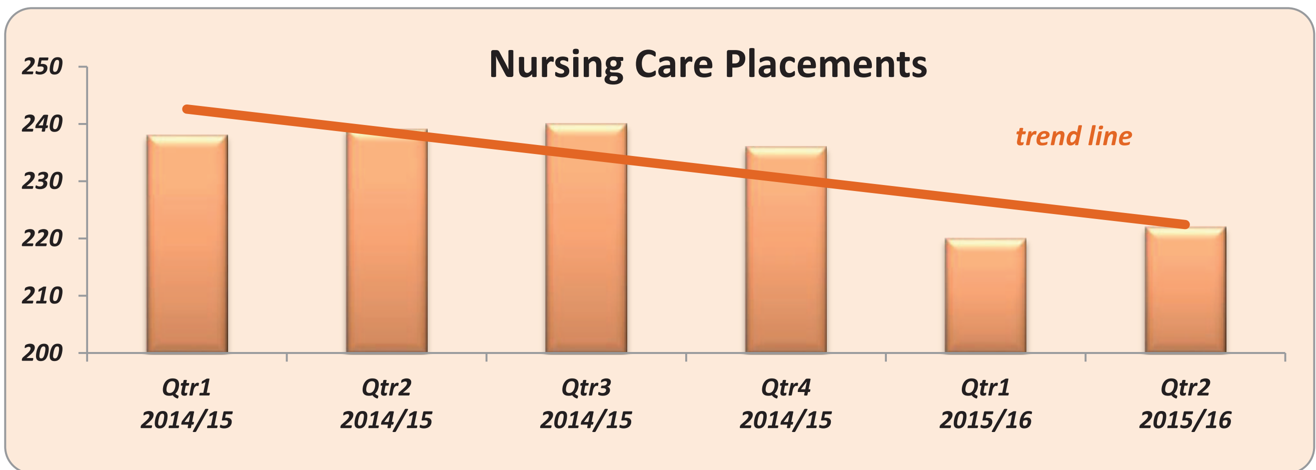
Services *(quarterly snapshot)*	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16
The number of adults in a permanent **residential** placement during the quarter	394	386	372	363	336	336
The number of adults in a permanent **nursing** placement during the quarter	238	239	240	236	220	222
The number of adults receiving a **direct payment** during the quarter	508	508	510	518	523	507
The number of adults receiving **domiciliary care** during the quarter	889	927	953	983	965	951

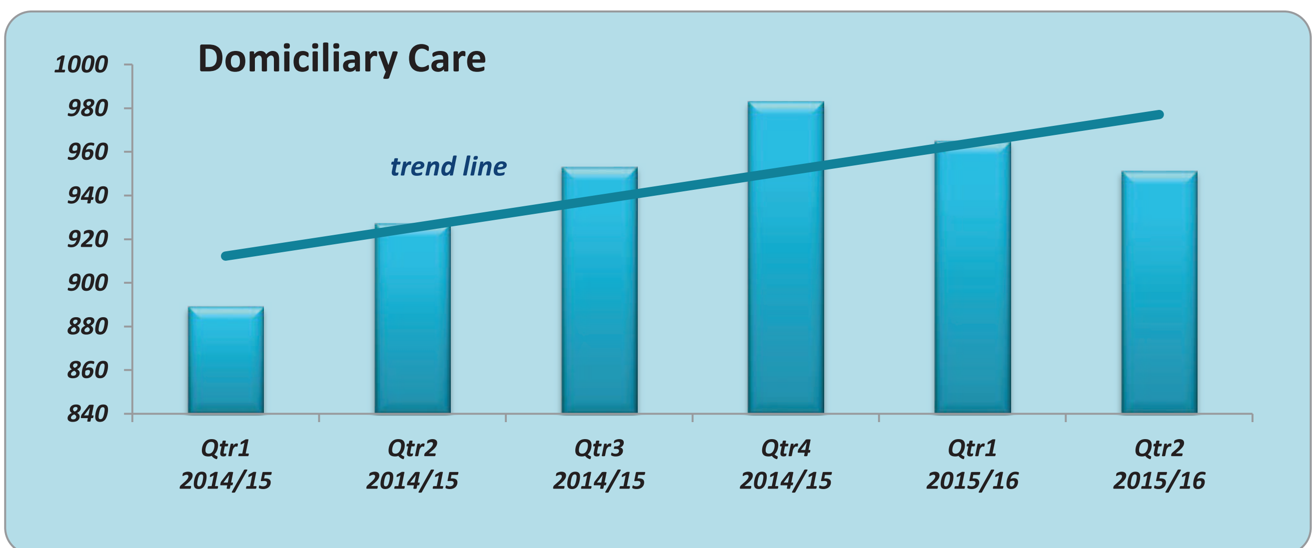


Local Performance Report

Quarterly Monitoring data - Services (quarterly snapshot)





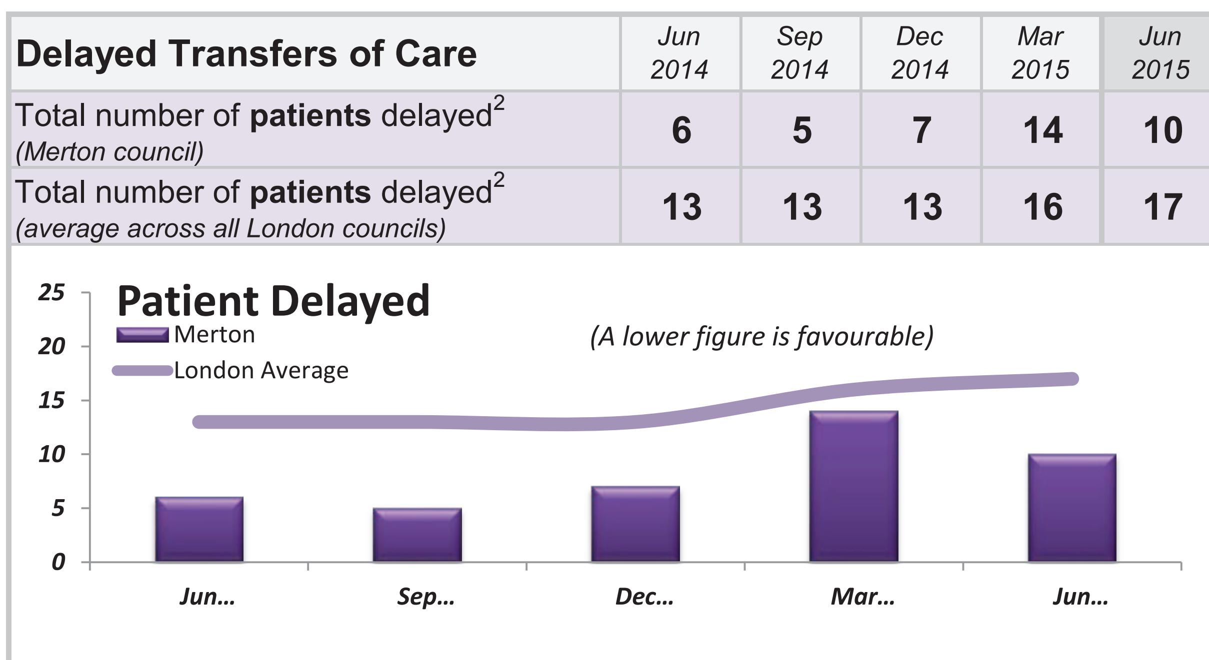


Local Performance Report

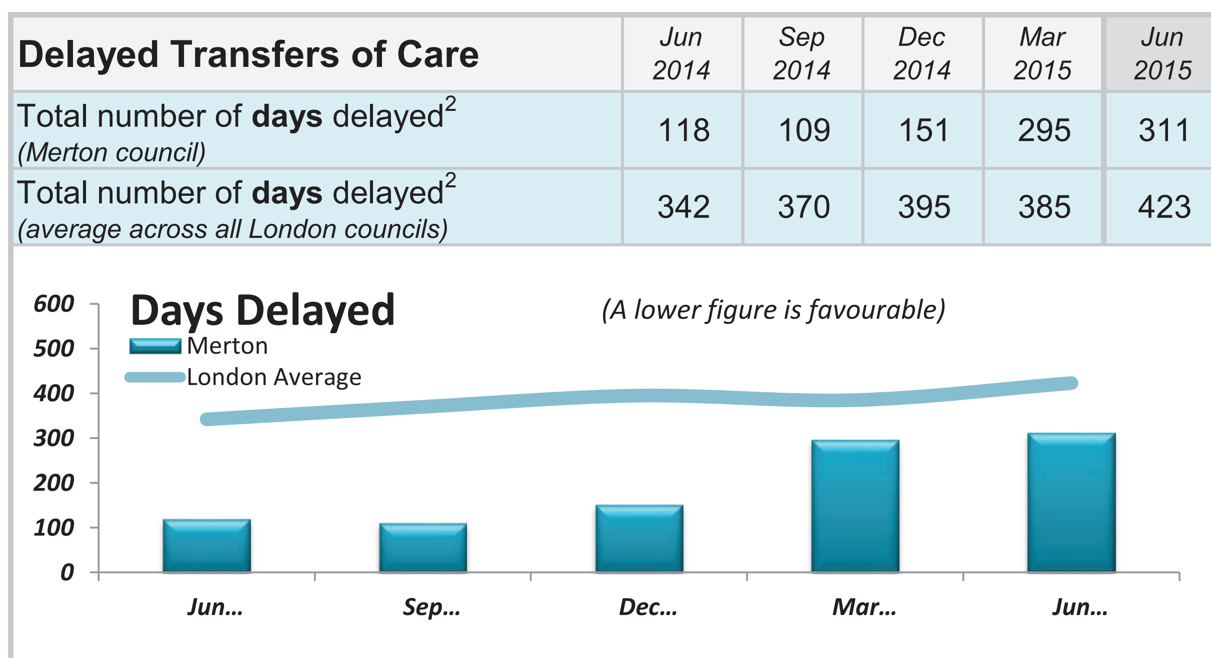
Quarterly Monitoring data

NOTE: The DTOC data for 2015 (quarter two) was not available at the time of producing this Local Account and but can be viewed via the NHS England website by using this link *www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/*

Delayed Transfers of Care	*Jun 2014*	*Sep 2014*	*Dec 2014*	*Mar 2015*	*Jun 2015*
Total number of **patients** delayed[2] *(Merton council)*	**6**	**5**	**7**	**14**	**10**
Total number of **patients** delayed[2] *(average across all London councils)*	**13**	**13**	**13**	**16**	**17**



Delayed Transfers of Care	*Jun 2014*	*Sep 2014*	*Dec 2014*	*Mar 2015*	*Jun 2015*
Total number of **days** delayed[2] *(Merton council)*	118	109	151	295	311
Total number of **days** delayed[2] *(average across all London councils)*	342	370	395	385	423

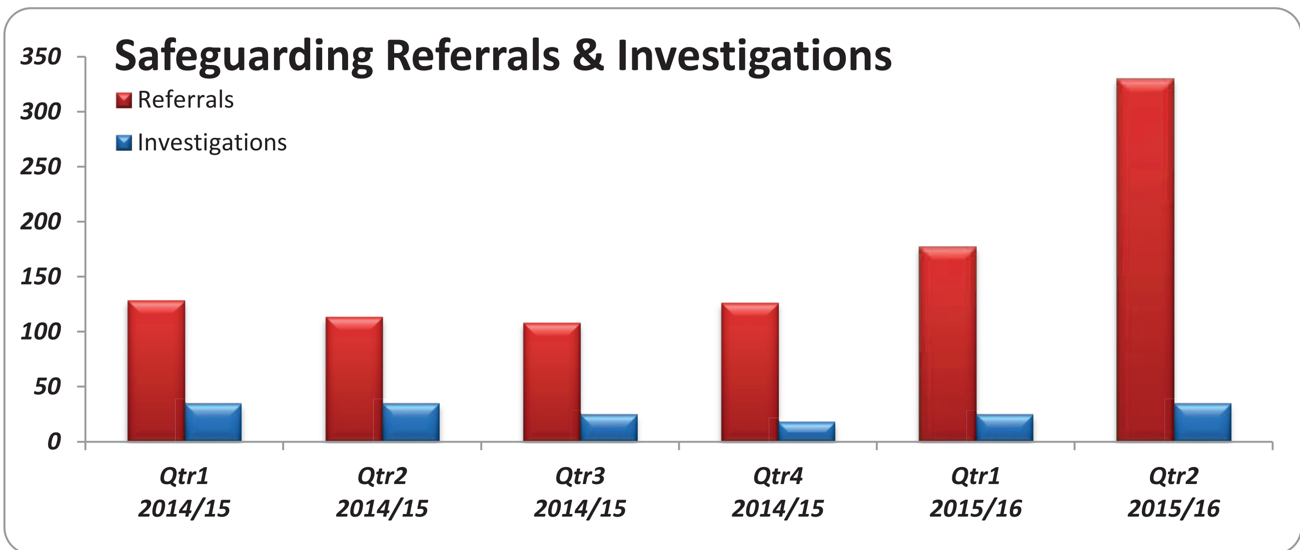


[2] *Data sourced from via the links titled 'Patient Snapshot Local Authority' and 'Total Delayed Days Local Authority' on the NHS England website via this link* *http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/*

Local Performance Report

Quarterly Monitoring data

Safeguarding Adults	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16
Number of safeguarding referrals received for each quarter	128	113	108	126	177	330
Number of safeguarding cases closed as an alert only for each quarter	76	49	56	60	113	140
Number of safeguarding cases closed as an investigation for each quarter	35	35	25	18	25	35
Number of safeguarding cases open at the end of the quarter	50	35	44	26	53	25



Customer and Carer satisfaction Surveys

Quality Assurance

655 Customer/Carer Satisfaction Surveys were received from customers following an assessment/ review from April 2013-March 2015 by the adult social work teams (283 surveys), MILES (Merton Independent Living & Engagement Team) – (163 surveys) and the Occupational Therapy Team following assessment and provision of equipment (209 surveys).

- The survey responses indicated a high percentage of customers found it easy to find information about the support provided by Merton Council with 52% having obtained this whilst in hospital or at their GP surgeries.

- A high percentage of customers advised that the service received from Merton Council had helped to improve the quality of their life, having increased by 3% from 92% to 95% over the last year.

- 96% of Occupational Therapy survey responses confirmed that the equipment /adaptation to their property has met their needs, with only 3% needing more help, 38% advising less help and 22% no longer needing any help from others.

- 96% of overall responses confirmed satisfaction with the contact and services that had been received, with 97% confirming that the care workers providing their service treated them with dignity and respect, and 94% confirming this had been provided on the day and time needed. Any comments advising concerns about providers being late etc., were followed up with the service provider and/or the contract monitoring officers.

- The Occupational Therapy Assessment Centre received 82 completed evaluation forms from customers who had visited their Assessment Centre which enables people to try out equipment. There were very high levels of satisfaction in the convenience of date and time (99%), and with the time given by the assessor to explain what was needed (100%) as well as confirmation that they were able to obtain equipment when offered a prescription when they had redeemed this at an accredited retailer for equipment and/or rails.

- The surveys also provide an opportunity for feedback and 80% of comments were complimentary on the OT surveys about the service or worker who had carried out their assessment and 44% on the adult surveys with the rest of the comments providing some general feedback.

Case file Audits - Quality Assurance

164 case file audits were completed by managers during the years 2013-15. The audits look at the customer journey covering assessment, safeguarding issues, the support being provided to customers and whether this was meeting the desired outcomes, as well as checking that the customer's electronic record was up-to-date.

- A high level of accuracy in the recording of data on the customer record was reported and confirmed that the data linked to performance monitoring and finance had been recorded accurately.
- The audits showed that where a customer was having difficulty dealing with finances a check had been made to ascertain who would be able to provide this i.e. help requested from the financial assessment team, or confirmation that assistance was available from a family member, Appointee etc.
- Audits confirmed that all carers were offered a joint or separate carers assessment of which 16% had declined the offer, and 95% had accepted information and advice relevant to their carer role, and that the opportunity to learn and develop had been discussed with them.
- All audits showed that customers' cultural, language, ethnicity and background had been considered when making plans for their care.
- The audits showed that the recording of the customer contact/case notes were up-to-date at time of audit and had improved from 95-100% over the 2 year period.
- 142 system audits were also carried out and showed that 100% of data recording on the social care database (customer electronic record) was up-to-date and accurate.
- The outcome of assessment was up-to-date on 95% of customer records. The recording of this is regularly monitored by the Performance Team providing regular reports to managers advising assessments/reviews where an outcome has not been recorded to ensure the completion of the information on the customer records.
- The audits showed an improvement from 63% to 72% of accuracy for the file location details recorded on Carefirst electronic record. The inaccuracy was mainly due to the move of manual client files when the divisional offices transferred to the Civic offices.

Let us know what you think about our

Adult Social Care Local Account:

We would welcome your views on the contents of this report to help us understand what you would like to see in future Local Accounts.

Please visit **http://www.merton.gov.uk/health-social-care/adult-social-care/asc-plans-performance/asc-performance.htm** before **31 March 2016** and complete the survey.

If you would prefer a paper copy to be sent to you please contact the performance team on:
020 8545 3093 or email:
communityperformanceteam@merton.gov.uk

Committee: Health and Wellbeing Board

Date: 24 November 2015

Wards: All

Subject: **Merton Clinical Commissioning Group (MCCG) Commissioning Intentions 2016/17**

Lead officer: **David Freeman Director of Commissioning & Planning, MCCG**

Recommendations:

A. For noting

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

Each year commissioners in the NHS are required to set out their priorities for the coming year and to describe how they will improve the health of the communities they serve. As some of these priorities may lead changes or developments that have an impact on existing contracts, it is national best practice to give providers six months' notice of any changes.

For changes to take effect from 1 April 2016, we must inform providers of our commissioning plans (or intentions) by the end of September 2015. It is possible for us to propose changes and developments at anytime thereafter but such changes must follow contractual rules in order to give providers adequate notice. Thus, to gain maximum benefit from contracts that begin on 1 April 2016, we must notify providers and partners of our plans no later than 1 October 2015.

This paper outlines Merton Clinical Commissioning Group's (the CCG's) plans and priorities for contracted services in 2016/17 and crucially our collaborative approach the co-design and development of services.

The commissioning intentions have been developed based on our work with patients, clinicians and LBM Public Health over the past year and are informed by evidence of effectiveness and best practice. Our plans are consistent with our 5-year strategy; the priorities set out in the Joint Health & Wellbeing Board Strategy for Merton (2015-18); and the South West London Commissioning Intentions.

2 DETAILS

The Commissioning Intentions are a critical part of the commissioning cycle. They provide an opportunity for the CCG to set out its plans and priorities for services whilst giving service providers the opportunity to engage in and prepare for change.

The document does not contain a complete list of all our initiatives, projects and service changes that are either already underway or are in the pipeline, but instead summarises the key priorities for the year ahead and which will need to be reflected in the commissioning of services for 2016/17.

It should also be noted that national planning guidance setting out detailed expectations of CCGs (and the NHS) is due to be published towards the end of 2015. This is a significant document for all health services and partner need to be aware that we will need to review our commissioning intentions in light of this guidance.
The Commissioning Intentions support our work on tackling the issues set out in the Joint Strategic Needs Assessment for Merton (published 2014), including the need to widen access to health and care services and reduce inequalities.

3 ALTERNATIVE OPTIONS

N/A

4 CONSULTATION UNDERTAKEN OR PROPOSED

As set out in Appendix B, the Commissioning Intentions have been developed based on a series of patient and clinical engagement activities.

5 TIMETABLE

The Commissioning Intentions we submitted to providers on 1 October in line with other CCGs across South West London. Any changes to services required by these plans will need to take effect from 1 April 2016, subject the NHS planning guidance which is due to be published in December 2015.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The Commissioning Intentions set out our plans for the future of services and thus how and where we spend our allocated resources. Our plans will need to be aligned to the Operational Planning guidance to be published by NHS England towards the end of 2015; the financial requirements and impacts will also worked through as part of our annual financial planning and contracting rounds.

7 LEGAL AND STATUTORY IMPLICATIONS

None of note

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Commissioning Intentions support our work on tackling the issues set out in the Joint Strategic Needs Assessment for Merton (published 2014), including the need to widen access to health and care services and reduce inequalities.

Furthermore, all new service developments or significant variations will be subject to an Equality Impact Assessment as required.

9 CRIME AND DISORDER IMPLICATIONS

N/A

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A

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

- Main Report – MCCG Commissioning Intentions 2016-17
- Appendix A – SWL Commissioning Intentions 2016-17
- Appendix B – Clinical & Patient Engagement overview

12 BACKGROUND PAPERS

12.1. None

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NHS
Merton
Clinical Commissioning Group

Merton CCG 2016/2017 Commissioning Intentions

David Freeman, Director of Commissioning & Planning

30 September 2015

Version 2.0

1. Introduction

The purpose of Commissioning Intentions

Each year commissioners in the NHS are required to set out their priorities for the coming year and to describe how they will improve the health of the communities they serve. As some of these priorities may lead to changes or developments that have an impact on existing contracts, it is national best practice to give providers six months' notice of any changes.

For changes to take effect from 1 April 2016, we must inform providers of our commissioning plans (or intentions) by the end of September 2015. It is possible for us to propose changes and developments at any time thereafter but such changes must follow contractual rules in order to give providers adequate notice. Thus, to gain maximum benefit from contracts that begin on 1 April 2016, we must notify providers and partners of our plans no later than 1 October 2015.

For the first time in 2015/16 we agreed two sets of commissioning intentions – one covering the collaborative work required across South West London (SWL) as part of the five year strategy for the sector and a further set, setting out what we need to do locally to meet our population's needs and to contribute to the SWL work. Both sets of commissioning plans are essential for helping provide a framework for all services delivered locally and regionally. This approach continues into 2016/17 and further details can be found in Section 3.

The national and local context

It is now widely recognised that the next few years represent a critical period of transformation in health and care services. Changes in how people live their lives and advances in health care knowledge and techniques mean people are living longer and that demand for care is rapidly rising. Nationally, unlike in previous generations, millions of people now have a long-term association with the NHS and each person relies on us to support them to live as well as possible with long term conditions. It is this changing need and rising demand which will create a £30bn funding gap in NHS resources by 2019 unless we seize the opportunity change the way we deliver care.

In 2015/16 the South West London Collaborative Commissioning partnership, of which Merton CCG is part, produced an *Issues Paper*[1] detailing what these challenges mean at a more local level. As a Clinical Commissioning Group we recognise the need to take steps to transform and secure sustainable services for our population. As will be seen below, our commissioning intentions have been developed with these ambitions firmly in mind.

This document

This document outlines Merton Clinical Commissioning Group's (the CCG's) plans and priorities for contracted services in 2016/17.

They have been developed based on our work with patients and clinicians over the past year and are informed by evidence of effectiveness and best practice. Our plans are consistent with our 5-year strategy; the priorities set out in the Joint

[1] The summary version of this paper can be found at: www.swlccgs.nhs.uk/wp-content/uploads/2015/06/SWL-issues-paper-summary-V5_WEB.pdf

Health & Wellbeing Board Strategy for Merton (2015-18); and the South West London Commissioning Intentions.

This document does not contain a complete list of all our initiatives, projects and service changes that are either already underway or are in the pipeline, but instead summarises the key priorities for the year ahead and which will need to be reflected in the commissioning of services for 2016/17.

Furthermore, national planning guidance setting out detailed expectations of CCGs is due to be published towards the end of 2015. This is a significant document for all health services and providers need to be aware that we will need to review our commissioning intentions in light of this guidance.

2. Aims and Ambitions

These commissioning intentions continue to articulate Merton CCG's vision for how health and care services will be delivered over the coming years. They capture how we are working across the health system to improve quality and drive efficiency. We will continue to do this by working together with all our partners and stakeholders in order to develop a health and care system that delivers sustainable services, value for money and meets our financial targets.

Whole Merton Vision

The challenges and demands on health and care services are now widely acknowledged. It is recognised that if we do not change and transform the way care is provided, including moving more services from hospitals into community settings and scaling up prevention, we will not sustainably be able to meet the needs of our population.

As a CCG we have long held the view that we must deliver more care out of hospital and closer to people's homes; over the last three years we have delivered and begun a number of initiatives to realise this ambition. We will continue this work in 2016/17 and we invite all providers to continue working with us on these plans.

Crucially we recognise that the scale of the challenges facing health and care services are such that we cannot expect to fulfil our responsibilities by working alone, or by looking at health needs in isolation from the wider issues that impact on well-being (such as housing, education, employment or healthy lifestyles).

That is why in 2015/16 we have been working on refreshing our vision for health and care in Merton. We want to better focus our efforts on more joined up thinking, planning and working across the borough. At the heart of our vision is the individual around whom a range of support and opportunities need to be organised; in this way we can develop sustainable services, ensuring people get the care they need in the right place, at the right time, and with the right outcome.

We are calling this holistic approach *Whole Merton* and although we are consulting with our partners and stakeholders before finalising the approach (expected to be no later than December 2015), the intentions set out below have been developed with this firmly in mind. Providers of our services therefore need to be aware that, building on our work to date, the aim of Whole Merton is to go further, quicker in delivering more care in out of hospital settings.

Merton CCG's Eight Priority Areas

Starting in 2014 we identified eight key priorities; these were developed based on the Joint Strategic Needs Assessment for Merton and have incorporated key national and regional priorities that have emerged over time.

Our eight priority areas are:

i. Older and Vulnerable Adults
ii. Mental Health
iii. Children and Maternity Services
iv. Keeping Healthy and Well
v. Early Detection and Management
vi. Urgent Care
vii. Medicines Optimisation
viii. Transforming Primary Care

These priorities remain critical in helping us organise and develop services to meet the needs of our population and as such, our commissioning intentions are set out against these areas. However, providers should be aware that the on-going work with stakeholders to finalise our Whole Merton approach may lead to adjustments in the way these eight priority areas are organised or articulated. This work will not impact on the commissioning intentions directly; these will become part of the new vision and strategic approach once finalised.

Our approach

In commissioning and developing services for our population it is essential that we work collaboratively and in partnership with our clinicians, patients, carers, the local authority, providers of NHS care and the public. This applies within our boundaries and across the region and where appropriate, nationally.

Our commissioning intentions are therefore predicated on joint working and co-design with service experts and users. In step with our organisational values, our approach throughout will also be based on being:

- ✓ Honest
- ✓ Organised and planned
- ✓ Patient focussed
- ✓ Inclusive and engaging
- ✓ Committed to high quality care and outcomes

3. Our main contracts

Acute, Mental Health and Community Services

Merton CCG is relatively unusual in not having a major acute hospital within the boundaries of our borough. People needing hospital treatment therefore travel mainly to hospitals provided by the following trusts (in order of greatest use):

- St George's University Hospital NHS Foundation Trust
- Epsom and St Helier University Hospital NHS Trust
- Kingston Hospital NHS Foundation Trust

As all the main hospital sites for these Trusts sit in other CCG areas (see figure 1), we are currently associate commissioners in all these contracts, requiring us to

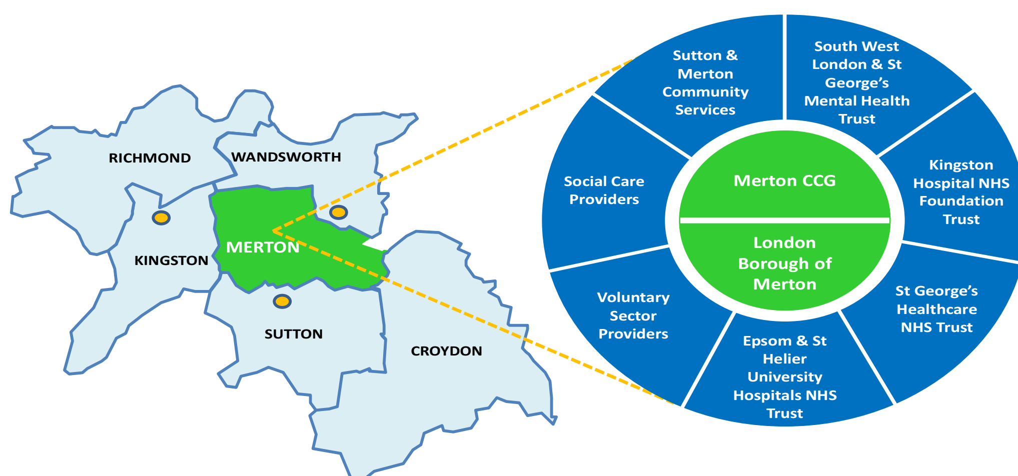
work in partnership with each lead CCG and provider to ensure the services provided are co-designed to meet the needs of our population.

Around 60% of our annual budget is spent on acute hospital services making this a key area for the planning and delivery of services. As such it is important that our commissioning intentions take account of those of the lead CCGs who act on our behalf and equally, it is essential that our requirements are reflected in the intentions prepared for the acute hospital trusts (see also *South West London Commissioning Intentions* below).

For mental health services, people will access services provided in the main by South West London and St George's Mental Health Trust; during 2015/16 the lead responsibility for this contract will transfer from Kingston CCG to ourselves as part of a wider review of mental provision across the sector.

Until 31st March 2016, we are the co-ordinating commissioner for the community services contracts with The Royal Marsden NHS Foundation Trust, who host Sutton and Merton Community Services (SMCS). Sutton CCG, the London Borough of Sutton and Merton CCG (also working on behalf of the London Borough of Merton) have concluded a process in 2015/16 to re-procure community services and thus, from 1 April 2016, each will have their own community services contracts. What this means for Merton is described further in section 5.

Figure 1: South West London locality map and the seven providers and five CCGs engaged with Merton



SWL collaborative approach and SWL Commissioning Intentions

The South West London Collaborative Commissioning is made up of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth CCGs. These six CCGs together with NHS England (who commission specialist and (currently) primary care services in south west London) are working in partnership under the umbrella name of *South West London Collaborative Commissioning* to implement a five year strategy for the local NHS in south west London.

The NHS faces a number of challenges in the years ahead and the CCGs are working together to deliver a long term plan to overcome these and to improve the quality of care in South West London (SWL).

To support this work, an overarching set of commissioning intentions has been prepared based on the strategic vision outlined in the Collaborative's Five Year Strategy (published in June 2014). The key areas of this strategy are:

- Urgent and Emergency Care

- Cancer
- Mental Health
- Maternity Care
- Children and Young People
- Integrated, Out of Hospital and Community Based Care
- Transforming Primary Care
- Planned Care

Merton CCG's eight priority areas align with the SWL key areas of focus and thus help ensure our work complements and contributes effectively to the wider SWL approach. The SWL Commissioning Intentions will be published by the 1 October 2015.

The Nelson Health Centre

On 1 April 2015, the Nelson Health Centre began providing key services in a new and proactive way. The modern facility has been developed to provide community based access to a range of outpatient appointments, diagnostics (including x-ray) and a range of mental health and community services. By the end of 2015/16 we expect the unit to be fully operational.

The outpatient and diagnostic services are especially important and innovative as they offer hospital-type services in the community for the first time. These services are delivered under contract by St George's University Hospitals NHS Foundation Trust and will continue to be a key part of our work to deliver more care outside of hospital settings. Our plans and requirements for these services in the future are included in these commissioning intentions.

Changes to Primary Care contract arrangements

Merton has twenty-four GP Practices across the borough. They range in size from large partnerships (our largest at The Nelson Health Centre has over 25,000 patients) to smaller surgeries, (our smallest has just over 3,500 patients).

In 2015/16 we are consulting with our membership proposals to take on delegated commissioning of GP primary care services from NHS England from 1 April 2016. This means rather than NHS England being responsible for GP services, Merton CCG will have a range of delegated powers to manage the contracts themselves.

If the proposals are approved by our membership, we will have the opportunity to more effectively co-design local services, integration and out of hospital care to be better aligned to our local priorities.

Other contracts

Merton CCG also holds contracts with a range of other hospitals, hospice, voluntary and independent sector providers.

4. Clinical and patient engagement

Merton CCG is committed to being a clinically led organisation and to working closely with patients, the public and other key stakeholders on the development and delivery of services.

The Commissioning Intentions set out in this document are heavily influenced by our engagement work over the last 12 months. We routinely work with clinical

leads and member GP practices to help guide us towards better ways of doing things. Equally, a number events and workshops have taken place with patients and stakeholders to gain a first-hand perspective on services and to help co-design and develop services that are effective and responsive to users.

In Appendix A we set out some of the clinical and patient engagement work we have undertaken which has supported the development of our Commissioning Intentions.

5. Our Commissioning Intentions

Below we set out our overarching plans for and requirements of services in 2016/17. These plans will be reviewed and further refined over the coming weeks in order to:

1. Take account of operational planning guidance to be published by NHS England by the end of 2015.
2. Provide a more detailed breakdown of the commissioning plans and subsequent activity requirements to help commissioners and providers plan for contract negotiations for 2016/17.
3. Take account of the outcomes of work to develop the Whole Merton vision and strategic approach, expected December 2015.

Our main strategic programmes for 2016/17

We will be working through four main strategic projects in 2016/17:

a. Community Services

New contracts will be signed for community services and a combined Musculoskeletal (MSK) and outpatient physiotherapy service, during October and November 2015. For both contracts, the approach has been to develop an increased focus on outcomes and we expect this to lead to significant transformation of services within Merton.

For community services, we expect new models of care to be developed from 1 April 2016 onwards, including embedding prevention and increased integration of care and pathways with other providers across the whole system including primary care, acute, mental health and social care. We anticipate the outcomes will include a reduction in avoidable non-elective admissions, improving outcomes for individual patients.

For musculoskeletal and outpatient physiotherapy services, we also expect new models of care to be developed from 1 April 2016 onwards, with increased integration of care and pathways with other providers across the whole system including primary care, acute, mental health and social care. Through this contract we will consolidate GP referrals into outpatient physiotherapy services into one provider, and introduce a single referral route for trauma and orthopaedic referrals into secondary care.

This means that we will decommission GP referrals to St George's Hospital for outpatient physiotherapy, along with non-urgent referrals for trauma and orthopaedics to all acute providers. We anticipate that clearer pathways, increased information and support for patients and more integrated services will result in reduced waiting times, reduced referrals to secondary care and reduced conversion rates to surgery, with better outcomes for patients.

b. Integration & Better Care Fund

Improved relationships, communication and integration between providers to deliver more holistic and person centred care is a key priority. Enablers for this way of working will include: development of a Multi-Agency Information Sharing Protocol to facilitate both provider and commissioner view of whole person service delivery; IT projects to facilitate information sharing to enable integrated service delivery and joined up commissioning between health and social care with the aim of giving users more personal control; and improved relationship (parity of esteem) between mental and physical health demonstrated by providers and during the commissioning process.

The Better Care Fund (BCF) remains a key driver for change across all of Merton's health, care and community partners and we will continue our commitment to this work.

In 2016/17, our BCF priority areas will continue to be: reducing emergency admissions; improving reablement; reducing length of stay; reducing permanent admissions to care homes; reducing delayed discharges of care and improving user and carer experience.

As can be seen through the commissioning workstreams set out below, these priority areas are an integral part of our plans for next year.

c. Better Health Closer to Home (BHCH)

Nelson Health Centre

The Nelson Health Centre is a key part of our transformation plans. 2015/16 has been about making the services and ways of working fully operational. In 2016/17 we will be looking for greater innovation and to extend the range and scope of services (sub-specialties) available at the centre.

We will work in partnership with providers, GPs and users of the services to explore opportunities and to further improve business as usual operations. The impact of this will be more services being delivered outside hospital settings and, through better access and earlier intervention, reductions in the number of patients needing more complex or specialist care. We aim to conclude this planning work with providers by the end of 2015.

East Merton Model of Care and Mitcham development

Developing services in East Merton is a top priority for the CCG. The health inequalities and challenges in the area require specific and targeted interventions. During the second half of 2015/16 we will be working collaboratively on the development of a new model of care that fully integrates health, social care, local authority and community based support to collectively tackle the health deprivation in East Merton. During 2016/17 we will work to confirm which services need to be commissioned and how they need to be delivered as part of the model.

Aligned to this work is the development of the new health facility which will act as a hub for the Model of Care. The new building, to be based in Mitcham, will need to effectively bring together the partners, providing facilities and space that will not only support, but enable this fully integrated way of working. It follows that we must agree our Model of Care before we finalise the design for the building; we are therefore working towards the building becoming operational towards the end of 2019.

As previously set out, our overarching aim is to provide more care out of hospital and in local settings. Whilst the development of the new building is critical, the development is still some years off and it is therefore important we work

continuously to address the health deprivation in East Merton. As a consequence we will explore the possibility of bringing some or all of the new model of care on stream during 2016/17.

d. Primary Care Transformation

New models for primary care – Federation and MCPs
NHS England's Five Year Forward View made an unequivocal commitment to ensuring the foundation of NHS care remains list-based primary care. However, it also recognises the pressures GPs are under and proposes a 'new deal' for General Practice: over the next five years the NHS is investing more in primary care, while stabilising core funding for general practice nationally over the next two years.

At the same time, new models of care are offered that will give GPs a greater role in the delivery of more services and which in turn are intended to support the long term sustainability of primary care.

In Merton we fully recognise these challenges and the pressures our GPs are under. We have committed to delivering the London-wide Transforming Primary Care strategy and in 2015/16, we are testing and developing our local strategy for the future of primary care.

We believe the future sustainability of local GP services rests in the development of a Merton GP Federation and ultimately in the creation of Multispecialty Community Provider(s) (MCPs).[2]

These models offer a focal point for a far wider range of care needed by registered patients which will bring benefits to the whole health and care system as well as securing the principles of registered lists.

In 2016/17 we will be looking to progress our plans for a GP Federation and in the longer term, MCPs. This will have an impact on prevention, early diagnosis and out of hospital services and in 2016/17 will be working closely with all our health and care partners to co-design the models of care that will emerge from this work.

Review of Primary Care Access for Routine and Urgent Care
By the end of 2015/16, we will have undertaken an integrated review of access to routine and urgent primary care services. This will include a review of GP out-of-hours services, the Wilson urgent care centre, NHS 111 and general practices.

The review will analyse a number of options for how services will change in 2016/17. This is likely to be achieved by increasing capacity during evenings and weekends and making more efficient use of Merton's local urgent care centre and community pharmacies. We will also aim to establish an urgent and emergency care network which will include our key partners and the integration of mental health crisis services.

In addition, we will be looking to exploit the latest technology to enable patients to go online or use their smartphone to access self-care and signposting information about common symptoms and available services.

GP Referral Support – Pathway Redesign
In 2016/17 we will, as part of our Outpatient Navigation programme, have fully implemented a software package (called DXS) in each GP Practice to support their referral decisions. It provides GPs with the current and relevant clinical material needed for given specialties, (for example, referral forms, care

[2] For more information on MCPs and other new models of care set out in the Five Year Forward View please see www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

pathways, local healthcare guidelines and patient leaflets). It also contains Merton's complete Directory of Services which provides GPs with visibility of all local services both within and outside of an acute setting.

Implementation of this system is expected to improve the patient experience and provide real-time granular level GP referral information. In turn this enables commissioners to review referral activity to inform commissioning decisions and redesign of care pathways. It will therefore be used to help deliver our aim of more care in the community and closer to (or within) patients' homes.

Our Contract Requirements in 2016/17

There will be two areas of contract management which will have a particular focus in 2016/17:

- Accuracy of counting and coding of hospital activity is vital for helping us manage and plan services and for ensuring they deliver within agreed budgets. In 2015/16 we have experienced some challenges with inaccurate data and reporting. Therefore in 2016/17 we will be looking to increase the regular review of the way providers use coding for activity to ensure that best value is in place within all pathways and service lines.
- Across the NHS there is greater recognition of the need to have robust arrangements in place for the contracting of mental health services. As part of this, we will be working with other CCGs in South West London to ensure the contracting mechanism for South West London and St George's Mental Health Trust are being delivered in the best way possible.

Procurements within 2016/17

We expect the following procurements to be carried out in 2016/17:

- East Merton Model of Care services.
- Completion of the NHS111/Urgent Care procurement – this is in collaboration with CCG partners across South West London.
- Routine and urgent care services (subject to recommendations following a review of these services).

Providers should be aware that we wish to work collaboratively to review all contracts and pathways on an on-going basis to ensure best value for money; this may lead to new or different services being required at any point during the year.

Commissioning Intentions 2016/17 by work stream

i. Older and Vulnerable Adults

Early Detection

- Redesign the memory assessment service to improve access and quality.
- Support the increased identification of those at risk of falling and further develop pathways for the prevention of falls.
- Develop partnership work to prevent excess winter deaths.

On-going Treatment & Management

- Deliver plans set out in the Carers Strategy (being developed in 15/16) to provide effective support for carers.
- Improve the dementia care pathway to ensure that people receive the right care and support at the right time.
- Develop more effective programmes for education and self-management.

Crisis Response

- Build on the progress of the last two years, to increase the accessibility and capacity of effective alternatives to acute care.
- Continue to develop pathways with London Ambulance Service to divert patients into local services where possible.
- Further develop pathways with 111, to divert patients into local services where safe and possible.
- Implement the urgent HARI pathway as an alternative to acute care.
- Work with acute trusts to develop frailty pathway and services which span across hospital and community settings, with the aim of reducing non-elective admissions and length of stay.

Recovery, Rehabilitation and Reablement

- Improve the use of rehabilitation and reablement services to help prevent admissions and facilitate discharge.
- Support the further integration of recovery services across health and social care to enable people to remain in their own homes.

Complex and End of Life Care

- Offer personal health budgets more widely for patients with complex needs.
- Implement the recommendations of the Continuing Healthcare Service review taking place in 2015/16.
- Improve quality and increase coordinated support to care homes, to improve patient care and reduce non-elective admissions.
- Improve care planning and care coordination in the community, with a greater proportion of people at high risk having a key worker.
- Ensure that people with complex needs and their carers are aware of the alternatives to 999 and 111, and have direct and easy access to the most appropriate support to meet their needs.
- Develop service delivery to enable more people to be supported in their preferred place of care and to improve the coordination of care in the last few days and hours of life.
- Maintain and improve the use of Electronic Palliative Care Co-ordination Systems (currently Coordinate My Care) and be responsive to the upcoming change of software and expanded use for patients with long-term conditions.
- When introduced, implement the pan-London standardised end of life care documentation.

ii. Mental Health

Prevention

- Ensure pathways are in place from IAPT to the new *LiveWell* provider.
- Promote mental health prevention, keeping-well messages, and services available in the voluntary and health and wellbeing sectors; this will help manage the number of people requiring acute health input.

Early Detection

- Increase staff awareness of mental health issues linked to physical health conditions, increasing referrals to Merton IAPT.

On-going Treatment & Management

- Implementation of plans from mental health stream in the Carers Strategy to provide effective support to carers.
- Pathway reviews to improve care and contingency planning across the whole system.
- Meet the new IAPT access and waiting time standards, ensuring that people

receive timely, effective treatment.

- Meet the new Early Intervention in Psychosis access and waiting time standards, ensuring that people with a first diagnosis receive timely, effective treatment.
- Further develop the model of community mental health services in Merton.

Crisis Response

- Commission more effective models for psychiatric liaison (children and adults) in acute hospital settings, in line with national guidance.
- Further develop services to respond more effectively to people experiencing mental health crisis, reducing the use of acute care and police custody suites, and ensuring a more effective and timely response from mental health services.

Recovery, Rehabilitation and Reablement

- Complete the replacement of mental health step down facilities, improving the mental health pathway and promoting recovery and independence following acute episodes of care.
- Embed new Tier 3 and Tier 4 alcohol services alongside the broader Public Health substance misuse services, following conclusion of the procurement process in 2015/16.

Complex and End of Life Care

- Offer personal health budgets more widely.
- Continue work to monitor and review people reported under Winterbourne View requirements, ensuring plans are in place for discharge from hospital registered services where appropriate.

iii. Children & Maternity Services

Prevention

- Increase capacity within the system to improve perinatal maternal health, increasing support for prevention during the pre-conception and perinatal period.
- Improve out of hospital mental health support for women and families in the postnatal period and first year of life.

Early Detection

- Improve access and waiting times for CAMH services through embedding the Single Point of Access; Key Performance Indicators will be developed for this service.

On-going Treatment & Management

- Improve the quality and increase the capacity of CAMH services, to improve patient outcomes and experience.
- Introduce the “You’re Welcome” standards across NHS providers in Merton.
- Development of the Carers Strategy to provide effective support to carers.
- Improved model of delivery to provide a flexible service to meet the needs of children, young people and their families.
- Development of asthma pathway (in partnership with the South West London (SWL) approach
- Consider options for increasing capacity to deliver holistic improvements in maternity services as set out in the South West London strategy

Crisis Response

- Work with partners including NHS England to develop services that can respond more appropriately to young people experiencing mental health crisis,

reducing the use of acute care and specialist mental health accommodation.

Recovery, Rehabilitation and Reablement

- Develop the community nursing model to improve consistency and quality of care.

Complex and End of Life Care

- Make progress in order to offer personal health budgets more widely.
- Development of a patient passport or resource for children with complex needs to improve care and patient experience (through the South West London Children and Young People's Complex Needs Network).
- Improved, more integrated care pathways for children with complex and multi disabilities.
- Development of the model of care across South West London for children who have been sexually assaulted.

iv. Keeping Healthy & Well

Prevention

- Support Public Health (part of the London Borough of Merton) with the Proactive GP pilot in East Merton, which includes developing proactive care standards through links with community health champions.
- Following evaluation of the pilots in 2016, full roll out will be considered. The aim will be to better manage people in the community and reduce elective and non-elective admissions.
- Support Public Health to implement a programme of frontline staff training to contribute towards the Every Contact Counts initiative across the borough, to ensure appropriate NHS staff are routinely offering brief advice and signposting on a range of healthy lifestyle topics.

Early Detection

- Extend learning and best practice gathered during the development of the East Merton Model of Care (see strategic programmes above) to other parts of the borough, with a view to developing/changing services to address early detection and admission prevention.

On-going Treatment & Management

- Work with Public Health on the procurement of a joint weight management pathway for Merton residents, as part of the Public Health commissioned *LiveWell* programme to start early in 2016/17.
- Work with Public Health on the delivery of a substance misuse pathway to be implemented in 2016/17 which will focus both on prevention and management and on bringing treatment services closer to home.

v. Early Detection & Management

Early Detection

- Promote access and uptake of NHS screening programmes.
- Review the current provision of diagnostics as part of patient pathways to improve flow.
- Improve access to first review after referral on from primary care services, in both community services (through the new community services contract), and in secondary care, including maximising utilisation of services at the Nelson Health Centre.

On-going Treatment & Management
- Embed self-management education and support into Long Term Condition care pathways by working with providers. (Expert Patient Programmes, pulmonary and cardiac rehabilitation, community specialist nursing, etc)
- Development of services available later into the evening and at weekends.

Recovery, Rehabilitation and Reablement
- Seek the development of Cancer Recovery packages, in line with national best practice to enable Primary Care to support people following cancer treatment.

vi. Urgent Care

Prevention
- 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.
- Improve access to out of hours care and support to reduce emergency attendances and admissions and to prevent crises in those with complex or long term care needs.

On-going Treatment & Management
- We will work with our providers to develop more ambulatory care pathways linked to our re-procured Urgent Care services.

Crisis Response
- Procurement of a new fully integrated 111/Urgent Care service will take place on a SWL wide basis during 2016/17.
- In tandem with this, we will review our Out of Hours services to support Primary Care and Community transformation to ensure patients can more readily access primary care services.

vii. Medicines Optimisation

Prevention
- Provide medicines optimisation input into public health and CCG schemes which include medicines to ensure relevant medicine choices are evidence based, are accessible and mechanisms of supply are legal and are in place.
- Ensure opportunities for medicines optimisation are considered as part of prevention pathways

Early Detection
- For schemes commissioned to provide early detection of long term conditions, we will ensure community pharmacy input is considered as part of pathways

On-going Treatment & Management
- Contribute to care pathway development to ensure that medicines are used in ways that are evidence based, cost effective and supports the delivery of quality care for patients
- Ensure that medicines are prescribed in the right care setting for patients and guidance in place for regular monitoring and review

Crisis Response
- Develop systems to ensure medicines management support is available for crisis management pathways in primary care.

Recovery, Rehabilitation and Reablement

- We will explore options for implementing a domiciliary Medicines-use Review service in community pharmacy to support recently discharged patients and housebound patients
- We will include the Care Home Pharmacist review in pathways relating to care in care homes

Complex and End of Life Care

- Review of the Palliative care service in community pharmacy to ensure adequate provision across the borough in line with service guidelines

viii. Transforming Primary Care

Transforming primary care is a programme being co-ordinated by NHS England (London Region). The key priorities set out below will be taken forward through the NHS Strategic Commissioning Framework for Primary Care and Merton CCG will be required to play its part in locally delivering transformation in this key health service provision.

Implementation plans in the Strategic Commissioning Framework include the areas of **Accessible**, **Co-ordinated** and **Proactive** care.

Prevention

- Embed prevention of smoking, screening for COPD and NHS health checks into GP practices to increase early detection of hypertension, COPD, hypercholesterolaemia, and those at risk of cardio-vascular disease.
- Jointly work with the local authority to incorporate healthy living and health promotion campaigns.
- Explore improved utilisation of voluntary sector services for direct and indirect health care pathways.

Early Detection

- Understand and reduce variation in prevalence rates across GP Practices.
- Use hard-to-reach-groups to case find patients and refer them to General Practice.
- Review ICT solutions within General Practice that can better support patient education and promote self-care.

On-going Treatment & Management

- Improve patient experience through pathway redesign, (please see section 5d. above).
- Take an active role in the PMS review (depending on the outcome of the role of MCCG in delegated commissioning).
- Roll out of Patient Online (designed to support GP practices to offer and promote online services to patients, including access to records, online appointment booking and online repeat prescriptions).
- Ensure 10 measures to improve GP recruitment and retention.
- Establish and promote the Merton Community Education Provider Network (CePN).

Crisis Response

- Implement routine and urgent care review, and establish urgent and emergency care network.
- Assess a range of ICT enablers which provide a platform for sharing patient records between out-of-hours, general practices, urgent care, London Ambulance Service, social care, community services and voluntary sector.
- Review primary care estate and consider options for delivery of access in hub(s). Application of the Primary Care Infrastructure Fund (an investment

programme to accelerate improvements in GP premises).

Recovery, Rehabilitation and Reablement

- At scale primary care provider development (eg GP federations and networks) to enable provision of services which support management of multiple conditions, recovery, rehabilitation and reablement.
- As a consequence, we will be looking to provide more care out of hospital and to reduce the number of patients who are currently required to be seen in hospital settings.
- Review scope for multi-speciality community provider model of care.

Complex and End of Life Care

- Review of Locally Commissioned Services (LCS).

6. Timeline and next steps

These Commissioning Intentions are a critical part of the commissioning cycle as they enable providers to make early preparations and give a focal point for engagement with clinical service leads and commissioners around service needs. Added to this, we will continue to work collaboratively with patients and other stakeholders to ensure changes achieve our ambitions for patient care.

The table below sets out the key steps in September 2015 to develop and finalise our Commissioning Intentions.

The commissioning intentions will be issued to all providers no later than 1 October 2015.

	Action	Timing
1.	**Submission for Governing Body meeting**	**15 Sept**
2.	**Update to MCCG Clinical Reference Group (CRG)**	**16 Sept**
3.	Circulation to MCCG CRG & membership for comment / input	21 Sept
4.	Circulation to for comment by Patient Experience Group reps	21 Sept
5.	*CSU deadline for collation (of drafts) across all SWL CCGs*	*21 Sept*
6.	**CCG Governing Bod (GB) meeting**	**24 Sept**
7.	Closing date for membership comment	29 Sept
8.	Closing date for Patient Experience Group comments	29 Sept
9.	**Collate all comments into final version & send (virtually) to GB for final agreement**	**1 Oct**
10.	Final submission to all providers	No later than 1 Oct

David Freeman
Director of Commissioning & Planning
30 September 2015

Appendix A & Appendix B

Please see separate attachments.

South West London Commissioning Intentions 2016/17

Draft v0.3

27/08/2015

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DRAFT

Document Control

Document version	Date of revision	Document status	Changes made
v0.1	07/08/2015	Draft	First draft
v0.2	19/08/2015	Draft	Amendments following feedback from DOC / CFO meeting
v0.3	27/08/2015	Draft	Amendments following feedback from CSU and workstream SROs

South West London Collaborative Commissioning

Commissioning intentions 2016/17

1. Introduction

South West London Collaborative Commissioning is made up of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups. The six south west London CCGs together with NHS England (who commission specialist and primary care services in south west London) are working together under the umbrella name of South West London Collaborative Commissioning to implement a five year strategy for the local NHS in south west London.

The NHS faces a number of challenges in the years ahead and the CCGs are working together to deliver a long term plan to overcome these challenges and to improve the quality of care in south west London (SWL). Although the South West London system is not currently failing operationally, it is under increasing strain with signs of deterioration in quality and performance. None of the four acute Trusts is currently meeting all of the London Quality Standards, and the financial situation is becoming more pressing.

The commissioning intentions described in this document are based on the strategic vision outlined in the CCGs' Five Year Strategy (published in June 2014), refreshed to reflect the progress of the Clinical Design Groups against delivering the strategy. The overarching vision set out in the strategy is that:

> “People in south west London can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable.“

This document provides the context for constructive engagement with providers and partners, with a view to achieving the shared goal of improved patient outcomes and service improvement within the fixed resources available, building on the work already undertaken in 2015/16.

We have aligned our commissioning intentions to the clinical areas of the five year strategy:

- Urgent and Emergency Care
- Cancer
- Mental Health
- Maternity Care
- Children and Young People
- Integrated, Out of Hospital and Community Based Care
- Transforming Primary Care
- Planned Care

As a programme we are mapping the interdependencies and commonalities between each of the workstreams to ensure that any overlap is managed, and also consider when Clinical Design Groups (CDGs) should work together to deliver against an area of work, for example Children and Young People working together with Mental Health to make improvements to child and adolescent mental health services.

The commissioning intentions around Transforming Primary Care have been excluded from this document as they are being taken forward through the NHS England (London Region) Strategic

Commissioning Framework for Primary Care, although we have included an update on work to date and the priorities for the next 12 months. Planned care has also been excluded from this document, as this workstream is being progressed in partnership with the Acute Provider Collaborative.

We have also included three of the key enablers for system change:

- IM&T and interoperability
- Workforce
- Estates

In 2015/16 a number of south west London Collaborative Commissioning CQUINs were agreed in provider contracts. Where a multi-year commitment was made, CCGs will work with providers to review 2015/16 progress and agree plans for 2016/17.

At the end of this document, we have included a summarised version of the commissioning intentions for ease of reference.

2. Urgent and Emergency Care

The Vision for Urgent and Emergency Care

In south west London, we believe that the urgent and emergency system service model needs to be transformed by the end of 2018/19 so people are:

- Supported to manage their conditions in their own homes through improved self-care and shared decision making
- Aware of the different parts of the urgent care system and when and where to access the care they need
- Provided with improved access to a well-connected and clearly defined urgent care system including Urgent Care Centres (UCCs), primary care, GP out of hours, 111, social care, London Ambulance Service, and other health professionals such as pharmacists and dentists
- Diagnosed, treated and able to go home on the same day through wide-scale implementation of Ambulatory Emergency Care Services as part of our work to improve the overall urgent and emergency care pathway
- Treated in high quality and safe emergency departments that meet the recommended levels of senior staffing and access to specialist equipment, as per London Quality Standards (LQS) with pathways designed to improve patient flow; meaning patients who access urgent or emergency care are not caught in bottlenecks as they move between services
- Supported with their health and social care needs in the community, enabled through Better Care Fund schemes, such as community nursing, reablement and rehabilitation services and investment in social workers
- Able to access emergency departments that deliver high quality specialist care; this will be achieved by implementing the recommendations in the Keogh report (to be published in 2014) and taking into account any national guidance on standards for urgent and emergency care services and consistency in the naming of such services
- Able to access alternative forms of high quality urgent care services which meet LQS and other nominated best practice standards, to alleviate pressure on hospital emergency departments and expedite diagnosis and treatment
- Given access to seven-day services in hospitals, complemented by seven-day services in primary care and the community to enable timely discharge
- Able to benefit from strengthened links between urgent and emergency care services and mental health psychiatric liaison services

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Progress in last 12 months

A peer review has been undertaken across all of the acute sites in south west London to benchmark services against the London Quality Standards (LQS) that relate to Urgent and Emergency Care and establish the change needed in order to achieve them.

South west London-wide principles for Ambulatory Emergency Care (AEC) have been developed and agreed to encourage providers to achieve a 20% - 30% conversion rate of non-elective admissions to AEC episodes.

An Urgent and Emergency Care Network has been established which is chaired by a clinician and includes representatives of all five of the System Resilience Groups and urgent and emergency care providers in south west London.

Priorities for next 12 months

Within the next 12 months the tariff for AEC will need to be set up, and this may also lead to the implementation of a shadow tariff to establish the impact. Providers will also need to start reporting AEC activity to feed in to this analysis.

The Urgent and Emergency Care Network will need to determine the Keogh designation of services according to the London-wide Facility Specification that is currently under development. They will also need to explore what needs to be put in place to enable NHS 111 becoming the 'front door' for urgent care, for example data sharing. A trajectory for organisations to work towards meeting the full range of LQS will be negotiated to facilitate achievement.

It will be crucial, over the next 12 months, for the Urgent and Emergency Care Network to work closely with the Clinical Design Groups working on Out of Hospital and Primary Care to strengthen the urgent care services provided by community and primary care organisations.

Commissioning intention 1: Acute providers to agree a trajectory to meet the full range of LQS

Commissioning intention 2: Ambulatory Emergency Care(AEC) – introduction of new tariff to support significant increases in AEC activity (trajectory of desired increase to be agreed with providers)

Commissioning intention 3: Providers to comply with UEC services designation process and contribute to the new SWL UEC Network

3. Cancer

The Vision for Cancer

South west London cancer services will focus on prevention of disease, early diagnosis and patient experience of treatment with an emphasis on patient choice and care provision in the community during active treatment, recovery, and, where necessary, the end of life phase. Every patient will be treated as an individual and offered the full support of the healthcare professionals involved.

Progress in last 12 months

Most of the service design elements of cancer care are driven at a national and pan-London level, and the Clinical design group has met to discuss the south west London implications of this work. National and pan-London groups are well represented on the CDG.

Priorities for next 12 months

During the next 12 months we will be working to articulate the vision in terms of the differences in the way services are provided and the way patients feel about the support and treatment they receive. This includes detailed work looking at two priority areas:

- Early diagnosis
- Living with and beyond cancer

The CCGs within south west London will work together to understand the current local provision, and the work already underway to deliver the national and pan-London service changes. We will develop a set of principles and standards across south west London that we will ensure are delivered through CCG design work, and ensure that common enablers such as IT, workforce and estates are addressed.

Commissioning intention 4: Delivery of the Transforming Cancer Services pan-London commissioning intentions

4. Mental Health

The Vision for Mental Health

The five year strategy outlines that people who need to use mental health services in south west London will, by the end of 2018/19, experience:

- Patients being at the forefront of developing and shaping the way services are delivered
- Action being taken to address inequalities in mental health services and improvements made, which reflect the needs of BME communities, the socially disadvantaged and vulnerable groups
- Better support being provided to Carers and more work being done to ensure their views are taken into consideration and they are treated like partners during the care planning process of a family member
- Community mental health services that reflect what patients want and are in a wider range of locations
- Services focus on evidence based recovery models with a greater emphasis placed on peer-led interventions
- Community pharmacist patients and GPs working collaboratively to improve the management of psychotropic medication
- Resources provided to facilitate the use of personalised budgets and a greater emphasis placed on delivering services that have successful recovery outcomes and patient experience.
- The effective management of physical health care, particularly with people that have severe and enduring mental illness to improve the disparity in mortality rates.
- Improved crisis services that are based on the recommendations set out in the crisis concordat

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- Developing services that take into account the recommendations set by the Schizophrenia Commission

Progress in last 12 months

There has been a great deal of work at CCG level on making improvements to mental health services, and the Clinical Design Group has met to discuss these developments in line with the five year strategy. The Clinical Design Group has identified the following priority areas:

- Parity of esteem
- Service development
- Commissioning and contracting mechanisms
- Establishing baseline capacity, capability and demand activity

Between September and December 2014, the CCGs led a consultation on reconfiguring the estate of SWLSG's trust. The sale of some of the Springfield site enables the redevelopment of all the state to meet required standards and regulations and provide the best environment for patient care and recovery. As part of the process there will be a reduction in the number of beds associated with an extension of community and name based care. The Joint HOSC approved the proposals and will reconvene this autumn to review the plans in the light of progress to date.

Priorities for next 12 months

During the next 12 months we will be working to articulate the vision in terms of the differences in the way services are provided and the way patients feel about the support and treatment they receive. We will work closely with service users and their carers to identify those areas that matter the most to them, and identify opportunities for improvement at a south west London and CCG basis. The interfaces with other workstreams within the programme will be explored, particularly around perinatal mental health, child and adolescent mental health services, wellbeing through and beyond cancer treatment and older people, and we will also work to strengthen the working relationships between key agencies including housing, policing, education and physical health.

The CCGs within south west London to understand the current local provision, and the work already underway improve mental health services. We will develop a set of principles and standards across south west London that we will ensure are delivered through CCG design work, and ensure that common enablers such as IT, workforce and estates are addressed.

Our work over the next 12 months will result in a number of commissioning intentions to be taken forward in 2017/18. We will also consider how mental health support will feature within emerging new models of care.

5. Maternity Care

The vision for Maternity Care set out in the five year strategy was that by the end of 2018/19 south west London maternity services would be designed in a way that:

- Prepares women and families for pregnancy and becoming parents through education and up to date evidence based information
- Provides care to women as individuals, with a focus on their needs and preferences
- Invests in improving continuity of care and carer, with a strong emphasis on midwifery led care for normal pregnancy and birth
- Provides care which meets the London quality standards for women with more complex needs, where obstetric care will be provided in our hospitals, with enhanced on site

presence of consultant obstetricians and dedicated obstetric anaesthetists, supported by a range of emergency services, should they be needed
- Values and takes on board feedback from women we look after and their families in order to drive continuous improvement in the quality of care

Progress in last 12 months

A peer review of the capacity and environment of care within the four SWL hospital based maternity units has been completed. This will inform consideration and planning of future commissioning and provision and models of maternity services for SW London.

The South West London Maternity Network (SWLMN) dashboard has been refined and there has been improvement to reported data against agreed definitions by all four units although this is yet to be completed. SWLCC has agreed to use the SWLMN dashboard as its local Clinical Commissioning Group (CCG) performance monitoring tool as it includes outcome measures as well as process measures. This will simplify the number of different dashboards that local maternity services have to populate at the present time and enable better comparison between dashboard parameters. The comparative dashboard metrics for publication on the network website have been agreed.

A specification for maternity services in SWL is in development that will support future commissioning and contract monitoring of maternity services. This should be ready for use by end of quarter two of 2015/16.

The SWLMN have worked collaboratively to agree protocols and pathways for:

- Screening, diagnosis and management of a morbidly adherent placenta (Placenta Accreta, Placenta Increta and Placenta Percreta). St George Hospital NHS Foundation Trust is now the agreed referral centre of expertise in managing this condition and the team there is supporting training of other colleagues across SWL to develop wider expertise.
- Management of Outpatient Induction of Labour using Propess®. This aims to reduce pressure on acute unit antenatal and labour beds.
- Implementing the Enhanced Recovery Programme following planned caesarean section. This will reduce average length of stay for post-operative women and babies on postnatal wards.

In addition through the maternity network:

- Facilitated two events hosted to enable networking with colleagues across SWL, to highlight current priorities for maternity services, and to share learning from the work that the Network is involved in.
- Piloted *"Whose Shoes"* across South West London to improve understanding of women and families experience of maternity services. This tool will be implemented across Greater London during 2015/16.
- Undertook a review of 2013 serious incidents that identified the three most common categories as unexpected admission to NICU, major postpartum haemorrhage and unexpected neonatal deaths. A specific task and finish group has been set up to explore this area in more detail to ensure consistency of reporting and shared learning opportunities.

Successful funding bids from Health Education South London for two projects:

- Implementation of Growth Assessment Protocol (GAP) training during 2015/16 as one method to screen for potential stillbirths.
- Scoping of roles and grading 0f maternity support workers. - completed. Outcome is being used through the four heads of midwifery to improve consistency of use of MSW staff.

Priorities for next 12 months

- Completion of any outstanding priorities from 14/15 such as full implementation of midwifery LQS and 114 hours of consultant obstetric presence on acute labour wards across all SWL providers. We will be working across commissioners to enforce standards not met including minimum midwifery ratio and consultant midwives.
- Completion and implementation of the specification for maternity services in SW London including agreement of the standard model specification for midwifery led units and their admission criteria.
- Develop and implement a standard maternity contract that includes the minimum and common set of data relating to maternity service user experience across the whole maternity pathway as well as the contents of the specification for maternity services commissioned by SWL.
- Analyse and improve understanding of what is a good outcome from a woman's perspective.
- Pilot new models where women receive care from no more than two midwives.
- Develop and pilot cross boundary models of care to improve continuity of care and carer foe women in SWL.
- Develop model of single point of entry to all SWL maternity services.
- Providing training in the use of GAP and GROW techniques to the SWL Trusts. Increase the proportion of women receiving midwifery led care and birth in none obstetric settings.
- Scoping the capacity and scope of community based midwifery services in SWL.
- Scoping of current and future estate requirements and availability relating to out of hospital maternity care.
- Review of the current case mix across maternity providers in SWL.
- Reviewing the Maternity Support Worker (MSW) workforce with a view to developing a consistent approach to job descriptions, training and competency assessments, and personal development.
- Achieve greater involvement of SWL mothers and fathers in the Network. Direct participation in work ensures we develop the type and quality of service that women and families need.
- Undertake SWL wide review of maternal medicine services including recommendations on future care of women with complex needs.
- Out of hospital pathways for maternity care agreed and signed off by providers, local authorities and commissioners.
- Further explore the opportunities for different commissioning models including outcome based commissioning and alternative contracting models.

Commissioning intention 5: Implementation of the new specification for maternity services

Commissioning intention 6: Meet the trajectory to achieve Obstetric Standards of the LQS by 2018/19 – provide a minimum of 130 hours of consultant obstetric presence on acute labour wards by 1st April 2017

Commissioning intention 7: Meet the trajectory to achieve Settings of Care Standards of the LQS by 2018/19 – provide for 20% of births to be Midwifery-led setting of care by 1st April 2017 and 3% of births to be home-births by 1st April 2017

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6. Children and Young People

The Vision for Children and Young People

The five year strategy set out the vision for the Children and Young People workstream, which is that by the end of 2018/19 we believe that children, young people and their families in south west London should experience care that:

- Promotes and educates them about good health and the prevention of ill health which in turn will encourage healthier life in adulthood
- Minimises disruption to children and their families and carers by providing enhanced community services
- Will ensure that we link our plans into schools and education services across south west London to gain as much momentum as possible to change outcomes
- Helps avoid unnecessary hospital admissions for children by providing better services in primary and community care
- Is of the highest quality and delivered by suitably qualified and experienced clinicians and nurses
- Promotes and supports a smooth transition for young people between child and adolescent mental health services (CAMHS) and adult mental health services
- Improves the identification of children with mental health problems and access to CAMHS , as well as ensuring more children and young people recover from episodes of mental illness
- Provides an anticipation of the same life expectancy and the same quality of life, regardless of where in south west London they come from

Progress in last 12 months

Over the last 12 months The South West London Children and Young People's Network has been established, as per the five year strategic plan, and this has been meeting for six months. The Network is a collaboration of commissioners, professionals and service users from the different sectors of care across south west London (health, public health, education, social care and third-sector). It consists of a Board and five workstreams based on patient segmentation.

The aim of the Network is to be an enabler for experts to share information from across south west London, and thus to help to co-design service improvement. It has strong links with the London Children's Strategic Clinical Network, with representation from them on the Network Board.

Progress of the Network over the last six months includes:

1. Work to incorporate the new London Strategic Clinical Network Asthma Standards for children and young people:
    - A training session for 49 primary healthcare professionals on Asthma management in children and young people
    - Design of a survey to be sent to all SWL GP practices to audit management against the Asthma standards, and to identify training needs – to be circulated in September 2015
    - Development of a register of all SWL children and young people Asthma leads
    - Discussion about the new Croydon Children's Asthma service and its initial outcomes
2. Discussion of the outcomes of the LQS peer review.
3. Collaboration with the Paediatric team in south east London, to utilise (with local modification) their acute guidelines for primary healthcare professionals.
4. Work to develop a SWL Children's Surgical Network as a pilot for London has commenced.
5. Acute site visits in July 2015 to map the local acute pathways for CYP; undertake qualitative interviews with service users; and collate data on patient segmentation. This work has been undertaken to identify if a group of patients could be potentially managed in an alternative non-hospital model of service delivery. This could form the basis for discussion of different

model options for non-hospital acute service delivery.

6. Discussions regarding the design of a pilot SWL hub for the care of children who have alleged sexual assault – a new group has formed to work to design some potential options for this service which will be presented to commissioners.

The Children and Young People Implementation Group, which is the delivery arm of the Network, agreed to focus on three key priorities during 15/16 which were:

- Asthma
- Mental Health
- Unscheduled care in OOH setting

Priorities for next 12 months

- Implementation of new system-wide Asthma standards across SWL, with supportive up-to-date, standardised training for primary healthcare professionals.
- Establishment of a pilot SWL children's surgical network.
- Exploration of non-hospital models of acute service delivery by the review of models currently in use both within SWL, London and further afield. (This work should be closely aligned to the parallel work of the London Children's SCN). Using the information gathered from the acute-site survey, the relevance of these models for SWL can be considered.
- Increased clarity of management of common childhood ailments and clarity of referral pathways for primary healthcare professionals – through the implementation of shared guidelines and the introduction of the MiDOS directory of children's surgical services.
- Development of potential models for a SWL pilot hub for the care of children who have alleged sexual assault.
- Development of stronger links with service-users to ensure that service-delivery is patient/family-focussed. This can be done through further inclusion within the Network, and through strengthening links with existing local service-user groups.

It is expected that providers are represented at both the Network and the Implementation Group by senior members of staff, Clinical Directors or above. This will be monitored on a quarterly basis.

Commissioning intention 8: All providers will meet the new London Asthma Standards for Children and Young People (2015)

Commissioning intention 9: By the end of 2016/17 every acute provider will meet the acute CAMHS LQS 21 – single access for children and adolescent health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old). Referrals to be available 24 hours a day, 7 days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call

Commissioning intention 10: Establish and pilot a Children's Surgical Network across SWL which meets the standards of the new London SCN Children's Surgical Guidelines (2015)

7. Integrated, Out of Hospital and Community Based Care

The Vision for Integrated, Out of Hospital and Community Based Care

In south west London we believe that by the end of 2018/19 people should experience Out of Hospital Care that:

- Helps people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates. This means that preventative advice is given by their care coordinator and they can access structured education.
- Helps to keep people with one or multiple long term conditions (LTCs) and complex needs stable. This means that patients at risk have been identified and assigned a care coordinator who intervenes when appropriate. Helps people who are at risk of losing their independence to access services which increase their ability to live independently and improve quality of life. When they are at risk, their GP or practice nurse is able to signpost them to a care navigator (or equivalent) to help to access services.
- Allows people to get timely and high quality access to care when they are ill, delivered in the community where appropriate. Improved signposting to services will ensure people know when and where to access the right services. Allows professionals to be familiar with the patient's circumstances, to support their preferences, and to provide continuity where agreed, while including them in making choices about their care through a care which is reviewed each time there is contact with their care coordinator.
- Supports people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home. People will know how they will be looked after when they leave hospital and their care coordinator or primary care team will contact them when they are discharged.
- People who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence. This means they receive appropriate reablement therapy whether at home or in the community, professionals will provide regular care until they are independent again. Where they suffer from mental health issues, a mental health support worker will assess their needs and plan further mental health care for them. They will also be actively connected up with voluntary sector services where these can help them to become more independent and enjoy life.
- Supports and provides education to both family and carers to ensure their health and well-being needs are met, and includes support to maintain finances and staying in work, where relevant.
- Helps people requiring end of their life care to be supported to receive their care and to die in their preferred place. People who are identified as being at the end of their lives are registered on Coordinate My Care which will hold information about their preference of care and place of death and prevent unnecessary admissions to hospital.

Progress in last 12 months

It is recognised that there is a need for consistent outcomes across SWL, irrespective of how services are commissioned and with which providers. During 2014/15 an Out-of-Hospital Framework has been developed setting out overarching Principles for community based integrated care, in line with national and local strategic direction.

The objectives of this framework are:

- To define aligned outcome focused Principles for Adult Community Services.
- Improving, sustainability, quality, equality and access for out of hospital care, especially for older adults with more complex needs.
- To enable commissioners to use the document locally as a guide to meet the needs of their

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local population.
- To address the financial case for change and the workforce gap.

Priorities for next 12 months

Crisis response has been identified as the next immediate priority. The CCGs are collectively exploring options for improving existing provision in time for Winter 2015/16, consistent with the Principles. These plans will be developed to run with full year effect in 2016/17.

Analysis of the impact of existing and new schemes and sharing of best practice will continue, in order to improve effectiveness and best use of resources. Services are asked to provide data on activity and outcomes.

Commissioning intention 11: Apply the agreed Integrated, Out of Hospital and Community Based care Principles Framework for adult community services across the system

Commissioning intention 12: The Crisis Response initiative, due for implementation in Winter 2015/16, will be developed and run with full year effect for 2016/17

8. Transforming Primary Care

The Vision for Transforming Primary Care

Patients make use of primary care services in a number of settings, including general practice, community services, mental health services, primary care based urgent care services and wider care delivered in the community such as dental, ophthalmic and community pharmacy services. In SWL we are working to achieve a service model for primary care that supports operating in an integrated manner, to deliver 24/7 care to those who need it. The coordination and alignment of primary care with out of hospital services is pivotal to supporting the delivery of quality driven urgent and emergency care.

The success of the five year strategy for primary care services will be on the basis of the development of federations /practice networks that deliver the London wide Strategic Commissioning Framework incorporating the 17 primary care specifications across:

- Accessible care i.e. providing a personalised, responsive, timely and accessible service.
- Coordinated care i.e. providing patient-centred coordinated care for patients with long term conditions or complex needs and GP patient continuity.
- Proactive care i.e. supporting and improving the health and wellbeing of the population, self-care, health literacy and keeping people healthy.

In turn, this will be enabled by:

- Technology-enabled services that support interoperability with different parts of the health and social care system.
- Planning and development of an appropriately skilled and well developed primary care workforce.
- Delivery of primary care from 'fit for purpose' estates/premises with regard to safety, quality, and suitability.

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Joint commissioning enables the improved model of primary care and this is being delivered by a SWL Joint Committee which came into operation as of April 2015 (the opportunity to move to delegated commissioning as of April 2016 is currently being considered). Prior to this, responsibility for primary care commissioning rested with NHSE.

Progress in last 12 months

- GP federations and networks are now in place across SW London; some are more established than others but there has been progress across all six CCGs in the last 12 months in their scale and set up. Work is progressing to implement the primary care specifications especially around access, with all CCGs supporting extended access to varying degrees.
- The SWL Primary Care Capital and Estates Forum has been set up and met and its role and remit will be to consider appropriate investment and support to ensure strategic development of primary care.
- In addition, the SWL Primary Care IM&T Forum is in place and due to report in September 2015 on commissioning objectives and levers that can be used to support providers in implementing record sharing systems and processes that meet the aims of SWL primary care transformation.
- The Emerging Leaders programme is up and running and supporting leadership development re: transforming primary care, integration and out of hospital care in South West London. For example primary care provider clinical leaders (involved in leading local practice networks or federations) are being supported to network, share knowledge and skills and develop greater insights and understanding around models of care and integration to support transformation.

Priorities for next 12 months

The priorities for the next 12 months to be taken forward through the work of the Joint Committee and the working groups that have been established to support it include commissioning intentions associated with:

- Implementation plan for the Strategic Commissioning Framework primary care specifications of Accessible, Coordinated and Proactive care.
- Application of the Primary Care Infrastructure Fund (investment programme to accelerate improvements in GP premises and infrastructure such as Information Technology).
- At scale primary care provider development (e.g. GP federations and networks).
- Roll out of Patient Online (designed to support GP practices to offer and promote online services to patients, including access to records, online appointment booking and online repeat prescriptions).

The remit of the Joint Committee also includes:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts).
- newly designed enhanced services
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF).

Commissioning intentions focussing on delivery against these areas will be developed in preparation for 2017/18.

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9. IM&T and interoperability

The Vision for IM&T and Interoperability

The following vision and mission statements have been discussed and approved by the SW London IM&T Strategy Board:

Vision: Integrated health and social care excellence enabled through technology, information, intelligence and insight.

Mission: Enabling high quality, timely and efficient health and care across settings through integrated, shared clinical records and, where required, care plans, appropriately accessible to the individual and at the point of care.

Key points encapsulated by these statements include:

- Improving the quality of health and social care services
- Ensuring timely provision of information
- Enabling a channel shift to the individual to promote self-care through greater access to their clinical information
- Maximising value for money and minimising costs through improving the efficiency of healthcare services
- Recognition that healthcare services are provided across different care settings
- Integrating information from disparate systems
- Sharing information appropriately, and therefore securely, across care settings
- Sharing information requires collaboration
- Clinical records and care plans are required within and across care settings
- The patient has a right for appropriate and secure access to their clinical information
- Appropriate access (i.e. adhering to information governance and data protection requirements) to patient information is required at the point of care, wherever that may be

It is crucial that transformation plans are informed by robust data from providers around their activity and patient flows. Commissioners expect Trusts to ensure contractual information requirements are met in full with particular regard to data accuracy and completeness.

Progress in last 12 months

In the last 12 months, SWLCC has:

- Mapped the IM&T requirements of the five year strategic plan and undertaken a baselining evaluation of existing clinical information systems in SWL through interviews with all provider organisations, local authorities and CCGs. This highlighted significant gaps in data sharing across SWL and recommended that the health economy in SWL collaborate to overcome these.
- Established buy-in from all providers, CCGs and local authorities to co-design a joint SWL IM&T Strategy via a Strategy Board with delegated responsibility for producing the strategy, and Primary Care and Provider Fora contributing to its development. These groups have highlighted the need to focus on clinical interoperability as a priority in year one.
- Engaged with existing suppliers of integration solutions in SWL to better understand their offerings and the potential for connecting clinical systems together using existing integration engines.
- It is anticipated that business case development and any required procurement will be

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completed by the end of 2015/16, with an intention to rapidly implement data sharing according to two priority use cases in collaboration with providers.
- The strategy will also highlight specific 'ways of working' in support of the implementation of the strategy. These are reflected in the commissioning intentions below.

Priorities for next 12 months

Over the next 12 months, SWL CCGs aim to refresh the governance of the existing SWL IM&T groups to enable them to take on an ongoing implementation role. Pending the completion of the strategy and the options within it, it is intended that CCGs will contribute to further resourcing a SWL-wide programme office for IM&T to support this implementation alongside existing CCG, provider and local authority teams.

Implementation will consist of:

- Establishing or augmenting ways of working that support the delivery of the strategy
- Continuing the contracting, and deployment or extension of any software solutions required to deliver the strategy

Commissioning intention 13: Providers to reach Level 4 of the NHS e-Referral Service Maturity Model by the end of 2016/17. This will be supported by CCG activities to promote ERS utilisation in primary care

Commissioning intention 14: The co-development and introduction of a shared information governance model between health and care providers in SWL, to support sharing of clinical information between organisational boundaries in support of direct patient care

Commissioning intention 15: Providers to work with commissioners to agree incentives to make progressive improvement in the timeliness, accuracy and completeness of data in patient records in support of specific use cases agreed within the SWL IM&T Strategy

10. Workforce

The workforce workstream is taking the models of care from our clinical design groups and mapping the workforce implications of implementation across south west London. It will work closely with Health Education South London (HESL) to understand the workforce constraints and enablers in implementation of the five year forward view and are engaged with the ten point plan to implement the new deal for building the General Practice Workforce. This work builds on a mapping exercise completed by the SWL commissioning Collaborative and supported by HESL in 2014 which identified significant gaps and the SWL Commissioning Collaborative transforming out of hospital care plans for shifting care into the community.

Priorities for next 12 months

The priority will be to work closely with other workstreams across the programme to ensure that the workforce impact of planned change is understood, articulated and addressed. To facilitate this, we will map the workforce initiatives planned or underway across a range of organisations including HESL, the trusts working together in the acute and community provider collaborations, emerging GP federations and cross reference these with the developing commissioning intentions of the six CCGs.

11. Estates

The Vision for Capital and Estates is to deliver a SWL local estate strategy that aligns to local CCG commissioning intentions to extract maximum value from NHS resources and reduce waste.
Source: Capital and estate forum terms of reference

Progress in last 12 months

Mapping of estates costs at SWL acute trusts to 2025 to determine:

- Maintenance backlog for each trust
- Cost of improvements necessary to reach 21st century standards
- Revenue implications of capital costs

Priorities for next 12 months

Aims:

- Development of the SWL local estate strategy
- Rationalise estate in south west London
- Maximise use of facilities
- Deliver value for money
- Enhance patients' experiences

These aims support those set out in the Five Year Forward View.

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South West London Collaborative Commissioning – Commissioning Intentions 2016/17 Summary	
Work stream	**Commissioning Intentions**
Urgent and Emergency Care	1. Commissioning intention 1: Acute providers to meet the full range of LQS by the end of 2016/17 (sanctions to be considered) 2. Commissioning intention 2: Ambulatory Emergency Care(AEC) – introduction of new tariff to support significant increases in AEC activity (trajectory of desired increase to be agreed with providers) 3. Commissioning intention 3: Providers to comply with UEC services designation process and contribute to the new SWL UEC Network
Cancer	4. Delivery of the Transforming Cancer Services pan-London commissioning intentions
Maternity Care	5. Implementation of the new specification for maternity services 6. Meet the trajectory to achieve Obstetric Standards of the LQS by 2018/19 – provide a minimum of 130 hours of consultant obstetric presence on acute labour wards by 1st April 2017 7. Meet the trajectory to achieve Settings of Care Standards of the LQS by 2018/19 – provide for 20% of births to be Midwifery-led setting of care by 1st April 2017 and 3% of births to be home-births by 1st April 2017
Children and Young People	8. All providers will meet the new London Asthma Standards for Children and Young People (2015) 9. By the end of 2016/17 every acute provider will meet the acute CAMHS LQS 21 – single access for children and adolescent health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old). Referrals to be available 24 hours a day, 7 days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call 10. Establish and pilot a Children's Surgical Network across SWL which meets the standards of the new London SCN Children's Surgical Guidelines (2015)
Integrated, Out of Hospital and Community Based Care	11. Apply the agreed Integrated, Out of Hospital and Community Based Care Principles Framework for adult community services across the system 12. The Crisis Response initiative, due for implementation in winter 2015/16, will be developed and run with full year effect for 2016/17
IM&T and interoperability	13. Providers to reach Level 4 of the NHS e-Referral Service Maturity Model by the end of 2016/17. This will be supported by CCG activities to promote ERS utilisation in primary care 14. The co-development and introduction of a shared information governance model between health and care providers in SWL, to support sharing of clinical information between organisational boundaries in support of direct patient care 15. Providers to work with commissioners to agree incentives to make progressive improvement in the timeliness, accuracy and completeness of data in patient records in support of specific use cases agreed within the SWL IM&T Strategy

DRAFT

Appendix B

Merton CCG Commissioning Intentions 2016/17

The table below sets out some of the Clinical and Patient Engagement activity that has taken place over the last 12 months. This work has played a vital role in helping us shape and define our Commissioning Intentions for 2016/17.

Clinical Engagement	Patient Engagement
Services for Adults	

• Extensive engagement with clinicians took place as part of the community services procurement. This helped to develop plans for innovative community-based models of care.
 	
• End of Life Care Engagement Events for professionals took place in order to inform the Strategy for 2014-19.
 	
• Clinical engagement took place in order to inform the development of the Dementia Health Needs Assessment (led by Public Health).
 	
• Integration: Information sharing with GPs and clinical leads (both face to face and through regular bulletins) to facilitate joined up care between multiple providers (this applies to all delivery areas)
	• Integration: Patient and user "lived experiences" in order to shape pathways for joined up Health and Social Care (also covered Mental Health and Urgent Care)
	
	• Extensive engagement with patients and the public took place as part of the community services procurement. This helped to develop plans for innovative community-based models of care.
	
	• End of Life Care Engagement Events the public took place in order to inform the Strategy for 2014-19.
	
	• Engagement with people with dementia and their carers took place in order to inform the development of the Dementia Health Needs Assessment (led by Public Health).
	
	• Towards the end of 2014 a public event 'Joining Up Health and Social Care' took place. The following key themes were explored:
	  ○ Crisis
	  ○ End of Life Care
	  ○ Dementia
	  ○ Carers
	  ○ Discharge from Hospital

Clinical Engagement	Patient Engagement
	○ Keeping Well at Home • The insights gained help to shape plans in these areas. • Patient engagement has informed plans relating to falls prevention and a patient representative is a member of the Falls Task and Finish Group (led by Public Health).
Mental Health	
• Engagement of Clinical Director for Mental Health in all aspects of service development. • Engagement of Clinical Director for 111 and OOH in IAPT procurement • Engagement of the CCG's Clinical Reference Group through discussions around approaches to mental health care. • Engagement of mental health clinicians as part of all service developments including Merton Mental Health Review, Accommodation Review and Norfolk Lodge.	• Extensive engagement took place with patients and carers in 2014 as part of the Merton Mental Health Needs Assessment and Review. The 2016/17 commissioning intentions are in line with the recommendations of the review in terms of improving crisis response and improving community services. • Extensive engagement took place as part of the London Borough of Merton-led Mental Health Accommodation Review in early 2015. • Various forms of engagement (including events, outreaching to user groups and inclusion of patient reps) as part of the procurement and mobilisation of the new IAPT service. • Engagement on plans to develop an alternative service to Norfolk Lodge, including a specific event, inviting comments on the service specification, and patient, carer and vol sector reps on the working group.
Children's and Maternity Services	
• Clinical engagement is secured throughout all areas of development and improvement through attendance at: ○ CAMH partnership Board ○ Multi Agency Provider Board for complex needs ○ SWL network board meetings and work streams.	• There is on-going engagement with children, young people and families on service development; we have also made use of the. CAMH Participation Officer to inform our planning. • Introducing the "You're Welcome" standards across NHS

Clinical Engagement	Patient Engagement
• The development of community nursing will require the process being co-deigned with clinicians.	providers in Merton, which requires providers to actively engage with children, young people and families. This provides valuable insights into how services are functioning. • SWL maternity network: patient representatives sit on the Board • SWL children's network: patient representation on the board and in work streams • Improving continuing care nursing: consultation and co-design on the new model of care with children, young people and families. • Improved pathways for children with complex and multi disabilities: engagement with patient representation and gaining feedback through an extensive range of forums and groups.
Long Term Conditions	
• There is a local GP on each of the Early Detection and Management Task Groups drawing up the plans for the delivery of services. Plans are then shared more widely with other local GPs before being finalised. • Extensive engagement with clinicians took place as part of the community MSK service procurement. This helped to develop the plans for a community-based rapid assessment and treatment service.	• The Cancer Health Needs Assessment, used to inform plans for Cancer screening services and survivorship programmes, included engagement with patients and the public. • Engagement with people with diabetes is taking place to inform the commissioning requirements for diabetes patient education.
Medicines and services in the community	
• Engagement with Clinicians is crucial for all medicines management commissioning intentions as the clinicians are the prescribers. Engagement routinely takes place via ○ Direct engagement with GP locality leads	• Community pharmacy services work on plans to engage with patients, carers and the public to ensure they are meeting the needs of all patient groups and do not introduce inequality. The feedback gained helps inform plans for improvement and

Clinical Engagement	Patient Engagement
○ Discussion and GP practice locality meetings ○ Discussion and debate at practice nurse forums ○ Working with pathway development GP champions ○ Inclusion of clinicians (both primary and secondary care) on the Medicines Management Committee, SWL Medicines Commissioning Group and all relevant working groups supporting their work.	enhancement. • Information sharing and feedback gathered at the Mitcham Carnival particularly around medicines use and waste.
Transforming Primary Care	
• Merton's Transforming Primary Care Board includes; clinical chair, locality leads. There are also a number of GP clinical engagement forums which the CCG has established to ensure primary care is engaged and owns primary care developments, (for example, PMS Review). These include; locality GP forums, CCG wide GP forum and CRG. • Through the review of routine and urgent care, there is a project workstream specifically on Clinical Modelling which will ensure Clinical Directors input to the options analysis. • GP Referral Support (Outpatient Navigation) has robust clinical engagement in terms of the process steps of designing the pathway and also in terms of clinical sign off. This is supported by pathway champions, lead Clinical Directors, Locality meetings and CRG oversight. • Health Help Now (website and smartphone app) development includes a range of stakeholders, including; community pharmacy, 111, out-of-hours, mental health and Merton CCG clinical leads for integration and access.	• The primary care support team triangulate information from a range of patient sources, including; Healthwatch, patient survey, NHS Choices, and its patient reference group and expert patient programme. • Through the review of routine and urgent care, there is a project workstream specifically on patient and public engagement. Local residents will have the chance to give us their views about these services and how they would like to access them in the future. • Health Help Now (website and smartphone app) development includes a range of patient consultation events, including; Merton's PRG, young advisors via MVSC, health champions via MVSC, feedback from other groups accessed by MVS, teenagers (from Local Council groups), young families (from Local Counil groups), and older people via MVSC. The project has also launched an extensive online survey and has a member of Merton's Patient Expert Programme on the delivery steering group.

Committee: Health and Wellbeing Board

Date: 24 November 2015

Wards: All

Subject: Community Services Procurement

Lead officer: Adam Doyle, Chief Officer

Lead member:

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

The evaluation and moderation of the community services bids was completed in August and the final procurement report was approved at the project board, LBM Cabinet, Finance Committee and CCG Governing Body during September. The bidders were notified of the outcome on 25 September and the contract award standstill period of ten calendar days ended at midnight on 5 October. The decision of the CCG and LBM to award a contract to Central London Community Health NHS Trust for Lot 1, and the decision of the CCG to award a contract to Connect Physical Health Limited for Lot 2, was announced publicly on 6 October.

The procurement phase is now complete and the mobilisation period for the new contracts will begin. A PID for the mobilisation phase has been developed and includes the proposed governance arrangements, which were agreed in principle by the procurement project board at its final meeting on 9 September. The board has been reconstituted as the Mobilisation Steering Group including membership from LB Merton and will sign off the PID virtually prior to its first formal meeting in November. The group will report to the proposed CCG Clinical Services Transformation Board.

A project team is in place including part-time senior project management support from the Senior Commissioning Manager for Integration and Older People. The CSU is providing support on finalising the contract.

Initial meetings with both providers were held in October and covered contract clarifications and the timetable for contract signature, mobilisation and communication plans, and governance arrangements. The intention is to be in a position to sign off final versions of the mobilisation and communication plans at the first meeting of the Mobilisation Steering Group in mid November. Heads of terms agreements have been signed, with the aim to achieve formal contract signature ideally before Christmas.

The project is currently on schedule to meet all agreed major milestones.

4 ALTERNATIVE OPTIONS

4.1. None

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. Patient engagement throughout the process resulted in the outcomes, objectives, specifications, procurement documentation and evaluation being shaped by the views and experiences of patients and the public. Engagement included dedicated events, outreach discussions with a number of voluntary and community groups, and patient representation on working groups and the evaluation panel.

6 TIMETABLE

6.1. The new contracts are currently being mobilised with a start date of 1 April 2016.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The financial impact of the procumbent has been modelled and both commissioning organisations are confident that new service will enable improved patient outcomes.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The CCG and Local Authority have procured 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 mobilisation.

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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Committee: Health and Wellbeing Board

Date: 24 November 2015

Wards: All

Subject: Transforming Care

Lead officer: David Freeman, Director of Commissioning and Planning, Merton CCG

Contact officer: David Freeman

Recommendations:

A. That the Health and Wellbeing Board notes the report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report meets the recent requirement of NHS England for progress with Transforming Care in Merton to be reported to the Health and Wellbeing Board. This initial report provides a brief background and summary of the current position. The Board is asked to note that a fuller report including future actions will be provided at the next meeting.

2. BACKGROUND

Transforming Care is the NHS England programme designed to improve services for those people with learning disabilities who also have mental health needs and/or challenging behaviour, following the Winterbourne View Review and the government response in 2012.

NHS England has recently set a series of Transforming Care standards for Clinical Commissioning Groups, one of which includes the requirement to report regularly on progress to the local Health and Wellbeing Board. This report sets out the arrangements and progress for those patients currently being reported under the Transforming Care requirements. A further paper at the next meeting of the Board will consider the wider requirements of the programme and what plans the local authority and CCG need to put in place to meet these.

3 DETAILS

Merton currently has three patients with learning disabilities or autistic spectrum disorders who are detained or placed in hospital settings, and so are reported nationally according to the Transforming Care requirements. All three patients are currently detained under Sec 3 or Sec 37 of the Mental Health Act 1983, for the purposes of treatment. None of the patients has been detained indefinitely and all are receiving active treatment.

London Borough of Merton leads on the case management of two of the patients, both of whom are allocated within the local authority's learning disability team. Merton CCG leads on the case management of the third patient who is allocated within the Merton Mental Health Recovery and Support Teams based at The Wilson Hospital.

Patient A is currently placed in a specialist learning disability locked rehabilitation service in Essex. Admitted July 2014. (Lead: LB Merton)

Patient B is currently placed in a specialist inpatient treatment service in East London. Admitted May 2015. (Lead: LB Merton)

Patient C is currently placed in a specialist ASD locked rehabilitation service in Essex. Admitted August 2012. (Lead: Merton CCG)

In December 2014, NHSE commenced arranging Care and Treatment Reviews (CTRs) which the patient's home CCG is required to chair. These are full multi-disciplinary reviews which also include the patient's family and the views of an expert by experience. The CTRs were held for patient A on 9 December 2014, patient B on 8 September 2015 and patient C on 6 January 2015.

All patients are regularly reviewed. Alternative options for accommodation are actively being sought for patients A and B in anticipation of them being ready for discharge over the next six months. Neither patient is currently ready for discharge. Patient C is still appropriately placed in hospital at this time.

Patient B is currently accommodated in a placement that is subject to CQC action. Following a recent CQC inspection, all further admissions have been suspended to this hospital until immediate improvements have been implemented. Despite this patient B seems to be flourishing in this placement . A safeguarding alert was also raised in the past month, this has been investigated and closed. The CCG Safeguarding Manager is aware of the alert. An extra meeting was convened to review the case with the CCG safeguarding manager. A CPA has been scheduled for the 20th November 2015.

4 ALTERNATIVE OPTIONS

None at this time.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. Not applicable.

6 TIMETABLE

6.1. NHS England and the Department of Health expect all patients with learning disabilities who no longer require hospital treatment to be discharged to alternative accommodation as quickly as possible. There are national annual trajectories.

6.2. The CCG and local authority will continue to be guided by clinical decision making in relation to each of these cases.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. None at this time.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. This area is governed by mental health statute, regulations and guidance.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. Transforming Care is designed to improve services for people who may have complex needs and whose human rights must be respected in how their care needs are met.

10 CRIME AND DISORDER IMPLICATIONS

10.1. None at this time.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. Risk management will form a key part of the case management role within each organisation.

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

13 BACKGROUND PAPERS

13.1. None.

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Committee: Health and Wellbeing Board

Date: 24 November 2015

Wards: All

Subject: JSNA Summary 2015

Lead officer: Kay Eilbert, Director of Public Health

Lead member: Caroline Cooper-Marbiah

Contact officer: Amy Potter, Consultant in Public Health

Recommendations:

A. To agree the annual Merton Joint Strategic Needs Assessment (JSNA) Summary document 2015

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents a summary of the Joint Strategic Needs Assessment 2015, setting out key health headlines, changes and trends under each of the life course themes. Also highlighted are key insights gained from work in Merton during the previous year that tell us about the health and wellbeing of our local population, and areas for sustained focus across Health and Wellbeing partners in the next year.

2 BACKGROUND

2.1. The Joint Strategic Needs Assessment (JSNA) analyses the current and future health needs of Merton's population to inform commissioning of health, well-being and social care services locally.

2.2. Merton's JSNA is structured on a life course model, looking at the health and wellbeing of our residents during pregnancy, early years, from children and young people, through to adults and older people. It covers lifestyle risk factors, physical and mental health, as well as the demographic make up of our residents and the wider environment within which our residents live, using the following themes:

- Merton the people
- Merton the place
- Health and wellbeing in Merton
    - Headlines (life expectancy, inequalities)
    - Pregnancy and maternal health
    - Children and young people
    - Lifestyle risk factors (diet, activity, smoking, alcohol, substance misuse)
    - Adults – physical and sexual health
    - Adults – mental health
    - Older adults

2.3. The analysis contained in the JSNA underpins the refreshed Health and Wellbeing Strategy 2015-2018, launched in June 2015.

3 DETAILS

3.1. Since January 2015, the Merton JSNA content is available online, fully searchable and more user friendly for commissioners and decision-makers across the council and partners. This enables the JSNA to be updated as and when new data or analysis is available, such as new Health Needs Assessments (HNAs). Summary findings can quickly be added to the online JSNA web pages, with links to the full reports, so that the intelligence is readily available to support commissioning decisions.

3.2. A JSNA Summary such as the one appended to this report will be prepared on an annual basis, summarising under each of the life course themes:

- key health headlines, changes and trends
- key insights gained from work in Merton during the previous year that tells us something new about our local population and how best to improve health and wellbeing, extend healthy life and address inequalities in the most effective way.
- key areas of focus for the next 12 months across Health and Wellbeing Board partners – these will be developed jointly with the CCG, CSF, the voluntary sector and other partners.

3.3. The JSNA Summary Document 2015 is appended to this report, and will be made available as a PDF to download through the online JSNA website.

3.4. A slide set of the data included in the JSNA Summary 2015 has also been produced, for use with partners, which will be presented at the HWBB meeting.

3.5 Next steps

The approach to the JSNA process will be reviewed early in 2016 together with partners to ensure it is both fit for purpose and meeting the needs of Merton. In future the JSNA could focus on a core data set supported by range of in-depth health needs assessments, ward health profiles and a range of easily accessible fact sheets. Full proposals will be developed with partners and reported as required to the Health and Wellbeing Board.

4 ALTERNATIVE OPTIONS

4.1. It is a statutory duty of Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment of their local area.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. None for the purpose of this report. Consultations routinely undertaken as part of developing Health Needs Assessments and service recommissioning, all of which inform the JSNA.

6 TIMETABLE

6.1. None for the purpose of this report. JSNA online pages are updated when new data is available. The JSNA Summary document to be updated annually in autumn each year.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. It is a statutory duty of Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment of their local area which informs the joint Health and Wellbeing Strategy and commissioners.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. None for the purpose of this report

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. The JSNA sets out data split by health inequalities where possible, to inform equitable commissioning.

10 CRIME AND DISORDER IMPLICATIONS

10.1. None for the purpose of this report

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. None for the purpose of this report

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

- JSNA Summary document 2015

13 BACKGROUND PAPERS

13.1. None

14 CONTACT OFFICERS

Amy Potter Amy.potter@merton.gov.uk

Dr Kay Eilbert Kay.eilbert@merton.gov.uk

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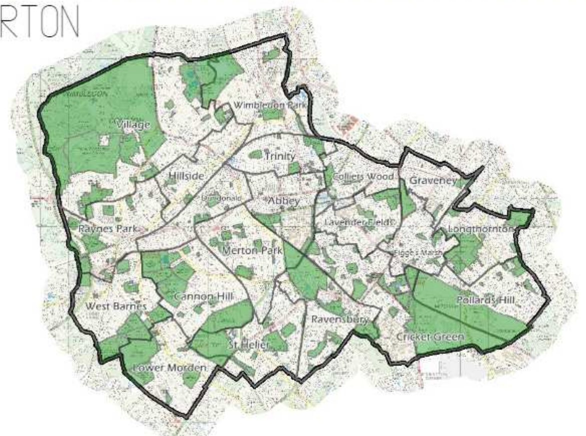
2015

JSNA Summary Document

ABOUT MERTON



London Borough of Merton

November 2015

London Borough of Merton
Joint Strategic Needs Assessment

Summary Document 2015

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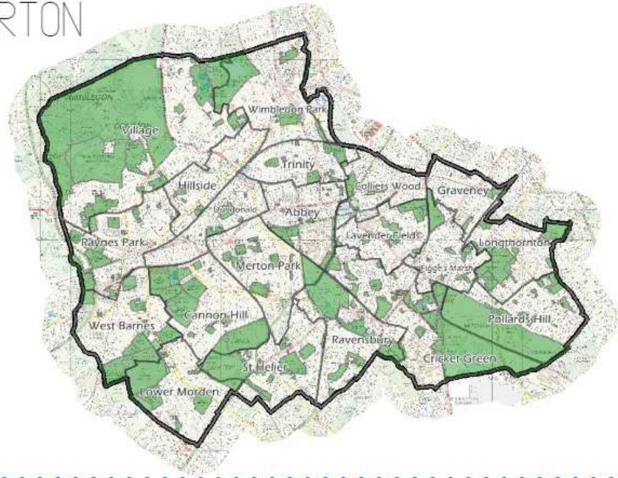
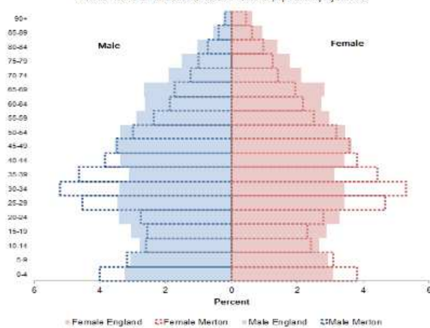
Borough Health Profile

ABOUT MERTON





Compared to England, Merton has a higher proportion of children (aged 0-9) and a higher working age population (aged 25-44).

POPULATION

205,100

residents in 2014

1 IN 3

residents are of **BAME** background

35% of Merton's residents are of BAME background, which is lower than London (49%), but higher than England (14%).

LIFE EXPECTANCY AT BIRTH

The male life expectancy at birth is 80.4 years, which is higher than the England average of 78.9 years.

The female life expectancy at birth in Merton is 84.2 years, which is higher than the England average of 82.8 years.

CRIME RATE

5 offences per 1000 population

lower than London (7.2 per 1,000 population).

Highest number of offences

1. **Anti Social Behaviour**
2. **Violence Against the Person**

DEPRIVATION

Index of Multiple Deprivation 2010

Merton is in Quintile 4, among the least deprived places in the country. However, this masks pockets of deprivation within the borough.

Children and Older People Deprivation

21% children (0-15) live in income deprived households.

17% older people (60+) live in pension credit households.

Overcrowding

16% of households are overcrowded (lower than 21.7% in London).

CHILDREN & YOUNG PEOPLE

School Readiness

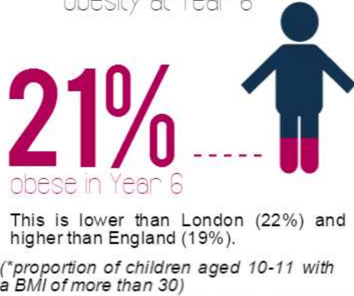
65% This is higher than London (64%) and England (63.5%).

(proportion of children achieving a good level of development at age 5)

CYP Admission for Injury

Merton has a rate of **884 PER 100,000** children and young people (0-17 years) admitted to hospital because of unintentional and deliberate injuries. This is lower than London (918) and England (1,181).

Obesity at Year 6

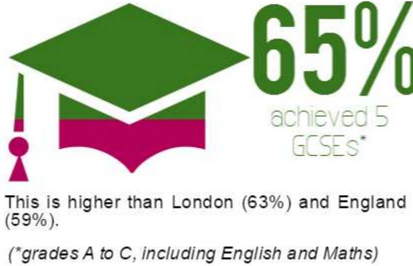


21% obese in Year 6

This is lower than London (22%) and higher than England (19%).

(*proportion of children aged 10-11 with a BMI of more than 30)

GCSE Achievement



65% achieved 5 GCSEs*

This is higher than London (63%) and England (59%).

(*grades A to C, including English and Maths)

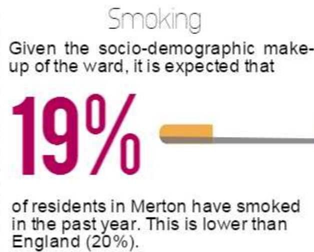
ADULTS

Healthy Eating

40% of over 16s consume 5 or more portions of fruits and vegetables every day. This is higher than London (36.4%).

Smoking

Given the socio-demographic make-up of the ward, it is expected that



19% of residents in Merton have smoked in the past year. This is lower than England (20%).

Obesity

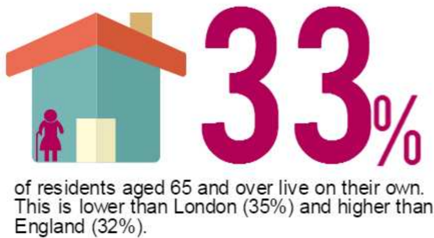
19% obese adults

This is lower than London (21%) and England (24%).

(*estimated proportion of over 16s with a BMI of more than 30)

OLDER PEOPLE

Living Alone



33% of residents aged 65 and over live on their own. This is lower than London (35%) and higher than England (32%).

Long-term Limiting Disability

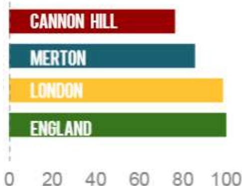
51% LIMITED

49% NOT LIMITED

49% of residents aged 65 and over reported that their day-to-day activities were not limited. This is higher than London (47%) and England (47%).

POOR HEALTH & PREMATURE DEATHS

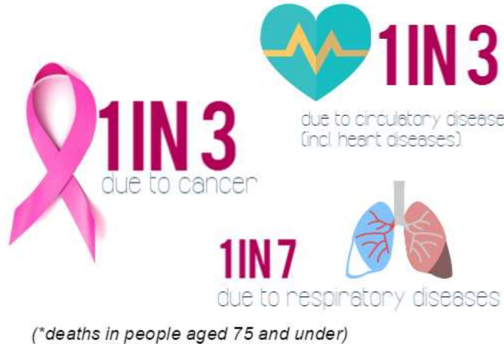
Hospital Stay for Alcohol-Related Harm



The borough has a SAR* of 85.6 for hospital admissions for alcohol attributable conditions. This is lower than London (98.5) and England (100.0).

(*Standardised Admission Ratio)

Main Causes of Premature Deaths*



1 IN 3 due to circulatory disease (incl. heart diseases)

1 IN 3 due to cancer

1 IN 7 due to respiratory diseases

(*deaths in people aged 75 and under)

MORE INFORMATION

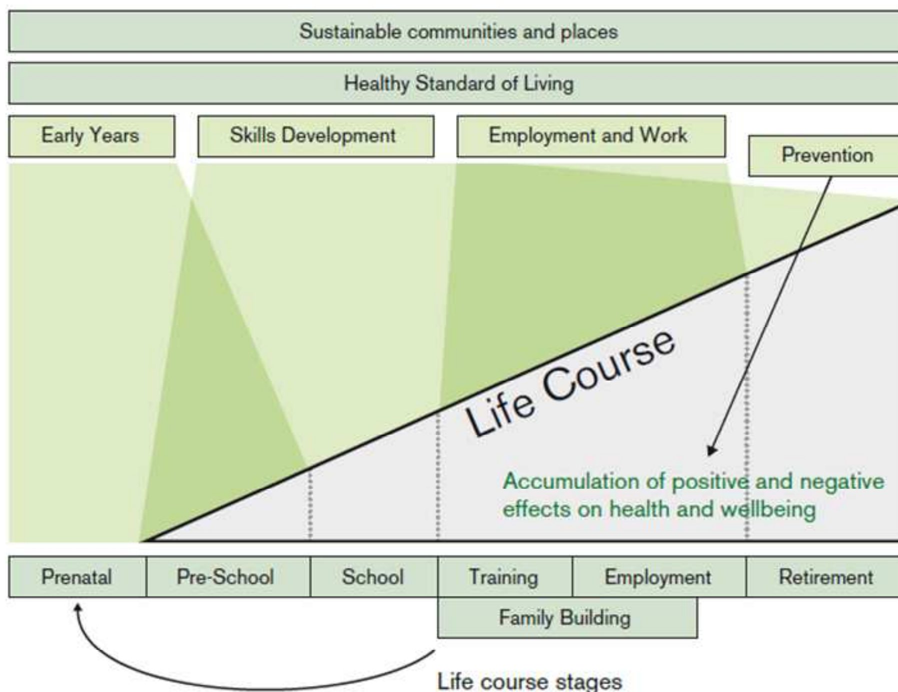
public.health@merton.gov.uk

www.merton.gov.uk/health-social-care/publichealth/jsna.htm

1. Merton's approach to the JSNA

The Joint Strategic Needs Assessment (JSNA) analyses the current and future health needs of Merton's population to inform commissioning of health, well-being and social care services locally. Merton's JSNA is structured on a life course model, looking at the health and wellbeing of our residents during pregnancy, early years, from children and young people, through to adults and older people. It covers lifestyle risk factors, physical and mental health, as well as the demographic make up of our residents and the wider environment within which our residents live. The analysis contained in the JSNA underpins the refreshed Health and Wellbeing Strategy 2015-2018, launched in June 2015.

Figure 1: Areas of action across the life course (Marmot Review 2010: Fair Society, Healthy Lives)



Since January 2015, the Merton JSNA content is available online, fully searchable and more user friendly for commissioners and decision-makers across the council and partners. This enables the JSNA to be updated as and when new data or analysis is available, such as new Health Needs Assessments (HNAs). Summary findings can quickly be added to the online JSNA web pages, with links to the full reports, so that the intelligence is readily available to support commissioning decisions.

A JSNA Summary will be prepared on an annual basis, summarising **key health headlines, changes and trends** under each of the life course themes. Each section will also highlight **key insights** gained from work in Merton during the previous year that tells us something new about our local population and how best to improve health and wellbeing, extend healthy life and address inequalities in the most effective way. This new research and evidence is summarised here, but available in full in the online JSNA. **Key areas of focus** for the next year are summarised, but again, more detail and previous recommendations are found online.

To complement the online JSNA and this summary document, Public Health has developed Ward Health Profiles for each of Merton's 20 wards, providing an overview of key health and related factors. Each profile

looks at the ward's demographic make-up, life-expectancy at birth, deprivation, crime, health indicators for children, adults and older people, as well as main causes of mortality.

2. Merton: the people and the place

Merton the people

- Merton has a increasingly young population
- The number of children (0-19 years) is forecast to increase by 2,200 (4.4%) between 2014 and 2020.
- The number of people aged over 65 is also forecast to increase by over 2,100 people (9.2%).
- As a whole, Merton is less deprived than the average for both London and England. However, three wards are more deprived than the average for London: Cricket Green, Figge's Marsh and Pollards Hill.
- Health outcomes are generally better than those in London and in line with or above the rest of England. However, there are inequalities between East and West, and within population groups.

The influences on health – social determinants of health – are the conditions in which people are born, grow, live, work and age. These conditions combine to create health and ill health and are dependent on a nurturing environment in childhood, the quality of education, employment and economic wellbeing, and the built and natural environment.

Summary of demographics

Merton's 2014 population projection is 203,200 people living in nearly 80,400 occupied households. Population density is higher in the east wards of the borough compared to the west wards.[1] Just over half the borough is female (50.6%) and the borough has a similar age profile to London as a whole.[1] Greater London Authority (GLA) population data (2014) shows Merton's current BAME population is 76,188. Black, Asian and Minority Ethnic (BAME) groups make up 35.1% of the population, lower than London (40.2%).[1,2] Based on GLA trend-based projections, Merton's population will increase by 13,245 people between 2014 and 2020.[1] The age profile is projected to change, with the most notable growth in those under 16 and over 50, and a decline in the proportion of people aged 25-35 years old. [1] Merton's ethnic composition is also forecast to change, with the BAME proportion increasing from 37% to 40%. [1]

Deprivation

The Indices of Multiple Deprivation (IMD) set out the relative position of local areas in terms of deprivation. Updated indices of deprivation were released in September 2015.[3] The IMD reflects the multidimensional nature of deprivation, with an overall score that is weighted most heavily on the domains of income (22.5%) and employment (22.5%), but also includes other domains (not just financial). East Merton and West Merton are less deprived than the average for both London and England. However, three wards are more deprived than the average for London: *Cricket Green*, *Figge's Marsh* and *Pollards Hill*. One ward, *Ravensbury*, is less deprived than the average for London, but more deprived than the average for England.

Health headlines: Inequalities

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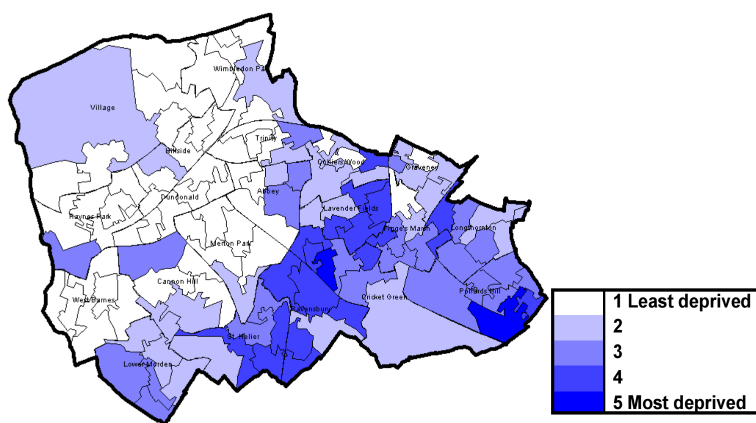
[1] GLA Population Projections 2013 Round.
[2] ONS 2011 Census; http://www.ons.gov.uk/ons/guide-method/census/2011/index.html
[3] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Health outcomes in Merton are generally better than those in London, and in line with or above the rest of England. However, there is a difference between the most and least deprived areas within the borough of about 7.9 years for men and about 5.2 years for women. Between 2009-11 and 2011-13 this gap increased by about one year for women. Premature mortality (deaths under 75 years) is strongly associated with deprivation; all wards in East Merton are more deprived and have higher rates of premature mortality.

Education

Education is linked to life expectancy and inequalities, and has a direct effect on health and social outcomes.[4] There is high overall adult educational attainment in the borough, however, two areas that fell within the 20% most deprived for education (in 2010). These areas also fell within the overall most deprived areas in 2010, reflecting an inequality in educational attainment.[5]

Figure 2: IMD 2010: Education, Skills and Training Deprivation



Employment

The relationship between health and low income exists across almost all health indicators.[6] Merton residents who are in active full-time employment are distributed all over Merton. However, unemployed residents are concentrated towards the east of Merton, and self-employed residents are concentrated toward the west.

New research and evidence since the previous JSNA 2014/15 report

East Merton health needs assessment (2013-14)

Key messages:

- The most important public health threats in Merton are heart disease, stroke, cancer and diabetes; respiratory disease is also common.
- Performance of the smoking cessation services was poor (*although since the HNA was undertaken, more recent data shows that the performance of the current provider is now bucking national trends and supporting more residents to stop smoking*).
- East Merton has a younger, poorer and more ethnically mixed population, who have worse health and shorter lives. Most of the excess deaths in East Merton are from cardiovascular disease and cancer, and diabetes is more common in East Merton than West. This is not reflected in admission rates, suggesting

[4] Measure of America and United Way American Human Development Project (2009). *Goals for the Common Good: Exploring the Impact of Education*.

[5] Department for Communities and Local Government. English indices of deprivation 2010

[6] London Health Observatory. Determinants of Health. www.lho.org.uk/LHO_Topics/Health_Topics/Determinants_of_Health/Income.aspx

that need for services in East Merton is not matched by uptake of inpatient services. Improving the quality of chronic disease management requires new models of care for East Merton.

Recommendations from this work are integrated into the 'Key Issues' at the end of this section

Merton the place

- Merton has more than100 parks and green spaces; 99.6% of Merton's area is within less than 400m distance from a publicly accessible open space
- Only 15.0% of outdoor space in Merton is utilised for exercise or health reasons
- There is a high level of housing need among Merton residents
- 6.2% of mortality in Merton is attributable to air pollution

Green environment

Open spaces and the physical environment place a key role in encouraging healthy lifestyles. Provision and utilisation of high quality green space is worse in deprived areas than in affluent areas.[7] Merton has more than 100 parks and green spaces, and 99.6% of Merton's area is within less than 400m distance from a publicly accessible open space (AMR 2013/14)[8]. However, only 15.0% of outdoor space is utilised for exercise or health reasons (PHOF 1.16) which is low (higher than 11.8% in London but lower than England 17.1%). Public Health and Green Spaces have worked together over the last year to provide more green gyms in local parks. Work is also underway with Culture & Leisure to identify and train a network of outdoor community physical activity instructors to encourage higher usage by those most inactive. The borough has also been successful in a partnership bid for funding from Sport England to increase the number of inactive residents using the Wandle Trail. The bid was led by the Wandle Valley Regional Park Trust and includes partners across Leisure, Green Spaces and Active Travel, the National Trust and other boroughs. It has been praised for its innovation, joint strategic working and involvement and matched funding from Public Health.

Housing and the built environment

The 2011 Census shows that there are 78,757 households within Merton:

Type of Housing	Owner-occupied	Social housing	Renting privately	Total
No. of households (%)	47,360 (60.1%)	11,102 (14.1%)	19,503 (24.8%)	78,757 (100%)

The number of households in Merton is projected to increase to 99,000 (15%) by 2021, an average annual household growth of 2.2%. This is ranked the fourth highest household growth in England[9] with much of the increase expected to be in single person households. Lone parent households are also set to increase by 9%. Merton's social housing stock is amongst the lowest in London at 14% of total stock. The London average is around 22% with social housing stock as high as over 59% in large boroughs such as Southwark. 58% of social housing and 63% of private rented homes are flats, compared with only 24% in the owner-occupied sector.

With projected increases in people aged over 65 years (an estimated 11% increase between 2011 and 2017),[10] one of the key concerns is the increase in older people living alone. This has implications for health

[7] https://www.noo.org.uk/LA/tackling/greenspace

[8] *Merton Local Plan Authority Monitoring Report 2013/14.*

[9] National Statistics, Department for Communities and Local Government (2013). *Household Interim Projections 2011 to 2021, England and its Local Authorities.*

[10] SHLAA.

and social care since 57% of the ‘fuel poor’ are aged 60 plus. Although the number of homeless households in Merton is amongst the lowest in London, homelessness is on the increase, with homelessness applications rising from 188 in 2010-11 to 279 in 2011-12 and the number of households accepted as statutory homeless increasing from 89 in 2010-11 to 101 in 2011-12. The borough’s most recent Local Plan Authority Monitoring Report (AMR) 2013/14 states that 440 additional new homes were built during the previous year, more than the annual target. This included 163 additional affordable homes (37%, just under the 40% target).

The Council’s Housing Strategy recognises that housing is much more than a roof over our heads: it is a fundamental part of our lives and contributes to health, ability to work, children’s education, and overall wellbeing. There are common themes running through the strategy, particularly regarding homelessness:

- Responding to Social Housing Reform to meet needs
- Preventing and addressing homelessness
- Meeting the needs of vulnerable and minority groups
- Regenerating housing and shaping neighbourhoods

For many households, access to suitable affordable housing is difficult, the demand for social housing far exceeds supply. Rising house prices lead to difficulties in accessing home ownership, and the welfare reforms have created new challenges. The role of the private rented sector is increasingly important, and there is an increasing pressure for this sector to provide good quality housing for those unable to access social or affordable home ownership.

Healthy High Streets

Merton’s AMR shows that 6% of shop units in the borough are A5 hot food takeaways (this does not take into account clustering, or the significant proportion of A3 restaurants that sell takeaway food), 1.5% (33) are betting shops, and 0.5% (10) are pawnbrokers or money service shops. These figures have not changed significantly since 2012.The Public Health team has undertaken a survey of the health of high streets around the Mitcham Town Centre area which is reported later in this document.

Transport

Promoting and enabling sustainable ‘active’ travel modes such as walking, cycling and using public transport enable people to integrate increased physical activity levels into their everyday lives. In Merton, car trips as a proportion of trips overall are higher than Inner London, although lower than Outer London. Against a backdrop of gradually falling car trips in outer London,[11] there is an opportunity to encourage reduction in private car trips and increase in more sustainable modes particularly walking and cycling. The rate of those killed and seriously injured (KSI) on Merton’s roads is 24.1 per 100,000 (2012-14), better than the London (29.8) and England (39.3). Public Health part fund the school travel plan officer in the borough, and the borough-wide Merton on the Move campaign is encouraging residents to do more active travel.

Air quality

Air quality is an important Public Health issue in London.[12] Local authorities have a statutory duty to manage local air quality and are required to carry out regular reviews and assessments of air quality. In 2013, 6.4% of mortality was attributable to particular air pollution in Merton (PHOF 3.01), slightly lower than London (6.7) as an outer London borough, but higher than England (5.3). Current monitoring indicates that the annual

[11] Travel in London Report 7, 2014, Transport for London

[12] The Health Impact of Air Pollution and the Role of Public Health England, PHE

mean nitrogen dioxide objective continues to be exceeded at roadside and nearby locations, and public health and environmental health colleagues are working together to consider how to tackle air pollution in the borough, to reduce both short and long term effects on health.

New research and evidence since the previous JSNA 2014/15 report

Planning and Public Health: best practice guide

Merton Public Health team, with the London Healthier High Streets Group, commissioned the Town and Country Planning Association (TCPA) to develop a practical best practice guide to public health involvement in the planning process for councils. This was developed and piloted in Merton by public health and planning and has been well received by other London boroughs and the GLA.

Review of policies: Local Plans, Health and Wellbeing Strategies and JSNAs

TCPA also reviewed borough policies, including Local Plans, Health and Wellbeing Strategies and Joint Strategic Needs Assessments across London. The review highlighted good examples of innovative planning policy (e.g. to promote active travel, to limit fast food takeaways), and concluded that Health and Wellbeing Boards (HWBBs) should set firm priorities in the Health and Wellbeing Strategies for Public Health engagement with planning. HWBBs should also consider engaging built and natural environment officers (Planning, Housing) through inviting a senior officer to sit formally on the Board or setting out mechanisms for regular engagement and collaboration on key priorities.

Estates regeneration Health Impact Assessment (HIA)

Circle Housing Merton Priory (CHMP) plans to regenerate three estates in Merton over the next decade starting from 2016: Ravensbury (Morden), High Path (Wimbledon) and Eastfields (Mitcham). Public Health has supported Future Merton to undertake an HIA of the plans, by providing an HIA framework, as well as data at ward and estate level to establish a baseline of health and wellbeing of the population, and identify vulnerable groups. Public Health also continues to discuss an approach to evaluating the impact with Future Merton and CHMP.

Qualitative Health Impact Assessment of private sector housing in Merton (2015)

Public Health and the Housing Environmental Health team jointly commissioned the Building Research Establishment (BRE) to conduct a HIA of private sector housing in Merton. Poor housing impacts health, from risk of falls to exacerbation of chronic conditions and a contributing to excess winter deaths.

Key findings:

There are an estimated 8,967 category 1 hazards in Merton's private sector stock; the estimated cost of mitigating these hazards is £33 million, with £13.3 million in the private rented sector. If these are mitigated, the estimated total annual savings to society in Merton are £3.7 million (£1.5 million to the NHS).

Recommendations:

An active housing enforcement strategy and work by landlords to mitigate category 1 hazards is necessary, in accordance with legislation in the Housing Act 2004. Landlord Accreditation Schemes can help educate landlords on the need to mitigate hazards. Professionals working with families should also be made more aware of landlord duties. The hazard of damp and mould, flames, hot surfaces and falling between levels particularly affects children, and a multi-agency approach to education, accessing local knowledge with Health Visitors or through Children's Centres, is crucial to reducing these hazards. Initiatives to reduce the incidence of falls are one of the more cost effective strategies, and targeting dwellings occupied by persons over 60 will bring the greatest benefit.

Merton the people and the place: key Issues and focus areas for the coming year

There are clear inequalities in life expectancy for both gender and levels of deprivation between East and West Merton. Addressing this requires national, regional and local action across government, the NHS, the voluntary and community sectors and the private sector, and effective local delivery focused on health equity across all policies. Most importantly, it requires participation and empowerment of individuals and local communities. High-level recommendations to achieve this include:

- Understanding the social determinants of health and the role of local government in creating health, enables Public Health to make the most of its new home and advocate for more effective use of local government levers, including early childhood development, education and training, employment, and licensing and planning. A number of current local initiatives tackle multiple/cross-cutting objectives to reduce health inequalities, such as promoting active travel and access to green spaces across the social gradient.
- Prioritising prevention to reduce future need for health and social care services.
- Strengthening partnerships with the voluntary, community and business sectors can enable broader reach, by embedding health as part of all frontline work.
- Strengthening a targeted approach to address differences in health and social outcomes across Merton, and responding to our increasing ethnic diversity. Efforts should be spread proportionally across all social groups, according to need.
- Ensuring more robust data is captured through health needs assessments and to improve population service access, through health equity audits, for example, to improve understanding of service needs.

Areas for further work across local HWBB partners include:

- Conducting Health Impact Assessments (HIAs) to understand the local impact of changes to the welfare system and public sector cuts, particularly on health inequalities; and considering how to achieve fair economic growth and regeneration, along with health, that benefits all sectors of our population.
- Further support for locally developed and evidence-based community regeneration programmes that use spatial planning to: remove barriers to community participation and activity; reduce social isolation; and provide opportunities for integration of health, social care and determinants of health.
- Build on the Qualitative Health Impact Assessment of private sector housing in Merton, to develop an approach to tackle cross-cutting issues such as fuel poverty, climate change, excess winter deaths, and falls.
- Scoping underway across Public Health, Adult Social Care (ASC), Merton Clinical Commissioning Group (MCCG) and partners to conduct a joint adult disabilities HNA in 2016 to improve the quality of disability data available to inform commissioning decisions.

3. Merton voice

- Overall Merton residents remain generally positive about their health and wellbeing, with around 90% reporting that they are satisfied with life, felt happy yesterday and feel that life is worthwhile. However, there are variations between groups, for example those with disabilities.

Annual Residents Survey HWB questions

The Merton's Annual Residents' Survey was carried in September/October 2014. Overall Merton residents remain generally positive about their health and wellbeing, with around 90% reporting that they are satisfied with life, felt happy yesterday and feel that life is worthwhile.

- Reflecting concern about crime, 'feeling safe in your local area' is the area that most residents feel needs to be improved to improve their sense of health and wellbeing (52%).
- About a third (31%) of Merton Residents say that their sense of health and wellbeing could be improved by increasing their satisfaction with how their area looks.
- A quarter (24%) felt that satisfaction with health and mental health could be improved, and 1 in 10 residents rate local health services as poor.
- However, there are differences between population groups, for instance those with disabilities score themselves less positively across all the wellbeing measures in the survey compared to non-disabled people, and only just over half of disabled people agree that the council is listening (53%) compared to 60% of non-disabled people.

Results available from: http://www.merton.gov.uk/council/performance/residentssurvey.htm

Merton young residents survey (2014)

The residents survey included a section on feedback from young residents, based on interviews with nearly 250 young people. Overall, young people are fairly positive about their health and wellbeing, with 92% saying that they are fairly satisfied with life. Young people's concerns are generally similar to those of adults. Litter is the biggest concern, but satisfaction with street cleaning remains positive. Bullying also remains a key concern although concerns have reduced four percentage points from last year (25%) and are in line with the London average (26%), but the level of concern over crime has fallen significantly by 11% this year.
Merton council is viewed positively by young residents, with: 77% feeling they get the services they need (a slight increase from 2013); 84% feeling that the council does enough to protect young people (a significant increase); and 89% agreeing that Merton is a good place to live. Significantly more young residents in Merton feel that the council involves young people, compared to the London average. The perception of many services by young people continues to be better than the London averages, including local health services, libraries, and sixth form education.. Services such as parks, playgrounds and open space, activities for young people, local health services and the police demonstrate a marked improvement from last year.

Results available from: http://www.merton.gov.uk/council/performance/residentssurvey.htm

Annual GP (2015) patient survey

- 80% of respondents with Merton GPs felt their experience was 'good.' This is similar to last year's result, however lower than England overall (85%).

- There was variation across the borough in experience of GP surgeries across the borough.

Results available from: https://gp-patient.co.uk/

'My Voice Matters: My Inclusion Matters' (2014)

A debate was hosted by Merton Centre for Independent Living in December 2014 on 'Access and Inclusion for disabled people in Merton,' which included a workshop on health. Key points expressed included:

- Concerns that people weren't being treated holistically by the health profession: "there needs to be a wider perspective of people's access and health needs"
- The need for preventative care: "Prevention really needs to be taken seriously"
- Referrals were highlighted as an issue with GP services, hospitals, health centres, mental health teams, and rehab facilities, as was the need for more flexible access to appointments.
- Concerns over the Nelson Centre and co-ordination of health services were expressed.
- GPs receptionists were felt to be asking personal questions; some people reported positive experiences with pharmacists.
- The lack of communication between health and social care, and discharge from hospital not having been properly planned were discussed.

Changes advised to make health more inclusive and accessible were:

- Being more mindful of the layout of GP receptions, to include less boundaries and be more inviting.
- Supporting patients to become the experts about themselves and available services.
- Improving communication and joined up services by health professionals.

Healthy high streets consultations (2015)

In 2015, the Royal Society of Public Health (RSPH) published a report looking at the health of high streets across the UK, recognising the positive and negative impact that businesses on the high street – from food outlets to hairdressers, cultural centres to payday loan shops – can have on the public's health. Taking the opportunity of the review of the borough's Statement of Licensing Policy and the proposed introduction of a new Cumulative Impact Zone (CIZ) around Mitcham Town Centre and Figge's Marsh, Public Health commissioned two pieces of work in mid 2015 to look at the health of some of Mitcham's high streets:

Youth Inspectors

A group of Youth Inspectors spent 2 days walking the area covered by the proposed Mitcham CIZ, noting whether premises they passed sold alcohol or fast food, and the appearance of stores and streets, as well as any antisocial behaviour or litter. In addition to alcohol findings discussed later in this document, they found that although there was fresh fruit or vegetables on sale in at least 60% of premises that sold food ingredients (convenience stores, corner shops, grocers, off-licenses, supermarkets etc), a quarter of these had low stock, limited selection or poor quality produce on offer. Fast food outlets made up three quarters of the available food provision, and that there were very limited healthy food options. The majority of litter noted was smoking-related (cigarette butts, packaging), followed by fast food packaging. Youth Inspectors unanimously felt that betting shops and payday loans shops made the high street less healthy. Their general impressions were that the high streets around Mitcham were unhealthy: "it is due to the amount of alcohol and unhealthy food that is for sale in area that make it an unhealthy high street."

Healthwatch Merton

Through face-to-face consultation in Mitcham Town Centre and an online survey, Healthwatch gathered people's views of the kind of high street/town centre they would like to have in their community as well as

finding out what they didn't like. In addition to the findings on alcohol set out later, the Healthwatch work found:

- Almost 40% of people felt there were too many fast food outlets in the area, and that they would like better access to healthy foods including more restaurants that provide healthy options.
- Respondents felt that there was a strong link between the availability of alcohol in the area and people visibly drinking in public during the day and night as well as anti-social behaviour, which residents and visitors to Mitcham found intimidating.
- A significant proportion of respondents also felt that there were 'too many betting shops' with people strongly linking this to anti-social behaviour and crime.
- Almost 10% of participants commented that there was too many barber shops in the area. A number of respondents felt that there has been a link between the increase in barber shops and crime.
- A regular feature of discussion was the lack of amenities and activities, particularly for children and young people. A number commented on the closure of McDonalds and felt that this was a focal point for socialising. The lack of interesting shops, cafes and leisure/cultural activities to attract people to the town centre was raised.
- A number of respondents raised the lack of sufficient toilet facilities in the town centre as an issue.
- Another common topic for discussion was the lack of engagement by the Local Authority with residents and visitors to the area around the Rediscover Mitcham project.

Merton voice: key Issues and focus areas for the coming year

- Commissioners have a legal duty to seek the views of service users and patients when commissioning services. This includes looking at users' experience of existing services, and seeking views about planned changes to services before they are made.
- A better understanding of patient or service user experience can help drive improvement by showing where efforts need to be targeted. Commissioners can draw on a wide range of data sources, including national and local, and qualitative and quantitative, to support this process.
- Commissioners also need to consider what the appropriate involvement approach for different projects is. For a major service change, formal public consultation will be required. When seeking to improve health outcomes and access to services for specific groups, engagement may include social marketing insight work to help understand the beliefs and attitudes that influence health behaviours and use of services.
- It is important that commissioners are proactive in seeking views from marginalised groups who often experience poorer health outcomes, often referred to as 'seldom-heard voices'.

Areas for further work across local HWBB partners include:

- Conducting Health Impact Assessments (HIAs) to understand the local impact of policies and commissioning decisions, particularly on health inequalities
- Scoping underway for a joint adult disabilities HNA in 2016 to improve the quality of disability data available to strengthen the JSNA and inform commissioning decisions.

4. Pregnancy and maternal health, early years, and children and young people

The Marmot Review, *Fair Society, Healthy Lives*, identified giving every child the best start as the highest priority in reducing the inequalities gap that exists between different groups of people. Action to reduce health inequalities needs to start before birth and be followed through the life of the child to improve adult health outcomes. *The Healthy Child Programme: pregnancy and the first five years of life (DCSF and DH 2009)* sets out an integrated approach to improving the health and wellbeing of children and supporting families and sets out recommended standards for service delivery.[13] Improving health and well-being outcomes and reducing health inequalities is a major focus for pregnancy and maternal health, early years and children and young people in Merton.

Changes in PHOF data from the previous year[14]

Positive	Negative
Reduction in: • Smoking at time of delivery • Infant Mortality & low birth weight • Excess weight in 4-5 year olds • Children living in Poverty • Pupil absence • Children NEET • Under 18 conceptions • Hospital admissions for unintentional and deliberate injuries 15 – 24 year olds • First time entrants to the youth justice system Increase in: • Childhood Immunisations • Breastfeeding initiation	Increase in: • Excess weight in 10 – 11 year olds • Hospital admissions for unintentional and deliberate injuries (0-4 and 0-14 years)

Health and Well-being: pregnancy and maternal health in Merton

The determinants for poor pregnancy and maternal outcomes include obesity, alcohol consumption, drug misuse, homelessness, mental health, teenage pregnancy, domestic violence and sexually transmitted infections. Women on low income, women with a low level of education and previously ill women are more at risk of developing complications during childbirth and after delivery.

Health headlines and context for Merton

[13] Healthy Child Programme (2009). Department of Health (DH), Department for Children Schools and Families (DCSF).
[14] This table, and those later in the document, reflects positive or negative changes in data since previous PHOF compared to the most recent data available. This does not reflect the size or significance of the change, or trends over time. For indicator values and benchmarking see: http://www.phoutcomes.info/

- There has been a 29% net increase in births from 2,535 in 2002 to 3,292 births in 2014.[15]
- There is a much higher proportion of children aged 0-4 years and adults aged 24-44 years compared to England (from the 2011 Census age profile).[16]
- Infant mortality is slightly less than London and England, at a rate of 3.6 infant deaths per 1,000, compared with 3.9 regionally and 4.1 nationally (2011 – 2013 pooled data).[17]
- Smoking in pregnancy for Merton (2014/15) is 4.4% which is lower than London (4.8%) and England (11.4%).[18]

Figure 4. Maternity Indicators 2014/15

Maternity Indicator 2014/15	St Georges Hospital	Kingston Hospital	Epsom and St Heliers Hospital
Booking assessments completed by 12+6 gestation	82.2%	92.7%	87.3%
Caesarean section rate	23.1%	28.8%	27.5%
Unplanned Caesarean-section rate	13.4%	14.8%	17.9%
Midwife to births ratio	1 : 27	1 : 32.5	1 : 27
*Breastfeeding Initiation**	92.8%	88.3%	84.0%

*Source: South West London Maternity Dashboard 2014/15 * Breastfeeding initiation data from HSCIC website*[19]

Analysing Merton resident women's births (2014), the following has been observed:

- 97.9% of births were in NHS hospitals, 1.5% at Home and 0.5% in non-NHS hospitals. 51.9% of women gave birth at St George's Hospital, 19.1% at Kingston Hospital and 16.2% at St Heliers Hospital; the remaining were at other hospitals or at home.
- 58% of births were to women in East Merton and 42% to women in West Merton. The wards with the highest proportion of births in 2014 were Figge's Marsh (7.1%), Cricket Green (7%) and Wimbledon Park (6.5%).
- There are more women in the older age range giving birth in Merton than the national average.
- 6.6% of babies born had a low birth weight (<2500grams), less than London (7.3%) and England (7%).[Error! Bookmark not defined.] 96.8% of births were singleton births and 3.2% were twins.

New research and evidence since the previous JSNA 2014/15 report

NICE guidance

- *Intrapartum care: Care of healthy women and their babies during childbirth (December 2015).*

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[15] Births Summary tables 2014, ONS
[16] 2011 Census age profile, Merton v England
[17] HSCIC website: https://indicators.ic.nhs.uk/download/NCHOD/Data/04N_161CRP2_13_D.xls
[18] HCCIC website: http://www.hscic.gov.uk/catalogue/PUB14258/stat-wome-smok-time-deli-eng-q4-13-14-tab.xlsx
[19] HSCIC website: http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2014/03/Breastfeeding-1415Q4_v2.xlsx

- *Safe midwifery staffing for maternity settings (February 2015)*
- *Improving maternal and child nutrition (July 2015)*
- *Diabetes in pregnancy: management of diabetes and complications from preconception to the postnatal period (February 2015)*

Relevant local strategies for this topic

- *Merton Health and Wellbeing Strategy 2015 – 18*
- The *South West London Maternity Network* launched in July 2013.

Pregnancy and maternal health: key Issues and focus areas for the coming year

- Ensuring that infant mortality and low birth weight remain low in Merton, by: addressing child and family poverty and housing needs; reducing maternal obesity and improving nutrition; and ensuring good access to antenatal care and support during the first year of life, targeting areas of need..
- Considering options to increase capacity to deliver holistic improvements in maternity services, as set out in the South West London strategy.
- Ensuring effective delivery of the Family Nurse Partnership, targeting mothers aged under 20 years.
- Improve data quality around breastfeeding and ensure a greater focus on targeting areas/groups with lower breastfeeding rates.
- Reviewing the rate of caesarean deliveries, elective and emergency, and how this can be reduced.
- Ensuring the South West London maternity dashboard is monitored to provide standardised data from providers, and there is robust data analysis to inform commissioning.
- Ensuring the new national Maternity and Children's Data Set, which over time will result in comprehensive data (HSCIS-MCDS), to inform local commissioning.
- Conduct a needs assessment on improving health and well-being outcomes on maternal health.

Health and wellbeing in the early years in Merton

To ensure the best start in life for a child, the areas that matter the most are a healthy pregnancy; good maternal mental health; secure bonding with the child; love and responsiveness of parents along with clear boundaries, as well as opportunities for a child's cognitive, language and social and emotional development. Access to high quality services also facilitate good development in the early years. Early intervention to support children's readiness for school is important in improving the long-term health, emotional, educational and social outcomes of young people and reducing the risk of negative outcomes such as anti-social or violent behaviour or children not achieving their potential.

Relevant local strategies for this topic

- *Merton Health and Wellbeing Strategy 2015 – 18*
- *Children and Young People's Plan 2016 - 19*

Health headlines and context for Merton

- There are 15,000 (7.5%) 0-4 year olds, which is expected to rise by 780 by 2017.
- 59.9% of children achieve a good level of development at age 5, slightly below the England (60.4%) and London (62.2%) average (2013/14).[20]
- There is a 38.9% gap in child development at age 5 between the lowest 20% achieving a good level of development in the Early Years Foundation Stage and the overall average for Merton (2013).[20]
- Childhood immunisation coverage in general has been below London and England levels and the World Health Organization's target of 95%; there is variation in levels of immunisation coverage by GP practice.
- 100% of children's centres, and 85% of schools in Merton have been judged as good or outstanding (2014/15).[Error! Bookmark not defined.] 78% of users of children's centres live in areas of deprivation (2014/15).[Error! Bookmark not defined.]

[20] ChiMat website: http://atlas.chimat.org.uk/IAS/dataviews/view?viewId=282

- 29.2% of 5 year olds are estimated to have experienced decayed teeth, slightly higher than England (27.9%) but lower than London (32.9%) (2012).[21]
- Emergency attendances for children aged 0-4 years were higher (698.2 per 100,000) than London (648.4 per 100,000) and England (483.9 per 100,000) in 2010/11.[22] Hospital admission rates for unintentional and deliberate injuries for 0-4 year olds are 135.2 per 10,000, higher than London (105 per 10,000), and lower than, but statistically similar to England (140.8 per 10,000).

New research and evidence since the previous JSNA 2014/15 report

Review of Health Visitor services in Merton (2014)[23]

Key messages:

Service user feedback: 89% of parents/carers rated the service good or very good; the top 4 extra support needs for families were *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*; and of those parents who had extra support needs, 70% stated their needs were met; 19% partly; 8% not by the Health Visitor service.

Recommendations: Ensure greater joined up commissioning; greater integrated delivery; communication with other services and service users; efficiencies through capacity planning; and transition planning for transfer of commissioning responsibility to the Local Authority.

Early years: key Issues and focus areas for the coming year

- The high birth rate and increase in children under 5 will place additional demands on affordable childcare, nursery provision and health services, in particular on newborn and child screening, immunisations and six-week checks.
- Continue to deliver effective, impactful and evidence based parenting programmes, targeted where necessary to support families and child development focusing on those who are hard to reach.
- Commissioning of Community Health Services, which includes Health Visiting (including Family Nurse Partnership), School Nursing, Specialist Nursing for Children Looked After, Care Leavers and the Multi-Agency Safeguarding Hub (MASH) and Children's Community Therapy and Specialist Healthcare Support and Co-ordination has taken place with new service specifications from April 2016 onwards.
- Ensuring families move seamlessly through services with issues identified early on, and support provided in a timely way, by reviewing, aligning and developing an Early Years pathways pilot between GPs, Maternity Services, Health Visiting Service and Children's Centres services to foster new ways of working and scale up across the borough if successful..
- Monitoring mobilisations of the new Community Services contracts to ensure a smooth transition period and implementation of new service specifications, and the integrated 2 year reviews between Health Visiting Teams and Children's Centres
- Using the transfer of Health Visiting commissioning responsibility from NHS England to Public Health as an opportunity to tailor services to better meet local needs and address health inequalities.
- Continue to improve childhood immunisations rates towards reaching the World Health Organisation (WHO) target by developing and implementing a joint action plan to take forward recommendations from the Immunisations Scrutiny Review.

[21] National Dental Epidemiology Programme for England, Oral Health Survey of five-year-old children 2012.
[22] ChiMat 2013 data
[23] London Borough of Merton – Review of Health Visiting Services (2014)

- Focus on improving 'School readiness' scores 'Good Level of Development at age 5' indicator to ensure the best start in life for children.
- Continue to focus on attracting families living in areas of deprivation to engage with a wide range of Children's Centre services including access to play and stay and early education groups, job clubs, child health services, midwifery and antenatal as well as targeted home visiting services.
- Reviewing data on hospital attendances/admissions for children aged 0-17 years, including a focus on the 0-4 age group, and further developing local initiatives to reduce A&E attendances.
- Deliver evidence based training for frontline staff coming into contact with families to increase their knowledge and skills to provide brief advice and signposting/referral for a range of lifestyle issues.

Health and wellbeing of children and young people in Merton

Many life-long health behaviours are set in place during the second decade of life. Physical activity declines across adolescence, particularly for young women, and nutrition often falls short of national recommendations. Around one in five school pupils aged 11-15 are obese.[24] Poor health relates to the circumstances in which young people live; their access to health care, education and leisure opportunities; and their homes, communities, towns and cities. It also reflects individual and cultural characteristics such as social status, gender, age and ethnicity, values and discrimination.[25]

Relevant local strategies for this topic

- *Merton Health and Wellbeing Strategy 2015 – 18*
- *Merton Children and Young People's Plan2016 - 19*

Health headlines and context for Merton

- There are 50,148 children and young people aged 0-19 in Merton (25% of the total population); this is forecast to increase by around 2,200 (4.4%) by 2020.[26] The proportion of BAME people in the 0-19 age group is forecast to increase from 38% in 2004 to 52% in 2020.[27]
- There are fewer children living in poverty (15.8% or about 7,240 children) compared with London (23.5%) and England (18.6%) [Includes all dependent children under 20 years old]. However based on the Income Deprivation Affecting Children Index (IDACI) 2015, Merton has 6 of the top 10% most deprived LSOAs of England which include Pollards Hill, Figges Marsh, Cricket Green and Abbey wards. This highlights the inequalities that exist between the east and the west of the borough.
- There is an increase of nearly 15.4% in levels of excess weight (overweight and obesity) in children aged 5 to 11, from just over 20.9% at Reception level to 36.3% at Year 6 level (2013/14). At Reception this is lower than London (23.1%) and England (22.5%); at Year 6 this is higher than England (33.5%) and similar to London (36.3%). There is variation by gender, ethnicity and area, and level of deprivation.
- There are increasing numbers of children with statements of SEN with ASD.
- Nationally and in Merton there has been an increase in children in care and on a child protection plan. Merton's Children in Need (CIN) rate per 10,000 (355.1 in 2013/14,) is lower than the London average

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[24] Key Data on Adolescence 2015. Association for Young Peoples Health (AYPH). Public Health England and CRIPAAC

[25] Health Policy for children and adolescents. No. 6. World Health Organisation (WHO) http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf

[26] GLA Population Projections 2013 Round, SHLAA capped, age range creator

[27] Ethnic profile of 0-19 age group 2014-2020 – GLA 2013 round SHLAA – based ethnic group population projections

(367) but higher than the National (346).[28] The rate of children subject to a child protection plan in Merton (40.3 2013/14) are higher than the national (42.1) and London (37.4) rate.

- There has been an increase in the number of looked-after children (LAC) in Merton.
- The estimated prevalence of Mental Health disorders suggests there are a total of 2550 children and young people aged 5-16 in Merton experiencing a mental health disorder (adjusted for age and sex).[29]
- The hospital admissions rate for 10 – 14 year olds for unintentional and deliberate injuries is 106.1 per 10,000, higher than London, lower than but statistically similar to England (112.2 per 10,000). The rate for 15-24 year olds is statistically better than England at 105.2 per 10,000 versus 136.7 per 10,000.
- Hospital admissions as a result of self-harm is 191.2 per 100,000 10 – 24 year olds which is lower than England (367.3 per 100,000) [pooled data 2011/2012 – 2012/13].[30]
- Hospital admissions for alcohol-specific conditions in children and young people aged under 18 are the ninth highest in London (although still lower compared with England).
- 88% (326 of 370) of high need 'troubled families' turned around from 2013 to 2015. This means either getting children back into school, cutting youth crime/antisocial behaviour across the whole family, getting adults into work or reducing the costs to the taxpayer of tackling their problems.
- The teenage pregnancy rate has decreased to 22.1 per 10,000 15-17 year olds in 2013 from 2012 (24.3 per 10,000). This is also lower than the England average of 24.3 per 10,000.
- In the year prior to September 2014, the London Borough of Merton Child Sexual Exploitation service has worked with 67 cases, between the ages of 11-17 years old which is a combination of clients who have actually been exploited and those at significant risk of being exploited.[31]
- 4.3% of young people aged 16-18 years are Not in Employment, Education or Training (NEET) in Merton which is higher than London (3.4%) but lower than England (4.7%) in 2014.[32]

New research and evidence since the previous JSNA 2014/15 report

CAMHS health needs assessment (2014-15)[Error! Bookmark not defined.]

Key insights gained from this work included:

- Nationally and locally, CAMHS is being prioritised to improve the support available and emphasise strategies that contribute to preventing mental health disorders and improve emotional wellbeing.
- Population projections suggest that need for Child and Adolescent Mental Health Services (CAMHS) is likely to increase in the coming years, with particularly high growth in the numbers of 10-14 year olds.
- Better quality data is required to more effectively monitor, plan and prioritise services.
- Engagement with children and young people needs strengthening locally.
- A new CAMHS Strategy sets out a comprehensive plan for transforming local services, with cross-agency working to ensure all efforts are fully integrated across health, education and social care, reflecting an increased emphasis on prevention and early intervention initiatives.

[28] Merton Children and Young People's Plan 2015-18
[29] CAMHS Needs Assessment. London Borough of Merton. Public Health 2015
[30] ChiMat website: http://atlas.chimat.org.uk/IAS/dataviews/view?viewId=450
[31] Child Sexual Exploitation needs assessment. London Borough of Merton. Public Health 2015
[32] Public Health Outcomes Framework (PHOF) - www.phoutcomes.info

Child Sexual Exploitation Review (2015) Error! Bookmark not defined.

A rapid review of the evidence for tackling Child Sexual Exploitation (CSE) in Merton was conducted.

Key commissioning recommendations were:

- Consult on and agree a local multi-agency (pan London compliant) dataset for CSE.
- Ensure: accurate and proactive recording of children and young people at risk of CSE by Police and Health services; use of data to effectively identify and monitor children and young people at risk of CSE (including use of the CSEGG 11 indicators); regular audits of all CSE referrals; review of data capture and analysis in order to inform strategic and operational planning; and a consistent and systematic recording process to map and monitor persons of interest and perpetrators.
- Continue to build awareness and resilience in children and young people to help prevent them being sexually exploited, and give conspicuous care to young people placed out of borough, so that they are effectively linked in to appropriate CSE services. The types of exploitation include inappropriate relationships, peer-on-peer, gang/group associated and organised/networked sexual exploitation.

Looked After Children health needs assessment (2015)[33]

Key findings:

Strengths in Merton:

- A strong strategy & planning focus on Looked After Children and Young People (LACYP) priorities and best practice, and focus and consensus on areas of concern for LACYP in health.
- Health outcomes for LACYP are better than England averages.
- Specific services are perceived as working very well (e.g. virtual school, substance misuse services)

Areas for improvement in Merton:

- Improving joint working in health, wellbeing and social care services: clear roles, communication, information sharing, service pathways, and training
- Improving access and continuity of care for LACYP in health services, especially CAMHS, and broader engagement with LACYP and carers
- Addressing disparities in health outcomes persist in comparison to peers.

Recommendations were in the areas of: *Strategy and Commissioning; Workforce Development; Prevention and Early Identification; and Systems*. Needs assessment findings and recommendations will be addressed by the London Borough of Merton (LBM) and Merton Clinical Commissioning Group (CCG), through the development of a detailed plan outlining actions, responsibilities and timelines.

Children and young people: key Issues and focus areas for the coming year

- Implementation and monitoring of the refreshed *Health & Well-being Strategy* 2015-18 and the refreshed *Children and Young People's Plan* 2016-2019.
- Planning for the rapid increase in the primary school age group that will increase demand for: school places; SEN provision; and children's social care services.
- Developing a joint work plan on obesity across the HWBB partners. Merton has signed up to taking forward the Healthier Children, Healthier Places toolkit (Sector Led Improvement, based on the work of the GLA and the London Health Improvement Board towards a London obesity framework.)

[33] Looked After Children's needs assessment. London Borough of Merton. Public Health 2015

- Developing a Multiagency Provider Board for children with complex needs to drive through improvements in the complex care pathway and provide joined up services.
- Continuing to develop the multidisciplinary EHC Team to support implementing the new Education, Health and Care (EHC) plans to ensure provisions that meet the needs of children and young people with SEND (up to 25 years) and their families.
- Transforming CAMHS locally through the implementation of the CAMHS Strategy overseen by the CAMH Partnership Board.
- Undertake needs assessments on areas identified as priorities within the year to improve outcomes for children and young people
- Evaluating the impact of the local targeted Healthy Schools programme in the East of the borough, with a view to making recommendations on the framework model for delivery.
- Continue to deliver a NEET strategy with resources focusing on engaging with more vulnerable young people.

5. Healthy lifestyles in Merton

- Lifestyle risk factors explain around 40% (39.6%) of total ill health with the leading risk being diet, closely followed by smoking and high body mass index (BMI).
- Across the most deprived areas in England, the leading risk factors are smoking, high BMI, and high blood pressure.

Changes in PHOF data from the previous year

Positive	Negative
Reduction in: • **Smoking at time of delivery** • **Excess weight in 4-5 year olds** • **Sickness absence (% working days lost)** **Increase in:** • **Breastfeeding initiation** • **Successful completion of drug treatment - non-opiate users**	**Increase in:** • **Excess weight in 10 – 11 year olds** • **Smoking prevalence (total; routine/manual)** • **Admission episodes for alcohol-related conditions (narrow definition)** **No change in** • **Inactive adults** • **Successful completion of drug treatment - opiate users**

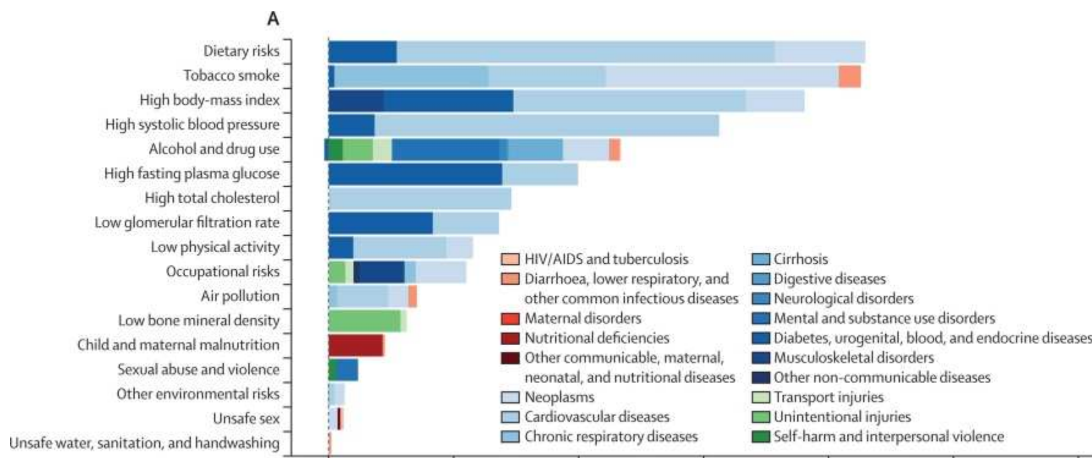
The recently published analysis of the Global Burden of Diseases[34] shows that across England, our health has improved considerably since 1990 in comparison to other high-income countries, evidenced by an increase in average life expectancy of 5.4 years. However, analysis shows:

- Premature mortality has fallen dramatically, but rates of morbidity have not, which means that we are living longer but spending more years in poor health; and
- Progress made at national level is not matched by improvement in health inequalities.

Lifestyle risk factors explain around 40% of total ill health with the leading risk being diet, closely followed by smoking and high body mass index, BMI (see Figure 4). Across the most deprived areas in England, the leading risk factors are smoking, high BMI, and high blood pressure. Alcohol and drug use are more highly ranked risk factors in more deprived areas compared with less deprived areas.

Figure 4: Disability-adjusted life-years (DALYs) attributed to risk factors in 2013 in England

[34] Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013



New research and evidence since the previous JSNA 2014/15 report

Review of the Livewell Service:

Livewell is the borough's main commissioned service to support residents with behaviour change around smoking, diet, physical activity and alcohol. In 2015 Public Health commissioned an independent review of the service, to inform re-commissioning of the service from April 2016.

Key findings***:***

- There is a clear need for lifestyle health interventions in Merton, particularly smoking cessation in the East of the borough to prevent smoking related co-morbidities.
- Setting health improvement targets for individuals is important; the role of health trainers and health champions to address this is critical to secure targeted and lasting benefit in the community.
- LiveWell's impact against locally defined needs has been strong; 80% of those seen by the service were from the east of the borough (areas with highest health inequalities).
- The service was perceived by professional stakeholders to be making a positive contribution towards the health and wellbeing of those residents in need of access to health improvement and stop smoking services. It was felt LiveWell offers a service that addresses the diverse needs of BME communities and concentrates its efforts where the need is greater.

In May 2014, Merton Clinical Commissioning Group (CCG) conducted a community services survey with its GP practice membership including the LiveWell Service; feedback was positive.

- There was a view that health improvement the approach needs to be more holistic, addressing more than only the physical risk factors that people present with.
- It was felt that more could be done to gain the support of other associated services such as housing, where staff are in direct contact with people.

The review concluded that the service going forward should be funded through a block contract, not be subject to PBR which was unlikely to add value, and service targets should be used to adjudge the likelihood for contract continuity and extensions beyond the initial 3 year period.

Healthy weight and diet

- Nearly two thirds (58.3%) of adults aged 16+ in Merton (around 100,000 people) are currently overweight (40.3%) or obese (18.0%).
- Modelled estimates of fruit and vegetable consumption in adults show that Merton is significantly better than the England average.
- Food poverty is worse in the East of the borough.

A healthy weight is defined as a Body Mass Index (BMI) of between 18.5 – 24.9 kg/m^2. More than this is defined as 'excess weight' which includes overweight (BMI 25-29.9) and obesity (BMI>30); less than this is 'underweight'. Excess weight is affected by complex social and environmental factors, including increasing access to unhealthy energy-dense food and environments which are not conducive to people of all ages getting out and getting active (i.e. 'obesogenic' environments which promote weight gain). The Foresight report 'Tackling Obesity: Future Choices' highlighted that humans are biologically vulnerable to obesogenic environments.[35] Obesity significantly increases the risk of ill health and a range of chronic diseases, particularly type 2 diabetes, stroke and coronary heart disease, cancer and arthritis. Annual costs to the NHS for treating obesity-related illnesses are estimated to be £4.2bn,[36] in addition to the wider costs to society including sickness absence and costs to social care.

Halting the rise and reducing population levels of obesity requires a system wide approach across the life course to address the 'obesogenic environment' in which our residents live:

- **Prevention** throughout the lifecourse but particularly in early years, supported by an environment which makes the healthy choice the easiest choice.
- **Treatment** through a range of multi-component weight management services (see NICE guidelines) for those who are overweight and obese, through to bariatric surgery for morbidly obese patients.
- Full use of **policy and regulatory levers**: obesity needs to be recognised as a priority for policy making across sectors other than health, and there is evidence that 'whole setting' approaches (e.g. in schools) are more effective than targeting individual behaviour change. Similarly, regulatory approaches have been more successful for other health issues (e.g. tobacco) than individual behaviour change; this is likely to be transferrable to healthy weight, e.g. sugar taxes or mandatory food labelling.
- Good nutrition is essential for maintaining both mental and physical health and in the prevention and management of diet-related conditions such as cardiovascular disease, cancer, diabetes and obesity. UK dietary recommendations are represented by the Eatwell Plate which shows how to achieve a balanced diet for people over 2 years of age.

Health headlines and context for Merton

- Nearly two thirds (58.3%) of adults aged 16+ in Merton are currently overweight (40.3%) or obese (18.0%). This is similar to London (57.3%), and significantly lower than the England average (63.8%).[37]
- The trend is upwards; forecasts predict obesity will affect 60% of men and 50% of women in Britain by 2050.[38] Similar trends towards increasing overweight are likely to be seen in Merton unless there is a step change in behaviours and environments.

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[35] Butland B, Jebb S, Kopelman P, et al. Foresight report: Tacking obesities: future choices - project report. London: Government Office for Science, 2007

[36] National Obesity Observatory, 2010

[37] Sport England Active People Survey 2012 & 2013 GLA SHLAA Capped Round Population Projections

[38] Butland B, Jebb S, Kopelman P, et al. Foresight report: Tacking obesities: future choices - project report. London: Government Office for Science, 2007, quoted in PHE (2014) Adult obesity and type 2 diabetes

- Nationally the health of most population groups would benefit from an improved diet. There is a lack of comprehensive local data on diet and nutrition as dietary surveys are both complex and expensive. The only data on fruit and vegetable consumption in adults, a modelled estimate, shows that Merton is significantly better than the England average.
- Food poverty is worse in the East of the borough as indicated by the higher usage of the food bank.

New research and evidence since the previous JSNA 2014/15 report

Research about the food environment

Since 2014, Public Health Merton has hosted dietician students on placement, who have conducted a number of pieces of work including:

Food poverty:

An analysis of food poverty as evidenced by food bank usage found:

- Just over 2,000 clients accessed the Trussel Trust food bank in 2013/14; 78% of clients were from the east of the borough, consistent with the patterns of deprivation.
- Families experience summer holiday hunger leading to a rise in demand in August.
- The food bank regularly sees clients who do not have cooking facilities.

Recommendations for action: the inclusion of advice on eating well on a low budget with the food parcels that are given out; and exploration of opportunities for 'Eat Well, Spend Less' courses that teach people how to cook on a low budget; and advice on food budgeting, hygiene and nutrition.

Healthy Options in and around Children's Centres:

Dieticians spoke to staff at an East Merton's Children's Centre. Unhealthy snacks were brought in to afterschool clubs, but staff did not feel they had the knowledge or skills to broach the subject, given: healthy lifestyles may not be a high priority for parents facing bigger challenges (e.g. food poverty, benefit issues, mental health); and knowledge and skills relating to healthy lifestyles are limited. They reported limited access to fresh food locally: fast food outlets are abundant and there are limited supermarkets within walking distance (basic mapping of the area revealed 41 take-away outlets within 1 mile).

Recommendations for action included support and training for Children's Centre staff around healthy eating messages.

Mapping of fast food outlets

- There are currently 135 fast food takeaways (A5 units) in Merton; this number has not significantly changed in the last 3 years. There are 215 restaurants and cafes (A3 units); this number has increased by 12.5% in the past 3 years. A3 units tend to be restaurants in less deprived areas (e.g. Carluccios), but be indistinguishable from fast food takeaways in more deprived areas (e.g. Fried Chicken shops).
- The wards with the highest number of A5 takeaways, and the highest rate of takeaways per 100,000 population, as well as the highest density of takeaways per km2 are Abbey and Figge's Marsh. These should therefore be targeted for interventions such as Healthier Catering Commitment, or for responding to planning decisions around change in use to A5.

Recommendations for future work include investigating the food purchasing habits of young people and families around schools, and breast feeding friendly cafes in Merton.

Availability of cookery courses

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338934/Adult_obesity_and_type_2_diabetes_.pdf

Dietician students also mapped services that aim to improve the cooking skills and/or nutrition knowledge of the residents of Merton. They found that there were some healthy food and nutrition courses available, but that there may be inequalities in provision and financial and cultural barriers to access.

Consultation about the food environment: Merton Food Summit

Public Health brought together organisations working across the food cycle in Merton in April 2015 for a Food Summit, to establish a baseline for food-related activities across the borough and to identify priorities for partnership action.

Relevant Local Strategies

- *Merton Health and Wellbeing Strategy 2015-2018*
- *Merton Food Charter (Available from http://www.merton.gov.uk/health-social-care/publichealth/mertonfoodcharter.htm)*

Healthy weight and diet: key Issues and focus areas for the coming year

- We must make tackling obesity a borough-wide priority, to reduce the current and future burden of ill health in Merton attributable to unhealthy weight. Action must be cross-sector and cross-organisational, involving the council, NHS, voluntary sector and partners, and go beyond individual behaviour change, to reshape the built and social environments in which our residents live, travel and work; including development of a cross-borough healthy weight strategy across the lifecourse, taking into account both individual behaviour change and work with planning and environmental health to drive changes to the obesogenic environment.
- Joint working between Environmental Health and Public Health to further develop the Healthy Catering Commitment with local fast food outlets, and a responsible retailers scheme with convenience stores around increasing access to healthy and affordable food and reducing the sugar. Consider how to further embed sustainable healthy food provision into the mind-sets of local businesses, schools, healthcare providers and other public sector organisations.
- Continuing to work across LBM Planning and Public Health teams to embed impact on health as a criterion for planning considerations, and corporately to embed healthy and sustainable food procurement and supply across the public sector.
- Joint working across the partnership to promote and implement the Merton Food Charter, a borough-wide vision for creating a healthy sustainable food environment in Merton.
- Commissioning of a new integrated weight management and health improvement procurement based on evidence of best practice and NICE guidelines, including brief interventions training of frontline staff across the borough, including outside the health sector, to increase confidence and competence of staff in supporting behaviour change.
- Continuing to develop and monitor the impact of internal LBM and external 'healthy workplaces' outreach with Merton Chamber of Commerce, providing local businesses with a framework for supporting employees to be healthier and more productive.
- Considering how to gather more conclusive data on the dietary habits of Merton residents as well as on other healthy lifestyles, as we have no local healthy lifestyles survey data.
- Working to increase fruit and vegetable consumption, oily fish and fibre, and reduce salt, sugar and fat in the diets of Merton residents, especially in low income groups, concentrating efforts to improve healthy eating environment in Figge's Marsh and Abbey wards.
- Developing alcohol prevention work, highlighting links between alcohol calories and weight.
- Engaging in national advocacy around action on the food environment, particularly sugar.

- Conducting a food poverty needs assessment, based on the recent Sustain Food Poverty report.

Physical activity

- In Merton, the number of residents who are active enough to benefit their health appears to have increased slightly since 2012, although 1 in 4 Merton residents are inactive.
- Men (50.4%) are more active than women (31.6%) in Merton: this gap, and that between different ethnic groups, is larger than elsewhere.

Public Health England's 'Everybody Active, every day' (2014) framework states that physical inactivity is costing the UK an estimated £7.4bn a year, is the fourth largest cause of disease and disability in the UK and directly contributes to one in six deaths in the UK.

Health headlines and context for Merton

- In Merton, the number of residents who are active enough to benefit their health appears to be increasing, with 60.5% of residents active for the 150 minutes per week recommended the Chief Medical Officer, which is higher than in 2012 (54.4%). This is not significantly different than London (57.8%) and England (57%) averages.
- Positively, the number of residents who are classed as inactive (taking part in less than 30 minutes of activity per week) in Merton (23.6%) is significantly better than London (27%) and England (27.7%). This is particularly encouraging and the overarching message should encourage all groups to do a little more activity on top of what they currently do. However, it is unacceptable that 1 in 4 Merton residents are inactive and so moving those who are inactive to a significant level of activity should be prioritised as this has the greatest benefit.
- The Active People Survey (APS) shows that 40.7% of residents are active once a week; compared to 38.1% in London and 35.5% in England. The trend data shows a large increase between 2012 and 2013, possibly as a result of the Olympics, but participation fallen back and is now at the same level as it was in 2009.
- Men (50.4%) are more active than women (31.6%) in Merton. This pattern echoes both London (Men 43.9% vs. Women 32.3%) and England (Men 40.6% vs. Women 30.7%), however it is noticeable that there is a larger gap between the genders in Merton than regionally or nationally, which seems to be because men are more active in Merton compared to London and England.
- In Merton, residents with a White British ethnicity are more active (42.9%) than both London (38.3%) and England (25.1%). Residents from Black and Minority Ethnic groups (37.75%) are as active as London (38.2%) and more active than England (33.9%). It is noticeable that there is a larger gap between the ethnicities than is seen at regional or national level, which should be explored further.
- Participation by age in Merton is relatively similar to the regional and national picture. As residents age they become less physically active, which is of concern due to the protective effect that physical activity has on a number of conditions such as diabetes.

New research and evidence since the previous JSNA 2014/15 report

Physical Activity Audit (2015)

Merton Public Health commissioned the UKactive Research Institute to conduct a physical activity service assessment, building on existing partnerships and engage with a wide range of local stakeholders including private, voluntary, and public sector organisations. This was in response to Public Health England publishing

the 'Everybody Active, Every Day' (EAED) framework that sets out opportunities for action using four domains; active society, moving professionals, active environments and moving at scale. At the time of writing (October 2015) the findings of the assessment are still being finalised, but initial findings include:

Insight:

- A clear ambition for greater cohesion between teams within the local authority, and a determination to raise physical activity as a priority, and awareness of physical inactivity issues amongst senior officers.
- A link between Transport & Town Planners and Public Health has been recognised as significant at a strategic level and is being utilised to influence planning and health impact assessments.

Strengths:

- Active workplaces in both the public and private sectors, and active travel specifically focused at schools and communities. Healthy walks programming is free, inclusive, and progressive.
- Health inequalities have been identified, targeted, and are being monitored.

Development Opportunities:

- Communication – both within authority (interdepartmental) and externally (planned and targeted marketing campaigns to raise awareness of campaigns).
- Evidence based group and one-to-one physical activity programming.
- Engrain physical activity within policies, commissioning, and planning across the life course that will contribute to a wider active society, and link local health policy to planning, transport, and housing.
- Develop knowledge and engage professionals within education, sport and leisure, health and social care, planning and transport, and the clinical commissioning group to facilitate action and increase awareness to a level in line with healthy eating and smoking cessation.
- Improve the systematic use of evaluation in existing and planned.

Relevant Local Strategies

- *Merton Health and Wellbeing Strategy 2015-2018*
- *Merton Culture and Sport Framework*

Physical activity: key Issues and focus areas for the coming year

- How to effectively monitor the activity and inactivity levels across Merton, to ensure that resources are targeted at the most in need groups.
- How to utilise the evidence based 'PHE Everybody active, every day' framework to increase activity/reduce inactivity in Merton, implementing the findings of the UK Active physical activity service assessment, exploring in greater detail the Active People Survey to identify priority groups and emerging trends and working across the partnership to create an environment and culture that is conducive to physical activity.
- How to work in partnership with primary care to support prevention agenda and increase physical activity brief interventions.
- How to get the appropriate 'mix' of activities and intervention to drive up participation e.g. leisure centres, active travel programmes, green outdoor activities, sport/other cultural activities e.g. dance

Smoking

- Percentage of the population that smokes (2014/15): Merton 15.5%, London 17.0%, England 18.0%.
- Merton appears to have bucked the national trend in smoking cessation, with 517 four-week quits in 2014/15, compared to 495 in 2013/14 (up 4.4%), which appears to demonstrate the successful approach of our local stop smoking service (LiveWell).

Smoking is one of the biggest causes of death and illness in the UK. It significantly increases the risk of developing more than 50 serious health conditions, for the individual who smokes, and for their family, friends and colleagues through second hand smoke. There is a strong link between cigarette smoking and socio-economic group, and smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK.

From 1st October 2015 it has been illegal to smoke in a car or other vehicle with anyone under the age of 18. This provides an additional opportunity to encourage and signpost smokers to the Merton stop smoking service. LBM is currently re-commissioning smoking cessation services as part of the integrated healthy weight and healthy lifestyles service.

Health headlines and context for Merton

- In Merton, 15.5% of the population smoke, not significantly lower than either London (17.0%) or England (18.0%). Since 2010, the prevalence of smoking has been decreasing nationally and regionally. In Merton, the prevalence has fallen from 16.2% in 2010; although the prevalence is slightly higher in 2014 (15.5%) than 2013 (13.9%), the difference is not significant.
- 254.8 deaths per 100,000 are attributed to smoking in Merton, lower than London (275.9) and England (288.7). However this appears to be increasing since its lowest point (238.9) in 2009-2011.
- Smoking rates tend to be higher in areas of higher deprivation. The prevalence of smokers from routine and manual backgrounds/households in Merton (20.2%) is higher than the average for the borough (15.5%). The rate appears to be decreasing over time from 23.5% in 2011/12 to 16.5% in 2013/14, but up again to 20.2% in 2014. This is still lower than London (25.3%) and England (28.0%).
- Smoking in pregnancy has detrimental effects for the health the baby and health the mother. 4.4% of mothers in Merton smoke at the point of delivery, lower than London (4.8%) and England (11.4%).
- Nationally, the number of people who successfully quit smoking through NHS Stop Smoking Services in 2014/15 is down 23% on 2013/14 figures. Partially explained through a drop in prevalence, there is anecdotal evidence that this is in part due the increase in use of e-cigarettes.
- Merton appears to have bucked the national trend, with 517 four week quits in 2014/15 compared to 495 in 2013/14 (up 4.4%), which appears to demonstrate the successful approach of our local stop smoking service (LiveWell).
- Local service data for the stop smoking service shows that in 2014/15
  - Just under 80% of the successful quitters were from white backgrounds.
  - 278 (53.7%) of the successful quitters were female.
  - The largest group of successful quitters (29%) were aged between 45 and 59 years
  - The majority of successful quitters were from managerial and professional occupations (23%), closely followed by routine and manual occupations (22%) and then retired (15%).
  - The majority of successful quitters used Varenicline (Champix) only (165), followed by those who used a combination of licensed nicotine containing products (163), those who used a single licenced nicotine containing product (127) and those who did not have any licensed or unlicensed nicotine containing product (31).

- 447 (86.4%) of successful quitters attended one to one support from the service, 64 (12.3%) attended drop in clinics and 6 (1.1%) received telephone support.

New research and evidence since the previous JSNA 2014/15 report

Smoking Insight and Sector Led Improvement on Tobacco

Smoking Insight

Public Health Merton commissioned Cause Action Ltd, working in partnership with Skyrocket Research and The University of Greenwich to deliver a project aimed at encouraging and supporting more Merton residents who smoke to engage with the (LiveWell) Stop Smoking Service.

The main findings from the insight phase were:

- The current service – its delivery model and promotion – is attractive to, and welcomed by, those smokers who are willing to give up and open to support.
- New services will need to be designed to attract smokers with different mind-sets – for example those who might consider cutting down but do not want to quit.
- It is likely that smokers are being "lost" in the time between hearing about the service from a health professional, or self-referring, and attending their initial session. This "customer journey" process needs to be analysed and improved.
- GP practices need to easily access all services options available to patients and take a more proactive role in ensuring smokers find a service that suits them.
- Relationships and processes between GPs and Pharmacies can be improved so they collaborate to ensure as many smokers as possible access benefit from the service.
- Options for adapted recruitment activity include focusing on smaller geographical areas, using "lung age" to initiate engagement, developing deeper relationships with Community Groups, dentists and hospitals, and sending personalised invitation letters.

At the time of writing (October 2015) components two and three are still in development, but the insight phase has already been beneficial to the current service as well as contributing to the commissioning of the service, as part of the integrated health improvement service, that will start in April 2016.

CLeaR – Sector Led Improvement

Merton took part in the CLeaR (Challenge, Leadership and Results) assessment on tobacco. The process culminated in an action plan that will build on current performance and areas for development, including

- All partners agreed that more joint working would be good, to target action effectively.
- Exploring links between antisocial behaviour and underage sales and developing actionable intelligence on other areas of concern e.g. underage sales.
- The embedding of a public health role in the regulatory service division provides an innovative opportunity for joint work.
- Exploring the role of CQUINS, Quality Premiums and other incentive programmes to embed prevention and making every contact count.
- The opportunities arising from the emerging use of e-cigarettes and the need for clear and consistent messaging around the benefits and concerns of their use.
- The opportunities that would be realised from the development of a tobacco control alliance and action plan for Merton, which the evidence seems to suggest would be crucial to tackling tobacco.

Relevant local strategies for this topic

- *Merton Health and Wellbeing Strategy 2015-2018*

Smoking: key Issues and focus areas for the coming year

- Joint recommissioning between LBM Public Health and MCCG of an integrated healthy lifestyles and weight management service, including smoking, around a single point of access.
- The role of e-cigarettes to support people to quit. PHE recently published their position, including a call for stop smoking services to engage with smokers who want to quit using e-cigarettes. The local service is 'e-cigarette friendly' and is developing protocols and point of sale promotional materials.
- Partnering with primary care to support the prevention agenda e.g. the GP pro-active pilot.
- Supporting smoke free environments. We are putting up signs encouraging smokers not to smoke in the 55 playgrounds in Merton. Although not enforceable, this compliments the smoke free message across Merton. We are also working with litter enforcement officers to offer a refund of a fine for dropping cigarette butts if an individual is referred to local smoking cessation services and quits.
- Supporting enforcement teams to deliver test purchases of age restricted products, at a time when budgets are decreasing.
- Capitalising on the smoke free cars legislation, emerging evidence on e-cigarettes, smoke free playgrounds and further strengthen an already well performing service to (1) support more Merton residents to stop smoking or (2) minimise the harm caused by smoking.

Substance misuse (drugs and alcohol)

- The performance of the drug treatment system (as measured by the successful completion of treatment), remains strong in Merton; indicators place Merton in the upper quartile of nationally-recorded performance.
- However, the treatment naïve population (those who have never accessed treatment) needs to be verified.
- Health and wellbeing indicators for young people in treatment locally are improving in line with national trends; successful completions of treatment for young people (94%) continue to be above national average (79%), and re-presentations to services are low (3%) compared to England (6%).
- Hospital admissions due to alcohol conditions and substance misuse are higher than England averages for young people.

Substance misuse is often a symptom as opposed to a cause of vulnerability for young people, many of whom have broader difficulties that are compounded by drugs and alcohol which require addressing simultaneously (PHE 2013). Social deprivation, poor housing, crime and association with those involved in crime, along with poor diet, low income and potentially less opportunity for educational attainment can all contribute to negative life experiences and chances for those affected by them.

A broad range of integrated preventive and specialist young people's substance misuse interventions are essential to achieve positive outcomes for young people through both reducing risk and building resilience.
Specialist interventions for young people's substance misuse also provides value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 in the long term (PHE 2013).

Health headlines and context for Merton

- The performance of the drug treatment system, as measured by the Public Health Outcomes Framework (PHOF) indicators 2.15i and ii, remains strong in Merton with planned discharge for opiate users at 16.1% year to date against an 11 – 17% target.
- Planned discharges year to date for drinkers is 55%, placing Merton in the upper quartile of nationally-recorded performance. Merton is also within the top quartile for successful completion rates for non-opiate users.
- The rate of Hepatitis C testing in Merton has shown considerable improvements, particularly for new clients. This group has shown a steady increase in testing rates from 54% of those eligible in quarter one 2014-15, up to 78% in quarter one of 2015-16.
- Numbers of young people in specialist substance misuse treatment reduced minimally in 2014-15, in line with national trends and in spite of reduced numbers of young people entering youth justice services. Early data from Q1 2015/16 indicate numbers are increasing to previous levels.
- Numbers of young adults (18 to 24s) in young people's services have remained steady for the last three years. Successful completions of treatment for young people (94%) continue to be above the national average (79%) and re-presentations to services locally are low (3%) in comparison to national averages (6%).
- Outcomes for young people entering specialist treatment in Merton are good with young people both reducing use of alcohol or drugs and becoming drug free following treatment.
- Health and wellbeing indicators for young people involved in treatment locally are improving in line with national trends. Patterns of drinking and drug use behaviour are also shifting from weekday /evening activity to weekend activity, all at lower levels following treatment.
- Merton's specialist young people's substance misuse service has been re-designed to integrate substance misuse treatment with detached youth provision and sexual health promotion, creating a new Risk and Resilience Service. This will ensure evidence-based substance misuse interventions are linked to the broader context of young people's lives, building resilience and reducing risks.
- Hospital admissions due to alcohol conditions for young people are lower than the regional average but higher than England averages. Hospital admissions due to substance misuse for young people aged 18 to 24 are, however, higher than both regional and England averages.

Relevant Local Strategies

- *Merton Health and Wellbeing Strategy 2015- 2018*
- *Merton Strategic Plan 2015 -2016*
- *Merton Children and Young People's Plan 2015 – 2018*
- *Merton Adult Services Commissioning Strategy 2015 – 2018*
- *Merton Joint Teenage Pregnancy and Substance Misuse Strategy 2014-2017*

New research and evidence since the previous JSNA 2014/15 report

Tier 4 (commissioned substance misuse inpatient) review

Public Health and MCCG commissioned a review of the Tier 4 substance misuse services in early 2015, to inform future commissioning decisions. The review clearly demonstrated both need and demand for T4 provision and in particular residential and community detox and residential rehabilitation, provided options

for development of services, and recommended transfer of T4 contract management T4 to Public Health to ensure alignment to whole treatment system.

Adult Substance Misuse Service Consultations

A consultation was conducted around the re-tender of the Adult Substance Misuse Service. This highlighted the need to commission accessible services closer to the Borough (the inpatient detoxification service located in Crawley, Sussex, currently forms part of the Adult Service retender). Two events were held with GPs and pharmacies in November 2015 around new models of care for substance misuse, including development of Shared Care in primary care.

Consultation regarding drinking issues in Merton has highlighted the need to work more effectively with hard to engage drinkers, as well as continuing to undertake preventive work through identification and brief advice and training for professionals.

Public Health and Licensing: Data Analysis and Consultation about the Alcohol Environment

To ensure an environment and a culture in the borough that prevents and addresses alcohol-related problems, the Merton Public Health team and partners engaged in the planning and licensing process:

Data analysis:

The Director of Public Health is now a Responsible Authority, and able to comment on licensing applications. In 2014, Merton Public Health, jointly with 5 other London boroughs, commissioned Safe Sociable London Partnership (SSLP) to develop a scanning tool which pulls together postcode-level public health data relevant to the licensing objectives into an easy to interpret graphic and dashboard. Since October 2014, this data has been used to inform Public Health representations to the Licensing Committee, and has been well received by other Responsible Authorities.

Consultation:

Public Health provided qualitative and quantitative data to inform the review of the borough's Statement of Licensing Policy:

- Public Health conducted an analysis of local data around antisocial behaviour, violence, ambulance call outs and other alcohol-related harms in May 2015 to inform the decision both on the implementation of a new cumulative impact zone (CIZ) in Mitcham Town and the area of the zone.
- In August 2015 we commissioned a team of Youth Inspectors to audit 165 shops and premises in the proposed Mitcham Town CIZ. They found many convenience stores or supermarkets sold alcohol, and the majority sold super strength alcohol and alcohol in single cans. Just over a third of stores had significant advertising of alcohol outside, in the window, or clearly visible from outside the store. They concluded that overall, the high streets were unhealthy due to the amount of alcohol and unhealthy food for sale in the area.
- Healthwatch Merton gathered local residents' views on the proposed Mitcham CIZ using an online survey, two 'pop up cafes' in Mitcham Town Centre and a drop-in at a local GP practice. 192 people participated, a third of whom felt that Mitcham Town Centre has too many alcohol shops. Among responses directly relating to the alcohol environment were concerns about street drinkers and litter, with comments regarding broken glass and beer cans on the streets. There was significant mention of anti-social behaviour and crime and safety during the night. Several respondents noted a desire for restrictions on alcohol, fast food and betting shops in the Town Centre.
- A locally commissioned research project into young people's substance misuse and annual substance misuse data also confirmed higher levels of alcohol use by young people in Merton in comparison to national figures. Young people whose families were affected by substance misuse also reported accessing alcohol through the home from parents or older siblings.

Substance misuse: key Issues and focus areas for the coming year

- Developing preventive work on substance misuse and promoting access to services and advice.
- Redesigning, commissioning and mobilising a new integrated substance misuse service to be in place in 2016, maintaining investment in treatment and rehab services, while developing increasing focus on prevention and service delivery in primary care. The new service must have proactive links with the young people's Risk and Resilience service, and key support agencies, including mental health.
- Validating 'treatment naïve' population numbers i.e. those not accessing services (last refreshed in 2012), and identifying and using suitable methods in the new service to engage this population.

- Analysing local and national data to identify trends and issues (e.g. New Psychoactive Substances)
- Audits: A&E liaison data to ensure appropriate advice and referrals; pharmacy provision and needle exchange; and supervised consumption, for adults and young people.
- Auditing and supporting PSHE provision in respect of Drug and Alcohol Education in Primary, Secondary and Alternative Education Provision.
- Continuing to influence alcohol licensing applications and awards in Merton through provision of public health data and intelligence, and joint work across all Responsible Authorities to promote a safe and sociable alcohol environment in the borough.
- Supporting the new service to target detached youth activity to areas of high need in the borough and enable fast-tracking of vulnerable young people requiring treatment into specialist provision.

6. Adult health and wellbeing in Merton

Physical health

- There is variation in the prevalence of many long term conditions across Merton
- In 2013/14 Merton CCG had the highest prevalence of COPD compared with statistical neighbours, and the second highest prevalence in SW London comparable with NHS Kingston CCG. (QOF 2013/14)
- There is lower uptake in Merton than the national average for breast and cervical screening, and bowel screening uptake is lower than in Richmond, Sutton and Kingston.
- Research found approximately 2/3 of the eligible population of Merton have not had a health check.

Chronic long-term conditions are a major cause of morbidity, mortality and costs to the health and social care system locally and nationally. There is enormous potential for prevention and early detection and management of these conditions to reduce hospital admissions and bed days. Transforming health care delivery, to achieve less reliance on hospital services and more imaginative and effective use of community-based approache,s provides people with more accessible care, strengthens collective health resources and reduces the burden on the acute sector. The NHS Health Checks Programme is key to identifying people at risk of these conditions through screening or surveillance and enable prevention and early intervention.

Smoking, poor diet, overweight/obesity, unhealthy lifestyles and lack of physical activity are modifiable risk factors common to many long term conditions. These risk factors are linked with income, socioeconomic position, levels of education, stress and unhealthy coping mechanisms, and multiple co-morbidities. Consequently, there are well established health inequalities and potential equity issues (access) linked with many long term conditions.

Changes in PHOF data from the previous year

Positive	**Negative**
Reduction in: • **Under 75 mortality rate for CVD and preventable CVD** • **Emergency readmissions within 30 days of discharge** • **Preventable sight loss- age related macular degeneration** **Increase in:** • **Recorded diabetes** • **Flu vaccination coverage, at risk populations and 65+**	**Reduction in:** • **Cancer screening coverage - breast and cervical cancer** **Increase in:** • **Female mortality rate from causes considered preventable** • **Under 75 mortality rate from cancer** • **Under 75 mortality rate from respiratory disease and preventable respiratory disease**

Health headlines and context for Merton

- In 2013/14, Merton CCG had the highest prevalence of COPD compared with statistical neighbours, and the second highest prevalence in SW London comparable with NHS Kingston CCG (QOF 2013/14).

- There is variation in the prevalence of long term conditions across Merton. Further work is planned to ascertain the "unwarranted variation" locally.
- A significant proportion of the population in Merton who are likely to have conditions such as COPD and diabetes have yet to be identified.
- In Merton (QOF, 2013-14), the recorded prevalence of diabetes (adults) is 5.6% (England 6.2%).
- NHS Merton CCG has prioritised diabetes early detection and management and had two quality premium metrics around structured education and increasing the detection of undiagnosed cases.
- Overall, Merton CCG does well on measures relating to neurological conditions, with a slightly higher spend for better outcomes compared with CCGs nationally.
- While local neurological services are highly valued, reports indicate that some individuals experience delays in access to ongoing care.

New research and evidence since the previous JSNA 2014/15 report

Cancer health needs assessment (2014)

Key findings:

- 54% of all cancers in Merton CCG are breast, lung, prostate or colorectal cancers
- 70% of people with cancer have at least one other long-term condition.
- Lower uptake than national average for breast and cervical screening (Breast screening uptake in Merton is 66.2% and in England 75.9%, cervical screening uptake 69.7% in Merton and 74.2% in England). Bowel screening uptake lower than in Richmond, Sutton and Kingston. Low screening uptake among Black and Asian Minority Ethnic groups (BAME). Most screening targets in Merton are missed during the month of August; therefor interventions are needed to overcome this.

Neurological conditions health needs assessment (2014-15)

Key messages:

- Merton CCG does well on measures relating to neurological conditions, with a slightly higher spend for better outcomes compared with CCGs nationally; non-elective inpatient care represents the highest proportion of the neurology budget, and comorbidities play a significant role in care needs.
- Local services are valued, however some individuals experience delays in access to ongoing care.
- Inequalities are observed in use of health services; there are higher rates of admission among people from 'other' ethnic backgrounds and those from more deprived areas of the borough.
- Commissioners should ensure sufficient capacity exists in community services to ensure access to ongoing therapies for individuals with neurological conditions, and integrated local pathways across secondary, community and social care address support needs of people with neurological conditions.

NHS Health Checks insight research (2015)

Insight research was commissioned to inform a social marketing plan to increase NHS Health Checks uptake.

Key findings:

- Those that have not had a health check are more likely to be younger, male, live in the east of the borough, be South Asian, be smokers and be less engaged with primary care than those that have.
- Of those who have not yet had a check, 65% would be "fairly" or "very" interested in having one.
- Reaching less engaged groups: health checks need to be delivered and promoted differently for different segments. This includes optimising the invitation process and uptake in pharmacies.

NHS 7 day working review (2015)

A rapid review was conducted to provide an evidence on the prioritisation of seven day NHS working in Merton. Key findings:

- There is a need to lower the rate of unplanned admissions for Ambulatory Care Sensitive Conditions (ACSC) generally, and unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s.
- There is a need to prioritise areas that impact the top 5 conditions leading to unplanned admissions (all ages) over weekends: influenza and pneumonia, dehydration and gastroenteritis, asthma, Chronic Obstructive Pulmonary Disease (COPD) and cellulitis.
- There is a need for particular provisions for frail older people with multiple long term conditions.
- There is a need for a systematic approach to seven day working, and learning from the minimal evidence available to minimise the risk of failure.

Pharmaceutical Needs Assessment (2015)

Key findings: The PNA identified that access to pharmaceutical services for the residents of Merton is good and that there are currently no gaps in the provision of essential and advanced services, however there was a gap in the provision of the minor ailments service (an enhanced service) on Sundays in the East Merton and West Merton localities.

The full PNA is available at http://www.merton.gov.uk/merton_pharmaceutical_needs_assessment.pdf

Relevant local strategies for this topic

- *Merton Health and Wellbeing Strategy 2015-2018*
- *NHS Merton CCG Operating Plan*
- *NHS Merton CCG Cancer Action Plan*

Physical health: key Issues and focus areas for the coming year

- Improvements in early detection and management of long-term conditions provide opportunities for the quickest gains in life expectancy. Identifying people at risk of long term conditions through screening or surveillance, along with improved access to services, will improve residents' quality of life and reduce the need for more expensive acute services.
- The CCG should consider new models of service provision that involve more care being provided in community settings and less at hospital sites. A whole systems approach focusing the model of care is needed to deliver 'integrated' services. This should include access to support for primary prevention and for secondary prevention in primary); these services should work in close partnership with social services.
- Merton CCG should continue to take steps to lead improvement in the quality of primary care management of chronic diseases in East Merton. A networking approach to primary care development may be an important way of achieving this.
- Interventions to support individuals to reduce risk factors need to be in place. A programme of personalised advice and support services has been introduced to support healthy lifestyle choices; this includes the Stop Smoking Service. Commissioners need to monitor and evaluate its success.

- Wider local authority input through existing contracts with services such as leisure and housing, and through planning responsibilities, will help to support people to achieve healthy lifestyles and will be of significance in reducing the risk of disease in a wider range of population groups.
- There are variations in the prevalence of diseases across Merton and these need to be understood better. For instance, there are clear inequalities in coronary heart disease (CHD), stroke, diabetes, respiratory disease (COPD) and cancer across the borough and between genders. Merton CCG should work with practices to reduce these variations, to ensure that patients are identified early and receive timely and appropriate treatment and support for their condition.
- Developing, refining and evaluating the Proactive GP Pilot and consider extending to all GP Practices.
- In diabetes, more needs to be done locally on: helping people and families to achieve and maintain a healthy weight; early identification of those at risk and having disease; ensuring access to appropriate services to support people with diabetes to control their blood sugar levels and reduce potential complications; reducing GP Practice variations and better achievement of the care processes; and ensuring that the Merton GP Practices take part in the National Diabetes Audit.
- Ensuring implementation of the National Diabetes Prevention Programme, the National TB Strategy and specifically the LTBI (Latent TB Infection) testing programme in Merton.
- Improving uptake and coverage of screening, targeted at deprived areas and disadvantaged groups, is needed for early identification and improving outcomes. Commissioners need to use social marketing approaches to understand why the uptake of screening services is below national rates and how future uptake could be improved. Groups for particular focus are: people with learning disabilities, ethnic minorities, young women and socially deprived groups.
- Developing, refining and evaluating the ACE (Accelerated, Coordinated and Evaluated) Programme (sponsored by NHS England) to increase bowl cancer screening uptake in people 60 years and over.
- Statutory bodies in Merton should consider the extent to which a new health care facility in East Merton could contribute to health improvement in that locality.
- Commissioners should ensure that sufficient capacity exists in community services to ensure access to on-going therapies for individuals with neurological conditions and that integrated local pathways across secondary, community and social care address relevant support needs of people with neurological conditions.
- Pending plans: Review of paediatric upper respiratory tract infections and asthma, neurological conditions action plan, and HNAs in asthma, CVD, diabetes, COPD, and learning disabilities.

Mental health

- Black ethnicities and people from the most deprived areas of Merton were over-represented and Asians under-represented in in both the in-patient population and the (CMHS) populations.
- There are 1926 people with dementia, a prevalence of 0.9% for Merton CCG, higher than England (0.7%), and London (0.7%).

Mental health:

One in four people in the UK will experience a mental health problem in the course of a year. In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by Disability Adjusted Life Years (DALYs)[39].

People experiencing a physical health condition are also more likely to suffer mental ill health. The reverse is also true: mental ill health may often increase the risk of physical illness. [40] There are key inequalities in physical health for people with serious mental health problems. Mental ill-health can be both the cause and the consequence of social exclusion leading to a vicious cycle of homelessness, unemployment, and worsening physical and mental health.

The cost of mental health problems to the economy in England have recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years (NEPHO). The Greater London Authority published a paper in 2014, 'London Mental Health: The invisible costs of mental health;'[41] it estimates that mental ill health impacts result in around £26 billion each year in economic and social costs to London.

Dementia

Dementia is a progressive syndrome, characterised by widespread impairment of mental function. Dementia is associated with complex needs particularly in the later stages, and is one of the major causes of disability and dependency among older people. Both prevalence (known cases) and incidence (new cases) of dementia rise exponentially with advancing age however; it is possible to have dementia when you are younger. Alzheimer's disease is the most common form of dementia and may contribute to 60–70% of cases[42].It can be overwhelming not only for the people who have it, but also for their caregivers and families. The National Dementia Strategy (2009)[43] advocates for 'Improving public and professional awareness and understanding of dementia' as a key contributing factor to the prevention of dementia.

[39] World Health Organization (2008) Global Burden of Disease Report. WHO http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html

[40] Royal College of Psychiatrists Physical Illness and Mental Health

[41] London Mental Health: The invisible costs of mental ill health; Greater London Authority, January 2014 http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf

[42] World Health organisation Dementia Factsheet http://www.who.int/mediacentre/factsheets/fs362/en/

[43] The National Dementia Strategy 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

Changes in PHOF data from the previous year

Positive	Negative
Reduction in: • Social Isolation: % of adult social care users who have as much social contact as they would like • Depression/anxiety among social care users • Depression prevalence • Suicide rate Increase in: • % of adults in contact with secondary mental health services who live in stable and appropriate accommodation • Satisfaction with social care support & protection • Employment of people with mental health disorders • Dementia diagnosis rate	Reduction in • Self-reported well-being - people with a high anxiety score • Rate of recovery for IAPT treatment Increase in: • Gap in the employment rate for those in contact with secondary mental health services, and the overall employment rate • Emergency admissions for neuroses • Schizophrenia emergency admissions • Excess under 75 SMI mortality • Premature SMI mortality • Emergency hospital admissions for intentional self-harm

Health headlines and context for Merton

- Overall Merton does well on many measures of mental health, with lower spend and better outcomes. Modelling predicts increased demand for mental health services over the next 5 years.
- The 3 top causes for in-patient admission were *schizophrenia, psychoactive substances and mood affective disorders*. The 3 top causes for Community Mental Health Services (CMHS) referrals were *mood affective disorders, psychoactive substances and schizophrenia*.
- There are 1926 people with dementia, a prevalence of 0.9% for MCCG, higher than England (0.7%), and London (0.7%). Black ethnicities and people from the most deprived areas of Merton were over-represented and Asians under-represented in in both the in-patient population and the (CMHS) populations.

New research and evidence since the previous JSNA 2014/15 report

Adult Mental Health Needs Assessment (2014)

Key findings:

Where there is room for improvement:

- Equity: Under-representation of Asians and over-representation of black minority ethnic groups.
- Services that address dual diagnosis of substance misuse and mental ill-health, and hidden harms.
- Personality disorders (PD): Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. There needs to be more and better access to psychological treatment (DBT/MBT).
- Primary care variation by practice, variable quality outcomes and under-diagnosis. Primary Care management of the physical health of Merton residents with schizophrenia; more work is required to ensure the physical health of residents with schizophrenia is better managed in primary care.

- In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012- August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%.

Dementia health needs assessment (2015)

Key findings:

Where Merton is doing well:

- Dementia continues to be an area of high profile and priority and robust stakeholder engagement.
- Merton has made substantial progress in identifying and diagnosing those with dementia, and there is a wide range of sources of information for dementia advice and services.
- The Community Mental Health Team (CMHT) has coped with increased demand and caseload (although this is a key future consideration).

Where there is room for improvement :

- Tackling dementia stigma through increased education to all stakeholders.
- Reducing variation in dementia diagnosis rates between GP practices and between localities.
- Improving data capture around ASC caseload and cost of people with dementia.
- End of Life Care (EoLC) discussions with people with dementia and their carers.
- Improving the process for reacquiring social services support after hospitalisation for residents with dementia, and tackling the misinformation about the entitlements of people who are self –funding.
- Better out of hours support and crisis support for carers, and increased availability of GPs as a source of information and advice on living well with Dementia.
- Increasing the available community activities, particularly for Black and Minority (BAME) groups
- Tackling the service gap of an older people's psychiatric liaison resource for residents in acute care.

Mental health: key Issues and focus areas for the coming year

- The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting[44].
- A range of targeted and outcome specific early intervention and support services should be considered, culturally sensitive to Merton's BAME groups, to promote mental health wellbeing and reduce stigma.
- Merton must take a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.
- For people with mental ill-health unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.
- The range of accommodation in Merton for people with mental health need should be reviewed, to establish current need, and enable planning for the future provision of housing and support options.
- All employers in Merton (including in LBM and MCCG) should be sensitive to potential mental health issues underlying sickness absence, ensuring adequate occupational health provision, employee assistance programmes to prevent the build-up of stress, and promotion of healthy workplaces.
- Ensuring stop smoking services are available to Merton residents with mental ill-health.

[44] http://www.fph.org.uk/parenting

- Ensuring that relevant services are aware of the Dementia Hub in Merton and how patients with dementia can be referred to it, particularly GP practices.
- Strengthening services for dual diagnosis of substance misuse and mental ill health, to ensure early identification, clear eligibility criteria, referral and care pathways, and robust outcome measures.
- Developing services and pathways to reduce demand on acute beds, by increasing care for the mental and physical health of the frail and elderly in community settings, and providing a holistic assessment.
- Front-line staff and health care professionals in primary care must be trained to better recognise and refer in mental ill-health and the early signs of dementia.
- Carers' needs must be addressed and a new Carers strategy must be developed for Merton.
- Variations in quality and under-diagnosis need to be understood in greater depth and minimised in primary care, particularly in GP practices in East Merton.
- The physical health of Merton residents with mental health conditions needs to be monitored regularly.
- Dementia: ensure sufficient capacity of the Community Mental Health Team (CMHT), and that any developments to the memory assessment service are in line with Memory Services National Accreditation Programme (MSNAP) recommendations; and reduce the disparity in diagnosis rates between GP practices and investigate the cause of the variation.
- Finalising and taking forward the implementation plan for MH overall, and the crisis concordat plan, and developing the Dementia strategy for 2016-2020
- Adult mental health peer support services review and developing pilot programmes are currently underway
- Implementation of the London-wide Digital Mental Wellbeing Project in Merton, once procured.

Sexual health

- STI rates are increasing: Merton ranks 23 out of 326 local authorities for the rate of Gonorrhoea which is a marker of high levels of risky sexual behaviour (96.9 per 100,000). This is a marked increase since the last available data in 2011 when it was 76.6.

Sexual health is a wide ranging public health issue. Most of the adult population of England will be sexually active at some time. Many people, including health professionals, are not comfortable talking about sexual health issues and some groups are at high risk of poor sexual health due to stigma and discrimination which can impact their ability to access services. Commissioning of effective interventions and services is essential to improving outcomes.

In England, 50% of pregnancies are unplanned which has a major impact on individuals, families and society. When this is a teenage pregnancy, there are many specific adverse consequences for both mother and child. The cost of teenage pregnancy to the NHS is estimated at over £63m a year, and the estimated cost of benefit payments to a teenage mother for three years after birth is between £19,000-23,000[45].

[45] Teenage Pregnancy Next Steps: Guidance for local authorities and Primary Care Trusts on the effective delivery of local strategies, 2006, Department for Education and Skills.

It is estimated that one person is diagnosed with HIV every 90 minutes. Over half of those newly diagnosed are diagnosed after the point at which they should have started treatment[46]. Each new case of HIV infection is estimated to represent between £280,000 and £360,000 in lifetime treatment costs[47].
Young people aged 15 to 24 years, men who have sex with men (MSM) and black Caribbean ethnic groups experience higher rates of STIs. In Merton 42% of new STIs were seen in 15-24 year olds and 26.8% (where sexual orientation was disclosed) in MSM.

There is considerable geographic variation in the distribution of STIs, HIV and teenage pregnancy across Merton. Rates of STIs, HIV and teenage pregnancy are strongly correlated to socioeconomic deprivation, with the highest incidence in the east of the borough. Access to services is lower in this part of the borough.

Changes in PHOF data from the previous year

Positive	Negative
Reduction in: • Teenage conceptions • Late diagnosis of HIV • STI re-infection rates (used as a marker for risky sexual behaviour) **Increase in:** • Chlamydia diagnoses amongst 15-24 year olds showing increased success of the programme	**Increase in** • Sexually transmitted infections • HIV prevalence • Chlamydia (all ages) and Gonorrhoea

Health headlines and context for Merton

- In 2013, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Merton was 2063.4 (compared to 2015.6 per 100,000 in England). This is an increase since the last available data from 2011 when it was 1987.8 which indicates increasing success of the local screening programme.
- In 2013, Merton ranks 23 out of 326 local authorities for the rate of Gonorrhoea which is a marker of high levels of risky sexual behaviour. The rate per 100,000 is 96.9. This is a marked increase since the last available data in 2011 when it was 76.6.
- In Merton, between 2011 and 2013, 39% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 45% in England. This is a downward trend since last JSNA.
- In 2013, the under-18 conception rate per 1,000 female aged 15 to 17 years in Merton was 22.1, while in England the rate was 24.3. This shows a continued downward trend for Merton.
- Among women under 25 years who had an abortion in 2013, the proportion of those who had had a previous abortion was 32.8%, while in England the proportion was 26.9%
- In 2013, Merton is ranked 306 out of 326 local authorities in England for the rate of GP prescribed Long-acting reversible contraception (LARC), with a rate of 22.7 per 1,000 women aged 15 to 44 years, compared to 52.7 in England.

[46] A Framework for Sexual Health Improvement in England, 2013, Department of Health.
[47] Sexual health commissioning in local government, 2015, Local Government Association.

New research and evidence since the previous JSNA 2014/15 report

- There has been a refresh of the sexual health and contraceptive data for Merton provided by Public Health England. New information on the effectiveness of Pre-exposure Prophylaxis (PrEP) to prevent men who have sex with men being infected with HIV.
- Increase in STIs across London – especially Syphilis and Gonorrhoea. Merton has seen an 8.9% increase in Gonorrhoea which is indicative of risky sexual behaviour.
- Increasing evidence on the effectiveness of online testing and home sampling for STIs and HIV.
- Independent review of local contraceptive and sexual health services was undertaken in 2014/15.

Sexual health services user survey (2014)

- A survey of user satisfaction of GUM and contraceptive services, conducted in 2014, showed that most were extremely or fairly satisfied with the: expertise and friendliness of staff; information given; location of service; confidentiality. Users were less satisfied with: convenience of opening hours; getting their results; making an appointment; and onward referral to other services.
- Main barriers to access were: fear of being seen by someone they know; services not being available at convenient times; and fear that family/friends will find out they are using a sexual health service.
- Key issues were wish for: increased service availability; further signposting; greater involvement of community groups; and service maintenance.

Relevant local strategies for this topic

- *Merton Children and Young People's Plan 2015 – 2018*

Sexual health: key Issues and focus areas for the coming year

- Continue to implement the recommendations from the young people's sexual health and substance misuse needs assessment (2013) – see online JSNA for specific recommendations
- Sexual health services are mandated to provide comprehensive, open access, sexual health services for their local population.
- STI rates are increasing at the same time as budgets are being reduced so creative solutions will be needed in order to meet Public Health Outcome Framework targets.
- As sexual health services are open access and demand led, there is a risk of budget over spend.
- There will be a community based level 2 contraceptive and sexual health service from April 2016.
- Procurement of level 3 sexual health services contributing to London wide transformation of services.
- Provision of HIV home sampling to MSM, part of national Public Health England procurement.
- Support to GPs to increase provision of LARC .
- New prevention and support services targeted at MSM and Black Africans commencing in April 2016.
- It is important to keep a continued focus on teenage pregnancy, which is associated with poorer outcomes for both young parents and their children.
- Implementation of the Healthy Living Pharmacy model rewarding good practice in pharmacies.
- Embed the condom distribution scheme for 13-24 year olds into the young persons risk and resilience service.

7. The health and wellbeing of older adults in Merton

- There are more older people in the west than the east of Merton and the older people in the east are more deprived

There are more older women (in terms of population numbers) than men in Merton; there are 13,740 women as opposed to 10,983 men aged 65 and over. There is a higher prevalence of osteoporosis and rate of falls in women than in men therefore there is a greater need for falls prevention services for women in Merton. There is an east and west divide in falls prevention services.

Changes in PHOF data from the previous year

Positive	Negative
Reduction in: • Emergency hospital admissions for injuries due to falls in persons aged 65-79	Reduction in: • Older people's perception of community safety Increase in: • Social Isolation of Adult Social Care users • Emergency hospital admissions for injuries due to falls in persons aged 80+ • Emergency admissions for fractured neck of femur in persons aged: 65 and over; 65-79; and 80 and over

Health headlines and context for Merton

- Older people make up 12.3% of the population of Merton; this is predicted to grow by 14.7% in the next 10 years. Of people aged 65 and older 44% are men and 56% are women. There are more older people in the west than the east of Merton, but those in the east are more deprived.
- Overall the health of people aged 65 and over in Merton is better than the England average based on proxy measures such as Disability Free Life Expectancy (DFLE) at 65.
- The increase in older people leads to demand for falls prevention services as well as health and social care resources to deal with the issue of falls.
- In Merton there is an NHS-led specialist falls services and a range of fall prevention initiatives in the form of keep fit and exercise classes provided by the voluntary sector. There are two Leisure Centres and a pool which all provide concessionary membership fees for people of retirement age depending on the membership .
- There are initiatives provided by Merton Council as part of the strategy entitled "Celebrating Age – Valuing Experience" a strategy for people aged 50 and above including increasing physical activity in older people.

New research and evidence since the previous JSNA 2014/15 report

Falls prevention health needs assessment (2014-15)

Key messages:

Where Merton is doing well:

- Merton's emergency admissions rate for a broken hip (2012/13) was 13th lowest of 32 London CCGs.
- The rate for Merton residents who return to their usual place of residence following admission for a hip fracture (a proxy measure for availability and quality of community care and home-support services) is similar to the London and England rate, and most comparators.

Where Merton is not doing so well:

- Merton has a significantly higher rate of older people, older women and those aged 80 and above being admitted to hospital for falls related injuries compared to the England average.
- The falls-related mortality rate in the people aged 75 and older for both men and women is second highest of all the 11 comparators.
- Merton is slightly below the national average in terms of the osteoporosis QOF indicator (percentage of patients aged 50 to 74 years with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent)
- The Merton rate for admissions into care homes (a proxy measure for delaying dependence and preventing frailty) is higher than similar local authorities and the London rate.

Service User Consultation:

Three broad themes that emerged from consultations with service users were: Service users' understanding of the determinants of falls; the Merton falls pathway, and barriers to accessing falls prevention services.

Service Providers

The overarching themes that emerged from consultations with Service Providers were: primary prevention and shared ownership of the issue of falls, the referral process into the SMCS Falls Prevention Service, and collaborative working and true integration.

Over 75s review (2015)

- There is limited evidence of interventions that work in the community to reduce hospital admissions.
- An overriding theme is the use of multidisciplinary case management of targeted groups, with effective data collected on outcomes and costs.
- Size of GP practice is associated with number of admissions; larger practices have fewer admissions, as they have the capacity for specialist clinics services and higher ratios of GPs to patients.
- A&E and non-elective admissions and attendances, as well as ambulance call out data, provide better signalling on which groups to target in Merton. Falls Prevention and Nursing Home Liaison are two areas not already incentivised, where more can be done in primary care.

Befriending literature review (2014)

Key messages:

- Social isolation and loneliness contribute to poor health outcomes of older people. Low intensity initiatives to address this are required in Merton for the growing over 65s population, to reduce or delay the need for health and social care services.

- Best practice guidelines suggest no specific model, but that services should involve service users in planning and delivery of services and be responsive to their needs, promote access for those most likely to benefit, necessitate collaborative working from local partners, and be outcomes-focussed.
- Befriending initiatives are a potential low-cost, low-intensity intervention to reduce the social isolation and loneliness experienced by older people. Various service models exist, including face-to-face and telephone based schemes alone or in combination.
- Little evidence exists on the effects of befriending interventions on reduced ill-health and use of services, however qualitative data demonstrates positive effects on quality of life and well-being.

Community navigators (2015)

A review of community navigators services was conducted. Key messages include:

- Many interventions exist to reduce, isolation and loneliness in older people; befriending, social group schemes and community navigators have been reported to be more effective.
- People who use befriending or community navigator services report that they were less lonely and socially isolated following the intervention.
- When planning services, strong partnership arrangements need to be in place between organisations to ensure developed services can be sustained
- Successful programs ensure older people's involvement in planning, implementation and evaluation.
- Successful services have a clear model and focus, strong recruitment partnership practices for volunteers or key staff and standardised data collection to capture and monitor outcomes.
- Interventions of community navigator schemes tend to be unstructured, personalised and fall on a wide continuum making it challenging to compare outcomes or measure cost-effectiveness.

Relevant local strategies for this topic

- *Merton Health and Wellbeing Strategy 2015-2018*

Older adults: key Issues and focus areas for the coming year

- A joint and integrated approach by the CCG and Local Authority is required in falls prevention to: promote physical activity among older people, provide health promotion and prevent frailty and accidents (Objective 4 of the DH systematic approach to fall prevention at a population level) .
- There is a need to strengthen links with the Fracture Liaison Service (FLS); particularly for those with fragility non- hip fractures which tend to precede hip fractures.
- Consider developing a Falls Prevention and Bone Health Locally Commissioned Service (LCS) and targeted work for residents aged 65 years and over in East Merton ACSC NEL admission and ambulance call-out hot spots in Abbey, Colliers Wood, Cricket Green and Figge's Marsh wards.
- Dementia: Ensure sufficient capacity of the Community Mental Health Team (CMHT), that any developments to the memory assessment service are in line with Memory Services National Accreditation Programme (MSNAP) recommendations, and investigate and reduce the disparity in dementia diagnosis rates between GP.
- Complex patients, defined as patients whose primary AND secondary diagnosis includes ACSCs (ICD10 Codes) and additionally dementia, Parkinson's disease and Multiple Sclerosis (MS) are a small percentage of NEL admissions in patients over 50, are likely to be high cost patients and worth targeting.

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Committee: Health and Wellbeing Board

Date: 24th November 2015

Wards: All

Subject: The Time for Prevention is Now - Merton Annual Public Health Report 2015

Lead officer: Dr Kay Eilbert, Director of Public Health

Lead member: Councillor Caroline Cooper Marbiah

Contact officer: Kay Eilbert

Recommendations:

A To note Merton's Annual Public Health Report – The Time for Prevention is Now.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report presents The Time for Prevention is Now - Merton's second Annual Public Health Report.

2. DETAILS

2.1 The second Annual Public Health Report for Merton makes the case for prevention and celebrates the work of Public Health and its partners since the transition of Public Health from the NHS to local government to address health inequalities and embed prevention.

2.2 Beginning in 2013 with a Merton Partnership conference focussing on health inequalities, participants used evidence from the Joint Strategic Needs Assessment to agree that a major challenge lay ahead in reducing unfair health inequalities in Merton.

2.3 Two key objectives for the Public Health team developed: prevention and health inequalities. Public Health developed strong relationships with Council colleagues, Merton CCG, the voluntary sector and local organisations across the borough to make progress.

The first evidence of this productive partnership approach was the Health and Wellbeing Strategy **Merton the Place for a Good Life** with a strong focus on reducing health inequalities and delivering prevention.

2.4 The annual public health report sets out the strong social and economic case for prevention and explains how the five themes of the Merton Health

and Wellbeing Strategy are helping to deliver this setting out examples of work in place and underway.

2.5 A slide set highlighting some of the key issues is attached in Appendix 1 of this report and the full Annual Public Health Report will be circulated at the Health and Wellbeing Board meeting.

3. NEXT STEPS

3.1 Much has been achieved but many challenges remain. More progress could be made to convince local decision makers about the importance of the public health approach and of working across a system to embed prevention and to reduce health inequalities. Using policy levers within the council for better health requires more will rather than financial resources, offering significant opportunities to create more fair and healthy communities in times of financial constraints.

3.2 Seizing this as an opportunity for focusing resources on keeping people healthier longer will also require an understanding that wellbeing is created through a combination of healthy people and economic prosperity, clearly priorities for all partners. Economic growth will only be sustainable where it sits alongside health and wellbeing to include more fair opportunities for all and where our high streets and town centres make the healthy option the easy one for individuals to take responsibility for their lifestyle choices.

We can use this as a catalyst for increased prevention. We will need the will to make difficult choices that reflect our values and priorities. We can grasp this opportunity to focus on keeping our residents healthy and reduce the significant health inequalities in Merton.

4. ALTERNATIVE OPTIONS
None for the purpose of this report.

5. CONSULTATION UNDERTAKEN OR PROPOSED
Not for the purpose of this report.

6. TIMETABLE
Not for the purpose of this report.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS
Not for the purpose of this report

8. LEGAL AND STATUTORY IMPLICATIONS
Not for the purpose of this report.

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The work of Public Health is focused on addressing inequalities of health.

10. CRIME AND DISORDER IMPLICATIONS

Not for the purpose of this report.

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Not for the purpose of this report. .

12. APPENDICES – the following documents are to be published with this report and form part of the report

Appendix I Merton Annual Public Health Report 2015 slides

13. BACKGROUND PAPERS

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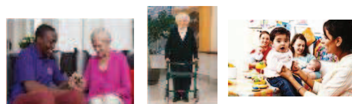
The Time for Prevention is Now

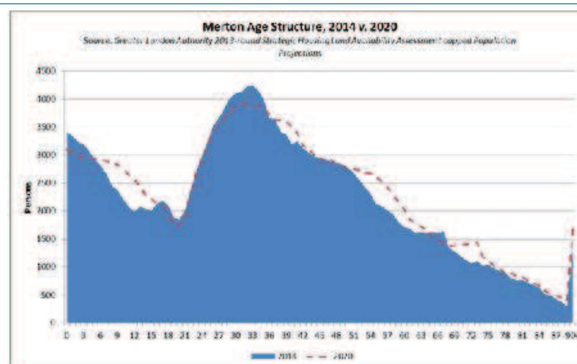
Keeping People Healthy Reduces Health Inequalities



Merton's Second Annual Public Health Report
2014/15

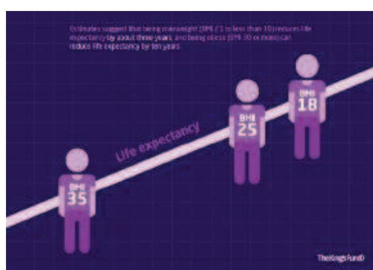
The Case for Prevention

- **Ageing population with changing health and social care needs**
- **Changing patient and public expectations** with greater choice demanded by patients
- **Advances in medical technologies**, including pharmaceuticals as knowledge expands to cure and extend life



The Case for Prevention

The Case for Prevention



Being overweight can reduce life expectancy by three years; being obese by 10 years

Smoking, diet, lack of exercise, and alcohol can contribute to poor health outcomes

The Case for Prevention

Every £1 invested in support for alcohol and drug addictions can return up to £5 in terms of savings to health and social care and criminal justice.

Work is good for your health as it increases self esteem and can reduce costs in terms of crime and health care

Health Impact Pyramid – a two pronged approach

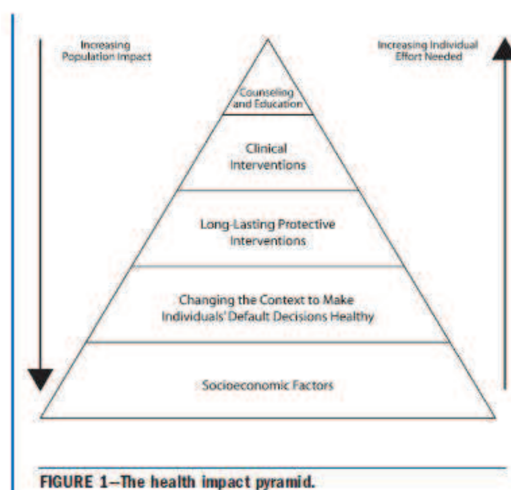
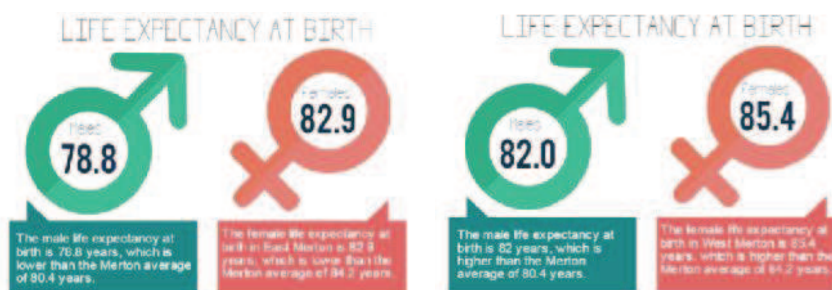


FIGURE 1—The health impact pyramid.

Merton the Place for a Good Life

East Merton | **West Merton**



The difference in life expectancy can be as much as 7.9 years for men and 5.2 years for women between the most and least deprived areas of Merton.

What we are doing in Public Health - Best start in life

From October 2015, Public Health took on commissioning of the Healthy Child 0-5 services, which includes health visiting and Family Nurse Partnership

Work on children and young people addresses inequalities through improved outcomes in readiness for school and school achievement, as well as embedding prevention.

What we are doing in Public Health - Good health

Merton on the Move is a cross borough physical activity campaign with a collective goal to travel the equivalent of 250,000 miles from Merton to the Moon.

Our Proactive GP pilot aims to embed prevention in GP practices

Age UK Handyperson subsidy scheme for Falls Prevention helps older, more deprived people to identify and reduce risks of falling

What we are doing in Public Health – Life skills, lifelong learning and good work

Support English for Speakers of Other Languages

- Classes that embed health messages, while providing language skills to increase control over one's life

Commission Healthy Workplace schemes

- Within the Council for staff to encourage healthy lifestyles and to ensure the Council provides healthy options

What we are doing in Public Health – Community participation and feeling safe

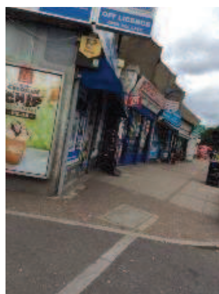
Work through communities to build resilience and capacity:

- **Health Champions**
- **Healthy Pollards Hill**
- **Contribute to reductions in social isolation of older people**

Merton Befriending Scheme provides face-to-face and telephonic befriending through volunteers on a one-to-one basis. In the first six months MBS has befriended and made a difference to the lives of 51 of the most vulnerable older people in Merton

What we are doing in Public Health – A good natural and built environment

Before



Public Health supported development of a Cumulative Impact Zone by working with local Youth Inspectors to audit alcohol availability and with Healthwatch Merton who organised a pop-up café to gather residents views

After

What we are doing in Public Health – Understanding Merton's Health

Developed user-friendly summary versions of the Joint Strategic Needs Assessment and Ward Profiles

Challenging Times – an Opportunity for Prevention

- Much has been achieved but many challenges remain
- More progress needed to convince local decision makers to embed prevention and reduce health inequalities
- Increasing financial pressures mean the focus remains on the more urgent health care and social care – but this could just be the catalyst for increased prevention
- Lets grasp this opportunity to focus on keeping our residents healthy and reduce the significant health inequalities in Merton.

Issues for consideration

- Can we agree that we should be using all our levers effectively to improve health?
- If so, which ones and how?